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"When I Spoke, I Spoke From the Heart": Empirical Insights and Therapeutic Lessons From an Indigenous Counseling Center

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Abstract

Indigenous Peoples in Canada experience inequities in behavioral health outcomes stemming from colonial subjugation, including tacit cultural assimilation through health care. Indigenous communities assert that culturally commensurate health interventions improve wellbeing. This study, conducted with clients and staff at a First Nations behavioral health treatment program, sought to identify how respondents conceived of the therapeutic endeavor with respect to possibilities for remedying colonial injuries such as the abuses of the Indian Residential Schools (IRSs). Thematic analysis of 32 interviews revealed that targeted therapeutic goals as well as specific counselor qualities were important for a positive therapeutic experience for those in the program. Ultimately, assimilative

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practices, such as the IRSs of the past and mainstream behavioral health treatment programs in the present may collectively contribute to the continuation of inequities in health outcomes for Indigenous Canadians. Decolonizing the therapeutic endeavor offers a potential avenue for positive change.

Keywords
behavioral health treatment, cultural commensurability, counseling norms, Canadian First Nations, Indigenous traditional practices, Indian residential schools

Significance of the Scholarship to the Public
Thematic analysis of interviews with clients, staff, and administrators from an on-reserve Canadian First Nations-controlled addiction treatment center found that targeted goals of therapy and specific qualities of counselors were important in facilitating a positive therapy experience for clients. Decolonizing therapy may impact positive change for Indigenous Canadians.

Introduction

Indigenous Peoples in Canada experienced devastating subjugation following European colonization in the early 1600s. Centuries of federal policies facilitated physical, spiritual, and cultural repression, including a myriad of efforts aimed at coercive and often brutal assimilation (Neeganagwedgin, 2019). Originally motivated by a desire to displace Indigenous Peoples from the land and natural resources (Farrell et al., 2021), many assimilative practices became normalized over time and continue into the present. These practices compound other colonial harms, referred to frequently as historical traumas, and collectively contribute to significant inequity in health for Indigenous Peoples in Canada today (MacDonald & Steenbeek, 2015).

Mainstream Psychology and Culturally Informed Practice

Mainstream psychotherapeutic treatment in North America was developed within Euro-colonial models that inform which behaviors are perceived as problematic and necessitate treatment, which treatments should be applied, and how treatment should be adapted (if at all). Decades of careful scientific evidence has demonstrated the success of these methods for many people.

Limited empirical evidence, however, exists regarding the effectiveness of these methods with Indigenous populations in Canada. Indeed, a recent systematic review of psychotherapy research with Indigenous Peoples found that very few studies empirically examined psychotherapy with these populations and called for increased research into the use and effectiveness of such interventions for these communities (Pomerville et al., 2016). This dearth of research exists despite the disproportionately high rates of mental health disorders within many Indigenous communities in North America.

Empirical research aside, North American Indigenous communities have long proposed that Eurocentric therapeutic models may be incompatible with Indigenous perceptions of the world, including both the causations of "disease" and effective treatments for them (Moodley & West, 2005; Nebelkopf & Phillips, 2004). These assertions are undergirded by a history of federal policies and scientific practices that have intentionally subjugated, abused, and alienated Indigenous Peoples, contributing to disparities in health outcomes, barriers to accessing treatment and support, as well as low engagement in research. Within the last twenty years, there has been a move within psychological research and practice, as well as allied health fields, to engage in culturally competent practices as a means of bridging the gap in health outcomes between White and minoritized populations (Sue et al., 2009).

A conceptual review by Wendt et al. (2022) noted that psychotherapy with Indigenous Peoples has generally followed one of four approaches in relation to cultural engagement and adaptation. The first limits psychotherapeutic interventions to empirically supported treatments, the second prioritizes the use of culturally adapted interventions, the third emphasizes flexibility in psychotherapy to meet individual client circumstances, while the fourth promotes grassroots Indigenous approaches. The majority of the recent interventions with Indigenous Peoples follows path number two and adapts interventions at various levels: surface (changing wording or adding pictures or images determined to be culturally appropriate), structural (incorporating cultural practices), or deep structural (incorporating underlying values) (Kowatch et al., 2019).

Although these approaches have some documented success (see Gilder et al., 2017; Morsette et al., 2012; Pearson et al., 2019), there remains substantial need to empirically identify and systematically describe actual on-the-ground grassroots Indigenous community efforts to design behavioral health approaches that have been tailored for their own populations. Such distinctive expressions of more general Indigenous commitments to self-determination may help to ensure "culturally commensurable" treatment approaches as one means of increasing equity and effectiveness in psychotherapeutic treatment (Wendt & Gone, 2011).

Cultural Commensurability as an Effective Approach to Counseling

Attention to cultural commensurability (the assessment of fit between mainstream counseling practices and emergent facets of local cultural psychologies) allows for a reflexive professional assessment of cultural orientations and assumptions that give rise not just to therapist knowledge and skills but to the therapeutic practices themselves. Importantly, culturally commensurable behavioral health treatment programs are frequently developed by members of the population or community within which they are applied. As a consequence, assessments of cultural commensurability are also revealing of features of hybridized treatments that mix or fuse both mainstream counseling practices and culturally specific Indigenous approaches to healing.

The existence of such programs within Indigenous communities raises two specific questions: How do Indigenous communities choose to alter the therapeutic process to suit their populations? And, based on such alterations, what does cultural commensurability in counseling psychology look like? As we noted previously, empirical studies of psychological treatment programs for Indigenous Peoples are lacking, and this is especially true regarding treatment programs that adopt a culturally commensurable approach. Indeed, systematic empirical investigations of these innovations are largely absent from the counseling literature owing to the time required for sustained interactions, methods necessary for in-depth (or "thick") descriptions, and challenges surrounding community access.

Indian Residential Schools and Truth and Reconciliation

In this study we seek to address this gap by analyzing interviews conducted with counselors, staff, and clients of a Canadian First Nations-administered behavioral health treatment center located on a remote reserve in Northern Manitoba. Although this center focused on substance use treatment, the outpatient program featured in this inquiry specifically sought to address the legacy of abuse associated with the Indian Residential School (IRS) system in Canada. This study is distinguished from existing research on culturally competent psychological services for Indigenous populations by its empirical access to an actual treatment setting in combination with the inclusion of Indigenous respondents in all roles within the therapeutic endeavor.

