James Smith Cree Nation: A Field Practicum Report

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by

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Abstract

The following is a report regarding my practicum experience at James Smith Cree Nation. The purpose of the practicum was to gain graduate level social work knowledge of, and practice in community capacity building, clinical counselling, and clinical group development for the specific population of First Nations people within their home community. Through individual, group, and community work, the challenges and benefits to the practical learning experience of a non-Indigenous helper within James Smith Cree Nation are explored. The report also highlights current literature surrounding being a non-Indigenous helper, Indigenous and Western healing knowledge and practice, and the concept of two-eyed seeing. The challenges, values, and ethics surrounding a personal experience of being a non-Indigenous helper within a First Nations community are explored. Using the personal experience and literature, the report provides recommendations for non-Indigenous helpers who want to work in First Nations communities in a collaborative manner. The report recommends that non-Indigenous helpers should expect to feel challenges of being under prepared, uncomfortable, and not immediately accepted by the First Nations community. In order to overcome challenges, non-Indigenous helpers must strive for cultural competence through humility and self-reflection, an openness to understanding cultural differences, and utilizing culture when appropriate.
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Chapter One: Introduction

I was afforded the opportunity to build a relationship, over several months, with the James Smith Cree Nation. As a non-Indigenous male who wants to work directly with First Nations people, it was important to allow time to establish a relationship of trust and mutual respect with the community in order to provide competent and ethical practice. I believe that building trust and community presence over a longer timeline contributed to being accepted by the community.

Community work does not occur in isolation, and therefore I needed to be accepted by the community in order to effectively offer professional support. Current research indicates that communal acceptance may be difficult to obtain for non-Indigenous helpers; historically, such newcomers were unknowingly intrusive and culturally insensitive agents of change (Silver, Ghorayshi, Hay, & Klyne, 2006; Weaver, 1997). In order to provide more culturally appropriate practice than these communities have experienced in the past, I have attended courses through the social work program at the University of Regina which increased my knowledge regarding First Nations, Métis, and Inuit people. However, the knowledge does not, on its own, fluidly translate into practical skills when working in a First Nations community.

The practical skill deficit and lack of confidence, surprisingly, added value to the practical experience. Rather than entering as someone with knowledge to push upon a community, I was able to enter humbled and genuine. I do not mention my lack of abilities to devalue what I offer to the community; rather, the community pulled the necessary skills from me as it required.

The Community
James Smith Cree Nation (JSCN) is a Cree First Nations community 70 KM East of Prince Albert, Saskatchewan. Historically, James Smith Cree Nation was known as Fort-a-la-Corne and was used as a gathering place for fur traders (James Smith Cree Nation, 2016).

The JSCN is comprised of three separate Cree communities: James Smith, Peter Chapman, and Chakastapaysin (James Smith Band, n.d.); all of which fall under Treaty 6 (James Smith Cree Nation, 2016). The three communities share resources provided from the Prince Albert Grand Council (PAGC). There are three chiefs for their respective bands; at this time, however, the PAGC recognizes James Smith Cree Nation as representative for all three communities (Prince Albert Grand Council, 2016). During my practicum, an election occurred which resulted in Chief Wally Burns replacing former Chief Justin Burns.

A community, obviously, is measured by more than this formal overview of governance. My informal perspective of the community is guided by experiences with community members, both professionally and personally. The community is comprised of caring members whose focus is on family well-being and the establishment of a better home for future generations. As an illustration of this focus, the community’s response to questions surrounding program development and supports is inevitably centered around their youth.

The Agency

In my professional capacity, my role was to support community members within the school, the health and youth center, and in their homes; I primarily worked out of the James Smith Health Clinic. Alongside its mental health supports, the James Smith Health Clinic provides a variety of services to JSCN such as the diabetes program, dental support, day care, maternal health, community health, nursing, home care, water safety, and medical transportation (James Smith Cree Nation, n.d.).
The employees of the health clinic were comprised of community members, Indigenous non-community members, and non-Indigenous non-community members. The environment was upbeat and positive, which I believe is a result from a combination of two factors: the health director’s attention to employee self-care and a socially active staff. The staff were consistently joking and smiling, having potlucks or in-house meals, and always open to professional or informal conversations. The open and accepting environment was valuable to me as it provided a safe learning space as a practicum student.

**Practicum Objectives and Activities**

The purpose of this practicum was to gain graduate level social work knowledge of, and practice in community capacity building, clinical counselling, and clinical group development for the specific population of First Nations people within their home community.

Further, I had particular objectives to achieve over the course of the practicum: first, to develop enhanced cultural competency; second, to gain a greater “on the ground” understanding of the impact of colonization and ongoing oppression of First Nations people and communities; third, to learn the intricacies of program/group development within a First Nations community; and finally, become familiar with the current literature that examines the complementary interaction between Western and First Nations knowledge and healing practices and the role such interaction can have in achieving greater individual and community wellness.

My practicum supervisor advised me that roles can blend and become difficult to define when supporting a community. I was advised that the roles of professional, friend, co-worker, and an advocate may be difficult to distinguish with time and an increase in community trust of the helper. Kirmayer, Brass and Tait (2000) would attribute role blending to the small, close, and remote nature of First Nations communities and that practitioners are expected to alleviate the
practical restraints by assuming many roles (p. 613). In order to provide clarity despite role blending, I chose three overarching practicum activity categories: clinical counselling, clinical group development, and community capacity building. I will discuss the roles I played in each category.
Chapter Two: Practicum Activities

My practicum activities of clinical counselling, clinical group development, and community capacity building could be categorized into three social work practice categories micro, macro, and mezzo, respectively (Birkenmaier & Berg-Weger, 2007). Micro work was provided on an individual basis with clients. Mezzo work was provided with clinical group development and implementation. Finally, macro work was demonstrated through youth mobilization and community crisis response. I will elaborate on each category, beginning with clinical counselling.

Clinical Counselling

Recent research reveals that clinical counselling with First Nations individuals requires a nuanced and particular approach. For instance, Howell-Jones’ (2005) doctoral dissertation at the University of British Columbia highlights the importance of engagement when working with Indigenous populations. According to Howell-Jones, engagement in a positive counselling relationship is one that encompasses “holistic approaches, relationship strength, connection to the Aboriginal community and resources, and respectful acceptance of Aboriginal practice and spirituality” (p. 112). In order to provide engagement to each individual, I ensured that I presented as non-judgmental in my verbal and non-verbal body language and as open and accepting to cultural practices; I also made efforts to illustrate my attempts to blend my Western knowledge with First Nations knowledge. I explicitly explained to the individuals I saw in counselling sessions that I was going to blend Western and First Nations knowledge and asked them to advise me which, if either, was more helpful in their lives.

The clinical counselling I practiced primarily involved talk therapy and/or psychoeducation focused on cognitive behaviour therapies and Choice Theory (Beck, 1979;
Glasser, 1998). Individuals met with me to discuss personal and social struggles. The talk therapy approach I used rarely involved directing individuals to improve their mental health. Rather, my practice hinges on the premise that the individual knows how to invoke change in their lives, and my role is to guide them through the process of change. Change for any individual can be quite difficult, especially when individuals are exposed to frequent and intense difficulties. Clinical counselling with JSCN members led me to conclude that there are a significant amount of trauma and difficulties facing individuals living in James Smith.

Some of the difficulties I heard surround personal anxieties and self-regulation struggles, addictions issues, and family violence. I also heard stories of parental abandonment, which occurred most often as physical absence or emotional absence through substance use. Lastly, individuals shared their stories of past and current sexual abuse and assaults.

I provided clinical counselling in three primary locations: Bernard Constant Community School, the James Smith Health Clinic, and in the individuals’ homes. Each location had its own particular benefits as well as pitfalls. Examples of potential pitfalls were: overcrowding, a lack of privacy, and social propriety; each factored into my approach as I moved from location to location. I attended many of the youth at the school in order to provide the least amount of disruption to their daily schedules. Finding a place to meet with the youth, however, did meet with some challenges. Specifically, sessions would occur in the same room as dental therapy, which sometimes resulted in conflicting schedules. Meeting space was limited at the school which resulted in location and scheduling inconsistency for the individuals I tried to support.

