Understanding Indigenous Women's Lived Experience of Engaging in Activities to Heal from Intergenerational Trauma

by

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Abstract

This study investigated Indigenous women's experiences of healing from trauma. The legacy of colonization and Indian residential schools continues to impact Indigenous peoples through historic and intergenerational trauma. Very little research exists on the impact of historic and intergenerational trauma on Indigenous women, including treatment and intervention for complex trauma.

In-depth interviews took place with four Indigenous women from a First Nations community in Southwestern Ontario. These women self-identified as experiencing, and engaging in healing activities to recover from trauma, including intergenerational trauma. Interview transcripts were analyzed using Interpretative Phenomenological Analysis (IPA).

Results from this study revealed that each of the participants reported experiencing a profound sense of isolation and loneliness at the start of the healing journey. The participants also described their healing journey as long, and happening during different segments over time. Results also showed that all women found counselling to have a significant impact on their healing journey. As healing progressed, participants also described being able to connect to others, wanting to give back to their community, engage in learning more about their culture, and also described a deeper spiritual connection.

The findings of this study affirm current research and indicate the continued need for, and availability of, both traditional Indigenous and mainstream psychological intervention approaches. In order to work with Indigenous populations, mental health therapists using mainstream psychological approaches must be trauma-informed (including complex trauma and dissociation), resilience-informed, and culturally-informed, and culturally-humble. Future

research may consider further understanding around the reported isolation women experienced as they healed from trauma. This research also provides recommendations to counsellors and to the First Nations community from where the participants reside regarding healing from intergenerational, complex trauma.

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Preface

This thesis is an original work by Tina Shrigley. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Understanding Aboriginal Women's Experiences of Healing”, No. Pro00075955, January 19, 2018. No part of this thesis has been previously published.

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Chi-Miigwetch

This research would not have been possible without the input, collaboration, and participation of the four Indigenous women who chose to share their life experiences with me for the purposes of this research. I am truly grateful. I am also grateful for the input and support of key stakeholders from Walpole Island First Nation, including Mike Dashner, Director of Operations of Walpole Island First Nation; Donna Day, Central Intake at Enodmaagejig Social Services; and Colleen Johnson, Band Representative of Walpole Island First Nation. And so I say, chi-miigwetch, thank you!

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Chapter 1: Introduction

Indigenous women in Canada are in crisis. They are at increased risk for spousal violence, substance use, poverty, unemployment, and breakdown of the family (Statistics Canada, 2011), which have all been linked to historic trauma (Bombay, Matheson, & Anisman, 2009). Furthermore, higher rates of mental illness such as anxiety, depression and PTSD have been linked to historic trauma in this population (Bombay, Matheson, & Anisman, 2009; Wesley-Esquimaux, & Smolewski, 2004; MacMillan et al., 2008). Indigenous women also face a "double burden", or intersectionality, in that they are discriminated against both for being women and because they belong to a disenfranchised and marginalized group. Their challenges are not necessarily shared by non-Indigenous women, nor by Indigenous men (Hanson, 2012; Havinsky et al. 2010; Hankivsky & Chrisoffersen, 2008).

It is well established that Indigenous peoples continue to be affected by the intergenerational transmission of historic trauma (Bombay, Matheson, & Anisman, 2009; Brave Heart, Chase, Elkins, & Altschul, 2011). Intergenerational trauma refers to the cumulative emotional and psychological wounding over the lifespan of individuals and across generations, generated from massive group trauma (Brave Heart, 1998; Wesley-Esquimaux & Smolewski, 2004; Linklater, 2013), including colonization and residential schools. Indigenous scholars describe these collective, historic traumas as being incredibly destructive to their culture and state that many may not have healed from this pervasive damage (Smith, 2003; Antone, 2014; Linklater, 2014). Unresolved trauma is contagious. When the effects of trauma are not resolved, and there is no support for dealing with it, trauma will be passed from one generation to the next (Aboriginal Healing Foundation, 1999; Linklater, 2014; Yehuda, 2015). In fact, researchers tend to agree that present-day Indigenous communities are a reflection of the legacies from their

traumatic pasts (Bombay, Matheson, & Anisman, 2009; Linklater, 2014). Researchers also suggest that intergenerational trauma results in complex trauma in the individual, which makes trauma treatment more specialized treatment and a process (Haskell & Randall). It is also recognized that when Indigenous people seek help, they report not having their needs addressed fully, not being heard. They also report feeling retraumatized by this lack of regard and concern for their physical and mental health (Linklater, 2014; Bradley, Dunn, Lowell & Nagel, 2015; MacMillan et al., 2008).

This research is situated around conducting an interpretive inquiry of four Indigenous women living on a reserve in southwestern Ontario, Canada. The purpose of this interpretive inquiry is to increase understanding of Indigenous women's experiences of healing from intergenerational trauma. This research will be considered as not only a way to understand women's experiences of recovering from trauma, but also a reflection and evaluation of this newfound understanding and how it might impact my counselling work with Indigenous women who are impacted by intergenerational trauma.

A note about terminology used in this dissertation

In order to respect the participants of this study, the researcher asked what term they would use to identify themselves. One woman chose Indigenous, two participants did not have any preference, and one woman asked to be identified as Anishinaabe Qwe (Ojibwe for Anishinaabe woman). During each interview the researcher used the terms each participant requested. However, in writing this research a common descriptor needed to be selected. The International Journal of Indigenous Health also recommends the use of the term Indigenous. The United Nations has also adopted the term in their working groups. The term is a self-declared term, instead of being government imposed (International Journal of Indigenous Health, n.d.).

As such, the term Indigenous will be used throughout this study as it is more decolonizing than using government-imposed terminology. The only exception to this will be when quoting an article that uses other terminology such as Aboriginal or First Nation(s).

When speaking about trauma that impacts many generations, different terms can be found throughout the literature including historic trauma and intergenerational trauma. In this paper I am assuming that some of the traumas by which the participants are impacted is historic (trauma from colonization, residential schools). Thus, the term intergenerational trauma will be used throughout this dissertation to describe historic trauma that affects future generations. The only exception to this will be when quoting an article that may use the term historic trauma.

Purpose of Study

The main research question to guide this study was: *How do Indigenous women experience activities that support healing from intergenerational trauma?*

Chapter 2: Literature Review

In order to understand Indigenous women's journey in present day healing from trauma, we as researchers, counsellors, and psychologists-in-training must attempt to understand and appreciate Indigenous history, traditional ways of knowing, colonization, and the impacts of colonization on Indigenous peoples. This literature review will be divided into three sections: history of Indigenous people, including women; research about trauma, complex trauma, and intergenerational trauma, and ending with a section on clinical interventions for the treatment of trauma and complex trauma, and Indigenous ways of healing.

The following section is by no means an exhaustive account of the history of Indigenous peoples, but the information is shared with the intent that readers can better understand the impacts of colonization and cultural oppression as it is related to Indigenous people's mental health and recovery from intergenerational trauma.

Section A: Indigenous History

The People of Walpole Island First Nation, Past and Present

Walpole Island First Nation is located in Southwestern Ontario and is comprised of delta islands on the Canadian side of the mouth of Lake St. Clair. This geographic area is known in the Anishnaabe language as *Bkejwanong,* meaning *where the waters divide*, referring to the channels of the St. Clair River, which empties into Lake St. Clair (Lytwyn, 2009).

The people of Walpole Island First Nation are Anishnaabe, which is the autonym often used by the Ojibwe (or Chippewa), Odawa (or Ottawa), and Potawatomi peoples and their corresponding First Nation communities in Ontario. Anishnaabe means "one of the people", "original people", or "original man" (Minnesota Historical Society, 1973). These three nations spoke similar dialects of the same language (Algonquin) and had common cultural and spiritual

beliefs. According to traditional history, these three nations were part of the council known as the Three Fires of the Anishnaabe. The role of the Ojibwe in the council was to be the "keepers of the faith", the Odawa, the "keepers of the trade", and the Potawatomi the "keepers/maintainers of the fire" (Minnesota Historical Society, 1973). The council met for military and political purposes and maintained relations with other nations during the 17th, 18th, and 19th centuries. In the 19th century, under British colonial administration, the people became divided into separate "bands" and their geographic boundaries became known as reserves. In this geographic area, in addition to Walpole Island, bands were created at Aamjiwnaang (Sarnia), Kettle and Stony Point, and Thames River (Lytwyn, 2009).

Well before the arrival of Europeans, ancestors in the area now known as Walpole Island First Nation lived peacefully and used available resources such as animals, fish, plants, and minerals for commerce, social and ceremonial purposes. Most people lived in small family groups close to areas of family hunting, fishing, and gathering places. During high seasons for fishing and maple sugar processing, for example, larger groups came together at seasonal village sites. Agricultural practices for the growing of corn, beans, and squash had already been well established before European contact (Lytwyn, 2009).

Anishnaabe life in essence focused on unity and the "oneness" and harmony with people, nature, animals, and Spirit (Minnesota Historical Society, 1973). Anishnaabe people had innate knowledge that they were inextricably linked with the land, its cycles of seasons, and other cycles of living things including the cycle of birth, growth, death, and new birth. It is very important to contemporary Anishnaabe people who practice traditional ways of knowing to know where they come from, geographically, but also historically. Their history is often told from generation to generation through story and songs.

European Contact and the Root of Injury

Prior to European settlers arriving near Walpole Island territory, Anishnaabe society was collective, and self-sustaining and emphasized the strength of unity, community and family kinship, and governance by traditional laws (Minnesota Historical Society, 1973). Initially the arrival of Europeans in the late 17th century to Walpole Island territory involved minimal disruption to the Anishnaabe people's way of life. Fur trade and military posts enhanced traditional economy and trade with fur, game, and fish. However, things began to change after the British defeated the French in the Seven Years' War in 1760. The British appeared to be less interested in trade and more interested in acquiring Indigenous land and resources. The Council of the Three Fires along with their allies, led by Odawa War Chief Pontiac resisted British encroachments. As a result, in 1763, King George III issued a proclamation that recognized Aboriginal Title and outlined a treaty-making process by which the British Crown could purchase land. In subsequent years, British agents in the Detroit, Michigan area would negotiate a number of treaties involving the traditional territory of Walpole Island First Nation (Lytwyn, 2009). This was just the beginning of chronic and pervasive displacement and disconnection at the hand of settlers of Indigenous people that continued to occur, and continues to occur to this day.

Indigenous peoples are currently on a journey toward healing from historic trauma (Brave Heart 1998; Wesley-Esquimaux & Smolewski, 2004). However, as Linklater (2014) eloquently and emphatically states, "it is necessary to declare that the root of injury has been caused by colonial violence, which was significantly enforced by governments through legislation and institutions" (p. 21).

Colonization

Lee (1992) defines colonization as the, "subjugation of one people by another through destruction and/or weakening of basic institutions of the subjugated culture and replacing them with those of the dominant culture" (p. 212-213). Colonization resulted in a cultural genocide of Indigenous people. At the time of European contact, the Indigenous population was estimated to be approximately 500,000. Soon after contact, there was a significant decline of fifty to ninety percent of the population. Indigenous people in Canada were nearing extinction (Long, 2014; Lee, 1992). Violence and warfare between Europeans and Indigenous peoples, and Indigenous people's lack of immunity to diseases brought by Europeans contributed to the rapid population decline. Cultural subjugation by Europeans, treaties, and eventually the Canadian government continued to impact the Indigenous population. Poor living conditions, nutrition, and poor access to health care resulted in high death rates of Indigenous peoples compared with non-Indigenous populations. Displacement from their lands also resulted in a change of diet and scarcity of resources previously gathered from the land (Long, 2014).

Colonization continued from first contact with Europeans through to Canada's birth as a nation. When the federal government started to establish settlements, Indigenous communities were impacted. In 1876, the Canadian federal government passed the Indian Act. This act legally defined who was able to claim "Indian" status in Canada along with the accompanying rights and obligations that accompany Indian status. The Indian Act also set boundaries and structures for the reserve system and Indian "self-government" (Long, 2014; Royal Commission on Aboriginal Peoples (RCAP), 1996). According to the Act, the government had the power to prohibit traditional ceremonies, dictate how bands elected leaders and carried out their "self-government" practices, and lease uncultivated reserve land to non-Indians for agricultural uses. The Indian Act of 1876 also gave power to the federal government to move entire reserves if they deemed it

necessary, and the government was also granted power to remove Indians from their communities and send them to residential schools (Long, 2014; RCAP, 1996). The Royal Commission on Aboriginal Peoples (1996) report detailed the numerous and far-reaching impacts of European colonization and the implementation of the Indian Act. The report stated that cooperation and collaboration of the visions, strengths, and wisdom of both Indigenous and non-Indigenous peoples are needed in order to work toward reconciliation of the many negative impacts and consequences of colonization (RCAP, 1996; Wesley-Equimaux & Smolewski, 2004).

Continued colonization has produced Indigenous people's current conditions (Lee, 1992). These colonization-induced health and social problems have made it difficult for Indigenous peoples to return to their traditional ways of knowing, to experience the world and their connection with both living and non-living beings in cyclical, holistic, and spiritual ways (Long, 2014). Continued colonization, cultural oppression and forced assimilation without regard for Indigenous people's traditions, way of lives, autonomy, and well-being have had a dramatic impact on their physical and mental health (Kirmayer, Tait & Simpson, 2009). If, as Linklater (2013) stated that the root of all historic trauma of Indigenous peoples is the violence and displacement by European settlers, then continued oppressive maltreatment has retraumatized and further traumatized an entire culture.

Indian Residential Schools

Indian Residential Schools were run by the Canadian federal government in partnership with many Christian churches (e.g. Catholic, Anglican, Presbyterian, and United) and operated between the 1870s and 1990s. It is estimated that 150,000 Indian, Inuit, and Métis children attended Indian Residential School during that time. The federal government was financially

responsible for Indian Residential Schools. The mission of the church-run schools was to "kill the Indian in the child", meaning to strip Indigenous children of their language, their culture, their spirituality, their traditional ways of knowing, and their families in order to become good Christians with Eurocentric ideologies (Truth and Reconciliation Commission of Canada (TRCC), 2015; Antone, 2014). The school system, in accordance with the Indian Act, forcibly removed children from their families, homes, and communities for extended periods of time. Children were severely punished if they spoke their own language, or acknowledged their Indigenous heritage in any way. Many former students shared stories of the pain they endured when a needle was pushed through their tongue if they spoke the language of their home. (Hanson, 2012; Antone, 2014; TRCC, 2015).

Indigenous children were literally stripped of their innocence and their culture. Once Indigenous children arrived at the schools, their personal items and clothes were taken away and they were forced to wear school uniforms instead. Residential school uniforms were not designed to take into account the weather, and as a result many students reported they were freezing in the winter, or overheated in the summer months. Female students' hair was cut and male students' heads were shaved, despite the belief in some Indigenous cultures that long hair was a symbol of power and awareness and should only be cut when grieving a family member's death (Antone, 2014). Students at Indian Residential schools could not engage in traditional songs, dances, or ceremonies. They were disconnected from their families and communities, and could not engage in traditional practices or lean on their classmates to connect through shared traditional language and practices for fear of horrific reprisal. Students were victims of emotional, verbal, physical, and sexual abuse, neglect, and torture. Indian Residential Schools appeared to have achieved their goal: Indigenous children were stripped of their culture and of their identity, however not

without extensive negative effects. Many Indigenous people still feel disconnected from their culture and identity and this continues to affect their health and well being to this day.

In 1996, the Royal Commission on Aboriginal Peoples (RCAP) report recognized that those affected by Indian Residential Schools must be acknowledged and recognized, so as to empower them to take a stand, to voice their grief and anger, and to have their stories heard (TRCC, 2015). Following the RCAP report, *Gathering Strength*, Canada's Aboriginal Action Plan was unveiled. This included a *Statement of Reconciliation* acknowledging the federal government's role in the development and administration of Indian residential schools. In 2001, the federal Office of Indian Residential Schools Resolution Canada was created to manage and resolve the large number of abuse claims filed by former students against the federal government. In 2004, an Assembly of First Nations Report on Canada's Dispute Resolution Plan to Compensate for Abuses in Indian Residential Schools lead to discussions to develop a holistic, fair and lasting resolution of the legacy of Indian Residential Schools. This resulted in the negotiated Settlement Agreement that was approved by all parties and implemented on September 19, 2007.

In 2008, Prime Minister Stephen Harper offered a public apology to Indigenous people of Canada on behalf of the federal government's involvement in Indian Residential Schools. Various churches also involved in the residential school systems also issues apologies. (Hanson, 2012; Antone, 2014; TRCC, 2015). The Aboriginal Healing Foundation (AHF) was created in 1998 to manage a one-time federal grant to help individuals and communities heal from the abuse that took place in residential schools (Antone, 2014). They have since provided funding to many projects, including those that help to encourage Indigenous people to engage with Elders, participate in ceremonies and reconnect with their Spiritual and traditional roots. In addition,

funding for long-term counselling was made available through the First Nations and Inuit Health Branch of Health Canada for former residential school students and their children, and grandchildren (Antone, 2014, TRCC, 2015).

In December 2015, the Truth and Reconciliation Commission of Canada released a summary of their final report regarding the path toward reconciliation from Indian residential schools. The TRCC was established in 2008 under the Indian Residential Schools Settlement Agreement. The Commission's mandate was to:

- Reveal to Canadians the complex truth about the history and ongoing legacy of the church-run residential schools, in a manner that fully documents the individual and collective harms perpetrated against Indigenous peoples, and honours the resilience and courage of former students, their families, and communities; and
- Guide and inspire a process of truth and healing, leading toward reconciliation within Indigenous families, and between Indigenous peoples and non-Indigenous communities, churches, governments, and Canadians generally. (TRCC, 2015).

The report lists several "calls to action" in several areas including child welfare, education, language and culture, and health, including mental health (TRCC, 2015). Regarding health, the Truth and Reconciliation Commission of Canada made calls to action for the government to identify and establish goals and close gaps in health outcomes, in collaboration with Indigenous peoples, between Indigenous and non-Indigenous peoples, including mental health, suicide, and availability of health and mental health services. The Commission called the government to action to provide sustainable funding for existing and new Indigenous healing centres to address the harmful physical, emotional, and spiritual effects of Indian residential

schools. The Commission also called out to decision-makers in health care and medicine to recognize the value of Indigenous healing practices within the Canadian health care system and use them as part of treatment in collaboration with Elders and Indigenous healers, if requested by Indigenous patients (Calls to Action 19, 21 & 22, TRCC, 2015).

The TRCC's recommendations substantiate the need and value of healing from the impacts of historic trauma in culturally competent and trauma-informed ways.

Before exploring impacts of intergenerational trauma on Indigenous women, it is important to understand the historical underpinnings that have, and continue to negatively impact Indigenous women's cultural, social, physical, and psychological health.

Historical Context of the Marginalization of Indigenous Women

Traditionally, Indigenous women offered a sense of grounding and strength to their communities. Most Indigenous societies were matriarchal, with women essential to the economy of their family and community (Halseth, 2013; Hanson, 2012). The role of "mother", referring to not only the biological role, but also referring to leadership roles, whether political, or medicinal, was honoured. Women were viewed as a vital force in the development and maintenance of culture and were revered because it was believed that they were more closely connected to Mother Earth and Creation (Halseth, 2013). Many Indigenous societies were also matrilineal (descent was traced through the female lineage) and matrilocal, meaning that, in some Indigenous cultures, when two people were married, the man moved into his partner's family's community, adopted their practices, and contributed to their society (Hanson, 2012). In general, historians and experts tend to agree that in many Indigenous cultures, the roles of men and women were viewed as balanced and complemented each other (Halseth, 2013; Hanson, 2012; Bourassa, McKay-McNabb & Hampton, 2004).

With European contact came cultural assimilation, including the imposition of patriarchal values and rules. Indigenous people were considered inferior, but colonial settlers felt that Indigenous women were more inferior because of their gender, thus devaluing Indigenous women's role in their communities (Halseth, 2013). The imposition of policies during the period of 1869-1985 greatly impacted the health and well-being of Indigenous women, and continues to profoundly affect Indigenous women's health and well-being to this day (Bourassa, McKay-McNabb & Hampton, 2004). The 1996 RCAP report highlighted the significant discrimination against registered Indian women because of the 1876 Indian Act (RCAP, 1996; Long, 2014; Halseth, 2013). The implementation of the Indian Act ultimately enforced a patriarchal system over Indigenous societies' matriarchal system. Power and authority were bestowed, not only on non-Indigenous males who enforced these new rules, but also to Indigenous men as they were seen as superior to Indigenous women. Formerly a society considered to have relatively egalitarian gender roles, was now unbalanced where Indigenous men were given power over women (Halseth, 2013; Hanson, 2012; Bourassa, McKay-McNabb & Hampton, 2004).

Women were also stripped from their Indian status and accompanying rights if they married a non-status man (Long, 2014; Hanson, 2012; Halseth, 2013). As Eurocentric assimilation was forced upon Indigenous culture, the belief in the inferiority of women began to permeate into Indigenous communities, resulting in women's declining sense of cultural identity, feelings of self-worth, and sense of belonging (Bourassa, McKay-McNabb & Hampton, 2004; Halseth, 2013). Indigenous women started to lobby the federal government for an amendment to the Indian Act, especially given the passage of the Charter of Rights and Freedoms in 1967, which made gender discrimination illegal. However, it was not until 1985 when the Indigenous women finally succeeded in their relentless advocacy and an amendment was granted through

the passage of Bill C-31. Women who were exiled from their homes and communities and stripped of their status were able to have their status reinstated (Bourassa, McKay-McNabb & Hampton, 2004).

A commitment to healing

Many members of Walpole Island First Nation have made a commitment to help other heal from various manifestations of trauma including helping to heal and prevent substance abuse issues, intimate partner violence, and suicidality. There are many band-run organizations that also have developed programming and offer social and medical services to those at-risk or in need including Walpole Island Social Services, Walpole Island Health Centre, and Chatham-Kent Community Health Centre (Walpole Island site). Over the years, many of the individuals working in these centres strived to link to services in outside communities so their own community members had more convenient access. For example, thirty years ago, counsellors from outside the community were invited to provide service out of the Walpole Island Social Services Building. Also, a child and youth mental health agency out of Sarnia, Ontario has a walk-in clinic once a month out of the same building.

Walpole Island First Nation also uses restorative justice practices and healing circles as part of their youth and adult justice programs. Restorative justice refers to an approach to justice that focuses on addressing the harm caused by the crime, holding the offender responsible for their actions, and providing an opportunity for those directly impacted by the crime to have space to speak their needs following a crime (Department of Justice, 2018).

Section Summary

In conclusion, Indigenous peoples have endured personal, familial, community, and cultural genocide for hundreds of years. While this endurance in itself speaks of a deep resilience

within this population, it has also left a lasting imprint on the physical and mental health of Indigenous peoples in the past, present, and generations to come.

The next section will begin to discuss the various types of trauma, manifestations of trauma, and the psychological impacts of colonization and contemporary traumas that affect Indigenous peoples, and especially Indigenous women.

Section B: Trauma

What is trauma?

In psychological terms, "trauma" refers to events that harm the psychological integrity of an individual. A specific stressful event is not necessarily traumatic in itself, but may be in how it impacts a particular individual. Therefore, not every individual who experiences an extremely stressful event will be traumatized, or meet the criteria for PTSD (posttraumatic stress disorder); however, some events are so horrific and/or extreme that there is increased likelihood that they would be traumatizing to most people (Breslau, 2001; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). In addition, not every individual experiences trauma the same way (Levine, 1997; Herman, 1997; American Psychiatric Association, 2013). However, Carlson & Dalenberg (2000) state that in order for an event to be traumatizing it must be experienced as extremely negative, uncontrollable, and sudden. Witnessing something happen to someone else, or learning that a traumatic event occurred to a close family member or friend can also be traumatizing (American Psychiatric Association, 2013).

Judith Herman (1997) describes psychological trauma as an "affliction of the powerless" (p. 33). She continues,

> At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human

> beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. (Herman, 1997, p. 33)

When certain symptoms are present for a particular length of time, then a psychologist, after taking history and doing a thorough assessment may diagnose a client with posttraumatic stress disorder (PTSD).

Posttraumatic stress disorder (PTSD)

According to the DSM-V (Diagnostic and Statistical Manual, Fifth Edition), diagnostic criteria for PTSD include a history of exposure to traumatic events either through direct experiencing, witnessing, or learning that the traumatic event impacted a close family member or friend. This exposure must meet specific criteria through four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. These symptoms must persist for more than one month and must cause "clinically significant distress or impairment" in one or more area of functioning (American Psychiatric Association, 2013, p. 272). The final criterion is set to ensure that symptoms are not attributable to a substance or medical condition.

There are two specifications noted regarding the diagnostic criteria of PTSD. The first is a delayed expression where full diagnostic criteria may not be met until at least six months after the event. The second specification describes a dissociative subtype of PTSD, where an individual meets full criteria for PTSD, but also experiences symptoms of depersonalization and derealization (American Psychiatric Association, 2013, p. 272).

Individuals with PTSD may involuntarily engage in re-experiencing through intrusive thoughts, which may also include sensory, emotional, physiological, or behavioural components.

Distressing dreams that replay the traumatic event is an example of intrusive thoughts. Individuals may also experience dissociative states, in which aspects of the past traumatic event are relived and the individual feels as if the event were occurring in the present. Individuals also persistently avoid stimuli associated with the trauma including thoughts, memories, feelings, and talking about the event. They may also avoid activities, situations, or people that serve as reminders of the event.

Negative alterations in cognitions or mood can include dissociative amnesia, or an inability to remember important aspects of the traumatic event. In addition, an individual can experience persistent negative expectations of self and others. For example, an individual may believe such erroneous cognitions as, “I cannot make good decisions”, “The world is not a safe place”, “I cannot trust anyone”, or that “It is my fault”. Negative mood associated with the traumatic event may also include persistent feelings of horror, fear, anger, guilt, and/or shame. An individual may also feel an inability to experience positive emotions including happiness, joy, and satisfaction. Concentration and focus may also be impacted in those who experience PTSD. In addition, individuals with PTSD may have difficulty falling asleep and staying asleep due to nightmares, safety concerns, and/or heightened general arousal. Individuals with PTSD may also exhibit a heightened sensitivity to potential threats, and may display a startle response to loud noises or unanticipated movements. (American Psychiatric Association, 2013).

Simple versus complex trauma

Simple posttraumatic stress refers to symptoms resulting from a single-event trauma, for example, a motor vehicle collision. Conversely, complex trauma manifests from chronic, most times interpersonal, and protracted traumatic experiences (van der Kolk, McFarlane & Weisath, 2006). Individuals who experienced a single-event trauma, while horrific, often experience

resolution of their trauma (through psychotherapy, for example) quicker than those with a more multidimensional, pervasive impact of complex trauma (van der Kolk, McFarlane & Weisath, 2006; Martin, 2014).

A complex trauma framework

When considering the lived experiences of Indigenous people, a traditional trauma framework is not enough (Haskell & Randall, 2009). Such a framework takes an exclusively individualized approach and fails to acknowledge the ways in which social justice, oppression, discrimination, and colonization impact systems and has pervasive effects on communities. For Indigenous populations, it is imperative to acknowledge and understand that many of the impacts of trauma are rooted not only in an individual's unique life stories, but by historical and contemporary systems that create a continuously traumatic environment for Indigenous men and women to live.

A complex trauma framework sheds light on some of the individual and systemic forces at play that impact Indigenous people's lives and livelihoods.

What is complex trauma?

The construct of complex trauma was first described by Judith Herman (1992) to help define and explain a set of symptoms and manifestations that were unexplained through the definition of trauma and PTSD. Field studies were done to further define complex trauma in the hopes that it could be included in the DSM-IV as a subtype of PTSD, however complex PTSD was not included in the DSM-IV, nor in the DSM-V (Korn, 2009; Herman, 1992; van der Kolk, 2005). Therefore, the term "complex trauma", while widely used, is not diagnostic, rather it is a term to describe symptoms of trauma that are not fully represented by the PTSD diagnosis. Still, its framework can help researchers, clinicians, and clients to understand in non-pathologizing language, the various coping and adaptation strategies that chronically abused and traumatized

individuals use in order to adapt and survive life circumstances (Haskell & Randall, 2009; Herman, 1992; Söchting et al, 2007).

Complex trauma is often used to describe individuals who have been exposed to prolonged interpersonal trauma, especially trauma that commenced at an early age. Interpersonal trauma refers to trauma that is often premeditated, planned, and caused by other humans. When these violations and/or exploitations occur within the family, or in other contexts that involve significant roles, it is usually repeated, can become chronic, and can escalate over time (Courtois & Ford, 2009; Courtois, 1999). Because of this, the victim does not often have adequate time to process what happened, or regain a sense of safety and feels as if they could be victimized at anytime, leading to states of hypervigilance and anxiety. For a child or adolescent, psychological energy that would normally go toward learning and development is directed toward coping and survival (Courtois & Ford, 2009; van der Kolk & d'Andrea, 2010).

Individuals who have been exposed to trauma at an early age are also more at risk for more entrenched and pervasive posttraumatic symptoms, which often makes treatment more complex and lengthy. For example, survivors of child abuse are more dysregulated and tend to have issues with interpersonal relationships, and affect regulation, including anger management issues (van der Kolk, Roth, Pelcovitz, Sunday & Sinazzola, 2005). Felitti et al. (1998) discovered several childhood traumas and/or adversities that predict several long-term consequences including disease, disability, and social problems. These childhood traumas and/or adversities, or as they are called, Adverse Childhood Events (ACE), include household dysfunction, abuse, and neglect. Recent studies also acknowledge low socioeconomic status, peer victimization, peer isolation and rejection, and exposure to community violence as ACEs, or childhood traumas and/or

adversities (CTA) (Finkelhor, Shattuck, Turner & Hamby, 2016; Sweeney, Air, Zannettino & Galletly, 2015).