The IRS system functioned in Canada from 1883 through the late 1990s. Collectively run by various churches and the Canadian Government, they were one of the cornerstone assimilative policies aimed at "civilizing" the Indigenous Peoples in Canada (Truth and Reconciliation Commission of Canada [TRC], 2015). In 1920, the Deputy Minister of Indian Affairs proclaimed "our object is to continue until there is not a single Indian in

Canada that has not been absorbed into the body politic" (TRC, 2015, p. 6). It is estimated that more than 150,000 Indigenous children were IRS students (Barkan, 2003). The Canadian government was motivated in these efforts by the desire to gain control over Indigenous lands and resources through divestment from treaty obligations (TRC, 2015). IRSs functioned by removing Indigenous children, often forcefully, from their families and communities and placing them in institutions designed explicitly to sever ties with family and culture (Royal Commission on Aboriginal Peoples, 1996). A subsequent national review of the system deemed IRS efforts and aspirations as "cultural genocide" (TRC 2015).

The IRS system has been implicated in innumerable harms to Indigenous children, families, and communities, compounded by generations of exposure, including contributing to stark inequities in behavioral health (Bombay et al., 2014). In addition to devastating social, political, and educational impacts, IRS attendance has been associated with elevated prevalence of suicidality and depression, alcohol and substance use disorders, and psychological distress (Bombay et al., 2014; Gone et al., 2019). Following the closure of the last residential schools in 1998, the Canadian government convened the TRC to investigate thousands of allegations of physical, emotional, and sexual abuse suffered by survivors of the institutions (TRC, 2015). The TRC was allocated $72 million between 2007 and 2015 to do this work, which included gathering witness testimonies from across Canada, national educational events, historical documentation, and finally, the development of 94 recommendations intended for further reconciliation (TRC, 2015).

The Present Study

The outpatient program in this study received funding from the Aboriginal Healing Foundation, an Indigenous-managed nonprofit whose mission is to "Promote and enhance holistic healing of residential school impacts on [tribal members] utilizing traditional and contemporary practices" (Gone, 2008, p. 133). This organization predated and anticipated the work of the TRC. Importantly, all clients and the vast majority of counselors, administrators, and staff at the outpatient program were members of the Tribal Nation on the reserve where the facility was located. The healing facility itself aimed to incorporate traditional healing practices, including use of the Indigenous medicine wheel, into their substance abuse treatment programs. Within this context, this study asked, "In what ways do Indigenous staff and clients conceive of the therapeutic endeavor with respect to distinctive possibilities for remedying and transforming colonial injuries such as the abuses of the IRSs?" Insights gained from this inquiry may inform the development of future culturally commensurate behavioral health

intervention programs with North American Indigenous communities, and empirically illuminate a range of cultural adaptations to therapeutic interventions within counseling psychology.

Method

This article reports findings from the novel analysis of data originally collected from 2003–2004 (see: Gone, 2008, 2009, 2011) at a Canadian Northern Algonquian First Nations treatment center. Prior analyses have identified ideals of counseling practice for Indigenous counselors and clients at the center and contextualized healing within the unique therapeutic setting (Gone, 2011; Pham et al., 2023). To build upon this earlier work, for this research, we asked: In what ways do Indigenous staff and clients conceive of the therapeutic endeavor with respect to distinctive possibilities for remedying and transforming colonial injuries such as the abuses of the IRS? Importantly, this is distinct from much of the earlier literature in Indigenous psychology by asking Indigenous individuals who were actively engaged in the therapeutic process—as both clients and staff—what they want and value in counseling services.

Despite the twenty years that has passed since these interviews were initially collected, these data appear to remain unique, as we know of no other research (outside of this study's parent project; see Waldram, 2008) that document both provider and client perceptions of on-the-ground integrative service delivery in a reservation-based treatment setting. Further, the richness of the interviews invited contemporary reanalysis to do service to the valuable insights provided. By honoring the generative capacity of the data collected to the greatest extent possible, we aim to avoid the common research practice of under-utilizing the gifts of time and knowledge shared by interview participants. Moreover, reanalysis of existing data over time (using similar interpretive methods) affords additional opportunity for methodological checks between multiple researchers. Finally, a related article (Pham et al., 2023) based on this same reanalysis has recently appeared, presumably attesting to the validity and value of this approach for counseling psychology. In sum, we believe that the benefits of knowledge shared despite a prolonged analysis and dissemination process outweigh the risks that the passage of time might otherwise introduce.

The study team comprised the senior author, an American Indian (*Aaniiih*-Gros Ventre) clinically-trained research psychologist; the first author, a mixed-race American Indian/White (descendant Tolowa, Chetco) early-career biological anthropologist; and the second author, an early-career Vietnamese American psychiatrist. The senior author conducted the initial interviews and directed and supervised the research. The first and second authors conducted the analyses and contributed to the writing and revision of the article.

Background

Beginning in 2000, the reserve-based addiction treatment facility that is featured in this study received funding from the Aboriginal Healing Foundation to address the legacy of harm stemming from the IRS system. This healing center was funded to develop a 10-week, holistic healing program structured around the integration of traditional Indigenous practices into mainstream addiction treatment, thereby promoting positive Indigenous identity and healthy coping skills. All participants identified as Indigenous and all clients, and nearly all counselors and staff, were members of the First Nations community on whose reserve the center was situated.

In contrast to mainstream counseling centers, only some of the providers had received formal degrees in counseling; however, all received structured training through regional seminars and workshops, many sponsored by the healing center itself. Clients suffered from intra- and interpersonal issues stemming from long legacies of colonial subjugation, including abuses while attending residential schools. Many turned to substance abuse in lieu of other coping skills. The senior author conducted 32 semi-structured interviews over 7 weeks between October 2003 and May 2004 in order to document the center's objectives and approaches to healing (Gone, 2008, 2009, 2011; Prussing & Gone, 2011).

Participants

Participants were identified and recruited by center staff using purposive sampling methods so as to include a diverse sample of individuals knowledgeable about the therapeutic services provided at the center. Participants included (current and former) center administrators, residential and outpatient counselors, and outpatient clients. Interviews were conducted until saturation was achieved. For their participation, and in accordance with the wishes of the healing center's leadership, respondents received university-branded merchandise for completing interviews. No one refused to participate when approached and all respondents provided informed consent to participate in the research.

Final recruitment included 33 participants: 11 former outpatient clients; 14 counseling staff; one past executive officer; one current executive officer; one counseling program coordinator; and 5 community members with close ties to the center, including service as a board member or cultural practitioner. All clients were outpatient and the majority were men (64%). Client age ranged between 20 and 62 years (median 30). Eight had completed the program themselves. Two clients had attended residential schools, although all had parents or grandparents who were survivors of the IRS system. Participants were assigned study identification numbers to protect anonymity, with pseudonyms employed for publication and reporting.