Counselling at the health clinic provided individuals with a more Western approach to talk therapy exemplified by one-to-one sessions, in an office, using a Cognitive Behaviour Therapy/Choice Theory model or psychoeducation. Initially, I provided a great deal of
counselling in the office and I assumed that the entire community desired a more Western approach. It later became clear, though, that my initial judgement was only guided by the individuals who were willing to enter the health clinic for mental health support. However, it became apparent that the individuals who would seek out a more traditional approach would not set foot in an office to engage in talk therapy. Furthermore, many community members stated they do not believe confidentiality is maintained within the health clinic walls, and concordantly were not willing to meet there. This pervasive communal perception was a significant barrier to providing support to the community as a whole. With individual apprehension to meeting at the health clinic, I also completed counselling sessions in the individuals’ homes.

Home visits provided the most amount of autonomy to the individual because they chose where, when, and how their session occurred. Home visits were, however, difficult to complete as an outsider. Often, family members (and sometimes the individuals) met me with caution as I am visibly not from the community. I typically introduced myself with the same mantra, “Hi my name is Anthony and I am practicum student from the health clinic”. Following the introduction, there was typically a verbal or non-verbal exchange that let me know if I was able to enter the home. Following formalities, many community members would joke that I looked like an “Indian Agent” or “Child and Family”. I found the best approach was to respond, in-kind, with humour at the time and, for following visits, wear jeans and leave the note pad in the vehicle.

Clearly, then, the more Western approach that I used at the clinic gave way to an approach more sensitive to the individual needs of First Nations community members in their own homes. These approaches were each informed by my academic research and clinical philosophies; however, the exact manner in which I presented as non-judgmental, open to communal practices, and “blended” in approach differed greatly given both the patients and
spatial contexts of the counselling. As I mentioned at the outset, knowledge alone did not suffice in this particular setting, and the community helped me to develop skills of adaptation, flexibility, and individualized care in order to bridge the gap between knowledge and practice.

Clinical counselling was the most consistent role that I engaged in throughout the practicum experience. Counselling provided a safe place for the individual to speak about the concerns they believe are unique to them. Over time, I was able to see themes arise from many individual stories. The themes, in turn, guided clinical groups and allowed the individual to see they were not alone in their struggles or concerns.

**Clinical Group Development**

Since the initial population I provided support to at James Smith was predominantly students, the decision was made to provide a clinical group at Bernard Constant Community School for youth in grades 8 – 12. My supervisor and I began two talking circles at the school; she facilitated the female youth and I facilitated the male youth. According to Gone (2011), a talking circle allows young Aboriginal men an opportunity to share their stories and concerns surrounding family relationships, addictions, bullying, which may be supported by their peers and professionals. Unfortunately, inconsistency in my schedule alongside room availability in the school made the talking circle unreasonable at the time. Inconsistency also did not allow the safe space needed for individuals to disclose personal concerns. If consistency would have been provided for the talking circles, the participating individuals may have felt the safety and support required when sharing personal information with others. Without the structure required for safe personal disclosure, group attendance waned and the decision was made to discontinue the talking circles.
Using the experience and knowledge I gained from the defunct youth talking circle, I began the men’s healing circle. My practicum supervisor explained the difference between a talking circle and a healing circle: a talking circle takes the principles of a healing circle but can be facilitated by community members, whereas a healing circle must involve an Elder. Further, the talking circle is an opportunity to air concerns, grievances, and successes in a safe place; a healing circle is a place for healing and is a group guided by an Elder (Gone, 2011). I was able to enlist the support of an Elder who offered his knowledge and guidance at each meeting.

The men’s healing circle was an intellectually rewarding experience in which I further learned the value of consistency, and it also reaffirmed my aforementioned lesson in flexibility. I quickly discovered that if I wanted people to attend the healing circle, I had to ensure they could count on the meeting to occur in the same place at the same time. Conversely, I also had to be flexible in the start time of the meetings and be open to late attendees. Each week the group directed the discussion topics for that evening. As the organizers of the healing circle, our approach blended Western and First Nations methodologies - I provided the more Western approach to group support in the form of psychoeducation, and the Elder shared his stories and experiences. The groups, I believe, are a strong example of how two-eyed seeing (see Chapter Three: Literature Review – Two-Eyed Seeing) can be implemented to support communities (Martin, 2012).

The organization of our group was a carefully planned undertaking and took into consideration the literature surrounding such a support plan. One such study by Kirmayer et al. (2000) argues that particular caution must be taken when organizing clinical groups. The authors of the study state that providing Westernized mental health groups to First Nations people can embody or individualize health concerns that are actually structural in nature (p. 613). If a
member of the group were to discuss their personal history of alcoholism, for instance, Kirmayer et al. (2000) warn that other group members could potentially view that member as an individual defined by their alcoholism; because alcoholism is a generational and community concern, it should be viewed as a structural or systemic issue rather than embodied in a particular group member. Because of this potential to individualize, Kirmayer et al. (2000) caution against narrating personal traumas in a group setting. With this caution in mind, the groups I supported utilized a more psychoeducational model focused on cognitive strategies for invoking positive change and did not allow much opportunity for divulging past traumatic events.

**Community Capacity Building**

Community capacity building for the purpose of the practical experience closely aligns with the community development vision of Nickson, Dunstan, Esperanza and Barker (2011). Nickson et al. (2011) envision the community development process with Indigenous people as enabling community stakeholders within and outside of the Indigenous community to work together, obtain a greater historical understanding of colonialism, and foster greater understanding, respect, harmony, and inclusion (p. 87). Further, according to Schnarch’s (2004) critical review of the Ownership, Control, Access, and Possession (OCAP) report, capacity building is fundamental to Aboriginal nation building (p. 87). My focus on community capacity building at JSCN was to increase youth volunteerism with the Youth Action Council (YAC) and increase mental health capacity in crisis support interventions through Critical Incident Stress Management (CISM) groups. I will begin by outlining the YAC and its purpose followed by my role in CISM groups.

An initiative from the PAGC, the YAC is meant to provide young community members a platform to voice concerns and strive for drug- and alcohol-free communities. I was advised that
the YAC was in need of revitalization and was provided with a few key names to contact among the community’s youth members. I attended the school to meet with them personally, and it was clear by their subsequent involvement that personal and positive attention is extremely motivating for these young people.

Following the personal meetings, the youth were excited to get to work. The youth were tasked with presenting at the PAGC’s “Reserves Against Drugs and Alcohol” conference on one of many healthy alternatives to drugs and alcohol use. The healthy alternative chosen for James Smith was “Family game nights as an alternative to substance use”. A display stand was completed and the youth made their presentation to other communities who belonged to the PAGC. The members of the YAC were rewarded for the hard work that they put into their presentation and earned second place for their ability to engage and inform the public.

Once the presentations to other communities were completed, the YAC was in a position to establish itself within its own community. YAC elections were held and members were sworn in as junior chief, junior vice-chief, treasurer, secretary, and junior council members. Interestingly, after the establishment of positions occurred, followed by a few meetings with other YAC groups from other communities, there was notably less need for my assistance. Intentional or otherwise, I was not informed of meeting dates or discussions. I did not take it as a personal affront, as it likely was not a conscious choice to not inform me of the meetings. Regardless of whether the YAC intentionally or unintentionally did not inform me, my assistance was simply not needed; this was another success of the YAC group, because, I believe, their self-sufficiency was a remarkable achievement. My purpose as a community capacity builder was to provide support and step away when the community fulfilled its own needs. I advised the youth that if they needed support, all they had to do was ask and I would provide it.
Unfortunately, some community events cannot be planned for and require immediate interventions in the form of crisis support. During my time at JSCN, one such crisis arose when a youth member committed suicide. I provided crisis support by being a team member based on a model called Critical Incident Stress Management (CISM). CISM is a Western model of responding to crisis with a focus in debriefing and diffusing; the model allows individuals to discuss personal trauma and gives strategies for reducing secondary and vicarious trauma (Pack, 2013). CISM was chosen by the Prince Albert Grand Council in hopes of preventing individual and community trauma from playing a significant role in later life following this crisis (Embracing Life, 2009).