The impact of trauma and adversities experienced in childhood are not limited to issues within childhood and adolescence. When left untreated, or unaddressed, traumas and adversities experienced as a child can lead to social, physical, and mental health issues across the lifespan (Van der kolk & d'Andrea, 2010; Finkelhor, Shattuck, Turner & Hamby, 2016; Sweeney, Air, Zannettino & Galletly, 2015; Dutra, Bureau, Holmes, Lyubchik, & Lyons-Ruth, 2009). Childhood traumas and/or adversities disrupt neurodevelopment and impair social, emotional, and cognitive development. These impairments then influence the adoption of risky health behaviours, which may lead to depression, suicide, substance abuse, PTSD, cardiovascular disease, homelessness, and shortened lifespans, to name a few (Felitti et al. 1998; Finkelhor, Shattuck, Turner & Hamby, 2016; Forgash, 2016). Individuals who endorse four or more ACEs on the ACE questionnaire are four times more likely to have depression and twelve times more likely to attempt suicide (Felitti et al., 1998). When a client who has a high number of ACEs also has early attachment issues and relational trauma, then they are at increased risk for PTSD, dissociative disorders, and personality disorders (Forgash, 2016).

Symptoms and manifestations of complex trauma from mainstream psychological research

Due to the multiplicity of past and present antecedents, complex trauma is difficult to identify accurately and treat effectively. Complex trauma is characterized by dysregulation in the following areas: affect, attention or consciousness, self-perception, perception of the perpetrator, relations with others, systems of meaning, and somatization (Korn, 2009; Herman, 1992; van der Kolk, 1996). Individuals who are traumatized at an early age, especially prior to the age of 14, tend to have problems in all areas listed above (van der Kolk, 1996; Korn, 2009).

Individuals with complex trauma often have difficulty with anger modulation and have self-destructive tendencies, including substance abuse and self-harming behaviours. They also may display dissociative symptomology such as depersonalization and derealization. Research indicates that dissociation tends to be related to prolonged and severe interpersonal abuse occurring during childhood (Frewen & Lanius, 2015; Lanius, Paulsen & Corrigan, 2014; Dutra, Bureau, Holmes, Lyubchik & Lyons-Ruth, 2009; Dutra et al., 2009).

Dissociation as a function of complex trauma

According to van der Hart, Nijenhuis, and Steele (2006), the essence of trauma is structural dissociation of the personality. The internal manifestation of dissociation in a single event trauma is a structural divide of the personality that includes an Apparently Normal Part of self (ANP) that manages daily life and personal care, and an Emotional Part of self (EP) that manages distressing content and intolerable reactions of the trauma. With regard to complex trauma, the structure of dissociation is similar to that of single event trauma, but more Emotional Parts (EPs) are necessary to try and manage distressing contents of multiple traumas across the lifespan.

Dissociation can be considered a disconnection between one's thoughts, feelings, memories, actions, or sense of self (American Psychological Association). Dissociation during and/or following a traumatic event can help a person tolerate emotions, behaviour, memories and thoughts that might otherwise to be too horrific and overwhelming to face and may manifest as derealization and depersonalization (van der Hart, Nijenhuis & Steele, 2006) or trauma-related altered states of consciousness (Frewen & Lanius, 2014).

Derealization, not fully being able to claim the traumatic event happened, and depersonalization, not fully being able to claim they were involved in the traumatic event are hallmarks of dissociation.

Frewen & Lanius (2014) describe four different trauma-related altered states of consciousness (TRASC): time, thought, body, and emotion. A TRASC of time results in individuals feeling as if they are truly back in the trauma as opposed to identifying what is going on as a flashback or nightmare.

The second trauma-related altered state of consciousness is where individuals may hear intrusive voices in their head related to themes of past life traumatic events and circumstances (Lanius & Frewen, 2016). For example, they may hear voices saying, “it is your fault”, or “you are stupid”. Note that these are not auditory hallucinations because the voices are heard inside of the head as opposed to hearing them externally. Also note the use of second person language in the examples given. This is an indication of trauma-related altered states of consciousness as it denotes depersonalization, as opposed to intrusive thoughts which are part of PTSD and trauma symptomology within normal waking consciousness and experienced in first person (eg. It is my fault, I am stupid, my partner thinks I am not important).

The third TRASC is body, or embodiment. Individuals with complex trauma may not feel completely present in their own bodies. They may have total or partial disembodiment. They also may feel as if their body, or parts of their body are not their own.

The final TRASC is emotion (affect), which includes numbing and shut down. This includes either feeling too much or feeling too little in order to regulate trauma-related activation of hyperaroused or hypoaroused states.

Dissociation as a function of complex trauma may not lead to a dissociative disorder; however, the more pervasive and chronic the trauma, and the less a person is able to manage the horrific content from those traumas, the level of dissociation can increase and lead to disorders such as Dissociative Identity Disorder and other related dissociative disorders as denoted by the DSM-V.

Complex trauma and identity

As introduced in the above section, individuals with complex trauma and dissociation (also referred to as trauma-related altered states of consciousness by Frewen & Lanius, 2016) often involuntarily incorporate negative cognitions and posttraumatic responses into their identity rather than placing the blame outside of themselves on the perpetrators and traumatic events that were beyond their control. For example, a person believing they were to blame for a traumatic event that happened through no fault of their own. Individuals with complex trauma often have complex relational attachment systems with their perpetrators. Perpetrators that were both abuser and caregiver, or held another position of responsibility can cause confusion for someone dependent on the caregiver. These complex relational attachments can also cause alterations in relationships with others. For example someone who experienced chronic abuse by a loved one, or person of authority, may learn not to trust others, and may not feel able to achieve a close, intimate relationship with others. Individuals with complex trauma may also report somatic reactions and have medical conditions that may relate to the type of abuse they endured, or may be a result of the impact of chronic stress on the body. Finally, individuals with complex trauma often feel hopelessness and a sense of despair over never being understood, and/or never being able to recover from their psychological anguish (Herman 1992; van der Kolk, 1996, van der Kolk & d'Andrea, 2010; Ford, 2010; Felitti & Anda, 2010).

Historical Trauma

The concept of historical trauma was first used in relation to Indigenous populations by Brave Heart (1998). The term originally stemmed from psychoanalytic literature regarding Jewish Holocaust survivors. In essence, historical trauma is defined as "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003, p. 7). Historical trauma was originally conceptualized to “frame current trauma exposure within the context to reduce stigma about emotional distress and responses to individual trauma, as well as highlight intergenerational collective trauma” (Brave Heart, Chase, Elkins & Altschul, 2011, p. 284). Sources of trauma originated from outside Indigenous communities and resulted in a spectrum of dysfunctional and hurtful behaviours, including violence, abuse, and addiction. These behaviours in turn were re-enacted over generations inside communities.

Many of these external traumas have been mentioned, but Gagne (1998) suggests that Indigenous people’s residential school experience is a key contributing factor that perpetuates the cycle of trauma (as cited in Menzies, 2010). While it is difficult to accurately determine the reach of historical trauma through generations, some scholars suggest that at least two (Menzies, 2010), or more (Lane, Bopp, Bopp & Norris, 2002 as cited in Linklater, 2014; Bezo & Maggi, 2015) generations removed from these externals traumas are “now being traumatized by patterns that continue to be recycled in the families and communities of today” (Lane, Bopp, Bopp & Norris, 2002, p. 9, as cited in Linklater, 2014, p. 23). Insidious, historical trauma expands from the threat of personal safety to the threat of an unsafe world for an entire population (Root, 1992, as cited in Menzies, 2010). As the effects of historical trauma pervade through generations, it becomes normalized and affected communities no longer can see the bigger picture of how social conditions continue to oppress and marginalize them (Menzies, 2010).

The Transmission of Historical Trauma

Historical trauma is transmitted, or passed from one generation to the next, in many different ways. Research using data from Holocaust survivors and their families suggest that neuroendocrine changes, as well as the influence of parental attachment styles (Morrisette, 1994), mediate intergenerational effects of trauma. In fact, research has indicated that children of Holocaust survivors had increased vulnerability to the negative effects of stressors and were more at risk for developing PTSD and depression (Bombay, Matheson, Anisman, 2009). Trauma is also thought to be transmitted genetically (Yehuda, 2015; Wesley-Esquimaux & Smolewski, 2004). This genetic transmission can happen directly when, due to a traumatic event, an epigenetic mark occurs and is transmitted to a child via reproduction (Yehuda, 2015). This can also occur through a set of environmental conditions that are presented to a child at conception, in utero, or postpartum that require genetic adaptations for the child to be able to cope (Yehuda, 2015). Studies have also shown that a mother's stress and level of affect dysregulation impacts a child's brain development in utero. This impacts children in that some may have decreased frontal lobe function, which assists with attention, problem solving and affect regulation (Schore, 2003).

In addition to biological and epigenetic transmission of trauma, trauma can also be transmitted through environmental factors such as parenting attachment styles, vicarious traumatization, and social learning (Menzies, 2010; Bezo & Maggi, 2015).

In summary, traumatic effects of colonization, genocide, and residential schools continue to weigh heavily on Indigenous peoples. These past traumas continue to be transmitted transgenerationally. Current life stressors and immediate traumas including abuse, addiction,

traumatic grief, financial stressors, and physical and mental health issues compound the historical trauma and continue the cycle of trauma transmission across generations.

Various terminology used related to past trauma affecting many generations has emerged in current literature such as the terms historic trauma, intergenerational trauma, and transgenerational trauma. Bombay, Matheson & Anisman (2014) use the term historic trauma in the way that was originally intended by Brave Heart, but state that historic trauma can have intergenerational impacts, such as trauma sustained by Indian residential school survivors suggesting that the two terms are in fact not interchangeable, that perhaps intergenerational trauma is a manifestation of historic trauma. Since this research is investigating the impacts and healing activities of trauma from previous generations, and acknowledging that many of the roots of this trauma is historic, the term intergenerational trauma will be used.

Risk and Protective Factors

A number of factors have been identified as conferring risk or protection for individuals being impacted by traumatic events. The traumatic event itself, contextual factors surrounding the event, and an individual's characteristics all contribute to a person's risk for developing psychological sequelae to trauma.

Research suggests that interpersonal violence is more traumatic than natural disasters because it disrupts one's core sense of trust and attachment. Interpersonal violence is also often experienced as intentional as opposed to natural disasters, which can be described as an act of God, or natural accident (Breslau, Chilcoat, Kessler & Davis, 1999; Carlson & Dalenberg, 2000). In addition, meaning-making is another factor that influences an individual's risk or protectiveness from stressful events. Life-threatening events and events that involve significant attachment loss, like an Indigenous child being removed from his or her family suddenly and

without explanation to attend residential school or to enter the foster care system, also create high risk for the development of post-trauma symptoms and PTSD.

Prolonged exposure to repetitive or severe events such as child abuse is likely to cause the most severe and lasting negative psychological outcomes (van der Kolk & D'Andrea, 2010; Carlson & Dalenberg, 2000). Chronic childhood abuse, attachment loss, and neglect may have the most pervasive and negative psychological effects on an individual because neurobiologically, children have limited integrative and meaning-making ability, and require a safe and secure attachment for social and emotional development (van der Kolk & d'Andrea, 2010).

Social support is also an important protective factor in buffering the impacts of trauma (Brewin et al, 2000). Furthermore, a lack of appropriate response to the traumatic event and lack of acknowledgement of both the traumatic event and the after-effects of the event on an individual can increase a person's risk for developing post-trauma symptoms and PTSD (McFarlane & van der Kolk, 1996).

Culture and community also have protective effects against the development, and entrenchment of post-trauma symptoms, including PTSD (McFarlane & van der Kolk, 1996; deVries, 1996; Linklater, 2014; Ungar, 2013). The loss of language and culture of Indigenous peoples through Eurocentric assimilation, disregard by government officials, and processes that failed to acknowledge and treat Indigenous peoples humanely contributed to an increased risk of lingering effects of trauma in this population (Linklater, 2014).

Gender as a Risk Factor. As individuals, Indigenous people have an increased incidence of traumatic pasts, especially in the form of violence, sexual abuse, and assault (Söchting, Corrado,

Cohen, Ley & Brasfield, 2007). However, studies have shown that women are more at risk to develop PTSD than men, perhaps because of increased risk of interpersonal violence, or because of neurobiological or hormone differences (Boon & Drajier, 1993).

The role that social, economic, racial, and historical determinants play in the mental health of Indigenous women cannot be understated. Unfortunately, very little research has examined the mental health of Canadian Indigenous women. Most research regarding the physical and mental health outcomes of Indigenous women uses data from the Ontario First Nations Regional Health Survey, which examined the health status of Indigenous peoples living on-reserve (MacMillan et al., 2008). This study reported that Indigenous women are more at risk for mental health issues than their non-Indigenous counterparts. Indigenous women in their twenties are more than three times more likely to commit suicide than non-Indigenous women. While fewer Indigenous women reported drinking regularly than in non-Indigenous populations, a higher proportion of Indigenous women reported having five or more drinks on one occasion, indicating the possibility of increased binge drinking behaviour in Indigenous women (Grace, 2003; MacMillan et al., 2008).

In addition, according to this survey there is also a higher incidence of major depression among Indigenous women than men, and girls than boys. It was also reported that a greater percentage of Indigenous women reported meeting with a health professional about their emotional or mental health than non-Indigenous populations.

At least three quarters of Indigenous women have indicated that they have been the victims of family violence. Prevalence of sexual abuse is generally higher in Indigenous women (44.8%) than in non-Indigenous women (30.1%) (Grace, 2003; MacMillan et al., 2003). Indigenous

women also report a lack of support from police authorities, the justice system, and from male chiefs and council members regarding these matters, which may prevent women from reporting violence and receiving appropriate psychological and community supports. As Halseth (2013) writes, “for some women, a legacy of these abuses has been a loss of self-esteem, alcohol and drug abuse, and the perpetuation of an existence where violence and abuse are the “norm”” (p. 11).

Indigenous women have faced, and continue to face increased physical and mental health issues due to contemporary issues such as abuse, addiction, violence, low socioeconomic status, and oppression. As previously discussed, this prolonged and repeated exposure to abuse and neglect is associated with complex posttraumatic stress disorder. However, it is important to remember that high rates of violence against Indigenous women are not only related to lower socioeconomic status, but to the legacy of colonization and to the residential school system where many experienced sexual, physical, and emotional abuse.

Section Summary

Recent research suggests that intergenerational trauma experienced by Canadian Indigenous populations presents as complex in nature (Haskell & Randall, 2009; Söchting et al, 2007). Complex trauma impacts an individual at all levels: genetically, neurobiologically, cognitively, behaviourally, emotionally, physically, socially, and spiritually (Haskell & Randall, 2009; Söchting et al, 2007; Frewen & Lanius, 2014; van der Kolk, 2014). In other words, complex trauma impacts our connection to self, to others, and to the world.

Dissociative processes that result from complex trauma perpetuate this disconnection in the form of depersonalization and derealization (van der Hart, Nijenhuis & Steele, 2006)

impacting a person's sense of time, thoughts, emotion, and embodiment (Frewen & Lanius, 2014).

In other words, a person with complex trauma has difficulty staying "present" on many fronts. They are in a chronic state of fear and are expending significant mental energy to manage mental contents related to their past traumas. In individuals with complex trauma, dissociative processes mitigate states of hyper- and hypoarousal, which may lead to isolation from others, avoidance potentially leading to addiction and substance abuse, self-harm, and increased risk for completing suicide (Courtois & Ford, 2009; Courtois, 1999; Korn, 2009; Herman, 1992; van der Kolk, 1996).

The overwhelming nature of the traumas maintain the dissociative structure and the resulting symptomology. Complex trauma leads to the loss of an integrative capacity, which leads to an individual not being able to resolve trauma. Its entrenched and pervasive manifestation impacts a person's ability to benefit from mainstream trauma therapy and also can cause them to dysregulate and become further retraumatized from therapies that are not complex trauma-informed and dissociation-informed.

The next section explores mainstream clinical trauma interventions and Indigenous ways of healing. Mainstream interventions explored include evidence-based trauma resolution interventions, and guidelines for the treatment of complex trauma.

Section C: Intervention and healing from trauma and complex trauma

Healing activities from mainstream psychology and from Indigenous teachings

Hart (2014) emphasizes that health care providers and mental health practitioners must be open to the idea that Indigenous people may engage in both mainstream and traditional activities

of healing. It is with this in mind that the following sections will describe both evidence-based approaches to the treatment of trauma and traditional Indigenous activities of healing.

A Mainstream View of Trauma-informed Treatment

The following section will describe two widespread and well-established psychotherapeutic approaches to trauma treatment: EMDR (Eye Movement Desensitization and Reprocessing) Therapy, and Cognitive Behavioral Therapy (CBT). Treatment guidelines for complex trauma will also be described in this section.

Eye Movement Desensitization and Reprocessing (EMDR) Therapy

EMDR Therapy is an evidence-based therapy for the treatment of trauma, including the treatment of posttraumatic stress disorder. This psychotherapeutic approach is based on the accompanying Adaptive Information Processing (AIP) model, which posits that there is a "neurological balance in a distinct physiological system that allows information to be processed to an "adaptive resolution" (Shapiro, 2001, p. 30). Based on Shapiro's AIP model, dysfunction occurs when information about a trauma becomes maladaptively stored in the brain, complete with original images, cognitions, emotions, and somatizations. The memories, complete with the maladaptively stored information, remain in state-specific form, which makes it difficult to process through to resolve (van der Kolk, 1996). It is hypothesized that information becomes maladaptively stored for many reasons including the absence of social supports at the time of the incident, and the sense of powerlessness and horror of the situation. Also, the brain's developmental stage at the time of the incident may limit a person's ability to make sense of the situation (van der Kolk & d'Andrea, 2010; van der Kolk, 1996). The use of "dual attention stimuli", including bilateral eye movements, bilateral auditory stimuli, or bilateral tactile stimuli, help to create a physiological state that facilitates information processing. While the mechanism

of action of the dual attention stimuli has yet to be definitively determined, research has suggested that dual attention stimuli assists the client to stay present while processing disturbing material from the past, and helps to stimulate areas in the brain related to working and long-term memory, thus facilitating the processing of traumatic material (Nieuwenhuis, Elzinga, Ras, Berends, Duijs, Samara & Slagter, 2013; Maxfield, Melnyk & Hayman, 2008; Kuiken, Chudleigh, & Racher, 2010).

There are eight phases in EMDR Therapy. Phase one includes taking client history and establishing rapport. Phases two and three involve preparing and assessing a client's readiness for trauma reprocessing. The preparation phase may include psychoeducation, and the introduction of affect management skills to increase a client's ability to tolerate both positive and negative emotions. The assessment phase refers to the agreement between therapist and client of working on a particular traumatic memory and setting up the image, negative and positive cognitions, emotions, and body sensations that are related to the image. In determining what aspect of the traumatic memory will be worked on, the client begins to prepare. Having the client identify negative and positive cognitions, emotions, and body sensations associated with the specific traumatic memory, activates memory networks in the brain related to the traumatic memory (Shapiro, 2001; van der Kolk, 2014). This process allows for the traumatic memory to be reprocessed and for adaptive information to be integrated for complete resolution of the traumatic memory. Subjective Units of Distress (SUDs) on a scale of 0-10 are reported for how distressing the memory feels to the client in the current moment. Also, a 7-point Validity of Cognition (VOC) scale is used to measure how true the positive cognition feels to the client in the current moment when he or she thinks of the traumatic memory. These measurements were

integrated into EMDR therapy for research purposes, but to also help the therapist and client track progress during therapy.

Phases four to seven include trauma reprocessing using dual attention stimuli, the installation of treatment gains, re-assessing through the use of a body scan to determine if there are residual discernible physiological resonances to the traumatic memory being targeted, and appropriate time to safely close down the session. During these phases, the client is first asked to bring up the image in their mind of the traumatic incident and to be mindful of the negative cognition, positive cognition, emotions, and body sensations associated with that image. The EMDR therapist then asks the client to follow the therapist's fingers as he or she moves them bilaterally within the client's field of vision. The client essentially follows the therapist's fingers with their eyes, back and forth, at the pace set by the therapist. The therapist attunes to the client's level of affect, facial expression, breathing patterns and other feedback provided by the client to determine the length and pace of each set of dual attention stimuli. However, Sharpiro (2001) uses 24-36 saccades (passes back and forth) per set. The use of the dual attention stimuli (eye movements, audio, or tactile) facilitates reprocessing of the traumatic memory. During reprocessing, clients are invited to notice whatever happens. They do not need to hold onto the initial traumatic image. Studies suggest that dual attention stimuli, especially eye movements, engage the memory networks, help clients to stay present, as opposed to fully reliving the traumatic memory. Clients often report feeling like they are sitting on a train watching the scenery go by, but not necessarily able to grasp on to any one image or memory. Clients may also feel different body sensations, and may feel intense affect. Typically, affect may increase and then peak before lowering before the end of a dual attention stimuli set. After the set, the therapist asks the client what they are noticing right now. The client gives a brief report to help

the therapist know that the client is reprocessing, is not reliving the trauma, and is still able to stay present (Shapiro, 2001). A client may report that he or she is noticing decreased hyperarousal responses in their body, or that they do not feel as sad or angry. The therapist then invites the client to just notice and begins another set of dual attention stimuli (eg. eye movements). This process continues until the client reports feeling calmer, or until the client starts to report adaptive information (eg. It's not my fault). The therapist then asks the client to go back to the incident in their mind and report what they are noticing. SUDs are re-measured to track progress. If SUDs are not zero, then reprocessing continues. If SUDs are zero, then bilateral stimulation is used to help strengthen treatment gains, including the positive cognition. Once the client reports that the positive cognition feels true (VOC 7/7), then the client is invited to think about the traumatic memory while scanning their body for any sense of disturbance. If the client reports discomfort (eg. heart racing, upset stomach), then more reprocessing occurs until the symptoms have abated. Once the body scan can be done without disturbance, the client and therapist discuss a future scenario that may elicit a similar response to the current memory that was reprocessed. For example, a client who was in a motor vehicle collision may consider a future scenario of driving past the accident site. The client is invited to run through the future situation in their mind like a movie and, if any disturbance is felt emotionally, cognitively, or somatically, to report it to the therapist at which point the therapist will use dual attention stimuli to process through the disturbance until the client reports relief. This process is continued until the client can imagine the entire future scenario without disturbance (Shapiro, 2001).

Phase eight is a re-evaluation phase, which allows the therapist and client to revisit the work done in a previous session to determine if further reprocessing needs to be completed on the

traumatic memory, or if they can move forward to working on another traumatic memory, or other treatment goals (Shapiro, 2001, 2012).

Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) is considered the gold standard treatment for many conditions including depression, anxiety, anger, and PTSD. Early CBT therapies for PTSD included systematic desensitization, relaxation training, and biofeedback. Later CBT therapies such as prolonged exposure therapy, stress inoculation training, and cognitive processing therapy focused more specifically on PTSD symptoms and incorporated emotional and/or information-processing theories (Cahill, Rothbaum, Resick & Follette, 2009). Cognitive Behavioural Therapy uses learning theories to explain the development and maintenance of PTSD symptoms. For example, re-experiencing and arousal symptoms are considered conditioned emotional responses that result from classical conditioning during the traumatic event (Hayes, Follette & Follette, 1995; Cahill, Rothbaum, Resick & Follette, 2009). Initial responses may be directly due to the trauma, however, persisting symptoms are a result of an attempt to mediate trauma-induced distress, often through operant control.

Emotional processing theory posits that PTSD occurs due to the "development of a fear network in the memory that elicits escape and avoidance behaviour" (Foa & Kozak, 1986; Cahill, Rothbaum, Resick & Follette, 2009). This fear network is thought to hold a large number of stimulus elements, meaning that it is easily accessed, thus manifesting symptoms of hypervigilance and hyperarousal. Emotional processing theory suggests that successful treatment for PTSD involves correcting the pathological elements of the fear structure. Two conditions are proposed to correct these elements: activation of the fear structure, and providing new

information that includes elements that are incompatible with existing pathological elements. Exposure therapy is an example of these two conditions at play to activate and modify that traumatic memory in order to reduce the fear activation (Foa, Riggs, Massie & Yarczower, 1995; Cahill, Rothbaum, Resick & Follette, 2009).

There are many mechanisms of action that are posited to relate to improvement of PTSD symptomology. First, the act of repeated imaginal reliving of traumatic memories is thought to promote extinction of conditioned fear reactions, which in turn reduces trauma-associated anxiety. Second, the process of confronting the memory truncates negative reinforcement of cognitive and behavioural avoidance of cognitions, feelings, and reminders of the trauma. Third, it is thought that by reliving the trauma in a therapeutic setting that feels safe and supportive to the client helps to infuse a sense of safety into the traumatic memory, helping the client to feel that the trauma is no longer dangerous. Fourth, focusing on the trauma helps to parse the traumatic memories from other nontraumatic events, helping the client to realize that the trauma was a specific occurrence and not necessarily an accurate representation of their world. Fifth, imaginal reliving can help the client to change the meaning of their PTSD symptoms from a position of personal incompetence to one of mastery. It can also allow a focus on challenging and modifying negative self-evaluations (Foa, Hembree & Rothbaum, 2007).

CBT vs. EMDR

Both EMDR Therapy and Trauma-Focused CBT are considered recommended treatments for trauma and PTSD. Comparison studies and meta-analyses of both therapies prove effective, however, research is less consistent as to which approach may be more efficacious in the treatment of PTSD. Some research points to more efficient treatment effects and the benefit of

less homework with EMDR Therapy (Rothbaum, Astin & Marsteller, 2005; Lee, Gavriel, Drummond, Richards & Greenwald, 2002; Capezzani et al., 2013); however, other research suggests no significant differences between Exposure Therapy and other forms of cognitive-based trauma therapy including stress 37noculation therapy, cognitive processing therapy, cognitive therapy, and EMDR (Foa, Dancu, Hembree, Jaycox, Meadows & Street, 1999; Power et al., 2002).

A "Phase-Oriented Approach": Treatment Guidelines for Complex Trauma

Even though the treatments described above are evidence-based and recommended as effective treatments for PTSD, as described in the previous section about complex trauma and dissociation, treatment must be modified when working with clients with complex trauma. Failure to properly assess and identify clients with historic trauma and chronic prolonged exposure to trauma, may result in abreactions and treatment failure, not to mention potential retraumatization and rupture of the therapeutic relationship. For clients who have had attachment trauma and chronic abuse, it may be difficult to use cognitive behavioural strategies right away to challenge the cognitive distortions that the world is a dangerous place. These individuals may have countless examples to substantiate their beliefs, but very few, if any, experiences of truly feeling safe.

The International Society for the Study of Trauma and Dissociation (ISSTD) recommends a "phase-oriented approach" in response to providing a carefully guided, tailored treatment to clients with complex trauma (2011).

The first stage emphasizes establishing safety, stabilization, and symptom reduction. In this stage, the focus is on rapport building, careful and paced information gathering, and the

introduction of affect management skills to increase clients' sense of self-efficacy and autonomy in managing their symptoms. The second phase involves confronting, working through, and integrating traumatic memories. The third phase emphasizes identity integration and rehabilitation. In other words, this phase of therapy involves clients constructing new meaning to their experience; grieving the loss of innocence, identity, and what might have been; and finding new ways to experience their lives (ISSTD, 2011; Steele, Van der Hart & Nijenhuis, 2005; Van der Hart, Nijenhuis & Steele, 2006). Psychotherapy approaches, like EMDR and trauma-focused CBT can, with some modification, be adapted in order to work with clients with complex trauma in accordance with ISSTD's guidelines (Korn, 2009; Van der Hart, Groenendijk, Gonzalez, Mosqera, & Solomon, 2013, 2014).

Traditional Ways of Healing from Trauma

Publications from the Aboriginal Healing Foundation, and recommendations from The Truth and Reconciliation Commission of Canada strongly encourage reconnecting back to culture and using traditional ways of healing to address the widespread trauma and effects of trauma and intergenerational trauma on Indigenous communities (Waldram, 2008; TRCC, 2015). These recommendations are not to only use traditional approaches, but to have more traditional healing programs and services available, in addition to, and perhaps even in collaboration with mainstream psychological/mental health services.

While mainstream psychological "scientist-practitioner" schools of thought focus on evidence-based intervention in the treatment of trauma-related disorders, Indigenous ways of helping are centered around on an interconnectedness to spirit (McCormick, 1997; Hart, 2014; Dumont, 2014). Indigenous people embracing traditional knowledge and spirituality recognize that spirit connects all life in all forms (Hart, 2014). Part of healing then involves fostering the

relationships with self, others (in this world and those who have passed on), elders, animals, elements, and with the spiritual realm, in other words, with all of their "relations" (Hart, 2014; Dumont, 2014). In connecting with spirit and the Creator, Indigenous people can connect with their purpose in the world, including how they are meant to contribute to others in their community (Hart, 2014; Lane, 2002).

Values also serve as guidelines for Indigenous people to follow on their path to healing. Specifically the Teachings of the Seven Grandfathers share seven values that are shared community values. The seven values include respect, love, truth, bravery, wisdom, generosity, and humility (Hart, 2014). These values may be learned from elders, or family members through stories, or through modelling. In addition, common Indigenous belief is the principle that healing comes from within and the principle that the healing of individuals and the healing of communities must go hand-in-hand (Hart, 2014; Lane, 2002).

The medicine wheel may also be used as a guide for Indigenous people to help achieve balance and harmony in their health and wellbeing. There are many medicine wheels across various tribes throughout the nation. Generally speaking, medicine wheels are represented by a circle divided into four equal parts. The wheel, and its segments, represent an interconnected system of teachings including the elements, directions, seasons, and the cycle of life. All parts of the wheel are important and interconnected. Imbalance in one area, affects all of the other areas in the wheel, and thus a person's life. The teachings from the wheel stress that balance, harmony and respect in all parts of the wheel are necessary for survival (Hart, 2014). Elder Jim Dumont (2014) presented an "Indigenous Wellness Framework" using the medicine wheel to describe four aspects of wellness: physical, spiritual, emotional, and mental. He further defines wellness from an Indigenous perspective as a, "whole and healthy person expressed through a sense of

balance of spirit, emotion, mind, and body. Central to wellness is belief in one's connection to language, land, beings of creation and ancestry, supported by a caring family and environment" (Dumont, 2014).

Indigenous helping activities involve experiencing and understanding their place within this interconnectedness with spirit and their relations. Each person's journey is unique, but is supported by family, friends, and her community. Some traditional Indigenous healing activities may involve participation in ceremonies and practices including ceremonial lodges and dances, birthing and naming ceremonies, pipe ceremonies, fasting, feasting, and smudging. People may also seek help from a traditional healer who may use stories, drumming, song, and plant medicines to increase a person's health and wellbeing (Hart, 2014).

