AMERICAN PSYCHOLOGICAL ASSOCIATION

Journal of Counseling Psychology

ISSN: 0022-0167

2023, Vol. 70, No. 5, 451–463
https://doi.org/10.1037/cou0000673

Ideals of Counseling Practice: Therapeutic Insights From an Indigenous First Nations-Controlled Treatment Program

Tony V. Pham[1], Rachel E. Wilbur[2], and Joseph P. Gone[2, 3]

[1] Department of Psychiatry, Massachusetts General Hospital, Boston, Massachusetts, United States
[2] Department of Global Health and Social Medicine, Harvard Medical School
[3] Department of Anthropology, Harvard University

Indigenous Canadians suffer disproportionately from mental health concerns tied to histories of colonization, including exposure to Indian Residential Schools. Previous research has indicated that preferred therapies for Indigenous populations fuse traditional cultural practices with mainstream treatment. The present study comprised 32 interviews conducted with Indigenous administrators, staff, and clients at a reserve-based addiction treatment center to identify community-driven and practical therapeutic solutions for remedying histories of coercive colonial assimilation. Thematic analysis of semi-structured interviews revealed that counselors tailored therapy through cultural preferences, including the use of nonverbal expression, culturally appropriate guidance, and alternative delivery formats. Additionally, they augmented mainstream therapeutic activities with Indigenous practices, including the integration of Indigenous concepts, traditional practices, and ceremonial activities. Collectively, this integration of familiar counseling approaches and Indigenous cultural practices in response to community priorities resulted in an innovative instance of therapeutic fusion that may be instructive for cultural adaptation efforts in mental health treatment for Indigenous populations and beyond.

Public Significance Statement

Thematic analysis of interviews with administrators, staff, and clients from an Indigenous-controlled addiction treatment center on a Canadian First Nations reserve identified two major ideals for counseling practice: *tailoring therapy through cultural preferences* and *augmenting therapy with Indigenous traditions*. Adherence to these ideals resulted in an innovative instance of therapeutic fusion that may be instructive for cultural adaptation efforts in mental health treatment for Indigenous populations and beyond.

Keywords: Canadian First Nations, mental health treatment, Indigenous traditional practices, cultural adaptation, communicative norms

The Indigenous peoples of Canada, comprising more than 630 distinct First Nations, Inuit, and Métis communities (Government of Canada, 2022), currently represent 5.1% of the Canadian population (Statistics Canada, 2021). Place-based connection to the land and environment since time immemorial has contributed to rich cultural and social practices that promote well-being outside of mainstream Euro-Canadian systems. Despite inherent strengths associated with deep traditional local knowledge and practice, the enduring impacts of colonialism—including socioeconomic and environmental dispossession, ongoing structural racism, and family separation through policies like the sixties scoop and Indian Residential School (IRS) system (MacDonald & Steenbeek, 2015; Sunga, 2017)—have directly resulted in some of the greatest health inequities of any population in the nation (Kim, 2019; Kirmayer & Brass, 2016; Nelson & Wilson, 2017; Okpalauwaekwe et al., 2022). Today, Indigenous Canadians suffer disproportionately from problematic substance use (Elton-Marshall et al., 2011; Wells et al., 2014), suicidality (Eggertson, 2015), depressive symptoms (Boksa et al., 2015), and other mental health concerns (Morton Ninomiya et al., 2020; Okpalauwaekwe et al., 2022). These outcomes are usually

This article was published Online First May 18, 2023.
Tony V. Pham https://orcid.org/0000-0002-3261-8185
Rachel E. Wilbur https://orcid.org/0000-0002-3008-962X
Joseph P. Gone https://orcid.org/0000-0002-0572-1179
This study was undertaken as part of the *Models and Metaphors of Healing Project*, led by J. B. Waldram. Completed under the auspices of the Canadian National Network for Aboriginal Mental Health Research (Laurence J. Kirmayer and Gail Guthrie Valaskakis, coprincipal investigators), the overall Healing Project was funded by the Canadian Institutes for Health Research. The University of Michigan Department of Psychology provided the senior author with discretionary research funds and research office space to facilitate early analysis of the data. In addition, transcription costs were underwritten by the research fund provided to the senior author during his tenure as a Kellogg Scholar in Health Disparities in 2003–2004. The authors have no conflicts of interest to disclose.

Data and study materials are not available for outside access.

Correspondence concerning this article should be addressed to Rachel E. Wilbur, Department of Global Health and Social Medicine, Harvard Medical School, 14 Story Street, Suite 400, Cambridge, MA 02138, United States. Email: rachel.elizabeth.wilbur@gmail.com

attributed to systematic assaults on Indigenous well-being, especially through the IRS system.

Briefly, the IRS system was officially initiated by the Canadian government in the 1880s. Inspired by the federal Indian boarding schools in the United States, IRSs were explicitly designed to remedy the nation's perceived "Indian problem" by forcefully severing family and cultural ties through coercive assimilation of Indigenous children into Euro-Canadian society (MacDonald & Steenbeek, 2015). The system functioned through government/religious partnership until 1969 and was not abolished until the 1990s (Royal Commission on Aboriginal Peoples, 1996). While enrolled, children as young as 3 years of age received substandard education and engaged in menial tasks, laboring to maintain school functions through activities like farming, cooking, and cleaning. Upon first entry, children's hair was cut, their clothing was destroyed, and they were forbidden from speaking their language or practicing their religion. Physical, mental, and sexual abuse was rampant (Royal Commission on Aboriginal Peoples, 1996). Many former attendees of the schools have reported experiencing significant psychological challenges in the years following attendance at the institutions (Bombay et al., 2014), and prior research has found elevated rates of anxiety, depression, and substance use among former attendees (Barnes & Josefowitz, 2019; Bombay et al., 2019; Hackett et al., 2016; Kaspar, 2014).

While Indigenous peoples in Canada differ dramatically in relation to geography, culture, religion, and language, they share a history of exposure to colonization through the IRS system (MacDonald & Steenbeek, 2015), which has profoundly impacted not only well-being but access to effective mental health care. Mainstream approaches to mental health treatment have demonstrated mixed success within Indigenous contexts when compared to other, non-Indigenous populations (Benoit et al., 2003; Geana et al., 2012; Gone, 2004; Harding & Oetzel, 2019; Hodge et al., 2009; McCabe, 2008). In addition to the direct impacts of discrimination by health care systems and providers (Boyer, 2017; Kitching et al., 2020), geographic barriers introduced by the isolated nature of many reserve populations (Friesen, 2019; Nguyen et al., 2020), and economic disparities experienced by many urban ones (National Collaborating Centre for Indigenous Health, 2019), divergent perceptions of wellness and approaches to healing between Euro-colonial and Indigenous perspectives have been noted (Lavallee & Poole, 2010). Efforts to address this disparity have focused on increasing the cultural competency of therapeutic providers, and even (in some instances) undertaking a more intensive integration of traditional Indigenous practices into mainstream therapy (Moodley & West, 2005; Nebelkopf & Phillips, 2004; Wendt et al., 2022).

These efforts stem from a growing recognition within diverse settings of the strength of Indigenous cultural practices as contributing to elevated well-being and Indigenous "survivance": the active presence, repudiation of dominance, and success in a postmodern world (Vizenor, 2008). Given the heterogeneity of Indigenous populations, these integrative approaches often experience the greatest success when tailored to the unique needs, culture, and history of specific Indigenous communities (Kowatch et al., 2019). Although decisions regarding cultural adaptations to mental health are frequently determined by distant experts, in this study, we focus on the cultural adaptations to treatment that were designed and implemented by local counseling staff and administrators. Importantly, all of these decision-makers—including providers—were Indigenous-identifying. Therefore, the therapeutic environment in which clients received care, and the specific nature of care provided, were designed with the specific needs of Indigenous people in mind. This enables a unique opportunity to draw important therapeutic lessons from this integrative effort, and may serve as a valuable exercise for developing similar integrative treatment approaches for other Indigenous communities and beyond.

In this study, we address the following research question: What community-driven practical solutions do Indigenous administrators and staff integrate with modern therapeutic practices to address the legacy of coercive assimilation through the IRS system for community members on a Canadian First Nations reserve? The insights gleaned from such inquiry may beneficially inform related cultural adaptations to treatment approaches for mental health problems across a wider variety of services and settings. Such adaptations might be especially useful for behavioral health providers, including counseling psychologists who work with Indigenous clients.

