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"CREATING CULTURAL SAFETY WITH INDIGENOUS CLIENTS AS A SETTLER  
DRAMA THERAPIST": A HEURISTIC STUDY

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**ABSTRACT**

This research paper accompanies a ten page zine that supports non-Indigenous drama therapists in striving towards achieving cultural safety within their relationships with Indigenous clients. The zine and accompanying research paper document my personal process of cultural learning about Indigenous clients and communities, and my understanding of their potential needs vis-a-vis non-Indigenous care workers. In these documents, I share what I have learned about establishing cultural safety from an Indigenous perspective, and the specific cultural needs of Indigenous clients, whilst connecting my new knowledge within the framework of Western therapeutic ethics. This paper consists of a literature review that discusses Western models of cultural care and Indigenous perspectives on health and cultural safety, surveying the positive and negative efforts that Western systems of counselling and therapy have attempted within Indigenous communities, and highlighting specific ways to reconcile these relationships between Indigenous clients and non-Indigenous therapists. In this paper, I review past research, present the steps of my heuristic process from data collection to analysis and, finally, synthesize my results creatively into a zine.

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## **Introduction**

In this heuristic self-inquiry, I will investigate how I can offer culturally-safe drama therapy to my First Nations, Inuit and Métis clients as a settler. In my preliminary readings, I found that there are cultural and systemic barriers to the effective delivery of mental health services to Indigenous populations in Canada (Howell-Jones, 2005). I was struck with the reality that, although there is a high need for mental health services in the population (Garrett et al., 2014; Howell-Jones, 2005; Kirmayer, Simpson & Cargo, 2003; Stewart & Marshall, 2017; Vukic, Gregory, Martin-Misener & Etowa, 2011), there are few culturally-appropriate services for Indigenous clients, as evidenced by the underutilization of services and high drop-out rates (Garrett et al., 2014; Howell-Jones, 2005; Whaley & Davis, 2007). My research question is: how can I, as a settler, offer culturally-safe drama therapy to my First Nations, Inuit and Métis clients? My secondary question will be: how can I make space for my client's cultural needs and perspectives without engaging in cultural appropriation?

### **A Note on Nomenclature**

The first challenge to this research and literature review is choosing an appropriate term for a group of people who are so diverse in nature, world-view, legal, social and religious systems that to generalize them is inaccurate and reductive. In discussion, policy, and research, however, it helps to have a language that addresses the similarities of these original peoples and their shared values, political concerns, and aspirations regarding settlers (Goforth, 2007; Howell-Jones, 2005).

Aboriginal is most commonly used in the academic and official mainstream language, while the more informal term Native is “so broad as to be meaningless” (Marks, 2014, para. 15; Howell-Jones, 2005). However many reject these terms as they are defined by, and in relation to, the oppressor and the dominant language (Beavis, 2016, pp. xiii-xiv). For



example, “The term Aboriginal obscures the distinctiveness of the First Peoples of Canada — Inuit, Métis and First Nations” (Report of the Royal Commission on Aboriginal Peoples [RCAP], 1996, p. 20). The word “Indian” is now considered a slur, as it is associated with oppressive settler-state institutions and policies and awkwardly preserves the ignorance of the first settlers’ perceptions of Indigenous people of North America/Turtle Island.

The term Indigenous is often used alongside Aboriginal, Native, and Indian (Celeste McKay Consulting, 2015; Stewart & Marshall, 2017). Although it is most often used in international contexts, the word “Indigenous” is becoming preferred as it highlights the similar struggles of groups against colonization and evokes a solidarity across borders. Unlike Aboriginal, it also connotes a historical relationship to the land. The Assembly of First Nations (in Stewart & Marshall, 2017) defines Indigenous peoples in Canada as “comprising [of] three distinct cultural groups: First Nations (status and non-status Indians), Métis, and Inuit” (p. 73).

To reflect the Canadian landscape, I will use the terms Aboriginal and Indigenous, interchangeably, and I will refer to the terms First Nations, Inuit and Métis whenever I am speaking more specifically about these distinct cultural and geographical groups. Sometimes, the colloquial term ‘Native person/peoples’ will be used as well to reflect the self-referencing norms of First Nations, Métis and Inuit people and organisations in Montreal/Tio’tia:ke.

This research occurs on unceded Mohawk territory (known as Tio’tia:ke in Mohawk and Montreal in English) within an Anglophone academic institution (Concordia University), and so will reflect the realities of this Canadian landscape as well as my own intersecting identifiers (race, gender, immigration status), which will be explicitly located within the heuristic process.

## **Defining the Problem: Cultural Oppression and Systemic Racism in Mental Health Care**

In order to understand culturally-appropriate mental health service delivery to Indigenous peoples in Canada, it is important to begin by reviewing the particular contextual situation of these communities so as to understand the geopolitical and socioeconomic realities that make their situation unique. These realities are rooted in a troubled historical relationship between European settlers and Indigenous populations that has been well-documented by RCAP (1996) and, later, the Truth and Reconciliation Commission of Canada (TRC, 2015). This contextualization includes a discussion of how colonization and its subsequent intergenerational effects have had, and continue to have, devastating effects on the mental health and safety of Indigenous populations (Howell-Jones, 2005; Kirmayer, Simpson & Cargo, 2003; RCAP, 1996; TRC, 2015).

One of the many issues plaguing Indigenous health today has to do with land rights and governance (RCAP, 1996). The occupation and misregulation of Aboriginal territories by the Canadian government and displacement of its peoples to isolated, resource-poor areas (disregarding treaties and intertribal tensions), has had many disruptive effects. Besides displacing them from their homes, and creating a sense of loss and disempowerment, this treatment has created an interruption in the social, legal, and knowledge transmission and production systems of many Indigenous communities (Howell-Jones, 2005; Kirmayer, Simpson, & Cargo, 2003; ; RCAP, 1996; TRC, 2015).

Aside from disregarding treaties and Indigenous self-governance, the Canadian government used public systems such as residential schools, Indian hospitals and foster care agencies to separate individuals, often children, from their families in an attempt to “kill the Indian in the child” (Thielen-Wilson, 2012, p. 282) and absorb them into the dominant settler

state (TRC, 2015). Languages were banned and forgotten, spiritual practices and customs outlawed, and familial relations eroded. Many have called this historical relationship a physical and cultural genocide (TRC, 2015). The Truth and Reconciliation Commission of Canada (2015) explains that cultural genocide can be defined by the “destruction of those structures and practices that allow the group to continue as a group” (p. 1). These geographical displacements and disruptions combined with the cultural/linguistic degradation that resulted from the legacy of residential schools, Indian hospitals and the Sixties’ Scoop, caused a discontinuity in the collective identity of Indigenous communities, and the pervasive intergenerational alienation that ensued, continues today (TRC, 2015; Muirhead & Leeuw, 2005; Garrett et al., 2014; RCAP, 1996; Kirmayer, Simpson & Cargo, 2003).

The colonial racism that created these legacies continues to pervade contemporary systems and policies in ways that criminalize Native peoples and undermine their ability to care for themselves and their families/communities. As a result of these institutional aggressions, Indigenous people are still overrepresented in out-of-home care and are removed from their families at an alarming rate (TRC, 2015; Kirmayer, Simpson, & Cargo, 2003). They are more likely to experience a range of psycho-social problems such as mistreatment, addiction and substance abuse, suicide, accidental death, sexual and physical violence, crime, poverty, incarceration and mental health problems (Garrett et al., 2014; Howell-Jones, 2005; Stewart & Marshall, 2017).

Kirmayer, Simpson & Cargo (2003) have found that Aboriginal peoples suffer from most physical health problems at much higher rates than other Canadians;

They have 6–7 times greater incidence of tuberculosis, are 4–5 times more likely to be diabetic, 3 times more likely to have heart disease and hypertension and twice as likely to report a long-term disability. Injuries and poisonings are the main cause of

potential years of life lost; Aboriginal peoples have 1.5 times national mortality rate and 6.5 times national rate of death by injuries and poisonings. (p. 16)

The inequities directly resulting from the legacy of colonization do not stop at physical illness, but include mental health and social welfare issues;

The incarceration rates of Aboriginal people are 5–6 times higher than the national average. In a recent survey, 39% of Aboriginal adults reported that family violence is a problem in their community, 25% reported sexual abuse and 15% reported rape. About 4% of First Nations children were in custody of Child and Family Service agencies in 1996/97. [...] Age standardised suicide rates of Aboriginal youth are 3–6 times the general population. (Kirmayer, Simpson & Cargo, 2003, p. 16)

Despite these alarming numbers, there is somehow a disproportionate underutilization of mental health services and high treatment drop-out rates (Howell-Jones, 2005; Garrett et al., 2014; Whaley & Davis, 2007). The Royal Commission on Aboriginal Peoples (1996) found a lack of services sensitive to Indigenous peoples' histories or that meet their specific needs (RCAP, 1996, vol. 3). Parallel to this inadequacy in mainstream mental health support, the stigmatization of shamanic or traditional healing and ritual processes has deeply disadvantaged Indigenous clients to access and maintain positive health outcomes (Stewart & Marshall, 2017). Howell-Jones (2005) outlines the main challenges to mental health service provision are: the imposition of a biomedical model vs. a holistic model that simultaneously considers mind, body and spirit; an individualistic culture-bound orientation that privileges independence and isolates problems and treats the individual without treating the social and political systems that contribute; fragmented delivery systems vs. an integrated and community approach to mental health service provision; and a lack of knowledge of Aboriginal values and practices and ways of knowing and healing.

Sue & Sue's (2008) *Counseling the Culturally Diverse* also thoroughly investigates the shortcomings of practicing a culturally-bound Western system of helping that is based in claims of objectivity, superiority and scientific rationalism and offers caution about how to expose our biases and avoid enacting cultural oppression. The dominant culture's values of self-efficacy, individuality, personal responsibility and achievement, fail to consider aboriginal values of connectedness, extended family support networks, the effects of colonization on feelings of agency, worthiness, and spiritual health (Howell-Jones, 2005). Sue & Sue (2008) believe that we have "done harm to culturally diverse groups by invalidating their life experiences, by defining their cultural values or differences as deviant and pathological, by denying them culturally appropriate care, and by imposing the values of a dominant culture upon them" (p. 38).

### **Locating the Research**

With any research, especially a heuristic inquiry, it's important to locate the author and context of the research to understand not only the environment from which it is born, but also all of the possible interacting variables that bias its perspective. To begin with, this research is taking place within the anglophone academic institution Concordia University, on the island of Montreal, in the Francophone province of Quebec. This land is unceded traditional Mohawk territory; "the island called 'Montreal' is known as Tiotia:ke in the language of the Kanien'kehá:ka, and it has historically been a meeting place for other Indigenous nations, including the Algonquin people" (McGill University, n.d.). This makes for a complicated colonial landscape from within which I embark on this necessary research.

I, the researcher and subject, am an Egyptian immigrant-settler in my late-twenties, having lived in diaspora almost all of my life, I speak the colonial languages English and French, and no Aboriginal languages. This cultural position makes it challenging for me to

access many Indigenous perspectives. As a gender non-binary queer person of color (she/her, they/them pronouns), I am committed to an anti-oppressive and feminist orientation, that is spiritually-grounded but secular-agnostic. My complex identity gives me a unique perspective on race, gender/sexuality and spirituality.

As a participant in multiple Western systems: therapy, academia, Western research methodology, I am immersed in a Western colonial perspective, and am myself considerably assimilated. I am light-skinned, high-functioning/neurotypical/able-bodied, educated and class-privileged. My research supervisor identifies as “Argentinian-Canadian-Jewish, cis-gendered, educated, middle-income, able-bodied woman with light skin and racialized features” (Bleuer, 2015). I bring to this work my particular perspective and the rich process of learning that I underwent this past year to strive to be culturally-responsible and safe while working with Indigenous clients.

## **Literature Review**

Becoming sensitive to the historical experience of Aboriginal peoples and their ongoing marginalization today is required of care workers who work with Indigenous clients. How do Western-derived psychotherapies talk about multicultural counseling, particularly in terms of Aboriginal peoples? How can the field of drama therapy respond to the call for Reconciliation (TRC, 2015) and do its part to help fill the gap in providing culturally-appropriate mental health services? What can drama therapists learn about cultural safety with Indigenous clients from current models, such as the Maori model of cultural safety (Ramsden, 2002), or Sue and Sue's model of Multicultural Counselling and Therapy (2008)?

In this section, I will explore the concept of cultural safety, borne out of Indigenous health care and research, alongside corresponding Western models of cultural care in counseling and therapy, including Sue & Sue's (2008) theory of Multicultural Counseling and Therapy [MCT], and the North American Drama Therapy Association's Guidelines on Cultural Response/ability in Training, Research, Practice, Supervision, Advocacy & Organizational Change (Sajjani et al., 2016).

### **Cultural Safety**

In the aftermath of colonialism, we are becoming sensitized to the damage that structures of power and government have had, and continue to have, on Indigenous people and their mental health treatment. Cultural biases, stereotypes, values and worldviews formed by mainstream social systems create barriers to health and negatively affect the therapeutic alliance between Indigenous clients and non-Indigenous therapists, as well as help-seeking and drop-out rates for Indigenous clients (Howell-Jones, 2005; TRC, 2015; Ball, n.d.). In the light of these realities, Indigenous peoples need a healthcare service delivery that

acknowledges the post-contact impact on Aboriginal peoples' health and empowerment, and commits to a fully-collaborative relationship based on mutuality and self-sovereignty (Ramsden, 2002; Brascoupé, 2009; Howell-Jones, 2005; Ball, n.d.).