Learning the original language is,

> the most expressive communication of the spirit, emotions, thinking, behaviour and actions of the people. Language is the "voice" of the culture and therefore that true and most expressive means for the transmission of the original way of life and way of being in the world. (Dumont, 2014, p. 8)

Ross (2014) identifies twelve differences between Indigenous healing and mainstream interventions. Many of these differences are also highlighted in other works (Hart, 2014; Dumont, 2014; Manitowabi, 2014; McCormack, 1997). The differences Ross (2014) discusses involve the utilization of Spirit and spirituality and healing. That Indigenous healing places a large emphasis on (re)connection with the Creator.

He also indicates that Indigenous healing looks at the term “health” much differently than mainstream medical and/or psychological models. Medical models often view health as the absence of disease. Ross (2014) writes,

> A healthy person is thus someone who understands that he is a nested component of that complex web of interconnections, who acknowledges fundamental dependence upon them, who is aware that he has been given significant responsibilities and who is determined to fulfill them as best he can. His “self” interest is perhaps better understood as his “other” or “all” interest. (p. 229)

Acknowledging that a person is just one part of the whole and that they are also a vital component of community, family, culture, and spirituality, and being interconnected with these aspects in a good way defines health.

Another major difference involves the mutual healing of both community and individual. Years of oppression and trauma affected individuals and communities, including their spiritual beliefs and culture at-large were also affected. Thus, individual healing must occur in concert with community healing and vice versa. Ross (2014) states that individual healing is situated within a social context. This interdependence suggests that group healing can minimize self-blame while increasing self-growth, while allowing the community to heal, to witness each other’s stories, and to provide compassion and understanding.

Group healing can include participation in sweat lodges, opening circles, and ceremony. In these sacred spaces, members are invited to share their issues, and are given the opportunity to share their own stories of healing and/or growth, including teachings from Elders (Ross, 2014).

While group healing can be a powerful way to heal as well as to connect to community and culture, there would have to be pre-existing community or group healing, otherwise members may not feel comfortable coming forward to participate in the group. A sense of trust, maintaining confidentiality, and respect toward others would need to be in place, and would need to be modelled by the group leader(s) as well as the participants.

Indigenous Women and Healing

Indigenous women traditionally have been the foundation on which nations are built. They were respected matriarchs: healers, governors, visionaries, and nurturers. As described earlier, these traditional roles were lost after the passing of the Indian Act. Women were disenfranchised, truncated from their rights, their land, and their identity (Rego & Rego, 2014). Counsellors who practice cultural competence and incorporate cultural safety within their practice can provide a framework for practice that may help Indigenous women to feel more safe and comfortable in a therapeutic relationship. Also, counsellors who are culturally competent can recognize the historical impacts Indigenous women have faced and how this impacts their experience of intergenerational trauma (Rego & Rego, 2014; Long, 2014; Hanson, 2012; Halseth, 2013). Rego & Rego (2014) suggests a combination of traditional healing and mainstream approaches to open new pathways of healing and understanding. Other considerations when providing counselling to Indigenous women include being aware of oppressive barriers that might limit Indigenous women from accessing services, assessing Indigenous women's support network and ensuring that they has some sort of support either through family, friends, or agency, and being aware of the impact of colonization on paternalistic policies that may be present in agencies and health care systems that might minimize or discriminate a woman's account of her life circumstances (Rego & Rego, 2014, p. 141-142).

In summary, traditional Indigenous practice involves connection with individuals, family, communities, self, and spirit. Specific practice may involve participation in ceremony, involvement of Elders, (re)learning cultural traditions and values, a renewed connection with ancestry, language, and stories (McCormick 1997; Hart, 2014).

Rationale for this Study

The widespread torture, abuse, oppression and trauma afflicted on Indigenous peoples in Canada through colonization and Indian residential schools, among other colonizing practices, are increasingly acknowledged by Canadians, governments, and mental health practitioners (TRCC, 2015; Linklater, 2014; Hatala, Desjardins & Bombay, 2015; Archibald, 2006; RCAP, 1996; Long, 2014; Halseth, 2013). The legacy of these historic traumas transcend time and place and continue to impact present and future generations of Indigenous people in the form of oppression, violence, abuse, substance abuse, neglect, self-harm, suicide, traumatic grief, cultural disengagement, and physical and mental health issues (Halseth, 2013; MacMillan et al, 2008)

Intergenerational trauma combined with these contemporary traumas can result in symptoms consistent with complex trauma, which has long-term impacts on a person's affect regulation, concentration, self-perception, sense of safety, relationships with others, and sense of helpless and hopelessness (Herman, 1992; Korn, 2009; Courtois, 2010).

As previously discussed Indigenous women are more at risk for increased mental and physical health issues, including PTSD, depression, and suicide. Despite data that suggests significant increases in these issues, there is limited research regarding mental health prevention and intervention for at-risk Indigenous women (Halseth, 2013; MacMillan et al., 2008; Grace, 2003; Bourassa, McKay-McNabb & Hampton, 2004).

While many have expressed the need for decolonizing methods of mental health counselling for Indigenous populations, including the treatment of intergenerational trauma (Brave Heart et al., 2011; Linklater, 2014; Lee, 1992; Hatala, Desjardins & Bombay, 2015; Archibald, 2006; Legacy of Hope Foundation, 2011, TRCC, 2015), aside from recommending the availability of both mainstream and traditional ways for healing, little is known about best practices in the treatment of complex trauma for Indigenous women.

The pervasive and entrenched nature of complex trauma stresses the need for the provision of specific, nuanced treatment as recommended by the ISSTD in order to prevent further retraumatization and dysregulation. That being said, these best practices in the treatment of complex trauma are from a mainstream perspective and are not culturally-informed.

Research that focuses on Indigenous women's experiences of healing from complex, intergenerational trauma can begin to bridge this gap in literature and in clinical practice. Given the systemic oppression and intergenerational trauma Indigenous women have faced over generations, it is important not only for them to have a voice in sharing their experiences of engaging in healing activities, but also for counsellors to learn about and make space for Indigenous helping practices (Hart, 2014).

It is hoped that this research project initiates an ongoing discussion and further collaboration to provide healing activities for Indigenous women that are complex and intergenerational trauma-informed, dissociation-informed, culturally-informed, and resilience-informed, and that include treatment options for both mainstream and Indigenous approaches.

This research project is aimed at exactly such listening with the goal of increased respect and understanding first with Indigenous women's experiences of engaging in healing activities to heal from complex, intergenerational trauma.

Chapter 3: Methodology and Methods

In this section, I will discuss the methodological and philosophical underpinnings of Interpretative Phenomenological Analysis and then I will discuss the specific methods I used for this study.

Methodology

To be interested in Indigenous women's experiences situates this research in the constructivist paradigm with a commitment to hermeneutical (interpretive) approaches to research. Taking hermeneutical approaches to research encompass an, “awareness that each person has a standpoint, horizon, perspective, forestructure, or prejudice and that dialectical engagement is needed to support a "fusion of horizons" with others” (Ellis, 2006, p. 112). In other words, since everyone has their own experiences, views and values which shape their opinions and stance in the world, their perspective is limited. Talking to others and learning their experiences from their place and experience in the world connects these differing standpoints and creates a more holistic understanding, or “fusion of horizons”.

What is Qualitative Research?

Denzin and Lincoln (1994) describe qualitative research as, "multimethod in focus, involving an interpretive, naturalistic approach to its subject matter (p. 2). Qualitative researchers attempt to make sense of, interpret, deepen understanding, and generate new insights about phenomena in terms of the meanings people attribute to them (Denzin & Lincoln, 1994; McLeod, 2000). From this perspective, qualitative research can be conceptualized as malleable, a kind of *bricolage*, in that the researcher, the *bricoleur,* is a "Jack of all trades or a kind of professional do-it-yourself person" (Denzin & Lincoln, 1994 p.2.) By this, Denzin and Lincoln (1994), mean that the qualitative researcher has many options with which to design research. The

qualitative researcher can piece together his or her own set of qualitative practices that would best facilitate a deeper understanding of a phenomenon. Denzin & Lincoln (1994) write that the product of the bricoleur's multifaceted and agile efforts is like a, "complex, dense, reflexive, collage-like creation that represents the researcher's images, understandings, and interpretations of the world or phenomenon under analysis" (p.3).

A Constructivist Paradigm

Constructivism is a philosophical paradigm based on a relativist ontology and a subjectivist epistemology (Guba & Lincoln, 1994; McLeod, 2000). Relativism holds that humans do not have access to a "real" external world, rather they can only access representations of the world in their consciousness based on local and specific constructed realities. In other words, constructivism is based on the notion that the truth is socially negotiated; meaning is not uncovered, or discovered, but it is constructed (Crotty, 1998; Guba & Lincoln, 1994).

Furthermore, Guba and Lincoln (1994) describe epistemology as transactional and/or subjectivist and that findings are created. To unpack this further, epistemology focuses on how knowledge is acquired, what knowledge is, and what people know (or do not know). The constructivist paradigm answers these questions through a subjectivist approach where emphasis is placed on the individual. Individuals have the power to construct knowledge, according to the subjectivist approach, and each individual can construct his or her own truth, which is also shaped by social and cultural realities (Crotty, 1998; McLeod, 2000; Guba & Lincoln, 1994). In addition, knowledge is accumulated through vicarious experience, meaning that knowledge evolves through a "hermeneutical/dialectical process, as varying constructions are brought into juxtaposition" (Guba & Lincoln, 1994, p. 112).

Furthermore, the relationship between, and values of, both the researcher and participant are included and considered as formative in shaping and creating inquiry outcomes. Constructivists go so far as to state that to exclude values would be, "inimical to the interests of the powerless and "at-risk" audiences, whose original constructions deserve equal consideration with those of other, more powerful audiences and of the inquirer" (Guba & Lincoln, 1994, p. 114).

What is Interpretative Phenomenological Analysis?

Interpretative Phenomenological Analysis (IPA) is a qualitative methodology that examines how people make sense of, and understand their life experiences (Smith, Flowers & Larkin, 2009). This approach has become more widely used within sport psychology, health psychology, clinical psychology, and counselling psychology. Interpretative Phenomenological Analysis (IPS) is a qualitative methodology which is informed by three key areas of the philosophy of knowledge: phenomenology, hermeneutics, and idiography. Phenomenology describes the "what" and "how" of individuals' lived experiences and explores the universality, or commonalities, between participants' experiences (Cresswell, 2013). Hermeneutics is a philosophy of interpretation, which aims to discover what lies between what the participant has said and what is meant (Smith, D., 2010). In other words, IPA is engaging in a double hermeneutic: the participant is trying to make sense of her world and the researcher is trying to make sense of the participant trying to make sense of her world, (Smith, J., 2004; Smith, J., 2011).

Jonathan Smith, the pioneer of IPA, identifies three key features of Interpretative Phenomenological Analysis (2004). Firstly, he describes IPA as idiographic, which refers to the detailed examination of one case before moving on to the next. Idiography concerns what is

specific, or particular. Only when each case has been examined individually and in-depth is there an attempt to perform cross-case analysis for convergence and divergence between narratives and themes. Secondly, IPA is inductive in that hypotheses are neither verified or negated on the basis of relevant literature. Instead, IPA researchers are encouraged to be open to unexpected themes emerging and to be flexible in their data collection and analysis techniques. Thirdly, IPA is interrogative in that results of the analysis are discussed in relation to psychological literature (Smith, J., 2004). Interpretative Phenomenological Analysis emphasizes depth, rather than breadth in its analysis of the phenomenon under study and so recommends using smaller sample sizes (Piekiewicz & Smith, 2012; Smith, Flowers & Larkin, 2009).

Philosophical Underpinnings of Interpretative Phenomenological Analysis

Phenomenology

Phenomenology was developed by Edmund Husserl in the late nineteenth century (McLeod, 2000). Husserl refuted Descartes' belief that truth could be achieved through the use of logic and rationality and instead argued that examining the foundation of every day experiences was necessary in order to truly understand a person's emotions, actions, and perceptions of life (McLeod, 2000).

Husserl argues that to be phenomenological one must reflect on the fundamental structures of experience in order to achieve the ultimate truth (Smith, Flowers & Larkin, 2009). Modern qualitative researchers have taken a departure from Husserl's strict commitment to the search for the ultimate truth, or “certitude”, and acknowledge that participants' reports are relatively constructed and contextualized, thus representing "a" truth as opposed to "the" truth (McLeod, 2000).

Husserl uses the term "intentionality" to refer to the conscious awareness of an aspect of one's experience. He also was a proponent of researchers "bracketing", or setting aside, their own worldviews in order to purely and fully understand another's experience (Smith, Flowers & Larkin, 2009; McLeod, 2000).

Phemonenological ideas continued with Martin Heidegger, a student of Husserl. While he attributed some aspects of his knowledge to Husserl, Heidegger departed from some of his mentor's ideas and moved phenomenology in a hermeneutic and existential direction (Smith, Flower, & Larkin, 2009). Because of his emphasis on hermeneutics, Heidegger questioned the possibility of any knowledge existing outside of an interpretive stance within the world of people, relationships, and language. In essence, he believed that human beings can be thought of as tossed into a world of relationships, language, and objects and that being in this world is perspectival, temporal and contextual; it is always in-relation-to something. Therefore, in order to understand an individual's experience, a researcher must engage in meaning-making, or interpretative, activities (Smith, Flowers & Larkins, 2009). Jean-Paul Sartre extends Heidegger's emphasis on the worldliness of experience and the relationship between self and others, and the relationship between self and the world. Sartre's work is key in phenomenology in that it provides social and relational context to further analyze the self, not as a separate entity in the world, but a connected and relational participant in the world (Smith, Flowers & Larkins, 2009).

Hermeneutics

Hermeneutics is the theory, or philosophy, of interpretation. Etymologically, "hermeneutics" is Greek, meaning "interpretation". The word hermeneutics was first used by Plato and was often used with another word, which meant "divination" (Smith, D.G., 2010). At

the time interpretation was reserved for translating divine messages (eg. omens) in order for the messages to be understood and shared with others. This tradition of divine interpretation continued in an attempt to provide interpretation of biblical texts. With the rise of technology and the ability to provide the public with mass copies of literature and biblical texts post-Enlightenment, more than a select few became able to interpret and thus interpretation extended into secular texts.

In the early nineteenth century, Schleiermacher described three key themes in hermeneutic inquiry: the inherent creativity of interpretation, the pivotal role of language in human understanding, and the interplay of part and whole in the process of interpretation (Ellis, 1998; Smith, D.G., 2010; 1991).

The first theme describes a creativity of interpretation by illustrating that the interpreter works "holistically, rather than using classification systems, in an effort to discern the intent or meaning behind another's expression" (Ellis, 1998, p. 15). Smith (1991) further adds that, "texts, works of art, and so on, are expressions of a creative spirit which any interpreter must somehow engage if interpretations are to be made that are faithful to an author's original intention" (p. 190).

The second theme emphasizes the importance on language in understanding studied phenomena. Schleiermacher emphasized that interpretation cannot be performed by following a series of mechanized steps, instead he stresses that interpretation is an art requiring a wide range of skills, including intuition (Smith, Flowers & Larkin, 2009). Ellis (1998a) explains that language contains both traditional and cultural context, which can be both enabling and

inhibiting to the researcher depending on concepts and/or language in her repertoire with which to think and interpret.

Finally, the third theme is concerned with the interplay of “part” and “whole” in the process of interpretation. Interpretative inquiry focuses on a back and forth nature that travels between the specific and the general (Ellis, 1998a; Smith, 1991). Ellis (1998a) writes that in order to "understand a part, one must understand the whole, and to understand the whole, one must understand the individual parts" (p. 16). This movement is circular in that it has no natural beginning or end point, which is why it is referred to as "the hermeneutic circle".

Moran (2000) states, "the proper model for seeking meaning is the interpretation of a text and for this reason Heidegger links phenomenology with hermeneutics. How things appear or are covered up must be explicitly studied" (p. 229). Heidegger also believed that the reader and researcher brings their own fore-structure, including prior experiences, assumptions and preconceptions, to the relationship and that this impacts the interpretation (Smith, Flowers & Larkin, 2009). Heidegger's emphasis on forestructure and its intertwining role in encounters with others causes a re-examination of the role of bracketing in the interpretation of qualitative data.

Packer and Addison (1989) write that interpretation is "the working out of possibilities that have become apparent in a preliminary, dim understanding of events. And this pre-understanding embodies a particular concern, a kind of caring" (p. 277). Furthermore, they state that interpretive accounts are not stabs in the dark or uneducated guesses, rather they are guided by the fore-structure of projection.

While some critics of qualitative research or interpretive inquiry may oppose projection, Packer and Addison (1989) state that it is the forward arc, the projection, that makes

understanding possible. It is important, however, to remember that while the forward arc of the hermeneutical circle brings with it the researcher's projections, it is the backward arc that monitors, or evaluates, a researcher's first impressions. These first impressions are not only evaluated, but it is the combination of projection and understanding that creates new understanding. More about the importance of fore-structure in interpretive inquiry is described within the context of the role of the researcher in the following section.

Patterson and Williams (2002) state that unless "something is completely foreign, we approach it with a preliminary understanding that is shaped by past experience, life styles, and culture" and "understanding inevitably involved reference to that which is already known (p. 23). In other words, it is impossible to bracket prior knowledge. Forestructure then becomes the foundation on which knowledge is built (Patterson & Williams, 2002). However, Gadamer also acknowledged that there were both blind prejudices that were unjustified, and legitimate prejudices. Blind prejudices hold unwarranted stereotypes and tradition, whereas legitimate prejudices are considered productive and open to change. Gadamer felt that a fundamental hermeneutic epistemological question was how to distinguish legitimate prejudices from blind and other unproductive, unjustified prejudices (Packer & Williams, 2002).

Role of the Researcher

To achieve appropriate forestructure, Packer & Williams (2002) stated that researchers must engage in careful interpretive research that seeks reciprocity, interaction, and dialogic interviews in which the interviewer is providing information about him or herself. These elements not only help to foster a relationship with the participant, but also act as a built-in form of validation within the interview process.

Denzin and Lincoln (1994) state that the qualitative researcher must understand that research is an interactive process shaped by his or her personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting. Therefore, the narratives, or stories, are accounts couched and framed within specific storytelling traditions, often defined as paradigms (e.g. positivism, postpositivism, constructivism) (p. 3).

While perhaps some qualitative researchers may believe it best to come into a situation with their preconceptions bracketed, as a *tabula rasa*, they cannot deny that it is through the lens of a qualitative researcher's biography that the true understanding and meaning of a particular phenomenon can occur. Guba and Lincoln (1994) describe the inquirer's voice from a constructivist paradigm as that of a "passionate participant" actively engaged in facilitating the "multivoice" reconstructions of his or her own constructions as well as those of all other participants (p. 115). It would be difficult to engage in constructivist interpretive inquiry without a willingness on the inquirer's behalf to be engaged and impassioned in the dialogical interpretive process.

Interviewing

Interviewing can mean different things depending on the context and medium being used. For example, interviewing can take on an investigative journalistic tone, providing the "hard hitting" questions that are meant to pull the truth out of a politician, or business executive. Interviews for interpretive inquiry search for the truth, but do not force it out of participants; rather, as Sandra Weber (1986) writes, a researcher's quest for knowledge must not trump the respect and dignity for the participant. To avoid the potential for abuse and betrayal, Weber suggests *inviting* people to participate in an interview (1986). It is important that this invitation is genuine and that during the interview, the researcher is "genuinely present, committed, and open

to the participant" (Weber, 1986, p. 65), a stance that is similar in person-centered counselling (Rogers, 1959).

It is important for interviewers to consider the different ways that a power imbalance can occur, especially when working with oppressed populations. For example, Weber illustrates that "as long as it is the researcher who records, asks the questions, and decides how to deal with the interview material, the balance of power usually remains firmly in his or her hands" (p.67). Weber (1986) reiterates the importance of the relationship dynamic and to find a balance between interview and conversation. Interviewers can still be present and engage with participants through non-verbal gestures and body language. Weber (1986) also expresses that the best moments of an interview are when the "interviewer and the participant are both caught up in the phenomenon being discussed, when both are trying and wanting to understand...They are talking to each other, rather than past each other" (p. 69).

Decolonizing Research Methods

Research in itself is a privileged act. To be a part of a university institution, through which most research takes place, and be able to learn to "study" a certain topic, or population denotes power over that topic or population, especially when studying those who are marginalized and oppressed. Decolonizing research methods refers to a critical examination of Western, "empirical" ways of questioning, studying, and examining and deconstructing those methods and creating culturally safe and humble ways of understanding the world (Tuhiwai Smith, 2012). The "truths" Western researchers yearned to discover were examined through the lenses of Western epistemology and Western philosophy, which when seeking to understand experiences of another culture leads to further oppression, and significant damage to many

Indigenous communities (Battiste, 2001; Kovach, 2010; Lavallée 2009; Smith, 1999; Wilson, 2008).

Over the years, increased literature has been published regarding Indigenous research methods, which include Indigenous epistemology, may include ceremony as part of research, and prioritizes benefitting and healing deep cultural wounds afflicted by Western research(ers) through honouring culture, community and Indigenous ways of knowing. Denzin et al (2008) and Smith (1999) posit that decolonizing research is an ongoing process of unlearning and relearning the roles of research and educator, and taking responsibility for participants.

Kovach (2005) suggests the following assertions of Indigenous epistemology, or theory of knowledge, to guide research:

1. A person's experience is a legitimate way of knowing
2. Storytelling, an Indigenous way of sharing knowledge, is also legitimate.
3. The dynamics between researcher and participant is a natural part of the research process
4. A way of knowing that is both collective and reciprocal to the community.

Some Indigenous scholars suggest that research methods can be "borrowed" from other paradigms so long as they are congruent with the "ontology, epistemology and axiology of the Indigenous paradigm" (Wilson, 2008, p. 12). He cautions that applying a Western methodology in an Indigenous context may not be congruent because of the underlying philosophies and theories of thought. Still Datta (2018) remains optimistic that a bridge can be built between Western methodologies and Indigenous context if done with careful attention to the process, and collaborating with Indigenous stakeholders. In addition researchers must be continually vigilant

to recognize the persistent presence of colonialism, oppression, and power in Western research training taught in post-secondary institutions, and in current Westernized research practice (Datta, 2018).

Building a bridge between Western methods and Indigenous contexts

Keeping the above information in mind when I embarked on this research, I first considered my place and space and whether I was even the right person to engage in Indigenous research. I reflected on my privilege and power and whether I would be taking away an opportunity for an Indigenous person to do this research.

Embarking On This Research

I met with the former executive director of a social services agency on the First Nations community where I was providing counselling services at the time, along with other staff members and the community's band representative and asked what topics they would be interested in being researched and what topics would be serve the community in helping the community to heal. Through collaborative discussion it was determined that understanding better what activities women engage in and what their experiences were regarding these activities and their healing journey, and how they come to healing was important. Those that I spoke to felt it was appropriate for me to embark on this research as someone known in the community and who had some understanding about the community's culture and both Western/mainstream and Indigenous ways of knowing and healing. Also, they appreciated I was trauma-informed and practiced cultural humility.

Choosing a Method

A Western method that is grassroots in nature and involves participants wholly in the research process Participatory Action Research (PAR). Researchers have used PAR when engaging in research with Indigenous populations, or populations of a different culture or expertise (Zavala, 2013; Denzin, Lincoln & Smith, 2008). PAR is often chosen as a methodology because of its,

> participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities (Reason & Bradbury, 2001, p. 10).

Participatory Action Research transfers power from the research and shares it amongst key stakeholders who are often community members. Knowledge is transferred as stakeholders also engage in research, participating in method development, data collection, data analysis, and the dissemination of results to the public.

While PAR meets a lot of the criteria for decolonizing research, and lends space for incorporating Indigenous ceremony and epistemology into its design, it was determined through collaboration with community partners that implementing PAR for this type of research would not be ideal. Elders and community stakeholders I spoke to shared concerns of confidentiality with a PAR approach and wondered if this would affect prospective participants coming forward. Some Indigenous researchers suggest having Indigenous practices, or ceremony as part of the research process. The presence of an Elder during the interviews, smudging, prayer, and possibly offering the gift of tobacco in gratitude of participating in the study are all possible examples of

honouring and incorporating Indigenous ways into research. Once again, I spoke with Indigenous community stakeholders prior to the design of this research study and they expressed concerns about having an Elder present during interviews for support and to offer ceremonial practices because not all members of the First Nation community are open to Indigenous practices and having this as part of the research method could limit participants who may identify with a Christian faith, or who do not identify with spirituality or faith at all. If the research was to be open to any and all activities of healing, then the research method should be culturally safe, but also allow for Indigenous women who may not partake in Indigenous ways to feel they could participate in the study.

Decolonizing Interpretive Phenomenological Analysis

Decolonizing research approaches are often qualitative, phenomenological, and hermeneutic in that these approaches focus on the participants' experience as truth and honour their stories as fact. Given the suggestions regarding research methods, I felt that Interpretive Phenomenological Analysis (IPA), with a few modifications, would offer a culturally safe, trauma-informed, decolonizing research method for prospective participants, that it would be a positive experience for all involved, and not damage the already existing relationship I had with some First Nation community members, nor cause harm to the wellbeing of the participants.

As previously mentioned, the nature of IPA is rooted in honouring participants' experiences and as such there is more of a power balance between participant and researcher. As described above, the research is required to be present, an engaged listener, and passionate about the project and about learning from the participants. This engaged and passioned listening leads to the researcher's understanding combined with the participants' experiences help to form the

"fusion of horizons", a shared understanding, between the two parties, and hopefully with the reader.

Modifications to IPA

Modifications were made in the way questions were asked and with analysis. There is not one firm way to do these two tasks within IPA. The modifications made were still in keeping with the philosophical underpinnings of IPA in that the questions were designed in a way to elicit information about the participants' lived experience (phenomenological), and that interpretation of the stories of participants' lived experiences will take place (hermeneutics). Also detailed examination of each participants' story took place before analysis of the stories (idiographic).

Pre-interview Activities. Using Pre-Interview Activities is not part of IPA, but is a way to allow participants to share their lived experiences in a more controlled way in the sense that they get to choose the activities they want to speak about and also get to choose how much they share about each topic. Also, using drawing as part of PIAs allows participants to engage in storytelling through an arts-based method, which may help Indigenous participants access Indigenous knowledge and contexts in different ways. Through this activity the participants have the power to choose and respond in their own way without judgement, probing questions or expectations from the researcher (Ellis, Hetherington, Lovell & Vickzo, 2013).

Open-ended questions. In kind, the interview questions were designed with similar care to be open, non-judgemental and provide space for participants to share what they feel comfortable sharing. Questions invite, rather than probe. Participants can choose how to respond, rather than feel pressured to answer in a particular way.

Fidelity checks. Following meeting with each woman, I transcribed the interviews and created their narrative portrayals. Once they were completed, I shared the narrative portrayals with each participant, including the quotes that I was planning on using. Each woman had an opportunity to modify and/or redact what they shared in the interview. This was to both ensure that each woman had an opportunity to edit their story, and to ensure that my interpretations of their story were correct.

About the Researcher

I am a 38-year old white female and I have been working with Indigenous populations in Sarnia, Ontario as a counsellor for the past ten years.

How I came to Sarnia, Ontario. My ancestors settled on Indigenous land in the 18th century in the United States and Canada emigrating from England and Scotland. My paternal ancestors settled in Pennsylvania as farmers after leaving England for unknown reasons. In the 19th century, my paternal line moved to the Niagara area in Ontario, Canada and eventually settled north of Toronto in a rural area. They continued to farm and were practicing Mennonites. My great-grandfather was born in southern Ontario and was raised in a family who moved away from the Mennonite way of life, but still farmed to try to make a living. He eventually moved to Sarnia, Ontario as a tool and dye worker and raised a family. He and his wife raised three children. My grandfather married and they had three children.

My maternal ancestors emigrated from Scotland and England to Montreal and Eastern Ontario. My maternal grandfather came to Sarnia, Ontario to work as a welder. He found employment with a local union and helped to build and repair structures in Sarnia's then-booming petrochemical plants. They raised three children in a small trailer in Sarnia. My

maternal grandmother was a stay at home mom until her husband died of mesothelioma (a type of lung cancer caused by exposure to asbestos). My mother was fifteen.

My parents met in high school. They got married after their first year of post-secondary school. After they graduated, they returned to Sarnia to find work, to be near their families, and have a family of their own.

How I came to this work. My maternal grandfather had strong values in Christianity and socialist ideals. He was anti-establishment and valued family and community. He led his family in church at home every Sunday and actively wrote letters to scholars and ministers and to the editor of the local newspaper addressing ways to apply Christian principles to everyday life, including the importance of family and the role of fathers in the family. He was concerned that individuals' values were being highjacked by values set upon them by corporations.

My mother was very influenced by how she was raised and the values her parents, in particular her father, modeled in her home. She was also very affected by not only his early death, but that he died because of his work and the lack of emphasis put on safety precautions when handling hazardous materials like asbestos.

When I was three years old my mother decided to go back to school to get her Masters in Social Work from Michigan State University. At the time, she was working in an agency to support individuals with developmental disabilities. She continued working full-time and returned to school part-time. She graduated five years later and worked in outpatient social work at the local hospital. My mother eventually started her private practice. Throughout her work, she was always advocating for the disenfranchised and oppressed populations with whom she worked. Still striving for recognition and justice for her father's death, she started to help other

workers and their families advocate for compensation and recognition from the Workplace Safety and Insurance Board (formerly the Workers' Compensation Board). She was part of a group of individuals who advocated for a not-for-profit organization called the Occupational Health Clinic for Ontario Workers to open a new location in Sarnia, Ontario. This organization employed doctors, occupational health nurses, and other health care staff who help individuals to substantiate their WSIB claims, whether it is through further medical testing, documentation of work history, or sharing relevant research. I was a teenager when my mother was involved in this grassroots activism group and was inspired by her involvement. Both my father and I helped where we could and eventually the clinic was approved to open in Sarnia. At first, the approval was on a short-term basis, but shortly thereafter was given funding to be a permanent clinic, one which continues to operate with the same mandate, twenty years later.

My mother had an enormous influence on my life. She would teach me about systems in our world and how they helped or hindered certain populations. I learned early on about people and communities who manipulated and abused others and how it impacted their victims. I always knew I wanted to be in a helping profession, but was unsure that I wanted to follow in my mother's footsteps.