Method

This study is based on a fresh re-analysis of research undertaken in a Canadian Northern Algonquian First Nations-controlled treatment setting during 2003–2004 (see also Gone, 2008, 2009, 2011b). Although prior research reported the meaning of healing in this therapeutic setting, the present study sought to directly focus on discovering ideals of counseling practice as identified by Indigenous respondents in the original interviews. Given the salience of the colonial legacy for therapeutic activities undertaken in this treatment setting, the paradigm for inquiry that shaped this study was the critical-ideological paradigm (Ponterotto, 2005). Despite the time that has passed since the interviews were initially collected, these perspectives remain an important and underexplored avenue of inquiry within counseling psychology.

The study team consisted of the senior author, a clinically trained American Indian research psychologist (*Aaniiih*-Gros Ventre) who conducted the initial interviews and directed and supervised the research, the first author, an early career Vietnamese American psychiatrist who led analyses and contributed to the writing and revision of this article, and the second author, a mixed-race American Indian/White (descendant Tolowa, Chetco) early career biological anthropologist who contributed to analyses, writing, and revision of this article. All three authors have extensive experience conducting research around health in American Indian and First Nations settings.

Background

In-depth interviews occurred at a reserve-based addiction treatment center (or "Healing Lodge"), a comprehensive description of which has been previously documented (Gone, 2008). In brief, the center was situated in a northern reserve (reservation) in Manitoba. Starting in 2000, the center received funding from the Aboriginal Healing Foundation (AHF), the Indigenous-led nonprofit initially funded by the Canadian government established to respond to the legacy of abuse stemming from the IRS system. Toward this aim, the center developed a 10-week, structured program of "holistic healing" that sought to promote and enhance Indigenous identities and practices alongside contemporary mental health treatments and healthy coping skills.

Clients were known to suffer from intra- and interpersonal issues, with many turning to substance abuse in the absence of alternative coping skills and robust cultural identity. Nearly all participating staff and counselors working at the center were members of the First Nations community in which the center was located. While most counselors from the center had not completed formal degrees in counseling, all received training through routine opportunities offered by regional seminars and workshops, sometimes sponsored by the Healing Lodge. Over the course of 7 weeks between October 2003 and May 2004, the senior author conducted 32 semi-structured, one-on-one interviews (including one joint interview) to document the center, its objectives, and its approach to healing in case study fashion (Gone, 2008, 2009, 2011b; Prussing & Gone, 2011).

Participants

Current and former administrators, counselors, and outpatient clients of the center were recruited in person for participation in this study by center staff. While participants were not systematically screened, staff employed purposive sampling methods to select a wide variety of individuals with knowledge about the center and its objectives. Participants were consented and interviews were conducted until data saturation was achieved. In accordance with center leadership wishes, all participants received university-branded merchandise for their participation. No participants refused participation when approached.

Ultimately, 33 participants with experience or expertise related to community healing were recruited, including 11 former outpatient clients, three administrators (one past executive officer, one current executive officer, one counseling program coordinator), 14 service providers (including nearly all counselors employed by the center), and five other community members with close ties to the center (e.g., board member, cultural practitioner). Clients (36% female) ranged in age from 20 to 62 years old (median 30 years age) with eight having completed the program. All clients had parents or grandparents who participated in residential schooling with two participating themselves.

By focusing on this variety of respondents, this study takes a novel approach to integrative program evaluation by including providers as the unit of analysis. The successful integration of traditional and mainstream approaches to mental health treatment for Indigenous populations requires knowledge and lived experience in tandem with formal mainstream training, with significant potential to inform future program development.

Measure

The senior author conducted all interviews, drawing on his prior personal experience and professional expertise with respect to American Indian reservation life in the USA to interact and engage with other Indigenous respondents in this Canadian First Nations reserve setting. Interviews followed a semi-structured, open-ended format in which the participant's personal identity and history were solicited during the first half of the interview (e.g., "How would you describe your [Indigenous] background?") and questions about therapeutic activities and beliefs were queried in the second half (e.g., "What is healing as you understand it?"). Interviews with counselors also followed a counselor interview protocol (Waldram, 2008) without modifications. Questions from the counselor interview protocol included "What kind of training is needed to work with your clients?"; "How would you describe your [therapeutic] approach?"; "What makes [for] a good therapist?"; and "What challenges do you face in your efforts to heal?" The semi-structured nature of the interviews allowed for rich elaboration by participants while still allowing for comparability across interviews by the research team.

Procedure

The senior author was invited to conduct this study as part of a multisite project funded by the AHF to document Indigenous community healing practices by grantees (Waldram, 2008). The community consented to participate in the research, which was approval by the institutional review board at the University of Michigan. Prior to the interviews, only administrators and service providers had prior contact with the senior author. During interviews, only the senior author and the interviewee were present. Interview duration ranged from 29:17 to 279:58 min, with most lasting about 80 min. Each in-depth interview was audio recorded by the senior author and transcribed by research assistants into Microsoft Word. Given the elapsed time between the initial study and this article, no participants were available to review the analysis; however, a prior comprehensive report of the study was submitted to program administrators and counseling program staff for their review and approval.

Data Analysis

Thematic analysis was selected as the appropriate analytic approach. Thematic analysis is a qualitative method for analyzing and organizing patterned data into codes and themes. Given the potential for deep nuance, thematic analysis allows for the wide and fine-combed exploration of respondent meaning-making. While prior literature has discussed the metalinguistics of therapeutic talk within the context of substance abuse (S. E. Carr, 2010) and Indigenous communities (Darnell, 1981, 1991, 2006; Farnell, 1991, 1995), the first author elected to conduct this thematic analysis using an inductive, or data-driven, approach around the assumptions of talk therapy, identifying latent themes based on ideas and assumptions that underlie what respondents conveyed in their interview responses.

To ensure a deliberate, rigorous, and theoretically sound thematic analysis, the authors followed a six-phase guide and 15-point checklist for good thematic analysis by Braun and Clarke (2006, 2022), in which each of the authors is trained and experienced. For phase one (Familiarizing yourself with your data), the first author read the transcripts twice to become familiar with the depth and breadth of the data. Throughout these readings, he noted initial ideas for patterned meanings (codes). For phase two (Generating initial codes), the first author used the qualitative analysis software program *NVivo* to formally code the data according to its explicit (semantic) content. The senior author verified the codes against the original interview transcripts. For phase three (Searching for themes), the first and senior authors sorted repeating patterns of codes into themes. These themes took on a hierarchical level with themes nesting inside other themes (subthemes and themes).

The first and senior authors cross-examined each theme to ensure fidelity across retained and collated textual extracts of each theme.

For phase four (Reviewing themes), the first and senior authors refined these themes by judging their validity, accuracy, and meanings in relation to the original data. This involved rearranging, breaking down, and interrogating for internal and external heterogeneity, ensuring that data cohered within clear, consistent, and distinct themes. All authors developed a thematic map to illustrate these relationships (see Figure 1). For phase five (Defining and naming themes), authors named each theme by matching the underlying patterns and distinctions. For the sixth and final phase (Producing the report), authors documented the analysis using a unifying narrative that went beyond description of the data by describing the themes, subthemes and codes within a coherent and logical story. Except for being unable to consult the original participants for review of these findings, this analysis and presentation adheres to all 15 criteria of Braun and Clarke (2006) list of criteria for good thematic analysis.

Moreover, we have attended to all 77 items identified by Levitt et al. (2018) with respect to journal article reporting standards for primary qualitative research in psychology. Finally, owing to prior arrangement with the relevant reserve community, data and study materials are unavailable for outside access.

Results

In addressing our research question, we focus on respondent-designated ideals for how talk therapy should be practiced for Indigenous clients at the center. These ideals, identified through our analysis as two major themes, included *tailoring therapy through cultural preferences* and *augmenting therapy with Indigenous traditions* (see Figure 1). Names attributed to quotations are pseudonyms. A summary of these two themes and their key components can be found in Table 1.

Tailoring Therapy Through Cultural Preferences

According to interview respondents, talk therapy-as-usual should be tailored through Indigenous cultural preferences with respect to nonverbal expressions, seeking counsel, delivery formats, sharing stories, and expressing humor.

Nonverbal Expressions (n = 27)

Twenty-seven participants emphasized the utility of nonverbal expressions during therapeutic talk. Nonverbal communication can express therapeutically important meanings, and within modern talk therapy is an important element of patient–provider interaction. Within some Indigenous cultures, nonverbal communication can be as important verbal expressions. Respondents identified three relevant forms of nonverbal expression.