Measure

The senior author conducted all interviews. During the process, he relied on personal and professional experience, grounded in American Indian reservation life in the United States, in order to engage with First Nations participants in the Canadian reserve setting. Interviews were semi-structured and open-format and included questions about participant identity, personal history, therapeutic activities, counseling experiences, and the meaning of healing. The semi-structured nature encouraged participant elaboration while allowing for comparability during analysis. (A copy of the interview guide is available on request from the senior author).

Interviews with counselors included additional questions around professional training, therapeutic approach, perceived qualities of effective therapists, and therapeutic challenges. Questions for counselors included: "Tell me about your life's journey so far, in a way that you feel explains how you came to be here in this healing centre today?", "What is 'healing' as you understand it and practice it here?", "How would you describe your approach to working with clients?", "Are personal or life experiences necessary to work with your clients?" and, "Do you use 'traditional' methods?" as well as "Do you use 'Western' methods?"

Questions for clients included, "I would like you to tell me the story of your future, how do you see it unfolding from this day onward?", "What is 'healing' as you understand it and practice it here?", "Is there a unique [Indigenous] approach to healing?", "What type of healing do they offer at this centre?", "How would you describe the 'problem' or 'problems' that you are trying to remedy through your contact with this healing centre?" and, "What are the symptoms of the problem? What are the causes?".

Procedure

This study was part of a multi-site project funded through the Aboriginal Healing Foundation with the goal of documenting Indigenous community healing practices (Waldram, 2008). The senior author was invited to conduct the study, the community consented to the research, and the protocol was approved by the Institutional Review Board at the University of Michigan. Interviews were private (only senior author and interviewee present), lasted between 29 and 279 minutes (median 80 minutes), and were audio recorded before being transcribed by research assistants into Microsoft Word. The twenty years that elapsed between the initial study and this analysis meant that study participants were unable to review the analysis; however, prior reports were submitted to program administrators for review and approval.

Data Analysis

Interviews were interpreted through thematic analysis, a method of qualitative inquiry that enables the identification and organization of patterned responses into codes and themes. As a data-driven approach, thematic analysis allows for the identification of latent themes, which affords insight into respondent meaning-making beyond what is conveyed in explicit fashion. The authors progressed systematically through all six requisite phases of analysis, adhering to the 15-point checklist for good thematic analysis, as prescribed by Braun and Clarke (2006).

The first phase was familiarization with the data, in which the authors read the transcripts in their entirety more than once in order to become familiar with the data, and noted initial ideas for codes. The second phase was generating initial codes, in which the authors used *NVivo* (a qualitative analysis software program) to formally code the data according to its semantic content. These codes were reviewed and verified by the senior author. The third phase was searching for themes, in which repeated codes were sorted into hierarchical themes and associated subthemes.

The fourth phase was reviewing themes, in which authors considered the relationships between themes and subthemes, and in relation to validity, accuracy, and meaning relative to the original interview transcripts. Once themes and subthemes were solidified, the authors developed a thematic map illustrating the relationship between and among themes. The fifth phase was defining and naming themes, in which the authors determined a label for each theme and subtheme in accordance with underlying patterns and distinctions. The final, sixth phase, was producing the report, in which the authors produced the final report by documenting details of the analysis using a coherent and logical narrative inclusive of themes, subthemes and codes.

Ultimately, the analysis adhered to all 15 of Braun and Clarke's (2006) criteria for good thematic analysis, with a single exception: given the amount of time that passed between initial interviews and analysis completion, we were unable to consult with the original participants for review of the findings. In addition, this study met all relevant (66 of the 77) items identified by Levitt et al. (2018) in relation to journal reporting standards for qualitative psychological research (the remaining 11 items were not applicable to this study). Due to original and standing agreements with the reserve community on which this research focuses, data and study materials are not available for outside access.

Results

We focused on ways that Indigenous staff and clients at the addictions treatment center conceived of therapy as providing avenues through which to address colonial injuries of abuse, specifically those stemming from exposure

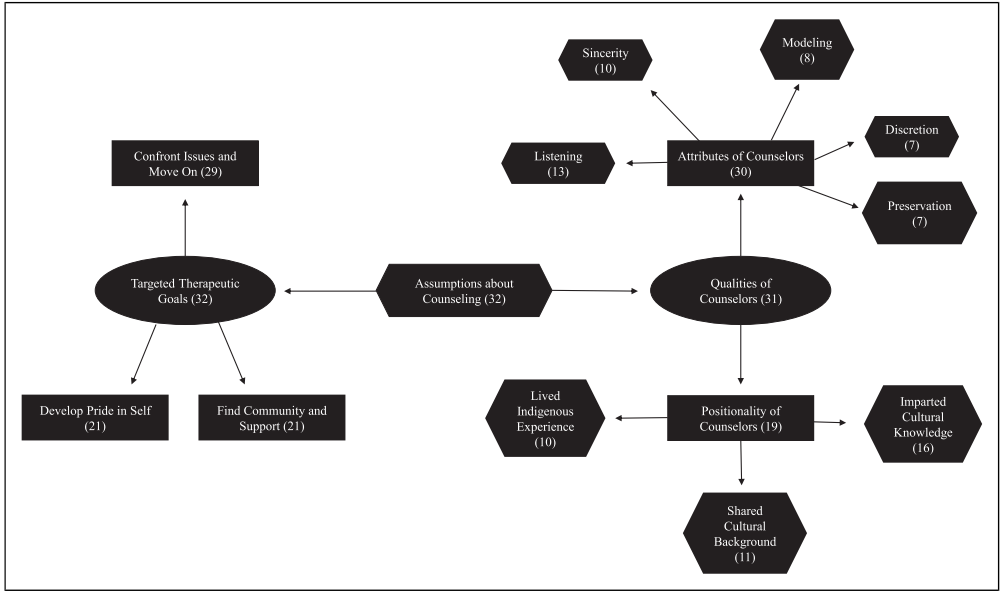

Figure 1. Thematic map for analysis of conceptions of the therapeutic endeavor (with number of respondents endorsing each theme or subtheme).

to the IRS system. Specifically, we asked, "In what ways do Indigenous staff and clients conceive of the therapeutic endeavor with respect to distinctive possibilities for remedying and transforming colonial injuries such as the abuses of the IRS?" Study participants indicated that healing and transformation may occur most readily through Targeted Therapeutic Goals (comprising three subthemes) and Qualities of Counselors (comprising two subthemes, each with additional more foundational themes: see Figure 1).

Targeted Therapeutic Goals (n=32)

Thirty-two participants discussed three goals that therapeutic talk is intended to achieve: (a) Confront Issues and Move On, (b) Find Community and Support, and (c) Develop Pride in Self.