Academic experiences and influences. I entered my undergraduate degree in Kinesiology in 1999 with the intention of being a physiotherapist. I was heavily involved in physical fitness, working as a group fitness instructor and personal trainer and had benefited from physiotherapy following a number of injuries. Two weeks into my program I learned about sport psychology and all thoughts of becoming a physiotherapist vanished. I wanted to be a sports psychologist and help elite athletes perform at their very best. Yet, that did not sit very well with me. I liked the idea of helping people removing the mental and emotional blocks in

order to live their best life. But I wanted to help general populations with this, not just elite athletes.

At the end of my undergraduate career, I was not sure how next to proceed. I wanted to learn more about the body and how it responded, and healed, from stress. I also wanted to learn more about psychotherapy and interventions to help people heal from stress. I first went back to school to become a registered massage therapist and worked in a private practice for close to five years. I learned a lot, but I felt I could better help others as a counsellor. Once I completed my Masters degree in Counselling in 2009, I complemented this degree with training in a trauma resolution therapy called EMDR therapy. I started using it in my work under consultation at the community college where I worked, and then further specialized in that therapy and with traumatized populations once I started my private practice in 2011.

My clinical specialty continues to be in trauma therapy, specifically working with clients with complex trauma and dissociation. I am a certified EMDR Therapist and an approved EMDR Consultant. I am also training to become a trainer of EMDR Therapy. I have extensive advanced training in incorporating phase-oriented treatment for complex trauma and dissociation into EMDR Therapy. I have also completed an eight-week Indigenous cultural competency course offered through the Provincial Health Services Authority (PHSA) in BC and the Southwestern Ontario Indigenous Health Access Centre (SOAHAC). I also attended a 5-day intensive training on trauma, resilience, and restorative justice. During my pre-doctoral internship as a counsellor within Counselling Services at the University of New Brunswick, we had the opportunity to take Indigenous Cultural Safety training throughout my 12-month contract.

I am currently a Registered Social Worker in the province of Ontario through the Ontario College of Social Workers and Social Service Workers and work in private practice. In my private practice I have worked with children, adolescents, and adults. The majority of my work has been with Indigenous populations, providing individual counselling both on and off-First Nation communities. Through this work, I have made connections with key stakeholders on reserves including mental health intake coordinators, program directors of social service agencies, and elders. Over time, I have developed trust and rapport with these individuals and they have welcomed me into their community to offer counselling for their people. Most of my First Nation community work has been on Walpole Island First Nations through their Social Services department. I have also provided counselling on-site for children at Walpole Island Elementary School, a band-operated school, and at a public high school in a nearby town where the majority of Indigenous adolescents attend.

Acknowledging privilege. The purpose of sharing information about my ancestry and how I came to this work is to give context regarding my place within and around this research. I am a white, non-Indigenous woman whose ancestors arrived onto Indigenous land from England more than eight generations ago and from Scotland four generations ago. I came from a middle-class home with parents who valued education. I am an only child and thus was afforded more opportunities to travel and participate in extra-curricular activities.

I commit to the ongoing process of continuing to reflect upon my privilege and how it impacts my work with others along with the ongoing process of challenging oppressive systems in my personal professional practices by engaging in proactive actions of allyship and education, not only to decolonize the practice of counselling and psychotherapy, but to help Indigenous and other oppressed populations heal emotionally and mentally.

Research Method

Research Site

Participants chose to have their interviews for this study in a secure, confidential office building in Sarnia, Ontario, approximately 50 kilometers from Walpole Island First Nation. One participant requested her interview take place at a private space in a public library near where she lived, and the researcher accommodated this request. Participants were also given a choice to meet using office space within the social services building on Walpole Island First Nation. The researcher was also prepared to go to participants' homes should they offered and stated they would feel more comfortable having the interview in their home.

Participant Eligibility

Potential participants were screened for the following inclusion criteria:

- Adult females (over the age of 35)
- Must be a member of Walpole Island First Nation
- Must describe their mental wellness as okay or better
- Engaged in activities that facilitate healing from personal and intergenerational trauma, including, at some point in time, individual counselling and/or psychotherapy.
- Can communicate in English

Exclusion criteria included potential participants who do not meet the inclusion criteria, as well as those who were previous clients of the researcher. This exclusion criterion was put in place so as to avoid any conflict of interest, or risk of dual role, thus potentially threatening the therapeutic relationship.

Procedures

Recruitment

Purposive sampling was used to recruit four First Nations women who are currently living on Walpole Island First Nation. In addition to the Walpole Island First Nation Social Services, advertisements were posted at Walpole Island First Nation Health Services, the on-reserve health clinic, and at the local band office on-reserve. Potential participants contacted the researcher directly to indicate interest, or to ask questions. Potential participants participated in a brief telephone screening with the researcher to ensure inclusion criteria were met. Each woman who contacted the researcher met criteria to participate in the study. Once four participants were recruited, advertisements were removed from the abovementioned sites.

Interviews

A field test was employed using pre-interview activities (PIAs) and interview questions with one person to determine if the PIAs and interview questions were adequately constructed to not only yield rich and meaningful data that relates to the overarching research question, but also to determine if the questions were constructed in a manner that is respectful of culture and tradition. The participant reported that all questions felt appropriate and respectful and the researcher decided after transcription and a review of the data received, that the combination of PIAs and questions asked would have the potential to yield rich data.

Before the interview commenced, the researcher explained informed consent and reviewed the nature and purpose of the study. Once the participant gave consent and any questions were answered, the researcher introduced the Pre-Interview Activities (PIAs). The researcher provided all supplies including paper, markers, pencils, erasers, pens, crayons, and

pencil crayons to complete the PIAs. Participants were encouraged to complete at least four PIAs. A complete example of pre-interview activities can be found in the Appendix F.

Pre-interview activities (PIAs) facilitate a participant's recollection during interviews and may also enable them to more deeply express or depict feelings and perspectives. Ellis (2006) states that pre-interview activities will inform the interview conversation, thus facilitating in the shared experience and meaning of participant and researcher. The use of drawings was also found to be effective in elucidating insight during interviews (Cristancho, Bidinosti, Lingard, Novick, Ott & Forbes, 2014; Ellis, Hetherington, Lovell & Vickzo, 2013).

Sample PIAs include:

- Draw a diagram to show where your support, or support systems, come from.
- Think of an important activity that you do. Make two drawings showing a "good day" and a "not so good day" with that activity. Feel free to use thought bubbles or speech bubbles.

Two to three interviews took place with each participant to allow for rich data and also for opportunity for relationship building, information clarification, and also for a "closing" session to ensure proper termination including a discussion of supports and services that are available should the participant require emotional support or choose to further their healing. These interviews were scheduled at the participants' availability.

After introductions were made with some brief conversation for rapport building, the researcher reviewed informed consent, confidentiality, and other housekeeping items. Once the participant provided her signed consent, the researcher explained the PIAs and gave the

participant time to complete the activities. Upon completion, the participant was asked to share her PIAs and explain them in her own words. It was at this point that the researcher started to record the interview. Following the participants' explanations of her chosen PIAs, the researcher asked general "getting to know you type questions", to establish rapport and eased into more specific questions pertaining to the overarching research question. At the end of the first interview, the researcher offered the participant time to debrief her experience, if necessary. The participants were given a sheet of community referrals for counselling and community referrals to access traditional healing at the beginning of the interview. The researcher reminded each participant of this information sheet and provided information about a follow up meeting to ask follow-up questions and/or to allow the participant to review the narrative analysis and quotes the researcher would like to use in the publication of her dissertation.

Analysis

This analysis for this research is guided by qualitative Interpretive Phenomenological Analysis (IPA). Both pre-interview activities (PIAs) and interview transcripts were analyzed using suggestions from Smith, Flowers, and Larkins (2009) and Ellis (2009; 2006; 1998). The analytic process in IPA is presented as less of a process or method and is more of a collection of strategies to use, which are drawn from interpretative, hermeneutical analysis.

Transcription. Interviews were transcribed by the researcher to maintain confidentiality and also allowed the researcher to have more contact with the participants' narratives to help lay the foundation for further analysis and interpretation. Transcription documents, including the digital raw interview file and notes, were saved on a password-protected document on a password protected computer.

Analysis and Interpretation. Analysis through the use of narrative meaning units is consistent with hermeneutic principles (Smith, Flowers & Larkin, 2009; Polkinghorne, 1995). This process includes the identification of stories, or narratives, within each participant's transcript, delineating the topic of the story, key ideas and/or metaphors expressed, and possible themes the key ideas may fit into (Ellis, 1998). Appendix G proposes a table to systematically analyze data and to pose questions, which may inform interpretation. Through the identification of stories within each participant's narrative, the researcher proposes to continue to read through the transcript to develop familiarity and an internal dialogue of what it might mean for participants to have these experiences, in order to foster the development of a more interpretive account. After each participant's accounts are analyzed, this process is repeated across cases as a thematic analysis.

Ethical considerations

There are many ethical considerations when working with Indigenous participants. Before this study was conceptualized, the researcher spoke with both the Executive Director and Intake Coordinator of Walpole Island Social Services. Parties present collaborated on potential ideas for research and what the benefits and implications of this research might be for them as an agency, and for the community at large. Both the Executive Director and the Intake Coordinator verbally consented to the researcher proposing and engaging in this research. The researcher also met with the Intake Coordinator, the Band Representative of Walpole Island First Nations, and the Director of Operations of Walpole Island First Nation and proposed her research to them and asked for feedback. Discussion was held regarding ownership and access to the research materials and how this research could lead to other research opportunities which are in alignment with their own research interests. Following our meeting, all three parties present approved the

research proposal and consented to advertising at key places in the community including the Band office, health centres, and the Social Services office.

Research involving Indigenous peoples. In accordance with the framework offered by the Panel on Research Ethics for research involving Aboriginal peoples (2014), I have, and continue to, foster relationships with the Walpole Island First Nation community. I have received permission from the Walpole Island First Nation to carry out this research and have consulted with various stakeholders in the Walpole Island community before considering and developing this research topic. I will also continue to maintain open channels of communication with my community partners to ensure that goals between both parties are continually clarified as needed and understood.

Aside from following standard ethical guidelines with human subjects, additional considerations are as follows.

Respect for Persons. As a white researcher studying Indigenous women, it is important to ensure the autonomy of research participants, especially because of the historical oppression and continued vulnerability of Indigenous communities, and Indigenous women. All documents, including informed consent, were created in easy to understand language and were explained orally in addition to written format to ensure that all participants understood the nature of research. Participants were informed of their rights, that they could end the interview at any time, that they given the opportunity to read and edit transcripts, and had the final say of what aspects of their interview would be used for analysis and publication.

Dual Role. As mentioned earlier, since the researcher has provided counselling to clients on-reserve, pre-screening measures were put in place to ensure that her past clients were not recruited for this research project. It was important that the role of therapist and client did not get confused or muddled with the role of researcher and participant. As the researcher was the sole recruiter of participants and contact person, there was not a possibility that past clients were accepted to be part of this research.

Confidentiality. Participants were informed that all data published would include non-identifying information. They were also encouraged to consider that Walpole Island First Nation is a small community of approximately two thousand residents, so confidentiality and the use of non-identifying information would be extremely important. Doing case studies with an interpretive emphasis was used as a way to protect participants and the personal stories they shared (Merriam, 1998). Case studies and narrative portraits were used to introduce participants holistically, but analysis of narratives were used to provide aggregate material about other parts of the case studies not only to demonstrate potential themes and discrepancies, but to ensure participants' personal stories and reflections are non-identifiable.

Participants were given the opportunity to review the transcript from their interview and their personal case study, including the narrative analysis that the researcher compiled and were able to make any edits necessary.

Limits to confidentiality were explained before the interview began so participants knew when the researcher would have to breech confidentiality as a means to protect the participant's safety, or the safety of others.

Potential Risks

While the purpose of this research was to gain new insight and understanding into First Nations women's experience of healing from emotional trauma, there was a possibility that some participants disclosed upsetting material was triggering. I took great care to develop and revise interview questions that were not intrusive, or disrespectful; however, some participants may have decided to disclose emotionally distressing information which may cause emotional dysregulation and upset. Participants were first invited to share whatever they feel comfortable with and were told that they can stop the interview whenever they like, for whatever reason. In that case, I would have stopped the audio recording device and provided community resources for the participant to connect with if they needed further support (Appendix C).

Potential Benefits

This study offered an opportunity for Indigenous women to share what was important for them in their healing process. Just as talking about their healing journey may have been upsetting, providing Indigenous women the space to speak in a respectful, non-judgmental environment may have also provided an opportunity for healing. Also, it afforded them the opportunity to inform practice. It gave them voice. It gave them the right to offer input to affect change in things that mattered to them. There is also the potential benefit for the executive director and program and intake coordinators of Walpole Island Social Services to gain more understanding of the healing journey for participants. It is possible that this may help them in the development and evaluation of programs for the community. It is also possible that this research will better inform clinical practice across the counselling professions in working with this population. Finally, this research can help me understand better and help better to Indigenous women who have endured the effects of complex, intergenerational trauma.

Chapter 4: Participants' Narratives about Healing

This chapter contains the narrative analysis of each participant followed by a description of the healing activities in which they participated. Each narrative analysis was written in a way to share each participant's story of how they came to engage in healing activities and what their experience of engaging in healing activities was like for each participant. I used large sections of each participant's narrative in order to preserve the context and content of their stories. This also minimizes researcher bias and prioritizes the participants' voice throughout. Each participant's story is presented individually because, while there are many commonalities in their stories, each story is different and all are worthy of being read. It also provides evidence for themes presented in the following chapter.

This chapter begins with a collective history of all four participants. A collective history is illustrated here to maintain confidentiality of the participants as well as to show the similarities of the type of traumas that each participant faced that led to their healing journeys.

Collective History

All participants of this study are part of the collective threads of the tapestry of intergenerational trauma. To respect each participant's confidentiality, and because there are many similarities, a brief collective trauma history follows.

The four female participants are residents of a First Nation community in Southwestern Ontario. Their ages range from late 40s to early 60s. Three participants had immediate family members who were taken to Indian residential schools, the fourth participant attended residential school. All members described various forms of abuse, neglect, and/or substance abuse by their parents which they feel negatively impacted how they were raised, and also impacted their

relationship with their parents and future relationships with others. All participants shared various forms of disconnection from others: struggles connecting in romantic partnerships due to difficulty trusting others and knowing how to communicate love in healthy ways, low self-esteem, and not participating in community or cultural events inside or outside of their community. Most participants shared that they had difficulty regulating their emotions, including anger. Some participants shared feeling chronically responsible for other people's feelings and described codependent type relationships with others.

All participants grew up in poverty. Most participants grew up in a First Nations community, while one participant grew up in a large urban city not far from the First Nations community, but moved to the abovementioned First Nations community when she was a teenager.

All participants have children and some have grandchildren. Some of the participants shared that their children struggle, or have struggled with emotion regulation issues, substance abuse issues, and have been in trouble with the law.

With regard to their healing journeys, all participants engaged in both traditional and "mainstream" healing activities to address their trauma and the symptoms and/or behaviours stemming from their traumatic histories. Because of their healing journey, all participants work in the community as a way to share their knowledge and pay it forward to the community. In addition, all participants have attended, or are currently attending post-secondary schools (college and university) in order to increase their ability to help their community heal from the effects of intergenerational trauma.

Given the nature of each participant's traumas and how these traumas have impacted them, the participants would have been considered to have symptoms consistent with complex trauma prior to the commencement of their healing journeys.

Narrative Portrayals

Mary

Mary was in her 60s and had grown up in a large family in a First Nations community. She was exposed to neglect and abuse in her household. In spite of any income the family received, there were many children in the family they were living in extreme poverty. Mary said her mother was good at giving hugs, but was negligent in meeting her children's emotional needs in other ways. In fact, Mary said that it was not until she started counselling that she realized that her mother loved her and that being hugged by her mother was a non-verbal expression of her mother's love. Mary is a residential school survivor who has struggled most of her life to feel like she could truly connect and relate with others and feel understood. She said she felt closed off emotionally, and to connecting with others was extremely difficult after a close family member died. She said that she became mean toward others and isolated herself from others. Mary describes herself as a very religious and spiritual person and has relied on faith and prayer as a resource for survival and healing for many years.

About the Interview Process. The interview with Mary took place at the researcher's office space in a medium-sized city in Southwestern Ontario proximal to the First Nations community being studied on March 4, 2018. Overall, the interview went smoothly. After the research was explained and consent explained and given, she completed the Pre-Interview Activities. The researcher stayed in the room with the participant in case she had any questions. She completed the following Pre-Interview Activities:

- Draw a diagram to show where your support, or support systems come from
- Think of a component of your life that is very important for you. Make a timeline listing critical times or events that changes the way you experienced it
- Use colours to make three drawings that symbolize how your experience of healing from trauma has changed over time
- Use three colours to make a diagram or abstract drawing that shows what it is like for you to recover from trauma
- Complete this sentence: Trying to heal from trauma is like…

Following completion of the PIAs, Mary described each of the activities she completed prior to me asking other prepared open-ended questions. The participant thoughtfully answered all prepared questions. During the interview with the prepared questions she referred back to her Pre-Interview Activities (PIAs) frequently to help illustrate what she was saying, or to refer back to what was already discussed. After I transcribed the interviews and did a preliminary narrative analysis, I contacted Mary by phone with follow-up questions. She willingly answered the questions. She said she had given the questions thought prior to their meeting and once again provided insightful answers to the questions. The participant also had an opportunity to read the transcript and/or the narrative analysis. The participant stated that she was impressed with the analysis and how accurate it was. She also provided a couple of content errors, which I edited. Following this second interview, the researcher met with the participant a third time to share with her the revised narrative analysis and to debrief the interview experience, though the participant said it was not necessary to debrief, that she found the process affirming. She also said that she “has a book in her” and this process helped her to think about that more.

Narrative analysis for Mary. Mary is in her sixties and surmises she has been on her healing journey in different "waves" for the past 40 years. The narrative analysis below demonstrates the different sources of support or healing that Mary experienced throughout her life.

Early Life: "Saved for a reason"

Mary grew up in poverty with her mother, father, and was one of twelve siblings. She was the victim of neglect and witnessed violence. Home was not a safe place for her; she did not have a safe and secure attachment with her parents. She found a refuge of love and safety with her grandfather. She said she would spend time in his barn as he tended to the horses and they would talk. Her grandfather was a spiritual man and would spend time with her and give her spiritual guidance.

She shared that when she was a child, her mother told her a story about how her grandfather saved her life. Mary said that when she was an infant she almost died. She continued,

> So I was in the hospital and my grandfather came in to be with my mom and me in recovery that night of the operation. My mom said I died three times. My heart stopped beating and my grandfather would just pick me up and pray me back to life every time. (Interview, March 4, 2018)

She said that other people in her First Nation community would treat her as if she were special. She said that she was the only person for whom they had a birthday party. She said that once hearing the story she felt she was saved for a reason and had a purpose in life. She also said

that it gave her a sense of confidence, a drive to succeed and "to take risks" (Interview, March 4, 2018).

Another safe place for Mary was elementary school. She attended school in her First Nation community until Grade 8. She recalled how much she enjoyed learning at school. Unfortunately, her safe person and safe place were short lived. Her grandfather died when she was seven years old. In her own words:

> After that there was this sadness that I carried all the time...From that sadness I became very hard and mean, so I used mean words with people and I was lost. I didn't really have any real direction and plans. And my life was very scattered and unsettled. And I was closed to other people and let people in only because they were useful at that moment. I was very uncommitted… Didn't know myself at all. Didn't know what I didn't like. (Interview, March 4, 2018)

Mary continued enjoying elementary school until she graduated from Grade 8. She was forced into Indian residential school for Grade 9. Her enjoyment for learning and penchant for curiosity stifled, she said, "…It took me three years to get to Grade 9. I kept quitting and running away. I never did go back to school. I just did not. Just the connection wasn't there anymore." (Interview, March 4, 2018)

Returning to learning

After she left residential school for good, Mary recalls living at home in poverty with her parents and siblings. She said her parents were struggling to put food on the table. A social worker from the community was involved with Mary's family and finally gave her mother an ultimatum: that Mary engage in this new program to teach young people life skills, or she would

call Child Protective Services. Mary's mother conceded and enrolled Mary in the program. Mary quickly connected with instructors in the program who taught her basic life skills. For example, the instructors went with her to the bank to open a bank account, and taught her basic budgeting skills. This program gave her a sense of connectedness, independence, and purpose. She also said that she got her first job through this program as their art designer for certain promotional and publication materials, which led to other paid work. She recalled continuing to meet people who would take her under their wing, who believed in her potential and skill sets and hired her for positions. She recalled meeting a "German woman" who acted as a mentor to her and suggested she enrol in University. By this time, Mary had completed her GED and believed she did not meet criteria for admittance to university. The "German woman" thought she could register as a mature student, believed that she had what it took to go to university, so she took her to the local university and helped her register.

Mary continued to share instances during her formative years where she felt certain people and certain employment opportunities came to her as if they were meant for her. She shared she met a "non-Native couple" who provided great emotional support to her during a time of need. She said "sometimes we'd sit up until two or three in the morning and just let me talk and cry and talk, just get things out" (Interview, March 4, 2018).

First wave of healing

Becoming a mother was the conception of healing for Mary. She expressed, "it's like I felt something happening inside when I first saw her and I knew it was love that was happening. I discovered love from being a mom. When I was pregnant with her." (Interview March, 2018) This did not come without fear. She said that she witnessed her older and younger siblings

struggle to provide care for their children and many of her siblings had their children taken into foster care. She did not want that to happen to her and her children. She stated the following:

> So, my whole pregnancy with my first daughter I used to cry to my husband that I wanted to love. I did not want to - I wanted to love this baby. That's what I cried, "what if I don't love this baby"? But here I just fell head over heels in love with her. So, she just came along and changed me. Now I had a sense of commitment, now there's a future. I discovered feelings, feelings are real, my emotions came alive, I had vision - because I had direction because I knew that I wanted her to be safe, there were things that I wanted for her. A really strong sense of responsibility came with that. I learned that I could be a nurturing person, and caring, and accepting. All of those things changed (Figure 1.1). (Interview, March 4, 2018)

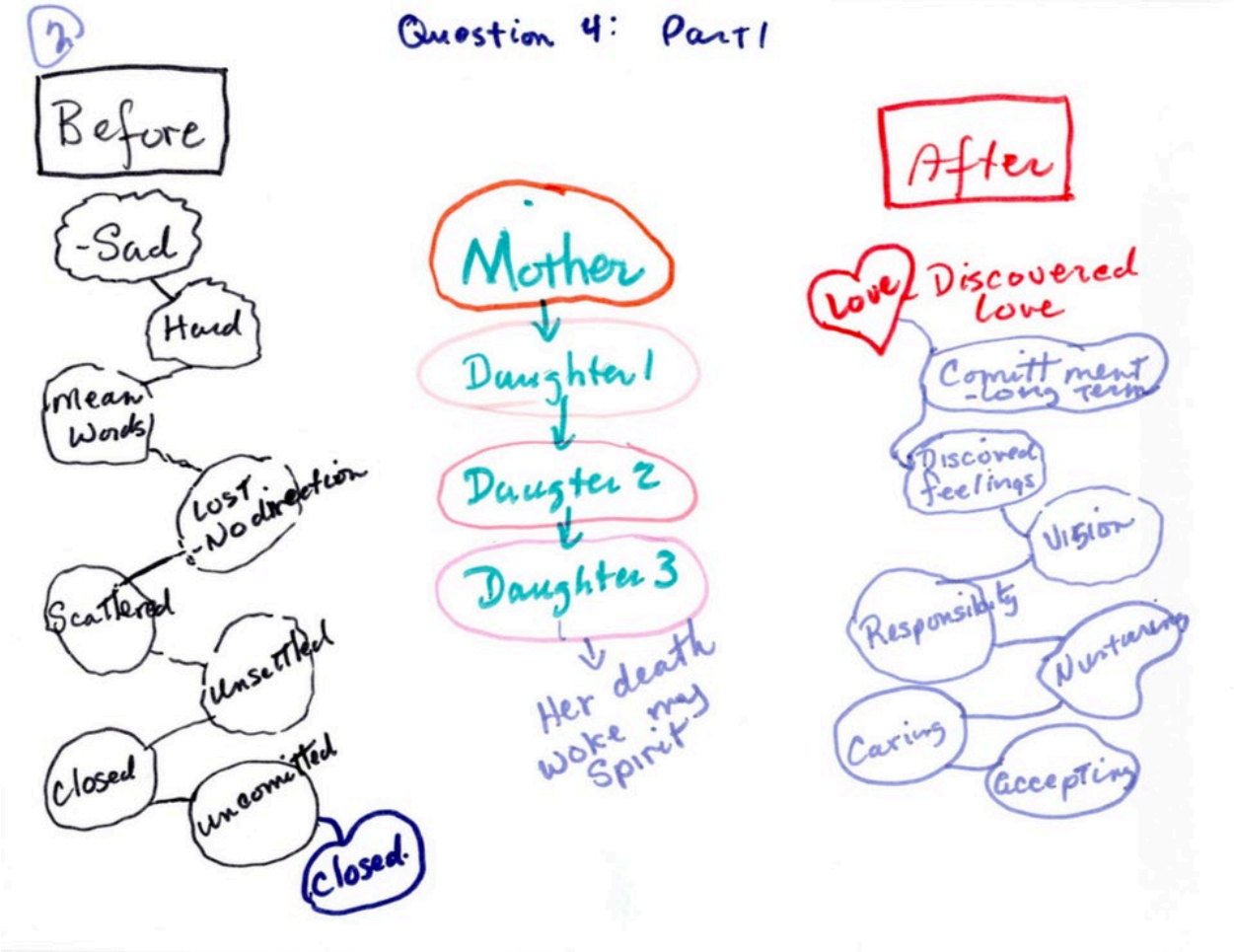

Figure 1.1 Pre-Interview Activity completed by Mary

Second wave of healing

Mary's second wave of healing came in response to the death of one of her daughters. With this wave of healing, she said she had a "spiritual awakening", which led to a change to a new church. She said her daughter's "death woke my spirit" because, "I was spiritually dead before… And I learned there how loving God is. I have an intimate relationship with Him. So that's my foundation." (Interview, March 4 2018)

Third wave of healing

Her third wave of healing also came in response to significant loss. Three of her immediate family members died within a year of each other and she was struggling to cope. She reached out to a grief worker in her community and asked to be connected with a counsellor who specialized in grief. From there, Mary said much more healing happened in the following ten years of therapy. Another factor that contributed to healing in this "third wave" was the birth of her granddaughter. Mary called it, "the perfect storm of healing" to have counselling start along with the arrival of her grandchild. (Interview, Mary, March 4, 2018). To her, "my grandchild is one of the important people in my life. Because I've noticed I have tremendous amount of love for her. And there's also trust involved in there because I find she really trusts me and I work really hard at not breaking that or doing anything to hinder that." (Interview, March 4, 2018)

Mary's healing journey: "being turned inside out and upside down all at the same time"

Mary used three different colours to explain her healing journey from before she started on her healing journey to now. She explained,

> Before the healing started - dark, jumbled up - all scattered. As my healing journey began, it started to straighten out, started to get less jumbled and ongoing healing is

> bringing more clarity. All different colours. I'm clearer - my communication is clearer. I can say what I need, what I want, what I feel. Express my thoughts and just gotten to know me… I'm learning how to look after me. It's getting easier all the time. That's why [the lines in the drawing] are still squiggly, but it's getting less and less. (Interview, March 4, 2018).

More specifically she described how her healing journey wasn't easy, that it was like, "being turned inside out and upside down all at the same time" (Interview, Mary, March 4, 2018). Still, Mary felt compelled to continue her healing through counselling (Figured 1.2). In her words:

> [I] did not want to go there. But I also knew it was hindering me. I knew it was impacting my behaviour and emotions. So, I knew I had to go there and I did actually prayed and said, "okay. I want to deal, I want to feel...I want to feel". and it started. It accelerated. But it was a good thing for me. Looking back, it was a very wise thing to allow myself to go through that. Because I had to. I can see how different I am as a result. It's been quite the journey. (Interview, March 4, 2018)

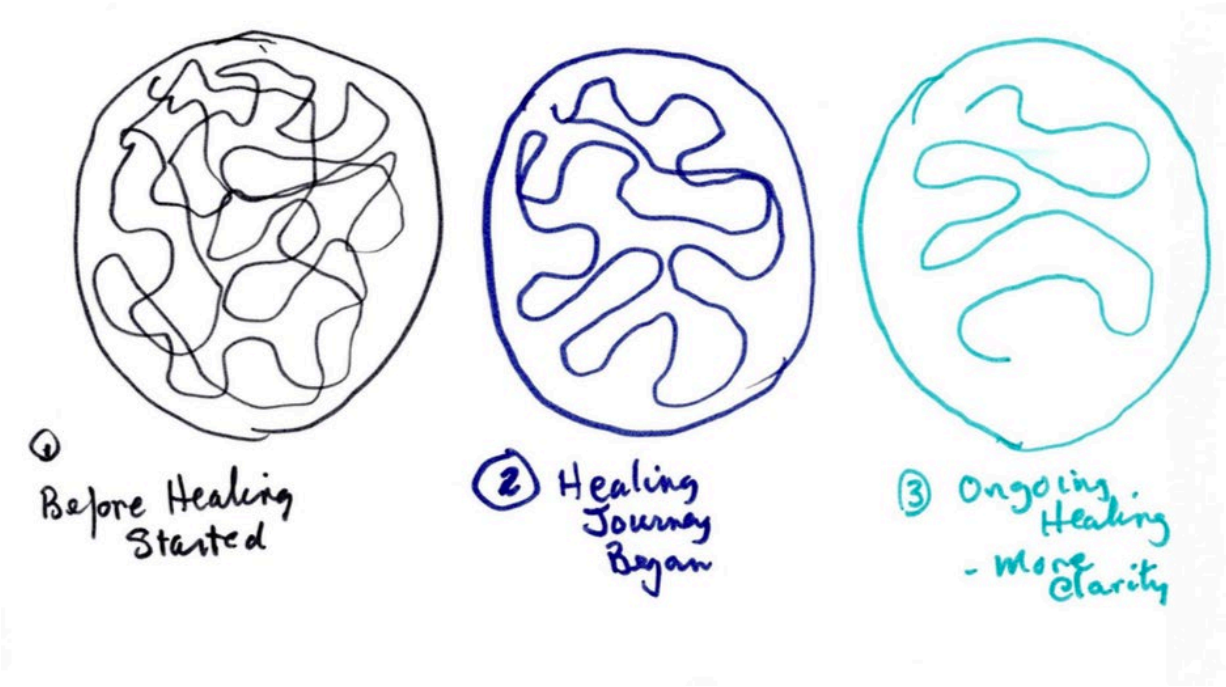

Figure 1.2 Pre-Interview Activity completed by Mary

Healing and reconnecting with self through family, community and spirituality

Throughout the interview, it became apparent that family, spirituality, and giving back to the community are important to Mary. She spoke about wanting to take what she has learned about her own healing journey and help others heal from trauma through teaching, sharing, and loving community members to the best of her ability. What she reads about and studies on her own time are not only for her own benefit, but for the benefit of those with whom she works. She also said that she benefits from helping others, that they "sustain" her and "affirm" her. (Interview, Mary, March 4, 2018) She attributes her ability to open her heart and begin to love others and allow herself to be loved by her children and grandchildren. At her foundation is her spirituality. Mary mentions numerous times where she has prayed for guidance, for support, and for the ability to open her heart and love. She also used prayer to help her through counselling as

a way to affirm that she was doing the right thing to help her heal from her past traumas, and to help find comfort during emotionally painful times.

