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Abstract

Critical Incident Stress (CIS) in emergency workers and in victims of crises is widely held to be the possible precursor to Post Traumatic Stress Disorder (PTSD) if left unattended. Indeed, the symptoms for CIS and PTSD overlap in all category areas. Today, the commonly used treatment for trauma in emergency workers is Critical Incident Stress Management (CISM). This system of interventions includes a debriefing session which facilitates people to fully remember the trauma events and their own reactions to it. CISM models were conceived and designed within and from a typically white, western viewpoint. However, one agency in Vancouver, First Nations Emergency Services Society (FNESS), provides CISM debriefing interventions and training to Native emergency workers and Native victims of crises. The purpose of this study was to document how Native participants perceived the CISM model as FNESS presented it and to understand whether the intervention was culturally meaningful for the First Nations participants in the CISM sessions. This study examined whether the mainstream CISM model, which is currently used by this agency, is culturally meaningful for populations of another culture receiving it. Narrative interviews were conducted with participants to determine their reactions to the session, their feelings regarding information presented, and their ability to make cultural meaning of the experience. Narrative analysis was used to determine themes across individuals. Theoretical implications of this research include addressing the gap in the literature of the subjective experiences of participants in CISM; no studies have used a purely qualitative methodology to study this topic. Also, this study looked at the important issue of the cross-cultural application of a mainstream intervention, particularly for a population with a history of complex traumas. Practical implications include providing information into the perceived effectiveness of the FNESS approach to a CISM framework and providing an opportunity for recipients' opinions to be heard.
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The Problem

Introduction

Many people are not comfortable with the idea that we are living amidst a context of genocide and historical trauma. There appears to be a deep-rooted and societal ability to deny the reality of the pain and suffering imposed on First Nations people by Western settlers. The history is well documented. But the approach to healing is a difficult, complex and sometimes threatening one. Attempting to bridge the gap between dominant white culture and minority Native culture poses multi-layered problems of knowledge, psychology, identity, ownership and politics. Therefore, it is of the utmost importance that when any intervention or technique is proposed for use in the healing of trauma in Native communities, that it be assured to be culturally, politically and psychologically appropriate.

First Nations historical trauma is not a phenomenon that can be taken lightly by anyone. The roots of the behavioural and emotional difficulties that Native people face throughout North America today - alcoholism, domestic violence, depression, anxiety, suicide, substance abuse and alienation, arise from the process of colonialization taking place over the last 500 years (Duran & Duran, 1995, p.25). Research shows that reactions to oppression in Native groups mirrors the kind of psychological impact that survivors of the European Holocaust face (Weaver, 1998, p. 205). This kind of trauma is multigenerational, social in nature, culturally pervasive and multi-faceted. And because Native populations co-exist with the dominant culture group by which they have been oppressed, they face a constant reminder of their oppression on a daily basis.

First Nations groups in North America are unlike any other ethnic population. Their therapeutic needs are compromised by the fact that most modes of therapy, research in psychology and theories of recovery come from a base of knowledge that has been created by the dominant culture who created their trauma. As Duran and Duran point out, Native people often face a double bind when they attempt to deal with dysfunctional
behaviours. If they pursue a traditionally western approach to healing their trauma they face the risk of further alienation, misunderstanding and oppression. If they do not pursue psychological healing, they continue to deny their pain and their need for recovery (Duran & Duran, 1995 p. 39).

One agency in Vancouver proposes to provide an intervention that is specifically designed for use with First Nations populations. First Nations Emergency Services Society provides a variety of services for Native communities throughout BC. One of those services is Critical Incident Stress Management (CISM) services and training. According to the CISM co-ordinator, they have successfully married western knowledge of trauma symptomatology and traditional Native healing practices and ceremonies. The knowledge of trauma and trauma reactions provided in training arises from study in the area of white American medical emergency services workers. The goal of the agency is to provide a culturally appropriate service by blending this knowledge with Native healing knowledge present but unattainable due to traumatic disconnection.

In the Post-traumatic Stress Disorder literature, integration of the experience, or reconnection with values is cited as being an important component to trauma recovery (Herman, 1992; Matsakis, 1996). It is apparent that among emergency workers, trauma is a frequent and inherent part of job functioning and that this system is in place to help workers deal with and overcome their natural reactions to these events. But it is of the utmost importance to ask whether this system, created by and for white, western emergency services workers, is appropriate for the kind of trauma faced by First Nations people?

Rationale

Despite the research done on the topics of trauma, coping, Critical Incident Stress (CIS), debriefing efficacy, and cross-cultural interventions, there has been very little effort to find out whether it is beneficial to apply the CISM model to Native populations. Much
research has been done in the area of Native trauma and possible approaches to healing. But there is only one study that looks at the cross-cultural application of crisis intervention techniques (Weaver & Wodarski, 1995). One of the reasons for this is that addressing First Nations trauma is a relatively new phenomenon. This has been a difficult and painful issue for both Native and white people.

Another reason for the lack of study of this particular issue seems to be that because of the depth and breadth of trauma faced by First Nations people, there is an assumption that long term healing is needed. Critical Incident Stress Debriefing (CISD) is defined as being separate from counselling in its time parameters; it addresses only immediate and short term crisis reactions. Therefore, it is a new approach to helping First Nations communities.

Another possibility for this gap in the literature is the cultural context of “the problem” and “the solution.” This intervention on its own does not come close to providing adequate attention to issues of cultural relevance or cross-cultural awareness. And the point of healing in First Nations communities is to reconnect with historical trauma which is rooted in cultural genocide.

Because there has been so little study of the application of crisis intervention techniques to First Nations communities, and no study in the area of CISM and First Nations communities, and because historical trauma is such a serious issue, it is important that this research endeavour to understand the appropriateness or inappropriateness of marrying this therapeutic technique with this issue.

Approach to Research

Because the main issue at the root of this research is cultural trauma, it is appropriate that I used a qualitative methodology. To use a scientific or positivist approach would be ethnocentric and would provide an understanding of the data from a wholly western viewpoint. The goal of the healing process of First Nations people is to
liberate themselves from the oppression and devastation brought on by imposed colonialization. Considering that empirical study objectifies and quantifies human experience, it would be a further imposition and oppressive action if this research were empirical in nature.

Particularly, I used a narrative approach to understand the impressions of participants. Narrative methodology allows for a deconstruction of cultural biases and assumptions while allowing for a co-construction of meaning between the researcher and participant. The researcher attempted to make the cross-cultural context transparent to the reader with hopes of providing an accurate, appropriate and respectful process.

I used participant/observations of a training session which presented a CISM model of crisis intervention to a group of First Nations people. I then interviewed the training leader and participants to provide a fuller and richer supply of information on which to base my discussion ideas on the “fit” of this intervention with this group, and on which the reader can base her/his own conclusions of this study.
Chapter Two

Review of Literature

Trauma

Post-traumatic Stress Disorder

The word “trauma” is a generalized description of the common experiences of survivors of horrible life events. It is considered to be a normal reaction to an abnormal circumstance (Herman, 1992; Joseph, Williams & Yule, 1997; Matsakis, 1996). Whether the trauma is a natural disaster, horrible accident or human atrocity, the person’s regular system of self-defence is overwhelmed and disorganized when neither resistance nor escape is possible (Herman, 1992; Matsakis, 1996). The response to being overwhelmed can be seen in physiological, cognitive, emotional and behavioural systems. Herman holds that dissociation is the hallmark coping mechanism of the profound changes that occur within these systems (1992), and that it is this misplaced coping mechanism which at once works to relieve the sufferer yet prevent processing and future recovery. Normal coping responses are exaggerated, becoming the three main categories of traumatic response: intrusion, or reliving the experience through flashbacks and nightmares, avoidance or numbing of feelings, and hyperarousal, the persistent expectation of danger.

Trauma theory tends to come from a western viewpoint, attributing universality to trauma reactions. Cross-cultural literature on trauma shows that there are cultural differences in how people interpret and express trauma reactions. This topic will be addressed in the “cross-cultural interventions” section of the literature review. The information provided on trauma in this section is necessarily from a western platform.

Trauma theory today is a marriage of traditional cognitive and social psychology. It arose from the cognitive/behavioural theories of the 1980’s. Joseph, Williams and Yule (1997) provide a comprehensive overview of the various theories of PTSD since the origin of the diagnostic label to the present. Attempts to explain the mechanism of trauma have included the descriptive theory of emotional processing, the biological theory of learned

It is widely held that the reason for extreme reactions is that traumatic events call into question the basic beliefs and assumptions that we hold and that are used in the formation of knowledge of the self, the world, and the self in the world (Herman, 1992; Matsakis, 1996; Park & Folkman, 1997). Negative events destroy fundamental perceptions of safety, coherence and meaning in rules of living. For this reason, existential therapies have been propounded to be an appropriate fit for the treatment of trauma (Frankl, 1963; Lantz, 1996). Duran and Duran (1995) propose utilizing an Jungian analytic archetypal psychology when working with other cultures. The use of dreams and symbols as the vehicle serves as a bridge across cultures and an appropriate window into the trauma reaction.

Because the common precursors of trauma are states of powerlessness and a lack of control (Herman, 1992), the first step in recovery is typically the creation of safety and conditions of empowerment in victims. Once this is established, recovery takes the form of reconnecting fragmented response systems - bringing together the physiological, emotional and cognitive experiences of the trauma. This is accomplished through systematic retelling of the traumatic event with steadily increasing inclusion of repressed information (Herman, 1992; Joseph, Williams & Yule, 1997; Matsakis, 1996). Simultaneously, a systematic reworking of the meaning of the event takes place, until, once the story is complete, the person is able to ascribe meaning values and learning opportunities to the experience (Park
& Folkman, 1997). In particular when working with clients from other cultures, it is important during this process to also utilize traditional healing ceremonies and practices (Duran & Duran, 1995; Sue & Sue, 1999; Ramirez, 1998; Weaver, 1998; McGoldrick, Giordano & Pearce, 1996).

This technique of controlled reliving has been utilized with war veterans (Lebowitz & Newman, 1996) and with testimonials of torture survivors (Lebowitz & Newman, 1996; Agger & Jensen, as cited in Herman, 1992, p. 181). This narrative approach to making meaning is seen also in Herman’s approach to finding a moral from the retold story (1992). Once a moral, or meaning statement, is found, she suggests positive action and life restructuring in order to further facilitate integration and resolution of the experience (Herman, p. 207). As well, Matsakis proposes victims learn from the experience through self-reflection and questioning new perspectives on the world, the self, the nature of control, meaning and spirituality (1996, pp. 219-220).

The idea that trauma is an individual experience is increasingly included in the western literature. Social constructions such as world view, life schemes, and basic assumptions are frequently referred to within the context of the individual experience (Gluhoski & Wortman, 1996; Janoff-Bulman, 1992; Newman, Riggs & Roth, 1997).

**Critical Incident Stress**

Because Critical Incident Stress Debriefing (Mitchell, 1981) was a system designed specifically for the stress of white, North American medical emergency services workers, it is necessary that we understand the nature of this type of stress. The literature here wholly refers to white emergency workers and there is no literature on the experience of cross-cultural emergency workers.

“Critical Incident Stress” (CIS) (Mitchell, 1981) is the term most commonly used in the literature to describe the stress reactions, or trauma, experienced particularly by emergency workers. CIS is called “a natural reaction of a normal person to extremely
abnormal situations” (Lewis, 1993). This is the same descriptive phrase routinely attached to PTSD.

It is important to mention that CIS is not a diagnosis, but is a neologism. It is compared to PTSD symptomatologically. Symptoms of CIS exist across four categories, physiological, behavioural, cognitive and emotional. The DSM-IV criteria for PTSD states that symptoms in the areas of hyperarousal, avoidance and intrusion must persist for at least 30 days to be diagnosed as PTSD (APA, 1994, p. 426). The symptoms widely recognized for CIS are the same symptoms lasting less than or up to 30 days (Harkins, 1996). So, we could say that CIS and PTSD exist along a continuum of the same phenomenon.

Operationalization of the constructs “critical incident” and “CISD” remain unclear in the literature. Kureczka (1996) believes that “critical incident” is a fluid definition because of the phenomenological nature of the appraisal process; incidents may be appraised differently by different people. Weiss, Marmar, Metzler and Ronfeldt (1995), in looking at why some emergency medical workers suffered more chronic PTSD symptoms than others, found that personality factors, general adjustment, trauma history, family history and avoidant thinking were linked with a more chronic course of symptoms in fire-fighters (pp. 363-367).

First Nations Trauma

In order to fully comprehend the applicability of CISM design to First Nations populations, it is necessary that we have an understanding of the nature of trauma and stress in this population. As was clear in the preceding section, CISM was created specifically for the “critical incident stress” that is felt in emergency worker populations. First Nations trauma appears to be of a different nature:

So this is my legacy and the legacy of many Indians, both reservation and urban. Our loss extends back over many generations to the time of first contact with the Europeans.
We have lost our ethnic identities, our cultures and traditions. We have lost our
languages, our customs, our lifestyles, and our religions. We have lost our parents and
grandparents, our extended family and clans, our sense of community and our
knowledge of ourselves as 'people'. We have found systematic oppression and racism.
We have found depression and anxiety. We have lost ourselves again in alcohol, drugs
and suicide. We are survivors of multigenerational loss and only through acknowledging
our losses will we ever be able to heal (excerpt from Rose P.'s story, Tafoya & Del

Throughout the literature the terms “Native,” “First Nations,” “Native Americans,”
and “Indian” are used interchangeably. I choose to use the terms “Native” and “First
Nations” to refer to this group as these terms imply their presence here before colonialization.

Although much of the data on First Nations trauma arises from native populations
in the United States, there are indications that, while Native cultures differ widely, the traumatic events that occurred across nations, from first contact to residential school abuses, were similar in nature. Therefore, clinical and treatment issues can probably be generalized and applied to Natives throughout North America.

The recent literature on this topic is clear and consistent in its treatment of the traumatic experiences Native people have faced over the last 500 years. Of note is the lack of quantitative study in the area of First Nations trauma. Of course any First Nations issue subjected to Western “scientism” would be highly inappropriate and would serve to further perpetuate the westernization of this minority group. For this reason my choice of methodology fits and reinforces the stance of the research.

Also in agreement throughout the recent research is the use of language to describe the severity, intensity, depth and breadth of trauma in the history of First Nations people. Words routinely used to encompass their experience are “holocaust,” “ethnocide,”
"genocide" and "multigenerational trauma." For Ramirez (1998), using the word "holocaust" in her healing project with Native people was part of a strategy to encourage the public to become aware of the terror, torture and death of Native people (p. 306). Duran and Duran (1995) use the concept "soul wound" to explain life problems faced by Native people; pervasive problems such as alcoholism, suicide, abuse, school drop-outs, anxiety and depression are caused by issues of repeated injustice, betrayal of trust and invalidation inherent in the colonization process which wound Native people at the level of their souls (p. 24).

As Duran and Duran (1995) also show, once a group has been assaulted genocidally,

"psychological ramifications occur: the complete loss of power brings despair, the psyche internalized what appears to be the genuine power which is the power of the oppressor. Self-worth of the individual and group sunk to a level of despair equalling self-hatred; the self-hatred is either internalized or externalized. Research shows the results of internalized self-hatred in suicide (Duran 1989) and alcoholism. Externalized self-hatred is violence." (p. 29)

The level of violence in Native communities is unparalleled in any other community. Native communities have the highest rate of violent crimes, homicide and suicide and domestic violence - almost double the US rates for all other races (Abban, 1982 and French & Hornbuckle, 1982 in Duran & Duran, 1995, p. 29).

Under the guise of education, the federal governments of both the US and Canada, starting as early as the 1800s, implemented policies whose effects were the systematic destruction of Native family systems, culture and identity (Duran & Duran, 1995, p. 28).

At the beginning of colonization in North America there were over 10 million Native people. By 1900 there were only 250,000 (1995, p. 25). Ninety-seven percent of the Native population in North America was destroyed by 500 years of extermination, oppression, assimilation and subjugation. Native people have been subjected to one of
world history’s most systematic attempts at genocide. This is the physiological and psychological devastation that inflicted the "soul wound" and which is still felt to this day (1995, p. 25).

Because of the severity of traumatic experiences described throughout the literature, researchers repeatedly stress that First Nations people and their experiences are not comparable to any other ethnic population (Duran & Duran, 1995; Morrissette, 1994; Ramirez, 1998; Sue & Sue, 1999; Weaver, 1998). As Weaver sites, the issue of sovereignty places Native people in a unique position relative to other groups of colour in North America. Indigenous people are not just ethnic or cultural minorities within a larger society (1998, p. 209). Native people had established resources and communities, unlike immigrants. They suffered multiple losses of resources, land, traditional ways, family structure, transmission of cultural values, sense of identity, trust in the word of the dominant culture, and worldview. They suffered repeated abuses; forced education in residential schools, forced moves to reservations, separation from family, inability to speak Native languages, and emotional, physical and sexual abuse at the hands of the dominant white culture.

Sue and Sue (1999) show that minority populations are more likely to encounter problems such as immigrant status, poverty, cultural racism, prejudice and discrimination in addition to the common stresses experienced by everyone else (p. 11). And particular to First Nations people is the fact that resolving past losses is difficult when the presence of the colonizers is a constant reminder of the trauma (Duran & Duran, 1995, p. 39). Native people are put into a "double bind" by being Native and living as a white person. Alcohol is seen as one method of coping with this persistent double bind (1995, p. 39). The use of western therapies in the healing process brings about another bind: either remain alienated from therapy by choosing not to work on psychological problems or risk further exploitation and misunderstanding by a western therapeutic system (Duran & Duran, 1995, p. 18; Sue & Sue, 1999, p. 284).
For this reason, the history of native/white relations since first contact presents the context of the treatment for Native people (Duran & Duran, 1995, p. 26). Successful clinical interventions are not possible in a Native setting unless the provider of the agency is aware of the socio-historical factors that have had a devastating effect on Native people (1995, p. 26).

In terms of the clinical understanding of Native trauma, most of the research approaches this issue from a Post-traumatic Stress Disorder standpoint. Duran and Duran (1995, p. 33) developed a scheme of progression of PTSD in Native communities arising from the process of colonization. First contact entails initial shock, threat and initial losses; the trauma beginning here has a collective impact on continuing losses. Economic competition brought about the loss of land and resources which were used, stolen and destroyed by settlers. The invasion/war period saw the brutal genocidal tactics of the government implementing policies of extermination by force; this brought on a refugee syndrome. During the subjugation/reservation period, Native people were subdued by force and relocated to areas unfamiliar to them; this destroyed culture and community structures. And the residential school period was designed to destroy the family unit, traditional culture passed from parent to child, worldview, language and tribal affiliation. The forced relocation and termination practices also brought on a refugee syndrome and a concentration camp syndrome (1995, p. 32-34).