Confront Issues and Move On (n=29). Twenty-nine participants described the necessity for counseling to assist clients in confronting issues or experiences of concern and then moving on. This was particularly true in relation to IRS attendance, which was often assimilative and abusive. John (staff) described the emotional weight involved in seeking to address the enduring effects of IRS attendance through therapeutic processing of these experiences:

> It doesn't go away 'til [clients] 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. And that's how powerful this experience about residential school [was].

Clearly, the opportunity to confront and express such powerful emotions was one hallmark of successful therapeutic engagement.

Part of this weight derived from participant contextualization of current issues within early life disruptions, including residential school but also extending to other forms of cultural oppression and loss resulting from colonial subjugation. These experiences were frequently described as permeating across personal, family, and community dimensions. For example, Andrew (client) commented on how alcoholism emerged as an ineffective grief coping mechanism in the absence of culturally intact or other meaningful forms of self-expression:

> For instance, my father when he was hitting my mom, sometimes I thought it was my fault, but it wasn't. 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. It gets me mad. It angers me. I like to reach out to them and talk about it instead of bringing it on when they're drunk.

Expressions, like those Andrew described, were clearly marked as maladaptive.

Barriers that prevented individuals from confronting, processing, and moving on from early life disruptions were perceived as contributing to self-blame and ineffective rumination. This concern was especially salient in relation to IRS attendance, as the institutions instilled self-critical attitudes among attendees. Mary (staff) described this harmful cycle:

> Everybody can learn from traditional Western styles. You know, by talking about it. But then when you talk so much about it, it seems like you're just stirring the pot. You're not really dealing with it cause you're talking about it. And repeating it so much. Then it gets to a point where, "Okay, didn't you deal with that already? Let it go already." You know, instead of stirring the pot all the time. The way I see it, you let it go and you deal with it, you don't have to keep repeating it over. Like some people, they go from one therapist to the next and repeat the same story over and over again. And it seems like they never healed from that experience. So they just keep repeating the pattern and repeating the pattern because they really don't want to go into the healing aspect of it.

Perpetual rumination without eventual transition to healing was believed to contribute to poor outcomes at not only the individual level, but for family members as well.

When individuals were unable to confront their issues, participants noted that blame was sometimes misdirected towards loved ones. Lucy (staff) noted the negative consequences of repressed resentment:

> 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 builds up like a pressure cooker. That's why family violence was experienced in our culture. Our people were brainwashed to think that our culture was evil. Our people acculturated by learning, by taking on other cultures' practices and way of thinking.

In this way, an inability to transition towards healing was associated with assimilation and shame in Indigenous identity, fostered through colonial practices like the IRS. Indigenous oral histories as well as non-Indigenous historical reports indicate that domestic violence was not tolerated, and was therefore exceedingly rare, within most precontact communities in the Americas (Duran et al., 1998). Within the example above, the participant highlighted the dual burdens introduced by colonial subjugation: trauma and adversity resulting from settler-colonial policies, and the stripping away of culturally salient means of addressing resulting deleterious impacts on wellbeing.

Find Community and Support (n=21). In addition to the necessity of confronting issues and moving on, the role of community also emerged as an important component of the healing process. Twenty-one participants stated that therapeutic talk should help Indigenous individuals find community and support. Amanda (client), for example, attributed her therapy success to family involvement:

> The one most important, crucial thing that helped me is seeing this therapist. Because it wasn't my idea to go to this person in the first place. It was [my husband]'s idea to go as a blended family. And I was scared to go.

In this way, therapy was a group effort, engaged in by multiple family members with the intention of supporting the healing process of one of its own kin.

Return to family or community and the strengthening of social ties was perceived to be important in remedying colonial injury. This point was reiterated by Jane (staff), who identified colonialism as contributing to the challenges people faced and highlighted community as a means of healing:

> Then after that, we realized, you know, this incident might perpetrate other incidents. You know, so we need to stop it so we should do a community healing. And we'd bring the community together. And we'd heal as a community because of what happened.

In this sense, the community, in addition to the individual, was designated as an important focus of intervention.

Develop Pride in Self (n=21). In addition to the disruption of family and community ties, colonialism worked to strip Indigenous Peoples of their cultural identity. In light of this, twenty-one participants described how therapeutic talk should empower Indigenous individuals to rediscover meaning and pride in themselves. For example, David (staff) described how one therapeutic workshop focused on ancestry:

> They went back and took a look at their family of origin. And they did a genogram. And in the genogram they described where the violence started. Where the alcohol abuse started. Where the sexual abuse started. Like where all these things that impacted their lives started. You know the root causes of where they learned it from. So then they took a look at it and they seen, like, it was a pattern that went on from one generation to the next.

Practices such as this allowed participants to shift feelings of blame for substance use away from perceived personal failings and toward structural and systemic harms.

Such a shift provided an avenue for engaging in healing while developing pride in self, which many participants identified as being previously absent. Joan (client) noted that:

> Deep down inside I still felt that I was longing for something, that I was longing to find my—what was my personal identity. And I was being more or less envious with other people, how they were, figuring that they had better lives than I did, they had it better. But I gradually started to realize that I wasn't the only one. I heard similar stories.

For participants, selfhood was deeply tied to cultural identity, with some participants indicating that healing could occur through reengagement with Indigenous identity through family, tribe, and community.

Marie (counselor) explained as follows:

> Identity is important. Identity is really important. You need to be proud of who you are. You need to know your [tribe] and your [tribe's] way of life to be proud. You have to also realize that in our way of life, that alcoholism is part of it, that it's cost our people a great deal of pain.

In this way, knowing one's identity in relation to shared culture, history, and values provided an avenue for healing, as did acknowledging the structural nature of the original harm.

Qualities of Counselors (N=31)

Participants emphasized the importance of specific counselor qualities that could affect the therapeutic process owing to Indigenous sensitivities to historical exploitation. John (staff) described this frustration: "I was having an interview with this doctor. You know I felt a lot of bitterness towards the system because of the whole child and family system work, the government system per se." This bitterness towards the system could serve as a barrier to the continuation of care and the effectiveness of treatment. Fortunately, respondents conveyed that some counselor qualities might positively contribute to the transformation of colonial injury. Thirty-one participants discussed counselor qualities in relation to Attributes of Counselors and Positionality of Counselors, respectively.

Attributes of Counselors (n=30). Beyond the conventional contours of mainstream professional attributes, 30 participants endorsed that a counselor's

"aura," and/or "vibe" could mediate counseling benefit. Important counselor attributes included listening, sincerity, modeling, discretion, and preservation of client autonomy. Although each of these attributes are likely to be valued in any counseling environment as they contribute to the relational ethos (Hook et al. 2013), the value of each characteristic reflected Indigenous values and expectations that render them particularly salient within the First Nations environment in which this treatment program was located. Various techniques were indicated as contributing to the achievement of these desirable attributes.