Cultural safety is a concept derived from a Maori model of nursing which came out of conversations between Irihapeti Merenia Ramsden and Maori nursing students about how to provide equitable health care to Indigenous communities in New Zealand (Ramsden, 2002). It is not an easy concept to define as it is both a process and an outcome, based on a subjective sense of safety as defined by the recipient of care, and requiring a ceding of power from care worker to client (Brascoupé, 2009; Ramsden, 2002; Ball, 2009). According to this model, care workers are not expected to become 'competent' or knowledgeable about other cultures because, although competence can help improve the encounter, it does not address any power discrepancy (Brascoupé, 2009). The cultural safety model focuses more on building trust (Ramsden, 2002) than demonstrating cultural knowledge. It requires "the transfer of power from nurse to patient and the renegotiation of traditionally held positions" (Ramsden, 2002, p. 179). Rather than privileging the simple acquisition of skills and knowledges, cultural safety identifies barriers to access that are created by the institution itself, by way of its dominance (Ramsden, 2002).

**Cultural safety in a Canadian mental health context.** This concept has been useful in framing appropriate encounters between Western systems/institutions and Indigenous clients/communities (Howell-Jones, 2005; Smye & Browne, 2002; Brascoupé, 2009). Although it is specific to the Maori and nursing contexts, cultural safety can easily be applied to the field of mental health (Brascoupé, 2009). However, it is important to note that as proponents of this concept, we must be careful not to dilute its meaning by removing it from its original context, and to respect its origins as a political tool for the empowerment and



safety of Maori recipients of nursing care. With that being understood, Vicki Smye and Annette Browne (2002) explored the relevance of the concept of ‘cultural safety’ to inform an analysis of mental health policy affecting aboriginal communities in British Columbia, Canada. They surmised that, having shared a history of colonisation and ongoing marginalisation, the Indigenous communities of Canada can benefit from the applications of this concept to policy and service delivery. The main differences found between these populations was that, generally, the health status of Maori people was better than “Aboriginal Canadians”, due “in part, to the larger representation of Maori in the overall population” and in the political sphere (Smye & Browne, 2002, p. 48).

Indigenous peoples of Canada have created their own models for cultural safety, connoted by the five cultural safety engendering principles: “respecting protocols, personal knowledge, promoting partnerships, engaging in due processes, and having a positive purpose” (Ball, n.d, p. 2-3). Respecting protocols means learning about and respecting local ways of engaging; personal knowledge requires the therapist to be conscious of their cultural perspectives and assumptions, to introduce themselves according to their social locators, and to share about themselves as an offer of trust; promoting partnerships involves creating a collaborative and mutual relationship with the client and within their communities; engaging in due processes means checking in often to ensure that the therapeutic plan aligns with the client’s needs, values and lifestyle; and, finally, having a positive purpose means ensuring real benefits from the therapeutic intervention (Ball, n.d.). In this way, cultural safety is relational and contextual. It has specific goals, measured by the recipient/client and it is outcome-based (Ball, n.d.; Ramsden, 2002), not theoretical.

Engaging in cultural safety requires interventions that foster trust and shift power, such as; flexibility with multiple relationships, acceptance of alternative worldviews,

self-disclosure and transparency, and conducting family and community interventions where possible (Howell-Jones, 2005). Naturalistic healing by land or water is an example of initiatives taken to meet cultural safety (Oulanova & Moodley, 2017). Consistent with the Indigenous symbol of the Medicine wheel, healing must be holistic and factor in the spiritual, emotional, physical and mental aspects of health and wellness (Brascoupé, 2009). The Indigenous healing movement integrates the individual with their family and communities, and promotes “participation in traditional healing and cultural activities, such as: culturally based wilderness camps, treatment and healing programs, counselling in groups, and community development projects” (Brascoupé, 2009, p. 25).

### **Western Models of Cultural Care: Multicultural Counseling and Therapy (MCT)**

It is important to tease out the differences between cultural safety and other models of cultural care, like cultural competence, or cultural sensitivity. While the latter two are based on a respect and acknowledgement of cultural differences with the intention of improving therapeutic interactions, cultural safety provides “care within the cultural values and norms of the patient” (Brascoupé, 2009, p. 7-8) and challenges institutional dominance by “transferring the power to define the quality of healthcare to Aboriginal patients according to their ethnic, cultural and individual norms” (Brascoupé, 2009, p. 7-8).

Due to the fact that it is a much newer concept of cultural care, the literature on cultural safety is still scarce, specific to its original context, and “largely qualitative and anecdotal” (Brascoupé, 2009, p. 7), whilst the research on cultural competence is more available and empirically-based. Cultural safety is fundamentally different to, and not synonymous with, cultural competence. It is rather a “paradigm shift” (Brascoupé, 2009, p. 10), that represents “a more radical, politicized understanding of cultural consideration, [...]based not on knowledge but rather on power” (p. 10).

The attempt to absorb the concept of cultural safety, which is tricky to define and measure, into an already existing body of Western-derived multiculturalism has the undesired effect of washing cultural safety of its political power (Ramsden, 2002). The concepts of cultural awareness, competence, sensitivity, humility, responsibility and appropriateness are helpful to the non-Aboriginal care provider in approaching cultural safety, but they are neither interchangeable nor equivalent to cultural safety (Ramsden, 2002) as they do not explicitly centre the recipient of care. These models still assume the non-Aboriginal service provider's superior ability to become an expert of their client's culture (Brascoupé, 2009).

Multicultural Counseling and Therapy (2008) is a model created by Sue and Sue that expands on the cultural competency model of care. It is defined as "both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process, and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems" (Sue & Sue, 2008, p. 42). The authors find that Western therapy has been guilty of cultural oppression towards culturally diverse clients by imposing its values onto them, thereby pathologizing clients' cultural values (Sue & Sue, 2008). Sue & Sue (2008) show how normalizing Euro-American standards erases and diminishes any other culture that comes into contact with them. Becoming more active, structured and involved as a therapist rather than passive, objective and detached is one example of how to counter this problem and meet the needs of the culturally-diverse client (Sue & Sue, 2008).

Steeped in nationalistic colonial myths about tolerating and accommodating the other (Brascoupé, 2009), multiculturalism continues to frame the liberal Euro-American standard

as normal, invisibilizing the non-European other in a meaningless mish-mash of diversity that obscures important differences between peoples. Furthermore, “by generalizing Aboriginal culture into the wider cultural mix of the modern Canadian state, it diminishes it and marginalizes the specific self-deterministic claims of Aboriginal people” (Brascoupé, 2009, p. 14). According to Brascoupé (2009), what is needed at this time is a comprehensive cultural safety training manual that synthesizes these models into a meaningful guide for the service of Indigenous communities.

### **Western Models of Cultural Care: NADTA Guidelines on Cultural Response/Ability**

This section concludes with a brief overview of how the field of drama therapy has worked these ideas of cultural care into its own Guidelines on Cultural Response/ability in Training, Research, Practice, Supervision, Advocacy & Organizational Change (Sajnani et al., 2016). This document was put together by the Diversity Committee of the North American Drama Therapy Association (NADTA) in an effort to respond to biases and discrimination, and to foster meaningful and just relationships with clients across cultural backgrounds. The main concept promoted within these guidelines is cultural response/ability, which is supported by two underlying concepts; that of cultural competency comprising “awareness, knowledge and measurable skills” (Sajnani et al., 2016, p. 142); and cultural humility, defined as a “process-oriented approach” that is life-long and other-oriented and works to uncover discrimination and bias through self- and societal- analysis of power as well as respectful and collaborative partnerships (Sajnani et al., 2016, p. 142).

In addition to engaging in an other-oriented approach that is reflexive of individual and systemic biases, the NADTA Guidelines call on drama therapists to avoid cultural appropriation (Sajnani et al., 2016). Cultural appropriation is defined here as “a dominant group’s use of the signs and symbols of people who have been systemically oppressed for

personal gain in status or otherwise” (Sajnanı et al., 2016, p. 144-5), different from “the mutual or permitted sharing of symbols and practices between groups” (Sajnanı et al., 2016, p. 145).

The Guidelines require that drama therapists are able to recognize that culture informs all aspects of the helping relationship, including the appropriateness and validity of assessment tools (Sajnanı et al., 2016). One way this is redressed is through actions such as; incorporating the use of languages requested by the client, attempts to deliver service in said language, and willingness to hire translators or “refer out to more qualified individuals or resources” (Sajnanı et al., 2016, p. 145).

The drama therapist is required to take seriously the informed consent process and use it as an opportunity to share detailed knowledge about the treatment process, and the drama therapist’s therapeutic orientation, to empower the client, to make explicit the shared roles and responsibilities, and to gain real consent and collaboration in the therapeutic process (Sajnanı et al., 2016). Informed consent also involves making explicit “the cultural context, power dynamics, internalized privilege and internalized oppression of both the therapist and the client” (Sajnanı et al., 2016, p. 145). Drama therapists must also seek “culturally specific resources” (Sajnanı et al., 2016, p. 145), become aware of barriers to service and recognize their own limitations. They are required to seek consultation and training, and recognize when they must refer their client to a better-equipped service provider (Sajnanı et al., 2016).

It is in these ways that Western-derived models of cultural care such as Sue and Sue’s (2008) *Multicultural Counseling and Therapies*, and the North American Drama Therapy Association’s *Guidelines on Cultural Response/Ability* (Sajnanı et al., 2016) are thinking through the recognition and horizontalization of power imbalances. Centring Indigenous knowledge-creation by incorporating cultural safety perspectives into mainstream Western

services and institutions would be taking this consideration and solidarity one step further towards an actual integration of Western and Indigenous mental health perspectives and practice.

### **Indigenous Healing Methods**

After a slow start, Western counseling and therapies are starting to recognize Indigenous healing and wellness perspectives. Sue & Sue (2008) propose a shift, where “in its attempt to become culturally responsive[...], the mental health field must begin to put aside the biases of Western science, to acknowledge the existence of intrinsic help-giving networks, and to incorporate the legacy of ancient wisdom that may be contained in Indigenous models of healing.” (Sue & Sue, 2008, p. 220). In order to centre Indigenous wellness concepts and avoid a culturally-dominant point of view, this literature review necessarily includes an overview of how Indigenous peoples and their communities have been healing. How can I, as a non-Indigenous settler and drama therapy intern, learn from and incorporate Indigenous perspectives on health and healing without appropriating? This is my secondary question.

Examining the literature, I found many examples of Indigenous healing methods (Goforth, 2007; Kirmayer, Simpson & Cargo, 2003; McCabe, 2008; McCabe, 2017; Oulanova & Moodley, 2017), and calls to non-Indigenous institutions for a collaborative and decolonizing approach (TRC, 2015). A summary of these methods found in Goforth’s (2007) literature review includes; the use of music and movement, humor, story, tradition and ritual/ceremony, encouragement of developing a strong ethnic identity, cultural values and worldview, spirituality, strong contact with Elders and traditional healers, community and family networks. Other sources put emphasis on the arts as a form of self-expression and empowerment, community action and social change (Muirhead & Leeuw, 2005; TRC, 2016; Vivian, 2013).

Practices considered beneficial and reparative by the Truth and Reconciliation Commission (2015) are holistic, connected to land practices and nature, collaborative with healers and Elders, include ritual or ceremony in the process of knowledge transmission and production, and are relational in nature. Kirmayer, Simpson & Cargo (2003) found that Indigenous identity itself can be a protective factor and mental health resource, because teachings about connectedness to the land, people and history, foster resilience. Interventions that are holistic, compatible with Indigenous perspectives, and conscious of historical and systemic oppressions are best (Graham & Martin, 2016). A strengths-based approach is preferred in counseling and therapy (Muirhead & Leeuw, 2005), because focus on resilience over pathology is empowering, validating and likely to produce better outcomes. For Indigenous peoples, these approaches must also “include the maintenance and revitalization of culture,[...] by encouraging artistic expressions and creative ways of knowing and being” (Muirhead & Leeuw, 2005, p. 6).

In the Report of the Royal Commission on Aboriginal Peoples (1996), institutions considered ‘cultural’, which I believe applies to the North American Drama Therapy Association, are asked to “to safeguard Aboriginal heritage from misappropriation and misrepresentation; conserve and revitalize Aboriginal languages; enhance the presence of Aboriginal people and cultures in the media; and support the literary and artistic expression of Aboriginal people.” (p. 549). Furthermore, training in Indigenous health perspectives and cultural exchange must happen at institutional levels: “Training in traditional Indigenous arts, philosophies of mental health and healing, as well as Indigenous practicum sites and guest speakers could all contribute to art therapy graduates having a broader understanding of the Indigenous worldview” (Vivian, 2013, p. 42).