Most of the literature on historical and genocidal trauma points out its historical and multigenerational nature. Literature here has emerged from research done with victims of the European Holocaust. Many dynamics of the Jewish experience are the same as the First Nations experience, except Native people do not have the acknowledgement and validation that it was a “holocaust.” In a study by T. Shoshan (in Duran & Duran 1995, p.193), violent sudden separation from closest family members determined the extent of survivors’ individual traumas. Incomplete mourning and depressive and sombre states of mind created in adult survivors by the experience were absorbed by their children from

Moskovitz and Krell (in Kestenberg & Kahn, 1998, p.118) explain that normal developmental tasks of growing up are mutilated beyond recognition by the trauma of loss and grief, danger and fear, hatred and chaos. Danieli, Rodley and Weisaeth (1996) show that recent evidence from Holocaust survivors and combat veterans supports the “vulnerability perspective” of trauma. This perspective states that stressful events serve as triggers that accelerate and unmask latent PTSD. Prior trauma leaves permanent psychic damage that renders survivors more vulnerable when subsequently faced with extreme stress (p. 5). Fogelman (in Kestenberg & Kahn, 1998), also states that the effects on the second generation are multidimensional especially regarding the relationship between the two psychological processing of identity formation and mourning (p.84).

Only a few authors have directly related the research from the Jewish Holocaust to the experience of the Native holocaust (Braveheart-Jordan & DeBruyn in Adleman & Enguidanos, 1995; Duran & Duran, 1995; Tafoya & Del Vecchio in McGoldrick, Giordano & Pearce, 1996; Weaver, 1998). Weaver (1998, p. 205) states that historical trauma and unresolved grief are a legacy that many First Nations people struggle with today. She contends that although it is discussed less frequently than the European Holocaust, Native genocide was no less devastating (1998, p. 205).

Tafoya and Del Vecchio compare the historical trauma of Natives with the Holocaust when they state that “the movie Schindler’s List is essentially a plea to remember, and that to remember is to speed the healing. This is the case for Native Americans in the United States today” (in McGoldrick, Giordano & Pearce, 1996, p. 47). Other researchers have opted to use recognized terms such as genocide, and holocaust to describe the historical trauma of Native people (Morrisette, 1994; Ramirez, 1998).

Middleton-Moz (in McGoldrick, Giordano & Pearce, 1996, p. 52) describes the psychological ramifications of forced assimilations. Children who were sent to boarding
school became strangers to parents, were not prepared to cope with either culture, and often felt confused and alienated from both western and Native ways of life. Adults who went to boarding school suffered from a pervasive sense of low self-worth, powerlessness, depression, and alienation from cultural strengths, and confusion about family roots and traditions; they felt abandoned. This increased confusion when faced with raising their own children, and dysfunctional parenting styles were created. If trauma is not resolved within the lifetime of the individual, this becomes the learning environment for children.

The term "acculturative stress" has been used to describe the anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms and identity confusion arising from the process of acculturation in Native communities (Williams & Berry, in Duran & Duran, 1995, p. 32). Decades of trauma negatively effect family systems, ideology and identity. Of importance in understanding the profound effect colonization has had on Native people is that dysfunctional patterns at some point start to be seen as part of the Native tradition (Duran & Duran, 1995 p. 34). Over time, their very identities become the manifestation of the assumptions and beliefs placed on them by the dominant culture.

The mechanism for trauma in Native communities, and indeed in other oppressed minority communities, is the internalization of oppression. It is commonly held in abuse dynamics that the generational nature derives from the abused identifying and internalizing the power of the abuser. Duran and Duran (1995) recount that the effects of physical, emotional, spiritual and sexual abuse on Native families is the internalization of the abuse whereby the abused becomes abuser (1995, p. 31). The oppressor (white people) is internalized and becomes such a part of personality that the person cannot differentiate between that part and his/her real personality (p. 30). This integration does not happen overnight, but takes generations of systematic weaving into the fabric of Native people.

There are a variety of negative coping strategies adopted by First Nations people as result of historical trauma and internalized oppression: learned helplessness,
passive-aggressive behaviour, compulsiveness, substance abuse, suicide, denial and 
scapegoating other Native people (Tafoya & Del Vecchio in McGoldrick, Giordano & 
Pearce, 1996, p. 52). As Paulo Freire points out (1986), self-depreciation is another 
characteristic of the oppressed. This derives from their internalization of the opinions the 
oppressors hold of them. So often they hear that they are good for nothing, know nothing 
and are incapable of learning anything, that they are sick, lazy and unproductive, that in 
the end they become convinced of their own unfitness (p. 49).

The effects of historical and current oppression are experiences of prejudice and 
discrimination. These are a social reality for minorities and affect their view of the helping 
professional who attempts to work in a multicultural arena (Sue & Sue, 1999, p. 31). 
Racial and cultural dynamics may intrude into the helping process, causing misdiagnoses, 
pain, confusion and a reinforcement of the stereotypes and biases both groups have of one 
another (1999, p. 31). As Braveheart-Jordan and DeBruyn point out (1995) without 
exploration into aspects of historical trauma and culture, most Native clients will not share 
their issues of culture and history (p. 362).

Throughout the literature there is a call for mental health professionals to gain 
awareness into the ramifications of historical trauma and into the dynamics of therapy. 
Western mental health professionals have a responsibility to be aware of the effects of 
multigenerational disruptions of positive development as a result of 500 years of historical 
trauma. We must acknowledge the persistent destructiveness of oppression and racism 
that Natives have to deal with on a daily basis. We must be aware of negative feelings on 
the part of the Native client toward the dominant culture, the government and government 
agencies which may impact negatively upon the development of transference. We must be 
aware and help clients to be aware of the multigenerational impact of the historical trauma. 
We must support them through the process of grieving personal and tribal losses of 
language, traditions, religions and identity. We must support the provision of positive, 
concrete well-defined role models as mental health professionals. We must support the
designing of Native treatment models based on healthy traditional values and practices (Braveheart-Jordan & DeBruyn in Adleman & Enguidanos, 1995; Martin-Baro, 1994; Tafoya & Del Vecchio in McGoldrick, Giordano & Pearce, 1996).

Suggested interventions for First Nations populations tend to be communal in nature. Duran and Duran advocate a community intervention because they consider the issue of the “soul wound” as a collective as well as an individual phenomenon (1995, p. 196). Because of the Native worldview, therapy should focus on restoring the whole community to harmony between the psyche and the Earth. It is necessary that a holistic approach is conceptualized and that services exist in a community context. Braveheart-Jordan and DeBruyn agree that because trauma experienced by Native people has been perpetrated on them as a group, many interventions used to address this issue have to be done within a group or at the community level (1995, p. 363). Martin-Baro believes that an individualistic view abstracts socio-historical realities and insists on locating the trauma in individuals. He suggests speaking of “psychosocial trauma” when referring to psychological problems arising from situations of war (1994, p. 124). This kind of trauma, he states, “is socially produced, as opposed to accidents, fires and natural disasters. Understanding it and resolving it requires looking at social roots” (p. 125).

Also, researchers tend to advocate the use of Native traditions in the healing process. The power and influence of traditional Native healing rituals should not be overlooked and should be integrated into the therapy (Morrissette, 1994, p. 390). Ongoing collaboration with the Native community in helping clients reconnect with their bands and relatives is imperative. Braveheart and DeBruyn focus particularly on issues of Native women, and they believe self-help groups and peer counselling efforts that include traditional values to facilitate improved coping skills and self-determination are having success in numerous Native communities (1995, p. 363). “Indians need to heal. Indians have not had a chance to deal with the pain... We (as Indian people) need to begin to deal with our own painful history.” (Ramirez, 1998, p. 309).
It is clear through a reading of recent relevant literature that Native groups are not considered to be suffering through the same kind of trauma as other immigrants, or as people from the dominant culture. Because the trauma is historical, multigenerational, culturally pervasive, social and genocidal in nature, it requires particular knowledge, awareness and approaches when dealing with it.

**Trauma Treatments**

**Critical Incident Stress Debriefing**

Introduced in 1983 by J. Mitchell, Critical Incident Stress Debriefing (CISD) was one specific type of trauma intervention designed for use with emergency personnel. Since then, Mitchell’s initial idea has grown into a larger system of secondary trauma care known as Critical Incident Stress Management (CISM) (Dernocoeur, 1995). CISD is a component of CISM which consists specifically of immediate, brief psychological group counselling. CISD teams, established in the United States, now exist in Canada and three other nations: Australia, Norway and Germany (Mitchell, 1988, p.48).

The purpose of CISD, and CISM, is twofold: to lessen the impact of distressing events on the personnel exposed to them and to accelerate recovery from those events before stress reactions damage performance, career, health or family (Mitchell, 1988, p.48). The CISD process typically consists of 7 stages of recall and discussion: introduction, fact, thought, reaction, symptom, education and re-entry (Neely & Spitzer, 1997, p.115-116). The stages are designed to allow expression of the experience of the trauma by each member of the group, as well as to educate about recognizing PTSD symptoms and reaching available resources. In this way it is psycho-educational in nature.

There currently exists a heated debate over the efficacy of CISD. Opposition is based on two main arguments: 1) there is no empirical evidence that CISM or CISD works; 2) CISM and CISD lack a legitimate theory base (Ostrow, 1996; see Mitchell & Everly, 1997 for rebuttal).
There has been little empirical evidence to show that the CISD process prevents the onset of PTSD, or even decreased levels of distress. The positive effects of CISD may be due to the positive effects of social support (Jenkins, 1996). However, anecdotal reports from participants are almost always in favour of debriefing (Dernocoeur, 1995, p. 34). Most studies looking for significant effects of CISD look for long term effects. By nature, CISD is a short term intervention, designed to decrease immediate symptoms and educate participants on future trauma developments. Jenkins (1996), who did a longitudinal, prospective and retrospective study on the efficacy of debriefing, ultimately concluded that it needed more study (p. 491).

The theoretical base for CISM or CISD was not elucidated in Mitchell and Everly's rebuttal (1997). However, the format for CISD seems to follow the stages of PTSD treatment. At several places in the literature CIS is compared to PTSD (Lewis, 1993; Bell, 1995; Tehrani & Westlake, 1994) In this way, CIS appears to be linked to PTSD theory and treatment. As PTSD is generally treated according to a three stage process of safety, remembering and integration (Herman, 1992), so CISD format can be categorized into safety (introduction and group norm setting) and remembering (facts, thoughts, feelings, reactions). The stage that is lacking is the integration process, or meaning making work of healing. Because the definition of Critical Incident Stress is limited in time to within days of the traumatic event, there is an assumption that the onset of PTSD has not yet occurred. CISD is designed to prevent the onset of PTSD. Perhaps this is why the meaning portion of recovery is neglected.

Cross-cultural Interventions

The literature in the area of cross-cultural interventions is consistent in theory and emphasis. All authors on the subject agree in the seriousness in which a Western practitioner working with a culturally different client should be taken. The literature focuses on three main areas. The first area is the role of the practitioner in cross-cultural
effectiveness, the second is the role of the culturally dominant institutions in creating psychological knowledge, and the third is suggestions for multi-cultural effectiveness.

To illustrate the importance of the role of every counsellor, therapist or mental health professional in any cross-cultural setting, we must ask ourselves, “what makes you, the counsellor/therapist any different than all those out there who have oppressed and discriminated against me?” (Sue & Sue, 1999, p. 7). The role is important precisely because until we know the answer to this question we are undoubtedly putting our clients at risk of further harm.

Ridley (1995) explains that the role of the white facilitator as expert is a paradox in multi-cultural society. He/she is the expert in the Western ways which dominate and which created the trauma in the first place (p. 47). So, a therapist’s good intentions are not enough. Themes of racism and oppression can and do occur at many points in the mental health fields, including training and education programs (Sue & Sue, 1999, p. 5). Duran and Duran (1995) believe that “without a proper understanding of history, applied social scientists operate in a vacuum, perpetuating neo-colonialism” (p. 1). They go on to say that a therapist who approaches Native people in a way that “does not account for the history of ethnocide perpetuated against Native Americans is him/herself a co-conspirator with that history” (1995, p. 28).

The position of the mental health practitioner is obviously a powerful one not only for minorities but for dominant culture clients as well. Much is written in the literature about the issues of client transference, professional ethics, and expertise. Therefore, it is even more important that a multi-cultural practitioner possesses the requisite skills to perform any therapeutic task competently. As Sue and Sue state,

mental health professionals have a personal and professional responsibility to a) confront and become aware of and take actions in dealing with our biases, stereotypes, values and assumptions about human behaviour, b) become aware of the culturally different client’s worldview, values, biases and assumptions about human behaviour, c)
develop appropriate help-giving practices, interventions, strategies and structures that take into account the history, cultural and environmental experiences, and influences of the culturally different client and d) change the policies, practices, programs and structure of our institutions that oppress the culturally different (1999, p. 7).

The body of literature on multi-cultural practices of individual professionals coincides with Sue and Sue’s assessment. Suggestions in order for professionals to become culturally competent generally cover the three areas of awareness of self in relation to cultural context, awareness of client in relation to different cultural context and ability to put the knowledge and awareness gained into appropriate practice and skills (Hickson & Kriegler, 1996, p. 145; Sue & Sue, 1999, p. 225; Weaver & Wodarski, 1998, p. 204). Weaver and Wodarski believe it is the practitioner’s responsibility to seek out relevant information in order to create a culturally appropriate intervention (1998, p. 219).

In particular for Native populations, Weaver and Wodarski believe the facilitator should be aware of the extent of the Native trauma so that he/she can include historical grief as one of the many factors in the healing process. Then they can explore the relationship between historical grief and the current presenting problem.

Braveheart-Jordan and DeBruyn, (1995) hold that the counsellor dealing with Native clients must develop cultural competence in all treatment modalities and must outline the therapeutic content regarding historical trauma. Further, they must address transference and counter-transference issues surrounding historical trauma and describe community healing utilizing self-help groups, peer counselling and community rituals (1995). For Sue and Sue (1999, p. 206), intervention leaders must be willing to seek the advice or utilize the services of traditional healers. The psychologist must work closely with traditional colleagues in traditional settings in order to best facilitate a therapeutic intervention (Duran & Duran, 1994, p. 88).

Also, along with gaining self-awareness, the culturally competent counsellor working with Native clients must be aware of complicated socio-political contexts as well.
For example, he/she must gain knowledge of how oppression, racism, discrimination and stereotyping effect them personally and their work; they must understand how they have directly or indirectly benefited from individual, institutional and cultural racism, and they must gain knowledge of their social impact on others (Sue & Sue, 1999 p. 225). As Duran and Duran (1994) state, “there is nothing more offensive to a Native American client than a therapist who is pretending to understand and provide therapy within a traditional perspective” (p. 87).

Addressing socio-political psychology, Martin-Baro (1994) believes that in order for psychologists to create an environment of liberation for the client, it is necessary for psychologists to intervene in the subjective processes that sustain structures of injustice and make them viable. “Psychologists must rethink their position with respect to continuing oppression and creating a psychology of liberation from oppression” (p. 46). Self-awareness is key here, as a mental health professional’s belief system shapes the way a situation is viewed and interpreted. Processes such as the identification of a problem and its origin, targeting an intervention, choosing an appropriate intervention and defining outcome are all grounded in a particular belief system that may be incongruent with the belief system of the client (Weaver & Wodarski, 1995, p. 215).

The second area that the literature addresses when dealing with cross-cultural issues is awareness of the origin of information. As Meyers, Echemendia and Trimble explain,

as we stand on the threshold of the 21st century, mental health professionals and psychologists more specifically continue to be predominantly Caucasian, to be trained by predominantly Caucasian faculty members and to be trained in programs in which ethnic issues are ignored, regarded as deficiencies or included as an after thought (Meyers, Echemendia & Trimble, 1991 in Sue & Sue, 1999, p. 6).

The frequent failure of programs for Native people is explained through this lens. Most attempts at providing services to Native people have ended in failure, but the failure
is generally blamed on the recipients rather than on the delivery. The problem is that most providers are trained in how to deliver to the dominant culture population (Duran & Duran, 1994, p. 8). Sue and Sue (1999) agree that the reason why ethnic minorities under-utilize mental health services and terminate therapy faster is because of the nature of the services; they are frequently antagonistic or inappropriate to the life experiences of the culturally different client; they lack sensitivity and understanding; they are oppressive and discriminating toward minority clients (p. 11). One major reason for this is that cross-cultural issues and practices are not addressed in the training of mental health professionals. Hickson and Kreigler (1996, p. 8) explain that when interventions are not cross-culturally sensitive, racial and ethnic factors may lead to alienation or an inability to develop trust or rapport, which then results in under-utilization of services and premature termination.

Problems in cross-cultural therapies arise from the different worldviews between Western and most other ethnic minority populations. For example, a Native worldview is spatial, process oriented, holistic, systemic and contextual, whereas a Western worldview is linear, factual, compartmentalizing and temporal (Duran & Duran, 1994, p. 14). The hierarchical, individualistic and content oriented Western worldview does not accurately describe the psychology or experience of other cultural worldviews. “To assume that phenomena from another worldview can be adequately explained from a totally foreign worldview is the essence of psychological and philosophical imperialism” (Duran & Duran, 1994, p. 25).

Hickson and Kriegler (1996) term the unquestioning acceptance of the Western worldview “cultural encapsulation” (p. 6). This can be seen in mental health professionals being too technique oriented, using a self-reference criterion for understanding experience, and not evaluating other viewpoints as valid.

Knowledge is constructed depending on the social location from which it is viewed. Therefore, we must take into account culturally bound understandings of
communication and healing. For example, major Western culture bound assumptions present in psychology are: individualism, verbal expression, scientific empiricism, the segmentation of self into mental, behavioural, physical and emotional parts, communication patterns, universality and hedonism (Martin-Baro, 1994, pp. 21-23; Sue & Sue, 1999, p. 67). As Ridley points out (1995), unintentional racism in psychology arises from this view of human behaviour when psychological disturbance is viewed as the cause for behavioural symptoms instead of looking at the effects of racism, discrimination, poverty, inadequate health care and poor education. It has been ethnocentrically assumed that the material taught in traditional mental health programs is equally applicable to all groups. And because a culturally different client’s worldview “is ultimately linked to the historical and current experiences of racism and oppression” from the dominant culture, he/she is therefore likely to approach counselling with a healthy suspicion as to the therapist’s conscious or unconscious motives (Sue & Sue, 1999, p. 5).