Listening (n=13). As is true in most counseling, participants expressed an interest in counselor attentiveness. In contrast to mainstream counseling conventions, however, thirteen clients and staff highlighted the cultural modality of intentional listening by counselors above verbalization as integral to the therapeutic process. Martha (client) noted that healing could begin through "just the reassurance of someone sitting there listening to me," an idea which was reiterated by James (staff), who explained that such attentiveness "manifests honor and respect."

Similarly, Jessica (client) commented on how a nonjudgmental, "listening ear" could facilitate a successful therapeutic relationship:

> My counselor 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. Very polite woman. Considerate and she wasn't critical, she wasn't being judgmental. Sometimes I would speak and she wouldn't cut me off. Like some counselors 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.

Engaging with others in this way was identified as unique and important within many Indigenous cultures more broadly. Kate (staff) commented on this, saying:

> My grandparents used to say to me [the] Creator gave you the ears to listen, and he gave us the mouth to speak very clearly. Your job is to sit there and listen. The Western knowledge, the Western theories, some of them conflict with my values.

Thus, intentional listening was perceived as a culturally-important trait that encouraged respectful and productive engagement between counselor and client.

Sincerity (n=10). As with a desire for attentiveness, 10 participants emphasized that a counselor should engage with sincerity, a request common to mainstream counseling interactions. More unique to the Indigenous population

represented by these participants, however, was the cultural precedent for sincere help-seeking found across many Indigenous religious traditions (in which the assistance of Spirit helpers partly depends on the sincerity of the human supplicant). Thus, in this setting, the sincerity desired from counselors extended beyond performance of one's role to emergent and authentic interpersonal responsiveness.

Specifically, a counselor should speak instinctively (i.e., "without thinking"). Rose (staff) noted:

> When I spoke, I spoke from the heart. I didn't think of what I was going to say before I said it. Don't think about what you're going to say, or don't try to say what they want you to say. And go with your instincts.

Such sincerity could prevent a counselor from asking the "wrong questions" or appearing too professional, goal-directed, and/or manualized, which was associated with appearing "dishonest," "inauthentic," and/or uncaring. Each of these were attributes that participants associated with the strict policies, authorities, and emotional rigidity of residential schools.

Modeling (n=8). When the client and counselor live within the same community, the counselor could model appropriate behaviors outside of the clinical setting. This appeared to be particularly important for eight respondents from this small community in which the treatment center was located, as staff and clients were likely to interact in quotidian activities outside of the treatment program. Although the necessity of "practicing what you preach" in clinical interactions in small communities is shared regardless of the specific population, the isolated geographic nature and additional social and structural barriers acting upon many Indigenous reserve communities further emphasizes the importance of unintentional dual relationships outside of official therapeutic spaces.

Mary (staff) illustrated this point with an example about alcoholism:

> Role modeling has a better impact on people as well just like living in this community here. [If] I'm telling people not to drink and then I'm going out there and doing that, then I'm not going to be a very good counselor to that person because I'd be lying to them.

In this manner, participants valued counselors who lived within the community and modeled healthy, strengths-based behaviors, thus teaching in an indirect fashion that simultaneously protected the personal autonomy of clients.

Modeling such behaviors was seen to be particularly powerful when clients were aware of a counselor's prior personal history with substance use. Joseph

(staff) explained this saying, "… you can't become a good counselor if you haven't got your own act together… how can you help somebody if you can't help yourself?" Mark (client) echoed this, saying "I knew this person from years before, and so my presumption was, well, he practices what he's talking here, you know? So I found it easier to accept his, not advice, but his teaching." In this way, counseling within this setting was not confined to the treatment center but overflowed in important ways into the community environment.

Discretion (n=7). Seven participants noted that successful counselors practiced discretion. Although this is frequently true for client–counselor interactions more generally, the importance of discretion within these circumstances was particularly emphasized due to the size of the community and the familiarity of many of the clients and counselors with one another outside of the treatment center setting. Specifically, it was important to preserve family reputations within a small community in which families live together—and vie for status and influence—for generations. Participants valued counselor discretion as an attribute that helped to assuage anxieties around opening up, especially with respect to fears about confidentiality.

Gary (client) described this necessity:

> I started talking and talking. All these emotions started coming out, you know—crying, laughing, crying, laughing, crying. I didn't even think of who was around. It was just that kind of atmosphere, give me that kind of atmosphere. I don't know if you ever talked to [Other Counselor]. And when he talks, you could feel the honesty, the truth out of him, eh? And he closes his eyes, and listens to you talk, you know.

Respondents noted the importance of honesty and discretion for key reasons.

Participants described gossip as a significant element of their communities. Resulting fear of judgment encouraged some clients to prefer counselors from outside of their community. Sarah (staff) described the disadvantages of opening up to a counselor from within the community:

> Sometimes clients, they don't trust their own people. Say I'm from this community, right? And then, maybe, a girl from the community came in, and I grew up with her or whatever. I know everything about her. She knows everything about me. She used to drink, she used to do this and that. So it's good to have someone like me from here. If you want a different counselor, by all means go for it. It's good to kind of have a different variety of counselors. Yeah, maybe one person will feel comfortable with the White person. And some don't, like the residential school survivors, people that still don't trust White people.

Participants also noted that some of their concerns about confidentiality arose due to exposure to residential schools, and the perceived shared role of outsiders in both professional therapy and the institutions. As Dennis (administrator) reported about a different counseling program that he was familiar with:

> The people that are therapists [there], I know them and I don't trust them. I don't trust their confidentiality. That's why I don't participate in the program. The system that we went through in residential school, the hurt has never stopped cause we're going through the same thing again.

In this way, mainstream therapy was perceived by some to be a continuation of the systems of assimilation and erasure that had caused, and continued to contribute to, significant damage to Indigenous individuals, families, and communities. Discretion regarding experiences revealed during therapy, particularly in relation to abuses suffered while at residential school, was seen for some to be a therapeutic requirement, and could not be trusted to counselors outside of the community.

Preservation (n=7). Apart from discretion, seven participants identified the importance of preserving client's autonomy. For some participants, violations of personal autonomy included a history of being labeled as "crazy" or an "alcoholic." Because of this, participants stated that counselors should abstain from judgmental language and behavior during counseling. As Rose (staff) noted, "I've been through [that kind of program], too, where I have to call myself an alcoholic in order to speak."