**A brief note on cultural appropriation.** Incorporating approaches from Indigenous cultures is tricky; on the one hand, it normalizes non-Western ways of being and centres Indigenous perspectives, but there is always the risk of cultural appropriation. As an example, the talking circle, “an aspect of the Sacred Circle” (Goforth, 2007, p. 24) has been incorporated into the mainstream in schools, therapies and even businesses, as it creates an atmosphere of equality and connection. However, it was shown that many Indigenous therapy clients believe this kind of “nativizing” of services is unnecessary or offensive (Thomason, 2012, p. 5). Knowing the importance of cultural concepts/items, such as the Medicine Wheel, to many Indigenous Canadians, how can I decide what is exchange and what is appropriation? How can I offer culturally-integrated counseling that incorporates the client’s culture, without appropriating it? I will attempt to answer these questions in my heuristic process.

### **The Position of Drama Therapy**

To conclude this paper, I will look briefly at how drama therapy may be especially suited to deal with the particular experiences of Indigenous clients. Drama therapy is an embodied action process, an experiential approach and a relational medium that allows for the exploration of feelings, narratives and solutions. Indigenous healing and cultural safety call for holistic approaches, and drama therapy might be considered holistic because of the way it incorporates the body, and the creative spirit or ‘soul’. Some Creative Arts therapists have also adapted their services by using natural materials, talking circles and Medicine Wheels (Vivian, 2013), techniques that foster decolonizing processes and build agency, such as Augusto Boal’s Theatre of the Oppressed (Goulet, Linds, Episknew & Schmidt, 2011) and games that increase self-sovereignty, leadership, trust, cooperation and communication (Yuen et al., 2013).



Many creative arts therapists have made parallels between their disciplines and shamanic practices, often claiming to be modern-day shamans (McNiff, 1981; McNiff, 1988; Moreno, McNiff, Schmais, Irwin & Lewis, 1988; Pendzik, 1988). Pendzik (1988) argues that drama therapy is rooted in ritual healing, and would benefit from studying shamanism (p. 90). Pendzik (1988) explores the similarities between drama therapists and shamans, namely in their ability to enter dissociative trance-like states, their belief in worlds of experience, and their similar reliance on externalization, dramatization and improvisation to address health concerns. According to Pendzik (1988), they also share a transcendental power that permeates the “social, personal and transpersonal” (p. 90).

Glaser (2004) also finds that Developmental Transformations’ (DvT) guide figure, its foundational concepts of space, encounter and extraction, as well as processes of shapeshifting, dreaming and journeying, all share much in common with shamanistic practices and perspectives. Both approaches require embodied creative healing and so, it is easy to fall prey to the romantic idea that the practice of DvT, and drama therapy generally, “could be enhanced with shamanic wisdom” (Glaser, 2004, p. 87). However, these exotifying perspectives on shamanism obscure the specificity of Indigenous worldviews and healing traditions, reducing them to tropes and stereotypes for the benefit of a eurocentric anthropological audience.

It is imperative to consider the threat of cultural distortion that marginalized cultures face when being examined and defined this way, through a Western-colonial lens, and then diluted and absorbed into the dominant framework. Unless a cultural exchange is reciprocal, it is likely to be appropriative and harmful. What would it be like if Indigenous traditional healers began calling themselves drama therapists without the necessary qualifications? Furthermore, positioning ourselves as the “modern” version of Indigenous healing traditions is patronizing

and disrespectful. It romanticizes Indigenous religions and customs, feeding it into a colonial narrative that propagates the binary view of Europeans as progressive, civilized people with secular-rational methods and Indigenous peoples as primitive with antiquated and superstitious customs.

Similarly, while Pendzik (1988) asserts how modern shamanism can be beneficial to drama therapy, she does not sufficiently consider the risks of taking concepts out of their culturally-specific context (Jones, 1996). In this way, the author is at risk of universalizing shamanism into a meaningless concept. The word shaman itself has been misappropriated by Western anthropologists and new-age spiritualists from its Asian context and used to describe a variety of healers, including Indigenous American ones (Schmidt, 2010). This is problematic because it washes diverse healing traditions of their own particular names and site-specific histories and forces them together into one colonial concept for the consumption and appropriation of non-Indigenous people (Schmidt, 2010).

When the dominant group lays claim to the ‘intellectual property’ of a marginalized group, it can harm the survival and wellbeing of the latter group. An important statement on intellectual property rights was made in the Report of the RCAP (1996), which I will include in its entirety:

“Intellectual property rights should allow Aboriginal people to control representations of culture and knowledge that belong to individuals or collectives. There has been controversy recently about copyright on oral traditions, legends and songs collected for publication. The search for herbal remedies known to Aboriginal healers continues, and traditional designs are being incorporated in high fashion products. All of these activities raise questions about the appropriate means of protecting Aboriginal intellectual property. In asserting claims to their traditional knowledge,

Aboriginal people are not trying to retreat from the world or make their culture inaccessible to others. In fact, the opposite is true. Aboriginal people are willing to share the wealth of their cultures and are anxious to have their knowledge of the land and environment used for the benefit of all. At the same time, they want to ensure that their knowledge is used appropriately and their identity portrayed authentically. They also want fair remuneration when their intellectual and cultural property is turned to appropriate commercial use. In other words, Aboriginal people want to protect their intellectual property rights” (p. 557).

To conclude the literature review, we have examined the ways in which mental health service delivery to Aboriginal Canadians has been culturally unsafe. We have determined how the literature defines cultural safety and how drama therapy can approach it through both Western and Indigenous models of cultural care, as well as learning about Indigenous healing approaches. As the subject of my self-inquiry, I am interested in discovering how my own dominance and privilege is the barrier to cultural safety and, through this process, develop the ways in which settler drama therapists, can be culturally-safe in their therapeutic interactions with First Nations, Métis and Inuit people.

## Methodology

For this inquiry, I used Moustakas' (1990) 6 stages of heuristic research to explore the question of becoming a culturally-safe (settler) drama therapist. The data reflects ways that the researcher found of approaching cultural safety. The final product of my creative synthesis is a zine that shares my experience of learning to engage in culturally-safe drama therapy with Indigenous clients in an accessible way.

## Heuristic Research

**What is heuristic research?** Heuristic inquiry is a research methodology that attempts to discover the meaning and essence (Moustakas, 1990) of an experience through methods of self-investigation, such as identification, self dialogue, tacit knowing, intuition, indwelling, focusing, and the internal frame of reference. Moustaka (1990) describes heuristic research's primary task as exploring a question or problem that is personally-salient and committing to a thorough and disciplined self-examination of one's "senses, perceptions, beliefs and judgments" (p. 2). In a heuristic methodology, there are 6 phases; these are Initial Engagement, Immersion, Incubation, Illumination, Explication, and Creative Synthesis. Data collection occurs from the Initial Engagement stage to the Illumination stage, after which the Explication and Creative Synthesis stages form the data analysis.

**Rationale.** Writing academic research is very demanding and having explored the violence of Western institutions within my own learning process, I knew early on that Heuristic would be the most appropriate tool for my learning. It was the most accessible to myself and my target audience and, because it placed me firmly within the research, allowed me to delve into my biases and perspectives. In addition, I felt it to be the least ethically-complicated route to take. Research was never a primary motivator for me to begin with, and I was eager to begin my clinical work, which I felt more suited for.

I very much wanted my research to be directly useful and immediately accessible to Indigenous peoples in accordance with Indigenous research values of reciprocity. Initially, I had explored the idea of engaging in an Indigenous method like the “conversational method” by Kovak because it was relational but, since I didn’t have the knowledge or the structural support (in terms of supervisors’ experience, and my own positionality) for it, my supervisor and I acknowledged our limitations as required by the North American Drama Therapy Association’s Cultural Response/Ability Guidelines (Sajnani et al., et al, 2016) and decided that we did not have the combined knowledge to engage in such a process ethically.

After much consideration with my research supervisor, we found that the least harmful methodology that I could use was a heuristic inquiry into my process of approaching cultural safety with Indigenous clients. Out of many research methodologies, it is one of the least objective/rational and seemed to be the most intuitive, connected, and creative. I saw heuristic methodology as a conversation with the self, and understood that to be a process of relationality too. Using a heuristic methodology would limit the potential harm that is inflicted by Western researchers on Indigenous peoples, who often enter communities with a detached and anthropological gaze and neglect to share the results of their research with their participants for the benefit of those communities. The projected benefits and implications of sharing my learning to the field of drama therapy, as well as Indigenous therapy clients, were important.

**Position of the researcher.** I believe that the reasons I was attracted to working with this community are related to my personal experiences as a queer immigrant of color. As an Egyptian, I am ethnically Arab and African. My ancestors were both colonized and colonizing. Adding to this ethnic complexity, I believe that the pre-Arab and pre-Islamic

history of the multiple conquests of Egypt has enhanced my sensitivity to concepts of indigeneity, settler-colonialism and nomadism.

I was also raised in a British schooling system in Kuwait and internalized the values of British imperialism, such as ideas about progress, secularism, privileging the written word, feelings of superiority over brown cultures, and more. Later in life, I worked hard to unlearn some of this conditioning but I also received great privileges in the Commonwealth (and globally) because of this assimilation. During this early formative period, I experienced racism and daily microaggressions from both the Kuwaiti society, of which I was an immigrant and second-class citizen, and from the assimilatory and colonial culture of the British school system that saw my cultural expressions as inferior. And yet, these experiences only entrenched my identity as a proud Egyptian, but made me very conscious at a young age of explicit and implicit racial hierarchies and pigmentocracy around the world.

As a closeted queer and gender nonconforming woman, I felt I had no place in my own home country and, having been an immigrant most of my life, the very concept of home had become elastic and elusive. The impact of these intersecting oppressions and intergenerational colonizations was deeply felt in me; my people and I had lost access to our ancient languages, religions, and ways of life. Furthermore, we had unconsciously replicated colonial systems and adopted viewpoints that were harmful to marginalized Egyptians (black, queer/trans, female) and their African neighbours. Thus, ideas about cultural revitalization and Indigenous resurgence have always been very alive for me, and have fueled my interests in life and towards this research question.

**Validity.** Regarding the question of validity, Moustakas (1990) frames ‘meaning’ as the more important construct. According to Moustakas (1990), “since heuristic inquiry utilizes qualitative methodology in arriving at themes and essences of experience, validity in

heuristics is not a quantitative measurement that can be determined by correlations or statistics” (p. 32). The judgment as to whether the data accurately reflects the experience is made by the primary researcher, who collects, analyses and evaluates the data before clarifying the essential themes of meaning and importance.

This research speaks to the experience of being a novice, being other, and exploring a drama therapist’s personal relationship to power and dominance in the world. In particular, it explores harm and benefit within my helping relationships with Native clients and the application of Reconciliation and cultural safety frameworks to my therapy work.

Anyone involved in therapy-related professions can benefit from the result of this research, from psychologists to nurses, social workers, theatre practitioners, cultural learners, teachers, and laypeople, as my learning experiences will be creatively synthesized and expressed in the form of a zine.

### **The Stages of the Process**

**Initial engagement.** Over the course of my second year in the Creative Arts Therapies Master’s program, I underwent a heuristic process of exploring how to become culturally safer as a settler drama therapist when working with Indigenous clients. The first step, *Initial Engagement*, is where the researcher discovers and encounters a topic of intense personal and social interest to them, and begins to reckon with it through self-dialogue and intuition (Moustakas, 1990). This stage occurred between August and November 2017, and in this step I began to formulate my research question.

In second year of drama therapy training at Concordia, we are encouraged to establish our own placement with a group of people with whom we would like to work. I was very passionate about working with Indigenous people, especially as a settler, because I felt it was my privilege and duty to give back a little of what I had been afforded. I noticed that there

didn't seem to be any long-standing internship agreements with any Native organisations within my university's placement options. From my experience living in the city, I knew that there was a high need for mental health care in this population, so I began to wonder why.

As a first step, I became curious and began to read. I read a literature review by Howell-Jones (2005) that talked about this institutional disconnection that I had noticed, where the author elucidated many of the barriers that Native people generally faced accessing basic care and health services. After preparing myself with preliminary readings, I sought out the outreach coordinator of one Native organization and tried to get a placement there offering my drama therapy services to whomever could use them. Howell-Jones' (2005) comprehensive study of the positive interactions between non-Aboriginal therapists and their Aboriginal clients prepared me well for my interview with the outreach coordinator as it made me aware of the barriers to service delivery, especially cultural ones. I was greeted with warmth but also a kind of weary skepticism. After all, how many well-intentioned interns just like me had come through their doors offering help and then disappeared after getting the hours they needed for their degree. I validated those sentiments and talked about what I could offer, speaking sincerely of how much I didn't know and wanted to learn. I promised to do the work on myself and get the necessary culturally-respectful supervision.

Through my readings about this population and the context of their colonization by European settlers and their descendants and institutions, I understood that trust would be fragile and would have to be gained - never rushed, assumed or forced. This was confirmed during my meeting with the outreach coordinator at the centre, who warned me that my first challenge to overcome would be no-shows and latecomers, since folks here were facing very big life challenges and, not only was I a settler, but a complete stranger to them (A. Rosado, personal communication, 2016). I was asked to consider avoiding the word "therapy"



because it had negative connotations of colonial authority, of prying and pathologizing, and could be a barrier to service delivery (R. Deutsch, personal communication, October 2016). When I was planning the advertisement for my first group, my on-site supervisor challenged my use of the drama therapy term ‘play’ because it could trigger unintended connotations of sexual assault in those affected by Residential School trauma (R. Deutsch, personal communication, October 2016).