Mary also attributes most of her healing to her counselling experiences. She said that the first two "waves" of healing were "natural healing" and prepared her heart to be ready to engage in deeper healing when the time was right. As she describes:

> I didn't know a thing about trauma 10 years ago. I started seeing a counsellor to help me get over this grief and then layers and layers and layers and layers were uncovered and we're still uncovering layers. I had a spiritual experience in 1996. I remember the year because the Spirit came and it was like my heart was a foyer, a lobby, with about five doors and those doors were all closed. And the Spirit, God, Spirit was moving like a fog or a wind wanting to get into those doors, just wanting to heal me. I would not open those doors. So, I had that vision all this time and that's why in the past ten years I finally said okay. I'll open them. But it was over ten years before I knew how - I didn't know what I needed to do to open them. So after I started counselling, then I knew. (Interview, March 4, 2018)

It seems as though Mary's resilience to survive the trauma she experienced and subsequently chose to engage in activities to help her heal, stem from her religious and spiritual beliefs, which were largely attributed to the influence of her grandfather and his teachings, including the story about how he saved her life. She also gained resilience in the life skills group she took as a teenager. As she continued her healing work in counselling, she stated she was able to be more curious and want to learn more about her culture. As her healing has continued, she

has been open to some Indigenous healing practices, and has started to learn her Native language.

While Mary reports more stability in her life within herself and in relationships with others, she said there is still a wish to be able to feel like she can be herself at home. Circumstances are such that she has extended family living with her and her husband and she feels this limits her ability to "nest" and feel comfortable at home. Since home was not safe growing up, it is understandable that she would feel this need to ensure that her home now feels safe. As an alternative, she has found an office space where she can be by herself and feels she can be herself, whether that means engaging in creative activities, resting, or doing work.

Mary's Healing Activities

During her interview and follow-up interview, Mary identified that she participated, or engaged in, the following activities that she found were healing:

Faith-related activities. Mary grew up in a household where prayer and Christianity were important. Throughout her life, especially during times of struggle, she turned to prayer, and attending church to help give her guidance and strength. As previously mentioned in her narrative, as Mary got older, she realized that changing denominations was more supportive and less shaming and helped her on her healing journey. She turned to her faith to assist her with believing in herself through doubts that she would not be a good enough mother, and also to help her through the grief of losing her daughter, and other difficult losses.

Counselling. After multiple losses, including a sibling and a parent, Mary needed more than her faith to help her grief. She contacted her community health centre and was referred to a counsellor outside of the First Nations community for counselling. It is here that Mary said that

she began to heal deeper wounds, including childhood attachment trauma, and the trauma of being in residential school. She described the process as painful, long, and arduous. She described that she did EMDR Therapy with her therapy, but that she also learned strategies to help her to manage her emotions and also had sessions that were just talking. Counselling helped Mary to decide and prepare to enter the process of compensation for residential school survivors. She also said that she has been in counselling for ten years and continues to work on deep-rooted trauma as it becomes necessary, and on grief from her experiences, and creating new meaning, sense of self, and way to connect in her world.

Talking to friends. In her twenties, Mary said that it was really beneficial and healing for her to talk to people who listen. She identified two friends, one in particular, who would listen to her and allow space for her to express her feelings without necessarily offering solutions. Later in life, she no longer had contact with these friends, and often felt alone in her experiences, not feeling like she had emotional support from her partner.

Learning. Mary shared that she loved learning as a child, but was robbed of that continued joy once she was forced into residential school. As a teenager a child protection worker mandated that she attend a life skills course, which served as a catalyst for continued learning, including attending university. Learning also continues for Mary as she says she does her own reading and learning about trauma to better understand herself and her experiences as well as to be able to help others.

Teaching. As a teacher, Mary said that during her counselling, something that sustained her and affirmed the process of healing for her was working with her students and feeling connected with them: knowing she was grateful for them and that they appreciated what she was

sharing with them. This activity may not have been a direct healing activity, but it helped to justify, or bolster her strength through difficult emotions being processed during psychotherapy. Having something to share and being able to identify with her students also helped Mary give meaning to her experiences in that she feels her purpose is to now help others heal who have experienced trauma.

Becoming a mother and grandmother. As described above, Mary said that becoming a mother and grandmother was very healing for her in that it helped her to learn how to love and be loved. It opened her heart to new experiences and to love that she never realized was possible.

Winona

Winona is in her fifties and has been on her healing journey for approximately thirty years. Winona's struggle with substance abuse for many years finally led to accepting and listening to the spirituality that was always inside her, but she ignored. Connecting with this higher power and engaging in traditional activities helped Winona to fight her once overpowering addictions and lead her on the path to long-term sobriety. Winona lived with her mother and lived in poverty. Her mother was resourceful and tried to live of the land as much as possible. Her older brother was taken away to residential school and never returned. Winona never met her brother, but she felt his loss through her mother's grief.

About the Interview Process. The interview with Winona took place in an office space in a medium-sized city in Southwestern Ontario proximal to the First Nations community being studied, Ontario on March 7, 2018. After the research was explained and consent explained and given, the interview started with Winona completing the Pre-Interview Activities (PIAs). I stayed in the room with her in case she had any questions. Following completion of the PIAs, Winona described each of the activities she completed prior to me asking other prepared open-ended

questions. The rest of the interview went smoothly and all questions were answered. Winona seemed to willingly share information and clarified her statements when asked. Shortly after the interview was completed, I transcribed the interview and completed a draft of a narrative analysis based on the information provided. I spoke with Winona on the phone two more times to ask clarifying questions. I then provided the narrative analysis to Winona for her feedback and approval. She said that she found the process positive and helpful to see and the narrative analysis and was able to view certain aspects of her history with more self-compassion.

Winona chose the following Pre-Interview Activities:

- Draw a picture or diagram of a place that is important to you and use key words to describe the parts, or describe what happens in each of the parts.
- Think of an important activity that you do. Make two drawings showing a “good day” and a “not so good day” with that activity. Feel free to use thought bubbles or speech bubbles.
- Draw a schedule for your day/week/year and use colours to indicate how time is spent. Make a legend to explain the colours.
- Write a list of 20 important words that come to mind when you think about the idea or concept of “healing”. Then separate the words into two lists in any way that makes sense to you. Please show me the original single list and the second set of two lists.
- Complete this sentence: Trying to heal from trauma is like…

Narrative portrayal for Winona

Early years in “the bush”

Winona grew up in poverty in “the bush” with her mother, a remote area of her community, well removed from main roads. She said that her mother was a single parent and

played the role of mother and father in terms of the functional roles in the household. Her mother would, “chop the wood. She got the water, she gathered. The only thing she didn't do is hunt, but she cleaned the fish, the ducks… She could make a meal out of wild meat and go pick berries and wild onions out of the bush…She did it all…” (Interview, March 7, 2018). She said that her mother had physical health problems that she believed stemmed from her traumatic past, but that her mother never complained she, “literally worked through it”. She also indicated that her mother was not a religious or spiritual person, that she was “Traditional” in terms of the life she lived and how she lived it, but that was more of a function of living in poverty and not because of a commitment to living a traditional or spiritual way of life. Winona recalled that her mother told her all of her mother’s brothers went to residential school and that the only reason her mother did not is because her brothers hid her each time the Indian Agents came to the house. Winona had an older brother, but he was taken to Indian Residential school at age 6. She never had a chance to get to know her brother as she was born after he was taken away.

As a child Winona enjoyed playing outside in the ditches, in the bush, in the grass, and in the corn fields. In her words, “…playing around in the grass, barefooted, swimming or playing in puddles…where I wasn't supposed to be” (Interview, March 7, 2018). She also would spend a lot of time by her mother’s side while she was working. She said that her mother didn’t have a lot of time to play and connect with her as she was always working to keep up the home and provide for them.

Making a choice to live

When she was older, Winona struggled with substance use as a way to cope through difficult times in her life. She said that it wasn’t until she found out she was pregnant that she decided she wanted to make a change and try to overcome her addictions and trauma. She

described the struggle of trying to abstain from drugs and alcohol. She said that there were many attempts, but it was when her child was young, her partner told her to "straighten up". (Interview, March 7, 2018) She shared that was when she truly felt that she might lose her family due to her addictions, as her husband threatened he would leave and take her child with him. She said that she started going to Alcoholics Anonymous (AA) and had initially intended to "just do it and play the game", meaning that she would go to AA to tell her partner that she went, but still was not completely committed to living a sober life. But Winona said that the meetings had an impact on her. She said, "It was through going to those meetings that I made the choice to live". (Interview, March 7, 2018). In her words, "before I chose to practice my way of life and do the healing work, I was dead. And I would have been dead today probably if I didn't find a different way of being. And that took me back to my traditions and beliefs" (Interview, March 7, 2018).

Searching for a source of strength that could overpower her addiction

Winona shared that she has always felt led spiritually, but that she "adapted to a Western way of living" and ignored her intuition. Trying to overcome addiction meant that she had to find a source of strength as powerful as her addiction.

> …before I got pregnant I just didn't have any hope, or faith or understanding. And then when I got straightened up I needed a higher power because that's when I started looking because I had this big thing with religion and it didn't work for me because of residential schools so I had to find something that worked for me and that fit for me. (Interview, March 7, 2018)

When she started engaging in healing activities she said that she became more open minded to different types of healing. This led her to explore more holistic practices and spirituality. She said,

> I think my beliefs were taught to me through different people that have come into my life and I searched people out as well, but I've been very fortunate where Creator has put people in my life to say "you might want to try this lodge, or there's a teaching over there" so I've been very fortunate in that aspect. (Interview, March 7, 2018)

Grounded, free, connected, and full of spirit

Winona described her process of healing from trauma like a tree (Figure 2.1). As she described from an illustration she created as part of the Pre-Interview Activities,

> …before healing the tree is crooked, it could blow over, right? When you go through the healing process, you have roots, you're more stable, you've got grounding. This little blue spot is water and healing is like freeing - free flowing water able to just be. And then I put the last picture was a heart with words around it and after healing you can - I am a better grandmother, a better partner, a loving mom, a good human, and I am full of spirit. (Interview, March 7, 2018)

Learning to have self-compassion and awareness through understanding trauma

The journey to healing from trauma was not easy for Winona. She said that in the beginning she did not even know what trauma was and how her past hurtful experiences were contributing to her current struggles, but through spiritual and holistic practices, including counselling she has more awareness, understanding, and compassion for her feelings. In her words,

> …it was a lot of hard work, but I didn't know what triggers were and what could be triggered and why I did the things I did. So I had to find another way of operating and being. And dealing with my trauma and healing from trauma has been freeing and lightened my load so I can also - I'm not saying I'm not affected by it - but I can pretty

much say, oh this is coming from that. Or this is, you know, I gotta watch from my home that I'm not withdrawing. I have to watch that I'm not isolating, so I'm aware of my behaviours, I'm aware of my body. … And now when I feel like - when I need to cry, I just cry. It's like having respect for myself. And before I couldn't be alone and I love being alone now. (Interview, March 7, 2018)

She also said that healing for her has also been like the following,

Just being able to alone and quiet and still. Being able to be more mindful, more present. Get out of the head and into the heart. There’s a lot of - I can be such a head person when I'm experiencing stuff we've talked about, I'm in the head and it's important for me to be in the heart. (Interview, March 7, 2018)

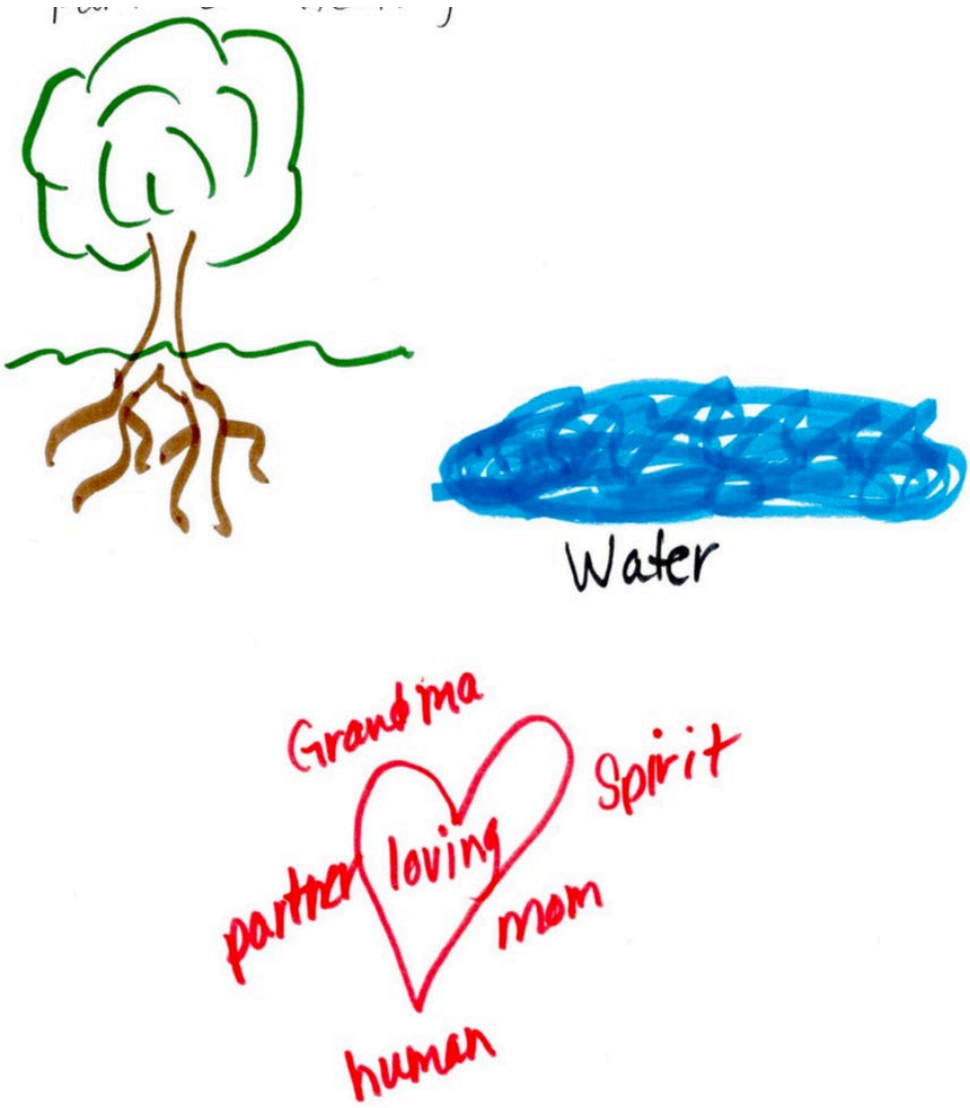

Figure 2.1 Pre-Interview Activity for Winona describing her healing process (March 7, 2018).

Sharing her knowledge and gifts with the community

Winona has lived a sober life for a while now and as she continues to engage in counselling and continue to learn from Elders and other healers, she said she feels more compelled to help others in her community. She already works in the helping profession in her community, but the more she understands about trauma and how it can manifest a variety of

emotional, physical, psychological, and spiritual issues, she wants to share what she has learned with others to help heal her community.

Home is where her healing continues

Home continues to be a place of safety and comfort for Winona. She said that she feels protected there and feels love. Her home has, "my favourite things, like it's got my medicines, my sacred items, stuff that I need in order to feel the way that I do". (Interview, March 7, 2018) Because of her involvement with the community, a sense of safety and protection at home allows her to be herself. She said one of the downsides of living and working in the community is always feeling immersed and connected to her fellow community members' issues. Feeling at home with her partner, her animals, and her sacred items helps to provide some separation and allows for her to engage in self-care so she can continue to do meaningful work in the community without experiencing compassion fatigue or vicarious traumatization (Figure 2.2).

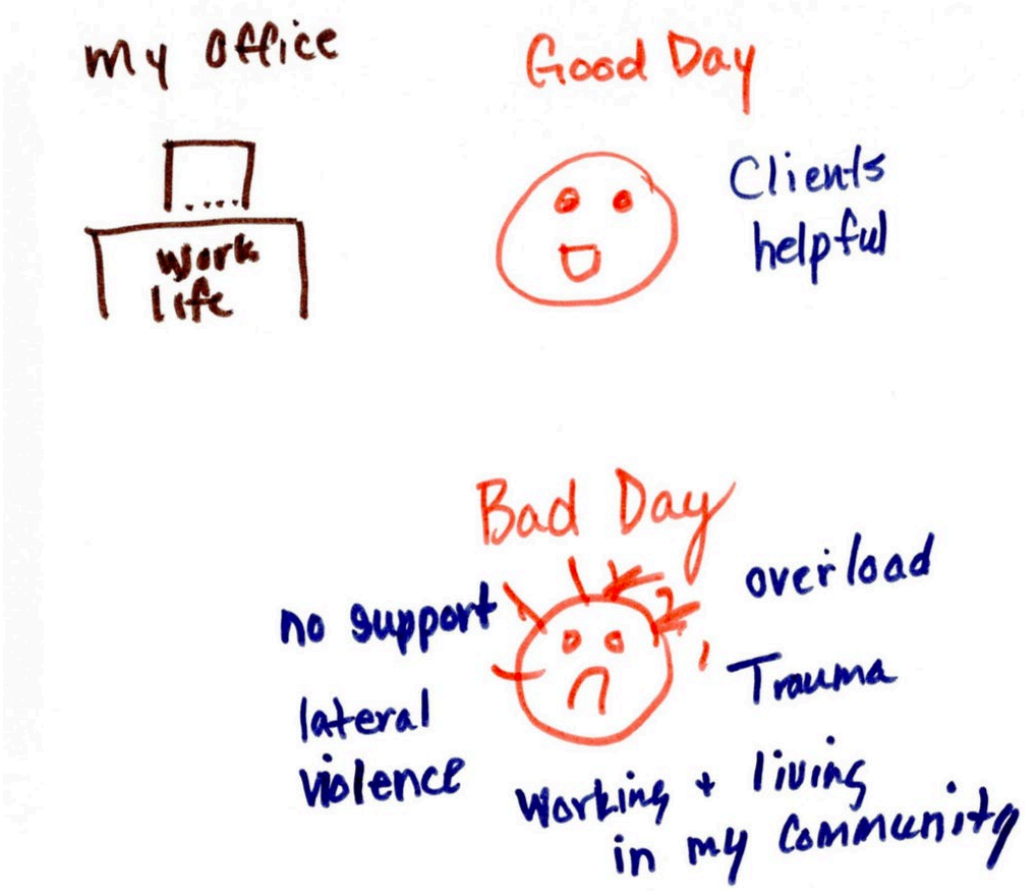

Figure 2.2 Pre-Interview Activity completed by Winona (March 7, 2018).

Winona's Healing Activities

Becoming a mother. When Winona found out she was pregnant, she started to address her substance abuse issues. This journey had many stops and starts for her, even after she gave birth to her child. But it was the threat of losing her child and partner that led to a continued journey toward sobriety.

Connecting to traditional ways. Connecting to a "higher power" than her own and listening to her internal wisdom led Winona to Indigenous teachings. Winona went to traditional healers, sweat lodges, healing lodges, participated in ceremonies to help her achieve sobriety and heal from past trauma. She also reconnected with culture by attending local community events

such as pow wows. Learning about Indigenous teachings and spirituality provided the foundation for continued healing, exploration and learning about herself, trauma, and her culture.

Counselling. Counselling provided Winona with the language of "trauma" and provided context for her experiences. A trauma-informed model of counselling helped to decrease shame and stigma around Winona's substance abuse issues and helped her see how her past traumas contributed to some negative coping strategies, including the use of drugs and alcohol. Winona described counselling that provided psycho-education, talk therapy, EMDR therapy and also provided affect management strategies. She said that she has been to a few different therapists over the years and while helpful, finding a therapist who has availability to suit her schedule has been difficult.

Learning and teaching. Along her healing journey, as she started to learn about trauma, including intergenerational trauma, Winona has engaged in reading and attending workshops about trauma so she can better understand herself and her community. She said she especially appreciates the work of Gabor Maté and that seeing behavioural and psychological disorders through a trauma lens has motivated her to want to continue to learn more and share what she has learned to her community to help facilitate healing from trauma.

Dawn

Learning has become a very important healing activity for Dawn. She has faced many losses close to her, including her partner and her child. Dawn experienced much conflict, lack of understanding, and empathy from many immediate and extended family members when she and her own family were struggling and, as a result, was alienated by most of her family. Growing up she felt neglected by her parents. Both of her parents were residential school survivors and not affectionate with Dawn and her siblings. As a child, Dawn was often left to her own devices to entertain herself. She mentioned growing up not feeling special or loved. Through this chronic isolation, she has found ways to find other meaningful connections to the community and to spirituality.

About the interview process. The interview with Dawn took place at an office space in a medium-sized city in Southwestern Ontario proximal to the First Nations community being studied on March 8, 2018. After the research was explained and consent explained and given by the participant, the interview started with Dawn completing the Pre-Interview Activities (PIAs). I stayed in the room with Dawn in case she had any questions. She talked about what she was creating while completing the PIAs. Dawn also referred to her PIAs quite a bit when explaining her PIAs, and when answering the interview questions. The rest of the interview went smoothly and all questions were answered. Dawn seemed to willingly share information and clarified her statements when asked. Dawn and I met in person to review the quotes I included in the narrative analysis, and the narrative analysis itself. During this meeting I also asked clarification questions, and Dawn answered them willingly. She did not request any changes made, and was pleased with the narrative analysis and the interview process in itself.

Dawn chose to complete the following Pre-Interview Activities:

- Draw a picture or a diagram of a place that is important to you and use key words to describe the parts, or describe what happens in each of the parts.
- Think of an important activity that you do. Make two drawings showing a “good day” and a “not so good day” with that activity. Feel free to use thought bubbles or speech bubbles.
- Make two drawings: one showing a “good day” and one showing a “not so good day” with respect to your healing journey. Feel free to use thought bubbles or speech bubbles.
- Use three colours to make a diagram or abstract drawing that shows what it is like for you to recover from trauma.
- Complete this sentence: Trying to heal from trauma is like…

Narrative portrayal for Dawn

First experience with counselling

Dawn is in her late forties and has been on her healing journey for over twenty years. Her healing journey first started when her son was young and had taken him to see a counsellor regarding his behavioural issues. A single mother for most of the time, she also decided it would be helpful for her to also access counselling to get some help with understanding her son’s issues further and addressing her own feelings and stresses around her son’s behaviour and raising him on her own.

Wanting to feel special

Dawn remembers the desire to be special when she was a child and for her parents not to have struggled as much financially. She said that she had an aunt that would make her clothes for her doll. She said that her aunt, “just took these pieces of material and sewed up these little

clothes for my doll. It was like ... like holy ... it was magic when you're a little kid". (Interview March 8, 2018). Dawn also expressed fond memories of spending time with her grandmother. She said she liked "just being there" with her. (Interview March 8, 2018). She also said the enjoyed swimming in the summer, but said otherwise she was not a very active child and did not play with others very much. She described that she did well academically and went to high school in a small town near the First Nation community and was in classrooms with mostly non-Indigenous students. She said that she thinks this was,

> 'cause I think I was probably a little bit smarter. Yeah. I wasn't with them [students from her First Nation community], I was different ... I was in this class, but I wasn't the same as them [non-Indigenous students]. … I kinda think I fit in more with them because they had probably more experience with different kinds of people, as opposed to the people from [where I lived]. (Interview March 8, 2018)

Learning to let go

Dawn shared that she is still on her own healing journey as issues continued with her son into adulthood. In fact, she shared the following about one of the most difficult things in her life that she had to struggle with and find meaning from:

> Letting my son go. He has an addiction problem. Ended up lettin' him go, not being able to help him. It's just really difficult. I had to figure out ... Who does that to their kid? Is this what other people do? I had to figure out ... Everybody's different, everybody's situation is different. I had to let him go. I'm sure I'll love him no matter what, but I don't have to approve of his behavior or his lifestyle. It always will be a sore point with me. (Interview March 8, 2018)

Knowledge is a powerful healing activity

Throughout the interview, Dawn shared that learning has been helpful to her on her healing journey. She gave several examples of self-learning including reading self-help books and using the internet to search for healing activities, and also inspirational quotes and articles to help her. She also mentioned that she had a friend who she also considers a teacher and/or guide (Figure 3.1). She said,

> She teaches me things. She's more, I guess, spiritual and goes to ceremonies. She has some of that knowledge and she teaches me things, like a different way of thinking about things, and she recommends I go and talk to a spiritual healer. She makes those arrangements for me, and I also learn from those, too. (Interview March 8, 2018)

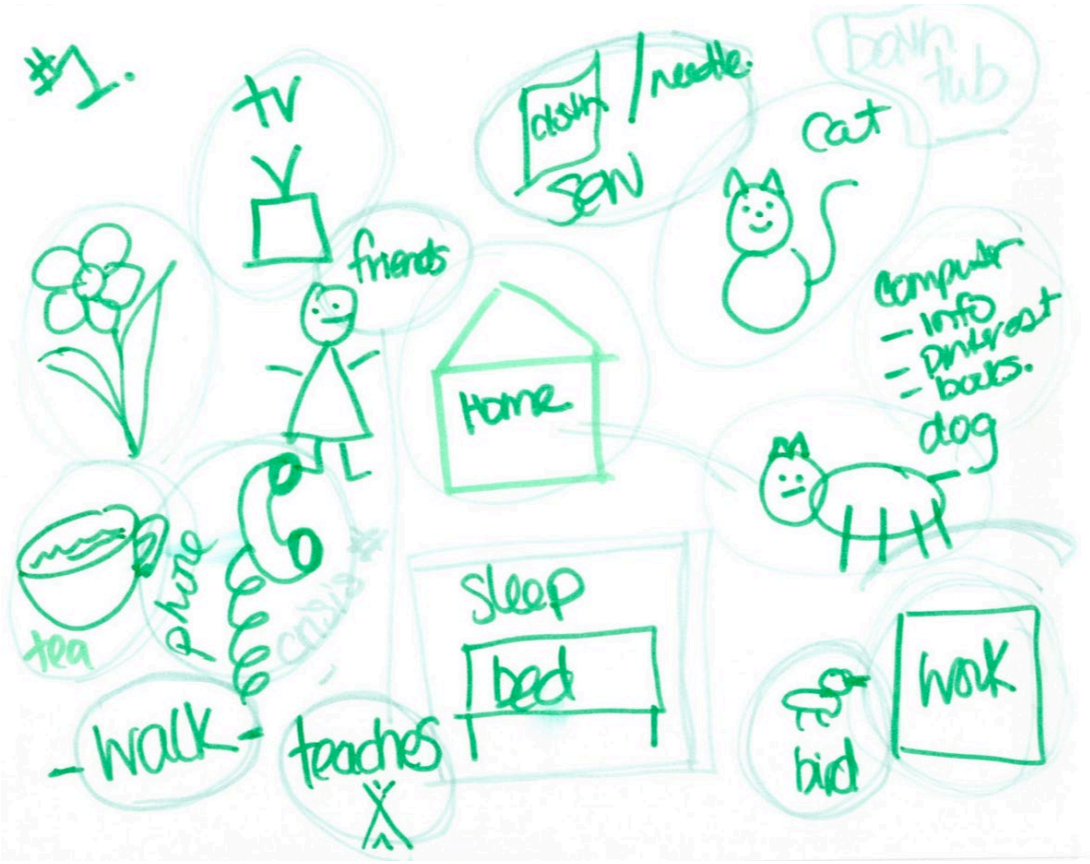

Figure 3.1 Pre-Interview Activity completed by Dawn showing her special place, her home, including where some of her self-learning and self-help takes place (March 8, 2018).