Crying (*n* = 23). While crying is often considered to be an atypical form of Indigenous expression, 23 participants maintained that crying could be an important expression during talk therapy. In the face of cultural expectations and personal hardship, Clara (staff) described how Indigenous people still needed to cry: "I didn't want people to see me crying because growing up we were always told not to cry, that it didn't help anything. You can get sick from holding all this negative stuff inside."

Silence (*n* = 14). Unlike crying, silence has been identified as an integral component of communication for many Indigenous populations, and within this study, 14 participants described how Indigenous individuals may elect to express themselves through silence. Participants contextualized silence as an Indigenous coping strategy that contrasted with the strict rules imposed by boarding schools. As Margaret (staff) described: "In boarding school we were always told not to speak up [so], you know, we're always quiet." To a certain extent, participants viewed the inclusion of silence within therapeutic talk as a form of restorative justice. As George (administrator)

Figure 1

Thematic Map for Analysis of Ideals of Indigenous Counseling Practice (With Number of Respondents Endorsing Each Theme or Subtheme)

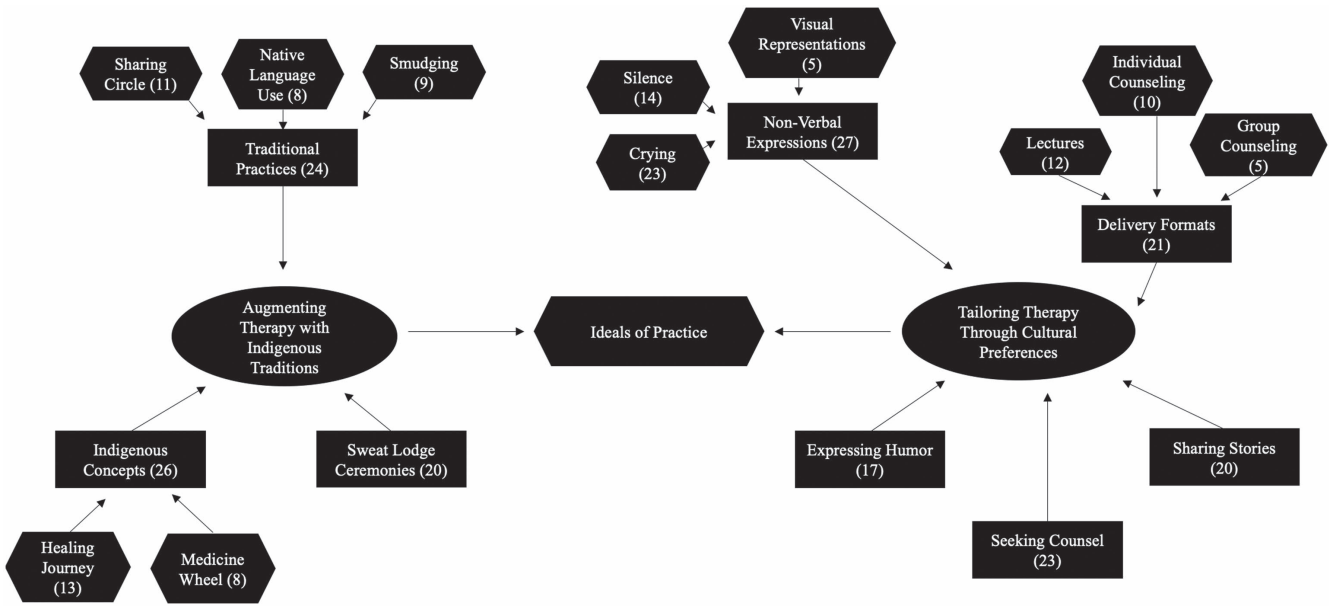

Table 1
Key Components of the Two Major Themes for Ideals of Indigenous Counseling Practice

Themes	
Tailoring therapy through cultural preferences	Augmenting therapy with Indigenous traditions

Nonverbal expressions
• Important aspect of therapy in many Indigenous communities. May include:
  ○ Crying
  ○ Silence
  ○ Visual representations
• Frequently overlooked in mainstream therapeutic models
	Indigenous concepts
	• Healing journey as spiritual endeavor
	• Medicine wheel
	  ○ Fosters integrative connection
	• Aligns with Indigenous perceptions of wellness rather than biomedical perceptions of health

Seeking counsel
• May be valued over receiving advice
• Adheres more closely to traditional forms of communicating guidance and sharing wisdom
	Traditional practices
	• Sharing circles
	• Smudging
	• Native language use
	• Promotes client confidence in counseling
	  ○ Provides appropriate, culturally familiar context
	  ○ Avenues for issuing guidance rather than advice (see Seeking Counsel section)

Delivery formats
• Format should vary according to context
• Lectures
  ○ Deemphasize the individual, reduce risk of stigma
• Individual counseling
  ○ Encourages agency
• Group counseling
  ○ Encourages social interaction
	Sweat lodge ceremonies
	• Sacred format to engage with human and nonhuman participants
	• Culturally appropriate
	• Confidential

Sharing stories
• Mutual, both counselor and client
  ○ Client: Opportunity to process experiences
  ○ Counselor: Opportunity to provide gentle, culturally appropriate guidance	

Expressing humor • Important communication tool for Indigenous peoples • In therapy, assists in navigating challenging topics	

mentioned, "You know, something has to be there for community members that are still suffering and in silence." Nevertheless, participants refrained from categorizing emotional silence as a pan-Indigenous concept. Lucy (staff) commented on how silence may even confuse certain Indigenous individuals: "Even my colleagues didn't understand the use of silence with [Indigenous] people." The emphasis on silence as an important form of Indigenous communication by participants, particularly in relation to experiences of trauma, demonstrated the importance of tailoring communication strategies to both the population and situation.

Visual Representations ($n = 5$). In addition to physical expressions, or lack thereof, five participants described how Indigenous individuals may choose to express themselves through visual demonstrations, illustrations, or drawings in addition to or instead of verbal communication. As Andrew (staff) stated:

> The other part that I use as a part of therapy is the drawing. It's self-explanatory. It talks about their trails where they've been. You recognize their drawings. You don't even have to say anything. They say it their own way. That arts and crafts. It might seem innocent but you do a lot of therapy there. That's when you really hear them talking.

Expression through visual representation therefore provided opportunities for clients to express difficult or nuanced experiences or thoughts through alternate modalities and in ways that may not have been possible through verbal expression.

Seeking Counsel (n = 23)

Twenty-three participants identified similarities between traditional approaches to seeking counsel or guidance and talk therapy. In particular, 12 participants related the appeal of seeking counsel to its historic role within Indigenous traditions and ceremonies and distinguished between "guidance" and "advice." Whereas participants associated advice with professional therapists and counseling, participants associated guidance with nonprofessional individuals and words of wisdom. For example, therapists could offer anecdotes from their own lives to guide a client. As Albert (staff) explained:

> I've come to learn that we don't give advice, that we give guidance. I have to give guidance in the best way we know how. By illustrating my own experiences. And the next thing you know, they're telling you their life story about this particular relationship. And then they come to a

> point where they come to a new realization, "Hey, it's not the relationship, it's me that I have to change." So that's makes a big difference.

Thus, in contrast to advice, guidance appeared to entail the sharing of firsthand personal experiences.

Participants also maintained a flexible classification for who could deliver guidance. For example, 13 participants viewed Elders as a prime source for nonprofessional counsel in light of their central role within Indigenous communities. As June (staff) expressed:

> In my recovery I went into a counseling session. I talked to the Elders. I told them what my problem was. So they said "Well, if you're going to help the people in the community, you have to help yourself first. You have to heal yourself first." I'm glad they [the Elders] were there at that time.

In this way, seeking counsel emerged as important for not only clients but counselors as well, adhering to traditional Indigenous practices of honoring and valuing the life experiences and guidance of Elders.

Delivery Formats (n = 21)

The format in which talk therapy was delivered emerged as an important theme within this population. Overall, 21 participants discussed the relevance of talk therapy's format and six participants agreed that the format of talk therapy should vary according to the context or person. It was perceived that the presence of a variety of formats enabled clients to benefit in different ways from each. As Jennifer (client) noted: "There'd be one counselor here one week, another one the next week, another one next week. It wasn't just one person. It was awesome." Nancy (staff) elaborated:

> When you go to these sharing circles and you hear other people talking about their stories, talking about themselves, what they went through, what they did to help themselves, their struggles, the good things, the bad things, it gives me ideas of what I need to do for myself. Then there's the one-on-one sessions that we do and we brainstorm.