One of the earliest advice given to me was to simply attend the centre’s events, sit and talk to people, be seen, be helpful and get to know the community (A. Rosado, personal communication, October 2016). Heeding this valuable advice, I went every week and just sat at a table doodling, and chatting with whomever approached me, sometimes introducing myself first, letting them know who I was and what I did. I got to know people and they got to know me, we shared space and sometimes ate together. In doing this simple, but daunting task at one of the Centre’s suppers, I managed to recruit my first client. This was also an integral part of my learning and fundamental to my research.

Bridging the gap between Native communities and ‘mainstream’ society required a more active effort, because the dominant eurocentric system that I was a part of had created barriers between us. An example of the first of these barriers was the Canadian Counseling and Psychotherapy Association’s [CCPA]’s requirements for supervision. The CCPA is an accrediting body from which many graduates from our program receive certification that helps them find work post-graduation. In addition to a Concordia University faculty supervisor, the CCPA (2019) requires students to find an onsite supervisor who has a minimum of a Master’s degree, four years of clinical experience and membership in a professional mental health association. I was offered supervision with a traditional Mohawk healer who had worked closely with this population for 25 years, but the CCPA requirements

proved a barrier to this very crucial stewardship because he did not have a Master's degree, a colonial qualification. In order to be able to work with this traditional healer, I had to find a co-supervisor who had a Master's degree in order to meet my CCPA credentialing requirements. Even though it was an academic and professional requirement for me, it felt patronising and dismissive of this person's expertise and invaluable perspective. It was one of the many barriers that I had to navigate in creating this placement. In hindsight, I understood that this was likely the main reason why there were little to no existing placement agreements between my university and Indigenous populations; community organizations usually offer little pay and do not draw many people with Master's degrees so students are not able to rely on these organizations for their placement hours.

As it happened, the Native Friendship Centre of Montreal catered primarily to individuals in precarious situations, and I quickly found that I was not qualified to deal with the levels of trauma and basic need (for food, shelter, medical care, etc.) within this particular organization. It also would have been too risky for me, as a student, to depend on it to fulfill my 200 client contact hours for my second year Master's degree requirements, so I had to quickly find another placement. I ended up finding another Native organisation to intern at, but the same problem of supervision came up. Eventually, my faculty supervisor, Jessica Bleuer, helped me to find a Métis supervisor within the university who could co-supervise with my new onsite supervisor.

And so, I had begun my process of cultural responsibility in those early moments of procuring, and preparing for, my internship. I learned how to respectfully approach individuals and communities, how to offer myself and be engaged, and how to notice and acknowledge structural barriers. This rapid and meaningful learning that was happening is what inspired me to choose this as my research topic. I could recognize the value of my

experiences, as a settler navigating the gaps in our societal response/ability to care for Native peoples. I felt strongly about sharing this knowledge with others, for the benefit of the Indigenous people of the land I had settled and also settlers in the mental health profession.

**Immersion.** After this initial engagement process came the *Immersion* stage. According to Moustakas (1990), this is when the researcher lives and breathes the question, seeking it in all aspects of their life, public and private, social and professional, attuning themselves completely to understanding the question wherever it exists. This stage took place over the course of many months between October and February, 2017. As part of this *Immersion* stage, I involved myself completely in all things related to Indigenous peoples, cultural safety, and my positionality as a settler. As I began to dialogue with this topic more deeply, in the *Immersion* stage, I learned that the needs of Aboriginal Canadians included everything from social advocacy, legal aid, land sovereignty and, of course, mental health care that is culturally-safe and does not oppress and pathologize them. This was also one of my *Illuminations*. For the sake of clarity, I will break my Immersion phase into separate categories; social and cultural, academic and professional.

***Social and cultural.*** I immersed myself in the Indigenous cultural scene of Tio:tia'ke/Montreal by attending cultural events such as art exhibits, galleries, pow wows, theatre productions, conferences about reindigenizing/decolonizing spaces and institutions, Indigenous film festivals, street art festivals, marches, protests, vigils. I joined facebook groups and mailing lists to keep current with Indigenous news and events.

I committed to attending as many Native cultural events as I could find and get to know as many people in the community as I could, becoming accustomed to introducing myself and sharing who I was and what I did. It was at one of these cultural events, the annual McGill Pow Wow, that I connected with the coordinator who would become one of my

supervisors at the placement we co-created. These two realizations would form part of my Illuminations; I was able to establish this internship by being actively involved in community events as much as possible, and by being transparent about the real and invisibilized cultural barriers of my work, showing humility and collaboration, readiness and flexibility.

In addition to cultural events, I read short story collections like “Me Sexy” that feature a variety of Native artists representing their own sexualities and reclaiming them from the tropes and stereotypes of the settler-gaze. I watched short films by Native and 2spirit artists during a film festival at my university, and watched plays around town that featured Native actors and/or Native themes. I watched TV shows like *Mohawk Girls* and *Blackstone* that provided so much insight about life on the reserves and the challenges those communities face. At an Inuit art exhibition, myself and other guests were invited to partake in eating raw game, fish and seal that was being offered, as a way of learning about Inuit culture through cultural sharing.

Even further than learning by consuming culture, I immersed myself in personal Indigenous relationships and committed to anti-oppressive action in my own life by utilizing my privileges as a tool for social transformation. One way I did this was by supporting my Native friends; going to their art shows, connecting newcomers to the local Native community, and using my social media platform to highlight Native struggles and concerns and rally allyship.

Another way I engaged in immersion on a social level was through joining a facebook group called *Settlement Reparations for Montreal and Surrounding Areas* (<https://www.facebook.com/groups/settlementreparationsmtl/>), that was initiated by a 2-spirit Inuk person to redistribute wealth directly from settlers to Native people in need. I also created fundraisers for families in need and, on occasion, bought groceries for the homeless

Inuit population downtown. I donated money to help keep ‘The Karihwanoron Mohawk Immersion School’ open, and also to support the #NoDAPL (No Dakota Access Pipeline) movement. These are just some of the ways I was personally and socially immersed in my research topic. I shared many conversations about these endeavours and documented my thoughts and feelings through journalling and drawing.

***Academic and professional.*** During the *Immersion* stage of reading, I prioritized readings by Indigenous authors and researchers in order to more accurately understand their lived experiences and reflect the cultural safety needs of Indigenous people in my research. I understood the particular needs of the population to recur around holistic world-views/practices, opportunities for artistic exploration, safe spaces for spiritual expression, a critical intersectional self-awareness on the therapist’s part, an other-oriented therapist, as well as using ethical models that reflect Indigenous values/perspectives on relationships. These illuminations are all also part of my final results.

As recommended by my faculty research and practicum supervisor, Jessica Bleuer, I completed the San'yas Indigenous Cultural Safety Training Program online, which gave me a factual, emotional and intersectional education regarding establishing cultural safety. I also attended monthly workshops in-house at the Native Friendship Centre of Montreal, such as *How to work with Indigenous youth around gender, sexuality, and sex*. As coursework for my supervision class, I completed cultural responsibility assignments that asked me to locate myself along intersections of power and privilege, to consider my biases and to explore my defenses. I read facebook articles disseminated by Indigenous groups, especially local artists like Dayna Danger, Nina Segalowitz, Lou Lou la Duchesse de Riere, Lindsay Nixon and Adrienne Loon.

**Incubation.** Eventually, I stepped back to allow for the process of *Incubation*. The Incubation stage is where the researcher steps away from the question/problem to allow the learnings to settle into understandings, or reveal themselves as Illuminations (Moustakas, 1990). The researcher no longer sustains the intense focus of the previous stages and detaches from the topic to allow for growth to occur implicitly (Moustakas, 1990). During this stage, I made sure to take care of my needs for space and tranquility. I took vacations with my friends and did not think about my research, or anything serious, at all. I allowed the work that I had done to percolate inside me and consolidate into tacit knowing (1990). I did not return to my work for 3 or 4 months from February to May of that year, 2017.

**Illumination.** Finally, the *Illumination* began in earnest after the termination of my relationships with my first Indigenous clients in May 2017. According to Moustakas (1990), the Illumination stage is the revelation and distillation of important and novel understandings, the clarification of missed or confused realities, and can only happen organically, once the researcher is open to the workings of their intuition. Illuminations are often described as little a-ha! moments experienced by the researcher about their topic. For me, this period of Illumination continued developing up until January 2019. It took a long time for me to write this part of the research, especially because I was dealing with many personal challenges at the time. Therefore, this stage took the longest time to complete and proved the most difficult. During this long period, however, I became deeply conscious of the knowledge I had collected and absorbed in my body, and began to collect my illuminations.

Post-incubation stage, I realized that my learning had entered immediately into my work and was validated by the feedback from my clients and supervisors. Through this process of validation, many things became illuminated for me.

***Boundaries.*** In establishing a therapeutic alliance, I struggled to navigate the Western conceptions of boundaries required of me as a therapist. There is often a conflict between a Western understanding of boundaries vs. Indigenous perspectives on relationships. For example, the Canadian Counselling and Psychotherapy Association (CCPA) guidelines on dual relationships restricts the therapist from engaging in multiple relationships with their client. The North American Drama Therapy Association's Code of Ethics (NADTA, 2019) similarly encourages therapists to avoid dual relationships whenever possible. This is for the sake of having clear lines and defined roles between therapist and client. However, I quickly learned that in Native communities that I was working in, there was an expectation to be involved in the community, to attend social or public functions outside of the therapy office, to be present and seen, to be willing to help out or volunteer with other tasks, and to create a sense of collaboration and power-sharing rather than the distance that Western therapists are encouraged to maintain between themselves and their clients. These multiple relationships were a way to build trust as a settler; to demonstrate my willingness to help in whichever ways were needed, and to show up in the community and be vouched for. This was part of the humility lesson I was learning, because it humanized me as a settler therapist and mitigated the colonial separation between myself and my clients.

***Professional neutrality.*** Another difference in boundaries between Western therapies and Indigenous wellness perspectives is the concept of professional neutrality. Through my heuristic process, I learned that Indigenous therapeutic perspectives acknowledge the vulnerability of the therapist more than Western therapies might. I understood the latter to prefer a more detached, blank-slate therapist. However, I learned through client and supervisor feedback, as well as my online training and readings, that a therapist whose stance

is authentic, humble and discloses often is more suited than one whose stance is neutral, ‘professional’, and authoritative.

I used disclosure often and with clear decolonizing intentions; to identify and socially locate my relationship to power; to model vulnerability and demonstrate humanness, to establish trust by demystifying the therapist, and in order to explicitly acknowledge structures of power and oppression in the client’s life. In my perception, Western perspectives seemed to have more boundaries around the therapist sharing freely of themselves, especially around our own healing journeys. This being said, the North American Drama Therapy’s Cultural Response/Ability Guidelines encourages drama therapists to be transparent about power dynamics and social identities in session (Sajnani et al., 2016).

***Colonial vs. Indigenous health perspectives.*** I found that there are cultural biases in mainstream health perspectives that differ from Indigenous perspective. For example, in my experience as a Middle Eastern immigrant, Western societies tend to privilege individualism/independence, secularism, scientific rationalism, and capitalist ideas of efficiency and productivity. These cultural assumptions are also discussed in the literature (Howell-Jones, 2005; Sue & Sue, 2008). Whereas, within Indigenous healing perspectives, relationships are the site of healing, and the measure of health is connection to the land, and living in harmony with each other, and with animals, plants, rocks and all life (Garret et al., 2013; M. Standup, personal communication, October 2016; Stewart, Moodley & Hyatt, 2017; Vivian, 2013). Healing must also be decolonial, since negative health outcomes in Indigenous communities are associated with the intergenerational effects of colonization (TRC, 2015; RCAP, 1996). For this reason, there is a higher focus on community and family interventions in culturally appropriate Indigenous health models (Stewart, Moodley & Hyatt, 2017). Working with community and family are ways to counter the disruptive effects of residential



school abuses on families and communities (Goforth, 2007). Gratitude and connection to spirit are fundamental to Native perspectives on wellness and relationships, as I learned during multiple workshops and in supervision with Indigenous supervisors (M. Standup, personal communication, October 2016; R. Deutsch, personal communication, October, 2016).

***Systemic barriers to therapy.*** In my process, I explored many structural barriers to care; some were socio-economic barriers, some were linguistic. I learned to bring food to session, or to give services in French (my weaker language) as a way of overcoming these barriers and increasing access.

I experienced a lot of clients struggling to be on time, often not showing up to session. I found this difficult because I depended on my clients for hours and so the stress of my academic/professional requirements was affecting the quality of my care, and cultural safety. It seemed that Western therapeutic boundaries around time were related to a capitalist colonial cultural bias. I had to work around the strict expectations of Western therapies around respecting the therapy hour. I worked hard with my clients to negotiate these boundaries and eventually decided on a 30-minute grace period in which clients were able to come to session 30 minutes late and have their session extended by a corresponding 30 minutes. This was one way that Western boundary norms clashed with Indigenous norms, and how I approached it from a cultural safety perspective.

***Advocacy.*** Cultural safety requires an engagement in advocacy work. Therapists must be involved in activism and community work also, otherwise we are only helping our clients to get used to an oppressive situation. I found that the settler therapist's cultural safety work is not limited to the therapy space but all of the institutions and structures involved in the

delivery of care. I learned to use my privilege where I could, to change the systems that oppress my clients.