Connecting to ancestry and culture

Learning for her not only connects her to knowledge to heal herself, but also connects her to other teachers, including those who help her to reconnect to her culture. Dawn also expressed that it was important to her to reconnect to her culture through exploring her family's ancestry. She said that she does not know much about her extended family and that there are few family members in her community. She explains,

> My one family side comes from [the United States] and we're Potawatomi. How we got here, I don't know, and I want to learn. There are very few of my family on the island. I want to know what happened to them. At the library, these people all get together… once a month, and you can go through … stuff and figure out who's who. And this is an ongoing process for me, but I want to know where my people come from… I would like to see pictures. I think that's the difficult part. I would like to see what they looked like, the people before me, and do I look like them? (Interview March 8, 2018)

Making the decision to live and continue to heal

When asked about what healing from trauma was like for her, Dawn illustrated that before healing began she felt she was walking around with a "dust cloud over her head" (Interview, March 8, 2018) and did not feel very connected with the world. She felt like she was living in a fog. As this was part of her Pre-Interview Activity, she explained this through the drawing she made. She said,

> yellow is for happiness, sunshine… When I came out of it [the fog], I had ... the color yellow was in my head. I don't know why. And the realization is like I wanna live…

That's where it's black, then it goes to gray. The green is always gonna be there 'cause you're learnin' and growin' and developin' to be a better you (Figure 3.2). (Interview March 8, 2018)

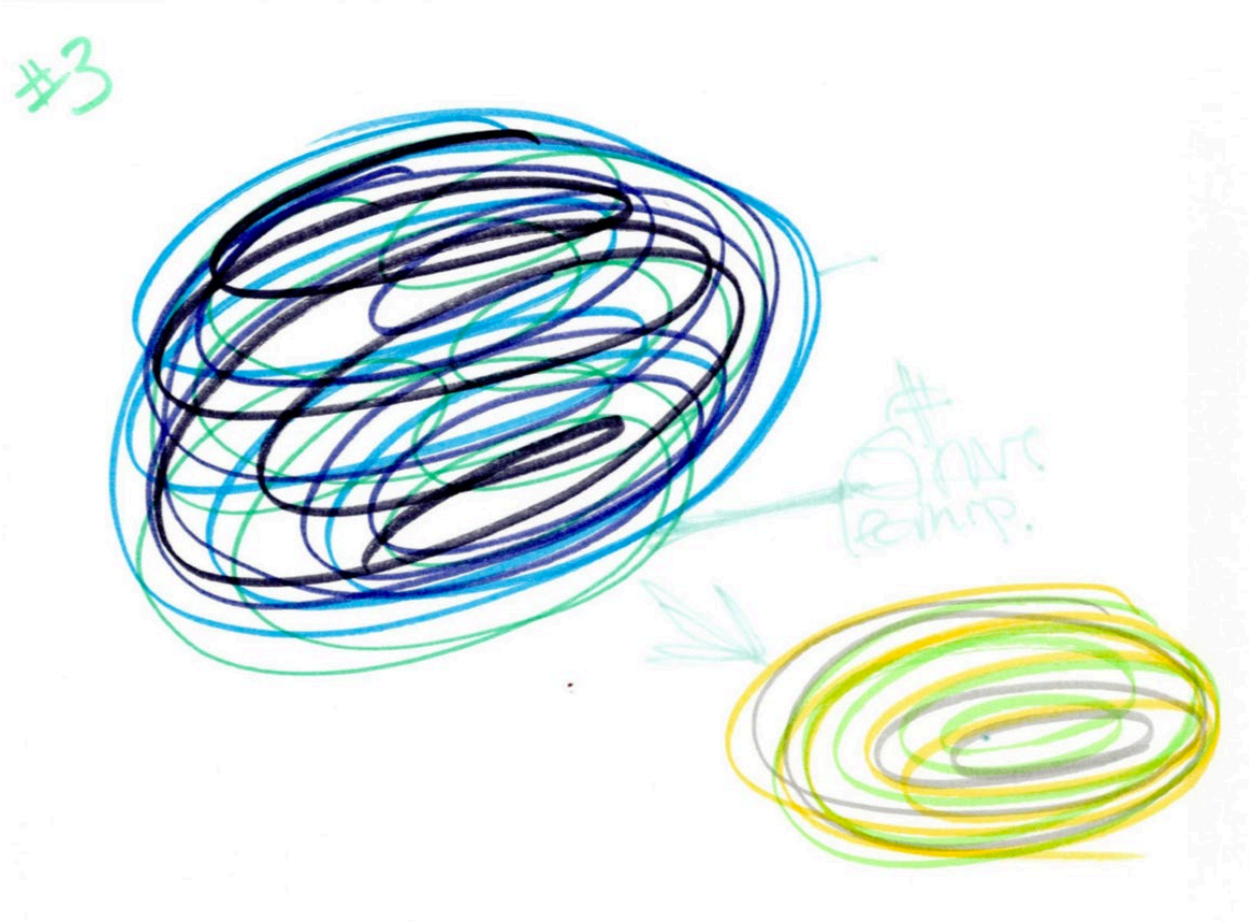

Figure 3.2 Pre-Interview Activity completed by Dawn, March 8, 2018

Shared learning and understanding with others

Dawn also mentioned that the process of healing from trauma for her involved a lot of self-discovery and learning to understand herself. She said that she was also able to have more self-awareness and empathy for herself and others. In her words,

> For me, I want to be better, get better, think about things in a different way, because maybe I was just thinking like this: I have to understand all of this stuff to think better, understand better, and function better to get me over here. And then there's a bunch of more stuff you have to understand that relates to this or this or this. And then you just get better and hopefully you help somebody else out along the way. That's how I see it… I get to experience with clients some stuff, and I learn from that experience and it helps me, too. Yeah, I don't disclose my personal history with them or anything, it's just "I understand your pain, I can hear it in your voice, you're feeling so helpless right now". Yes, that's it. (Interview March 8, 2018)

The healing journey is not a straight path

Dawn also shared that participating in healing activities was not always easy for her, that sometimes she wanted to give up and not continue working on herself. With regard to counselling she said,

> It's worth it, do it. It's hard, there's probably different stages, different timelines that you might not want to do it, but continue, keep going. Because even coming here at some point it's like, "I think I'm tired of coming to counseling," or I would make a new appointment later. But then I still kept my appointments, I never canceled and I just came anyway. I don't know, I guess that's a good thing, because at some point you don't know whether ... am I doing a good thing or am I just going through a routine and ... But no, it was helpful. Even though you think you're ... you're not cured, but you still keep going…keep going, and you have to face those things and do something that scares you, and you can't get over it, you just gotta go through it. (Interview March 8, 2018)

Dawn's Healing Activities

Learning. Dawn shared that she took it upon herself to do a lot of research and learning to help herself feel better including reading about happiness, ways to be happy, and how to heal from trauma.

Counselling. Dawn shared that she engaged in the counselling first to help her child, and then wanted counselling for herself to get some support around events regarding her child. She continued in counselling regarding relationship traumas with her child and addressed other traumas affecting her. Dawn said that her therapist used EMDR Therapy, psychoeducation, talk therapy, and neurofeedback to facilitate trauma treatment.

Float Tank. Through her resourcefulness, Dawn found a float tank in her area and decided to try it based what she had researched about it. In her description of this activity she said that it was profound in that this was where she made the decision that she wanted to live and continue on her healing process. Prior to this, Dawn was feeling despondent, hopeless, and alone. She said the float tank was relaxing, meditative, and enlightening. She only participated in this activity once, but it gave her space to come to the realization that she wanted to continue healing and living.

Indigenous Teachings and Healing. Dawn said that she has a friend who has connected her with Indigenous healers and certain ceremonies to help her heal. She said that engaging in these activities was relatively new to her and she appreciates learning the teachings from spiritual leaders, healers, and from her friend.

Genealogy. A way Dawn is trying to feel more connected to family is to do research on her family's history. Dawn said that she feels isolated and disconnected from her family in her

community. Coming from a small family with few extended family members in her community, going to monthly genealogy meetings where she has access to resources to help understand her family's lineage and to perhaps better understand her culture.

Robyn

Robyn was in her mid-forties and started her healing journey after the birth of her first child, over twenty years earlier. She spent her childhood years in a large urban city living with different members of her extended family, but said that she spent some time as a child living on a First Nations community in southwestern Ontario with her grandmother. When she was a teenager she moved to the First Nations community mentioned above and has lived there since.

Robyn was very involved in physical activity and sports growing up. She did not have much contact with her mother or father, but was very close to her brother. Robyn suffered maltreatment, neglect and abuse by her mother and always felt that her mother did not want her. She said she was best friends with her brother and that he protected her during times they were in potentially dangerous situations. Growing up in a large urban city, Robyn said that she witnessed racism and violence, not toward her, but toward other minorities, including her brother.

About the interview process. The interview with Robyn took place in a private space at a community centre on March 10, 2018 at the participant's request. After the research was explained and consent explained and given by the participant, the interview started with the participant completing the Pre-Interview Activities (PIAs). The researcher stayed in the room with the participant in case she had any questions. The rest of the interview went smoothly and all questions were answered. There was some background noise and the researcher had to ask the participant to repeat herself a couple of times throughout the interview for clarification. Robyn and I met in person to review the quotes I included in the narrative analysis, and the narrative

analysis itself. I also asked a few more questions to help clarify a couple of Robyn's quotes. She did not request any changes made, and was pleased with the narrative analysis and the interview process in itself.

Robyn completed the following Pre-Interview Activities:

- Draw a diagram to show where your support, or support systems, come from.
- Draw a picture or a diagram of a place that is important to you and use key words to describe the parts, or describe what happens in each of the parts.
- Write a list of 20 important words that come to mind when you think about the idea or concept of "healing". Then separate the words into two lists in any way that makes sense to you. Please show me the original single list and the second set of two lists.
- Complete this sentence: Trying to heal from trauma is like…

Narrative portrayal for Robyn

Role of her brother

Growing up, Robyn participated in a lot of physical activities. She said she was "competitive" and over the years participated in dance and many sports including soccer, baseball, track and field, and hockey, to name a few (Interview March 10, 2018). She also said that growing up she felt supported and protected by her brother. In her words,

> he was like my first friend…our entire lives…we had each other, and also, he was just my safety. The different homes we were in, like even when we were separated, he was my safety-And, I mean, just, by earliest memories I mean, we were always together so, people came and went but he was always there. (Interview March 10, 2018)

Forgiving her mother

With regard to her healing journey, Robyn shared that once she had her first child, she felt compelled to confront her mother. In her words,

> I think for me the biggest, you know, thing that just like completely changed my life is with my mother. Some things I'll take to my grave, but through it all there's only two years of my life, you know, twelves until I was fourteen. I mean I can't ... The sheer contempt I had for her I've never felt towards another human being in my life, but when after I had children I was wanting just like answers. So, I would ask my mom - you know it was the only time I ever drank with her - I was about twenty five or more. I said, “can I ask a question that I'll never ask again? Did you want me? You know, did you want me?” She's like ... She put her head down and she started crying and she had a story, but she said, “no”. My thing is right at that moment it didn't matter why or whatever, I forgave her. For me it was like, I knew I wasn't great. I fell to the floor and my life began then. I truly ... I truly forgave her. Like, truly with all of my heart and soul. I know I couldn't do it by me alone. I know after anyway my life began. I've never felt that way about another person, ever. (Interview March 10, 2018)

Forgiveness important for health

In light of this event, Robyn said that she learned that you build “hate in your heart when you can’t forgive” (Interview March 10, 2018). With regard to forgiveness, she says,

> I think my key, I guess, to peace or whatever is to forgive. For me anyways, it keeps you healthy. It keeps you humble. It's hard to do. … It is, but it's hard to do. It's so hard, but I never turned back. (Interview, March 10, 2018)

Even as a young woman, during some of the worst moments with her mother, she tried to let it go and forgive. Robyn said,

> And through it all, like whatever I suffered, at my mom's hands, I never raised my voice to her. I never swore at her. I never hit my mother. I just took it, because she gave me life and she didn't have to. It's like, well, it's done. It's done. It's not someone else's judgment of whether you feel you are done with it or not. It's your own personal journey. Some people go their entire lives, right? It just taught me something. It's something to grab on a little bit harder. (Interview, March 10, 2018)

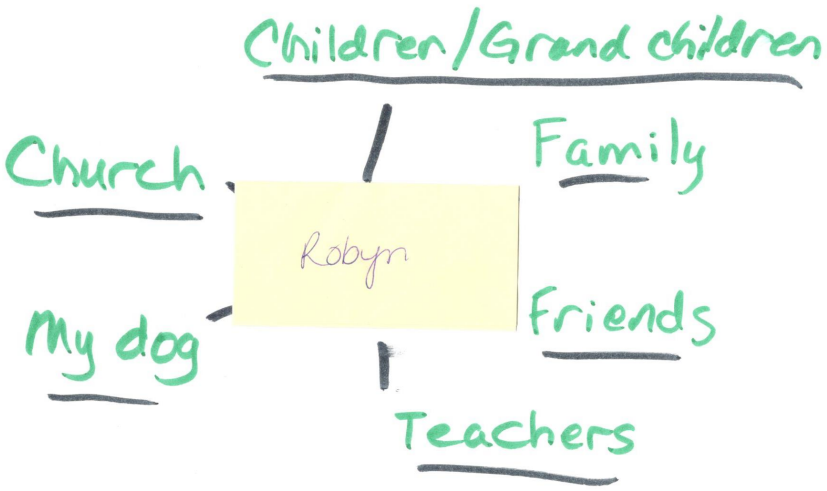

Figure 4.1 Pre-Interview Activity completed by Robyn showing where her supports come from.

Many of these supports are also tied into her home (Figure 4.1).

Home is filled with love and nature

Currently, Robyn finds solace in her home. She says that her home is, “important 'cause my family gathers there. So memories I have. My children visit. My grandchildren play and

spend time here with me (Figure 4.2) Laughter, happiness. It's mine and, it's my place, you know and, all the world that I can go in. It belongs to me". (Interview, March 10, 2018)

She also finds solace is the company of friends and her dog. She also said, "I like to walk. I like to spend time with my grandchildren and, you know, spend time with my son, my youngest boy, he's still at home. Spending time with him and make him feel special. Just, you know, talking with him and my dog". (Interview, March 10, 2018)

Home is also important to Robyn because it provides her with a safe haven to help her grieve (Figure 4.1). She says,

> Trauma is devastating at times … you know and the hurt, confusion, or pain that's going on at the time. How you deal with it is just really one day at a time. You know, there's that grieving process and I probably hole myself up for a couple days and just shut in ... That's how I personally grieve, you know? (Interview, March 10, 2018)

The importance of teachers and learning

Robyn also said that she values teachers in her life, both academic and spiritual, including teachings from her church. She continues to learn, not only to improve her own health and well-being, but to help others and to give back to her community.

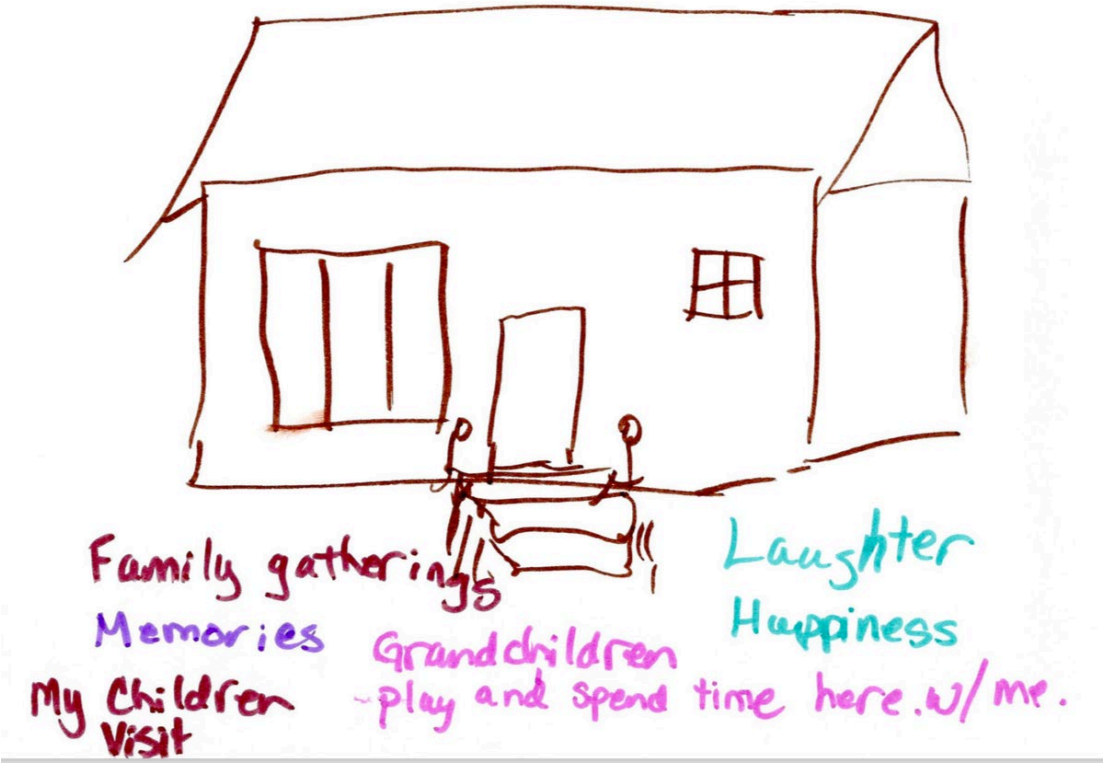

Figure 4.2 Pre-Interview Activity completed by Robyn illustrating a meaningful place (March 10 2018)

"Healing from trauma is like walking down a dark, lonely road…"

She continues to state how sometimes healing is a solitary process,

> Trying to heal from trauma is like walking down a dark lonely road…just feel alone. Alone and I guess, probably guilt at times like, somehow you feel responsible for somebody else's actions. It's just, it's a grieving process you know and, and there's this just a moment in time that not everybody in time can be holding your hand and patting you on the back and, in the end it's your work. It is and, to be able to become complacent with you know, you can't change anything and realizing that there's still hope. (Interview, March 10, 2018)

The power of acceptance and prayer

Something that also helped Robyn on her healing journey was

> to keep things in perspective and get to that, it's all about me. I mean about how you feel. I tried to take that away from myself and seeing that it's not just, you know, life is perfect, it's just kind of accepting my role in whatever. Healing is not always one sided, so just coming to terms with the people I've hurt and the things I've done. Truly I can't change it. I can say sorry to a million people, but not everybody is going to accept it, but I know the strength to me is when I prayed. When I just meditate on the good things of people. There's good in everybody and sometimes it takes a little bit longer to see those qualities, but I've tried to, whatever it is, just find something and leave it at that. (Interview, March 10, 2018)

She continued that now she is

> mindful of people's feelings and truly living by it. It just brings me peace, you know? … It's easier to justify this person you've become. I didn't like the person I was when I had those feelings towards my mom. I just didn't and for all the things I thought I would just fight it and ask for forgiveness, because that contempt in my heart ... It'd make Gandhi kill, and it was awful. It really was, it was just terrible. (Interview, March 10, 2018)

Overall, she has learned, and keeps trying to practice staying positive, letting go of negative judgments, forgiveness, and trying to move forward in life the best way that she can. In her words,

> We all have it [tough] at times, but for the most part life is good. I'll find something good about it. I believe that too though, you know. All I want is like, what anybody else wants,

> you know, just prepare for the race, because life's a gift. Life's a gift. I just always think in my mind I want to do more good than I've done harm. (Interview, March 10, 2018)

Robyn's healing activities

Becoming a mother. Robyn shared that it was stepping into this role as mother that led to her wanting to talk with her mother about difficult topics so she could come to a place of acceptance and forgiveness.

Talking to her mother. Robyn said that she confronted her mother directly about past issues, primarily whether or not her mother wanted to have Robyn when she was still pregnant with her and once she was born. After her mother shared her answer that no she did not want her, Robyn said that she then had context and a reason as to why her mother's behaviour toward her was so abusive, mean, and cruel. She was then able to start to forgive her mother and feel like she could accept what happened and move on.

Prayer and Spiritual Activities. Robyn used prayer and attended church to help give her strength and guidance around forgiving her mother and accepting her actions. Robyn said that she did this with other situations in her life where she was wronged by others. Her faith and spirituality bolstered her own empathy and compassion toward others so she did not harbour any more resentment toward those who hurt her in the past.

Counselling. Robyn said she used counselling on a short-term basis, and as needed, but relied more on her own resilience and spirituality to help her resolve her traumas. Counselling for Robyn seemed more solution focused and oriented toward cognitive behavioural therapy.

Chapter Summary

This chapter shared each participant's narratives about healing and engaging in healing activities to recover from complex trauma stemming from intergenerational trauma. The chapter began with sharing a collective history of the four participants followed by each participant's narrative. Process information about the interview and how it was structured is also included within each participant's narrative. The purpose of this chapter was to display the narratives individually in order for each participant to share her story, but also to display the narrative information prior to illustrating common themes across each narrative. This gives the reader more context and depth of the participants' lived experiences in engaging in their healing process, including their healing activities. Finally, this chapter also included themes found in each participant's narrative, along with a list of healing activities each person engaged in along their healing journey.

The next chapter will provide themes common across all four narratives with supporting documentation.

Chapter 5: Analysis of Narratives about Healing Activities

The next chapter will identify and discuss the identification of themes across the four analysis of narratives as they relate to the research question. Key themes from the analysis of narratives will be presented and/or illustrated in this section with supporting quotes from the participants' narratives. The themes are organized and will be presented in the following order:

1. The complexities of healing from intergenerational trauma
    a. The healing journey can be non-linear and non-consecutive
    b. The process of healing is isolating and difficult
2. Protective factors that facilitated the healing process
    a. Someone who supports and believes in them from an early age as later support to heal from trauma
    b. Religion and/or spirituality as a protective factor
3. Motherhood: A catalyst for change
4. Counselling as a transformational healing activity
5. Reconnection to Indigenous worldviews
    a. Reconnecting to identity, culture, spirituality and/or faith as an outcome of healing
    b. Sharing new knowledge and gifts with others

This chapter will conclude with researcher's observations about the research process, including challenges and interesting experiences as researcher.

The Complexities of Healing from Intergenerational Trauma

The following two themes describe common aspects of the healing process in general.

The healing journey can be non-linear and non-consecutive

Throughout the interviews, each participant indicated in some way that their engagement in healing activities was a non-linear journey. Dawn shared how at different points in her life, she did not want to continue with counselling, but she kept going for support and for a routine.

> It's worth it, do it. It's hard, there's probably different stages, different timelines that you might not want to do it, but continue, keep going. Because even coming here at some point it's like, "I think I'm tired of coming to counselling," or I would make a new appointment later. But then I still kept my appointments, I never canceled and I just came anyway. I don't know, I guess that's a good thing, because at some point you don't know whether ... am I doing a good thing or am I just going through a routine and ... But no, it was helpful. Even though you think you're ... you're not cured, but you still keep going (Interview, March 9, 2018).

Mary described how she went through many different “waves” of healing over time, starting with becoming a mother, and now attending counselling to address issues related to being in residential school.

In other words, participants engaged in healing activities at times they felt they needed it, or when their life allowed time to engage in healing activities. This may have looked like attending counselling for a certain number of sessions, and then taking a break for a time until participants felt another contemporary issue arise. Additionally, participants also took “breaks” when life was chaotic, or there was a lot of change. After these acute issues settled, some of the participants reinitiated healing activities. While many of the participants have been on their

healing journeys for decades, they may not have been consistently engaging in healing activities that whole time. (Interview, March 4, 2018)

The process of healing is isolating and difficult

Every participant spoke of feeling lonely on their healing journey, and expressed that the process of healing was emotionally painful.

Robyn expressed that, “Trying to heal from trauma is like walking down a dark lonely road. … Just feel alone.” (Interview, March 10, 2018).

Mary also shared that the healing process was painful, especially,

> the hardest part for me was looking back at - I was quite embarrassed sometimes about my behaviour. But I had to look back to see where it was coming from. It was embarrassing. And to look back at events and to feel shame all over again. So that was the hardest part. To look at all of those things. To be exposed, myself. (Interview, March 4, 2018)

Dawn described the healing process difficult, but a necessary part of her mental health. In her words healing is, “hard emotional work, it's difficult, but it's good for you. It's kinda like, "frick, I hate going to the gym, but it's good for you”.” (Interview, March 8, 2018)

Winona shared that part of the hard word was learning what trauma was and how her past traumas informed her current thoughts, behaviours, and feelings. She said that healing was, “a lot of hard work. Probably didn't even know I had trauma. Didn't even identify from trauma. Didn't identify what trauma was.” (Interview, March 7, 2018)

Despite the isolation and emotional pain of each of their emotional journeys, each participant emphasized the value healing and said it was worth it. Mary shared that prior to her

healing journey she felt unworthy of trust, unworthy of healing and did not feel like a human. She elaborates,

I know we don't see each other as worthy - worthy of trust or anything like that - but as you go along in your healing, that changes. You start to see that you are a human being. Same as everybody else…you are worth it. You're worth the struggle. You're worth the struggle that you'll go through on your healing path. (Interview, March 4, 2018)

Winona spoke of feeling free after the struggle of healing. She said, “go with it. Be open. Because the reward on the other side of dealing with it is so freeing that you'll be able to breathe. And you won't feel stifled” (Interview March 7, 2018).

In summary, each participant noted that they felt disconnected from others during their healing journey and that the journey was difficult and emotionally painful, however, they also stressed how necessary the process was to help them feel an increased sense of self-worth, increased trust in others, and an increased ability to connect with others, including their community and their culture.

Protective factors that facilitated the healing process

The following two themes each describe how protective factors like an early connection to a loving, supportive person, and spirituality and/or religion can assist with the healing process.

Someone who supports and believes in them from an early age as later support to heal from trauma

Each woman’s narratives included someone in their early lives that love them, believed in them, and with whom they felt safe and secure. This person was not necessarily a parent-figure, and was not always in their lives for a long time, but the women reported to draw strength, courage, and resilience from this person while on their healing journeys.

Mary shared of her connection with her grandfather and how she was told the story of how he prayed her back to life as an infant and how hearing this story gave her faith that she had a purpose in life and helped her through tough times. In her childhood, she spent time with her grandfather to seek refuge from a chaotic home. To recall she stated, “I would like to crawl up and hang over and watch him and ask him questions. And I thought that I was the only one - it was special time between me and my grandfather” (March 4, 2018). She also mentioned that her grandfather, “had a really big influence on me when I was really young; we were very connected. He was a very spiritual man” (March 4, 2018).

Mary shared how she was close with her mother, and learned a certain type of grit by spending time with her and learning how to survive oppressive living conditions. Dawn spoke about how her aunt made her feel special by sewing clothes for her dolls. Finally, Robyn spoke about the connection, love, and sense of protection she felt from her brother.

Each participant had a person, or person(s) that were not necessarily their primary caregivers who represented a safe and secure attachment along with a source of love, trust, and wisdom to them. These people helped each participant in different ways, but all admitted the person was a positive, loving influence and their presence, or remembering their presence, helped them through difficult situations. For example, Mary’s grandfather helped her to feel important and loved; Winona’s mother demonstrated the value of hard work and perseverance; Dawn’s aunt helped her to feel special; and, Robyn’s brother provided a sense of safety, love, and trust.

Religion and/or spirituality as a protective factor

All of the participants described a deeper or renewed connection to spirituality and/or religion as a result of their healing process. Some of the participants stated that they denied any intuition or inner wisdom to connect with spirituality and/or religion during the beginning of their healing journeys. For example, Winona shared that at the beginning of her healing journey she realized she needed to connect with the higher power of spirituality and traditional practices in order to fight her addictions. She said,

> it was just a time in my life where I had been considered myself an atheist. Not then, but before I got pregnant I did and I just didn't have any hope, or faith or understanding. And then when I got straightened up I needed a higher power because that's when I started looking because I had this big thing with religion and it didn't work for me because of residential schools so I had to find something that work for me and that fit for me. (Interview, March 7, 2018)

Winona shared that she felt the inner wisdom of traditional knowledge and spirituality was always inside her and around her, and that she was being led toward it. However, she said she ignored this intuition, or pull, toward that way of life. In her own words,

> I think it [connection to Spirit and spirituality] was always there but I wasn't open to it as a young woman. But when it really started was probably maybe around 24-25, but I think it was always there, but I was not seeing it, not knowing I was being led. (Interview, March 7, 2018)

For Mary, religion was always present in her life from an early age. However, as an adult, she found the need to leave her congregation for another Christian denomination that she felt was

more in alignment with her current values. She said that she felt this move caused a profound shift in her healing journey. As she explained.

> I was raised in the Anglican Church and it seemed like God was way outside. I was taught that God was a punishing God, was mean and things like that. …when shortly after our daughter died I had a rough time dealing with it and I went to an Evangelical type service and I listened to the message. That night I became "born again" and what happens is your spirit gets renewed and your spirit comes alive. Because I was spiritually dead before. So that's the foundation that I have. And I learned there how loving God is. I have an intimate relationship with Him. (Interview, March 4, 2018)

As her healing journey continued, Mary said that she has started to embrace some of her traditional spiritual teachings, however, her connection to the Evangelical church remains strong and an important part of her support system.

Through each of their healing journeys Mary and Winona reconnected with their religion and spirituality, respectively. Each of them described that they were closed off in some ways to their chosen path to a higher power prior to their healing journey started, but during difficult times, turned to something they felt was stronger and more powerful than themselves to help alleviate their suffering and help facilitate change. Dawn and Robyn also shared that through their individual healing processes their connections with spirituality has deepened.

Motherhood: a catalyst to change

This next theme illustrates the common theme of motherhood initiating the necessity and/or desire to start their healing journey. While each participant may have entered the healing process to deal with a contemporary trauma, they realized that their contemporary problems had

roots that transcended past their own lives into generations before their time. Because of this learning, and learning about trauma, all participants continued on their healing journey to address core trauma wounds stemming from intergenerational trauma.

Becoming/Being a Mother as motivation to heal

When it came to each of these women choosing to start their healing journey, all four women linked their decision to motherhood. Participants 1, 2, and 4 all felt the need to change something in their life when they found out they were pregnant.

Mary felt that finding out she was pregnant was a healing activity in itself as she began to feel love for her unborn child, but she also started to make decisions to want to continue to feel love and feel emotions, which led to engagement in other healing activities such as prayer and educating herself about different methods of parenting.

When Winona found out she was pregnant she decided that she wanted to make changes to live a sober life. She said that she engaged in healing activities like AA, but struggled to stay sober until finally her partner threatened to leave and take their child with him. Then she shared that she decided that she needed something in her life that was stronger than her addiction and found it in her spirituality. Connecting with traditional ways of knowing and healing helped her to find strength and become (and continue to be) sober.

Dawn’s son started to have behavioural issues at school and sought out counselling for him. In doing so, she realized the emotional toll this was taking on her life and that there may also be patterns in how she reacted from her past and she also started to get counselling was resourceful and openminded in learning about other healing activities like traditional healing, meditation, prayer, reading self-help books and/or online articles, and reaching out to friends for support.

After Robyn had her first child, she realized that she had some unfinished business with her mother. Through having a difficult discussion with her mother, she was able to forgive her mother for how she treated her when she was a child. Robyn continued her healing journey being compassionate to self and others, practicing forgiveness and letting go of things in her life that she could not control. She attributes her church and spirituality as helping her on her healing journey.

While becoming a mother was not an intentional healing activity at the outset, the meaning each participant gave to becoming a mother led to the desire to want to improve their lives.