For Duran and Duran, a clear indication of the inadequacy of the Western system of psychology is the ever changing Diagnostic and Statistical Manual (APA, 1994, p. 67). If it falls short and needs repeated updating in white culture, imagine the deficiencies when applied to Native culture.

Many trauma education programs do attempt to incorporate cross-cultural material. However, those that do usually have them serve as complement to a Western service delivery. This practice is “disrespectful and doomed to failure” (Duran & Duran, 1994, p. 88). For these authors, if equality and power balance is not achieved through an appropriate emphasis, it is continuing the hegemonic approaches that are part of the current policy of Western medicine.

As well as looking at the many problems and difficulties faced in multi-cultural intervention practices on an institutional level, the literature also states some suggestions for overcoming those problems. Besides individual practitioners gaining knowledge and
insight into multicultural issues, the chief suggestion for finding a solution to difficulties in this area is to approach multicultural practices from a blended point of view.

Duran and Duran (1994) find integrated approaches effective. They suggest a bridge between the two paradigms so that Western practitioners do not approach Native ways of healing with scepticism (p. 9). They propose that models of treatment most effective are those in which traditional Native thinking and practice are utilized in conjunction with Western practice (p. 87). In order to accomplish this integration the therapist must understand and validate traditional Native cosmology. But it is not enough for the therapist to simply learn and apply cross-cultural techniques; he/she must believe and practice the beliefs in personal life.

The models developed by these authors were successful because of their validation of traditional values. They hold that it is not enough that a program have traditional components; it must have traditional Native psychology as its core metaphor. This puts emphasis on Native psychology as the core of the program, not the periphery (Duran & Duran, 1994, p. 88). Because the client must be helped to understand and to work at coping in the actual life-world around them, to adjust and work in a white environment and still maintain a sense of identity, the approaches must be blended. It is the blending of traditions that allows the client to get in touch with their identity. They are accomplishing an improvement in self-esteem and ridding themselves of an internalized oppressor (1994, p. 97). To this end these authors suggest using drawing, dream work, group work, ceremony, traditional healing, sweat lodges and spiritual leaders to facilitate healing (p. 149). Morrissette (1994) also encourages Native clients to seek the guidance and advice from chiefs, elders and/or a medicine person in healing (p. 387).

Other suggestions in achieving a culturally competent program include providing a historical context within the content. Any therapeutic program must take into account a historical overview because a client is unable to begin to deal with issues of violence
without understanding the dynamics of historical violence perpetuated against his/her culture (Duran & Duran, 1994, p. 106).

Also, interventions should be group oriented because counselling that focuses solely on the individual rather than the client as a member of a family or community may not be appropriate in some cultural contexts (Weaver & Wodarski, 1995, p. 216). Duran and Duran (1994) go on to suggest that there must be “gatekeepers” who, understanding the process of colonialization, could be present at any intervention to ensure that information and ideas presented are committed to fighting any perceived act of hegemony on Native communities (p. 7).

Martin-Baro (1994) sums up the challenge that mental health professionals face. He states, “we must choose whether psychological knowledge will be placed in the service of liberating the oppressed minority or whether it will continue to overshadow, categorize and dehumanize the reality of the oppressed” (p. 46).

Gaps in the literature on cross-cultural interventions occur in the lack of attention paid to the subject of cross-cultural crisis intervention. There is little in this area, particularly in the area of First Nations crisis intervention. Also, much of the literature was produced in the United States, leaving the researcher to generalize to Canadian First Nations populations.

In terms of healing the wounds created by historical trauma, clinical practitioners in this area must exercise caution. A therapist who approaches First Nations people in a way that does not account for the history of ethnocide perpetuated against this group is him/herself reinforcing and maintaining the mechanisms of that history. Native people generally view each traumatic event as arising from the original historical trauma. “Drinking and then people getting in car accidents, those behaviours come from this historical situation” (in Ramirez, 1998, p. 306).
Crisis Interventions for First Nations Communities

There is no literature on the specific topic of the applicability of crisis interventions to First Nations population. And there is scant information in the crisis intervention literature about its applicability to populations of other cultures. There is little discussion of the application of cultural differences to crisis intervention techniques or theory. I was able to locate only two sources that addressed the topic of cultural differences in crisis interventions.

Weaver and Wodarski (1995) outline the importance of culture when looking at crisis induced trauma. Culture is a primary determining factor in a client’s assessment of the origin of a traumatic event, its meaning and impact, and in his/her coping strategies around the event. They go on to say that, “culture has implications for the way in which people respond in times of crisis” (p. 215). Not only will a culturally different client respond differently to trauma than a Western client, it is precisely in the moment of crisis that the culturally different client may be most vulnerable to cross-cultural challenges. “When clients are in crisis, their severe distress often results in a lowering of psychological barriers...” (p. 213). Recent evidence from Holocaust survivors supports the “vulnerability perspective” of trauma which states that prior trauma leaves permanent psychic damage that renders survivors more vulnerable when subsequently faced with extreme stress. This means that stressful events can serve as triggers that accelerate and unmask latent PTSD (Danieli, Rodley & Weisaeth, 1996, p. 5).

Because of this vulnerability, if a human services professional does not assess the meaning of culture for the client, the service provided is likely to be based on stereotypes and inappropriate assumptions rather than actual cultural variables which can further harm an emotionally vulnerable client. “Providing biased and culturally inappropriate services...can lead to further oppression of clients at a time of particular vulnerability” (Weaver & Wodarski, 1995, p. 214). Also, it may be that during a crisis a client is more likely to adhere to the cultural norms and values with which they are most familiar, or
most comfortable. This is important knowledge that crisis intervention practitioners must have in order to avoid causing further confusion or harm.

Common mistakes made by crisis intervention professionals when working with cross-cultural clients mirror those discussed in more general cross-cultural intervention literature. These are: providing crisis services that are individually oriented when clients are community oriented, emphasizing the here and now when historical factors are relevant to the client’s trauma, assuming that a “cause and effect” linear explanation of experiences is appropriate when clients have different worldviews, and emphasizing a reliance on formal interventions for recovery rather than utilizing naturally occurring support networks (pp. 216-217).

Gilliland and James (1993) also state the risks associated with incompetent crisis interventionists in multi-cultural situations. They warn that “such theories and assumptions are usually so ingrained in our thinking that they are taken for granted and seldom challenged by even out most broadminded leaders and professionals” (p. 13).

Literature in this area outlines the same guidelines to cultural competence as is seen in the multi-cultural literature. Providers must obtain knowledge of the cultural context of the clients he/she is working with including historical, political and psychological contexts; she/he must obtain insight and self-awareness of the cultural platform from which she/he is working including biases, assumptions, dynamics and therapeutic implications for the client; and the provider must know how to translate this knowledge into culturally appropriate skills and interventions.

It is apparent through the literature on Native trauma experiences and multi-cultural competence that these areas frequently overlap. Weaver and Wodarski suggest that since Native identity is grounded in a sense of group membership, group interventions are particularly appropriate (1995, p. 206). Gilliland and James (1993) agree that ideally, issues of trauma should be addressed by the group within a Native context. Because of the intensity and depth of pain experienced by Native people over the last 500
years, it is imperative that anyone working in a therapeutic context with this population be well educated in the skills needed to be culturally competent, lest further harm be committed.

Methodological Review

Methodology in the area of CISM and cultural applicability to date are non-existent, but, research in the area of CISM has been quantitative in nature, utilizing self-report instruments as measures of experience. Despite this methodological tendency, few randomized controlled studies have been completed in the areas of cross-cultural applicability and CISM (Wessely, Rose & Bisson, 1998). The difficulty in having controlled studies is due to the nature of the study populations; they are necessarily naturally forming and so cannot be randomized. Also, due to the breadth and depth of the constructs “culture” and “meaningful,” quantitative operationalization seems difficult. Also, it would be inappropriate to use a quantitative and empirical methodology with First Nations groups. Because it is an objective and objectifying process, it would conflict with the holistic and subjective nature of First Nations culture. The dehumanizing aspect of quantification would serve to perpetuate the alienation process that has inflicted trauma in the first place.

Although it is clear that more quantitative research needs to be done to clarify the mixed conclusions of CISM, the richness of the perception of “meaningfulness” cannot be missed. In this study, I looked at cultural meaningfulness among First Nations mental health workers who attended a CISD training session. I sought to document whether they found it meaningful and personally and culturally relevant. I also looked whether or not this debriefing training session, which was presented by a First Nations agency to a First Nations group, was perceived as being valuable to the participants. Narrative methodology fits this approach because it is descriptive and not inferential, and it provides a technique of gathering rich, personal, experiential information. Also, it does not seek to quantify, or
categorize, but instead to co-construct meaning in a transparent way. This makes it particularly fitting for cross-cultural research. (Kelley & Clifford, 1997).

As is consistent with narrative methodology, I did not look for any particular themes or answers. Instead, I documented personal accounts of impressions as they were recounted to me. I used open ended interview questions to elicit a discourse from which I ascertained the participants' impressions of the session, and their own personal process of understanding as it relates to historical trauma interventions.

Narrative theory is fitting for this research because the point of narrative research interviewing is to understand the meaning of respondents’ answers. It holds that the interview process is more than the traditional western approach of asking questions and eliciting accurate responses. Instead, it looks at the interview as being embedded in a context that is present through the interviewer and the respondent (Mishler, 1986). While traditional empirical methods of interviewing seek to factor out these subjective variables so that a more "truthful" response is garnered, narrative theory states that it is impossible to factor out all variables effecting the meaning of the question or the answer and further, that it is impossible to understand the meaning of a response when the context for that meaning is disallowed (Mishler, 1986, p. 3).

Each person carries with them their own personal and cultural context and approach to situations that differs from others. These differences are precisely what created the impressions I documented. My presence in the interview process also affected the understanding of the questions and so affected the created meaning of the responses. The individual contexts that I brought to the interview process are factors such as my ethnic background, my cultural knowledge, my gender, my SES, my educational background, my age, my appearance, the way I ask a question, the words I chose to use, my approach to the research and my attitude toward each respondent. These factors can be considered to be a context within which the participants formed an understanding of the questions being asked. From their particular understanding their responses were created. I
then interpreted the meaning of their answers according to my understanding of the visual, verbal and social cues I witnessed. I made every effort to attend to the ways in which my presence influenced the research process.

Because each partner in this discourse brought with them their own context, I documented as accurately as possible my own understanding of this context. By informing the reader of my own attitudes, beliefs, assumptions and impressions throughout the interview and analysis process, I hope to ensure the goodness and authenticity of the work. Each reader of this research will be able to judge for themselves the quality, credibility and trustworthiness of my documentation and will be able to take their own meaning from it (Bailey, 1996).

In choosing methodology, I looked at other alternatives to narrative interviewing and narrative analysis before deciding upon these. When looking at the relatively unsettled field of crisis intervention and trauma, particularly in the area of Critical Incident Stress Management, I considered using grounded theory to explore the process of cultural applicability for these participants. However, grounded theory is exactly that, explorational. Its inductive approach does not suit the nature of the study because cross-cultural theories abound already (Kelley & Clifford, 1997).

A purely narrative approach to this question allowed me to gather rich text and to interpret experience, which has not been used with this population or topic to date. A narrative approach adds to the literature by presenting the experiences of participants involved in this type of debriefing. Anecdotal reports of western participants' experiences are available, but have not been studied to date (Dernocoeur, 1995). Also, a narrative approach is more appropriate for use with First Nations people because it most closely fits a Native worldview. It is process-oriented, socially contextually bound, non-judgmental and permits cultural influences to be included in the results.

Most of the research in the area of First Nations trauma shows the importance of approaching Native clients with an openness to understanding their particular culture and
worldview. By using a narrative interview approach, I have invited each participant to re-construct their own history and understanding of events through open-ended narrative interview questions. This type of inquiry permits the expression of a closer approximation to the actual construction of meaning that takes place within each individual. The standard quantitative interview technique suppresses this re-construction in favour of an emphasis on "accurate" or "truthful" answers.

Also, by using a narrative approach, I have allowed for subconscious or subjective descriptions of impressions to be included. This will expand the traditional quantitative results of studies on CISM. It also provides strong data with which to clearly understand the experience of debriefing training in these participants.

Narrative approaches to therapy are widely seen in the literature on trauma (Carlsen, 1988; Herman, 1992; Spence, 1982; White & Epston, 1990). Work with Vietnam veterans, holocaust survivors and political refugees are only some of the groups with which this narrative approach has been used toward recovery (White & Epston, 1990). However, research with trauma survivors still tends to be quantitative in nature. Increasingly, researchers are using a multi-method approach which utilizes an open-ended interview technique (Folkman, 1997; Kelley & Clifford, 1997; Newman, Riggs & Roth, 1997). But to date, no studies utilizing a purely narrative approach have been done for this particular population with this intervention. It is clear that there is a need for such work to be done so that we can better understand the applicability of this approach to this group.
Chapter Three

Method

Design

My approach to the topic of First Nations trauma and Critical Incident Stress Management has two components. The first component consists of documenting a debriefing training session which is held by a First Nations agency for a First Nations group. First Nations Emergency Services Society (FNESS) both trains others in debriefing techniques and conducts debriefing sessions first-hand to various First Nations and white communities throughout British Columbia. The second component consists of gathering interview data from participants.

As background for the training observed, the standard model for Critical Incident Stress Management training currently accepted by FNESS is defined by the International Critical Incident Stress Foundation. The CISM standard format includes a 7-step process that spans from pre- to post- incident. The components of this process are: pre-incident preparation, education and training; demobilization of the traumatized group directly after the event; diffusing immediate reactions; critical incident stress debriefing; individual interventions; family interventions; and follow-up and referrals. As a guideline for this process, FNESS uses the Advanced CISM Workbook manual for training (Everly & Mitchell, 1999). From this format, FNESS says they have modified the training and debriefing sessions to specifically fit First Nations communities. The modifications include spiritual and cultural components as part of the format so that a greater sense of personal and cultural meaning is rendered to participants. In order to document their approach to First Nations communities, the first part of this research involved accompanying the CISM co-ordinator on a field trip to a scheduled training session. My documentation of this process included observations of the material presented, as well as observations of the reactions of participants to this training. I also wrote down my own reactions and experiences as I involved myself in the training.
The second part of this research consisted of conducting interviews with participants who experienced that training session in order to explore their experiences of it. I interviewed participants of the training who had the chance to apply their training in the field. I ascertained how this training affected their experiences when working with trauma victims. For all the interviews, narrative methodology elicited a rich, detailed account of their perceptions and experiences of CISM.

I then analyzed the narrative text, looking for themes of experience in each one. After the initial analysis was done, I presented my findings to each participant so that their input could be given as to the meaning and interpretation of their experience. Once we reached a mutual agreement of the understanding of the experience of this First Nations training workshop, the analysis was complete.

Population

The participants were 4 volunteers from a First Nations community in BC who underwent FNESS Critical Incident Stress Management training as well as the CISM co-ordinator who led the workshop. The size of the population was determined by taking into account the abundance of information gathered using a narrative technique. Because the purpose of this study was not to make broad generalizations about the effectiveness of CISM, but was instead a look at personal experiences of this training session, it would have been inappropriate and unnecessary to have a population any larger than 3 to 5. A small population provided the information that I sought to obtain in this study.

All participants volunteered to participate in this study and signed Informed Consent forms (see Appendix A). Because volunteer groups are self-selecting, there were no exclusion criteria for age, gender, years of work experience, or personal history.

I approached the participants about involvement in this study myself, at the beginning of the workshop, as an invitation from the CISM co-ordinator could have been
unethically influential. I presented them with a Letter of Introduction (see Appendix B) and a brief verbal introduction of myself and explanation of the research.

Data Collection

Data collection took two forms. Firstly, I documented my observations of the material presented in the training session, the behavioural responses I noted from participants in the training involved and my own personal reactions to the material presented. Secondly, I interviewed 4 participants who had just gone through the training session, as well as the CISM co-ordinator. All interviewees were given a choice between home, work or a neutral location such as a community centre in order to ensure an environment of safety and openness (Bailey, 1996). The interviews took place at varied locations which included one interview at home, two interviews at their place of work and one in a meeting room in a neutral office building. Each interview took approximately one hour.

My approach to interviewing entailed a minimum of leading questions and a maximum of reflecting, summarizing and paraphrasing statements. Questions that were posed were, “What was your experience of the debriefing session?” and “What did you like or dislike?” On the topic of cultural applicability, I asked, “Did you find this training session culturally relevant?” “Did you find it personally relevant?” “What was your impression of the cultural ‘fit’ of this intervention with this group?” “Did you find this training meaningful and applicable to First Nations people?” If participants answered in the negative, I followed up with “In what ways do you think the training could be improved?”

The interview with the CISM co-ordinator was somewhat different. I included alternate questions in order to elicit specific information about the agency and procedures. I asked him different questions than the participants because his role is significantly different from theirs. Questions I included here are: “What is your mandate or protocol when working with First Nations people?” “What are your agency’s goals in this area?”
“How do you account for any difficulties that arose in the workshop?” This last question arose as a result of tension I observed in the group.

Data Analysis

A qualitative analysis of the interviews was done in order to gain a fuller understanding of the experiences of volunteers. The questions asked elicited testimonies of the helpfulness, hindrance and general impressions of the debriefing training process and insights into each person’s individual cultural experiences.

In order to determine personal themes from the interview text, I analyzed and interpreted the data myself, which is the narrative tradition (Bailey, 1996). I interpreted the results according to theories of narrative interviewing which cover the content and form of the narrative, the context of the questions and answers and the relationship between the interviewer and the respondent in terms of roles and creation of meaning (Mishler, 1986, p. 75-116). After the interviews were transcribed, I summarized them by clarifying and reducing main ideas in paragraphs into one or two sentences. I looked for the overall opinions and feelings that each interviewee expressed. I referred to the transcribed tapes when writing the summaries so as to ensure accuracy of content and emphasis.