***Healing vs. helping.*** Settler therapists working in Indigenous communities are expected to be on their own healing journey. Colonization didn't just hurt the colonized, but also the colonizers, and it is believed that both need healing from its aftermath (Jessica Barudin, personal communication, November 2016; Provincial Health Services Authority in BC, n.d.). I learned through supervision at the Native Friendship Centre of Montreal the idea of helping, even the word "therapy", has unfavorable paternalistic connotations. There is an inherent power imbalance in it of helper-helped and it empowers the dominant framework. Whereas, "healing" is a term preferred in Indigenous circles, and I was asked to consider this when creating my first group (R. Deutsch, personal communication, October 2016).

***Cultural Appropriation vs. integration.*** There is a fine line between cultural appropriation and integration. It is hard to know this line and after the research is done, I still don't have a clear answer on this topic. In an effort to stay true to Indigenous principles and connection to nature, I used a lot of plant matter, rocks, branches, and other natural materials in my therapy. I received a lot of positive feedback from clients and Native supervisors about this choice so I understood it to be appropriate. However, in my readings, authors warned about the risks of "nativizing" services; it was seen as unnecessary and condescending (Thomason, 2012, p. 5). This must be a constant conversation to consider, and therapists should consult with elders and supervisors, as well as checking in with clients about their specific needs. For example, the literature often mentioned that using the Medicine Wheel as a pan-Indigenous holistic healing tool is beneficial (Ball, n.d.; Brascoupé, 2009; Goforth, 2007; Howell-Jones, 2005; McCabe, 2008; Vivian, 2013; Vukic et al., 2011). However, when I used it with an Inuk client, they expressed that it had no meaning to them and was not part

of their cultural perspective. Instead, I reoriented to the client and asked them if there was a similar tool or perspective within their own culture that we could use instead.

Another example that came up in my work was the use of masks. I had innocently assumed that using masks would be an appropriate dramatic intervention to include in my work with Indigenous clients. After reading and speaking with elders and supervisors, I learned that in some Indigenous cultures, masks are sacred and only certain people had the right to make them and use them at specific times during specific rituals (M. Standup, personal communication, October 2016). I had to reconsider the assumption that masks were an innocuous drama therapy tool, and become more careful about how and with whom I offered them as an intervention.

Another important consideration is simply acknowledging the limits of Western therapy, and knowing that it is not a failure to refer clients out to Native healing services. As drama therapists, we are not “shamans” (McNiff, 1988; Pendzik, 1988), and there is a real danger to confusing the two, and diluting the latter’s culture specific heritage. Naming and making explicit our bias as a Western-derived tradition is important, and a necessary part of cultural humility. There is much wisdom and validity in what our discipline can offer clients if we are power-conscious and humble about it, and ensure that we don’t romanticize and absorb other healing traditions.

**Explication.** This penultimate section called *explication* is where the research organizes and analyzes the data according to their internal frame of reference. The researcher uses the tools of focusing and indwelling to delve into the Illuminated qualities or themes, paying close attention to any subjective perceptions that give personal meaning to the findings. The researcher then “explicates the major components of the phenomenon, in detail, and is now ready to put them together into a whole experience” (Moustakas, 1990, p. 16).

**Data collection.** This process began by reading and learning the literature on the topic and then immediately applying what I learned in my therapy work with clients, and in supervision. After every therapy session, supervision session or class, and at every workshop or event, I would journal my thoughts and learning. I would write about my defenses, my mistakes and the things that worked well. I would have conversations with friends, peers, and community members about our learning and share important information. I documented all of my activities and understandings, in writing or video journals and often, as artwork.

My data collection consisted of: the literature review that I conducted, plus one year's worth of journaling and self-dialoguing work (in the form of journals, artwork, conversations, supervision notes, flyers/pamphlets), academic investigations in the form of cultural responsibility assignments, and exposure to various models of cultural care (through academic articles, multiple workshops on the topic of culturally-specific care, and 6 months of online cultural safety training mentioned previously).

**Data analysis.** At the very end of my data collection process, I began the analysis part of the process. The data analysis consisted of reading through all of my data and organizing it into similar sections. After sectioning my findings into groupings or major ideas, these groupings of ideas became my emergent themes. In total, I found fourteen overarching themes that encapsulated my findings. Major themes that I found to be heuristically meaningful were:

**Critical self-reflection.** Within this theme are considerations of the therapist's social identifiers and the necessary process of self-reflection, as well as recognition of the systems and traditions that the therapist is working within and how to ensure that these don't replicate historical and systemic transgressions within the therapeutic relationship (Sue & Sue, 2008; Howell-Jones, 2005; Ball, 2009; Ball, n.d.; Collins & Arthur, 2010; TRC, 2015; Hook et al.,

2013). This includes doing constant work to assess privileges, acknowledge defenses towards this self-reflection process, and mitigating the therapist's power over their client (Jessica Bleuer, personal communication, January 2017). I found this to also include being flexible and reworking interventions to fit the client's values and perspectives.

*Decolonizing health perspectives.* This theme recognizes the cultural bias of Western medical traditions and the need for decolonizing perspectives on health (Nuttgens & Campbell, 2010; Howell-Jones, 2005; Sue & Sue, 2008; McCabe, 2017). A common thread throughout the literature and heuristic process was the importance of collaborating with clients (and their communities) to centre and achieve their own perspectives on wellness (Howell-Jones, 2005; Nuttgens & Campbell, 2010).

*Informed consent.* This theme summarizes the continuous process of checking in and sharing knowledge that is required by the therapist to ensure the therapeutic process is consensual and that the client understands what they are undertaking, knowing also that they have the right to stop or adjust the process at any time (Sajnani et al., 2016).

*Supervisor/peer support.* This theme is about the importance of supervisor and peer support to keep the therapist supported and honest in their work, and to catch transferences and cultural assumptions before they become problematic or interfere with the work.

*Collaboration with Native elders and communities.* In order to do decolonial work, a settler therapist must be working under the mentorship and shepharding of the communities within which they work (Sue & Sue, 2008; Howell-Jones, 2005; RCAP, 1996). This includes being in contact and collaboration with Native elders, so that the therapeutic goals and interventions align with Indigenous values and lifestyles. This shepharding process is also important for cultivating humility as it ensures that the therapist directives are coming from a place of solidarity and cultural empowerment.

*Advocacy outside the therapy space.* This theme talks about the necessary work of the therapist outside the limits of the therapy session. In a decolonizing process, I found that it is not enough to see the work as limited by work hours, but to understand the work as systemic and requiring social advocacy. Otherwise, the therapist will always question whether they are empowering the client, or just helping them to adjust to an unjust and systemic situation. The settler therapist has significant privilege and power to push back against colonial processes and so, must engage in this often. This action is intended to demonstrate solidarity and trustworthiness, but also to avoid profiting off of the pain and systemic dependence of our clients. It is within the requirements of cultural safety to make safe all of the institutions and processes we ask our clients to enter into (Brascoupé, 2009; Ramsden, 2002). This is, of course, a lifelong process.

*Nurturing personal relationships with Indigenous people.* This theme is about nurturing the therapist's personal life in a way that it aligns easily with their cultural safety work with clients. If a settler does not have any personal relationships with Indigenous people, then how can they be expected to work closely and justly with Indigenous clients and communities? To build genuine understanding and familiarity, the relationship to Indigenous world-views cannot be solely professional. It may be seen as patronizing and/or predatory if the only relationships you have to Indigenous people is through your helping profession. The more a therapist is in frequent connection with Indigenous individuals and communities, the easier their work will reflect this closeness and camaraderie. This will also help to be more familiar with various points of view that the settler may otherwise have no access to because of their inherent power and cultural blindspots.

*Participation in Native culture.* This is about supporting Indigenous arts and events, and the general growth of communities. As therapists, we need to orient our stance towards

cultural empowerment of our clients, and we do this by offering ourselves as witnesses, as cultural consumers, patrons, and guests. This means attending plays, shows, Pow Wows, and anything that is open to the public, or where you have been invited. Respectful participation requires invitation, and self-reflection on the part of the settler about how much space they are taking and how they can best support these cultural expressions. For example, this could look like giving up your seat to a Native elder so that they can see better or sit comfortably. Or, if there is food offered, going last and not having a second helping until everyone has eaten. These are ways to be considerate and thoughtful about your power and entitlement.

*Continuous cultural learning.* This is a lifelong process, but also a stance. This theme is about the idea that, as a settler, you will never know everything and can always cause harm. Even the most well-intentioned person can hurt another, so it is important to not centre your intentions, but your ability to be humble and listen, or repair. You must always be learning about your clients and communities, keeping up to date on best practices and maintaining a process of self-reflection and accountability. You also must share the knowledge you are given to other settlers and be responsible for settler society and how it interacts with Indigenous society.

*Spirituality.* Spirituality is a necessary part of Indigenous healing (Howell-Jones, 2005), but it is tricky for settler therapists to engage in because of two reasons; Western medical systems were born out of scientific rationalism and privilege secularism to such a degree as to pathologize non-scientific expressions; colonial religious institutions such as the Christian Church have done much damage to Indigenous spirituality and deeply stigmatized and criminalized them (RCAP, 1996; TRC, 2015). For traditional spiritual needs, the therapist must be in connection with Indigenous healers and medicine-people so as to refer clients out (Sajjani et al., 2016; Vivian, 2013). Otherwise, the therapeutic process must be holistic and

engage the mind, body and soul in order to achieve a sense of spirituality that is non-specific but respectful of Indigenous perspectives. This can be through co-creating rituals, connecting to the land and nature, and recognizing plants and animals as having sacred healing functions. For example, although it is not appropriate for a settler drama therapist to use sage to smudge the room, it is important to ensure that the client is permitted to burn their healing herbs in the space (Oulanova & Moodley, 2017).

*Cultural appropriation vs. exchange.* This theme is about the limits of culture and how far cultures can be shared. The therapist considers how to create cultural safety and diminish the dominance of their own culture within the therapy space, whilst ensuring that they are not attempting to borrow, misuse or dilute aspects of the client's culture. This line is not easy to define and requires constant collaboration and conversation with friends, peers, supervisors, elders, communities, and most importantly, the client.

*Relationship to the land.* This theme is about how to connect therapy to the land as a way of countering the disembodiment of settler society to the natural space they inhabit. Therapeutic activities that foster a harmonious and mutual relationship to land and nature are in alignment with Indigenous values and community goals (Howell-Jones, 2005; Oulanova & Moodley, 2017; Vukic et al., 2011). Offices are a sterile environment that can feel restrictive to Indigenous clients, so taking them outside of the office can be beneficial to connecting with the land and nature. This, however, brushes up against a lot of Western therapeutic teachings and requires some thinking through.

*Boundaries.* This theme talks about relationship boundaries and the boundaries of the therapy space. Indigenous perspectives on relationships are fundamentally different to Western approaches. In supervision, I explored this theme at length and noticed that in Western systems, labour tends to be divided and hierarchical, and roles are defined strictly by



function. I learned through watching and participating (and supervision) that Indigenous communities view this division as colonial and contrary to their own world-views about mutual relationships and the oneness of all life (E. Fast, personal communication, January 2017). Within the latter's relational perspective, therapists are asked to socialize at community events and participate as a way of being perceived as a part of the group, and as humble and equal to others (A. Rosado, personal communication, October 2016). This teaching was often in opposition of the training I received that asked me to remain in-role and avoid dual relationships so as not to have conflicts of interest.

*Language.* This theme asks the therapist to be aware of language as a barrier to access, and to offer services to clients in the language of their choice (Sajani et al., 2016). If this is not possible, then the therapist should refer out to someone who can (Sajani et al., 2016).

**Creative synthesis.** After I found and organized the major overarching themes of importance in the explication section, I synthesized them in the last stage of the heuristic process: the *creative synthesis*. The *creative synthesis* is the final stage of heuristic self-inquiry, where the researcher transmutes all of the knowledge gained into a creative product, be it a story or poem or artwork, that uses verbatim material. I decided to create an instructional zine in order to share my knowledge in an educational and transformative format that weaves the tools of creative expression into the learning and publishing process (see Appendix).

A zine is a self-published and informal mock magazine that uses text and images to explore a topic or experience. I was drawn to the medium of the zine because it allowed for a more immediate, informal and creative way to disseminate information and points of view. With its history in punk and feminist scenes, zines are inherently political because they are easy to make and to distribute, and usually free or affordable. They are usually popular in

progressive and alternative circles because of this accessibility and (do it yourself) DIY aesthetic. I felt this would be a creative and compelling way to synthesize and present complex information in a direct, non-jargony way.

My aim was to be useful to Native communities and comply with their research values of reciprocity. This zine was how I could play my role in supporting other settlers to engage in a conscientious process that strived to do right by their Native clients. The goals of the zine are to introduce the topic of cultural safety and why it is needed in Canada, how it is different from Western-derived forms of cultural care, what principles and practices I found to be heuristically significant, and how to consider cultural appropriation in your work.

The final product of the zine begins with a section introducing who I am and locating myself as the researcher. Then it summarizes the existing Western-derived models of cultural care that I discussed in my paper; cultural awareness, cultural sensitivity, cultural competence, cultural humility, and the North American Drama Therapy Association's concept of cultural response/ability. The next section defines cultural safety and how it is different from the previously-mentioned models (similar to the description in the literature review section of this paper). After that, I briefly outline why it is necessary at all, and how it relates to the Canadian context. Next, I present my findings, which are the cultural safety principles and practices that I found to be heuristically-meaningful. On the following page, I explain how I discovered these findings through heuristic inquiry. I then dedicate a page to presenting how drama therapy is well suited to culturally-safe therapeutic intervention with Native clients. The last section of the zine talks about the dangers of cultural appropriation when attempting to nativize services. I end with a small bibliography to point my audience towards further reading.