Respondents identified three distinctive delivery formats in particular.

Lectures ($n = 12$). Lectures were raised as one of the important forms of talk therapy, with 12 participants noting specific reasons why counselors and clients may prefer lectures over other formats. From the counselor's perspective, lectures offered a broad venue for talking about general Indigenous concepts. From the client's perspective, lectures shifted the attention away from the attendee toward the lecturer, thus mitigating anxiety around being singled out, especially with respect to negative labeling that clients experienced outside of treatment. Chris (administrator) commented on the appeal of lectures among those not yet ready to share: "I saw people crying because they envied us for being able to speak on our experiences, and they couldn't bring themselves to do it themselves. I guess they aren't able to bring it out."

Individual Counseling ($n = 10$). While many participants endorsed the benefits of lecture-based approaches, others appreciated formats which allowed greater agency and privacy. This appeared to be particularly important given the small population of the reserve community in which the counseling center was located. Ten participants favored individual counseling for specific circumstances.

For example, individual as opposed to group therapy may benefit those who need to confront sensitive topics over multiple and/or long sessions. As Carmen (client) noted:

> What I found most helpful [was] the one-on-one. I was able to share some things that I couldn't share with the group. For one thing, I always felt silly about that story I just told you about, about being in the hospital and how I was being treated there. And then being in school and how it was there. And also some things that happened in the home. [The counselor] was the one that helped me get through my grief. I never really showed anyone in the group the real me, show my feelings. I'm always trying to be like I'm strong, you can't hurt me, nothing has hurt me.

Because some participants feared gossip within the community, individual sessions offered more privacy for subjects deemed too sensitive to discuss in group sessions. Elaine (client) noted the interconnected nature of community, privacy, and reputation:

> We did a lot of counseling. We'd talk, open up in public with members of the group. At first, I had a rough time answering questions. Because I felt out of place. Shy, most of the time. I didn't want to say anything to harm my reputation.

This example demonstrates the value of diverse delivery formats, as the appropriate form may differ for clients at different stages of their recovery process, and may also enable the navigation of powerful social pressures.

Group Counseling ($n = 5$). Finally, five participants described the importance of group counseling sessions for socialization and distraction from life's everyday stressors (e.g., addiction). Like lectures, group sessions allowed for attendees to find healing without feeling labeled. As Meredith (client) stated:

> It's lots of fun once you get in there and start listening. Because you listen to funny stories and all that. When it comes to your turn to speak, you just introduce yourself and all that. You won't have to say that you're an alcoholic or not, because you're not.

Thus, while lectures and individual counseling offered anonymity that was greatly valued by participants given the intimate nature of the community, group counseling introduced opportunities to build social cohesion and comradery during the often-challenging healing process.

Sharing Stories (n = 20)

While the environment in which therapeutic interactions occurred was clearly important to the participants in this study, they also emphasized the specific format in which experiences were shared by clients and guidance was provided by counselors. Twenty participants described how sharing stories could improve therapeutic talk. On one hand, clients could share their own stories to confront and move on from the past. On the other hand, counselors, like Elders, could share lessons or parables to guide clients toward healthy lifestyles.

For example, Albert (staff) relayed a story about one of their mother's lessons:

> I remember times when I would be hurt emotionally by something that happened, so my mom, she would take me out in the bush and she'd start telling me about certain herb. And even though I wasn't paying attention, she would see a little animal, say, a squirrel. And then she'd

> tell me about this squirrel … And she'd tell me all about these birds, like who cares, eh? And then pretty soon I forget about my problem … Like 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. 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. But I didn't realize then. See? I didn't realize what they were doing. But in the end, my mother especially, sharing this with me … it put my problem in a different perspective.

In much the same way that talk therapy was compared to Indigenous approaches to seeking counsel, storytelling was described as a culturally appropriate means of conveying guidance. One participant, Greg (client), recalled a lesson he received from an Elder:

> I used to talk to an Elder. [I asked] "Why do you feel this way?" An Elder would say, "No, I won't give you any advice." [Instead], he or she would tell you a story, and in that story you have to pick up what it is he's trying to tell you. I was confused "Yeah, okay." 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 Indigenous style, they tell a story and from that story you've got to tell what he's trying to tell you.

Receiving guidance from Elders in the form of stories, either those with official status or those older than the respondent (as in the case of Albert and his mother above), provided yet another means of indirect advising that requires individual engagement in the process rather than passive reception.

Expressing Humor (n = 17)

In addition to stories, 17 participants emphasized the important role of humor in both Indigenous culture and talk therapy. As Lucy (staff) tersely put it: "We know how to use jokes." Albert (staff) further illustrated how humor can help Indigenous individuals to confront and move on from the historical trauma of Euro-American oppression, forced boarding school, and postcolonial pathology, saying:

> One of the things that helped them [Native peoples] is their humor. Because I see that everywhere I go in our Native communities. Laughter is a good medicine. And I think that's what kept them alive, having gone through so much oppression. Their culture being banned, their cultural ways, through the residential school system, through Christianity, the Church, through the legal system, through that whole government.

Katherine (staff) described similar words of wisdom from an Elder:

> For a counseling session to be effective, in the words of one Elder, "If you can't make this person at least smile before getting down to work, you're in trouble and that person is in trouble." Ideally, you'd have this person holding their stomach laughing through the jokes you've told at the outset of the session before you start tackling the problems.

Nevertheless, Gloria (staff) offered a sober reminder that humor should always be complemented with a serious discussion about the matter at hand:

> They can laugh about things that are really traumatic, because it's already happened and they can talk about and laugh about it. [laughs]. That's just the way we are here in [Reserve], and I'm able to converse with them in the [Program]. And we can laugh about it. But we come back to it and say, "Okay, well, what did you learn from that? How did you feel back then?"

Thus, humor offered both a therapeutic means as well as a culturally acceptable opening for conversations around trauma.

Augmenting Therapy With Indigenous Traditions

While tailoring therapy through cultural preferences played a significant role in the therapeutic approach developed by the center, augmenting mainstream therapy practices with Indigenous traditions was also described as ideal. These traditions broadly included Indigenous concepts, traditional practices, and sweat lodge ceremonies.

Indigenous Concepts (n = 26)

While talk therapy has its foundation in secular, professional, and biomedical conceptions of mental health and healing, 26 participants emphasized the critical role that the integration of Indigenous concepts into mainstream talk therapy can play in improving relatability and success within this reserve-based patient population. Respondents identified two such concepts.

Healing Journey (*n* = 13). Thirteen participants described how talk therapy is a "healing journey" for the spirit. This journey metaphor invokes a lifelong process of therapeutic endeavor that attends to sacred matters. As an example, Albert (staff) described this healing journey in the context of a vision quest:

> [In] a vision quest, a person asks for guidance from the spirit world as to what the future holds for that particular person, for whatever particular reason, whether it be in any one of the four aspects of their being. [Let's] say they have maybe an illness. Maybe they're worried about whatever. Whatever they're worried about, whatever is perplexing their lives, they'll be able to have a better perspective again. A better perspective as to which direction to go, or which direction not to go.

In this way, the therapeutic process was aligned with traditional perceptions of healing as a spiritual process, guided by counselors or Elders, but ultimately undertaken alone.

Medicine Wheel (*n* = 8). In addition to sacred attention and spiritual guidance, participants identified the Medicine Wheel—a circle comprised of four quadrants that symbolizes holistic health and balance for many Indigenous communities—as a useful concept to integrate with other elements of talk therapy. Eight participants described therapeutic processes as an opportunity to holistically integrate the four aspects of the self—mind, body, spirit, and emotion—with respect to the Medicine Wheel. Amelia (staff) described the importance of merging talk therapy and the Medicine Wheel to foster such integrative connection:

> A lot of different [Indigenous] people and First Nation's people use the Medicine Wheel. They follow that in terms of their programs. And then in my lectures I talk about the Medicine Wheel and how everything is connected and interconnected. And then I show a graph of what [element] sits in each [of the four] direction[s].

The integration of the Medicine Wheel alongside mainstream therapeutic approaches provided an opportunity to attend to the holistic person—mental, emotional, physical, and spiritual—in

ways that may better address problems stemming from multifaceted legacies of adversity such as the IRS system.