I provided individual and group support to community members and other impacted parties such as the school staff at Bernard Constant Community School and the Health Clinic staff. Initially, my role was to identify and support the most affected community members. Once identified, the impacted individuals were provided with follow up attention from either myself or a more appropriate resource. Our goal was to reduce copycat suicides and increase the affected individual’s feelings of support. Following individualized care, the other CISM members and I held groups to debrief impacted community members. One of the groups was held for youth who were close friends to the teen. A second group was provided to the students of similar ages at the school, and lastly, the staff at the school were also given the opportunity to debrief as a group.

In each of the support roles in which I engaged, I had to be cognizant of my presence and be careful not to overstep boundaries. While my knowledge was valued and respected in the community, I needed to be wary of becoming viewed as the “professional” within the community. If such a perception were to arise, the potential for community members to rely on
my subjective opinion could arise alongside it, and such a reliance should be discouraged. As an “outsider” helper, I must carefully consider how perceptions of me within the community are formed and how best to navigate my role for community members. Through a literature review, I will describe the experience of being an ‘outsider’ helper, the Western and Indigenous knowledge, and the concept of two-eyed seeing.
Chapter Three: Literature Review

Being an Outsider Helper

Throughout the practicum, I continually returned to the dilemma of how I might positively impact the JSCN community despite my role as an outsider. Although there is limited research in the area of non-Indigenous helpers within First Nations communities, there are two studies which explore the non-Indigenous helper’s experiences. The first study suggests, through a social constructionist epistemology and a critical theory lens, that health workers who provide support in Aboriginal health experience four primary attitudes and characteristics: a lack of practical knowledge, a fear of practice, the work was too difficult, and, learning to practice regardless of the other three (Wilson, Magarey, Jones, O'Donnell, & Kelly, 2015, p. 4). Three of the attitudes and characteristics of the health workers (lack of knowledge, fear of practice, and too difficult) hinder working with Aboriginal populations. Over time, the helper’s attitudes and characteristics which hinder working with Aboriginal populations can lead to an overwhelming work relationship resulting in two likely outcomes: employment ends or the individual practices regardless of incongruent value systems.

The Wilson et al. (2015) study focuses on the helper’s individual qualities and the hindrance they can have on working with Aboriginal populations. A possible explanation for the tone of the study may be due to the sample populations being comprised of helpers with only a few years of working in First Nations communities and in other allied health positions including dieticians, speech and language therapists, and occupational therapists. More to the point, the study does not include many health care workers who supported First Nations communities over a long period of time, who can speak to the individual qualities which promote positive work with Aboriginal people, or who receive more training in cultural competencies similar to the
social work field. Thankfully, Bennett, Zubrzycki, and Bacon (2011) explored the experiences of social workers with a range of five to thirty years’ experience supporting First Nations communities and suggest competencies that support collaborative practice.

Bennett et al. (2011) found that Indigenous and non-Indigenous social workers had similar knowledge bases on cultural practices, customs, and expectations. While cultural knowledge was an expectation, the helper was most effective when they were accepted by the community. Experiencing community acceptance came from non-Indigenous helpers practicing self-reflection and awareness, developing relationships, engaging in individual and community introductions, using strong listening skills, and developing and earning trust (Bennett et al., 2011). Bennett et al. (2011) suggest that if non-Indigenous helpers would like a rewarding and worthwhile experience when working with Aboriginal populations, they must take on the individual role of obtaining community acceptance.

Wilson et al.’s (2015) study suggests that role that the individual plays and their value system can be a hindrance if left unchallenged. The work of Bennett et al. (2011), however, proposes how the individual and their value system can be a support when working within a First Nations community, leading to community acceptance. Combined, the findings from these two studies led me to conclude that as a non-Indigenous helper in a First Nations community, individual traits play a large role in community acceptance and whether the experience is, generally, overwhelming or rewarding.

**Western Knowledge**

The majority of my professional experience in individual and group support is founded on cognitive behavioural therapy (CBT) and Choice Theory informed by the work of Aaron
Beck (1979) and William Glasser (1998; 2000), respectively. I will now outline the literature surrounding the strengths and limitations of CBT and Choice Theory.

**Cognitive behaviour therapy.**

CBT is a therapeutic method, developed in the 1960s, with a focus on the individual’s interrelated thoughts, feelings, and behaviours (Beck, 1993). The premise of CBT is that thoughts guide feelings, which in turn guide behaviours in a cyclical process (Beck, 1979; Beck, 2011). For example, a young person with an upcoming exam may think, “I am going to fail this test” (thought) and become discouraged (feelings) resulting in not studying (behaviour). After neglecting studying and not doing well on the test, the original thought, “I am going to fail this test”, is reinforced and the cycle begins again solidifying distorted thinking as a core belief.

Dysfunctional thoughts are highlighted, explored, and challenged collaboratively by the mental health professional and the individual (Beck, 1993). Change does not come naturally or easily as belief systems and core value system guide thoughts, and subsequently both feelings and behaviours. A counsellor using CBT asks the individual to challenge ingrained facets of who they are (Beck, 2011; Sburlati, Schniering, Lyneham, & Rapee, 2011). A strong therapeutic alliance, or rapport, is essential in allowing the individual the vulnerability to challenge their core values or beliefs (Beck, 2011).

Therapeutic techniques used to increase the rapport used by the therapist include paraphrasing and summarizing, using empathetic statements, mirroring, attentive listening, and being non-judgmental (Kadushin & Kadushin, 2013). If a strong therapeutic alliance is not gained quickly, individuals receiving support may not remain in therapy. High dropout rates have been noted as a limitation to cognitive behaviour therapies (Cuijpers, van Straten, Andersson, & van Oppen, 2008). Those who continue with CBT should have an experienced and
effective therapist because the research suggests non-experienced therapists, or therapists who
provide unscripted therapy, limit the effectiveness of CBT (Johnsen & Friborg, 2015).

Cognitive behaviour therapy is well respected within the Western world as a
quantitatively validated treatment model (Vittengl, Clark, Dunn, & Jarrett, 2007). I have used
CBT as the basis for most of my previous and current clinical work as it is reasonably easy to
explain and be understood by both the therapist and the individual. However, depending on the
individual, Glasser’s (1998) Choice Theory is also a strong Western therapeutic model.

**Choice Theory.**

Similar to CBT, Choice Theory recognizes the components of thinking, feeling, and
acting, but Choice Theory suggests that physiology plays a role, which Glasser (1998) refers to
as “Total Behavior” (p. 62). Thinking and acting are the two components of Total Behavior in
which individuals have a considerable amount of control; according to Glasser (1998), feeling
and physiology result from the expression of the other two.

Choice Theory continues with the premise that each individual is driven by one genetic
need and four psychological needs. The genetic needs surround survival and include safety,
food, shelter, and breathing (Glasser, 1998, p. 25). The psychological needs we strive for are
love and belonging, power/significance, freedom/autonomy, and fun/learning (Glasser, 1998, p.
25). Glasser (1998) posits that how these needs are met throughout an individual’s life build a
picture of a “Quality World” (p. 44). The Quality World is then used as the litmus paper by each
individual as they gauge their life experiences vs. their expectations.

Glasser (1998) suggests that an individual’s problems are not grounded in a biological or
medical basis; rather, he proposes relationships in distress are at the epicenter of unhappy people
(Glasser, 2000). For instance, a therapist using Choice Theory would not say an individual has
depression; only their relationship(s) are not meeting the individual’s picture of their Quality World. The individual is advised to look at their needs to determine which relationships need work to improve their Quality World (Glasser, 1998).

Choice Theory is seen with skepticism from some psychologists for its refusal to accept diagnoses, which are a staple of the psychological world (Silver, 2013). Further, individuals living with a mental illness, or who have a family member with mental illness, may struggle with the idea they are choosing to have a mental illness such as depression or schizophrenia. Also, medication is typically used to support individuals with mild, moderate, and high need mental health concerns and psychopharmacology is not a supported modality in Choice Theory despite its effectiveness (White, 2005). Choice Theory does recognize that medication can make people feel better, noting medication does nothing to solve the underlying, relational, problems (Glasser, 2000, p. 24). Glasser (2000) argues that people have more control over themselves and their lives than they realize. Further, he postulates that when people reduce self-victimization they can overcome personal challenges that contribute to what the Western world considers significant mental illness (Glasser, 2000).