## **Findings**

In this section, I will present my results under two categories: the findings that are validated by my literature review, and those that either are absent or divergent from the literature review.

### **Findings Supported by the Literature Review**

Recommendation 1: Indigenous clients and communities require a culture-specific approach that is in accordance with their values and the promises of Reconciliation between settler society and Indigenous communities. There is a lot of distrust in this population towards settlers, and towards colonial institutions, because of past institutional oppression and erasure; gaining trust is especially important for a settler therapist, and without it no relationships can form or last (Ramsden, 2002).

Recommendation 2: Humility is integral in building trust, and is practiced by various methods: through allowing dual relationships (Howell-Jones, 2005); using disclosures to redress power imbalances and to identify the therapist's intersectional identities; through acknowledgement of oppressive systems (Howell-Jones, 2005); through repair when harm has been done in-person or historically; through the stewardship of local Native communities (Howell-Jones, 2005; Vukic et al., 2011); by being client-centred and positioning the client as expert of their own life and wellness; and, by positioning the therapist as perpetual learner rather than expert authority.

Recommendation 3: Creative arts offer a decolonial approach to healing that can bridge the gap between Western and Indigenous healing perspectives (Goulet et al., 2009; Muirhead & Leeuw, 2005). Art can build community, resilience and creative expression (Episkenew et al., 2013; Goulet et al., 2011). It can also support agency and self-sovereignty,

communication and improved relationships (Episkenew et al., 2013; Goulet et al., 2009; Goulet et al., 2011).

Recommendation 4: Therapeutic goals must be set in collaboration with clients so as to avoid imposing culturally-biased assumptions of health onto the client. It is important to work with the elders, families and communities of the client in doing so, in order to understand the values and lifestyles of the client and how best to support them to achieve their goals in accordance with their cultural perspectives on health and wellness (Howell-Jones, 2005).

Recommendation 5: The therapist needs to critique their Western-derived assumptions about mental health to ensure that they do not impose their cultural assumptions onto the client (Ramsden, 2002). For example, Western cultural perspectives might privilege independence more than some other cultures (Sue & Sue, 2008). Consequently, Indigenous clients that are more relationship-oriented could be pathologized as codependent rather than understood to be part of a collectivist culture. Another example of this is how Western society privileges secular and scientific rationalism (Vukic et al., 2011). This could lead to mislabelling our clients as psychotic or uneducated when, in fact, Indigenous perspectives hold their own legitimate explanations of natural and spiritual phenomena. This mislabelling could be the result of a colonial belief in the superiority of European civilization and thought, and is seriously damaging to our clients and their cultural safety.

Recommendation 6: Critical awareness of colonial systems and systemic oppression is part of the therapist's work, without which we risk pathologizing the client instead of recognizing systemic and intergenerational causality (Goulet et al., 2009; Sue & Sue, 2008). This does cultural harm to our clients and places the onus for change on them, instead of on society. Instead, we should recognize social determinants of health and the systems that

maintain ill-health in Native clients, empowering these clients to resist internalizing their oppressions.

### **Findings Supported by the Heuristic Process and Working with Clients**

Recommendation 1: I found that boundaries around time must be flexible to allow clients to attend sessions without being pressured by linear Western-capitalist standards of punctuality.

Recommendation 2: It is helpful to offer healthy sustenance as a way to counter systemic difficulties accessing healthy food. This should include checking for allergies first and avoiding common allergens such as peanuts.

Recommendation 3: In my experience, it is crucial to learn culturally responsive protocols for how to deal with colonial institutions like child welfare and police and also learn protocols for suicidality.

Recommendation 4: Despite the fact that past research finds nativizing services to be potentially risky and appropriative (Thomason, 2012), I found that, in my clinical work with clients, it was helpful to :

- a. Make the therapy space warm and welcoming, rather than sterile, clinical, or academic. This could mean moving tables and chairs out of the way and sitting on the floor. Or, having bright colors and plants instead of white walls and empty space. I found this out when I used an office space to work; my clients were more agitated, whereas when I used a space that was more informal and less office-like, my clients expressed contentment and said they preferred the latter space.
- b. Incorporate natural materials into the therapy to soothe the nervous system and connect clients to the land, the natural world and its seasons (Vivian,

2013; Vukic et al., 2011). This could mean using colored leaves in fall, or bringing different stones in to session as objects to use. Clients especially enjoyed this and often told me directly. I also learned this in supervision with Cathy Richardson (personal communication, January 2017). Having access to the outdoors is a great benefit as it helps clients feel connected to the land they are on and counters the institutional and colonial atmosphere of a traditional office (Oulanova & Moodley, 2017).

- c. For groups, it makes a lot of intuitive sense to sit in a circle as it inspires collectivity; is a connecting shape that forms cohesiveness and helps with group bonding. In my clinical experience, I noticed that groups were more able to participate in the therapy when we sat in a circle.

Recommendation 5: An authentic and informal disposition is crucial to building trust and a strong alliance with clients (McCabe, 2017). This means to avoid jargon and an expert or authoritative stance. It also means to use everyday language and expressions, mirroring the client's choice of language and expressions/colloquialisms.

Recommendation 6: It is important to advocate for your clients and their communities outside of sessions, and to use your privilege for their empowerment. This is to avoid desensitizing them to their systemic oppression and unnecessarily pathologizing the individual.

Recommendation 7: I found drama therapy to be an excellent medium for healing because it incorporates the body and therefore, is more holistic than other therapies, and has a direct relationship to the land/space. The body is also the site of trauma and so, it is greatly beneficial to use the body to work through and heal trauma.

## **Discussion**

### **Limitations**

This research has its limitations. The perspective is specific to me, since it was a heuristic self-study. This means it is not objective or quantitative, and the results cannot be verified by repeating the experiment. Even the research subject has changed: at the time of the data collection and analysis, I was still an immigrant to Canada, whereas writing this discussion section, I have been naturalized as a Canadian citizen and must contend with the new responsibilities of that identity and its palpable privileges. The former state made it easier to gain trust, as I was not seen to be as complicit with colonialism, being that I am of color and have suffered Anglo and French colonialism myself, but also because my ancestors were not the ones to create and benefit from the colonial system. However, since this new identity as Canadian citizen is so embedded in Western imperialism, it complicates my complicity and I might have had different challenges and results if I researched the same question again. I will have new challenges as I begin work with Indigenous clients in drama therapy contexts. In other words, the results of this research are specific to a moment in time in the researcher's life, a particular perspective that is now different to where I was when I began this research..

Another limitation of the study is that it is limited to a specific location and cultural situation: Montreal, Canada. Although the literature review is more international and comprehensive, the heuristic exploration focused in on local and Canadian issues. This adds to the difficulty of generalizability.

**Future Avenues for Research**

Having completed this process, I still have questions about the risks and benefits of nativizing services. It would be fruitful for settler therapists to better understand where the line is drawn between integration and appropriation. It is especially opaque a consideration for settlers, due to our cultural blindspots, so further research on this problem should be both qualitative and quantitative, and/or Indigenous-led.

Finally, it would be beneficial to have quantitative research that assesses the generalizability of the results of this research, so as to add to a steadily-growing interest in Indigenous issues and to further develop a Canadian-specific body of research on cultural safety in therapeutic practices.



## **Conclusion**

Indigenous peoples have suffered too long at the hands of well-intentioned settlers who claimed innocence for their ignorance. It is imperative that therapists align themselves in solidarity with these communities in order to remove barriers for their clients and decolonize their services. There have been so many documents written and persistent attempts made by Indigenous communities, both global and local, for Reconciliation and decolonization (or, reindiginization) and creative arts therapists need to meet these needs sincerely and courageously. If we consider ourselves to be helpers or carers, then we cannot stand by while Native youth continue to take their lives because of our society's apathy, ignorance and sloth. The time for justice and transformation is now. I will end this paper with a quote from activist Lilla Watson that says; "If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together" (as cited in Leonen, 2004).

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## Appendix

## Cultural Safety Zine

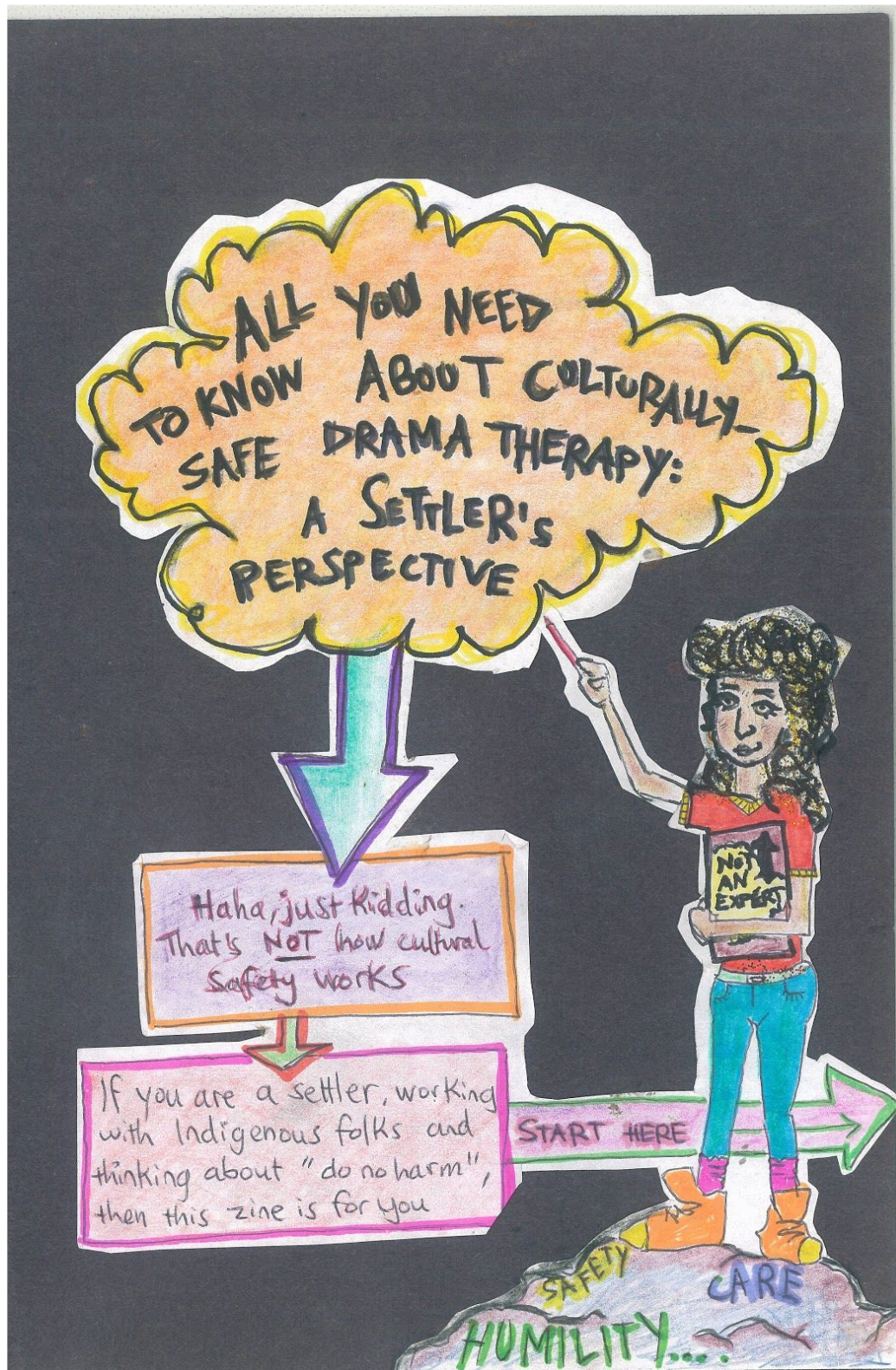
*Figure 1.* Front cover.



Figure 2. Page one.





Figure 3. Page two.