Traditional Practices (n = 24)

As with the integration of Indigenous concepts into talk therapy, the inclusion of other traditional practices similarly emerged as a common theme. Twenty-four participants considered such Indigenous traditions to be a critical aspect of talk therapy. Such traditions were perceived as promoting client confidence in the counselor by providing a culturally familiar context. Other participants reflected that the integration of Indigenous traditions made therapeutic talk appear less directive or advice-based (per above), which discouraged client attendance, and more in line with traditional approaches to guidance, which encouraged attendance. Three forms of traditional practice were described.

Sharing Circle ($n = 11$). Eleven participants identified sharing circles as a culturally appropriate form of group therapy. Sharing circles afford a ritual opportunity for participants to talk one after another without interrogation or interruption (i.e., in a sequence of monologs). These participants indicated that sharing circles could provide a naturalistic and informal setting that facilitated rather than hindered the sharing of sensitive information. Anna (client) discussed the therapeutic essence of sharing circles:

> We had sharing circles. It's where people sit around and talk about their life and their problems, how they were going to resolve them, their past, and their future. It was more to do with letting go of your burdens. Like child abuse, sexual abuse.

Another participant, Danielle (administrator) recalled the humble appeal of sharing circles. Although officially a component of the therapeutic program, the traditional approach was perceived to be both educational and healing:

> All these people are sitting in a big circle on the floor of all things. I remember all these muddy rubbers and boots by the door. And so I took off my high heels and I was trying to find a clean spot to put them in [laughter]. I had no idea what they were doing. And he was explaining about the Eagle Feather. And they were passing around this rock, like a stone, eh? And they were talking. And that was my introduction to our ceremonies. That was the best thing that ever happened to me. Cause I started to learn then.

In this way, sharing circles functioned as a traditional approach to group therapy that encouraged education, pride in Indigenous identity, personal autonomy, and the reduction of feelings of isolation.

Smudging ($n = 9$). Smudging, the burning of sacred plants as a means of purification, was another traditional practice that was frequently mentioned by study participants. In total, nine participants stated that smudging could help individuals overcome their fear of speaking. Meredith (client) described the flexible, instinctive talking environment that smudging engendered: "The first time I smudged, it just felt different. My body felt different. All the things in you just went down. I could speak better and say whatever. You don't think from your mind. Your emotion speaks for you." Through purification, therapeutic spaces were reclaimed, becoming traditionally safe, and thereby contributing to some clients' comfort in engaging with counselors and each other.

Native Language Use ($n = 8$). The use of Indigenous language is an essential component of many of the place-based and traditional knowledges which were threatened by assimilative residential school policies. Eight participants alluded to this by stressing the benefit of including Native language in talk therapy, highlighting the importance of language in the reclamation of lost traditions. Amelia (staff) described the familiar appeal of speaking in one's Native tongue:

> Our people, their first language here is [Native Language], and the second language is English. So a lot of times when our people talk to clients, they'll talk to them in [Native Language]. They'll counsel them in [Native Language]. That's why it's unique and different.

Conversing through Native language also facilitated access to unique, nonbiomedical terms for well-being and distress. As Greg (client) noted: "It's usually done in [Native Language] because it's more meaningful. That's the [Native Language] way to speak your own language. More meaningful than using all these technical terms in the Western style." Using traditional language rather than English is a practice of survivance, through reclamation and resistance, and may contribute to healing from culturally assimilative practices like the IRS.

Sweat Lodge Ceremonies (n = 20)

In addition to traditional practices, 20 participants endorsed the importance of formal ceremonies, particularly the sweat lodge ceremony, to augment therapeutic talk. These ceremonies offered a ritual format in which to talk, typically through prayer. Albert (staff) discussed the open and yet confidential nature of talking during formal ceremonies:

> Through ceremonies, through sweat lodges, through fasting, through vision quest and through healing circles or talking circles, we express to one another in confidentiality 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 … We can talk openly to one another because that trust is already there. It stays in there. It comes out in the way that person presents themselves, as you well know, our nonverbal often gives us away.

Different formal ceremonies presented different opportunities with relation to the center's therapeutic goals. Sweat lodges served as a venue for both therapeutic talk and problem solving, a topic mentioned by 18 participants. Albert (staff) further detailed the sweat lodge ceremony:

> The sweat lodge ceremony … It's a sacred ceremony [that] addresses all four areas of our being. It cleanses physically, mentally, and emotionally and spiritually, because in our cleansing ceremonies 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, the dark cloud above our heads. It gives us that opportunity to release. It gives us the opportunity to share with one another whatever teachings that have been passed down to us from our Elders. If we're sincere about the ceremony itself, we come out of there feeling refreshed in all areas. 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." You have a clearer picture as to how to go about it. And you have the support of all those people in that circle.

Similarly, Nancy (staff) noted the inviting and pressure-free environment of sweat lodges:

> There are things happening in the community, like sweats. Go to those. Just go, you don't have to say anything. You just observe for a while, and if you feel comfortable, share some of whatever it is you want to share. I encourage them to reach out for that help if they need it, even if it's just for someone to be there and to listen to them.

Sweat lodge ceremonies therefore provided multiple distinctive ways of integrating traditional and mainstream approaches to healing for participants in this study.

Discussion

Based on thematic analysis of interviews, we sought to determine what community-driven practical solutions Indigenous administrators and staff adopted alongside modern therapeutic practices to address the legacy of coercive assimilation through the IRS system for Indigenous clients in a Canadian First Nations reserve-based addiction treatment center. We found that counselors actively tailored therapy to the cultural preferences of the community while also at times directly augmenting mainstream approaches with culturally salient Indigenous traditions. Clients and staff noted this most frequently in relation to acceptance of nonverbal forms of communication, seeking counsel in ways that emphasized guidance rather than advice, and incorporating both Indigenous concepts and traditional practices into treatment. What is most striking about these strategies is their significance as forms of cultural adaptation designed to accommodate and therapeutically benefit Indigenous clients. Two underlying principles appear to drive these cultural adaptations: preserving personal autonomy and recasting therapy as a sacred endeavor.

Preserving Personal Autonomy

In her work with Plains Cree communities, cultural anthropologist Darnell (1981, 1991) traced cultural norms of communication that privileged indirection in speech, ambiguity in interpersonal interactions, and marked reticence—or even silence—in public forums. She traced these normative behaviors to a sacrosanct regard for protecting and preserving the autonomy of persons (whether human or nonhuman), which renders talk—especially talk in public in which one risks making demands on, overlooking, criticizing, or otherwise offending others—a potentially hazardous affair. Indeed, she highlighted community metaphors that captured this commitment, including stars that pass each other in the night sky without touching, or circles that touch only at their perimeters without overlapping. Moreover, Darnell described typical Elder speech as representing these cultural commitments, in which Elders who are consulted by younger community members often respond with monological narratives of firsthand experience that listeners are themselves responsible for applying to their own circumstances. In this modality, Elders do not tell younger persons what to do, or even what an experience means, as this would infringe on personal autonomy. Although the present study was undertaken with a different Cree community, Darnell proposes that the cultural commitment to preserve personal autonomy may in fact be universal for Indigenous peoples in Canada and the United States. This work is important insofar as it furnishes a cultural logic for understanding several ideals of therapeutic practice identified by staff and clients at the center.

Specifically, respondents at the center appeared to exhibit tacit regard for personal autonomy by incorporating Indigenous communicative norms into their ideals of practice. Nonverbal expressions (including silence, crying, and visual representations) obviously attenuate the interpersonal hazards of public speech (in which inadvertent offense might be given). Seeking counsel entailed a pursuit of "guidance" rather than "advice" in ways that reflect the commitments of Elder speech. As a delivery format, lectures entail one-way information-sharing that protects the autonomous person who may not wish to share in public for a host of reasons (including concerns about giving offense, confidentiality, and harm to family reputation). Sharing stories affords a conveyance of firsthand personal experience that need not include overt prescription of lessons learned or steps to be taken. Practicing regard for personal autonomy may have been an essential component of the therapeutic practice at the center due to the dehumanizing IRS experience of many clients, which entailed routine violations of personal autonomy. Therefore, the incorporation of culturally appropriate forms of communication which enabled the dignity of intact personal autonomy was likely a crucial component of therapeutic practice for adults experiencing enduring ramifications of IRS attendance. Critically, to be effective, these forms of communication must be practiced equally by all members present within a given social setting, which in this therapeutic environment included both counselors and clients.