Counselling as a transformational healing activity

Three of the four participants spoke about counselling as a healing activity that deepened their healing work and helped them get to the core of their issues. The fourth participant shared that she uses counselling now and again to get a tune up: to vent some feelings about a particular stressful, current issue. Other participants shared the following about their experience with counselling:

Winona shared what a good counsellor is to her. She said it would be,

> Somebody that listens to me and lets me have my space and that gives me feedback but doesn't give me the answers, you know? And is available. … some counsellors are months to see. And I gotta feel a connection. I've met with counsellors before where I've divorced them. I'm not getting anywhere with them, so I'm not feeling it, so you're not working for me. And I have no problem doing that (Interview March 9, 2018).

Mary shared how she initially attended counselling to address grief from experiencing multiple losses in one year. Because of the rapport she developed with her counsellor, Mary chose to face her fears and address some very difficult topics. In her words,

> The counsellor … in one of the first visits I saw her, she asked me if I went to residential school and I said yes just real quick. I used to respond, "Yes I went and nothing happened, I'm fine". But she knew. And about four years of us seeing each other I started going through the process of the second round (hearings) and I started opening up. I didn't want to pursue it but the office kept sending me letters. They'd send me a letter and I'd burn it, send me another set and I'd burn them. did not want to go there. Did not want to go there. But I also knew it was hindering me. I knew it was impacting my behaviour and emotions. So, I knew I had to go there and I did actually prayed and said, "okay. I want to deal, I want to feel...I want to feel". and it started. It accelerated. But it was a good thing for me. Looking back, it was a very wise thing to allow myself to go through that. Because I had to. I can see how different I am as a result. It's been quite the journey (Interview, March 8, 2018).

Dawn spoke of the value of attending counselling regularly, whether she wanted to or not.

> It's worth it, do it. It's hard, there's probably different stages, different timelines that you might not want to do it, but continue, keep going. Because even coming here at some point it's like, "I think I'm tired of coming to counseling," or I would make a new appointment later. But then I still kept my appointments, I never canceled and I just came anyway. I don't know, I guess that's a good thing, because at some point you don't know whether ... am I doing a good thing or am I just going through a routine and ... But no, it

was helpful. Even though you think you're ... you're not cured, but you still keep going. (Interview, March 8, 2018)

In summary, most of the participants found, and continue to find, significant benefit in attending counselling. One of the common statements about counselling was that it was through this process that they learned about trauma and how trauma, especially intergenerational trauma, could affect their lives. This was impactful for Mary, Winona, and Dawn as it gave them a different framework to understand themselves and how they were relating to others in the world. It helped them to develop compassion for themselves and others as they realized their psychological symptoms, addictive behaviours, struggle to "get over" past events, and relate to others is all part of the pervasive impacts of generations of oppression and trauma.

Understanding how trauma can impact identity, the body, mind, spirit, culture, and community, not only to one person, but to families, and generations was a key to Mary and Winona's desire to learn more about trauma and share this information to their community so people in their community could learn that there were reasons why they were struggling and it was not because of some sort of self-defectiveness: it was trauma-related.

Outcomes of their healing journeys

The following two themes illustrate the participants' perceived outcomes of their healing journeys. Many of the participants stated that healing is a life-long commitment, but were able to share that they are feeling much more connected to themselves, others, nature, Spirit/religion, their culture, their language, and their community. All participants also stated that it is part of their culture, but also a shared inner desire to want to pass on their newfound knowledge about trauma and healing to others in their community.

Reconnecting identity, culture, spirituality and faith as an outcome of healing

Many of the participants spoke about ways their lives have changed resulting from engaging in healing activities. They all shared a sense of reclaiming their identity and being a more connected, loving, and nurturing mother, wife, and grandparent. They also spoke about discovering and /or rediscovering their culture, including their language and teachings. While their culture also includes reclaiming their spirituality as it pertains to Indigenous teachings, some participants continue to actively participate in their Christian faith, and as such culture and faith are each represented in this theme.

As Mary shared,

> I spoke my language first, but … I've gotten away from it. It wasn't important to me as a teenager, but it's important now. Just our traditional practices, they're becoming more and more important now. Understanding how we did things. How we were as a people (Interview, March 8, 2018).

Winona recalled,

> Before I choice to practice my way of life and do the healing work, I was dead. And I would have been dead today probably if I didn't find a different way of being. And that took me back to my traditions and beliefs… I think my beliefs were taught to me through different people that have come into my life and I searched people out as well, but I've been very fortunate where Creator has put people in my life to say "you might want to try this lodge, or there's a teaching over there", so I've been very fortunate in that aspect.

> She shared that as a result of the healing activities she participated in, she is a "better grandmother, a better partner, a loving mom, a good human, and [I am] full of spirit (Interview, March 9, 2018).

Robyn shared that deepening her connection with her spirituality to practice forgiveness was the most helpful to her on her healing journey. In her words,

> I mean I still struggle with things in my heart, you know, but it builds hate in your heart when you can't forgive. I think my key, I guess, to peace or whatever is to forgive. For me anyways, it keeps you healthy. It keeps you humble. It's hard to do. …
>
> Personally like no counsellor or no psychologist could ever have given me that heart to forgive. So I think those, for me anyway, have been miracles. I was locked away, and I am a different person because of it. (Interview, March 10, 2018)

Dawn shared her desire to learn about her ancestry and discover more about her ancestors and she has been feeling disconnected from her family history. Engaging with a person who offers genealogical and historical information in her community has been and continues to be an important part of her healing process.

Some of the participants began their healing journey with a sense of faith through their chosen religion or spirituality, however they also described how they felt disconnect and, as Mary described "spiritually dead" and yearned for something more. Through their healing process each participant was able to discover and/or rediscover their connection with their chosen Christian denomination or Indigenous spirituality, and/or finding a way to walk in both

worlds. Also, through healing the participants have found they were less disconnected and closed off and more able and open to learn more about their culture and connect with their community.

Sharing new knowledge and gifts with others

Each of the participants shared that it was important to them to pass along what they learned about their experiences of healing and new knowledge to others.

Mary indicated that during some of the more emotionally painful times on her healing journey, she found solace in the fact that she was able to give back and share some of what she has learned about healing with the people with whom she works. She also said that teaching these "tools" and being with her students has been healing for her as well. She explains,

> I've learned a whole lot about myself and the tools, to sharpen my tools for relationships. And there I get an opportunity to give. Because I tell them one of the things about Indigenous people, we learn something we use it right away. That's the giving part (Interview, March 4, 2018).

She also spoke about new interests that have developed as a result of her healing journey. She said, "now I'm more interested in helping us identify and overcome our traumas has become our focus in my old age. Maybe because I'm doing that work right now on myself" (Interview, March 4, 2018).

Winona works with community members and also shared that being able to share resources, share psychoeducation about trauma and its effects on individuals and communities that she learned during her own journey is very meaningful to her. Someone she has gained a lot of knowledge about trauma and its effects from the writings and teachings of Dr. Gabor Maté. She said that since being on her own healing journey and learning from people like Dr. Maté, she

wants to focus on how to “free people from trauma. How to identify trauma and not mistake it for a learning disorder or like ADHD” (Interview March 8, 2018).

Dawn also works with community members and has shared her own learnings and resources that have been helpful to her with her clients. She also said that her clients’ experiences helped her as well. In her words,

> I get to experience with clients some stuff, and I learn from that experience and it helps me, too… I don't disclose my personal history with them or anything, it's just, “I understand your pain, I can hear it in your voice, you're feeling so helpless right now”… I think it's a learnin' process that you learn, so hopefully you can share your experiences ... to learn from your experiences, to help somebody else to be better or get through it or manage. (Interview March 8, 2018)

Robyn spoke briefly about wanting to “better the community” by contributing her knowledge, passion, and experience. She is currently upgrading her skills and learning at a post-secondary institution in the human services field so she can help the community in new and different ways (Interview, March 10, 2018).

In summary, all four participants felt a desire to give back to the community and share knowledge they gained from their healing experiences. This had led many of the participants into forms of employment in the community where they can disseminate this knowledge to their clientele. It has also inspired participants to continue to study and learn about trauma, manifestations of trauma from both mainstream and Indigenous teachings.

Chapter Summary

This chapter illustrated the themes across all four narratives as they related to the research questions. Supporting excerpts from relevant narratives were included to substantiate the themes. Themes shared included the process of healing, protective factors that facilitated the healing process, motherhood as a catalyst for change, counselling as a healing activity, and outcomes of healing.

The next section contains the researcher's reflections throughout the research process.

Researcher's Reflections

Challenges during the research process

For whom am I writing? One of the challenges during this research process has been finding the balance between writing for two different audiences: academia and Indigenous participants; psychologists and Indigenous communities. The primary reason I am engaging in this research in the first place is in part for fulfillment of my PhD in Counselling Psychology, from a program that follows a "scientist-practitioner model". This model encourages graduate students to incorporate science into practice, whether that be research or clinical intervention practice. Evidence-based interventions are encouraged in clinical practice.

While scientist-practitioner model informs and is informed by ethical and professional standards, it may not be culturally informed. Using medical and diagnostic terminology can be considered a colonizing approach in Indigenous populations. It is this such treatment and terminology that keeps some Indigenous people from seeking mainstream healthcare services, whether it be from their family physician, or a psychologist. Of course, there are "evidence-based" approaches to multiculturalism, but again, those are colonized approaches that may not consider Indigenous ways of knowing and living.

I tried to keep this in mind while I was writing this paper. My personal and educational background up to this point has been from a feminist, person-centered approach. I am aware that some of my writing may seem more passionate and from a viewpoint of "advocate" instead of a more stoic "researcher" point of view, and this was done purposefully to appropriately honour the history of Indigenous people's struggle to survive, and now their efforts to heal from trauma that is intergenerational, historic, and systemic.

Therefore, using language that is "psychological" and academic without further engaging in colonizing practices has been a challenge. It is my priority to engage in this research, including the writing of this research project to do no harm and to not contribute to the damage that non-Indigenous researchers have already inflicted on Indigenous people. However, I also understand that it is expected of me to write in a manner consistent with a PhD program in Counselling Psychology. I have two audiences. One audience requires me to challenge some of the normative, scientist-practitioner ways to honour the holistic healing process of Indigenous peoples, and another audience that essentially dictates whether or not I graduate from this program. The latter audience is situated in a system based in white, Eurocentric, scientist-practitioner academia.

I spent a lot of time sitting in front of my laptop with a flashing cursor taunting me, deleting and rewriting paragraphs, trying to satisfy one party or another. Then trying to satisfy both and ending up feeling confused, which means the reader would have also been confused. I did a lot of reflection about what was important for me to convey on both sides: the scientist-practitioner, and the decolonizing. I want to make sure that each step of my writing shows careful consideration and intent with the language used to both show my proficiency in psychological intervention and method, but also in decolonizing method and research.

In the end, I have attempted to do both, but have prioritized writing in a style that honours my Indigenous participants and their communities. I have tried not to pathologize participants' experiences and give context to the origins of complex, intergenerational trauma where appropriate. Still, I also have to honour what I have learned from my experience as an emerging psychologist who has had experience in providing trauma-resolution treatment to Indigenous populations for close to eight years. It is through these learnings from the participants' stories and from my own experience, that hopefully further collaboration and mutual understanding can occur to continue to decolonize psychology research and practice.

Additionally, when it came to research design, any training I received in various Research Methods courses in both my undergraduate and graduate classes failed to teach decolonizing methods and/or Indigenous methods of research. As such, I came to this research blindly and did my own research to ensure that this research was carried out in a respectful way that was not harmful. This went beyond general ethics, and even ethical procedures and guidelines specifically set for doing research with Indigenous populations. It meant building my knowledge base around decolonizing research methods and Indigenous research methods and reflecting on how best to carry out this research considering the population, the setting, and standard ethical research practice. It meant continually checking in with key stakeholders and a local elder regarding process, local cultural ways and community preferences, and it also meant continually checking in with my participants about their experience of the research process to make sure it was a respectful and safe place for them to share personal information.

How much is enough? One of the criticisms of qualitative research is that interviews may not be "in depth" enough thus not producing rich enough data. One of the attempts in this method to combat this, is to use PIAs to "prime the storytelling pump' so to speak and to have

multiple points of contact to allow participants to add to their story if need be, and for me to ask for more information or clarification. The essence of Interpretative Phenomenological Analysis is that the "data" are the participants' stories. I hoped that the PIAs and the clusters of questions (from general to more specific) were enough to elicit rich stories for analysis. The whole purpose of using these tools (PIAs and the clusters of questions) is to give space for the participant to share whatever she chooses without feeling pressured to answer probing questions. But what if the content shared in the stories was not sufficient to my own understanding or to potentially answering the research question? There were times that I had to ask certain participants for more information because when reading their narratives, it felt like something was missing. When I first spoke to Mary, I didn't know about her near-death experience as an infant and her grandfather praying her back to life, nor did I know about her experience going to a life skills course. I knew everything else shared in her narrative, but reading it over, I didn't quite understand how given her history of neglect, abuse, exposure to violence and substance abuse that she made the choices that she made to raise her children differently and give them what she felt she was lacking. The majority of her siblings had involvement with Child and Family Services (called Children's Aid in Ontario) and had their children put in care because they were neglectful or using substances and not able to be fully present as a parent. I wondered, what made her different? Certainly, it does not seem unreasonable that she would look at the circumstances and choose something different, but at the same token, I felt that there had to be something more to her story that led her to make those choices. Because of that, I contacted her again and shared my thoughts with her. Mary had already had an opportunity to read the narrative I wrote and also read her entire transcript. She approved of the quotes I used in her narrative analysis. I was very transparent with her, sharing with her my understanding of the

situation and wondering if perhaps there were other experiences in her life that may have contributed to the decision to raise her children differently, and also to explain her steadfast faith and commitment to religion. It was then that she shared those two stories with me and then I felt all the puzzle pieces came together to share her story. Mary agreed that those were important touchstone moments in her life that shaped who she was, her belief in herself, and the decisions that she made in life.

I could have asked other questions, more probing questions, but I wanted to honour Mary's decision to choose which stories to share with me and the depth in which she shared those stories. It was important for me to be able to justify why I needed to know more information before approaching participants with more questions.

For example, many participants spoke about using traditional healing practices: sweat lodges, healers, and ceremony as part of their healing journey. I intentionally did not ask more about what went on during these practices as many elders in the Anishinaabe culture feel it is inappropriate to share spiritual practice(s) with non-Indigenous people. My research question was about the participants' experiences and was not looking to write a "how to heal" manual. Some may criticize my decision as a lack of depth in research, but it is more important to me to have research as a healing activity instead of probing into territory that would be considered inappropriate, or theft of culturally sensitive information.

Staying reflexive. Throughout this whole process from its inception until this writing (and beyond), I have engaged in reflexive activities to continue to check my own privilege and ensure that I am acting with cultural humility and engage in this research in culturally appropriate ways. I have asked questions to key stakeholders, including an elder when I have

concerns or questions about due process and procedures, but mostly I have continued to do my own work through journaling, taking relevant courses, and reading articles and books to understand more about culture.

Part of the process for me was to explore my own ancestry and reflect on how my ancestors' experiences, privileges, traumas, and prejudices contributed to who I am today. If I am to do research about intergenerational trauma, which includes historical trauma, I should know my own history and how my history may have contributed to the traumas of Indigenous populations. Preliminary ancestral research took place through talking to some family members, but most research was through Ancestry.ca. It was an enjoyable project to explore over a number of months. My family name is unique and my family is quite small, so it was interesting to follow generations and generations back to my origins in England (on my paternal side). It was also very interesting for me to see that my ancestors had settled on North American land many generations ago (over two hundred years ago). This led to reflection about whether or not they would have interacted with Indigenous populations and how they would have treated the people on whose land they farmed. Did they know they were living and farming on land that was not inherently theirs? How did they feel about it? How did they feel toward Indigenous people? Was that even in their field of thought, to be concerned about "others" who were not like them? I know that I cannot undo what my ancestors did, or at the very least what my ancestors benefitted from by crossing the Atlantic onto formerly Indigenous land. But acknowledging that both my maternal and paternal ancestors came from England and Scotland and settled in parts of Eastern Canada, Western Quebec, and Pennsylvania helped to acknowledge my ancestors' roles in colonization. It also helped me to identify how I came to this research and possible prejudices and privileges that could limit my research and potentially cause harm to my participants.

Continually checking my privilege and staying humble about my knowledge of Indigenous culture and practice helped me to engage in this research project in a "good way", meaning a way that is intentional, without harm and is sensitive to the histories, traumas and oppression that Indigenous people face.

Insights regarding the research process

The value of qualitative research and PIAs. I really appreciate qualitative research, especially hermeneutic, phenomenological methods of research that make space for the participant to be the expert of their own understanding and experience, and to honour that understanding as truth. I find that many of the principles of interviewing are similar to that of counselling. I approach counselling with person centered theory/Rogerian theory as the foundation of my theoretical orientation and can translate this into qualitative research. This means that I value the participant as the expert of their own experience and have the right to stop the process at any time. Equalizing power as much as possible is important to me in any research or clinical endeavour and this method allows for the client to be expert and for their words to be held as truth and as "proof" unto themselves.

I am always surprised by the value that Pre-Interview Activities bring to a research interview. All participants referred back to their PIAs during the interview and many of the future questions in the cluster of questions asked after the explanation of the PIAs were already answered through the PIAs. I really enjoy providing this experience for participants. Normally PIAs are distributed ahead of time, but I knew that most of the participants worked fulltime and were involved in many things in their own home and community, so they completed them when they arrived for the interview. This seemed to go well as the content of what they illustrated in

their PIAs was fresh in their minds as they explained their activities and then related them to the interview questions.

Even though counselling is very similar to the interview process, it is a challenge for me to stay out of the way and allow the participant full reign to share their story without interruption. Therefore, it was imperative for me to show through non-verbal cues that I was present and a willing listener. Non-verbal cues used included engaged eye contact, sitting upright and slightly forward, nodding my head in agreement, facial expressions to show acknowledgement, empathy, compassion, and understanding where appropriate. Occasionally I would use brief verbal cues to let the participant know I was understanding what they were saying (eg. mmm-hmmms), but I did not want my voice to interrupt what they were saying, so I used this as minimally as possible.

Section Summary

This section provided a space for the researcher's reflections throughout the research process to encourage reflexivity regarding doing research with people from another culture, ensuring due process throughout this project, and a space to acknowledge the researcher's potential biases.

The next chapter will evaluate and interpret the results, discuss strengths and limitations of the study, and discuss how the findings relate to empirical research and theories about healing. The next chapter will also discuss possible implications to research, clinical practice, and Indigenous communities and/or organizations.

Chapter 6: Discussion

Restatement of Purpose

The purpose of this study was to learn more about the experiences of Indigenous women's engagement of activities to help them heal from the effects of intergenerational trauma by documenting the recollections, reflections, and personal understanding of four Indigenous women from Walpole Island First Nation, Ontario. These women self-identified as having experienced negative effects of intergenerational trauma including experiencing childhood abuse, neglect, attachment issues, and substance abuse issues to name a few. The accounts of the four participants provide a small sampling of an Indigenous women's experience of engaging in healing activities to address the effects of intergenerational trauma to professionals, communities, institutions, and agencies involved with the treatment of trauma, or trauma-related issues. The use of Interpretative Phenomenological Analysis (IPA), pre-interview activities (PIAs), narrative analysis and analysis of narratives, and participant review of the narrative and themes helped to decolonize the research. This approach also helped to respect, affirm, and validate each participant's experience. It is hoped that through this method and analysis that the resulting report of findings has presented each woman's story in an accurate and helpful way.

Given the size and nature of this study, it is not possible to generalize findings to develop an overall understanding of Indigenous women's experiences with engaging in healing activities to address effects from intergenerational trauma. Each woman's experience was individual, but the analysis and interpretation of the participants' experiences reveal certain commonalities and experiences surrounding their healing journey from intergenerational trauma. Some of these themes from the narrative analyses confirm elements and activities in the healing process that also relate to current literature, and some themes provide opportunity for further discussion, exploration, and perhaps research.

This chapter provides a discussion of the results, implications for research and practice, and limitations of this study.

Discussion of Results: relating findings to the literature

To review, the analysis of narratives of the four interviews with women who have engaged in healing activities to address effects of intergenerational trauma produced the following themes:

1. The intergenerational complexity of healing from trauma
    a. The healing journey can be non-linear and non-consecutive
    b. The process of healing is isolating and difficult
2. Protective factors that facilitated the healing process
    a. Someone who supports and believes in them from an early age as later support to heal from trauma
    b. Religion and/or spirituality as a protective factor
3. Motherhood: A catalyst for change
4. Counselling as a transformational healing activity
5. Reconnection to Indigenous worldviews (Becoming interconnected)
    a. Reconnecting to identity, culture, spirituality and/or faith as an outcome of healing
    b. Sharing new knowledge and gifts with others

Many of these themes are consistent with literature, including Indigenous ways of healing. However, these findings should be considered with caution given the small sample size and the focus on one First Nations community. In this section, the relationship between the themes and literature are discussed.

The Complexity of Healing from Intergenerational Trauma

Healing from complex trauma and oppression that took place over years and over generations is not easy, nor is there a "quick fix" in terms of mainstream intervention. Indigenous women in particular have been affected by intergenerational trauma on many fronts: physically, emotionally, mentally, spiritually, relationally, socially, culturally, economically, and environmentally (Haskell & Randall, 2009; Halseth, 2013; Hanson, 2012). In addition to this, many Indigenous women are continually oppressed and traumatized, and are constantly faced with life's challenges (Rego & Rego, 2014). While Indigenous women may want to heal from intergenerational trauma, it may be difficult to commit to the potential intensity and frequency that counselling, or other treatment may require given current life circumstances. Indigenous healing may involve participation in ceremony that occurs at a certain time of year, or seeing an Indigenous healer that may only come to the community once a month. Treatment centres often require travel, and some women may not be able to leave their children to attend. Some Indigenous communities may offer groups or workshops to address some of the manifestations of trauma and thus may only be offered certain times per year. This also brings up the issue of confidentiality and trust in the community. Some women may not feel safe or comfortable sharing their stories with other community members.

Lane, Bopp, Bopp, and Norris (2002) describe four stages of healing from trauma and substance abuse including deciding to change the behaviour, partial recovery, developing a new identity and way of life, and moving forward in life (full recovery). While these stages are mostly focused on healing from substance abuse, some cautious comparison can be made to the phases, or "waves", of healing described by the four participants from this study. Winona's journey certainly follows this path more than the others as she struggled with addiction. Other participants describe an inciting incident that elicited motivation and action. After some progress

they seemed to go about living their life until they felt the need to engage in deeper healing work following a new incident or trigger. Eventually enough change had taken place that the participants were describing changed behaviours and a renewal/reclamation or their culture, values, and identity.

A long, potentially episodic healing journey is also consistent with mainstream research on complex trauma. Courtois and Ford (2009) describe best practices for the treatment of complex trauma and state that for some clients, treatment may last for decades, whether provided continuously, or episodically. They also state that mainstream psychological treatment is not meaningful if it is completed in less than 20 sessions.

Currently in Canada, funding is available for counselling through the Indigenous Services and the First Nations Inuit and Health Branch. There are two sources of funding for counselling: Mental Health Counselling (MHC), for more acute needs, and the Indian Residential Schools Resolution Health Support Program (IRS RHSP). Each funding source provides up to twenty sessions of individual counselling; however, the IRS RHSP acknowledges the complexity and need for longer term counselling and will renew requests for additional counselling sessions, whereas the MHC program only allows 20 sessions per issue. Registered psychologists, registered social workers, registered psychiatric nurses, and registered psychotherapists (and other regulated mental health providers permitted to practice by legislation) are eligible to apply to be approved therapists for these programs. Part of the application includes demonstrating cultural competency and experience with Indigenous populations (Indigenous Canada, 2019).

Protective factors that support the healing process

All four women interviewed shared they had someone in their life that supported them and believed in them from an early age. Most of the women said that this helped them to believe they had a purpose in life, helped them to feel loved, and helped them to connect to religion and/or spirituality. This type of support can be seen as a protective factor against post-trauma symptoms and also helps to build resilience (Ungar, 2013). However, it is unknown as to how much of a protective factor the support person was in each participant's life because many of the individuals who were supportive and provided love did not have a direct hand in parenting, or passed away while the participant was still young. This also brings to mind the influence of meaning making and resilience. How a person defines or qualifies a person in their life may increase the protective factor and as a result, their resilience. Indigenous worldview supports this finding that increased connection with positive influences can facilitate healing and support connection with self and others (Ross, 2014).

Motherhood: A catalyst for change

As mentioned above healing from trauma, including intergenerational trauma, often begins when a person has "hit rock bottom", or feels they are in a safe enough place to share their emotions and their story with someone (Lane, Bopp, Bopp & Norris; Hermann, 1992). In this study, all four women shared that their healing journey began during various stages of motherhood. Most of the participants felt the need to make changes in their emotional health and behavioural health after finding out they were pregnant. Dawn started her healing journey shortly after her child was born. It is possible that these women felt they were in safe enough relationships and places in their lives that they chose to embark on their healing journey. However, another explanation may be posited from the field of health psychology. Researchers have identified that pre and post-natal women are more open to learn and engage in behavioural health changes. These, "teachable moments" (Atkinson, Shaw & French, 2016; Lawson &

Flocke, 2009), refer to circumstances or events that can lead to positive behavioural health change. It is possible that the knowledge these women had about their current situations led them to choose to make change for the health of their children. For example, Mary was raised in a home with emotional neglect. She also witnessed how some of her siblings, struggling with substance abuse and/or other issues, tried to parent their children, but Child Protective Services intervened due to suspect neglect. While she was scared that she would not have the capacity to love her first unborn child, she was resolute in not wanting to raise her child in the way that her siblings raised their children, so she did her own research and started to learn different methods in child-rearing. Becoming pregnant introduced an opportunity for Mary to choose to make change. Robyn engaged in a similar process. When she had her first child, she decided to talk to her mother to understand why Robyn was treated so poorly. Her mother shared her response and as a result of that, Robyn was able to start the process of forgiving her mother.

Research regarding teachable moments is mostly centered around middle-class populations that often do not include Indigenous women. The few studies that explore the phenomena of teachable moments with pre- and post-natal Indigenous women and these studies focus on Indigenous women from Australia.

Given the small sample size of this study, it is difficult to generalize results. Sharing this result is not to say that becoming a mother increases a woman’s ability to heal from trauma. However, it is worth critical thought and further research around other teachable moments connected to Indigenous women’s health and mental health that may promote increased understanding of intergenerational trauma and perhaps taking steps toward healing.

Indigenous worldview may also explain this phenomena that as a woman may focus more on taking care of her physical health in order to care for the health of her child, it may bring to light other areas in the medicine wheel (physical, mental, psychological, spiritual) that might need to be addressed. The role of mother and nurturer is highly valued in Indigenous culture and these women may have wanted to take the first steps of mother by caring for their own health, knowing that it also impacts their child's health.

Counselling as a transformational healing activity

Participating in at least one session of counselling was an inclusionary criteria for this study, so the fact that counselling was part of each participant's journey was assumed. However, most of the participants described their experience in counselling as where they address deeper, or core, issues including attachment trauma, abuse and other possible events they felt were the "root" of their issues. Participants also shared that this is where their issues were validated and respected. They also expressed how it was helpful to have a person outside of their community and who respected confidentiality with whom to engage in a therapeutic relationship.

Counselling was also the place where most of the participants learned what trauma was and related it back to what they experienced. They shared this was helpful to have a framework or lens to understand what was happening. Most participants also shared that therapeutic work in counselling was not easy, but that it was worth it because it helped them to understand themselves better and to be more connected in their world.

Based on this what seemed important for participants was a positive therapeutic relationship where they felt safe and trusted their therapist enough to delve into deep emotional territory. This description seems consistent with common factors of beneficial therapy (Wampold, 2015). He describes three common pathways in which psychotherapy is beneficial.

The first pathway describes a real, genuine relationship between the therapist and the client. During the second pathway client and therapist expectations of therapy are discussed and mutually and respectfully agreed upon. The third pathway is dependent on the first two in that with a strong therapeutic alliance, and goals of therapy established, the client will be more likely to enact on health actions that has been facilitated by the therapist through some form of intervention (eg. psychoeducation, cognitive-behavioural therapy) (Wampold, 2015).

This contextual model may help to explain how counselling may have been beneficial to these participants, despite having seen different counsellors who possibly have varying theoretical orientations and interventions. The contextual model presented above also posits that psychotherapy and/or counselling is highly dependent on the therapeutic relationship and thus healing takes place in a social context (Wampold & Imel, 2015). This is similar to Ross' (2014) explanation that Indigenous healing takes places within a social context; however, he refers to group healing only.

As mentioned, participants stated that counselling helped to provide and explanation for their issues. Through counselling, most of the participants learned about trauma and intergenerational trauma and how these traumas related to their current circumstances. This seemed to help participants be more hopeful about the trauma healing process, which is consistent with Wampold's (Wampold & Imel, 2015) second pathway of setting expectations.

(Re)connection to Indigenous worldviews

Once healing began to take place, all four women described a connection or reconnection to Indigenous worldviews. Participants who had some previous knowledge of Indigenous worldviews, both broadened and deepened their connection through learning their language, participating in ceremony, and tracing their ancestral line. All four women also strengthened and

their connection with their spiritual and/or religious beliefs. During her healing journey Mary felt that her church was no longer in alignment with her values, so she found another church of another Christian denomination that helped her deepen her spiritual connection. Winona always felt that the connection to Creator and spirituality were inside of her, but it was not until she tried many other ways to heal from addiction that she turned to spirituality and Indigenous worldviews. As she continued to heal, her connection to spirituality and Indigenous ways of healing deepened. She continues to learn and practice Indigenous ways of healing.

As each participant progressed on their healing journey, they decided that they wanted to share the knowledge with their community to help others heal from trauma. As a result, each participant completed post-secondary education and gained employment in their community with the intent to pay it forward to their community. This is in keeping with Indigenous worldview of sharing knowledge with others, as well as connecting to the community-at-large (Ross, 2014). It is also in keeping with pre-colonization roles of women within Indigenous communities (Halseth, 2013; Hanson, 2012). The women who participated in this study demonstrated great strength and resilience along their journeys and are now sharing that strength and resilience as they help others in their community.

Interconnectedness

The above-mentioned themes chronicle the journey toward healing, from feeling isolated on a “dark, lonely road” to reconnecting to self, others, and the world, and feeling connected with same. In other words, as literature describes, “interconnectedness”.