Choice Theory, similar to Indigenous knowledge, does not place high significance on diagnosis in order to support the individual. Similarly, Indigenous knowledge focuses on relationships, teaching value systems, and fulfilling roles in order to find spiritual, cognitive, emotional, and physical balance.

Indigenous Knowledge

Cree Elders teach the importance of building a strong community through lessons such as the Tipi Poles. The tipi pole teachings develop values within individuals such as thankfulness, sharing, drink, childrearing, hope, ultimate protection, control flaps, obedience, respect, humility,
happiness, love, drink, faith, kinship, and friendliness (Lee, n.d.). The teachings highlight the expectations of the individual which, in turn, build and maintain a strong community. Similar individual and community values are taught through the seven sacred teachings. The seven sacred teachings are wisdom, love, respect, bravery, honesty, humility, and truth (The Sharing Circle, n.d.). The seven sacred teachings are, like the tipi teachings, are intended to guide all the relationships and provide for a healthy and full life.

Indigenous knowledge relies on a consistent, stable basis of knowing, passed down through generations using stories and culture tools such as tipi teachings and seven sacred teachings (Lee, n.d.; Rybak & Decker-Fitts, 2009, p. 335-336; Ruml, 2011). Unfortunately, colonization caused a disruption of knowledge sharing from Elders and/or Knowledge Keepers to their children and have damaged the Indigenous communities’ potential for stability (Hall, Dell, Fornssler, Hopkins, Mushquash, & Rowan, 2015, p. 3). Decolonization through Indigenous peoples’ understanding of colonialism is the first step in Indigenous community development and returning to stability (Hall et al., 2015, p. 10; Silver et al., 2006). Community development through decolonization promotes healing for Aboriginal peoples and includes learning about systemic oppression and its ongoing impact on their communities (Hall et al., 2015; Silver et al, 2006).

Following decolonization, Indigenous knowledge involves a focus on the medicine wheel and returning the community to a balance of physical, mental, emotional, and spiritual well-being (Gone, 2011, p. 194). Key community members are not identified based on their ability to invoke change but on their ability to regain balance within the community (Silver et al., 2006). Some community development methods to regain balance using medicine wheel value systems have been popularized. One of the more popular models is “Reclaiming our Youth” from British
Columbia. “Reclaiming our Youth” focuses on teaching traditional value systems to younger generations, highlighting generosity, mastery, independence, and belonging as the four areas needing balance in their “Circle of Courage” teaching model (Brendtro & Brokenleg, 2002).

**Two-Eyed Seeing**

In 2004, Mi’kmaq elders Albert and Murdena Marshall innovated the term, “Two-eyed seeing” (Mi’kmaq word *Etuaptmumk*) to describe the formal acknowledgment of both Western and Indigenous knowledge (Hall et al., 2015, p. 1; Martin, 2012). Two-eyed seeing is the recognition of different ways of knowing, the merits/deficits of each approach, and most importantly, accepting that there are many answers to the same question. Two-eyed seeing is not the practice of two parties, with the same goals, working together for the same cause; it is the ability to respectfully continue despite cultural contrast and accept the inherent knowledge each party brings with them (Hall et al., 2015).

If two-eyed seeing is possible, culture must stand at the forefront of collaborative work (Gone, 2011; Wexler & Gone, 2012, p. 800). Collaborative work with a community involves a higher standard of ethical obligations to relationship building, the application of culture, and the sharing of responsibility, as well as credit (Holkup, Tripp-Reimer, Salois, & Weinert, 2004). Collaborative work and its high standard must have two parties willing to work together. As the literature demonstrates, both parties have knowledge that deserve recognition and mutual respect.
Chapter Four: Integration of Theory and Practice

Practice as an Outsider

The research of Bennett et al. (2011) was an invaluable resource and guide for my work as an outsider in a First Nations community. The research provided practical tools such as protocol for community introductions, guidelines for periods of self-reflection as well as tools to help me maintain constant awareness. Fortunately, I was afforded a practicum supervisor who had strong connections with the community, who provided opportunities for individual and community introduction, and who allowed adequate time for self-reflection and consultations. In terms of community introductions, I was also benefited by my supervisor’s respected place within the community; I am certain that if she were not accepted by the community, the introductions (which provided an immediate opportunity for relationship-building) would not have been as well received.

During the practicum, I built relationships with both individuals and agencies. It was my experience that the boundary between personal and professional relationships was ambiguous in James Smith Cree Nation. The sense of community is so significant that it was almost seen as culturally inappropriate to make requests from people without a full conversation. I learned that observing social proprieties in interpersonal relationships is more important than any single task one might ask of another in such interactions. I was forced to adopt a relationship-oriented approach rather than the task-oriented approach I am used to employing. This reorientation involved a difficult perspective shift and took a great deal of self-reflection about how my conversations were going with co-workers.

My periods of self-reflection involved looking back on conversations or preparing for future ones to examine what or why I was uncomfortable. I reflected on my ability, and
inability, to listen intently during conversations. On a personal note, I rarely reflected on conversations as they typically felt fluid and natural when outside of the First Nations community. However, I found that practicing self-reflection was almost forced upon me feeling out of place as an outsider as I was much more uncomfortable. Over all, self-reflection appeared to be beneficial as I recognized when I spent too much time thinking about a response to the individuals I was speaking with, instead of truly listening to them. Despite my personal struggles in second guessing myself, the community members did not explicitly highlight concerns with our conversations. On the contrary, community members demonstrated a certain level of acceptance and trust in me which came out in personal and professional conversations.

The trust from community members usually came in the form of informing me of significant events in their lives. People would disclose personal struggles and concerns alongside their successes. It was these conversations, which did not always occur within the walls of a counselling session, which made me feel as though I earned trust, respect, and acceptance in the community.

**Blending Western and Indigenous Support**

As I felt more comfortable within the community, I was able to express my perspective more openly. Often, within a counselling and group session, I would state that I came with a “not all-knowing” perspective. I explained that while I know about Western supports, I am learning Indigenous supports and that we would use whichever was the most appropriate given the contextual particularities. Eventually, I noticed connections between Western and Indigenous belief systems, particularly the medicine wheel with cognitive behavioural therapies and Glasser’s (1998) Choice Theory with Brendtro, Brokenleg, and Van Bockern (2005; 2014) Circle of Courage.
The philosophy behind the medicine wheel proposes that in order to be balanced, we must be giving to the spiritual, cognitive, emotional, and physical aspects of ourselves (Gone, 2011, p. 194). There are clear analogues in the philosophy of the medicine wheel to CBT’s principles of core beliefs, thoughts, feelings, and actions (Kahl, Winter, & Schweiger, 2012). As I explored the connections between these two models of healing, I began to use the similarities as a teaching tool in clinical settings. I explained how Western knowledge appears to be recreating Indigenous knowledge and how they built upon each other. For example, if an individual was not spiritual or religious (which appeared to be an uncommon occurrence within the James Smith Cree Nation), I was able to explain that an individual’s spiritual self could also be seen as their engrained belief system. A belief that has been taught and goes undisputed is comparable to spiritual beliefs. I was able to accommodate for the individuals who simply were not interested in traditional values, but lived within a community where Indigenous knowledge is indisputably prevalent.

The Circle of Courage from Bendtro et al. (2005; 2014), in my opinion, is similarly tied to Choice Theory. The Circle of Courage posits that individuals need independence, belonging, mastery, and generosity in order for well-being (Brendtro et al., 2005; 2014). Choice Theory’s teachings are remarkably similar: Freedom/autonomy (independence); love and belonging (belonging); fun/learning (mastery); and power/significance (generosity). While the ties between Western and Indigenous knowledge are not perfectly parallel, the similarities in the two knowledge bases were too apparent to dismiss altogether.