Recasting Therapy as a Sacred Endeavor

Counseling psychology has long celebrated the pioneering work of American Indian psychologist Eduardo Duran, who developed the concept of the "soul wound" in relation to postcolonial Indigenous well-being. At its core, Duran perceives the soul wound, a spiritual injury, as resulting from colonization (Duran, 2019). Given the reality of Indigenous peoples' contemporary experience within a colonized world, Duran's novel approach to treatment for the soul wound involves the "alchemical amalgamation of Western theory and [Indigenous] theory and practice" (Duran, 2006, p. 1). That is, Duran embraces elements of mainstream counseling techniques but appropriates and recontextualizes them for Indigenous use. Importantly, this innovative adaptation hinges primarily on conceiving and practicing the therapeutic as a sacred affair. Specifically, Duran's "soul wound therapy" overtly frames counseling sessions as ceremonial encounters (marked as such by prayer and offerings) and recasts personal problems (such as addiction or trauma) as living spiritual entities who must be engaged ritually for healing and recovery to occur (for a comparative analysis of Duran's soul wound therapy with traditional American Indian doctoring practices, see Gone, 2010).

Counselors at the center employed a similarly integrated approach to therapy, utilizing mainstream formats for intervention delivery while transforming the practice itself from secular to spiritual in orientation. Earlier publications from this research underscored the onus behind this shift as dependent on staff perceptions that effective treatment would necessarily include spiritual elements (Gone, 2011b). The current analysis revealed this shift occurring through concrete structural-level adaptations in center programs. For example, Indigenous concepts of the healing journey and the medicine wheel both attend overtly to the spiritual facet of human existence.

Traditional practices such as smudging entail the burning of sacred plants for purposes of cleansing and prayer, while the sharing circle is essentially the Alcoholic's Anonymous meeting format, minus the confession of powerlessness over alcohol but plus a formal ritual demarcation and a passing of a sacred object while sharing. Finally, the sweat lodge ceremony is a primary traditional Indigenous means for religious expression, including prayer and petition for health, help, and long life. The incorporation of spirituality in this fashion is likely an essential component of successful therapeutic approaches with North American Indigenous populations due to perceptions of holistic wellness that emphasize spirituality in ways that so clearly differ from biomedical definitions of health (Gone, 2016; Wendt et al., 2022; Wendt & Gone, 2016).

Structural Constraints of an Integrative Approach

Despite the important accommodations to include culturally appropriate and traditional practices that were identified by staff, the center also retained an underlying psychotherapeutic structure that included a central mandate in the context of talk therapy to *cathart negative emotions through verbal disclosure of past personal pain* (Gone, 2008, 2009, 2011b). This disclosure-and-catharsis mandate for participation in therapy sits in clear tension with other forms of indirect communication and protection of personal autonomy that were designated as ideals for counseling practice by Indigenous respondents. Within interviews, clients identified this discomfort by noting a disinclination to share within group settings, finding it hard to answer direct questions, and expressing concern about possible harm to individual reputation. As reported in prior work by Prussing and Gone (2011),

> the implicit commitment by advocates of cultural competence to preserving [self-referential talk] [as a] basic tenet of professional intervention can present formidable problems in postcolonial Indigenous societies where enduring norms governing who talks with whom (and under what conditions) depart substantially from the psychotherapeutic mandate. (p. 389)

Insistent adherence to such mandates—for example, by counselors who consider themselves to have benefited firsthand from these practices—may limit client benefit and participation, despite the presence of additional culturally aligned elements (Gone, 2010, 2011a). Indeed, this work identified client unease with facets of prescribed talk therapy as both stemming from culturally discordant expectations surrounding communication and representing a keen divergence from historical healing practices for the community (Gone, 2011b). While shared histories of colonialism and dispossession may result in similar discrepancies between culturally tailored approaches to therapy with respect to wellness needs in Indigenous communities, it is likely that the appropriateness of specific elements of mainstream talk therapy depends on the historical and situated contexts in which care is desired, needed, and offered. One important set of contexts in this respect are those Indigenous communities that continue to contend with the long legacy of coercive, government-mandated education for assimilation. For survivors of these schools within such community settings, the autonomy-reducing legacy of the IRS system may require additional innovations that further downplay treatment requirements based on key attributes of therapy culture, such as psychological mindedness and authentic verbal self-expression (Gone, 2021b).

Implications for Indigenous and Professional Treatment

Previous work has identified the success of the center at integrating traditional Indigenous cultural elements into mainstream therapeutic practice in both structural and deep structural ways (Gone, 2008; Prussing & Gone, 2011). Despite the reality that participation in treatment was mandated for the majority of clients, both clients and staff perceived elements of the center's approach to be effective at improving well-being. Findings from this analysis provide further support for the importance of thoughtful and respectful integration of Indigenous traditions and approaches to healing into mainstream talk therapy, while concurrently indicating potential pitfalls in application. Thus, recommendations for future interventions for Indigenous communities include strategies for embracing alternative approaches to communication as well as shifting the intervention aim away from health and toward holistic wellness.

Overwhelmingly, both clients and staff appeared to identify respect for personal autonomy as an integral component of the center's approach. Specific practices around communication, including the use of silence and indirection within the client–provider dyad were perceived as essential, particularly given many participants' history within the assimilative IRS system. Given the explicit intention of the IRS to reduce the agency of attendees as a means of assimilation, approaches to talk therapy that reinforced enduring Indigenous practices surrounding speech and communication helped ameliorate client disease. While interactive norms may differ somewhat by Nation, this finding supports the necessity of identifying culturally salient patterns of personal interaction and integrating them into treatment to maintain autonomy.

Beyond communicative norms, findings from this work also highlight the need for therapeutic interventions with Indigenous populations to intentionally re-define the baseline definition of "health" from a biomedical perspective, which perceives well-being as decomposable into separate physical and psychological domains (with minimal attention to spirituality), toward an Indigenous perception, which prioritizes holistic wellness and balance between the mental, physical, emotional, and spiritual (Hodge et al., 2009; McCabe, 2008). Indeed, within this study, the sacred domain in which some therapeutic elements were ensconced enabled clients to undertake spiritual journeys supporting wellness by overcoming structural constraints that replicate colonial practices. Shifting the therapeutic goal away from treatment and toward improved well-being is a recommendation made by Indigenous practitioners and scholars elsewhere (T. Carr et al., 2017), which we echo here.

Ultimately, it is essential to recognize that the integration of traditional Indigenous cultural elements into the therapeutic environment does not represent an idealized reversion to a precontact way of being. Instead, the braiding of traditional practices with mainstream approaches to talk therapy results in a unique fusion that is representative of the contemporary state of modern Indigeneity. Indeed, Indigenous people and communities are normatively engaged in charting a self-determined future that finds enduring continuity with longstanding Indigenous traditions. Programs aiming to improve mental health and well-being for Indigenous populations should include deep appreciation of cultural strengths while recognizing opportunities to incorporate mainstream elements with demonstrated benefit in pragmatic fashion. Indeed, Indigenous counseling psychologists have considered such integrative efforts for some time (Dauphinais et al., 1981; Robbins et al., 2012).

Finally, this agentic and creative approach to therapeutic innovation may also be relevant for tailoring counseling and therapy for other populations for whom various attributes of the "talking cure" remain foreign (e.g., many men, people from low-income communities, populations in the Global South, etc.). Counseling psychology was among the earliest of the subfields within psychology to embrace and promote cultural competence (Sue, 2001; Sue et al., 1992). The predominant approach to cultural competence in professional psychology, however, focused on provider attributes more so than on practice attributes. And yet, Kirmayer (2007) reviewed the underlying cultural concept of the person that is assumed by many forms of psychotherapy, leading Wendt and Gone (2012) to propose a shift away from primary interest in culturally competent therapists to an appreciation of culturally commensurate therapies.

Any assessment of the cultural commensurability of counseling and psychotherapy in a given setting or for a specific population will necessarily require focused inquiry concerning therapeutic practice. This study, along with related research that explicates and compares the logics and rationales of modern professional and Indigenous traditional therapeutic practices (Gone, 2010, 2016, Gone, 2021a), demonstrate specific approaches for doing this. Additionally, Hartmann et al. (2018, 2020) conducted clinical ethnography for similar purposes. In sum, counseling psychology would continue to benefit from open-ended, discovery-oriented approaches to explicating and understanding real-world counseling practices. This would seem especially imperative for settings and services that call for or require cultural adaptations, integrations, or fusions of therapeutic modalities and techniques toward a broader range of client benefit.