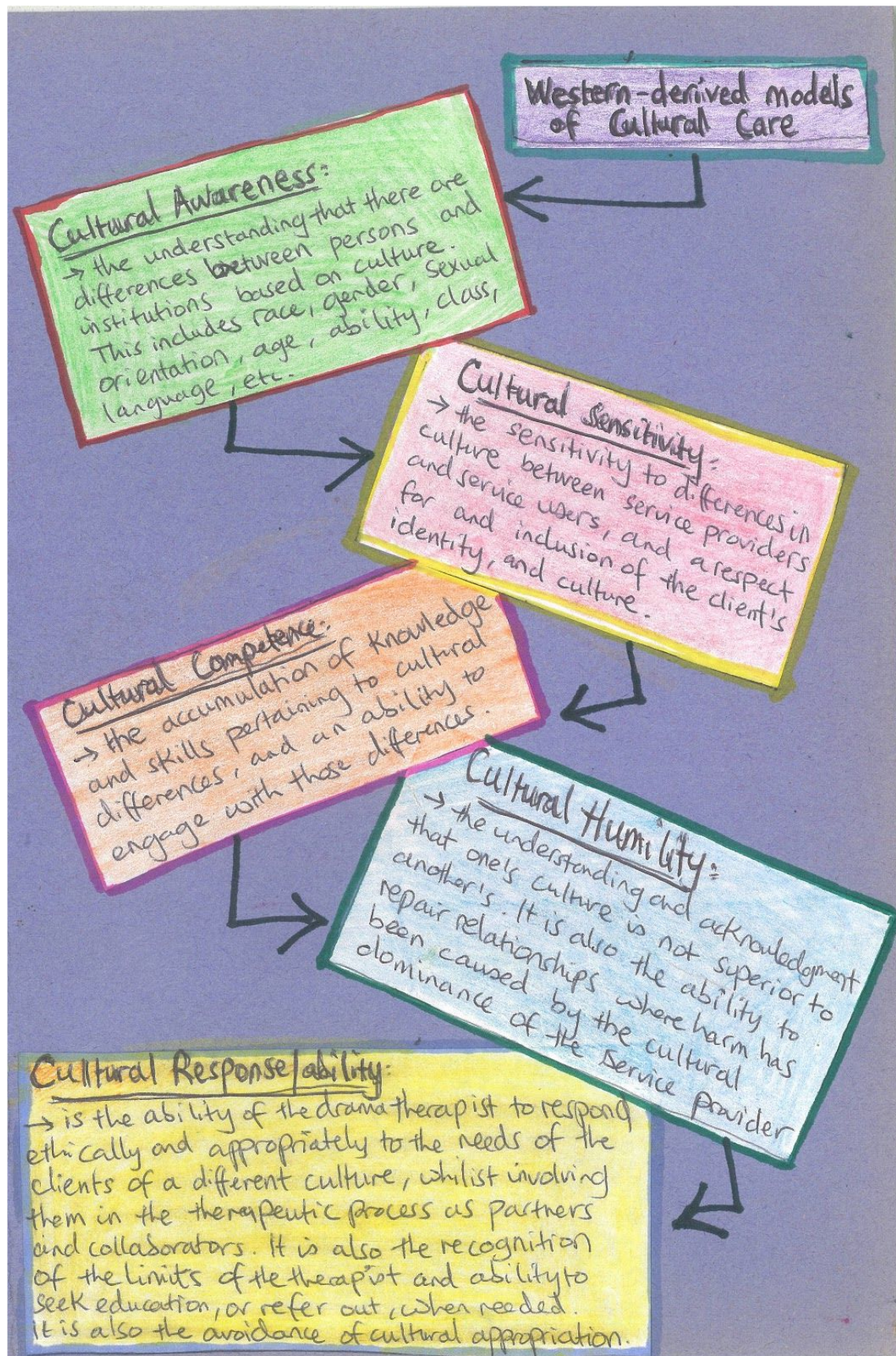




Figure 4. Page three.

**NOTE**

Cultural safety is not interchangeable with these forms of cultural care. It is grounded in Indigenous research & health perspectives. Absorbing or diluting it is colonizing.

Created in 1989 by Māori nursing students who were concerned about the safety of Indigenous nursing students, and their clients, whilst navigating a monocultural (and colonial) health system.

- identifies power relationships
- works to empower the client & diminish institutional & personal power in the service relationship of the service provider.
- It is an ongoing process of critical examination of the service provider's culture
- It is outcome-based, success is measured by the recipient of care.

(Ramsden, 2002)

Cultural safety is a continual learning process

- Therapists must be attuned to noticing and analysing personal and institutional differences, and removing cultural and systemic barriers.
- Therapists make adjustments to service delivery to ensure the client's culture is respected in the therapeutic interaction.
- Checking in and following up with the client ensures quality of service.
- Therapists must be prepared to acknowledge and repair harm that has been caused, personally or historically/systemically.

↓ therapist power = ↑ client safety



Figure 5. Page four.

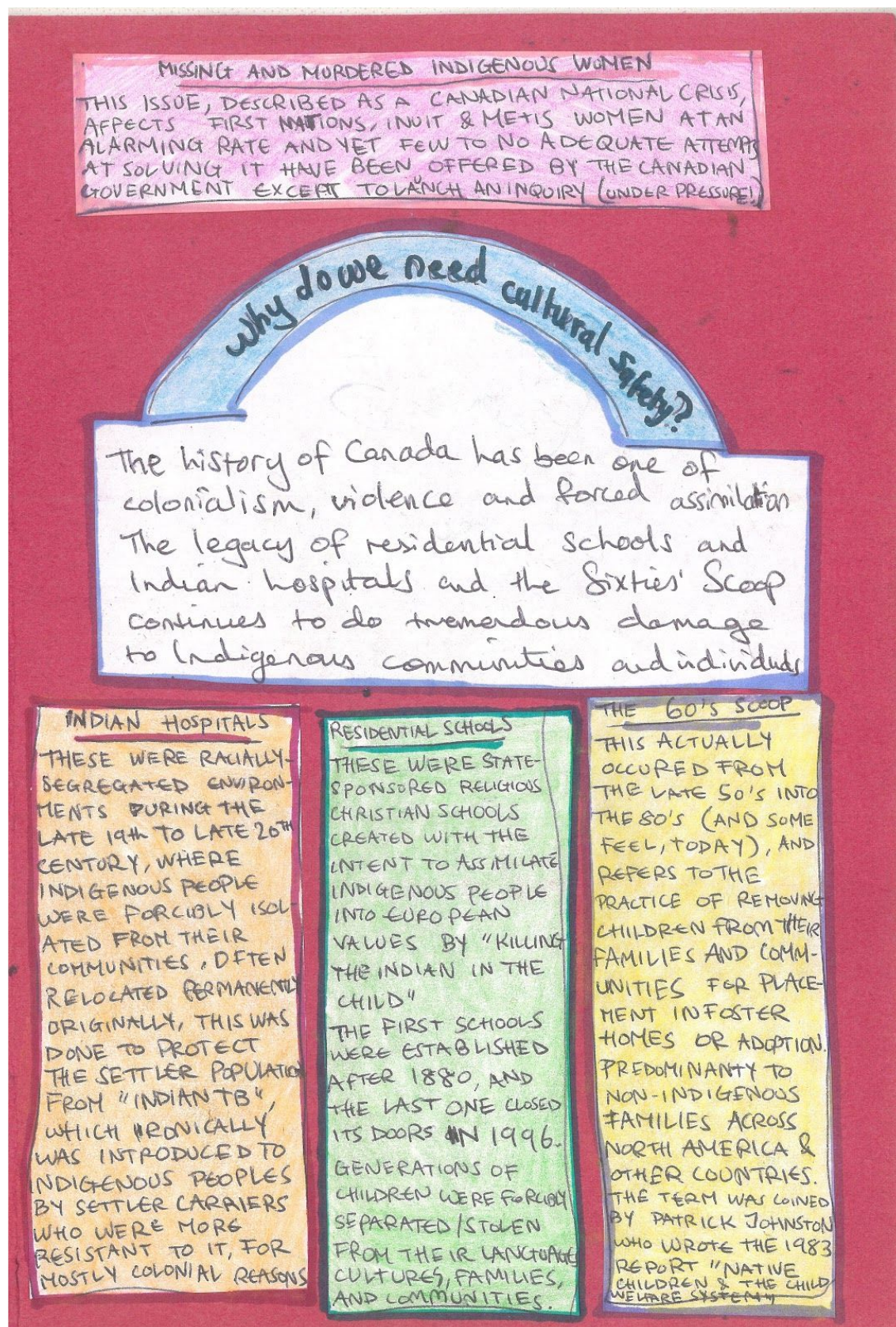




Figure 6. Page five.





Figure 7. Page six.

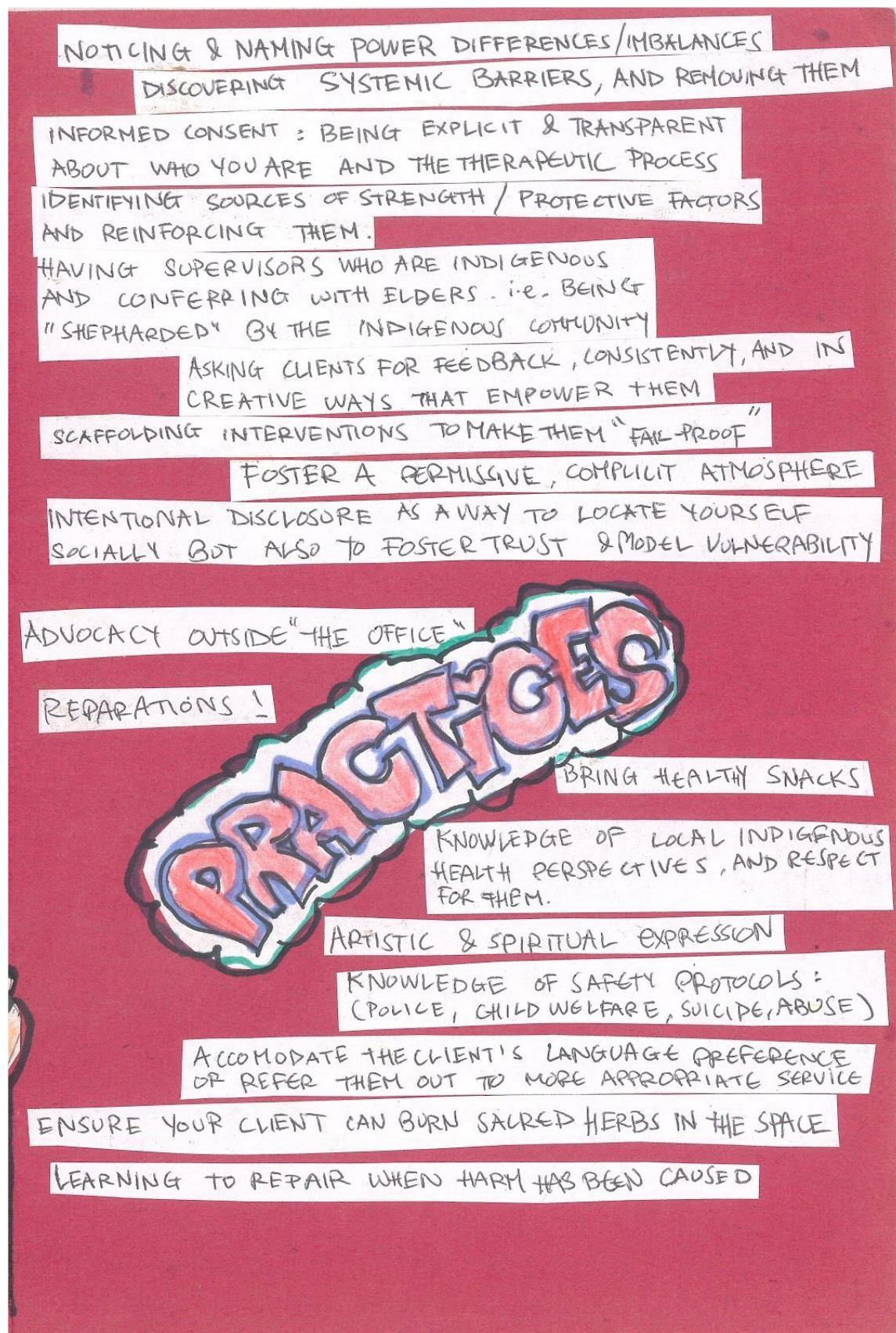




Figure 8. Page seven.

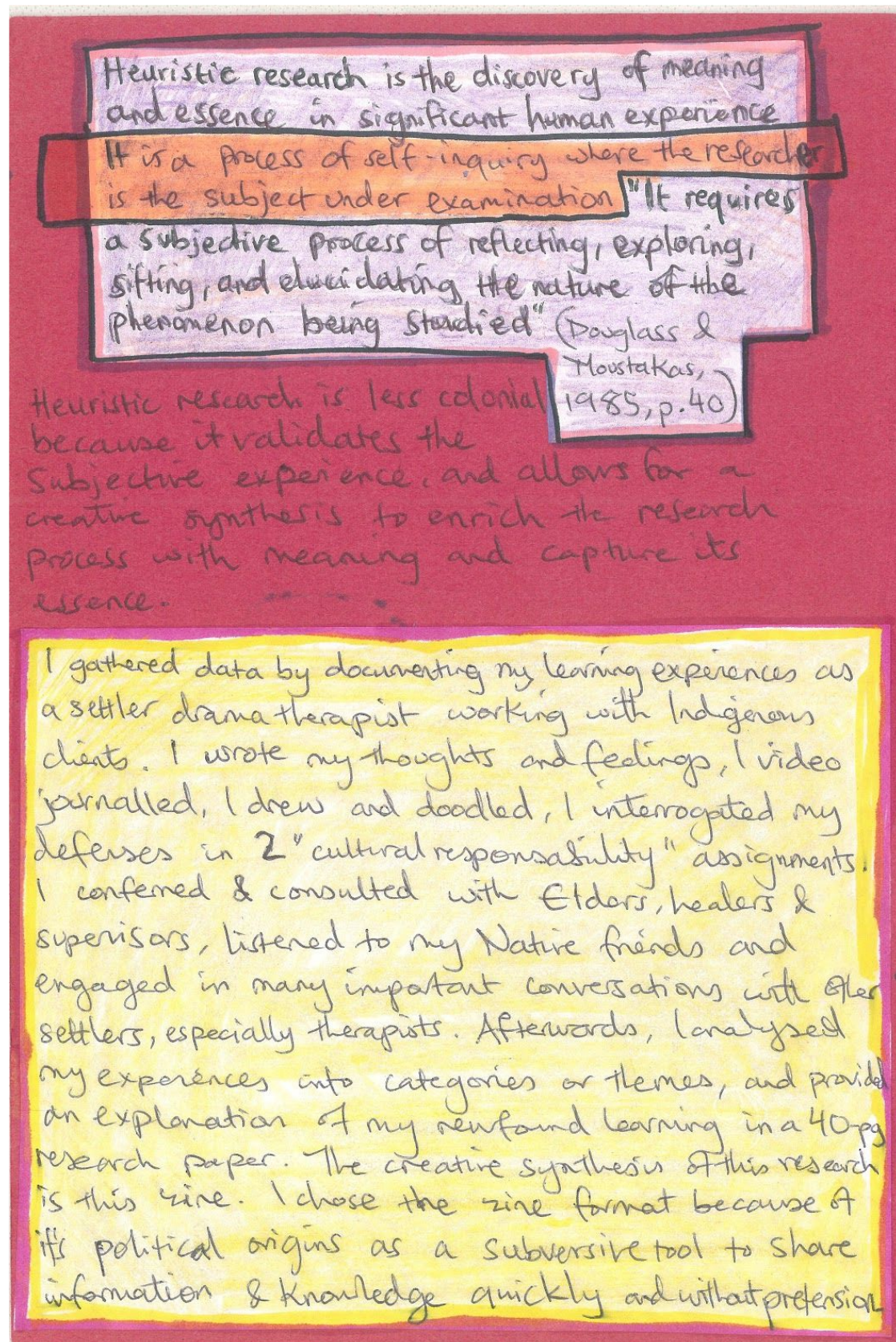




Figure 9. Page eight.