An important part of narrative analysis is delineating the context which the interview creates. I included a description of the interview’s context, the setting, the time of day, my own attitudes and beliefs regarding this interview and the participant involved in it. Awareness of the background influences in the meaning of the respondent’s answers is crucial to determining the meaning brought forth in the interview, particularly in cross-cultural interviews. As well, acknowledging the multiple roles of myself as interviewer, listener, and white researcher and the participant as respondent, story-teller and Native participant is necessary in order to make sense of shifts in roles and ways of relating. We worked together to create a mutual understanding of the respondent’s story.
Once I interpreted the responses, I did a member check in order to find out if my interpretation was consistent with the participant’s understanding of his/her own experience. Participants were given the choice of telephone, personal or e-mail interview. They received a copy of the summarized interview and were asked to make any changes or comments necessary to ensure that the summary was an accurate interpretation of their feedback. Once an accepted mutual understanding of the participant’s experience was created, I used this as the final interpretation for this research.

During this checking process I also asked two new questions of each participant, but not the group facilitator. I noticed in the original participant interviews that, although there were some positive comments about aspects of the workshop, the answers were skewed toward giving criticisms and suggestions for changing it. In order to account for any bias that might have occurred, I asked two questions regarding positive feedback about the workshop. The questions were: “Do you see the program as being valuable?” and “Can you give any positive feedback about the workshop?” Accounting for bias and accuracy checking will ensure that the quality of results are of a high standard.

When analyzing the summaries, I used a technique that involved separating each summary statement and categorizing it into its topic theme. I looked for repeated themes across the interviews, as well as any discrepancies or contradictions that may have occurred. I also looked for areas of content that were not addressed. Gaps in narratives are important information when looking at the context of information given. I remarked on the gaps, analyzing them for possible meanings. Each theme of agreement or contradiction is then outlined in the analysis section.

The summarized interviews are also subjected to peer review, in which two colleagues studying trauma and cross-cultural issues independently extracted themes within and between summaries. I then compared these to my own analyses for verification.

The criteria for evaluation was true to the standards of narrative analysis: quality, trustworthiness, credibility and authenticity. I was explicit with each of these latter three
areas of analysis in order to ensure the first (Bailey, 1996). This way others will be able to judge the quality of the results for themselves.

Each criteria has its own standards for practice within the narrative research. The overall quality of this research will be evaluated through the achievements of the other concepts of trustworthiness, authenticity, and credibility. ‘Quality’ can be considered to be the ‘validity’ of a body of research, both in quantitative and qualitative paradigms. However, as ‘validity’ is understood within an empirical context to refer to truthfulness or accuracy, the qualitative paradigm shifts the meaning of validity from outcome to process (Bailey, 1996, p.5). For validation to occur, I clearly outlined the research methodology and findings so that others are able to participate in the evaluation of the analysis. The validity of this study then shifts from referring to accuracy, to referring to the thoroughness and completion of the work. This is then also fulfilling the criteria of trustworthiness. Outlining all factors that may contribute to the context that I brought to the research and to the interactions with the participants will allow other researchers to evaluate the findings as thoroughly as possible. By being “transparent” with my process during research I hope to have achieved a high level of validity and quality.

Credibility in research can be understood as verisimilitude. Polkinghorne (1988, as cited in Bailey, 1996) argued that validity in narrative analysis depends in part on “results that have the appearance of truth or reality” and that are “well grounded and supportable” (Polkinghorne, 1988 as cited in Bailey, 1996, p. 5). By ensuring that my work has a high degree of ‘face validity’ ensured that I fulfilled the criteria for credibility. To achieve this face validity, I used two forms of credibility checking in the research process. The first was the member check which ensured that the summaries I included in the research were an accurate description of the experience of the participants. The second was the peer review check, which served to validate and authenticate my analysis.

Authenticity can be seen as “resonance” with the reader. It also implies that there is meaning to the work. By going back to participants with my analysis and ensuring that
my analysis of their story fits with their experience, I ensured authenticity of the work. I worked toward creating results that also resonate with other readers.

Thus, by striving toward trustworthiness, credibility and authenticity within this study, I have worked toward ensuring the quality of this work as judged by outside critics.
Chapter Four

Results

Results of this study are taken from two sources of qualitative data. The first source is my own participant/observation notes from the Critical Incident Stress Debriefing workshop that I attended. The summary of my experience will include not only the behaviours, procedures and reactions that I observed throughout the two day presentation, but will also include my own reactions, perceptions, thoughts and ideas during the presentation. By including my own personal account of the experience of the debriefing, I will be informing the reader of the context by which the second source of data was analyzed.

The second source of data is the interviews conducted with participants of the workshop and with the workshop facilitator. These interviews were approximately one hour in length and were narrative in style. I did not attempt to ask questionnaire style questions to each interviewee, but instead asked open, broad questions and allowed a mutually created discourse to take place. The resulting data is then a co-construction of the verbal interpretation of the experience of the CISD workshop.

The following sections present the researcher’s personal context, the summary of my participant/observer findings, the summaries of the participant interviews and the summary of the group facilitator interview.

Summaries of Data

Researcher’s Context

It is important that my own background and history with these topics is elucidated so that the reader can understand more fully the context in which the information was gathered and analyzed. The full accounting of this background will ensure that the results will be trustworthy and that the research itself is of the highest qualitative quality.
My history with CISM and particularly with First Nations culture is spare at most. I am increasingly astounded at the fact that I have lived my entire life on the same land as Native people and have had only minimal contact and even interest in Native issues. This speaks to the culture and attitude in which I was raised.

I was born in Victoria in 1967 in the neighbourhood of Fairfield. Victoria is a small city in British Columbia which is known for its “English heritage” and its “quaint” adherence to the values and traditions of the conservative English settlers who colonized it. Tourists enjoy abounding flower baskets hanging from British-style lampposts and lovely tea-time traditions and fish and chips at English-style cafes. References to British colonizers abound not only in landmarks and ceremonies within the city, such as high-tea at the Empress hotel, the Parliament buildings, the “Oak Bay Tea Party Parade and Fair” and the Royal British Columbia Museum, but also exist in the very names of the city and the province themselves. The only public references to Aboriginal heritage that I remember were the few Totem Poles erected around the Museum and within Beacon Hill Park. My heritage then, takes itself from the identity of the foreign power that colonized the very land upon which I was raised.

My family was a typical white, middle-class family. My mother was a housewife and my father was university-educated and worked as a scientist for the Canadian Government until he retired. We did typical family activities together: played cards, watched TV, went camping, had birthday parties, enjoyed music, and ate dinner together around the kitchen table everyday.

I was raised United Christian and went to Sunday school every Sunday growing up. I was a member of the Church choir as a child, was baptized and completed the Confirmation ritual to become a full member of my Church. However, upon reaching my teenage years I began to disconnect from that foundation in my life. I did not feel that that type of religious experience was an expression of my own spirituality. However, this has been an area in my life that I have only casually addressed. I have always felt a slight
aversion to organized religions, probably because of my own unsatisfying experiences. I consider myself more connected to personal “spiritual” feelings than to a formalized and rule bound doctrine.

The attitude of my upbringing was typical for its time as well. One of the most vivid memories I have as a very young child was when I was about 4 or 5 years old and I was walking down the street with my mother. I saw a discarded and burning cigarette on the sidewalk. Being that my mother smoked regularly, I was curious to investigate the experience. I picked up the discarded cigarette and was going to take a puff when my mother quickly took it from my hand and threw it back to the ground saying, “don’t touch that. A Chinaman could have had it in his mouth.” I, of course, was instantly repulsed at the idea of having almost shared saliva with a “dirty Chinaman.” Racial references of this kind were and are common in the culture that is my race, class and era.

What’s relevant for this research perspective was what we, as a family, did not do. We did not discuss important issues of the day. We did not have any particular political affiliations or opinions. And we were not educated about current events any further than what the CBC told us was true. My family were confrontation avoiders. In this way I believe we were a very typical white family of that generation. Up to the last year of my life, I have been hesitant to enter political discussions or debates. This is not only to my chosen lack of knowledge of political issues, but because of the discomfort I feel at entering into an area that raises debate, argument and emotional tone.

I recall no Native students in my elementary school. Perhaps they were there, but they were not able to work their way into my consciousness. Perhaps there were none. I remember Asian students, Polish, American and French, but no Native students. Where were they I wonder? Was it that Victoria was unusual in its racial make-up, or perhaps it was just the neighbourhood in which I was living?

High school was more liberal in its racial make-up. I recall one Native student, but looking in my high school yearbooks, I see that there were actually about ten. Perhaps I
remembered only that one student because he was the one that was acting in a way that I recognized as being the "Native" definition of that time. This student was characterized as being unstable and troubled. In school he frequently missed classes and was continually being disciplined for a non-compliant attitude. Outside of school I knew of his excessive use of alcohol and his proneness to get into violent fights. One night I witnessed this boy in a particularly brutal fight on the street outside of a house party. I remember observing other kids who were standing around the fight, watching and cheering the Native boy on. I felt disturbed, but did nothing as that seemed to be the behavioural norm of my peers.

I believe this boy stands out in my memory because of the tragedy that surrounded him. The other Native students were less memorable as they acted in what I considered a "normal" way. But the troubled boy, was the butt of cruel jokes and mockery, and he was obviously filled with pain. I don’t recall if or how anyone tried to help him.

My ignorance of First Nations people and culture changed when I entered University. I majored in Anthropology, focusing on cultural theory and study. Here we looked at First Nations history and culture in a more straightforward manner. One of my closest colleagues during my years in Anthropology was an older Native man who explained to me for hours at a time about the ethnocentricity of missionaries and the questionable assumptions of present day Anthropologists. He encouraged me to ask instructors the difficult questions regarding cultural bias, power dynamics and reciprocity.

However, the academic attitude I had recently adopted was not shared by most others outside of the Anthropology study halls. The year I graduated there was a scandal on the UBC campus. Engineering students published a newsletter that was made entirely of racist and anti-First Nations material. They distributed this newsletter across the entire Point Grey peninsula. I read the newsletter with my Native friend and I saw his reaction. Through him I felt, for the first time, the pain, humiliation, anger and victimization that Native people endure so regularly. I sympathized with his indignation, however, I, personally did nothing about it. I assumed someone else would. It was unfortunate and
shocking, but this was not “my” problem. Luckily for me, someone else did take action and the Engineering faculty in total was punished for its “insensitivity.”

As I began my counselling career I, of course, learned more about trauma. However, until this time, I never put the two issues together. As a member of the dominant culture, there is always present a discomfort at facing the pain my ancestors have caused. It is particularly important to deny it when we live with traumatized people as neighbours. Whenever the topic of First Nations struggles came up, I felt an instant aversion to looking at it. I would shy away from the topic in conversation, for fear of becoming too “political.” This was a throw back to my apolitical family roots. I was “uncomfortable” dwelling in politics too long; things get messy and depressing there.

This research project did not start out being focused on First Nations trauma. It began as an inquiry into spirituality and trauma. Through the natural evolution of research, I found myself plunged into the confusing, uncomfortable waters of a struggle that began with attempted cultural genocide and hasn’t ended. Because of this research, I am understanding the phenomenon of “white guilt.” I sometimes feel somehow responsible for the oppression that has taken place in “my” country. I know that cross-cultural theory suggests I come to understand my position in the power dynamics between our two races in order that I eventually become more aware of my effect in a counselling relationship. My only comfort with this process is that I am beginning to understand.

But it isn’t a comfortable kind of understanding. I realize now that there is a part of me that actually feels afraid of Native people. Perhaps this is a subconscious transmission of the “white guilt” of my culture. Or perhaps it is a transmission of the reluctance and attitudes of my family. Or perhaps it’s me. In any case, I am subtly aware that if I were to become a target of a long held in rage, my “white guilt” tells me I’d be helpless and they’d be justified.

So this research for me has been a process of awakening to a cultural and political reality that I’d sheltered myself from until now. I hope I can do something about it to
make this situation better. I hope this research can be a small contribution toward the complicated healing process of two Nations of people.

**Participant Observations**

This two day seminar on basic Critical Incident Stress Debriefing occurred in North Vancouver at a First Nations Community Centre. The facilitator had informed me of this workshop because I had been in contact with him regarding his work. He said he includes cultural aspects in his presentations to First Nations people. The purpose for my attendance was to witness and document how this First Nations agency had changed its format to fit a more spiritual or meaning oriented culture. My interest was in how this presentation had been made culturally relevant.

The population of participants consisted of approximately 30 people, all but 4 being Native. Participants also tended to be involved in mental health or education fields. For example, some professionals in attendance were Native Education instructors, Social Workers, Youth and Sexual Abuse Counsellors, and Community and Family co-ordinators. There were also present in this group a number of volunteers at a First Nations crisis centre. All volunteers were Native except two Caucasians. There was one elder present. This population could be described as being well educated in the fields of mental health and Native issues.

The presentation seemed planned and structured to me. The participants were asked to sit in a semi-circle, with the facilitator standing at the focal point. Behind him was a computerized projection system and large screen. Before the facilitator asked people to introduce themselves, I asked permission to speak to the group. I introduced myself and explained my task of gathering data for a thesis project. I handed out a letter of introduction and asked for interview volunteers at the end of the workshop.

The facilitator then asked participants to introduce themselves by stating their name, occupation, their interest in CISD and their goal for this course. After the
introductions, the facilitator introduced himself by stating what his goal for this course was. He said he wanted the group to teach him. He used self-referring deprecating humour to create a light and relaxed atmosphere. He then gave some background information on himself, saying that his ancestry was Scottish and Metis. He was a Caucasian fire-fighter in North Vancouver and started working at the First Nations agency in 1995. The agency asked him to teach CISD to First Nations fire-fighters. He felt he needed to connect the program to Native people, so he created a mask to symbolize trauma and transformation to healing. He passed around the mask.

The facilitator then went on to address informed consent issues. He warned the participants that talking about trauma may be a “trigger” for some.

The facilitator passed out a series of CISD paraphernalia such as pens, pins and workshop manuals. He began the presentation by going through the handout page by page on the screen. He worked straight from the handout, reading off the pages as he gave information to the group. The audience participation consisted of a “show of hands” to emphasize certain points the facilitator was making. He was very explanatory with the basic processes of trauma in individuals. When talking of the effects of stress, the facilitator included spiritual dysfunction as a recognition of cultural differences.

The facilitator lectured on the mandate of CISM workers and ways of decreasing stress. He talked about serotonin levels, synaptic messages, and limbic system functions in response to trauma. I noticed that I was quiet, insular and taking in information at my own pace. I noticed that I had been daydreaming. I was disconnected from the group and from the facilitator.

My attention was brought back into the room when the facilitator began to talk about the effect of trauma on belief systems. He said that culture dictates beliefs and that beliefs are shattered by trauma. He explained that human experience is the sum of sensory input and learned beliefs, emotional, behavioural and cognitive trauma stems from spiritual trauma.
Someone asked the question, “but the Creator doesn’t give you what you can’t handle.” The facilitator’s response to that was we must understand it in order to handle it. If we can’t understand what happened then we need to have faith, like the AA motto ‘let go and let God’.

There was another question about the difference between grief and trauma. The facilitator explained “it’s the challenge to the belief system that drives trauma. We can get stuck in trauma if we can’t grieve.” He went on to say that recovery from trauma happens when belief systems are reconstructed. Religion and cultural beliefs, rituals can help this to happen. In residential school these practices were stopped.

The facilitator explained the Debriefer’s job as assisting traumatized people to reconnect with their lost information such as cultural rituals. They do this by emphasizing repetition in order to access information in times of trauma. If Native people are not allowed to exercise their rituals and healing methods repetitively then the information won’t be accessible in times of trauma.

One of the group members asked to do a grounding exercise before we broke for lunch. We relaxed and grounded ourselves by connecting with “Mother Earth.” This was a relaxing and re-energizing exercise.

During lunch participants ate food provided by the Native Community Centre and mingled with each other. I felt at a loss in this group. I was aware that I was a member of the dominant culture coming in to study “them.” I had casual conversations and hoped volunteers would approach me, preferably Native volunteers, but none did.

After lunch we watched a video made by the Critical Incident Stress Foundation explaining emergency worker trauma. There was no First Nations references, no Native cultural content, nor was there information on spirituality or meaning making included. The approach was looking solely at what happens to an emergency worker when they are exposed to traumatic events through work. The video was symptom oriented.
When the facilitator used personal examples and disclosure to make his points the material felt more personally relevant. He uses the term “Creator” freely which appears culturally appropriate. However he uses the terms, “you” and “your community” which appears disconnected from the group.

Some confusion arose over the difference between trauma from a current event and trauma from past historical events. One participant asked if the trauma arising from residential school abuse could be dealt with by a CISM team. The facilitator replied, “No - it’s not a current trauma.” There ensued some debate over whether trauma felt today was current trauma. There appeared to be some tension over this confusion. Voices were sounding more irritated and the facilitator appeared to backtrack in his answer. He explained the time difference between PTSD and CIS. Some members talked about cultural trauma and questions of how to deal with healing abuse and creating coping skills. There appeared to be a need to find ways of healing in general and confusion between counselling and debriefing.

The idea of secondary victimization was relevant to this group. Members brought up the fact that secondary victimization is common in Native communities because community members almost always know the victims of trauma.

At the end of the first day, an elder in the group asked if we could have a prayer. We gathered in a circle and closed hands. The elder asked grandfathers, grandmothers and the Creator to help us learn and to keep is safe and then thanked them. This act felt much different for me than the rest of the day. This was the first time I felt like my soul had entered the room.

At the end of the first day the other two white people in the group approached me to volunteer for my research. I found it interesting that out of 30 people, the first and only volunteers I had were the two other Caucasians.

On the second day we continued in much the same format as the day before. At the lunch time break, discussions came up about “white guilt” and responsibility. There
seemed to be a shifting of focus from fitting Native people into a CISM model, to fitting
CISM information into Native culture. We also talked of spirituality and connectedness in
society in general. During lunch two First Nations women approached me about my
research. They asked questions and we discussed my views so far. One woman offered to
be interviewed. The other said she did not want to be interviewed, but that she would give
me her personal notes on this workshop when it was over.

I noticed over the break that the facilitator turned off the computer. He left it off
for the rest of the day. He spent some time with the woman who had become upset earlier.
I noticed that he was doing some EMDR techniques with her.

A thought occurred to me while we were reconvening: CISM does not fit with
First Nations people because critical incidents are never isolated incidents. The
background and history of First Nations people is filled with multiple traumas. Each
critical incident is cumulative over generations. Also, the CISM training session can be
therapeutic when it addresses group needs such as healing rituals. The standard process
contains no meaning or spiritually oriented content.