Limitations

This study includes a number of limitations. First, although we are able to infer the posited significance of Indigenous communication norms, such patterned preferences are inherently tacit. Therefore, while we rely on earlier sociolinguistic work by scholars such as Regna Darnell to inform our interpretation; thus, this aspect of our findings remains necessarily tentative. Second, the data collection on which the present study is based occurred in 2003 and 2004. Given the passage of time between original data collection and this current re-analysis, it is possible that communicative norms within the population may have shifted. However, therapy culture widely depends on psychological mindedness that is far from culturally universal. Finally, given the time that elapsed between data collection and analysis, we were unable to share our interpretations of the transcripts with original respondents. The original analyses and interpretations were shared, however, with the leadership of the counseling center that was the focus of this inquiry.

Conclusion

Based on 32 interviews conducted with Indigenous administrators, staff, and clients at a Canadian reserve-based addiction treatment center, this study identified community-driven and practical therapeutic solutions for remedying histories of coercive colonial assimilation. We found that counselors tailored therapy and preserved client's personal autonomy through incorporating Indigenous communicative norms such as the use of nonverbal expression, culturally appropriate guidance, and alternative delivery formats into their ideal counseling practices. Additionally, they augmented mainstream therapeutic practices with Indigenous traditions, including the integration of Indigenous concepts, traditional practices, and ceremonial activities. Through this process, therapy was recast as a sacred endeavor, with structural-level adaptations aligning programs at the center with Indigenous perceptions of holistic wellness. Collectively, this integration of familiar counseling approaches and Indigenous cultural practices in response to community priorities resulted in an innovative instance of therapeutic fusion that may be instructive for cultural adaptation efforts in mental health treatment for Indigenous populations and beyond.

References

Barnes, R., & Josefowitz, N. (2019). Indian residential schools in Canada: Persistent impacts on Aboriginal students' psychological development and functioning. *Canadian Psychology/Psychologie Canadienne*, *60*(2), 65–76. https://doi.org/10.1037/cap0000154

Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's Downtown Eastside. *Social Science & Medicine*, *56*(4), 821–833. https://doi.org/10.1016/S0277-9536(02)00081-3

Boksa, P., Joober, R., & Kirmayer, L. J. (2015). Mental wellness in Canada's Aboriginal communities: Striving toward reconciliation. *Journal of Psychiatry & Neuroscience*, *40*(6), 363–365. https://doi.org/10.1503/jpn.150309

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, *51*(3), 320–338. https://doi.org/10.1177/1363461513503380

Bombay, A., McQuaid, R. J., Schwartz, F., Thomas, A., Anisman, H., & Matheson, K. (2019). Suicidal thoughts and attempts in First Nations communities: Links to parental Indian residential school attendance across development. *Journal of Developmental Origins of Health and Disease*, *10*(1), 123–131. https://doi.org/10.1017/S2040174418000405

Boyer, Y. (2017). Healing racism in Canadian health care. *CMAJ: Canadian Medical Association Journal*, *189*(46), E1408–E1409. https://doi.org/10.1503/cmaj.171234

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, *9*(1), 3–26. https://doi.org/10.1037/qup0000196

Carr, S. E. (2010). *Scripting addiction: The politics of therapeutic talk and American sobriety*. Princeton University Press. https://doi.org/10.1515/9781400836659

Carr, T., Chartier, B., & Dadgostari, T. (2017). "I'm not really healed … I'm just bandaged up": Perceptions of healing among former students of Indian residential schools. *International Journal of Indigenous Health*, *12*(1), 39–56. https://doi.org/10.18357/ijih121201716901

Darnell, R. (1981). Taciturnity in Native American etiquette: A Cree case. *Culture*, *1*(2), 55–59. https://doi.org/10.7202/1077829ar

Darnell, R. (1991). Thirty-nine postulates of Plains Cree conversation, "power" and interaction: A culture-specific model. In W. Cowan (Ed.), *Papers of the forty-sixth Algonquian conference* (Vol. 22, pp. 89–102). Carleton University.

Darnell, R. (2006). Residential school discourses and the discourses of self-government: Changing resonances of land and language in Algonquian narratives. In H. C. Wolfart (Ed.), *Actes du 37e Congrès des Algonquinistes, sous la dir. De H. C. Wolfart* (pp. 149–160). Université du Manitoba.

Dauphinais, P., Dauphinais, L., & Rowe, W. (1981). Effects of race and communication style on Indian perceptions of counselor effectiveness.

Counselor Education and Supervision, *21*(1), 72–80. https://doi.org/10.1002/j.1556-6978.1981.tb01677.x

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native peoples*. Teacher's College Press.

Duran, E. (2019). *Healing the soul wound: Trauma-informed counseling for Indigenous communities* (2nd ed.). Teachers College Press.

Eggertson, L. (2015). Canada lacks national suicide prevention strategy. *Lancet*, *385*(9987), 2562–2563. https://doi.org/10.1016/S0140-6736(15)61147-3

Elton-Marshall, T., Leatherdale, S. T., & Burkhalter, R. (2011). Tobacco, alcohol and illicit drug use among Aboriginal youth living off-reserve: Results from the Youth Smoking Survey. *CMAJ: Canadian Medical Association Journal*, *183*(8), E480–E486. https://doi.org/10.1503/cmaj.101913

Farnell, B. (1991). Nak'ota mak'oc'e: An American Indian storytelling performance. *Yearbook for Traditional Music*, *23*, 79–99. https://doi.org/10.2307/768398

Farnell, B. (1995). Where mind is a verb: Spatial orientation and deixis in Plains Indian sign talk and Assiniboine (Nakota) culture. In B. Farnell (Ed.), *Human action signs in cultural context: The visible and the invisible in movement and dance* (pp. 82–111). Scarecrow Press.

Friesen, E. (2019). The landscape of mental health services in rural Canada. *University of Toronto Medical Journal*, *96*(2), 47–52.

Geana, M. V., Greiner, K. A., Cully, A., Talawyma, M., & Daley, C. M. (2012). Improving health promotion to American Indians in the Midwest United States: Preferred sources of health information and its use for the medical encounter. *Journal of Community Health*, *37*(6), 1253–1263. https://doi.org/10.1007/s10900-012-9564-x

Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice*, *35*(1), 10–18. https://doi.org/10.1037/0735-7028.35.1.10

Gone, J. P. (2008). The Pisimweyapiy Counselling Centre: Paving the red road to wellness in Northern Manitoba. In J. B. Waldram (Ed.), *Aboriginal healing in Canada: Studies in therapeutic meaning and practice* (pp. 131–203). Aboriginal Healing Foundation.

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology*, *77*(4), 751–762. https://doi.org/10.1037/a0015390

Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist*, *38*(2), 166–235. https://doi.org/10.1177/0011000008330831

Gone, J. P. (2011a). "I came to tell you of my life": Narrative expositions of "mental health" in an American Indian community. In M. Aber, K. Maton, & E. Seidman (Eds.), *Empowering settings and voices for social change* (pp. 134–154). Oxford University Press.

Gone, J. P. (2011b). The red road to wellness: Cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology*, *47*(1–2), 187–202. https://doi.org/10.1007/s10464-010-9373-2

Gone, J. P. (2016). Alternative knowledges and the future of community psychology: Provocations from an American Indian healing tradition. *American Journal of Community Psychology*, *58*(3–4), 314–321. https://doi.org/10.1002/ajcp.12046

Gone, J. P. (2021a). Decolonization as methodological innovation in counseling psychology: Method, power, and process in reclaiming American Indian therapeutic traditions. *Journal of Counseling Psychology*, *68*(3), 259–270. https://doi.org/10.1037/cou0000500

Gone, J. P. (2021b). Recounting coup as the recirculation of Indigenous vitality: A narrative alternative to historical trauma. *Transcultural Psychiatry*. Advance online publication. https://doi.org/10.1177/13634615211054998

Government of Canada. (2022). *Indigenous peoples and communities*. https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303

Hackett, C., Feeny, D., & Tompa, E. (2016). Canada's residential school system: Measuring the intergenerational impact of familial attendance on health and mental health outcomes. *Journal of Epidemiology and Community Health*, *70*(11), 1096–1105. https://doi.org/10.1136/jech-2016-207380