With respect to the center at which these interviews occurred, Gary (client) commented:

> I was always confrontational against healing and therapy and counseling. Always like, "You don't need that. It's up the individual him- or herself. You don't need therapy and counseling. That's people trying to influence your decision and how to live." Labeling myself as an alcoholic, as a drug addict, to me honestly was uncomfortable. In [this center], 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, what they've taught you, and how you feel with the current subject—relationships, suicide, grief, stuff like that. I've seen guys in this program that never spoke a word, never, unless they're drinking on alcohol, speak for an hour straight, just with the atmosphere.

When counselors provided freedom for clients from pathologizing labels, particularly those that proliferate within therapeutic programs as circulated by

counseling professionals, they thereby enabled some participants to engage more fully in the healing process.

Positionality of Counselors (n=19). In addition to desirable counselor attributes, nineteen participants suggested that counseling may best come from an individual who imparted cultural knowledge, shared a cultural background with clients, and had what was construed as lived Indigenous experience. Because of these factors, many respondents voiced a preference for Indigenous counselors.

Imparted Cultural Knowledge (n=16). Sixteen participants mentioned valuing those counselors who were traditional knowledge carriers. Anna (staff) explained this within the context of culture:

> Ideally, it would be an elderly person who is very personable, a healer, people oriented, in tune with their own culture, and their own identity, who is not judgmental. The person would have to know the [native language] language. This whole discussion around the life force. 'Cause so much of that is hidden in the language. The spirituality. The intonations. The tools. As for training in the Western world, if my choice was either of those two, I'd definitely go with the [native language] speaking, non-university-educated individual.

The kinds of knowledge in question pertained to Indigenous traditional language and cultural practices. In the example above, a dichotomy was presented between being culturally knowledgeable and academically knowledgeable, with clear preference for cultural rather than professional experience. Interestingly, those participants who indicated possessing limited traditional cultural knowledge prior to engaging in therapy at the center were some of those most likely to note its importance in the healing process. Having a counselor in possession of this knowledge then served the dual role of cultural educator and therapeutic healer.

Shared Cultural Background (n=11). Eleven clients espoused the values of clients and counselors sharing the same cultural background. Some respondents indicated that, when this was not the case, there was an increased potential for misunderstanding or worse, insensitivity. For example, Andrew (client) related a story:

> 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 she's a counselor. I know she's educated. But deep down I figure she doesn't know how we are; you know, she's White, I'm Native. I talked to her about three times, and I canceled all the rest of my appointments with her. Because I wasn't really compatible with her.

Thus, shared cultural background was in some cases more important to the client's willingness to engage in the therapeutic process with a given counselor than the counselor's demonstrated or acquired skill and expertise.

Concern over cultural compatibility also extended beyond shared experience. Some participants indicated that counselors who didn't share their Indigenous background were more likely to adhere to harmful, pathologized stereotypes of Indigenous Peoples. Jessica (client) offered an example:

> One worker told me when I was trying to do something for myself and something for my family, "Well that neighborhood, there's a lot of drunks go down there, a lot of drug dealers and bootleggers, children not listening to their parents, and stuff like that." [I thought to myself] "what does that have to do with me?" I didn't like that comment.

Participants were keenly aware of colonially-derived stereotypes of Indigenous Peoples and substance use, and were anxious to avoid counselors whose biases even unintentionally contributed to pernicious narratives.

Participants also feared that non-Indigenous counselors might incorrectly label contextually appropriate thoughts, emotions, and behaviors as pathological and indicative of an individual deficit, rather than recognizing them as the downstream effects of harmful experiences in childhood stemming from colonial activities, such as the residential schools. Gloria (staff) illustrated this through an anecdote:

> They don't realize what happened to people that went to residential school. That's why they label people. The others talk about "Why are these kids like that? What's wrong with the parents?" I start talking to some of them. And then they say, "Oh, I didn't realize that. I didn't realize there was such things at a residential school."

Thus, counselors without the lived experience of colonization were perceived as being less able to appropriately identify the root of behavioral health problems and address them.

Lived Indigenous Experience (n=10). Although participants highly valued a counselor's traditional and cultural knowledge, ten similarly emphasized the importance of sharing every day or "lived" Indigenous experience, and thus indicated a preference for Indigenous counselors. This was true even for counselors without formal training, who were in many cases preferred over non-Indigenous counselors with formal training. As Rose (staff) indicated:

> You can have [a counselor] that's very educated, that doesn't have the life experience of maybe the other person. I know that sometimes people are

> intimidated by this guy. [They're thinking] "I'm just as old as him and he's trying to counsel me."

Younger age was equated with fewer opportunities to acquire important life experiences and firsthand knowledge which could contribute to a counselor's ability to meaningfully offer guidance. Many participants instead expressed a preference for counselors with greater life experience, in keeping with the importance in many Indigenous communities of consulting Elders for their hard-won wisdom.

Additionally, an Indigenous counselor, particularly one from the same community, could induce greater expressivity from more taciturn clients. Michael (admin) offered a personal example:

> The school counselor comes in. This young boy is about 15 years old—just a rough looking kid. And they said, "We need a miracle worker for this child." I said, "Oh?" I said, "Where is he from?" ["Another First Nations Reserve."] I said, "Okay." And I said, "I probably know your parents," I said. "I know just about everybody up there," I said. "And they've all gone to residential school in that community," I said. "So I know who they are," I said. "And I went to school with them."

In instances such as this, professional training failed to afford the connection, trust, and understanding that lived and shared experience offered. The lived experiences of participants, including residential school attendance and associated intergenerational histories of harmful substance use, were seen by many to necessitate a familiarity that could only come from shared cultural, spiritual, and practical experience that elude counselors from outside the community.

At the same time, however, finding counseling from an Indigenous counselor might also bring disappointment or introduce additional complications. Jacob (staff) explained this contradiction:

> With healing, or in therapy, you need to have some kind of connection with your therapist. An [Indigenous] therapist can connect with their client. The [Indigenous person] doing therapy with [Indigenous Peoples] would have more of that bond. But by the same token, if they get enmeshed with their client, and they start trying (to) untangle themselves, that can cause an anger with the client. But if a White person did something that confirmed their untrustworthiness. The client will say, "Well, I expected that, he's White."

Besides sharing Indigenous background or community, four participants stated that life experiences could facilitate a therapeutic relationship during counseling. Participants valued life experiences because they made the

counselor appear more credible, authentic, and naturally "gifted." Sarah (staff) described the difficulty in talking about children with a counselor who had yet to become a parent:

> She'd come there and talk to us for an hour about parenting. And to me it was kind of silly because "Are you a parent," I asked her. And she goes, "No, I don't have no children yet." "Well, how do you know all this stuff, if you're not a parent?" [I said]. [She said] "Well, I went to school, books, books, you know." You have to be a parent to know how to educate people about parenting. That's the way I see it with parenting, at least.