After lunch the facilitator changed the format of the group because of the amount
of feedback he received. The chairs were arranged in a circle and we began with a prayer
asking the Creator to help us hear each other and learn. The group then remained standing
and we performed a smudge cleansing ceremony. The elder described the ceremony and
its meaning as he went around the group allowing each member to perform the cleansing
ritual. He started to my immediate left and went around the group, leaving me to be last.
My interpretation of this was that the elder allowed me the longest opportunity to observe
and learn before I had my turn.

After the smudge one member sang a traditional Native song while another played
a drum. The effect of participating in these rituals was a powerful one for me. The smudge
ceremony was moving. I felt much closer to the group and much more a part of the
learning than I had before. I also felt recognized because the elder took time to explain
each part of the ceremony. It allowed me to connect with the culture and feel much more respect for each member of the group because of the shared experience. I also felt more spiritually awake. I felt humble and reverent after this.

We continued the afternoon with a talking circle that allowed each person to check-in or give feedback about the group. One person said she was triggered by the terminology in the hand outs. She felt that seeing a Native mask beside the scientific words repeatedly was a subliminal message. She felt this was particularly damaging to residential school survivors. The response to this feedback was an explanation of the meaning of the logo by the facilitator.

Another member gave feedback about the previous day. She asked if this presentation fit the needs of the group. She cited that the residential school debate from the previous day was following the “rules” of CISM. This is an example of having to make the training program more appropriate for Native communities. She suggested to the facilitator that he consider the traumatic history of the community. I also wondered about the appropriateness of having a non-Native trainer give a workshop on trauma in a Native community. The first member then agreed that she needed a “heart to heart” response to her feedback.

During my check-in I expressed my gratitude to the group for allowing me to participate and observe. I said I hoped my research would be valuable to the process of healing trauma. I thanked the elder for explaining the rituals to me because this helped me to understand.

A third member told of a disturbing memory that came up for her during the first day. The member related a terrible incident when she was a young child of being involved in an accident that killed another child. This member became upset and began to cry. The facilitator reflected her feelings and then turned to educate the group about “triggers.” I felt uncomfortable with the level of safety that wasn’t provided for this member by the facilitator in his response.
At this point the group facilitator began to speak a lot and interrupted the flow of the check-in. He appeared concerned that all the information in this course be given out in the arranged time. He mentioned that we needed to get a lot done according to CISM guidelines or else he couldn’t give us certificates. I noticed that as he was talking people were losing connection with each other, there was stretching, fidgeting and shifting in chairs.

We continued the check-in. The elder in the group began to speak about the loss of connection that First Nations people feel with their ways of dealing with trauma and healing. He said people today see time differently. They are generally more aggressive. I understand this to mean that people feel more stress today than in the past. This has created challenges toward grieving. Rituals usually take time to deal with feelings. Now the rituals have gone. This seems like a violation of dead ancestors. First Nations people were taught that burials had to be ministered by a religious representative. Some people now are saying “No” and going back to old ways. The facilitator responded with accurate reflections and summaries of what the elder was saying.

The elder continued by saying that Native people have to become aware of their rights; that their rights were taken away by oppression. Some Native people wanted to bridge the gap between cultures by joining the white establishment, like becoming soldiers. Then when they returned, they were recognized. Others are still fighting for reclamation of their rights and rituals. This elder pointed out that the terminology and words of this presentation are not First Nations. Native people did not have words for those things because they just knew them.

The group facilitator then made a parallel distinction between debriefing and a healing circle. He said this structure was borrowed from ancient cultures.

Another member then expressed concern for the woman who was crying earlier. The facilitator received the feedback that the group needed a “check-in” structure. The idea of negotiation of cultural rules came up. Through the talk about the need for a
check-in it occurred to me that First Nations trauma is a larger issue than we are addressing. Reclamation of culture and reconnection with identity is a forefront need. Adapting First Nations people to the CISM process seems backward. They have their own healing rituals, their own approach to death and trauma. It would be more culturally relevant to adapt CISM to Native cultural traditions. Even over the last two days the format of this basic level training session had to change. It seems ethnocentric of the dominant culture to want to present white (scientific) material to First Nations people and think that adapting it by making more culturally sensitive is good enough. First Nations culture is particularly spiritual and healing oriented. Perhaps it would be a greater service to First Nations people to help in the process of reconnection with their own healing rituals.

He was asked about adapting debriefing to adolescents and elderly people. He was also asked whether there are any First Nations teams. He replied that there were two teams. He was then asked if there were elders on the teams. He replied that there was for the Nicola Valley team. He went on to say that the agency hopes to create 5 teams in BC before the end of this year. He hopes to have 8-10 teams eventually.

The elder of the group then spoke up about the lost tradition of paying respects when informal teams are called to do spiritual work. He said communities struggle to get messages to those with funding. The funding is not balanced. Police and emergency workers get therapy. First Nations communities are left to find their own. The facilitator replied to this that CISM is volunteer work and that it helps for regional communities to have their own emergency funds. The elder then said, “look at local funerals. Look at the numbers to see the effects on families. It’s cumulative.”

At this point the facilitator said it is important for us to finish getting all the CISM information we are supposed to. He talked about alternative therapies for trauma such as EMDR, Thought-Field therapy. He asked if he could talk about the EMDR intervention he provided for the upset woman at lunch time. She said she felt much better. I wondered
why he needed to take her aside from the group and treat her individually for her trauma. It did not seem to fit the cultural context of the day.

After the end of the day, I made arrangements with my volunteers for feedback interviews.

Interview #1 - “Harry”

Harry is a non-native male, 51 years old. He describes himself as being a novice in the area of counselling and debriefing and states that he has had only recent exposure to First Nations culture, although he has always had a “latent interest in Native issues.”

He felt the workshop was productive, that the information made sense to him. He felt the information was valuable and that it helped him personally to organise some of his own experiences in life. The leader explained how to deal with trauma individually, he explained how the psychology of the approach works on a 1:1 basis and this is how most people in the room were going to work, so this was useful.

However, Harry felt tension at the end of the first day and was surprised that the leader was presenting in a “mainstream” fashion. He stated that the leader, “missed something there.” Harry had presumed from the workshop that this was the leader’s first time working with a First Nations group. He felt it showed a lack of sensitivity to use a “white approach” to the presentation and that it seemed obvious that the leader should have asked about presentation style before the beginning.

This participant describes himself as feeling “taken aback” by the presentation for several reasons: the CISD model parallels Native style of gathering - that is, sitting in a circle and sharing in turns; the leader said he was of First Nations ancestry; the program was funded by First Nations Emergency Services. An example was the ‘residential school’ issue. This participant felt the leader failed to make the connection between that issue and this workshop.
In Harry’s description of his responses to the training, “relevance” became an important factor in the presentation of the material. Harry felt the CISD model is an appropriate fit for First Nations people: it adapts because the structure is similar to First Nations gatherings. He suggested a way to increase relevance in the material is to put more thought into how to link past trauma such as residential school abuses with CISM. He believes that when material is relevant to people they get more out of it, their attention is given easier.

As an example of relevance, Harry emphasized the difference between the group structure on the first and second days. The first day there was not enough culturally specific components - “zero on the first day.” He felt that the leader was making a token recognition of Native culture by including a logo and a mask - that his could have been further adapted. But Harry felt the leader’s response to feedback at the end of the first day was quick, supportive and showed an eagerness to learn. The second day was more relevant, felt better and decreased tension because more Native identity was brought in.

The fact that the first day was more “white” made Harry wonder about the procedures for a debriefing in First Nations communities. Harry suggests that CISM groups sit down with elders and healers in Native communities and redesign the presentation and the terminology to include more relevant material in a more culturally sensitive way. He would like to see spirituality made the first priority.

The key for Harry was respect and understanding of another culture. For him it’s “deadly important.” Healing is more effective, listening is made easier with respect and understanding right from the beginning. He could see the difference in the cultures in the presentation - First Nations are interpersonally oriented, and white culture is individually oriented. The first day seemed more individual which Harry felt was insensitive to First Nations participants.

Harry’s opinion of the program as a whole was that it was an excellent learning experience. He has since then used the information he learned at the training workshop in
real-life situations with his work. He said that the information he learned fit two crisis situations he experienced to a tee. He considers this information to have structured his knowledge and to have helped him to be more confident. To Harry, this program is a good idea for training First Nations people because anyone in a crisis situation should have this training; it helps the crisis make sense. There are more people in a crisis state per capita in First Nations communities so the more people who have this training in these communities, the better.

Harry appreciated the clarity and conciseness of the handouts and overheads. He felt it was good support for the verbal presentation. He also thought the group leader adapted to criticism well because he listened and took it to heart.

Interview #2 - “Jen”

Jen is a 29 year-old Native woman of mixed ancestry and she works in a local First Nations crisis centre. She works in the area of community development and residential school healing projects.

Jen found that there was a difference between the first and second day in the approach to information: the second day was much more human. On the first day the program felt information oriented, fast paced, with little opportunity to participate. The second day felt more integrated, more connected with more emphasis on the heart.

The program was relevant on an individual basis, i.e., learning the way people react to trauma. But as a member of a Native community, she felt the delivery lacked relevance. She stated that most First Nations people have a “foot in each world,” including herself, who is from mixed ancestry. First Nations groups in training share in a circle so they can connect and that didn’t happen that first day. The group sharing tradition is important in Jen’s opinion. She says when groups talk and share together it allows hearts to open up and healing to happen. Intellectually she could understand the western approach to information giving, but there could be a blending of traditions. Her Native
culture views information mainly through human experience and not so much outside of it. "Without being able to identify within ourselves the context of the information, it doesn’t work, it’s just letters on paper." She sited that oral tradition is an example of the difference. Native history is passed down orally which makes it connected to human experience. When the facilitator shared his personal experiences - she felt support for everyone else to share also.

Jen recalled that when the facilitator stated that residential school trauma was not a critical incident, it started some discomfort within the group. She heard people say the second day, "yeah that ticked me off - I was choked about that." She didn’t feel the difference was explained in a way that could be heard by the group. By the second day people were becoming more uncomfortable. She felt that as a group of First Nations people and the history what they’ve been through over the years, their context was not acknowledged. This created defensiveness. When the obvious is not acknowledged people start disconnecting from themselves.

Jen had praise for the facilitating skills of the group leader. She appreciated his effort and felt he was trying to perform as best he could. However, the course itself was being represented as a First Nations course, and she felt it was lacking there. She thought it was a regular course geared toward emergency workers, with the only significant difference being a native logo on the handout and a drum. The video used was in context with white origins of the presentations. Although the facilitator talked about First Nations communities showing that he did try to relate the course to another culture, it was not enough at all. There is a much deeper level to relate to. She stated, “unless you experience a culture you can’t really get it.” She considered the facilitator’s training was a representation of where he’s at with his own journey.

Jen felt that two days is not enough time to cover CISD information in a First Nations setting because the format needs to change. Participants need to be part of a
talking circle and there would have to be room for ceremony. In this way the workshop
couldn’t be kept on a schedule.

Also, Jen noticed that the facilitator warned us that triggers might come up for
people as we discussed trauma, but he did not talk about what would happen if they do.
She asked, “what are we going to do? I don’t know if people felt that level of safety.” She
felt that the training could help participants more by talking or doing a questionnaire and
exploring how to take this information and use it in Native communities with participants’
work. It would be helpful to explore whether individual work places have their own style
of doing things. “How can you as counsellor and community workers use this information
and put it into your training or whoever you’re working with? What are your client’s
needs? How would this fit into what you do, the way you do your work, your culture and
your traditions? How can we take this information and make it culturally relevant?”

Jen believes that even a “training session” or other information has to be feeling
oriented and therapeutic because of the history of trauma. “It’s not all that head stuff, it’s
about emotions and feelings and what’s in your heart.” The scientific information is only a
part of learning; there are other approaches missing. The emotional and spiritual approach
to information is very important. The learning experience has to be balanced. Most people
who are working in the community and helping have also been through the same
experiences so they need to look at personal relevance to integrate the information. “By
healing ourselves we’re better able to help others.”

In looking at the approach of the presentation, Jen feels that there needs to be
more relevance to the First Nations community instead of ambulance or fire-fighters or
rescue teams. She suggests using the medicine wheel as a tool to bring across the
information.

Jen stressed the need for integration between approaches in the training session.
She sees the benefit of the training received and feels that the information should be
blended with cultural beliefs and community traditions. “I could imagine that working in a
First Nations community that if it is more oriented to our culture and traditions we would use it more.” Jen suggests having the facilitator working with a First Nations co-facilitator who is aware and knowledgeable about traditional healing and can relate the information to traditional ways. But there still needs be a connection between the facilitator and the people. Jen suggests a woman co-facilitator to balance the mind and the heart, and add gentleness. Jen thinks the facilitator could still present the same clinical information, but in a different way and with someone to help him run culturally relevant training sessions. If that happened, Jen says she would feel more heard, more understood, and would feel closer to the group.

Jen feels that the idea of integration of cultural approaches is key. She sees a need to have integration between giving out information and exploring what really happens in First Nations communities; looking at the effects of residential schools, the ricochet/domino effect of trauma. “There has to be more compassion and understanding and a willingness to talk about everything that happened around residential school and how that relates to us and how that relates to the work we do and how that relates to trauma and critical incident stress management.” Jen feels there are much deeper issues than there was time for.

Jen sees that changes have to happen in the approach to healing for Native communities. After a critical incident happens the intervention could be done without this formal training. She believes the community could come together and do what they do around cultural beliefs and traditions of healing. When the facilitator talks about reactions and body sensations, the presentation is very mainstream, but the message to Natives is the same. The facilitator should look at the medicine wheel and use that as a tool and talk about traumatic experiences from Native history, like being torn away from their family and put into residential school and abused. He could go around the medicine wheel and look at how they’ve effected someone’s life, physically the illnesses, emotionally, mentally and spiritually. It’s the same information, just not presented with cultural relevance.
Jen questions the helpfulness of the debriefing approach in Native communities. She wondered, "how much does the debriefing help when you go in and you help a couple days and then you’re gone. That’s not the way we do things - to come in and put on a band-aid." Instead she believes that’s where therapy or help for the process of trauma should blend with culture, ceremony and traditional ways of healing. Communities aren’t set up the way they used to be, Jen explains. “There were healers and grandmothers to take care of grieving people and the men took care of other things. Other people would take care of the cooking and the children. And that still happens in communities but not always because of the broken families and broken situations.”

The ideal situation would be to go into a community, bring in some peers from the community and have a professional there. The facilitator would have to be somebody who could lead a traditional circle and who could take the knowledge from that training we received from the facilitator and express it and use it to do the work in a traditional way. Perhaps a debriefing team could help to set up a longer term intervention while they’re there.

Jen thinks the program is generally a valuable one and she is considering taking the next level in the courses. She thought the leader was professional, knowledgeable and experienced and she liked that he shared personal information. The training manual was clear and useful and she has referred to it in the intervening time.

Jen thought the program was informative, and personally relevant although she would like to see more time taken to look at applications to First Nations communities. Since the course is marketed as being a “First Nations” course, changes need to be made. If the course had not been labelled or particularly associated with First Nations groups then it wouldn’t have received such negative feedback.
Interview #3 - “Martha”

Martha is a 40 year old non-Native female. She has been working with the Native Community for 3.5 years. Martha stated that her general opinion of the workshop was that it was informative about trauma at a basic level. Martha has learned about trauma and PTSD prior to this workshop, so she received no new information from the 2 day workshop. She felt that the information given was relevant to the work that most participants would be doing because First Nations communities face those kinds of crises. However, the act of having a “white” person impart the information made it biased.

It is her belief that Native people are looking for a different kind of information than just looking at crises. She suggested shifting the program to incorporate the history of Native culture more. This way, people would be more open to the information. It is this question of “openness” to the information that came up for Martha when she heard that 2500 Native people had been trained with this workshop, but that there was little response from them in terms of becoming more actively involved in working with this program. Perhaps if this basic level of training was more culturally relevant, the process would be more accepted. Also, the cultural difference in terms of social support and interpersonal care could account for this lack of response.

She mentioned being surprised that the facilitator made differentiations between himself and the group in this language. He had said he was Metis, and yet used language such as “you people,” “your community.” Martha believes he should use language such as “we as a people” and “our community.” This would also serve to include the non-native people in the group.

Martha recalled that she felt uncomfortable the first day of the workshop. She felt that First Nations traditions were not acknowledged and practiced on the first day. The second day was seen as being better because after lunch the facilitator changed the format to encourage more cultural traditions. Martha sees the circle as keeping people connected, unified and respectful of other group members. She suggested that the facilitator speak
with the co-ordinator beforehand how to construct the group. A discussion with the group co-ordinator or an elder of the community prior to the group would ensure that traditions are being respected and followed. It was expected that a refinement of the information to fit First Nations culture had been done.

Martha also recognized that this particular group has a higher degree of personal awareness. They are more aware of their “triggers,” and so may be less affected by triggering events. This type of workshop may be felt much differently in other First Nations populations who have not had the benefit of therapy or mental health education.

On the issue of trauma, Martha views the separation of critical incident and trauma is a difficult process. She sees that in Native communities new critical incidents arise because of past traumas. This “domino effect” of crimes is then normalized and minimized. Martha understood the facilitator’s explanation of the definition of “critical incident”; his response that Residential School trauma is not “critical incidents” is technically correct. However despite what the technical correctness is, many in the community perceive residential school trauma and the fallout to be critical incidents because the incidents arising from it continue to occur on a daily basis. It will be generations before residential school will not be considered a critical incident because people will be continuing to work through it. When the facilitator explained the time criterion of critical incident as being current, excluding residential school trauma, Martha felt the group “shut down.” This discrepancy might not have arisen if the facilitator had recognized that residential school trauma is a critical incident for this community.

She sees greater issues with respect to trauma and culture that CISM does not address. Cultural identity was lost because of trauma. She said, “residential school beat the identity out of them.” She relates to that experience personally; she felt she lost her identity also from that environment. In order for recovery from this loss to happen, there needs to be individuals who remain connected to their identities to help others reconnect, such as elders.
In this way, Martha felt that the workshop needs to be more culturally specific. The information coming in needs to be changed. Spirituality needs to be included in both structure and content. Prayers and smudge should happen at the beginning of each day of the workshop and the spiritual effects of trauma, for example meaning and belief systems, could be the first thing addressed. Martha thinks there should be a circle debriefing at the end of the workshop to resolve any emotional issues that have arisen as a result of the workshop.