Harding, T., & Oetzel, J. (2019). Implementation effectiveness of health interventions for indigenous communities: A systematic review. *Implementation Science*, *14*(1), Article 76. https://doi.org/10.1186/s13012-019-0920-4

Hartmann, W. E., Gone, J. P., & Saint Arnault, D. M. (2020). Reconsidering rigor in psychological science: Lessons from a brief clinical ethnography. *Qualitative Psychology*, *7*(2), 169–184. https://doi.org/10.1037/qup0000170

Hartmann, W. E., St. Arnault, D. M., & Gone, J. P. (2018). A return to "the clinic" for community psychology: Lessons from a clinical ethnography in urban American Indian behavioral health. *American Journal of Community Psychology*, *61*(1–2), 62–75. https://doi.org/10.1002/ajcp.12212

Hodge, D. R., Limb, G. E., & Cross, T. L. (2009). Moving from colonization toward balance and harmony: A Native American perspective on wellness. *Social Work*, *54*(3), 211–219. https://doi.org/10.1093/sw/54.3.211

Kaspar, V. (2014). The lifetime effect of residential school attendance on indigenous health status. *American Journal of Public Health*, *104*(11), 2184–2190. https://doi.org/10.2105/AJPH.2013.301479

Kim, P. J. (2019). Social determinants of health inequities in Indigenous Canadians through a life course approach to colonialism and the Residential School system. *Health Equity*, *3*(1), 378–381. https://doi.org/10.1089/heq.2019.0041

Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry*, *44*(2), 232–257. https://doi.org/10.1177/1363461506070794

Kirmayer, L. J., & Brass, G. (2016). Addressing global health disparities among Indigenous peoples. *Lancet*, *388*(10040), 105–106. https://doi.org/10.1016/S0140-6736(16)30194-5

Kitching, G. T., Firestone, M., Schei, B., Wolfe, S., Bourgeois, C., O'Campo, P., Rotondi, M., Nisenbaum, R., Maddox, R., & Smylie, J. (2020). Unmet health needs and discrimination by healthcare providers among an Indigenous population in Toronto, Canada. *Canadian Journal of Public Health*, *111*(1), 40–49. https://doi.org/10.17269/s41997-019-00242-z

Kowatch, K. R., Schmidt, F., & Mushquash, C. J. (2019). Review of culturally-adapted cognitive behavioral therapy interventions for North American Indigenous children and youth. *Journal of Concurrent Disorders*, *1*(3), 5–22. https://doi.org/10.54127/LDMQ1890

Lavallee, L. F., & Poole, J. M. (2010). Beyond recovery: Colonization, health and healing for Indigenous people in Canada. *International Journal of Mental Health and Addiction*, *8*(2), 271–281. https://doi.org/10.1007/s11469-009-9239-8

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Journal of Psychology 73*(1), 26–46. https://doi.org/10.1037/amp0000151

MacDonald, C., & Steenbeek, A. (2015). The impact of colonization and western assimilation on health and wellbeing of Canadian Aboriginal people. *International Journal of Regional and Local History*, *10*(1), 32–46. https://doi.org/10.1179/2051453015Z.00000000023

McCabe, G. (2008). Mind, body, emotions and spirit: Reaching the ancestors. *Counselling Psychology Quarterly*, *21*(2), 143–152. https://doi.org/10.1080/09515070802066847

Moodley, R., & West, W. (2005). *Integrating traditional healing practices into counseling and psychotherapy*. SAGE Publications. https://doi.org/10.4135/9781452231648

Morton Ninomiya, M., George, N. P., George, J., Linklater, R., Bull, J., Plain, S., Graham, K., Bernards, S., Peach, L., Stergiopoulos, V.,

Kurdyak, P., McKinley, G., Donnelly, P., & Wells, S. (2020). A community-driven and evidence-based approach to developing mental wellness strategies in First Nations: A program protocol. *Research Involvement and Engagement*, *6*(5), Article 5. https://doi.org/10.1186/s40900-020-0176-9

National Collaborating Centre for Indigenous Health. (2019). *Access to health services as a social determinant of First Nations, Inuit, and Métis health*. https://www.nccih.ca/docs/determinants/FS-AccessHealthServicesSDOH-2019-EN.pdf

Nebelkopf, E., & Phillips, M. (Eds.). (2004). *Healing and mental health for native Americans: Speaking in red*. AltaMira Press.

Nelson, S. E., & Wilson, K. (2017). The mental health of Indigenous peoples in Canada: A critical review of research. *Social Science & Medicine*, *176*, 93–112. https://doi.org/10.1016/j.socscimed.2017.01.021

Nguyen, N. H., Subhan, F. B., Williams, K., & Chan, C. B. (2020). Barriers and mitigating strategies to healthcare access in Indigenous communities of Canada: A narrative review. *Healthcare*, *8*(2), Article 112. https://doi.org/10.3390/healthcare8020112

Okpalauwaekwe, U., Ballantyne, C., Tunison, S., & Ramsden, V. R. (2022). Enhancing health and wellness by, for and with Indigenous youth in Canada: A scoping review. *BMC Public Health*, *22*(1), Article 1630. https://doi.org/10.1186/s12889-022-14047-2

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Prussing, E., & Gone, J. P. (2011). Alcohol treatment in Native North America: Gender in cultural context. *Alcoholism Treatment Quarterly*, *29*(4), 379–402. https://doi.org/10.1080/07347324.2011.608593

Robbins, R., Hong, J., & Jennings, A. M. (2012). In the pause and listening to the little people: A folk healer's journey. *The Counseling Psychologist*, *40*(1), 93–132. https://doi.org/10.1177/0011000011410892

Royal Commission on Aboriginal Peoples. (1996). *Looking forward, looking back: Report of the Royal Commission on Aboriginal peoples* (Vol. 1). Communication Group.

Statistics Canada. (2021). *Projections of the Indigenous populations and households in Canada, 2016 to 2041: Overview of data sources, methods, assumptions and scenarios* (CAT No. 17-2-0001). https://www150.statcan.gc.ca/n1/pub/17-20-0001/172000012021001-eng.htm

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*(6), 790–821. https://doi.org/10.1177/0011000001296002

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sunga, S. (2017). Dealing with oppression: Indigenous relations with the state in Canada. *Ethics & Social Welfare*, *11*(2), 135–148. https://doi.org/10.1080/17496535.2017.1293118

Vizenor, G. (2008). *Survivance: Narratives of native presence*. University of Nevada Press.

Waldram, J. B. (Ed.). (2008). *Aboriginal healing in Canada: Studies in therapeutic meaning and practice*. Aboriginal Healing Foundation. https://www.ahf.ca/downloads/aboriginal-healing-in-canada.pdf

Wells, S., Bernards, S., George, J., & Graham, K. (2014). *Findings from researching health in Ontario communities: Aamjiwaang First Nation*. Center for Addiction and Mental Health.

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry*, *49*(2), 206–222. https://doi.org/10.1177/1363461511425622

Wendt, D. C., & Gone, J. P. (2016). Integrating professional and Indigenous therapies: An urban American Indian narrative clinical case study. *The Counseling Psychologist*, *44*(5), 695–729. https://doi.org/10.1177/0011000016638741

Wendt, D. C., Huson, K., Albatnuni, M., & Gone, J. P. (2022). What are the best practices for psychotherapy with indigenous peoples in the United States and Canada? A thorny question. *Journal of Consulting and Clinical Psychology*, *90*(10), 802–814. https://doi.org/10.1037/ccp0000757

Received December 8, 2022
Revision received March 21, 2023
Accepted March 21, 2023 ■

Retraction of Kivlighan et al. (2016)

The following article is being retracted: Kivlighan, D. M., Jr., Hill, C. E., Gelso, C. J., & Baumann, E. (2016). Working alliance, real relationship, session quality, and client improvement in psychodynamic psychotherapy: A longitudinal actor partner interdependence model. *Journal of Counseling Psychology*, *63*(2), 149–161. https://doi.org/10.1037/cou0000134

This retraction is at the request of coauthors Kivlighan, Hill, and Gelso after the results of an investigation by the University of Maryland Institutional Review Board (IRB). The IRB found that the study included data from between one and four therapy clients of the Maryland Psychotherapy Clinic and Research Laboratory (MPCRL) who either had not been asked to provide consent or had withdrawn consent for their data to be included in the research. Baumann was not responsible for obtaining and verifying participant consent but agreed to the retraction of this article.

https://doi.org/10.1037/cou0000697