**Use of Two-eyed Seeing**

As I recognized the similarities between the two epistemological approaches that guided my practice, I also learned to recognize the differences. Two-eyed seeing inherently requires the
individual to challenge their own beliefs about their skills and be guided by the needs of the person being supported. The guidance provided by the individual may conclude that the best support could come from another’s knowledge. Further, I had to be humble and know that I do not have all the answers. I learned that in many cases, culture may be the only aspect missing from an individual’s life and I am not the most appropriate support. Similar to allied health profession referrals, I would receive referrals from an Elder and I would also refer individuals to an Elder.

An Elder provides a perspective that I do not have the ability, nor right, to provide. Traditional lessons and value systems provide a consistent knowledge base for Elders, however, I learned that no two Elders are the same. I was taught that Elders cannot speak ill of each other as each Elder’s knowledge has value because of their unique journeys. It is the concept that each Elder has a unique knowledge which guided my respect for using two-eyed seeing. Each individual’s life is full of lessons and, as two-eyed seeing posits, we need to treasure the multiple perspectives (Martin, 2012). The people in need of support are the ones who benefit most from two-eyed seeing; they are given the opportunity to empower themselves by choosing the lessons which are most applicable to them. Individuals are also given the power to dismiss knowledge they do not see as valuable in their lives.

**Traditional and Indigenous Knowledge in Counselling**

The individualized counselling I performed does not typically accommodate for First Nations knowledge to come directly from an Elder. As such, I attempted to give the power of choice to each individual while avoiding cultural appropriation. It was not appropriate for me, as a non-Indigenous outsider, to purport I held the same level of understanding of Indigenous knowledge as an Elder. I was not comfortable sharing traditional stories, discussing the four
directions, or answering culturally specific questions as that knowledge is not mine to give. I was, however, comfortable using the medicine wheel teachings of physical, emotional, mental, and spiritual health (Gone, 2011). Should the individual be disinterested in traditional teachings, or if they were receiving traditional support from the community, I fell quickly into Western practices and highlighted the similarities discussed in the *Blending Western and Indigenous Support* section.

I believe that when I discussed the similarities between Indigenous and Western knowledge, the inherent cultural gap between me, a non-Indigenous mental health counsellor, and the First Nations community member was made a little smaller. Also, as similarities between me and the individual were highlighted, our therapeutic alliance appeared to increase. I took any opportunity to increase the therapeutic relationship as it is crucial to the success of counselling (Trimble, 2010).

After the establishment of a therapeutic alliance and the discussion of similarities between Indigenous and Western knowledge, I chose primarily modality to guide the sessions. Often, I opted to use medicine wheel teachings for individuals who presented with traditional value systems. I asked individuals specific questions around their physical, emotional, mental, and spiritual self. Specifically, I would ask questions such as, “in terms of your physical, emotional, mental, and spiritual self, where do you feel strong?” followed with, “what areas do you feel need work?” In moderate contrast, I used questions directed more toward a Choice Theory modality for those disinterested in receiving Indigenous based support from me. The questions I would use for Choice Theory were, “in terms of love and belonging, power and control, fun, and freedom, where do you feel strong?” followed with, “which areas do you feel need work?” Regardless of the modality used, the questions provided the individual an
opportunity to highlight their strengths, recognize their current state, and focus on specific areas to improve upon.

Regardless of whether a Western or Indigenous modality was established as a general counselling theme, I used more Western therapeutic teaching tools and psychoeducation in terms of specific techniques. For instance, I was most comfortable using Beck’s (2011) CBT psychoeducation as it is easy to explain and understand for most people. CBT’s premise that thoughts direct feelings which, in turn, direct actions appeared to be easily understood and accepted by most individuals with whom I interacted. It was common during counselling sessions for individuals to exclaim how they felt much more control in their lives following a brief introduction to CBT.

In summary, I wanted to provide blended individual counselling sessions and to utilize Western and/or Indigenous knowledge guided by the individual. I began many sessions discussing the similarities I saw between Indigenous and Western knowledge to increase the therapeutic alliance. I was wary of cultural appropriation and limited my use of Indigenous knowledge to more broad modalities such as the medicine wheel. I felt as though it would have been inappropriate to feign knowledge as a non-Indigenous person, whereas the medicine wheel and the questions I used allowed me use traditional knowledge and remain be culturally appropriate. My fear of being culturally inappropriate did lead me to primarily use Western teaching tools such as CBT psychoeducation. Despite being a Western concept, CBT’s ability to be easily explained and understood allowed for it to be a strong therapeutic tool.
Chapter Five: Challenges

I have never been one to see challenges or concerns as inherently negative. The personal challenges I experienced during my practicum led to personal growth and added value to the practical experience. I will focus on my challenges of being under-prepared for work within a First Nations community, my lesson in humility, and personal spirituality struggles.

Under-Preparedness

The University of Regina (U of R) Social Work program, in my experience, does try to provide students with a general ability to work in a culturally aware manner with Aboriginal populations. Cultural awareness, unfortunately, differs greatly from culturally appropriate practice. In urban settings, I feel as though the cultural awareness provided by the U of R Social Work program gave me confidence in my ability to work with Aboriginal people. Unlike urban settings, working with First Nations people within their home community appears to require significantly higher expectations in cultural knowledge. When I began to work directly within a First Nations community, I felt a personal skill deficit and lack of confidence. Specifically, I felt ill-prepared for the cultural expectations that were required when working within a First Nations community. In particular, I felt ill-prepared in how to respond to the prominence of Christianity and how to accommodate for both traditional and Christian values. Also, without the guidance of a strong practicum supervisor, constant and consistent Elder consultations would have been difficult to learn. Lastly, I was ill-prepared for the overarching wonder of how I fit within the community.

After consulting with my supervisor throughout the practicum experience, I concluded that working in a First Nations community simply may not be something that one can adequately prepare for. I was certainly placed out of my comfort zone and had to learn to adapt to the new
environment. This discomfort was perhaps a boon, though, because it allowed me to enter the First Nations community as a learner instead of a “professional.” The community may not have been as open to someone who enters and is perceived as a professional who is only there to spread, not share, knowledge (Bennett et al., 2011). It was far more valuable, and effective, to be myself among others who are simply being themselves.

Learning Humility

I have always considered myself to be a humble individual despite never having to challenge that notion. After months of being openly accepted and supported in the community, though, I learned a valuable lesson in humility. Following the suicide of a young person in the community, the crisis response team was charged with debriefing groups. Typically, I took a passive role in the debriefings, however, I was asked to lead one at the school. The debriefings thus far were following a CISM model which, it would be fair to say, does not inherently have Indigenous value systems incorporated. We did include Elders in the school debriefings as it was requested, and a quick discussion took place between team members regarding how to be culturally appropriate while following the training. It was decided that the Elders would open the debriefing and sit to the right of the team lead so the full circle could be completed and conclude with an Elder.

Unbeknownst to me at the time, leading was not how I would participate in the healing circles. The Elder led the circle and we discussed our feelings toward the suicide. I was passed the feather and shared my feelings of belonging and acceptance as a helper despite being an outsider, and the circle continued clockwise. While the circle continued, I internally struggled with how to provide the service we were expected to provide. When the feather reached one of the crisis response members, she began using the debriefing introduction and asked for support
from her peers. I, misreading the situation and the non-verbal cues, began to support her by talking. I broke protocol. I was immediately, and rightly, chastised.

I do not consider errors to be a direct reflection of my ability but simply a natural part of learning. I did, however, struggle with the consistent challenges directed at me as a result of a singular error. I was poked in the side and reminded to remain quiet, despite remaining mute, twice more while watching others break the circle to answer a call or use the bathroom, leave, and return without public reprimands; I was confused and discomforted because I did not understand the hierarchy of indiscretions. Lastly, comments directed at devaluing my knowledge about crisis response took place without an option to defend myself. I felt targeted and my expectations of what I believed a healing circle to be were not met. I believed a healing circle was a place where each person’s story and knowledge were valued; rather, I felt my initial story of acceptance and belonging was invalidated as a result of a singular error.

In essence, I felt unfairly targeted and overly chastised primarily due to being an outsider. In this particular experience, I learned two valuable lessons: first, I am quickly bothered with unhealthy thoughts when I do not feel comfortable in social situations; second, the event highlighted how I rarely feel uncomfortable socially and I should be appreciative of my privilege.