Lived experiences, particularly with substance use, were therefore perceived as providing an authenticity to the relationship between client and counselor that could not be achieved through the secondary acquisition of knowledge provided through academic learning.

Discussion

Participants in this study identified two important ways in which the therapeutic endeavor could aid in healing from colonial injuries, such as those that occurred through the IRS system. These dealt with targeted therapeutic goals as well as specific counselor qualities. In relation to therapeutic goals, both clients and counselors found merit in the idea of confronting issues and then moving on. They also identified the importance of community support during the therapeutic process and with encouraging client pride in the self.

Specific counselor qualities, including attributes and positionality of the therapist, were seen to be of great importance to the success of a given therapeutic relationship. Identified attributes included the ability to listen, expressions of sincerity, the modeling of appropriate behaviors, practicing discretion, and preserving client autonomy. Expressions of the positionality of counselors that were valued included possessing appropriate cultural knowledge, sharing a cultural background with clients, and benefiting from lived Indigenous experience.

Although many of these areas of emphasis share surface-level similarities with common desires in mainstream counseling practice, each instance exhibited subtle cultural and community nuances that differentiate them, rendering them specific to the North American Indigenous experience of continuing legacies of colonial subjugation. These differences were most notable within the broader context for healing, the cultural foundations of therapist effectiveness, the continuing salience of Indigenous knowledge traditions, and the active decolonization of the therapeutic endeavor.

Importantly, these findings remain salient for the illumination of the integration of professional and Indigenous approaches to healing and the

therapeutic endeavor, despite the fact that completion of a formal Truth and Reconciliation process was still years away. Indeed, reconciliation represents just the tip of the iceberg in relation to addressing the intergenerational harms of colonialism on Indigenous wellbeing.

Broader Context for Healing

Both in relation to therapeutic goals as well as desired qualities in a counselor, healing within the context of the behavioral health center was not perceived solely as an individual undertaking, but rather one that incorporated the community. This finding supports prior work with North American Indigenous populations on psychological substance use interventions that prioritized community transformation or revitalization rather than simply individual development (Gone & Calf Looking, 2011, 2015; Wendt & Gone, 2011). This emphasis on collective healing aligns with common Indigenous beliefs around relationality, in which no being exists in isolation (Tynan, 2021). Thus, family and other social relationships, interpersonal responsibility to both the self and others, shared histories of colonial subjugation, and cultural knowledge and practice all factored into the counseling endeavor. This was true both in relation to individual substance abuse (attributed to IRS attendance and associated intergenerational family disruption) as well as in relation to the pathways through which healing might occur (engagement with culture and community). Results indicate that individual healing could best, or perhaps only, be achieved through expansion of the therapeutic lens beyond individual history or pathology to include the broader sociopolitical and historical environment in which both individual clients as well as the counselors themselves were ensconced.

This differs from the modal approach to modern psychotherapy, which frequently focuses on the client as an egocentric individual in need of personal transformation (Gone, 2016; Kirmayer, 2007). It aligns, however, with evolving theories of Indigenous historical trauma that associate contemporary dis-ease with events and experiences of the past (Brave Heart & DeBruyn, 1998; Kirmayer et al., 2014; Sotero, 2006); Indigenous community discourses that probe the origins of problems, norms of wellbeing, approaches to treatment, and assessments of outcome in relation to Indigenous cultural and knowledge traditions (Gone, 2016); and "survivance," a neologist combination of survival and resistance that prioritizes an active Indigenous presence (Vizenor, 1994; Wilbur & Gone, 2023). Collectively, these models and theories situate the individual within a web of relations and their experience within a continuum of sociopolitical actions, events, outcomes, and interpretations. In short, counseling activities in this context required greater attention to sociocentricity beyond egocentricity and to contexts colored by histories and legacies of collective subjugation and oppression. Respondent

emphasis on identifying and evaluating counselor positionality within these extenuating environments clearly differentiated expectations of practice within this therapeutic setting.

Cultural Foundations of Therapist Effectiveness

Although much of the emphasis in mainstream counseling focuses on the identity and experiences of the client, respondents in this study asserted that several aspects of the counselor's identity and positionality harbored significant potential to impact the success of the therapeutic endeavor. This was particularly true in relation to the counselors' own Indigeneity, including their experiences as an Indigenous person, their familiarity with traditional culture, and their background in the reserve community in which the treatment center was located. In addition to an Indigenous identity, both clients and counselors particularly valued personal counselor experience with residential schools and substance use, which participants perceived as contributing to counselor relatability, reliability, and sincerity.

In many instances, first-hand experience was valued over formal education. In these instances, lived experience—grounded in shared social, cultural, political, and historical realities—allowed counselors to provide "guidance" rooted in hard-won personal experiences. These were visible and known to clients, and were privileged over formal "advice" developed through professionalization and training (Pham et al., 2023). Respondents also perceived that a shared cultural foundation limited the likelihood that counselors would engage in the perpetuation of racist tropes (eg., "the drunken Indian"), which echo previous findings which underscore the importance of counselor cultural humility in the therapeutic relationship (Hook et al. 2013).

Moreover, first-hand experience with substance use demonstrated to clients that counselors understood not only the multifaceted pressures that contributed to the development of substance use problems but the unique barriers within the community to sustained sobriety. Formal credentials, on the other hand, offered none of these assurances of common ground. Shared Indigenous identity, perceived as an initial indicator of mutual lived experience, enabled trust between counselor and client, which participants noted might otherwise be strained given some clients' past experiences with racial social hierarchies and associated power dynamics in the IRSs.

Although temporal distance from the dissolution of the residential school system has increased since these interviews were conducted, experience in IRSs and the elevated prevalence of substance use often associated with them remain prominent concerns in many First Nations communities (Government of Canada, 2011, 2022; Sansone et al. 2022). Despite the intervening completion of Truth and Reconciliation, counselor experiences with first the institutions themselves and then the government-initiated efforts toward

healing continue to foster new avenues for informed and respectful counseling.

Continuing Salience of Indigenous Knowledge Traditions

Essential to the recovery narratives of many participants, whether among current clients, counselors, or other staff with histories of problematic substance use, was engagement or reengagement with the Indigenous traditional practices of their First Nations community. Thus, the counselor role in many instances was expected to extend beyond the traditional bounds of mainstream therapy into that of cultural, and at times even spiritual, guide. Fluency in Native language, further, was perceived as offering an important avenue for healing not possible through English, the language of colonization in much of this former British territorial possession. Knowledge traditions, conferred through traditional language, provided opportunities for revitalizing client self-worth through the promotion of pride in Indigenous identity and connection to community and culture as entities greater than the self.