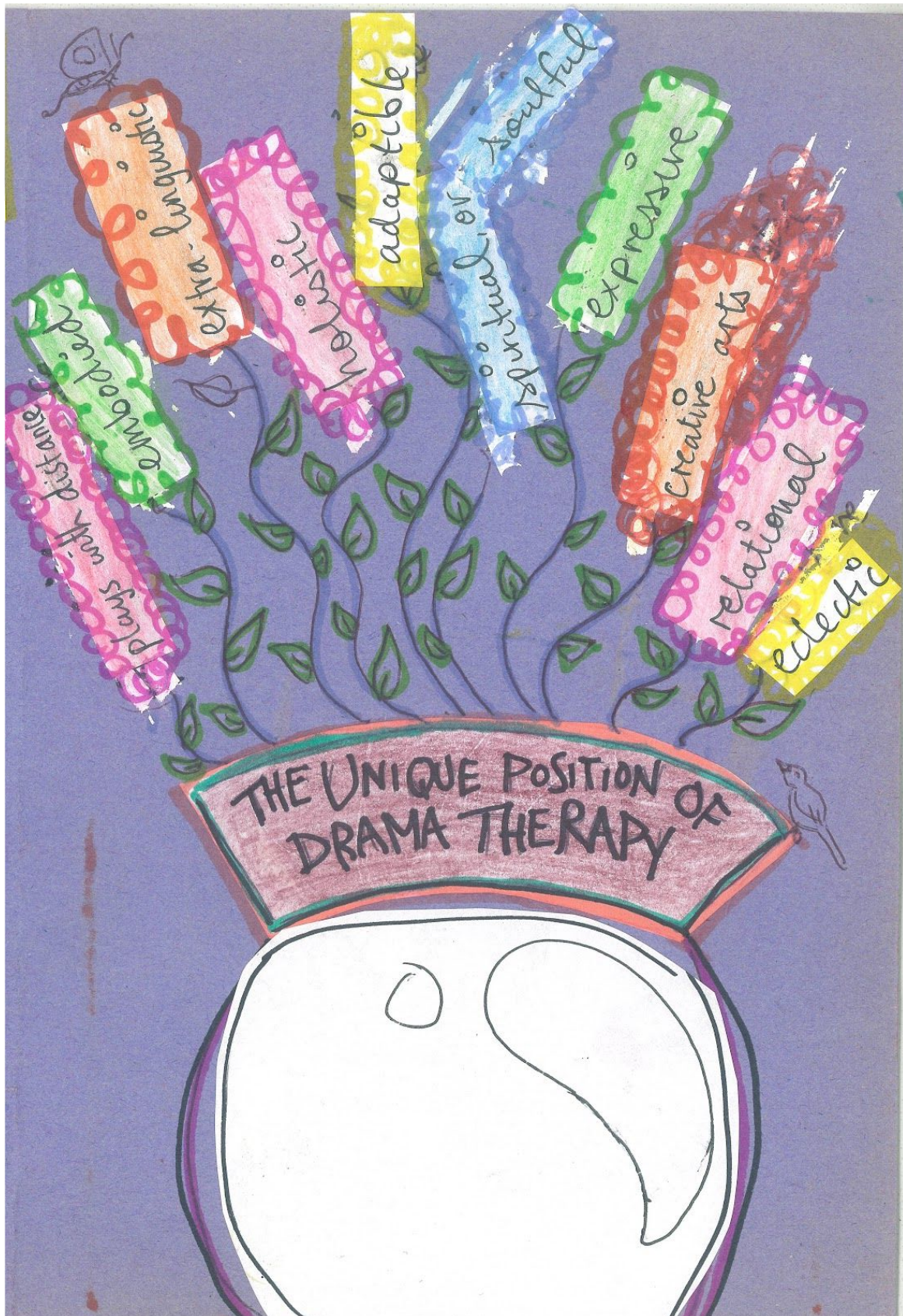




Figure 10. Page nine.

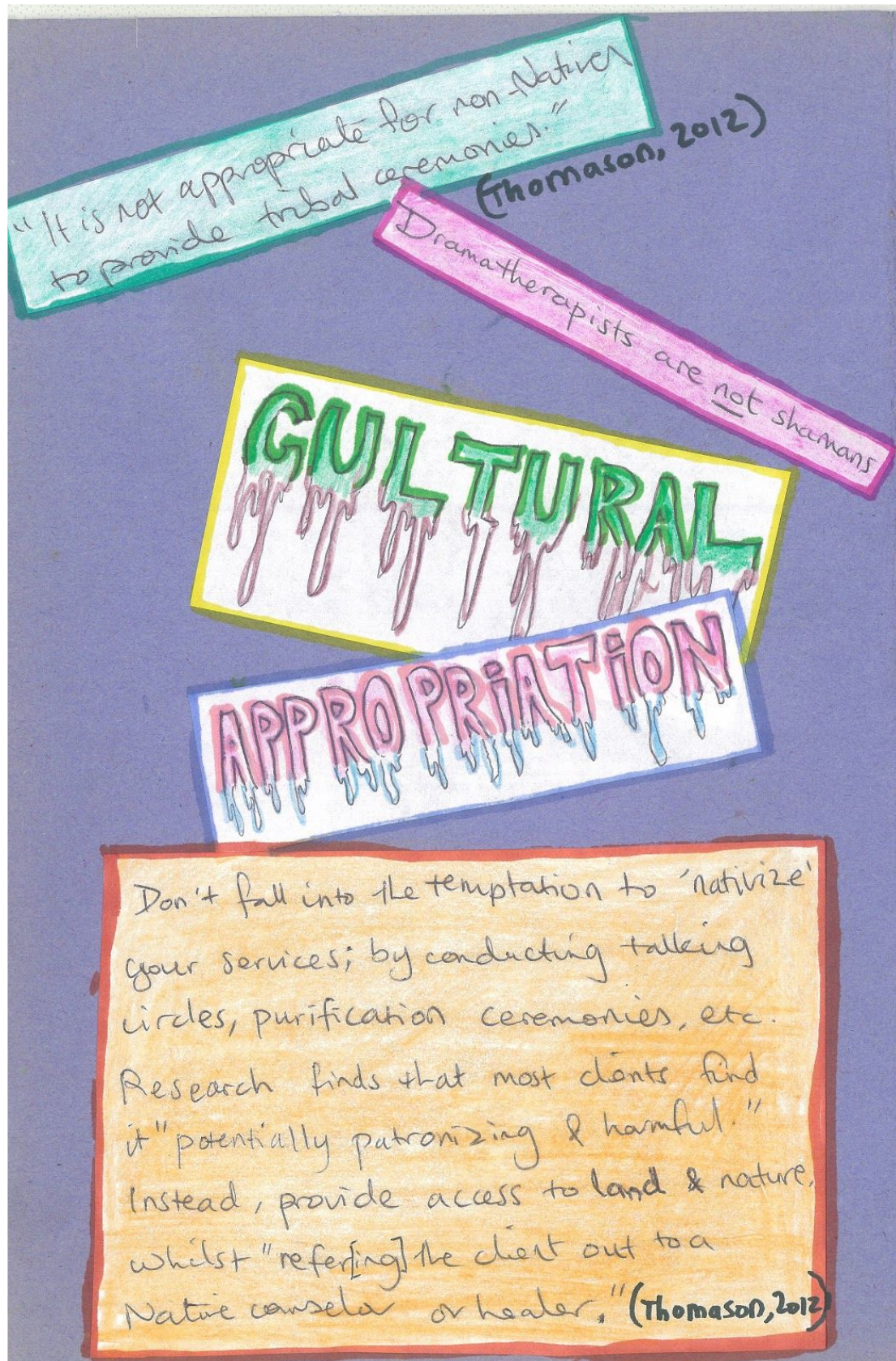
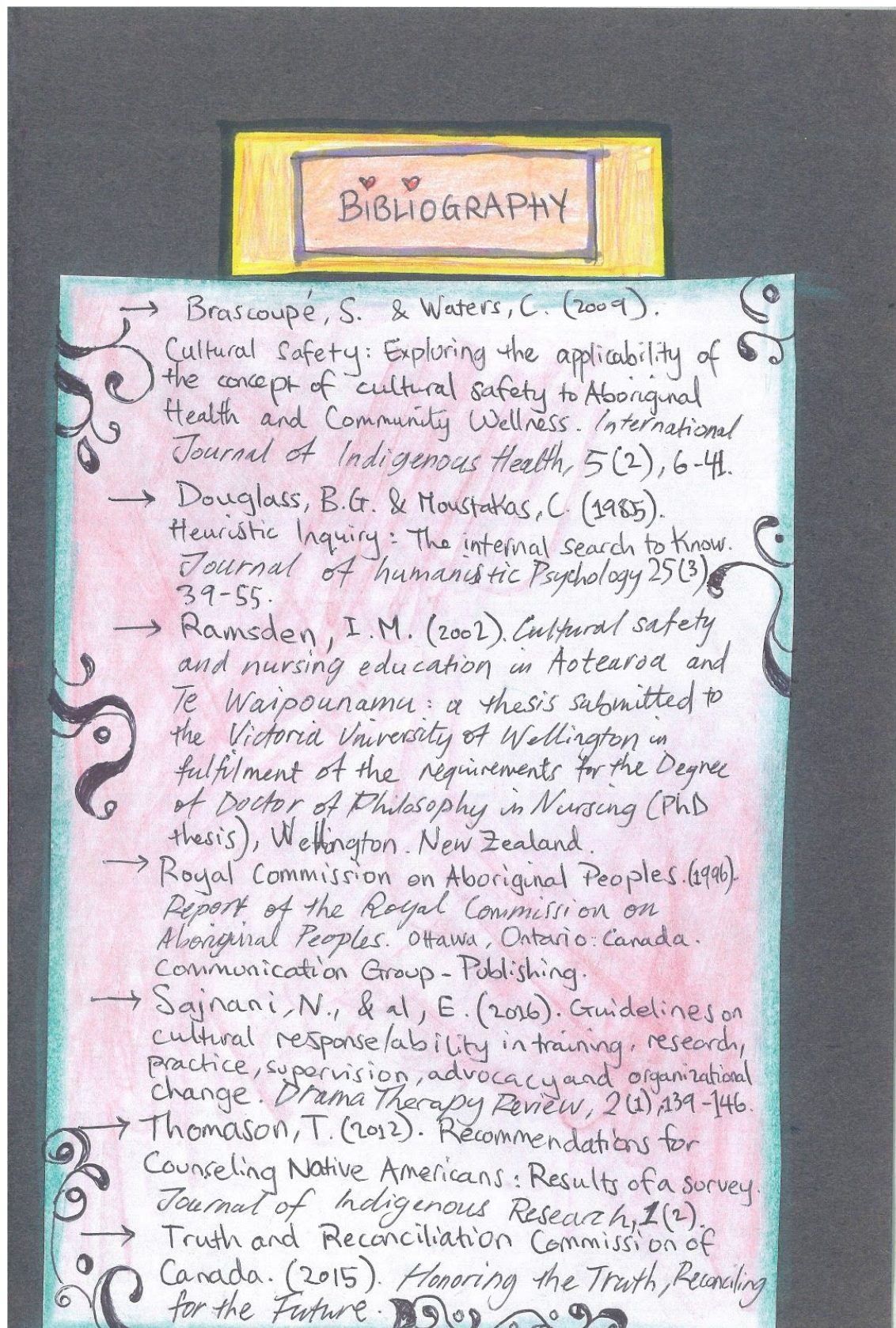




Figure 11. Page ten.





*Figure 12.* Back cover.