Elders teach lessons. This lesson allowed me to challenge my own values, beliefs, ideologies, and perceptions of where/when/how I belong. I am not promoting the devaluing of others in order to exhibit a “shared experience” of humility for past wrongs. For example, I would not condone someone to ‘bully’ a bully to teach how it feels. Regardless of what I believe best practice to be, the experience taught me that I do not always belong, despite my best
intentions. I learned to put aside my knowledge and be open to the knowledge of others. Most importantly, I learned the benefit of my inherent privilege and how I need to strive for humility.

**Spirituality**

Finally, my most significant challenge for me was that of spirituality. While I understand that there is a difference between spirituality and religion, at times it is difficult to differentiate when discussing the distinctions between a Creator and a Judeo-Christian God. I was raised as a Mennonite and have been an atheist for several years. I remain respectful of others’ religious value and belief systems in both my personal and professional life. Personally, I have family members that are actively religious and I try to be supportive of the religious events (such as baptisms, funerals, church events, and so on) in their lives. I do, however, hesitate in engaging at events if they oblige me to commit to something I do not believe in (i.e. baptisms and stating I will raise the child in a particular faith). I feel as though it is disrespectful to the religion and its participants if I am willing to stand up in front of everyone and blatantly lie. Professionally, I share the same values and practices of respect. I listen and respect a client’s beliefs, however, I am completely honest with them if they ask if my beliefs are similar. Personally or professionally, I always felt as though there was some ability to choose spiritual disclosures. However, with spirituality being such an integral aspect of JSCN, along with my desire to be accepted by the community, the choice to disclose my belief systems was restricted.

There is an intrinsic sense of spirituality within the community of JSCN. Community events, regardless of purpose, begin with prayers of thanks and end with blessings. Similar to family events, I am quite content to demonstrate my support by engaging in cultural practices as long as they do not request me to make claims with which I am uncomfortable. Over the length of the practicum experience, I was never asked about my spiritual/religious views. Consultations
with my supervisor led me to conclude that since spirituality is such an engrained part of the community, there was no need for people to inquire about my beliefs because spirituality is expected. I began to feel disrespectful, as if I was lying by omission, when I engaged in cultural practices such as prayers and smudging. Even though I know it is not the same, it felt as though I was engaging in some form of cultural appropriation.

Over time, and listening to the stories of others, I realized that each individual’s sense of spirituality varied. I learned that each individual is entitled to their own belief system and I gave myself the same privilege and levity in my guilt. I concluded that I am entitled to my own beliefs and can be allowed the same accommodations and respect others receive which is congruent with ethical social work practice and (CASW, 2005, p. 4). The sense I obtained from the community is that each individual’s experiences have led them to a unique knowledge of life and what they believe. Additionally, those experiences and knowledge carry equal value to my own experiences and knowledge.
Chapter Six: Achievement of Objectives

The objectives I set out to achieve when I began the practicum were: to develop enhanced cultural competency; to gain a greater “on the ground” understanding of the impact of colonization and ongoing oppression of First Nations people and communities; to learn the intricacies of program/group development within a First Nations community; and to become familiar with the current literature on how Western and First Nations knowledge and healing practices can complement each other in working towards greater individual and community wellness. I will provide an overview of how I believe these objectives were achieved.

Increased Cultural Competency

As mentioned in the challenges section, I felt ill-prepared in my cultural competency. My formal education provided an overview of Indigenous practices and belief systems. I do, however, believe in the concept of praxis. Praxis is the practical work within a specific field of study to guide learning (Praxis, 2016). Praxis was essential as I do not believe that I could have learned the intricacies of cultural competency from a solely theoretical source. I entered the community from a place of “not knowing,” which forced me to be more open and genuine. Further, akin to a child being scolded for misbehaving, Elders did not hesitate to teach me as I made mistakes such as speaking during a healing circle. I learned through my cultural inappropriateness as I was humbled and forced to be more self-aware.

Greater Understanding

My objective of a greater “on the ground” understanding of the impact of colonization and ongoing oppression of First Nations people and communities primarily took form in my interpretation of events alongside consultation with my supervisor. An example of my interpretation of colonization’s impact occurred on the first day during the meeting prayer. I was
prepared for a prayer to mark the start of a meeting, but I did not expect the prayer to be spoken in English, nor be of Christian denomination.

As soon as I isolated my supervisor, I discussed my concerns of Christianity’s role as a tool of colonialism. I was advised that I was not the first to mention how a seemingly blatant result of assimilation made its way into daily practice. The explanation I was provided is simple: there is an expected acceptance of each individual’s beliefs and knowledge. If the person offering the prayer was traditional, the prayer would be in Cree and to the Creator. If the person was Catholic, the prayer is in English and to God. Further, depending on the experiences and belief systems of the individual, prayers could take any form as long as their intent is to request guidance and purpose for the upcoming meeting.

As an outsider, the experience led me to conclude that the community fell victim to religious assimilation as a result of colonialism. Following a consultation with my supervisor, it was clear that the community would rightfully retort that they are accepting and open to anyone’s belief systems. Realistically, I have no desire or right to argue the accepting nature of the community to other’s religious views regardless of whether it was born of colonization or not. Unfortunately, not all aspects of colonization impact the community with the same qualities of acceptance and openness.

Residential school systems were a tool used to assimilate Indigenous populations which resulted in the physical and sexual abuses of many Aboriginal people (Dion, Cantinotti, Ross, & Collin-Vézina, 2015). During training sessions and in groups, discussions surrounding colonization tools such as residential schools were openly discussed. In these larger groups, trauma as a result of residential schools was often discussed at a community level in terms of the visible impacts of addictions, abuse, poverty, and so on (Nickson et al., 2011). Similar to large
groups, I noticed that smaller groups would discuss the sexual abuse within the residential schools while exemplifying that the face of trauma was, typically, Caucasian men.

In contrast to groups, the individual clinical settings allowed individuals to be more open in discussing their personal traumas. Individuals would discuss privately how the intergenerational impact of physical and sexual abuses beginning with residential school survivors impacted their daily lives. Due to the continued abuses, unfortunately, the face of trauma is not the white, male population the group settings describe. Contrarily, trauma on the individual level is, unfortunately, more often perpetrated by neighbours and family members.

I learned the importance of teaching about intergenerational trauma in clinical sessions and decolonization work (Hall et al., 2015). I believe that teaching how trauma permeates communities and manifests in relationships allows the individual to, at least to some degree, begin healing by lessening the disdain they have for their community member who harmed them. I hope to shift focus from anger toward the individual to understanding where trauma originates and how it manifests.

Program and Group Development

I learned the intricacies of program and group development through my interactions with the Youth Action Council, male youth talking circle, and the men’s group. I learned the importance of honouring traditions and the voice of the youth with the Youth Action Council. Further, as the youth became self-sufficient, I learned the importance of stepping back and allowing them to lead their progress.

Since the male youth talking circle failed to come to fruition, I learned the importance of consistency. The inconsistencies in scheduling, regular student attendance, and finding a space to hold the meetings were all factors in the talking circle’s unsuccessful implementation.
Additionally, the men’s group’s need for flexibility taught me the importance of not being too rigid. If the men’s group was not flexible enough provide support to individuals who attended late, or the men’s group did not discuss topics important to them in their current state, it surely would have failed with low attendance and uninterested participants.

To sum up the essence of successful program and group development within a First Nations community, I would claim that moderation is important. Being neither too flexible or too rigid allows for the helper to meet and support at the individuals cognitive and emotional state while still holding individuals accountable for change in their lives.

**Increased Knowledge Systems**

Throughout the practicum, I gained knowledge through informal settings such as lessons, stories, and conversations as well as formal literature exploration. The combination of both the informal and formal sources provided me with a breadth of knowledge. While the amount of information is vast, I believe there is a connection between Western and Indigenous belief systems. Specifically, the medicine wheel with cognitive behavioural therapies and Glasser’s (1998) Choice Theory with Brendtro et al.’s (2005; 2014) Circle of Courage.