Martha has personal experience with spiritual trauma. She endured much the same kind of abuse in a spiritual setting as the residential school abuses. It is her experience that this kind of abuse is a terrible thing and takes a long time to recover from. She understands that people dissociate from spirituality and that is it is harder to recover when the spiritual foundations have been shattered. She believes that if spirituality had been addressed in the workshop, it probably would have triggered people, but the population was of professionals in the field of psychology and healing and so they could have handled it. It is not enough to look at emotional, behavioural, psychology and physical aspects of trauma. The spiritual consequences of trauma must be looked at as well. Martha suggested using a medicine wheel to do this within the presentation in order to visualize this experience as well. Because this group is so aware and experienced with trauma, she felt that excluding this part is excluding a very large and important piece of trauma recovery for them.

Martha feels that healing has started through recognition, acknowledgement of the events that happened, discussions about events, awareness of victims rights and education. She says there are not enough First Nations people who are able to be a part of that process so there must be outside people involved. However, there are very few protocols about how non-Natives deal with First Nations trauma. There must be trust, sharing and an awareness of traditional cultural knowledge before non-Natives can have a part in the healing process. This will take time.
This population, because they are more experienced with working with trauma victims and they're more in tune with their own cultural connection would be more sensitive to the program’s content. Martha imagines that for this reason the group could be more critical of the workshop that the rest of the community would be.

The program was valuable because it increases awareness around trauma and reactions. It recognizes that Native communities are suffering through trauma, whereas in the past Native communities were pushed into the background. The program promotes introspection of trauma victims, looking into painful areas which people wouldn’t necessarily look at on their own. This can only serve to help in many areas such as domestic violence.

Martha thought the facilitator was effective and experienced and presented the information really well. She said she could have listened to him for a long time.

Interview #4 - “Donna”

This participant declined a taped interview, but instead provided me with written responses to the training session. Because the feedback was only 2 pages of notes, I am not summarizing, but am instead providing a verbatim transcription of the letter.

Punctuation marks and emphases are as they appear in the notes.

Notes from Day 1

“(The facilitator) speaks from one of life’s Best teachers - Experience.
I can feel that he has been around a lot of grief.

I did not find this workshop to be culturally relevant. The question confuses me. Culturally relevant? (The facilitator) spoke about Alaskan Airlines, Atlanta bombing and different states and issues, white people issues.
I didn’t feel the ‘Residential School’ issue was accurately addressed - “not current trauma” this is a remark only a dominant culture white person would say. I felt hurt by that comment, and again must suppress my feelings. It is current emotional trauma! If you want to call this workshop culturally relevant material you CANNOT override residential school effects on the Native Community. This workshop came from dominant culture view, I personally found it hurtful, I was personally triggered being a Native person. It was insensitive. Glad to add (feelings) it was all dealt with on my end.”

Day 2 - notes appear to be directed to the workshop facilitator.

“I liked your comment: as Therapists we sell hope.

Triggered? Yes - stress is in the eye of the beholder
the symbol 2x on every page, with words - Stimulus, Response, Stress, Trauma, Loss, Traumatic Event, Critical Incident, throughout the workshop triggered me. Mostly the symbol with these words was like a subliminal message to my brain and it was hurtful.
You said your body performs the way it needs to.
You talked about Belief Systems - one example you used - Children should outlive their parents. Children on the reserves are committing suicide and sniffing gas. Isn’t that ‘severely challenged belief systems’ that you’re talking about?
You said Culture is the core of trauma - Our Culture has the Residential School Syndrome. You talked of heart memory.
Recovering from trauma is reconstructing belief systems - to sing, drum, sweat, cleansing ceremony - that was “culturally relevant.”

I understand your point about Current Trauma - Suicides, Gas sniffing, planes falling, bombs, fires, car accidents
When you talk to a room of Jewish health workers about trauma you can bet your bottom dollar the Holocaust will come up.

I felt the question to Residential School was not properly addressed - Not Current Trauma. Your workshop triggered me because of the symbols on every page - like I first said, and that hurts me. Pages 21-25 hurt.”

Interview #5 - CISM Co-ordinator

(Note: The original summary was presented to the group facilitator for a member check in order to insure accuracy and validity. The group facilitator made some minor wording changes, however, he felt the initial interview sounded “disrespectful” and so he also chose to rewrite some sections, changing quotes and providing afterthought responses that were not included in the interview. The modifications which did not alter the meaning of statements have been included without notation. However, I cannot include the significantly rewritten portions because these statements were not included in the original text and so are not an accurate portrayal of the interview. Because the narrative approach is a collaborative approach, however, it is important that these changes be included. Therefore, I will place removed sections in parenthesis { } and additions in brackets [ ] so that the reader can have the full context of the interview and the results of the member check.)

The Critical Incident Stress Management (CISM) co-ordinator is a retired fire-fighter who works for an agency that provides a variety of services to First Nations communities. He has been trained in CISM in the United States and continues to upgrade his training and education on a regular basis. {removed: This CISM program has only been running for 4-5 years.} It began as training in CISM for First Nations fire-fighters and, in response to the discovery of the frequency of critical incidents in First Nations communities, was extended to work with a wider populations. [The program for communities in BC began on a part-time basis five years ago and was changed to a
full-time position three years ago in response to the high demand from community front-line workers for the courses offered within the overall program.

Although CISM is not new in emergency services, it is the first time it has been used in First Nations communities. For this reason, he admits, there are no protocols for working with First Nations communities in the area of trauma and CISM. However he stated the agency’s philosophy and goals. {removed: The primary philosophy is to pay attention to cultural activities around trauma that exist in communities already.} [added: The agency’s philosophy in relation to trauma is to respect the strong cultural healing activities that exist in communities already and to try to blend some ‘mainstream’ understanding of trauma with those practices.] He looks at how a CISM team can work with communities to make debriefing meaningful “as it relates to cultural practices there already.”

He tries not to interfere, but simply to add [added: when an invitation to help is extended from a community in crisis]. He explains that trauma {removed: disconnects people from known identity. He says that Native people are disconnected from their knowledge and that his position is to connect them with knowledge that is there. The cultural reconnection happens “by returning to cultural practices that have been soothing and comforting for 1000 years.”} [added: can cause interruption in thinking processes or difficulty in recalling information that is known. First Nations people are not different from others in that they may be disconnected from their knowledge as a result of trauma. Sometimes assistance is provided by helping them to reconnect with traditional healing methods, the memory of which is inaccessible due to the nature of the trauma. Cultural reconnection is an important aspect of the healing journey from trauma. “practice of cultural healing methods helps to make them more accessible after new traumatic experience.”] (Note: statement in quotes was an addition that was not in the original interview.)
His program has a good reputation, he says. People value it and he has received good response and welcome in the communities he has gone to. His goal is not to get communities to do their own work, but just to help them create teams for intervention. He gives the example of how a First Nations CISM team from Prince George could intervene at a critical incident in Squamish Nation. The basis of this approach is “peer driven, mental health guided” intervention teams made up of First Nations people.

The primary goal of his position is to impart information by instructing programs in communities. It is his agency’s mandate to help create CISM teams in order to improve emergency response in communities responding to trauma. He is there to do crisis intervention work, to educate people on how to deal with traumatized people. His mandate is also to create new intervention teams, particularly for First Nations communities. This is to reconnect them with information that trauma has disconnected them from. He feels that the CISM model is just as applicable to First Nations as to fire-fighters because trauma effects all people the same way. Any intervention following a traumatic event is helpful. First Nations people are not different in their response to trauma, but trauma creates suppression, {removed: and they are very suppressive} [added: and current crisis intervention models encourage people to acknowledge the event rather than allowing normal suppression to continue with possible long term effects. Since this is traumatic stress education and intervention, the hope is that dealing with current issues will prevent the layering of events thereby providing energy and opportunity for community members to deal more effectively with past trauma through professional therapy.]

Another goal this facilitator has is to make up a document that says there must be a liaison from the community to work with the team so that cultural needs particular to that Nation can be discussed. “We have to be culturally sensitive - not {removed: ride in on a charge} [added: charge in] and say ‘we’re here to save you’ but to help them create their own intervention.”
The process of a debriefing entails that the facilitator goes to a community, and, since there are only a few people in the province trained to facilitate, he is usually the facilitator. Then the team connects with a local mental health person and tries to find peers in training to attend the debriefing and learn. They contact a community liaison, like an elder, listen to the changes needed and incorporate cultural practices.

The position of the CISM teams is simply that they must be invited into any community and upon such invitation, that the individual community needs are identified and supported within any service the team may be asked to provide. They listen to the services requested, then incorporate cultural practices. For example, sometimes the elders want to be present in the debriefing group, but we say the members won’t talk about “ugly stuff because they’re afraid of hurting you.” So the elders begin with a prayer in the group and then leave. The goal is to blend approaches.

When asked about the lack of cultural specificity in training his response was "that it was just a training session.” His approach is that “you guys know that stuff - it’s not for me to come in here and put emphasis on what to do - I can’t possibly know all the cultural things about every First Nation community - it’s too much.” He simply provides information from a “western philosophy” such as CISM and debriefing. Then “let’s take this and make the best use of it as it blends.”

His response was that only general information on cultural issues can be used in training due to the wide diversity of cultures in BC. Each community of Nation is asked through the liaison person to identify specific cultural issues and healing rituals that may be blended with the CISM intervention. Because this information is universal - that is, the reactions are broad across cultures - the reactions to trauma are predictable and are outside of culture. The cultural aspect is what action people take with trauma.

He states that he has heard positive feedback about receiving useful information about the symptoms of trauma. The power of this information is that it is normalizing
experiences. He says there is a huge therapeutic value in this normalization, although therapy is not the intention of the training.

Regarding the “critical incident/residential school” debate, this facilitator explained that First Nations people don’t see time the way we see time. Trauma in the past is the same as trauma today. [added: critical incidents and residential school trauma are both traumatic experiences.] {removed: When he said critical incidents and residential school trauma weren’t the same, he was looking at the time difference.} [added: The time difference means that the CISM program is not the appropriate tool for healing past trauma.] But to Native people it’s all trauma.

On spirituality within the workshop, the facilitator said he did not include it at first, but that “he learned.” He now feels it is important to consciously include spirituality. He was told he was missing spiritual components. But meaning to people transcends the parameters he looks at. He touched on those ideas but didn’t go into them in depth because it was only a first level, basic course. It was designed to give a broad outline. If someone wants more they can come back to the Advanced course. The other courses deal with difficult debriefings, team formations, practice and communication skills. And there are cultural aspects in all the teachings.

The facilitator stated that there is culture in all organizations, even fire departments. The biggest difference is spirituality. First Nations culture is more free in their communication with the earth and with spiritual worlds. Trauma is about challenges to belief systems and recovery is about incorporating the event. His work is applied by marrying First Nations culture and scientific knowledge.

When asked about the changes from the first to the second day, the facilitator said that this particular Nation is strong culturally. Some groups are happy to have a Western presentation but they needed {removed: something different}[added: training in a manner that more closely represented their culture]. He was thankful to get feedback and to learn that he needed to ask the questions first about how to structure the presentation and the
information for them. Some communities tell him right away what they want. He stated that First Nations people are battling to regain their lost identity due to events like residential school abuses and that it's important that "mainstream society" shows them respect and validation. A strength of CISM is its flexibility. The CISM credo is "do no harm."

He emphasized that debriefing teams are not therapists. They only intervene with "current trauma." If that triggers historical trauma that's not the place of the debriefers. They then rely on referrals for other interventions. He hopes that his work may help begin the healing work and may help people to help others.

Researcher's Process

Before attempting to document the analysis, it is important to describe the researcher's process in doing this project and in working with this agency. This will ensure that results will be trustworthy as the context for the analysis will be fully described.

I was originally introduced to this topic by looking at the relationship of meaning-making systems to the recovery of trauma. I was interested in looking at whether spiritual or religious beliefs decreased recovery times in trauma victims. In order to look into this area, I needed to find a population that would be predictably traumatized within the time frame of a Master's thesis. I thought of Emergency Workers. In researching Emergency Worker trauma, I found that a trauma intervention was in place and was widely used. That intervention was the Critical Incident Stress Management system. This system is scientifically oriented, dealing only with the emotional, cognitive, behavioural and psychological symptoms of current crisis induced trauma. I wanted to take this existing system and study whether adding a spiritual or meaning-making component would enhance the experiences of participants in terms of recovery.

I was told by a faculty member at UBC that First Nations Emergency Services Society does CISM with First Nations people, and that they may even be able to provide
funding for this project to happen. This combination of cultural and particularly spiritual aspects of Native culture incorporated into the CISM model seemed ripe for study.

I approached the agency in November, 1999 for the two reasons of allowing me to study and document their approach to First Nations trauma and for funding possibilities. I met with the Assistant General Manager of the agency and with the CISM co-ordinator on staff. I gave the Assistant General Manager a budget proposal and verbally explained my project of documenting their approach. He told me the agency would have to present my proposal at the next Board meeting in December to determine their willingness to support this project. I then met with the CISM co-ordinator to discuss the possibility of working together. He stated that their approach to CISM does include meaning oriented material in a culturally relevant style. We agreed that it would be beneficial to work together to document these changes to debriefing. I was told that it would require possible travel across BC and that I should approach the Assistant General Manager for funding for this.

In December I again contacted the Assistant General Manager with hopes that the Board had approved my budget proposal so that I could make arrangements to accompany the CISM co-ordinator to a debriefing. He let me know that the Board was interested in funding my project but that he would have to wait until the end of January to see if there were any funds available to allocate to it.

I continued working on my proposal as my defence was approaching. I contacted the Assistant General Manager in the beginning of February to find out if funding had been allocated to me. I was beginning to feel anxious about getting to the data collection stage. I was told that there was no extra funding available at that time and that I would have to wait until the next fiscal year which would be April, 2000.

Because I was unable to pay for a ticket to Northern BC should a debriefing opportunity arise, and because time was advancing, I agreed to attend a two-day training seminar in North Vancouver which was being presented to a group of First Nations mental health workers by the CISM co-ordinator. I attended the training and over the next month
I conducted interviews of participants. When interviewing the CISM co-ordinator I again asked if I could be informed if any debriefing opportunities arise so that I could attend if financially possible.

Because of what I saw at the training, my thesis focus shifted from looking at what cultural or meaning-oriented changes were made by this agency to whether CISM is even an appropriate intervention for Native people. It seems to be a question that is more to the point of this healing process.

In mid-April I telephoned FNESS again to determine whether there was any amount of funding for this project to continue. I found that I was becoming frustrated with the hesitancy I was feeling for any finality to this question. I also felt financially strapped with administrative costs to keep this documentation going. At this point, the Assistant General Manager sounded surprised that I was continuing to ask for some kind of finality and he reminded me that FNESS had never agreed to fund this project, but that his words were that they were “interested” in funding the project. He then said he would have to go over the proposal again to decide whether they would fund this project. He passed me to the CISM co-ordinator who went over the budget with me item by item. We also again discussed the relevance of this project to their agency and the value such a project would bring them. The CISM co-ordinator agreed that this project was both relevant and valuable and he said he would give this project his endorsement.

I was somewhat confused and frustrated at this point. A month went by and I did not hear from FNESS. I called mid-May once again to talk with the Assistant General Manager about support for this project. He again sounded surprised and he said we would have to meet to go over the proposal. I explained that I did this with the group facilitator. He told me he needed to meet with me himself. We made arrangements to meet when he was back in the office two weeks later.

In our next meeting, the Assistant General Manager told me that they did not receive any funding for any projects in April so there was no funding for my project. He
did however, wish to receive a copy of my finished thesis so that he could then determine whether the research was “worth anything” himself. So, the agency provided me with what in his words was “a token amount.” He also commented that the agency had already contributed to this project by allowing me to attend and receive CISM basic training.

Further to my direct experience with this agency, another point gives me pause for reflection. The agency gave me a copy of an assignment that another Master’s student at UBC had done which was based on the debriefing of FNESS. This student did an 11-page evaluation of this agency for a Program Evaluation course he took in 1999. Within his assignment he documents his own process with this agency.

He approached them about his assignment. They were at first hesitant and asked many questions about him and his project. He was introduced to the staff of the agency. He was flown to Prince Rupert to meet with Board Members and present his project to them. He was then flown to another remote BC community where he was trained in debriefing. The “Program Director,” whom I think is the CISM co-ordinator, took an active part in developing his project. This Program Director also presented the student with 8 people for interviews. The Program Director also called the interviewees himself and explained the interview process.

It is curious to me why there should be such a different level of support for these two projects. I see them as being similar, however my project is a thesis which looks more in depth and specifically at the nature of Native trauma and the place CISD has in that, whereas the other student’s was a small program evaluation assignment. I wonder if gender or race was a factor in the level of support? I am white and female, the other student was Native and male.

I find this process an interesting one to document. It is clear that at points in my association with this agency I felt frustrated, unsupported and avoided. I am striving, however, to provide unbiased, neutral and accurate information about the feedback I received about the training session and its appropriateness in the realm of Native trauma.
Analysis

Resulting themes that emerged from the interviews and the participant/observations are: the performance of the facilitator, the goal of the intervention, the structure of the group, the material presented in the group, differences in the approach to trauma, and cross-cultural competence. I am also adding a section on research difficulties or points to mention in order to provide a full and comprehensive description of the research process.

Performance of Facilitator

In general, the feedback for the performance of the group facilitator fell into two areas. The first is positive and focuses on him as a human being. All participants in this research experienced the CISM trainer as capable with groups and as having tried hard. He was noted as being humorous, he used self-disclosure to make information more relevant, and he was seen as being quick and responsive to the negative feedback he received. There was a general feeling of appreciation for the effort that the group facilitator was seen to give to the group. This attitude can be seen directly in my interview with him when he states that he was thankful to get feedback and to learn from this experience. Donna thought the facilitator was quite experienced in the area of grief. Martha also thought he was experienced and effective in presenting the information. She said she could have listened to him for a long time.

The second area of feedback for the performance of the group facilitator was more critical and suggestive of change. The question arose about the appropriateness of the facilitator being non-native and talking to native people about trauma; this seems counter-intuitive. Having a white group facilitator brings bias into presentation of information.
There was also the question of his inconsistency with his identity. He mentioned his Metis background, but he presents as being "white." This discrepancy was seen in his language usage: he said "you" and "your community" throughout the presentation. There was some reported surprise that the facilitator made this differentiation between himself and the group. One participant believed he should have said "we as a people" and "our community" if he considers himself Metis. As a group facilitator, this would have unified the group.