The concept of interconnectedness is relevant and consistent with Indigenous ways of healing (McCormick, 1997; Lane, Bopp, Bopp & Norris, 2002; Lane, 2014). As mentioned in the review of literature, the theme of interconnectedness relates to the Indigenous spiritual belief that

we are all connected ("all my relations"): to each other, to nature, to animals, and to the elements (McCormick, 1997; Ross, 2014; Lane, Bopp, Bopp & Norris, 2002; Lane, 2014).

However, participants did not completely engage with groups or community, or even their culture or spirituality initially on their healing process right away. Participants described a sense of disconnection, of loneliness, and of isolation on their healing journeys. There appeared to be a time when the participants were disengaged from others. If they were relationships with others, they did not feel fully supported or like their partner would understand what they were going through. Even those participants who felt connected with religion or spirituality, still described a sense of loneliness when it came to healing. As healing progressed, participants began to connect more with those around them, including their community in a deeper and more frequent capacity. This finding is incongruent with literature which suggests that according to Indigenous ways, the individual heals within a social context (Ross, 2014).

According to mainstream literature about complex trauma, complex trauma can affect the ability to attach and connect. This is especially true if trauma is inflicted by core attachment figures (eg. parents, grandparents, and other caregivers), or there is a loss or removal from core attachment figures. This can affect a person's ability to relate and connect with others. In this community, many people experienced similar attachment traumas and similar adverse experiences. A community where many individuals are impacted by attachment-type traumas and pervasive relational trauma can lead to a community that is disconnected and not lending to an atmosphere of healing. So long as community members are still suffering from and living with the impacts of colonization, and intergenerational trauma, the capacity for individual healing to occur within a social context is compromised.

During their healing journeys all participants went outside the community for individual therapy, and some went outside of their community to attend ceremonies and healing lodges. Part of the reason for looking outside of their community was lack of resources; at the time there was not a healing lodge located in the First Nation community. Another reason for seeking healing services outside of the community was due to the need for anonymity. Most of the participants discussed concerns of other community members potentially knowing and sharing personal and private information with others if they attended counselling in their own community.

Recommendations

Considerations for the continued healing of the Walpole Island First Nation Community

One of the most important findings of this study was the sense of loneliness, isolation, and disconnection these four women felt along their healing journey. This may have occurred for many reasons, but it does bring forth questions surrounding the emphasis of Indigenous worldview and healing done within a group, or a community context. What can Walpole Island First Nation community do to help its female members feel less isolated as they go through emotionally painful (potentially, at times) healing? What are some of the reasons why women feel they were not able to reach out into the community for support through challenging times? What resources might be of most help to facilitate connection and understanding within the community?

It would be important for community members, including helpers and healers, to understand that embarking on a healing journey from trauma that stems from generations of trauma and oppression is not easy, may take a while, and that those on this journey may need to take several trips along this road in order to make it more manageable for them.

The Walpole Island First Nation community has many workshops, groups, and programs to help their members heal, including parenting groups, life skills groups, grief and loss groups, mentoring programs for at-risk youth, Indigenous-based substance abuse cessation groups, and workshops to help people find work, learn Ojibwe and discover their ancestry. A participatory action based program evaluation of these programs may be helpful to determine a needs-based assessment of its attendees to ensure that programming suits the needs of its members and of the community at large.

Workshops could be offered for community members, healers, and helpers on the WIFN community about trauma, complex trauma, and intergenerational trauma. Suggestions for healing, including counselling and spiritual activities could be discussed at that time. This information is important for WIFN community members to know so that they can see how oppression and colonization have left their mark, even today, and this may start the healing process of reducing shame enough for someone to access help.

All participants described the high value of giving back to the community, both during difficult times along their healing journey and now that most of their healing has taken place. Perhaps finding ways to increase volunteer capacity for Indigenous community members would be helpful (Lane, Bopp, Bopp & Norris, 2002). Perhaps giving back to the community and also finding a way to be connected to the community might help to build resiliency and a sense of interconnectedness, which may facilitate a person's healing journey.

Clinical Implications

Clinically, from the interviews and research, the following psychotherapeutic orientations and/or commitment to learning is essential in providing counselling and/or psychotherapy to Indigenous women: person-centered, culturally safe, trauma and complex trauma informed

(including dissociation informed), and resilience informed. A feminist-based approach would also be strongly encouraged (Rego & Rego, 2014). In addition, non-Indigenous clinicians should be culturally humble, meaning they should realize that they will never know exactly what it is like to live as an Indigenous person, and thus commit to continued learning, and defer to clients regarding their experiences of culture and spirituality. For example, it would be important to ask Indigenous clients during an initial intake session if they have any spiritual practices that bring them comfort or strength during times of adversity. Knowing this can help the therapist to guide the client to build resources around their spirituality (eg. during guided meditation exercises, clients could be invited to connect with an important symbol of their spirituality or religion).

Importantly, clinicians need to understand the treatment implications of working with individuals with intergenerational trauma and complex trauma and how to use the phase-oriented approach with their chosen theoretical orientation and interventions. With this in mind, clinicians need to understand the potential length and depth of treatment for someone with intergenerational trauma, as well as, that clients may choose do to this work in phases, whether purposely, or due to circumstances. Knowing this when discussing goals of counselling may be of some assistance.

Given the results of this research, it would be important for counsellors to be compassionate toward the isolating nature of healing, and to understand the systems that may contribute to this. Having this knowledge may guide therapists to provide validation if this occurs, and also points to the need for a strong therapeutic alliance to help support clients through this time.

The women who participated in this study also stressed the importance of psychoeducation around trauma, complex trauma, and intergenerational trauma to reduce shame, and self-blame. Once they understood how intergenerational trauma may have impacted their lives, and felt comfortable with a competent therapist who understood these concepts and knew how to guide a person through the healing process in a safe way, then they felt committed and willing to start the process.

Since approved FNIHB counsellors in the Walpole Island First Nation area are primarily non-Indigenous, it would be important for these counsellors to take cultural safety training, if they have not already done so. Also, it might be beneficial for a workshop to be developed for these counsellors, in collaboration with an Indigenous counsellor, or healer, to provide education on complex trauma, dissociation, the phase oriented approach, and how best to incorporate this into their practice.

Implications for Future Research

The results of this study suggest several avenues of further research that may continue to increase understanding of Indigenous women's healing journeys from the impacts of intergenerational trauma, including activities of healing, community programming, and best practices for culturally safe trauma treatment. Future research should be done with the interest of the First Nation community at its core and should involve the First Nation community as much as possible in all aspects of research, so long as it is appropriate and is congruent with the community's goals and values.

First, researchers may want to further explore healing activities of Indigenous women, and even more specifically women in this First Nation community. Given the fact that this was a small representation of women, researchers may want to replicate this study with a larger number

of participants, across First Nations communities in Southwestern Ontario, or beyond to increase understanding of this research topic.

Second, both mainstream and Indigenous healing activities were used by all four participants. Further research might evaluate programs currently offered in Indigenous communities to determine if services are meeting the needs of community members. Ideally this would also include an evaluation of mainstream counselling services either offered in the community, or off-site.

Third, further research and understanding around the phenomena of engaging in healing activities at the developmental stage of becoming a mother, or other phenomena that might lead to a catalyst of healing. Research including “teachable moments” and how that might impact an Indigenous woman’s journey of healing from trauma might help to inform pre- and post-natal programming, especially since most research on this topic has focused on behavioural health change, and has not focused on trauma or emotional health. Also, it would be helpful to understand cultural practices that may relate to “teachable moments” and if it would be beneficial in terms of research and in practice, how to present teachable moments to Indigenous women in a culturally safe and appropriate way.

Fourth, continued research on meaning making, trauma, and spirituality is needed to understand the influence and power of spirituality and/or spiritually based activities in healing from intergenerational trauma. Current research in this field speaks of trauma in a general term, but does not distinguish between a single event trauma and chronic, ongoing trauma, including systemic oppression and colonization. Understanding how meaning making and spirituality relate to healing from long-standing trauma and/or understanding how Indigenous men and

women who have faced intergenerational and chronic trauma make sense of their experiences, would contribute to counselling practice and may inform trauma-specific healing programs (both mainstream and traditional).

Fifth, research may want to continue to investigate the use and potential benefit of using Pre-Interview-type Activities in counselling sessions, including intake, with Indigenous adult clients who have experienced complex, intergenerational trauma. Initial exploration of some of these topics has been initiated by Friesen and Ellis (2017, 2016).

All of this suggested research should be decided upon Indigenous people, and done in collaboration, and with as much participation as possible of Indigenous community members.

Assumptions and Limitations

In this section, I discuss the three assumptions I made during the research process, along with study limitations.

Assumptions. The three assumptions I made during the research process include: participant honesty, participant willingness, and representativeness. First, I assumed that the women who participated in my research answered interview questions honestly and accurately, to the best of their ability. To increase this likelihood, I took time to explain how confidentiality would be maintained. Participants were also given the option to be interviewed at locations away from their community, and they were given an opportunity to review quotes and information used in the results section. I also implemented PIAs at the start of the interview to help clients express their thoughts and ideas through creativity and visual representation before our verbal discussion commenced. This may have helped the women to remember certain details, or refer back to their diagrams and drawings during the interview.

Secondly, I assumed that the women who participated in this study volunteered willingly. To assure this, I made sure that the women know they may withdraw from the study at any time without consequence.

Thirdly, I assumed that the views of the women in this study could be generalizable to other women in their First Nation community. Recommendations for future research and programming were derived from these community members' narratives, and while they may not represent themes of healing among all female survivors in the community, the participants' identity and representation as community members on this First Nation may help others in the community to find their way to healing.

Limitations. Because this is a study using Interpretive Phenomenological Analysis, a qualitative study, the participants' self-report is the primary source of information. The themes are drawn only from the participants' recollections and experiences. The research method was designed through the use of PIAs and open-ended questions (as opposed to probing questions) to elicit honest responses from the participants. As such, it is important to note that each person's journey healing from trauma is unique and some individuals, or other Indigenous communities may have had different experiences limiting the generalizability. That being said, many of the themes presented were broad, which may increase some of the relatability and generalizability of the findings from this study.

Considering these assumptions and limitations, some caution should be used when interpreting the findings as they may not be representative of all community members.

Conclusions

There is growing evidence to show that the impact of colonization, systemic oppression, forced attendance in Indian Residential School, and other traumas impacting Indigenous populations, including the fallout of these events lead to intergenerational trauma. The effects of intergenerational trauma can be transmitted at many levels including through DNA, through parenting, and through the loss of culture and community connection. The Truth and Reconciliation Commission, Indigenous communities, and other Indigenous-led organizations acknowledge the past, including the considerable pain Indigenous people endured, and are now focused on healing. As Indigenous communities decide how best to move forward and support their people in healing from intergenerational trauma, this research, and other current research supports a "collaborative approach" between community-based programs embedded in traditional ways of knowing and healing, and "mainstream" approaches including counselling. Research from this current study also support the need to develop and sustain a sense of interconnectedness, of giving and receiving, with safe and loving people, community, and spirituality, whether Indigenous spirituality, or another form of religion and/or spirituality. Depending upon a person's sense of spirituality, a "collaborative approach" with Indigenous teachings may not be an appropriate fit, but incorporating their meaning of spirituality would be beneficial.

This current research also shared that the participants all started on their healing journey during the development becoming a mother. Future research may consider how best to support pre- and post-natal mothers who want to begin their healing journey and how to develop a collaborative approach that supports Indigenous teachings and mainstream trauma-informed knowledge.

This research also suggests that all participants, while sharing common activities in healing, each had their own journey to walk and each had their own meaning to their past, and how best to heal from past traumas. Counsellors who provide trauma-specific treatment to Indigenous women should become educated on culturally-safe approaches to counselling, learn the history and also learn about Indigenous ways of healing, but continue to assess and treat each client individually and through a respectful and collaborative relationship, develop rapport and come to a mutual understanding of how the counsellor can best support the client of her healing journey.

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Appendix A: Research Agreement

Research Agreement between Walpole Island First Nation, Walpole Island Social Services, and Tina Shrigley (under the supervision of Dr. William Whelton, Associate Professor at University of Alberta)

Tina Shrigley ("the researcher") agreed to conduct the above-named research project with the following understandings:

1. The purpose of this research is to better understand how to support First Nations women as they engage in activities to help them heal from trauma.
2. The methods to be used are: face-to-face interviews (one-to-one); the interviews will be recorded and transcribed by the researcher; qualitative data analysis will be performed by the researcher to look for themes in the transcripts.
3. Community participation is to include: consultation with community elders as needed, interviews with participants who are community members, feedback sessions with participants to review findings and request any edits, and a meeting with Walpole Island Social Services and a representative from the band office to review the findings.
4. The development of this project is based on the researcher's connections and communications with community members. All efforts will be made to incorporate and address local concerns and recommendations at each step of the project.
5. At the end of the project, the researcher will participate in community meetings to discuss the results of the analysis with community members.
6. Information collected is to be shared, distributed, and stored in these agreed ways: (1) Individual meetings will be held for each participant to review the findings and provide feedback prior to writing of the final report. (2) A final report will be distributed to participants, Walpole Island Social Services, and Walpole Island Chief and Council. (3) The data collected is confidential and no name is attached to a record. (4) All data will be kept in a secure locked cabinet and/or in secure electronic form for seven (7) years, and Tina Shrigley will have sole access. (5) The researcher will be available to answer questions and assist community members who decide to use research findings for other purposes.
7. An Informed Consent form will be read and explained by the researcher at each interview, then signed and collected. A copy of the consent form will be left with the participant, which includes the researcher's contact information should the participant wish to contact the researcher for additional information.
8. The names of the participants will remain confidential and only known to the researcher. All efforts will be made to keep quotes and information non-identifying, however, the Walpole Island community name will be noted throughout the research as the findings will include community-specific specifications.
9. Project progress will be communicated to the community in this agreed way: A quarterly email sent to the Director of Operations of Walpole Island First Nations and one of the Supervisors (who share the Executive Director position) at Walpole Island Social Services, noting the activities completed.
10. Any communication with the media will require prior approval from Chiefs and Council.

Funding:
The researcher is not receiving any funding for this research project.

Benefits:
The researcher wishes to use this research project for their benefit in the following ways: by completing a dissertation as part of the researcher's doctorate in counselling psychology (PhD) at the University of Alberta, by publishing the report and articles about it, as well as presenting at conferences. The researcher will submit a final report to Chiefs and Council upon completion.
The benefits likely to be gained by the community through this research project are:

- Increased understanding of how to support women as they work to address and heal from trauma. This can help guide future community programming and evaulation with the goal of providing support to traumatized women and making helpful

activities/services/supports more available and accessible to the community.

- Increased community awareness of helpful activities to heal from trauma.
- Research to potentially substantiate the need for funding of community-based programs and activities that support healing from trauma.

Commitments:

The researcher's main commitments to the community are to:

- To do no harm to the community.
- To undertake research that will contribute something of value to the community.
- To abide by any local laws, regulations and protocols in effect in the community, and to become familiar with the culture and traditions (as appropriate) of the community.
- Inform the community about the progress of the project in a clear, specific, and timely manner.
- To communicate the results of the research to the community, and to share ideas as well as program and service development for mutual benefit and involvement.
- To abide by their own professional standards, their institution's guidelines for ethical research, and general standards of ethical research.
- Act as a resource to the community on trauma, intergenerational trauma, and possible activities that support the treatment (healing) of trauma.
- The researcher agreed to stop the research project in the following circumstances:
  - If community leaders decide to withdraw their support and participation.
  - If the researcher believes that the project will no longer benefit the community.

The community's main commitments are:

- To represent the interests, perspectives, and concerns of community meembers and of the community as a whole.
- To keep informed about the progress of the project, and help in leading the project toward meaningful results.
- To place the needs of the community as a first priority in any decision where conflict may arise.

Signed on Oct 18/17 (date)
By:

Michael Dashner, Director of Operations,
Walpole Island First Nations

Donna Isaac-Day, Central Intake Worker
Co-Acting Executive Director
Walpole Island Social Services

Tina Shrigley, Researcher

Appendix B: Ethics Information Letter and Consent Form

INFORMED CONSENT FORM

Research Title: Understanding Aboriginal Women's Experiences of Healing from Trauma

The Researcher

My name is Tina Shrigley and I have worked in the community and with community members since 2012 as a counsellor. I am now in school studying to become a Psychologist and will be doing this project as a student researcher for my doctoral studies at The University of Alberta. This research has the support of Walpole Island First Nation Band Office and Walpole Island Social Services. We hope that what we can learn together will help guide a healing plan for the community and will help other counsellors to learn how to best support you in your healing journey.

If you have any questions about the research, you can contact me or my Supervisor. Our contact information is below:

Research Investigator:	**Supervisor:**
Tina Shrigley, M.Ed. *Local Contact Information* 215 Mitton St. N. Sarnia, ON N7T 6H5 Canada shrigley@ualberta.ca (519) 331-0795	Dr. William (Bill) Whelton, Associate Professor Department of Educational Psychology 6-102 Education North University of Alberta Edmonton, AB T6G 2G5 Canada wwhelton@ualberta.ca (780) 492-7979

This Research

The research focuses on gathering information to understand how female community members heal after experiencing personal and intergenerational trauma.

This research has been approved by the Walpole Island First Nation Band Office and is also supported by Walpole Island Social Services.

You are eligible to participate if you are;

- Female, 35 years of age or older.
- A Walpole Island First Nation member.
- You would rate your current mental wellness as ok or better.
- You can communicate in English.
- You have engaged in healing activities to help you heal from trauma, including at some point in time counselling or psychotherapy.

As part of my research, I am asking you to do the following:

Attend two to three interviews. The first is a 1.5-3 hour interview. At our first interview, once I have your consent, I will ask you to complete some activities to help prepare you for the interview questions. You can choose from a list of activities which may involve some form of drawing, writing, or using symbols to describe a certain experience. You will then be asked to tell me about what you created. If you would like your activities to be included in picture form in the study, let me know. It is your choice, and it is okay to say "no". I will make sure that your name, or any other identifying information is not included, unless you tell me that is okay. If you allow me to include identifying information in my research, people who read the research will know you participated. This may include your community members, Chief and Council, other researchers, and members of my dissertation defense. If you would like, you can keep the originals of your activities. I will be taking pictures of them to preserve them as electronic data.

During the interviews, you will also be asked questions about your healing experiences. Your answers, and answers from other community members, will be gathered together to identify themes related to healing.

Once the interviews are complete and the themes have been identified, I will share them with you at a 1 hour feedback session and ask for your feedback. If there is anything you would like to delete or change from your interview, you are able to do so at that time. I will also ask you questions about your experience in this study at the feedback session. The interview and feedback session will be recorded and later transcribed. This data will be immediately transferred to a password-protected USB drive, which will be stored in a locked file cabinet in my office when not in use, along with the signed informed consent forms. The audio- recording will be transcribed, and all identifying information will be removed – this transcription will also be kept in the same locked cabinet. All data (i.e., audio files, transcripts, consent forms) will be kept in this locked file cabinet for five years after the work is presented. During this five-year timeframe, Walpole Island First Nation Band and Council may use data, that has been approved for use by each participant at each feedback session, with names removed and pseudonyms (a different name than your own) assigned instead, for other research purposes. After those five years, the data will be destroyed (i.e., professionally shredded and/or erased). Again, should you want your name included in this study, you may do so knowing the risks involved. If you allow me to include identifying information in my research, people who read the research will know you participated. This may include your community members, Chief and Council, other researchers, and members of my dissertation defense.

We will meet somewhere private and quiet that works for both of us. For example, an office at Walpole Island Social Services, my office in Sarnia, Ontario, or your own home would work.

The Research is Voluntary

You can decide if you want to participate in the research. There will be no problem if you say "no." You may also withdraw from the research at any time for any reason. If you withdraw within 2 weeks of the interview being transcribed, your data will not be included in the findings. If you withdraw more than 2 weeks after the interview is transcribed, your data cannot be removed. In such a case, you will be passing on the opportunity to clarify any misunderstandings, provide feedback, or request edits prior to the finalization of the results.

The Research is Confidential

All the information you give us will be confidential to the best of our ability.

There are risks to your confidentiality. Due to the small number of people participating in this study, the size of Walpole Island community, and that I am using what you say in my research, I cannot guarantee that people may not be able to identify you.

Here are the ways we have tried to reduce the risk of participants being identified by readers:

1. People may be able to identify you as a participant why what you say and how you say it. This is more likely if I use any long quotes of yours over 40 words. Also, if multiple quotes from you are used, that might increase the chances of someone putting the facts together and guessing who you are. Therefore, you will have an opportunity to review extended quotes before the research is published. To honour and recognize your story, you may choose to have your name included in the research. If you choose to have your name included, it may be viewed by people internationally, may be viewed by people in your community, and cannot be removed after the findings are shared.
2. To further reduce risk to confidentiality, we will give you a Research Number at the beginning of the interview. Only I will know which number goes with which name. No one else will know your name or what your answers are to the different questions. I will remove all identifiable information from any direct quotes I use.
3. Interviews and feedback sessions will take place in an office at Walpole Island Social Services, at the researcher's office in Sarnia, or your home, depending on your preference. At the Social Service office, confidentiality of participation is not guaranteed, as staff may see you arrive and/or leave, and as you know most community members are familiar with each other. You may choose to meet in your home for reasons of confidentiality. If you prefer to have the interview and feedback session in your home, I request that a room in the home be available for privacy from other residents.

Limits to what is Confidential

We will need to tell someone if anyone is at risk of abuse or neglect or harm. This includes yourself or anyone else, including a child under the age of 18 or an elder.

The Results of the Research

A report of findings will outline themes of healing. The report of findings will be shared with Walpole Island Social Services and Walpole Island First Nation Chiefs and Council, the participants, and any other recipients identified by the research team. I will also publish the report of findings in my dissertation. I may also write or speak about the research. Your name or any other information that might identify you will NOT be included in any writing or presentation, unless you request to be acknowledged for your story.

For five years after the findings have been presented, Walpole Island Social Services and Walpole Island First Nation Chiefs and Council may use the written copy of your interview (with your name removed and a research number/alternative name assigned instead) and the research findings, for other future research purposes.

If you want a summary of the results you can ask for at this at the end of this form.

The Risks and Benefits

You might feel some stress when being asked and answering questions about your healing journey. If you feel too distressed you can:

1/ decide not to answer a particular question

2/ take a short break from answering questions

3/ re-schedule your interview

4/ withdraw from the research at any time

You may also feel you have learned something about yourself as a result of answering the questions, and you may find that telling your story is healing for you.

If you have any concerns about your treatment as a participant, you may contact the Researcher's Supervisor at the information listed above.

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Consent for this Research:

I understand my participation in this research is voluntary.

I understand that signing this document does not impact my legal rights in any way.

I know I can withdraw from the research at any time.

I know I can ask that all my information be removed until 2 weeks after the interview has been transcribed.

I know that what I say will be audio-recorded.

I understand that direct quotes may be used in the results, any information that will identify me will be removed, and my name will not my included unless I request it to be included.

I further understand that at the feedback session I will have the opportunity to review the findings, clarify any misunderstandings, provide feedback, or request edits prior to the finalization of the results.

I am giving my consent to participate in this study.

I have received a copy of this Informed Consent signed by the Researcher

_____ _____

Participant Signature Date

_____

Participant Name (Print)

_____ _____

Researcher Signature Date

_____

Researcher Name (Print)

I would like to receive a report of findings:

Yes _____ (please provide e-mail address or home address)

Appendix C: Community Resources Handout

If you would like counselling support or crisis support, I can connect you with the following resources:

Counselling:

The following counsellors are approved through the First Nations and Inuit Health Branch. Those with a valid Status Card can receive up to 15 counselling sessions **at no cost** per year. Those who are a first or second generation family member of a Residential School survivor may be eligible for more sessions over a longer period of time.

Wallaceburg:

Margaret Myers, RP: 519-627-7655

Sarnia:

Glenn Ethridge, MSW, RSW: 519-466-3005

Jackie Turner, MSW, RSW: 519-346-1368

Chris Lindsay, M.Ed., RSW: 226-932-7111

Other community counselling resources:

Walpole Island Social Services

Central Intake Worker, Donna Isaac Day 519-627-6027

Chatham-Kent Community Health Services

(Offices in Wallaceburg and Walpole Island) 519-397-5455

Crisis Support

Indian Residential School Crisis Line 1-866- 925-4419

Canadian Mental Health Association Crisis Line: 1-866-299-7447

Appendix D: Recruitment Poster

LOOKING FOR PARTICIPANTS

Would you like to help your community members who are suffering from the effects of trauma?

Have you already been on your healing journey from trauma and are willing to share your story with me?

If you identify as a woman and are part of Walpole Island First Nation, you may be eligible to be part of this research.

- Private one-to-one interviews
- Participation is voluntary and confidential

Hi. My name is Tina Shrigley and I have worked in the community and with community members since 2012 as a counsellor. I am now in school studying to become a Psychologist and will be doing this project as a student researcher for my doctoral studies at The University of Alberta. This research has the support of Walpole Island First Nation Band Office and Walpole Island Social Services. We hope that what we can learn together will help guide a healing plan for the community and will help other counsellors to learn how to best support you in your healing journey.

Interested? Contact Tina Shrigley

519-331-0795 or shrigley@ualberta.ca

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Appendix E: Sample Interview Questions

Groups of Open-ended questions:

Group 1: Getting to know you questions

1.	If you had one week off a month, what are some of the things you would like to do with your extra time?
2.	If you could pick one thing that you wouldn't have to worry about anymore, what would it be? ... What would be the next thing?
3.	In all of your interests or ideas you have thought about, what has puzzled you the most?
4.	What is the most difficult thing you've ever had to do or, is there something you've done that was really hard to do, but you really wanted to do it?
5.	If you could spend two weeks with someone who does a special kind of work, what kind of person would that be?
6.	Describe or draw a picture of either a real person, a spiritual figure, or a fictional character you admire and would like to be like. Use key words to describe the person/character. Feel free to use thought bubbles or speech bubbles.

Group 2: Questions about her own childhood experiences:

1.	In your earliest memories of your own childhood, do you recall any places where you enjoyed spending time - inside places or outside places?
2.	Can you recall any particular activities that you enjoyed in different seasons of the year?
3.	Do you recall any daily routines or weekly routines that you enjoyed or looked forward to?
4.	Were there particular people that you liked spending time with or doing things with?
5.	If you could have taken a magic wand and changed some things about your childhood, what might you have changed?

Group 3: Questions about being an Indigenous woman:

1.	What are some of the best parts of being an Indigenous woman?
2.	What are some of the more difficult or challenging parts about being an Indigenous woman?
3.	When you think about other Indigenous women you know, or have known, how do you see yourself as the same, or different?

Group 4: Questions about her experiences of healing from trauma:

1.	What was your healing journey from trauma like for you?
2.	Prior to starting on this journey, what did you think it was going to be like to heal from trauma?
3.	What are some of the things you found helpful on your healing journey? What are some things that were less than helpful?
4.	What advice would you give to other Indigenous women who are starting their healing journey from trauma?

Appendix F: Pre-Interview Activities

Pre-Interview Activities (PIAs): About your life in general

Please **complete two or more** of the following visual representation activities and bring it to our interview. Please use pens, pencils and preferably colored markers on blank paper. We will begin our interview by having you show me and tell me about the ones you completed.

1.	Draw a diagram to show where your support, or support systems, come from.
2.	Draw a picture or a diagram of a place that is important to you and use key words to describe the parts, or describe what happens in each of the parts.
3.	Think of an important activity that you do. Make two drawings showing a "good day" and a "not so good day" with that activity. Feel free to use thought bubbles or speech bubbles.
4.	Think of a component of your life that is very important for you (for example, sports, money, relationship with a particular person, travel). Make a timeline listing critical times or events that changed the way you experience it.
5.	Draw a schedule for your day, week, or year and use colours to indicate how time is spent. Make a legend to explain the colours.
6.	Think of an important event in your life. Make two drawings to show what things were like for you before and after the event happened. Feel free to use thought bubbles or speech bubbles.

Pre-Interview Activities (PIAs): About your healing journey

Also please **complete two or more** of the following visual representation activities and bring them to our interview. Please use pens, pencils and preferably colored markers on blank paper We will begin our interview by having you show me and tell me about the ones you completed.

1.	Write a list of 20 important words that come to mind when you think about the idea or concept of "healing." Then separate the words into two lists in any way that makes sense to you. Please show me the original single list and the second set of two lists.
2.	Use colours to make three drawings that symbolize how your experience of healing from trauma has changed over time.
3.	Use three colours to make a diagram or abstract drawing that shows what it is like for you to recover from trauma.
4.	Complete this sentence: Trying to do heal from trauma is like…..
5.	Make a timeline listing key events that have changed the way you experience healing from trauma.
6.	Make two drawings: one showing a good day and one showing a not so good day with respect to your healing journey. Feel free to use thought bubbles or speech bubbles.

Adapted from: Ellis, J. (2006). Researching children's experience hermeneutically and holistically. *The Alberta Journal of Educational Research, 52*(3), 111-126.

Appendix G: Example Table Document for Analysis

Story No.	Context: PIA or Interview Question	The story (with some ellipses)	Topic of Story (this is the surface topic)	Key ideas expressed (motivations, beliefs, values, preoccupations)	Possible themes or topics that these key ideas might fit into
1	Q: what was it like for you as a teacher when the program began or when you first came to the school?	…what struck me is, when I was a mentor, …If I came ten minutes late or fifteen minutes late, I didn't think it was a big deal. I thought it was more important that I be a friend to this little girl and read with her. (2)	Mentors coming late	Previously she believed that the value of the program was both the friendship and the reading together	(A topic) Purposes of mentorship program (A theme) Her caring about both the friendship and the reading together at mentor sessions
2	Cont'd	…, it's very important to come when you're supposed to come or when you've said you'd come. I don't remember it being a problem when I was a mentor before, but I see it in the kids: They wait for their mentor, and so that's very important (2)	Kids waiting for late mentors	**What she cares about**: students' happiness It is important to her that the kids be happy and not hurt by disappointment etc.	(A theme) She cares about the program giving students happiness and not sadness (A topic) Mentors coming late as a problem in the program

Adapted from: Ellis, J. (19, March 2016) EDEL 667 Course Handout