The literature does not explicitly, or even implicitly, state there is a connection between CBT/Choice Theory and Indigenous knowledge systems. Indigenous knowledge states that balance is obtained through attention to our spiritual, cognitive, emotional, and physical states (Gone, 2011, p. 194). Similarly, CBT also proposes four states of one’s self: core beliefs, thoughts, feelings, and actions (Beck, 2011). More specifically, the individual’s spiritual self is similar to core beliefs, cognitive self is linked to our thoughts, one’s emotional self and feelings, and lastly our physical self is akin to our actions. Further, I believe there is a link between the Indigenous Circle of Courage framework and Choice Theory. The Circle of Courage’s needs of
independence, belonging, mastery, and generosity appear to parallel closely with Choice Theory’s freedom/autonomy, love and belonging, fun/learning, and power/significance, respectively (Brendtro & Brokenleg, 2002; Glasser, 1998, p. 25).

I believe that informal and formal learning regarding Western and Traditional knowledge and healing practices have dramatically increased my ability to provide appropriate support to both Indigenous and non-Indigenous populations. Further, the knowledge and healing practices will complement each other as I work with both individual and group populations.
Chapter Seven: Values and Ethical Considerations

Values

Long before I began my practicum at James Smith Cree Nation, I held the ontological philosophical assumption that there are multiple realities which are shaped by the perspectives of those experiencing the realities (Creswell, 2013). The multiple realities will vary greatly as they are constructed by the individual themselves, their value systems, experiences, and expectations (Creswell, 2013, p. 20). I believe that the best way to support others is first to understand, at least a glimpse, of their reality.

When I support individuals, in and out of professional practice, who have dramatically different realities than my own, I do not allow the gap in reality to be a barrier. I acknowledge to the individual that I have not shared the same lived experiences that they have, and I want to understand and support them with the best of my ability. I chose a practicum within a First Nation’s community to understand realities vastly different than my own, despite being less than 150 KM from where I was raised. Most often, the terms ontology, epistemology, axiology, and methodology, are used in reference to research. I, however, will use them as a method of describing reality. Further, I will describe the similarities and differences between an Indigenous worldview and my Western ontological (being), epistemological (knowing), and axiological (values), and methodological (doing) realities (Rowe, Baldry, & Earles, 2015).

Denzin and Lincoln (2005) describe ontology as ways of being and how reality is formed; epistemology as ways of knowing and the validation of knowledge; axiology as the values and ethics that guide practice; and finally, methodology as the tools and process of understanding (p. 183). Meanwhile, Rowe, Baldry, and Earles (2015) provide insight into the ontological, epistemological, axiological, and methodological views specific to Indigenous populations.
Ontologically, Indigenous cultures’ focus is on the connectedness of the physical and spiritual worlds alongside the connection to the natural world and kinship groups (p. 300). The ontological views of Indigenous people are quite different than my own. I have not felt a connection to the physical world in the same way an Indigenous person would and it has been many years since I felt a connection spiritually. Regardless, I believe that an individual’s worldview, despite being different than my own, carries the same legitimacy and is deserving of respect and understanding.

Epistemologically, Indigenous knowledge is not value neutral and is comprised of careful attention to the Indigenous voices and the expertise the individual holds regarding their own life (Rowe, Baldry, & Earles, 2015, p. 300). I share similar epistemological views regarding ways of knowing. Prior to clinical practice, I have always held the belief that while I can try and understand another’s point of view, I can never share it, as that individual’s knowledge is shaped by experience. Empathetic listening and curiosity is the best I can hope for in understanding another’s knowledge.

The Indigenous axiological views surround relational obligations, partnerships, and commitments to praxis, self-determination, empowerment, and healing (Rowe, Baldry, & Earles, 2015, p. 300). As an outsider, I want to be wary of becoming perceived as the “professional” as it is counterintuitive to both my own and Indigenous axiological views. Being a professional limits the self-determination and empowerment of the individual through unnecessary outside involvement as an individual’s fortitude can address most issues and concerns without aide. Further, I concur with Rowe et al. (2015) that praxis guided by theory is of great importance. Theory provides a groundwork for learning and practical work will inevitably fill the gaps that theory cannot fill on its own.
Finally, Indigenous methodology involves partnerships, recognition of different worldviews, and acknowledges contexts of Indigenous people’s lives, and gives credence to the voices and experiences of Indigenous peoples (Rowe, Baldry, & Earles, 2015, p. 300). While I am not completing research, I follow a methodology similar to Indigenous methodology in that individual stories are told and honoured and their experiences are validated. To elaborate, my professional support typically involves listening and exploring someone’s story to look for the strengths that guide their futures. Experiences give us a glimpse at how we will react to future situations; it can guide us down similar paths or alternate ones, depending on how the individual was impacted in past experiences.

My ontological, epistemological, axiological, and methodological perspectives are guided by my life experiences. Since my life experiences are constantly changing, I want to take the opportunity to give context to my current reality and position myself.

**Positioning**

At the time of this paper, I am an early 30-year-old cisgender, married male. I have a young boy and a partner in her 3rd trimester of pregnancy. I have terminated stable employment at the Prince Albert Parkland Health Region in outpatient community mental health to complete my practicum. Alongside my practicum, I began work as a private mental health therapist for the community of Prince Albert, Saskatchewan.

My history includes being raised predominantly in small towns within Saskatchewan with brief periods of urban living. Religiously, I was raised Mennonite and went through a lengthy period of Agnostic beliefs, and I am currently a firm Atheist. Despite adhering to vastly different belief systems than my family and extended family members, the relationships remain amiable.
I believe that my personal skills complement my professional skills and allow me the ability to maintain personal and professional relationships. My personal skills include being open, non-judgmental, and empathetic to almost any population. In a professional setting, my personal skills have allowed me to speak with sexual abuse victims and perpetrators, violent domestic partners, and significant drug misusers with compassion and understanding. I believe that my personal and professional traits also guide my ethics, which I will now outline.

**Ethical Considerations**

I was guided by both moral and professional ethics as I completed any work with the James Smith Cree Nation. My moral ethics are primarily comprised of my values to do no intentional or unintentional harm. I was less concerned with completing intentional harm as I had no plans to do so. I was, however, cognizant of ensuring that no unintentional harm comes to the individuals I work with or the JSCN community as a whole, as a result of my involvement with the community. As mentioned previously, one of my objectives was to gain greater understanding of the impact of colonization and ongoing oppression of First Nations people and communities, as well as the role I play as a non-Indigenous helper. I hoped to prevent being an unintentional colonizer by opening the dialogue regarding colonization and my role as a learner alongside demonstrating humility and limiting my tendencies to want to ‘solve things’.

My professional ethics guide my practice according to the CASW (2005) Code of Ethics by putting the individuals I support at the forefront, providing informed consent to counselling, and non-discriminatory practice (p. 3 - 4). Further, the Code of Ethics guides my work at JSCN to provide special attention to cultural awareness and sensitivity (p. 4). While I am guided by personal and professional ethics, ethical practice is not without personal struggle. For example, during the practicum experience, I set aside my personal beliefs regarding religion and
spirituality to demonstrate support for the religious and spiritual beliefs of First Nations people and the community as a whole. Despite the difficulty, I was able to reflect on my beliefs and values which I believe is important to maintaining a strong sense of self-identity.
Chapter Eight: Practice Recommendations

The challenges and successes of my practical experience, along with current literature, has afforded me some insight into how outsiders can provide more culturally appropriate support to First Nations communities. One overarching concept I noticed was, analogous to the role blending Kirmayer et al. (2000) mentioned, is that support is not limited to the confines of four walls. For example, I provided counselling support in an office, youth center, school, and outside while walking. On the same note, youth group planning was done in the youth center, school, while driving, and in the office. In other words, the helper uses opportunities as they arise to meet the needs of the community and empower the community and/or the individual as needed. Both the community and the individualized supports are important and each have nuances. I will attempt to distinguish practice recommendations for the outsider supporting a First Nations community in both a community and individual/clinical capacity.

Community Recommendations

Community introductions.