Another criticism of the group facilitator was in his failure to make a meaningful connection between the residential school trauma issue and this workshop. Every research participant mentioned that the lack of connection or discussion on this issue brought up tension and resentment in the group. One participant said the facilitator "missed something there." A participant stated that the performance of facilitator in this group was a representation of his level of progression in his own journey toward an integrated identity.

**Goal of Workshop**

This topic was a gap in the narrative. Each person implied that they had a goal but did not fully state what that goal was. The facilitator stated that the goal of his program "is not to get communities to do their own work, but to create teams for interventions." His agenda was to provide a "peer driven, mental health guided" intervention. He also stated that the goal is to "reconnect them with their cultural practices that have been soothing and comforting for 1000 years." In terms of his own performance in that setting, the facilitator stated to the group that he wanted "them to teach him."

This is not what I interpret as being the goal of the group. Although individual goals were not mentioned in interviews, during the initial introduction exercise, each person in the group was to state their goals for the group. My recollection was that each person wanted to learn more about trauma and how to deal with it. The fact that my recollection is not clear and that there appears to be a gap in understanding on this point
means to me that this need was not clearly discussed. The fact that there was so much criticism of the structure and approach of this workshop also points to the lack of agreement on goals for this group.

One of the values seen in this program is the recognition and validation it gives to Native communities who are suffering through trauma. The training program is considered a valuable therapeutic opportunity for participants because, “by healing ourselves we’re better able to help others.” One participant believes that even a training session has to be “feeling-oriented” and has to be therapeutic because of the Native history of trauma. Although this value is generally stated, this contradicts the goals of the program. The workshop facilitator stated repeatedly that therapy is not the goal and that if therapeutic work was to be done it should be outside of this workshop. The goal for the facilitator is to impart CISM information only. As he stated, the program goal “is not to get communities to do their own work, but just to help them create teams for interventions.” Clearly this is a discrepancy in the understanding of needs in this community.

**Structure of Workshop**

Many different points were made that refer to how the group is formatted. By structure or format I mean the shape the group takes in order to impart the information. For example, the group was hierarchical in format first, with the group facilitator standing at the front and imparting information in a didactic way. The second day was changed to fit a more egalitarian format entailing group led exercises, and a circular structure.

Some benefits noted in using a CISM format with this population include the similarity between the circular debriefing structure and the healing circle. The group facilitator explained to the group that the structure of debriefing was taken from “many ancient cultures.” The structural fit between Native culture and CISM was noted by one participant also. Also, the facilitator commented that the strength of the CISM model is its flexibility, which means it would lend itself to modification for many different populations.
All interviewees made mention of the format changes over the first and second days. The first day seemed pre-determined to be didactic and hierarchical. The determination was on the side of a white, information based experience in which the facilitator stood at the front and lectured while the group sat in a semi-circled around him. One participant summarized this by saying the first day had “zero” culturally specific structure or material.

The facilitator’s use of the computer to go through pages in the handout was seen inconsistently across the interviewees. One non-native participant felt comfortable and valued the handouts and computer presentation, while one native participant thought the presentation was of a less humanistic and connected nature because of this approach to information.

Also on the first day, the introduction exercise seemed contrary to Native ways of connecting in a circle; the facilitator asked people to introduce themselves in a structured way by stating their name, occupation, their interest in CISD and their goal for the course. In this way there is agreement that the delivery lacked cultural relevance to Native participants. Martha felt uncomfortable the first day because First Nations traditions were not acknowledged. One native participant explained that the group sharing tradition is important to First Nations participants; they share in a circle so they can connect with each other and a circle allows hearts to open and healing to happen. The non-native male participant was “taken aback” by the structural incongruence with Native culture he witnessed on the first day.

All interviewees agreed the second day felt better. Tension decreased because more Native identity was brought in. The approach to information was different on the second day. Whereas the first day was labelled as “information oriented,” “fast paced with little opportunity to participate,” the second day was seen as being more “human.”

Suggestions were given in the interviews about how to change the structure of the group so that it would be more fitting for First Nations participants. One change
mentioned was to take a closer look at triggers and how to deal with them. "Triggers" was mentioned by all participants. Although the facilitator warned the group that triggers might come up for people during the workshop, he did not adequately talk about what would happen if they did. This made one participant wonder about the level of safety in the group. This group was discussed in terms of its ability to handle triggering experiences. There is general agreement that because this group is more experienced in the areas of mental health and the helping professions and because they have a higher degree of personal awareness, they may be more resistant to triggers and better equipped to deal with them if they came up. The question arose about how this training would be received by a group that was less personally aware.

Another suggestion for improving the structure of the workshop was to make it based on more practical information for First Nations people. It might help participants better by addressing how to blend this information with Native knowledge and use it in Native communities. It would be helpful to look at what skills and information about trauma and healing are needed in the work places of First Nations mental health workers.

The idea of making "teams" of First Nations debriefers to travel to other Nations seems inappropriate to the peer reviewers. They thought the cultural differences across Nations makes it unfitting. However, one participant viewed this idea as appropriate because in his opinion, all Nations need to deal with trauma collectively, as their losses were very much the same. He thinks there is latitude for different Nations to connect as one People.

The general attitude toward the structure of the workshop can be seen in the words used to describe it: "mainstream," "academic instruction style," "white approach" and "white."
Material Presented

The previous section looked at only the format of the two-day workshop, whereas a large part of the feedback focused on the content of the workshop. Many positive adjectives were used to describe the material presented in that training course: productive, helpful, valuable, useful and therapeutic were some. The facilitator stated that he receives positive feedback regarding the usefulness of the material in the workshop as well. There is general agreement that this training provides information that can be effective and useful for individuals working with traumatized people.

Some participants said the information helped them to make some sense of their own personal experiences. In this way, the information is valuable in its therapeutic qualities. It is normalizing for recipients to hear the universal symptoms of trauma. A participant stated that this information seems appropriate particularly for crisis line workers, and that First Nations people would be using these interventions in one-to-one situations because First Nations people face crises as well and the more First Nations people who have access to this training, the better off First Nations communities will be.

Participants liked some of the material that the facilitator presented. Donna liked the idea that therapists “sell hope.” She connected with several ideas the facilitator presented: “culture is the core of trauma” and “your body performs the way it needs to.” She also remarked on some culturally relevant ideas about trauma recovery mentioned by the facilitator such as singing, dancing, sweating, and cleansing ceremonies.

Another value seen in this program is the recognition and validation it gives to Native communities who are suffering through trauma. Whereas in the past Native communities were ignored, this program increases awareness around trauma and reactions. The training program promotes introspective activities of Native trauma victims who are participants by helping them look into painful areas which perhaps they wouldn’t look at on their own.
Most of the suggestions for change in the area of program content are around the area of cultural relativity. There is consensus in the idea that this program contained a lack of First Nations information and practices. It was considered that the facilitator made a “token recognition” of Native culture with the mask, drum and logo and the video did not contain any references to First Nations culture, spirituality or meaning making but instead was considered to be from the context of the white origins of the presentation. The Elder in the group pointed out that the terminology and wording of the presentation were not First Nations words. He said Native people do not have words for these things because they “just knew them.”

This observation is in direct contradiction with what the facilitator said about the goals of the agency. He said the primary philosophy of the agency is to “pay attention to cultural activities around trauma that exist in communities already.” He also said the program must be culturally sensitive, that there are cultural aspects in all levels of training and that he “looks at how they can work with communities to make debriefing meaningful as it relates to cultural practices there already.” However, when asked in the interview about the lack of culturally relevant material observed in this training workshop he stated, “you guys know that stuff,” “it was just a training session,” and “it’s not for me to come in here and put emphasis on what to do - I can’t possibly know all the cultural things about every First Nations community - it’s too much.” There appears to be an incongruence between the philosophy of the program and the practice of training.

The idea of relevance came up strongly across the interviewees. Suggestions of using traditional healing approaches such as the medicine wheel as a tool to bring across the information were made. One participant stated “if the information isn’t more relevant to our culture and traditions we wouldn’t actually use it.” Donna did not feel the workshop was culturally relevant, although she was unsure what was meant by cultural relevance. She noted that the facilitator used examples from white American sources; she called them “white people issues.” She went on to say that in order to consider this
workshop culturally relevant, the presenter must address residential school effects. She felt this workshop came from a dominant culture view and that it was insensitive.

The question of why such little response to becoming more actively involved in working with this program was seen in Native communities was posed. Martha thinks it's a question of openness to information. Perhaps if this basic level of training was more culturally relevant, the process would be more accepted. Also, the cultural difference in terms of social support and interpersonal care could account for this lack of response. Perhaps if basic level of training was more relevant there would be more positive response.

Another theme noted within the content of the workshop was its lack of exploration into meaning, spirituality and belief systems. The facilitator stated that the agency is not therapeutic and that exploration of meaning transcends the parameters of his program. Yet he also stated that trauma is about challenges to belief systems and recovery is about incorporating the event back into belief systems and that rituals can help this happen. He recognized that in residential school cultural practices were stopped and that it is the debriefers job to “reconnect them with knowledge that is there.” However he did not incorporate those ideas any further into the structure or content of the workshop. When asked in the interview, he explained that he touched on those ideas but did not go in depth because that was only a first level course.

Martha thought there was a lack of attention to spirituality in both the content and the structure of group. She felt meaning and belief systems should be the first thing addressed, particularly with this population. Because of her personal experience with residential school trauma, Martha knows how difficult it is to recover spiritually. She believes this area should have been addressed with this group because it is not enough to look at emotional, behavioural, psychological and physical symptoms of trauma. She suggested using a medicine wheel and prayers throughout the workshop. The facilitator acknowledged in the interview that spirituality was absent and that he has learned to consciously include it.
Approach to Trauma

Another theme that was seen in the feedback and in my own observations was the discrepancy in the approach to trauma between the group facilitator and the Native participants. In particular, the "residential school trauma vs. critical incident" debate was mentioned several times.

The residential school trauma discussion on the first day created discomfort in the group. One participant heard people say "yeah that ticked me off - I was choked about that" after it happened. All interviewees agreed it is important to link residential school trauma to CISM. This way the information will be relevant to Native people. Donna stated clearly that the response "residential school trauma is not current trauma" is a remark that only a white person could make. She felt hurt by that comment and felt she was triggered into suppressing her feelings more.

Martha thinks the discernment of "trauma" and "critical incident" is difficult. New critical incidents arise from old traumas; the "domino effect" of crimes are then normalized and minimized in Native communities. Participants understood the group facilitator's technical answer to the question of residential school trauma, however there is agreement that he did not fully acknowledge the context of the question in order to convey respect for First Nations people.

A need to address deeper issues was expressed from several participants. There needs to be a definition and exploration of what trauma is in this workshop as a part of learning the information and as an acknowledgement of feelings about Native trauma. Healing trauma starts with recognition, acknowledgement of events, discussion and awareness of victims rights and education. Martha believes that Native people are looking for another kind of information besides just crises and she suggests looking at the Native history of trauma as well. For her, this would bring openness to the group. It is clear that the participants in a training workshop need to address their own healing.
I see a discrepancy in the facilitator’s stance on current and past trauma. On the one hand, the facilitator said trauma reactions are the same across cultures. “First Nations people don’t see time the say we see time - trauma in the past is the same as trauma today” and “trauma is trauma.” However he differentiates between critical incident trauma and long-term trauma. He implies that they are different and that his program is not equipped to deal with the latter. He also states that First Nations people are more “suppressive” than some other cultures, which also implies that their experience of trauma is different from others. This needs to be discussed and reconciled with the First Nations communities he works with because it is clear that Native people see their experience of residential school trauma as being very current and very much a critical incident in the present sense. And it is also clear that First Nations trauma is not the same as emergency worker trauma because of the cumulative or intergenerational effects.

Martha addressed this when she said there are greater issues to respect, trauma and culture, that CISM does not address. She pointed out that cultural identity was lost because of trauma: “residential school beat identity out of them.” Many thought trauma was a cumulative, “domino” effect and that there is not only trauma from an event, but also a loss of cultural identity that is part of Native experience. Donna made the poignant comment “when you talk to a room of Jewish health workers about trauma you can bet your bottom dollar the Holocaust will come up.”

One way in which the approach to trauma seen in CISM does fit the First Nations community is its emphasis on secondary victimization. This was seen as common in First Nations communities because people frequently know the victims of critical incidents.

**Cross-cultural Competence**

There are three themes that emerged from the interview summaries in the general heading of approach to First Nations culture. The first is the importance of integrating both Native and “white” approaches to information, the second is the use of traditional
ceremonies and rituals as a way of blending the two cultures, and the third was the understanding of the needs of Native communities in terms of time.

It was noticed that the workshop facilitator presented "white" information in an "mainstream" way and expected First Nations people to adjust to it. Instead, there is a general idea of the importance of putting Native culture first and adjusting the information to fit that. Participants suggest CISM training groups sit down with elders and healers in Native communities to redesign the presentation and the terminology to include Native culture. Although the workshop facilitator says he does this in debriefings, it was not seen in the training. As one participant said "unless you experience a culture you can’t really get it.” The elder of the group said that Natives need to keep reconnecting with their rituals and traditional ways. Native people have to become aware of their rights, the rights that were taken away because of oppression.

Participants stated that most First Nations people have a foot in each world. So there needs to be a blending of intellectual and spiritual approaches. Native culture views information only through human experience, not outside of it; for example the oral tradition of passing on information “humanizes” the information while written information “dehumanizes” it. Similarly, Harry felt that a cultural difference that needs to be addressed is that Native culture is more personally oriented whereas white culture is more individualistic. He sees this reflected in the change of format over the two days. Another participant believes scientific information is only a part of learning; there are other approaches missing. She said “it’s not all that head stuff; it’s about emotions and feelings and what’s in your heart.”

All participants acknowledged the benefit of the information as it was presented, but there is agreement that it must be blended with cultural beliefs and community traditions. Combining the emotional and spiritual approach to information is very important; this would provide a balanced learning experience. An approach to this would be a negotiation of cultural rules for this group beforehand.
There was general agreement that this program should use traditional healing ways like the medicine wheel to make the information relevant and practical for Native communities. This fits with the agency philosophy of using existent cultural healing practices. This theme is seen in that the eventual inclusion of Native traditions within the workshop helped to create a spiritual and inclusionary atmosphere for the participants.

An important suggestion of how to integrate the two cultural approaches was to have a Native female co-facilitator who is aware and knowledgeable about traditional healing ways. She could then blend the “white” information with traditional ways, making the information more practical and relevant to Native communities. The “balance between the mind and the heart” is important in creating an atmosphere of healing within the group itself as well. This would help the facilitator to run culturally relevant training sessions and it would create a stronger connection between the facilitator and the people.

Martha notes that there are few protocols for non-Natives working in the area of Native trauma. Yet there are not enough First Nations people who are able to take on the role of community healer so there must be outside people involved. The key to having this union work is establishing a trusting respectful relationship over time. Performing cultural rituals in groups, and having a Native facilitator present would allow members to feel respect and connection with other members. It would also allow non-Natives to be more connected to the group.

Another cultural difference noted in this workshop was the approach to time. Two days was not enough time in which to do an appropriate workshop about trauma to a First Nations group. Participants need to be part of a talking circle and there needs to be room for changes all of which make it difficult to keep to a schedule. Martha thought the facilitator should take more time to explain cultural discrepancies when they arise.

Trust and openness in Native communities are formed by taking time and being respectful and understanding. As one participant expressed, “respect and understanding” are “deadly important” when giving presentations to Native people. The facilitator
acknowledged that it is important that “mainstream society” show Native communities respect and validation, however the facilitator was concerned with covering all the proscribed material within the time limit and he interrupted a group member during the talking circle in order to hurry the pace. A discussion with the group co-ordinator or an elder of the community prior to the group would ensure that traditions are being respected and followed.

A gap in the summaries which I noted was the acknowledgement of the power differential that was set up by the program facilitator. As is typical in “white” society, there is an assumption of cultural bias, such as, not including Native cultural practices in a training workshop. I noted that all of the cultural ceremonies and practices that were experienced in the group, such as the grounding exercise, the prayers, and the smudge ceremony were initiated by the members of the group; the facilitator did not motivate the group to enact these rituals. Perhaps other groups who do not possess such self-awareness would accept the power differential presented to them in the structure of the group, and would not have empowered themselves through making suggestions for changes.

As it was, the course was represented as a First Nations course, because it was presented through a First Nations agency, and to a First Nations group. But there is consensus that the workshop was not a First Nations course. “It was a regular course geared toward emergency workers with the only significant difference being the native logo and the handout and a drum.” Martha explained that there was an assumption that the material had been modified to fit First Nations culture prior to the workshop. However, Native participants felt that the context of First Nations people in the group was not acknowledged; this created defensiveness and eventual disconnection. Jen thinks that since the course is marketed as being a “First Nations” course, changes need to be made. If the course had not been labelled or particularly associated with First Nations groups then it wouldn’t have received such negative feedback.
Chapter Five

Discussion and Suggestions for Further Research

Discussion

It is clear from the results of the observation and interviews that there are some aspects of CISM that feel appropriate and valuable to participants and there are some that do not. The group format of CISM fits with the Native emphasis on social interconnectedness rather than individualism. Viewing the debriefing circle as a talking circle was mentioned several times as being appropriate for First Nations groups. However the CISM approach to trauma does not fit because it is ahistorical and compartmentalized. Also, the lack of inclusion of First Nations cultural information was mentioned as being a serious oversight. Although the appropriateness of having a white group leader is questionable, participants appreciated him as trying hard and being a nice person. Also, the approach to healing does not fit because it does not take into account traditional concepts of trauma, healing, normalcy and health.

I would like to mention first the problem of using an intervention with at best mixed efficacy according to the literature. Not only has CISM not been tested, studied or designed for cross-cultural groups, this approach has been questioned even on western groups. This brings up ethical considerations of using a questionable intervention on an understudied population.

Of the aspects of this intervention that do not feel appropriate, the westernized approach seemed to be the most ill-fitting in the eyes of the participants. This fits with the literature on cross-cultural interventions and cultural competency. Many authors warn against the possible ill-effects of cultural incompetency in group leader. This is precisely what was seen in this training session: a clashing of worldviews between western content-orientation, linear temporality, individualism and empiricism, and Native process-orientation, non-linear temporality, socio-historical emphasis and a holistic approach to healing. These worldview differences explains the discrepancies that arose in
the understanding of how to use time, the trauma versus critical incident debate, the didactic teaching style and the reliance on westernized research and information.