This finding aligns with an often-noted preference within counseling research and practice with Indigenous communities for Indigenous traditional knowledge over mainstream scientific knowledge (Gone, 2012). Indigenous traditional knowledges have been characterized as HOPES (holistic, oral, personal, experiential, and storied; Brant Castellano, 2002; Gone, 2023), lending further credence to respondent's desires for Indigenous counselors with personal substance use and traditional cultural experience who could engage in the counseling process with clients using Native language. Indeed, Indigenous leaders and traditional healers have long asserted the benefits of culture-as-treatment (Gone, 2012), although empirical evidence for such interventions is notably sparce (Pomerville et al., 2016).

Active Decolonization of the Therapeutic Endeavor

Findings from this study contribute to ongoing discussions on the value of assessments of cultural commensurability in counseling and psychotherapy for Indigenous populations. Notably, efforts to achieve cultural commensurability—such as that practiced by the healing program that was the focus of this study—extend beyond merely tweaking mainstream interventions in a nod toward cultural practices, and instead constitute the development of a culturally hybrid therapeutic approach that benefits from the strengths of multiple healing traditions (Wendt & Gone, 2011). Such approaches might, for example, afford equal weight to Indigenous knowledge, experiences, and ways of being in the world alongside hegemonic Euro-colonial professional practices. This offers a means of recalibrating existing

power dynamics in the therapeutic arena, which have resulted in longstanding subjugation and inequity in health outcomes for Indigenous Peoples.

Importantly, as with all knowledge stemming from research conducted with a single Indigenous community, practitioners should exercise caution when seeking to apply these findings in a blanket fashion to other communities. The enormous heterogeneity between populations prevents the prescription of a one-size-fits-all approach to Indigenous counseling. Instead, these findings should inspire critical consideration of methodologic strategies for systematically tapping into counselor and client experiences, and only be applied as appropriate within the context of specific community and individual client preferences. The rote application of distantly designated "best practices" from one community may be harmful when employed with another.

Previous research on cultural commensurability in counseling underscored the importance of attending to the cultural underpinnings of not just counselor attributes (e.g., attitudes, skills, humility) but more importantly to the cultural underpinnings of counselor practices (e.g., value of expressive, self-referential talk). And yet, the valorization by respondents in this study of Indigenous cultural identity, experiences, and knowledge of counselors represents a self-determined reclamation of Indigenous orientations in the therapeutic relationship. For respondents in this setting, the intersecting complexity of culture and identity in counseling yielded high stakes in both who the counselor is as well as what they do (e.g., pressure clients to verbally disclose painful pasts; Gone, 2009, 2011; Pham et al., 2023). These nuanced trade-offs carry significant implications for counseling outcomes with colonized North American Indigenous populations and constitute a unique contribution of this work to the existing literature on Indigenous counseling practice.

The benefits of this clinic for the population it serves, therefore, may derive from its status as a treatment facility by members of the community, for members of the community, uniquely establishing cultural applicability alongside informed and experienced providers who meet the identity requirements of clients. In this instance, cultural commensurability is not the commitment of a single counselor toward their clients but something that is woven into the fabric of the center as a whole, contributing to client willingness to engage meaningfully in ways that might not otherwise occur. Thus, the derivation of structural, personal, and practical elements of the center from not only Indigenous practice but distinct cultural and historical realities for the specific community in which the center is based contribute to a decolonized therapeutic environment. Therefore, above and beyond questions concerning individual client outcomes in substance use treatment, the incorporation of Indigenous counselors and traditional practices at this center enacts resistance to longstanding colonial domination that both created Indigenous mental health crises in the first place and then subsequently purported to remedy them.

Rather than continuously reaffirming these Euro-North American notions of superiority, the respondents in this study promote a different way forward: decolonization of the therapeutic endeavor. In this case, we have been able to document a major Indigenous institutional achievement through this community's expression of *survivance* (Vizenor, 1994, 2008; Wilbur & Gone, 2023): the active presence of continuing Indigeneity in the center and its engagement with the community on its own generative terms. Importantly, such expressions are rarely recognized, let alone documented. Future empirical inquiry undertaken in partnership with Indigenous community treatment settings therefore promises to reveal and illuminate actual on-the-ground, in-practice therapeutic innovations that identify Indigenous survivance-in-action.

Limitations

As with any study, this work includes limitations. Most notably, almost 20 years passed between the time the data were collected and when this analysis was performed. During that time, it is possible that the therapeutic goals and attributes desired in counselors within this community have shifted; however, many of the same structural pressures and self-determining practices continue to shape life in this community. Relatedly, due to the amount of time which elapsed between data collection and analysis, it was not possible to share the findings of this analysis with the original respondents; however, the findings were shared with the leadership of the counseling center on which this study centered. It should not be assumed that findings from this study generalize to all other Indigenous communities, treatment centers, or programs across North America, as Indigenous Peoples in the United States and Canada have unique histories, cultures, and experiences. Findings from one group cannot be expected to apply seamlessly to another. Finally, interviews for this study were conducted prior to the TRC in Canada, which involved the intentional national reckoning with and attempted reconciliation for the legacy of IRS abuses for Indigenous Peoples in Canada. Perhaps in the wake of the TRC, Indigenous communities have been empowered to undertake even more far-reaching innovations in their treatment services that only future empirical inquiry will document.

Conclusion

Indigenous Peoples in Canada experience significant behavioral health inequities resulting from ongoing colonial subjugation, including tacit cultural assimilation through health care. Indigenous communities assert that remedy may lie in culturally commensurate health interventions that fuse traditional and mainstream health practices. This study explored a culturally commensurate behavioral health treatment program at a reserve-based First Nations behavioral health treatment program. Our goal was to empirically identify ways that

respondents conceived of the therapeutic endeavor with respect to the distinctive possibilities for remedying and transforming colonial injuries, such as the abuses of the IRS system. Findings reveal that there are targeted therapeutic goals as well as specific counselor qualities that facilitated a positive therapeutic experience for those engaged with the program. Ultimately, while assimilative practices of the past (such as the IRS system) and present (including behavioral health treatment programs derived from Euro-American beliefs and values) continue to collectively contribute to inequities in behavioral health outcomes for Indigenous Canadians, decolonization of the therapeutic endeavor offers a potential avenue for positive change.

Author Notes

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Joseph P. Gone, PhD, is an international expert in the psychology and mental health of American Indians and other Indigenous Peoples. A professor at Harvard University, he has collaborated with tribal communities for 30 years to critique conventional mental health services and to harness traditional culture and spirituality for advancing Indigenous well-being. He has published more than 100 scientific articles and received recognition in his fields through more 25 fellowships and career awards, including a Guggenheim Fellowship.