I share the sentiment with Bennett et al (2011) that, “[t]he introduction process for non-Aboriginal social workers also involves a willingness to share aspects of the personal and cultural self, in order to be seen as real and authentic” (p. 27). Being genuine is a scary concept when entering as an outsider into a tight-knit community, and my initial instinct was to adapt. However, it is best to acknowledge the differences and accept learning rather than to be disingenuous and parade around ignoring racial, cultural, value, and belief systems. Further to being real and authentic in the introduction process, I believe there are two additional aspects to community introductions: who introduces you and how you are introduced.
I was fortunate to have a well-respected counsellor, my practicum supervisor, introduce me to a variety of settings immediately. Her place as a community support gave credibility to me as a new outsider. Further, how I was presented had a significant impact as we purposefully went to all of the formal (health center, school, band office, treatment center, child and family services, etc.) and informal (day care and grocery store) to ensure that everyone knew who I was and what I could offer.

Understand value differences and seizing moments.

When working with a First Nations community, I learned quickly (to use a tautology) that a great deal of the work occurs, when it occurs. I understand that on paper, the sentiment may appear negative, however, the concept of work being completed as it can be completed fits well for the community.

To an outsider working with a First Nations community, life appears tumultuous and sporadic as events are planned hurriedly and/or cancelled because of a crisis event. As I gained more insight, however, I learned and accepted two sentiments: we are given as much as the Creator knows we can handle; and, what will happen will happen if it is meant to (Elder G. Burns, personal communication, February 3, 2016). The sentiments are not meant to diminish motivation or responsibility for tasks not occurring; they simply give credence to life’s instable nature and the role we play. The sentiments allow the helper to not become burdened in self-defeat following planned events becoming derailed due to life circumstances and it teaches the helper to capitalize on the more immediate motivations of individuals and the community.

Being present.

Along with having a community introduction and understanding value differences, there is an informal expectation to be present within the community. I had the opportunity to join walks
against bullying, to be present at PAGC functions, to attend funerals and wakes in order to make my presence known, but not always in the formal, professional capacity. Sometimes being present means attending the grocery store and speaking with community members. Often, being present means putting aside the agenda and having a personal conversation with an individual you typically would only have professional interactions with. Howell-Jones (2005) would argue that the clients also deserve the same opportunities to see the person and not the professional when outside of the clinical setting to strengthen community acceptance.

The First Nations community allows a unique opportunity for the professional outsider to not always be ‘on’. Within a First Nations community, the professional and the personal are not easily separated. One must strive to be accepted for their strengths and faults in both their professional and personal lives. Acceptance both professionally and personally may seem like a daunting task, however, my experience has led me to believe that no community member expected perfection in either aspect of life. Realistically, I believe being forthcoming with my faults made the task of community acceptance drastically easier as I became more genuine and authentic.

**Clinical/Individual Recommendations**

**Supporting professionals.**

Similar to the notion of being accepted professionally and personally, the lines between coworker and client can also be blurred. A noticeable difference between my previous mental health work experiences and those during my work at JSCN was my relationships with coworkers. In other mental health settings, I have been part of debriefings and consultations to alleviate the stress of personal and professional relationships for coworkers. At JSCN, private
conversations with coworkers consisted of debriefings, consultations, and sometimes took the form of therapy sessions.

Balancing the roles of coworker and therapist can be difficult and speaks volumes to the importance of setting boundaries and expectations. Boundaries and expectations, specifically surrounding confidentiality (and limits to confidentiality) along with pragmatic concerns such as where and how to meet, should be discussed immediately (Bennett et al., 2011; Howell-Jones, 2005).

**Incorporate culture.**

My experience and the literature make it quite clear: incorporate cultural practices into every aspect of support offered (Bennett et al., 2011; Howell-Jones, 2005). I attempted to incorporate culture in educational groups, therapeutic groups, and individual counselling as it demonstrated cultural competence and openness. Not all individuals are inherently traditional in their values and beliefs but, in my experience, they are forthcoming with the information (typically in private settings) and do not appear offended when support within the First Nations community is initially provided with cultural underpinnings.

While I am suggesting to use culture in practice, being culturally appropriate does not equal cultural appropriation. It is not the role of the outsider helper to engage in practices that are not their own. A few pragmatic examples how to incorporate culture without overstepping are to always invite Elders, make time for prayers and discussions, use circles when organizing people, start circles from left to right, clockwise, and allow time for each person to speak. There are many nuances to incorporating culture into practice; in fact, too many to reasonably list. Realistically, the best advice for incorporating culture is to find and consult with an Elder whenever possible.
Enter with curiosity and leave with humility.

Mental health workers and students alike come to First Nations communities with little knowledge of Aboriginal practices, values, and expectations, and only a surface level understanding of historical/current oppression and intergenerational trauma (McCormick, 1998; Trimble, 2010). At appropriate times, it is reasonable to explore the individual and community traumas with a state of curiosity and the purpose of learning. People will share their traumas if they are given a non-judgmental ear alongside their stories, culture, and successes – if they desire and do not feel manipulated.

Two helpers can enter a First Nations community with the same skill level and knowledge base, however, the work of Bennett et al. (2011) suggests that the helper who is humble and open to learning is more appropriate for working in a First Nations community. Humility opens the door for “information sharing, collaborative knowledge development, and honest communication [because] social workers need to earn trust and respect with the community, which takes time due to the history and ongoing practices of colonization” (p. 34). Entering a First Nations community with an attitude of all knowing leaves little opportunity for learning. I recommend entering the community with the impression that there is much to learn and leave knowing it was true.

Conclusions

I entered James Smith Cree Nation with a general knowledge of cultural expectations and practices, however, I believe my willingness to work on myself in terms of humility and genuineness allowed me acceptance into the community. Community acceptance allowed a safe dialogue between individuals and myself to discuss personal and community hardships and successes. One of my overarching objectives to increase my cultural knowledge was only possible as a result of community acceptance (Bennett et al., 2011). I want to summarize the
pragmatic gains from my practical experience in terms of clinical counselling, clinical group development, and community capacity building for the specific population of First Nations people within their home community as well as discuss the professional and personal impacts the experience provided me.

The most consistent role I fulfilled was in clinical counselling at the health clinic, school, and at people’s homes. In individual sessions, I used Western and traditional modalities such as Choice Theory, CBT, and Medicine Wheel/Four Directions teachings. Counselling allowed individuals to speak about the concerns they believe are unique to them. Despite feelings of uniqueness, larger themes became apparent to me which allowed some direction for clinical groups.

Clinical groups were developed to support male youth and male adults to address some of the system issues such as addictions, violence, relationships, and legal issues. I learned the importance of consistency and flexibility when facilitating clinical groups. If I wanted people to attend, I had to be consistent in location and time. I also learned to be flexible in the start time of the meetings and be open to late attendees or risk many participants being denied access.

I also addressed community capacity as I helped increase youth volunteerism and self-advocacy with the Youth Action Council and increase mental health capacity with community crisis interventions. The youth were provided an opportunity to advocate as elected representatives of their peers with a large focus on creating a drug/alcohol free community. The community crisis interventions were provided as a result of a crisis such as suicide or suicide attempts. During the crisis interventions, I was able to learn the value of blending Indigenous knowledge and Western developed crisis interventions such as CISM to meet the needs of a First Nations community.
My experience and knowledge is forever heightened and guided by the learning provided through the University of Regina and the James Smith Cree Nation. Professionally, I learned skills in community capacity building, clinical counselling, and clinical group development for the specific population of First Nations people within their home community. Further, I now have enhanced my cultural competency through direct practice and literature regarding colonization and its impact on First Nations people. Finally, I learned to use principles such as two-eyed seeing to blend my knowledge and the knowledge of others in the support of individuals, regardless of whether we share, or have vastly different worldviews.

Personally, I found great success at learning to be comfortable at not being comfortable. Feeling uncomfortable and out of place is an experience I am not familiar with because of the social privilege I possess as a Caucasian male in Canada. I was given the opportunity to be humbled by not immediately being accepted in every environment I enter; a concept that can only be truly understood when experienced. Further, feeling discomfort allowed the role of “professional” to be easily removed because, quite simply, I did not feel like a professional. Each community member, leaders, and Elders, were professionals of their own lives and experiences as they taught, guided, and navigated me through their community.

In essence, I believe that my experience at James Smith Cree Nation allowed me learning opportunities only available with direct practice, for which I am grateful. I hope to remain connected with the James Smith Cree Nation as I feel the knowledge I gained from their open community has yet to be repaid.
References


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