It seems also, from the literature, that these discrepancies would not have arisen and should not have arisen if the agency and CISM co-ordinator had been adequately knowledgeable about this group's cultural standpoint. For example, the segmentation of trauma symptoms into physical, emotional, psychological and behavioural, which is a truism in western psychology and CISM theory, did not fit in this cross-cultural context. Native ideology is based originally on a holistic approach. I find it strange to think that information disseminated at a First Nations CISM training workshop is approached with an assumption that a western worldview will be accepted as being accurate and appropriate information. Of course, they do indeed understand the information at face value, but only because this group has been subject to assimilation and oppression over the last 500 years which has forced them to adopt the worldview of white people. As one participant stated, "we have a foot in both worlds."

According to cross-cultural therapy literature, when creating a program of trauma intervention for ethnic minorities, we must ensure that colonialism, racism and oppression are not repeated in any form. Considering that CISM is based on white standards of information and research, was created by white men for use with western medical emergency workers, and that the co-ordinator is a white ex-fire-fighter who was trained by white trainers to disseminate this intervention to western clients, I think the question of whether this intervention could fall into a category of colonial or oppressive is prudent. It is ethically appropriate and necessary to ask questions about the applicability of this intervention cross-culturally before the intervention is undertaken. At the very least, any agency supplying a therapeutic service to First Nations groups should ensure that the facilitator is knowledgeable in cross-cultural intervention techniques and theory. Perhaps the co-ordinator has been educated in cross-cultural issues, and the observations and comments noted in this research are anomalies.
The fact that the CISM co-ordinator is white is notable. One participant suggested that he have a co-leader who is First Nations so that his information could be processed into a form that will be useful and applicable in First Nations settings. Problems that arise from having a white facilitator are what Duran and Duran (1995) describe when they refer to perpetuating colonialism. They warn of mistrust for the researcher or white facilitator because of the “soul wound.” This could explain the hesitancy of Native participants to volunteer for working on this research project until the second day, and it could explain my difficulty obtaining funding. Any white person in the role of a healer or information giver to Native people cannot deny the dynamic that exists between the two cultures. Therefore, it is important to look at whether cultural stereotypes were reinforced through the practice of having a white group leader work with Native groups or having a white researcher asking them for feedback.

It is clear that this agency has an understanding of appropriate and co-constructed goals for First Nations groups. Both parties wish to work toward having First Nations people be able to heal their own trauma using their own knowledge, rituals and ceremonies. The research in this area supports that goal. The danger lies in the means by which the ends are achieved. If the agency’s philosophy is to include as much as possible First Nations traditions, where were they in the training session? The group was made up of First Nations people, and presumably each of these people had their own experiences with the historical trauma perpetuated on their people. And the leader was aware that group members could possibly be triggered into remembering their own trauma. So why not create a group in which this was a part of the learning process? The literature clearly states that at no time should the historical context of First Nations trauma be ignored. Yet, CISM theory clearly states that it is not a therapy and is limited in scope by this parameter. In this way CISM does not appear to be cross-culturally appropriate in terms of meeting the needs of this population or in achieving the goals of CISM as well.
The approach to trauma was problematic as well. The CISM co-ordinator’s statement that “trauma effects everyone the same way...trauma is trauma” fits into Sue and Sue’s (1999) postulation that one of the major reasons for ineffectiveness in working with culturally different populations is the ethnocentric assumption that the material taught in traditional mental health programs is equally applicable to all groups (p. 16). It is clear from the literature that trauma is not trauma. Danieli (1996) shows this through the vulnerability perspective of trauma. There are different levels to trauma, different interpretations and different reactions according to culture and historical background. The CISM co-ordinator invalidated the historical-cultural context of the trauma and grief of the group. This mistake may stem from the wholly western context of the training he has received.

And the fact that CISM is limited to only an immediately recent crisis situation also brings up the aptness of this intervention with people who are steeped with historical trauma. This brings up several questions. “Is looking at trauma in First Nations communities from the point of view of critical incident research unintentionally racist because it denies the context of historical racism?” “Does teaching coping skills based on western trauma information negate the pre-existence of non-western style coping skills?” “Is it possible to extricate critical incidents from historical trauma?” and if so, “Is it possible to treat only the current traumas themselves without becoming involved in “therapeutic” treatments of the historical context in which they sit?”

All of the participants noticed and commented on the lack of cultural material incorporated into the workshop. I believe there were incongruent expectations of counselling. Whereas the co-ordinator felt that “you guys know that stuff,” two participants explained that there was an unstated expectation of cultural knowledge because the agency is a First Nations agency and the workshop was being presented to First Nations people. There was general agreement that there was an overemphasis on white cultural examples, such as the video tape and American crisis situations.
There appeared to be a lack of understanding of the cultural context, and a lack of understanding of the social focus and environment of clients. For Wrenn (in Hickson & Kriegler, 1996) this amounts to "cultural encapsulation" (p. 6). An example of this lack of cultural knowledge can be seen in the interview of the co-ordinator. He mentioned that elders sometimes wish to be present in debriefings, but that he asks elders to leave the debriefing circle because people often do not disclose the "ugly stuff" for fear of traumatizing someone else. I question whether this is culturally appropriate or an ethnocentric understanding of the process of trauma and healing. All of the literature on Native healing encourages clients seeking out guidance from chiefs, elders or healers.

Areas in which CISM is appropriate for First Nations groups include the structure and flexibility of the intervention. Because debriefing is conducted in a circular format with each person describing their experiences, it mirrors the talking or healing circle in Native tradition. The participants thought this was helpful and the group facilitator recognizes that this is a valuable bridge between cultures.

Also, the agency's philosophy of blending approaches is in agreement with the literature on Native trauma. FNESS' goal is to support First Nations people to use their own traditional healing knowledge, ceremonies and rituals in order to rebuild their Native identity, traditions and roots. Teams would consist of band members incorporating some western knowledge with Native knowledge and practice. This is precisely in keeping with the literature. Both the agency and researchers in this area promote the reconnection of Native people to their lost culture as a way of healing the wounds of ethnocidal trauma. Many of the participants suggested a blended approach would feel more respectful, authentic, and appropriate as well. In order for CISM to fit here it would be necessary to study how to make the blend between this western approach and traditional knowledge.

Another area in which CISM fits Native ways is in the use of the community level in setting up the debriefing and in performing it. Providing community interventions is also encouraged by cross-cultural theorists and practitioners. The fact that the training session
was provided for an existing community group was of great importance in the cohesion of
the group and the presentation of the material.

The participants in general found the workshop valuable and useful. Several of
them referred to their trauma manuals in the intervening time. It is clear that this
intervention has potential to be a useful tool in the healing process of Native communities.

Suggestions presented by participants and by the researcher in improving the
application of CISM to First Nations communities include having a group facilitator who
is educated and trained to be cross-culturally competence, blending western and Native
information and approaches in the training as well as the debriefing sessions, including
another facilitator who is Native and who is well-educated in the areas of Native trauma
and healing, discussing prior to the group what steps or changes are necessary to provide
a culturally appropriate presentation, approaching healing in these communities from a
First Nations perspective first and a western perspective second, and working to discern
what pieces of western information can be added to the existing Native knowledge of
healing.

Programs that have successfully approached the areas of Native trauma and
healing have the emphasis on First Nations culture and tradition. An example of a
successful Native intervention occurred in the Alkali Lake Band of Shuswap in BC. In ten
years this band decreased alcoholism from 95 - 5% by “creating a community culture
which no longer tolerated alcoholism as individual behaviour, while concurrently
revitalizing traditional culture.” Of importance is that tribal leaders assumed their
legitimate authority to govern and provided guidance to members of the band (Guillory,

Duran and Duran (1995) describe their Family and Child Guidance Clinic which is
part of the Native American Health Board in the San Francisco/Oakland area. Most of
their clients exhibit symptoms of PTSD. The authors state that it is vital to validate
traditional values because, “the component that is critical to this model is the traditional
one. It is not enough that the program have a traditional component; the program must have traditional Native psychology as its core.” (p. 88).

**Implications for Research**

Implications of this research are seen in the pioneering aspect of the topic and the methodology. Applying qualitative methodology to the topic of CISM is new, although anecdotal reports do exist. Also, looking at the application of CISM to First Nations groups is a first in the research.

Other implications include either refutation or support for the hypothesis that CISM is appropriate for use with First Nations populations. Whether CISM is found to have a positive, neutral or negative effect on perceptions of participants in terms of relevance and appropriateness could change the way CISM is viewed as an intervention.

Another function of this research will be to provide more literature on CISM itself. As can be seen in the previous chapters, CISM has received mixed reports of efficacy. Perhaps this research will provide another insight into possible areas of improvement and study.

This research is the first to look at an intervention working specifically with Canadian Natives. Most of the research is from American sources although it refers to events which took place across Nations in North America. This thesis also adds to areas of study that have been approached only sparingly: Canadian Native groups’ reactions to crises; application of CISM to Native groups; application to CISM cross-culturally; and research approaches to Native issues.

My goal throughout this research was to continue to open up post-colonial ideology into traditionally western areas of trauma treatment. Considering that I am a white, culturally western researcher, I hoped that by including my own personal context and position on the issue of First Nations trauma, that I will create an opportunity for
discourse on this issue. I also hope that other researchers will approach their “white guilt” and feelings of hesitancy and avoidance easier as a result of this research.

Another way I hope to create a post-colonial example of western research is by using narrative methodology is an example of how to provide a richer, unbiased context into cross-cultural research. To use a scientific or positivist approach would have been ethnocentric and would have provided an understanding of the data from a wholly western viewpoint. It also would have served to perpetuate the oppressive dynamic that exists between western culture and Native culture. Using narrative methodology, although still arising from a western viewpoint, provides more room for individual, cultural and societal differences to be included in the context of results.

**Implications for Counselling Practice**

A much needed aspect of this research will be to document the First Nations Emergency Services agency’s approach to training First Nations groups. The act of documenting their approach imparts this information to others in the counselling, trauma, cross-cultural and CISM fields.

Of note in this area is the realization through this work that this agency has not stopped to ask important fundamental questions about trauma and healing to this group. Questions of meaning, understanding, interpretation and definitions need to be addressed before any approach to healing can be undertaken. We need to ask, “what are trauma, critical incidents and stress in your culture?” “What words are appropriate and meaningful to describe these?” and “Is trauma different from critical incidents to you and how?” White people, even those with the best intentions, can define nothing for another culture. It is important to recognize that we need to start from the beginning and let this group define their own terms and meanings.

Another important implication for this research is the well-being of the participants of the CISM sessions. The information gathered shows how individuals reacted to CISM
training. This can only help to enhance the quality of service provided to any other cultural group who participates in debriefing sessions.

Of course this research is important in its usefulness to participants. Having research approach this topic with this methodology and this purpose it is, I hope, an encouraging experience for Native participants. The voices, needs and opinions of participants were considered crucial in understanding the cross-cultural crisis intervention process. I hope this shows that there is some movement toward genuine understanding in western educational institutions.

I plan to present my findings to both FNESS and to the group who attended the workshop in order to facilitate a sense of feeling heard and understood. It would be disrespectful to the First Nations group who attended the workshop and to the participants who volunteered to be a part of this research not to have access to the results. In order to acknowledge the importance of their position with respect to this issue.

Delimitations

In a traditionally quantitative sense, the validity and reliability and even the generalizability of this study are compromised by the qualitative design for several reasons. Firstly, the population is too small to ensure empirical validity of the results and generalizability of findings to a wider population. Secondly, the pioneering aspect of applying a qualitative design to a topic that has been researched quantitatively decreases outcome predictability. However, since the objective of this study is to understand 3 to 5 individual experiences, the question of whether my design fits empirical standards is moot.

An effect to be considered is the influence that narrative interview technique will have on the interpretations of the participants. As Williams (as cited in Bailey, 1996, p. 187) wrote, “narrative reconstructions are attempts to account for and repair breaks in the social order.” And Bailey writes, “they are meaning making events interpreted by the teller, then the analyst” (1996, p. 187). This means that the act of interviewing each
participant in a narrative fashion may influence their perception of cultural meaningfulness of the training session; any perception of cultural fit may be as a result of the interview process rather than the session itself. However, in keeping with the theory of narrative analysis, acknowledging this influence will keep the findings trustworthy.

As well, the purpose of narrative interviewing is not to extricate the participants’ experience from that of the interviewer; it is to recognize that the interview process is naturally a form of discourse from which individual experiences cannot be separated. Once assumptions and biases are delineated, the reader is able to judge the effectiveness, genuineness and trustworthiness of the research.

Limitations undoubtedly occurred in the cultural differences seen between myself and the participants. I may have been considered by the participants as being incapable of fully understanding the cultural context in which trauma and subsequent healing take place. My only recourse for this consideration is to admit that my context is unique to any other context regardless of culture. The narrative approach ensures that I have considered any differences or significant factors when analysing the information so that I could present findings that are authentic, credible and trustworthy.

A further limitation related to cultural differences is the issue of trust between myself and the participants. The participants may have been reluctant to volunteer and share their personal experiences with me for this reason. And, as it turned out, two of the interviewees were non-native people. The lack of Native people volunteering for participation is important to note in general terms of trust between First Nations people and white people. This is seen particularly in this field because Native people have no reason to trust the research and institutional education process of the Western society. It is clearly a justified phenomenon, and it may produce some bias in the results of this study.

Interpretation must be taken into consideration as well. Although the themes across the interviews appear similar, the comprehension of the interviews appears different. “Martha’s” interview was perceived by others as easier to understand and more
clearly written. Perhaps this is because both she and I are white, making the co-construction a smoother and more easily understood process.

The third theme I see is in the make-up of the population who attended the workshop. As mentioned, they are more experienced with working with trauma victims and they’re more in tune with their own cultural connection. Perhaps this made them more sensitive to the program’s content. Martha imagines that for this reason the group could be more critical of the workshop than the rest of the community would be. However, this also could mean that they were more resilient to potentially harmful oversights.

Suggestions for Further Research

There are many areas for further research that arise from this study. In particular, there is a gap in the CISM literature on cross-cultural applications of this technique. And of course, more research needs to be done in the area of CISM itself, to determine whether it is valuable and necessary or ultimately ineffective or even harmful to recipients.

More study should be done on general cross-cultural crisis interventions. One article exists on this topic only. It would be a valuable asset to the research literature to have examples and suggestions for cross-cultural applicability of these kinds of therapeutic interventions.

Also, further study should be done into the effect of crises on historical trauma survivors. Some work has been done with Jewish holocaust survivors, but none has been undertaken to understand this process in Native people. And also, there are questions as to the nature of Native trauma and approaches for healing. Most researchers advocate using traditional Native knowledge and rituals in the healing process. But what role do the oppressors play in healing? How can we be an appropriate and helpful part of the healing process?

Most importantly, research needs to be undertaken into the area of how to blend western therapeutic knowledge with First Nations healing knowledge. It would be
fascinating and important work to look at what aspects of recovery theory are truly necessary for First Nations people to gain and what information is already present in traditional Native knowledge.

Several questions regarding the process of crisis intervention in First Nations populations arose during this study. They were mentioned in the Discussion section of this study and I would like to add them here as a call to other researchers for possible studies. "Is looking at trauma in First Nations communities from the point of view of critical incident research unintentionally racist because it denies the context of historical racism?" "Does teaching coping skills based on western trauma information negate the pre-existence of non-western style coping skills?" "Is it possible to extricate critical incidents from historical trauma?" and if so, "Is it possible to treat only the current traumas themselves without becoming involved in 'therapeutic' treatments of the historical context in which they sit?"

The role of white researcher is also another interesting and telling subject for further study. I found myself discovering much more about my role in imparting information than I had previously discovered. To what extent is the literature on counselling, psychology and healing applicable to First Nations groups? By doing this research for this institution am I perpetuating a hegemonic discourse? And what can be done in the area of research to balance the information?

As a white researcher my journey through this research was not only full of academic learning for me, but it also showed me on a personal level how I approach cultural differences and societal shame. I realized the existence of an ocean of pain that being a part of white society encourages me to keep subconscious to myself. I learned that there is another world living beside me that I have not known. This realization is not an easy one. It hurts. It is uncomfortable. Even now, as I complete this project, I find myself slipping further and further back into the safety of my white world. It takes work and determination to be a part of the healing process. To this end, I learned that my voice can
provide a unique opening for others to admit the reality of Native history. Perhaps I can provide a platform for other white researchers to realize their position in history and begin a journey of conscious healing.
REFERENCES


Appendix A

Letter of Introduction to Volunteers of Research Study

Dear Volunteers;

My name is Megan Hughes. I am a Graduate student in the Department of Counselling Psychology at UBC. As part of my Thesis requirement, I am studying Critical Incident Stress Management (CISM). Particularly, I am documenting how First Nations Emergency Services approaches process with respect to First Nations culture. I also hope to find out how this training and intervention is perceived by participants. I hope that this study will provide insight into healing and recovery processes of Native people and that it will enhance the quality of experience for those who attend CISM training and who receive the intervention.

Because I am looking at people’s perceptions of this training, it is necessary that I focus on the experiences of those in the process. In order that I understand what this experience is like for those in training or recovery, I am asking for your participation in the following ways:

1. I would like to observe a CISM training session with the added components, which will be provided by First Nations Emergency Service Society
2. I would like to interview the leader of the training session
3. I would like to interview 4 volunteers who have just been through the training process

If you are willing to be interviewed about your experience, as a trainee of this intervention, I would like to talk to you at a place which is convenient to you. The interview would last only about 1 hour. In order to collect accurate information for this research, I ask that you allow your interview to be audiotape recorded. If you feel uncomfortable with what is on the tape I can erase that part of the tape in front of you. If you are uncomfortable with being audiotaped, I would ask that you allow me to take notes during the interview.

Confidentiality and anonymity will be strictly maintained. No actual names will be used during the interview, in notes or in the study. You will be asked to choose a “code name” and only I will have access to these names. Data from observation notes and interviews will be kept in a locked filing cabinet at my home. Only selected sections of data that will not compromise confidentiality will be shared with my thesis committee, and no one else will have access to the data. The data will be destroyed following the completion of my thesis.

Although I do not predict harm to occur, because this is a study in the field of psychology, names of counsellors will be provided to participants who request psychological services after the interview.
I have received a copy of this consent form for my own records. I consent to participate in this study.

__________________________  ______________________________
Signature                                    Date

__________________________  ______________________________
Signature of Witness                Date