

How is the Medicine Wheel considered in therapeutic practice?

ALEXIS G. FORD-ELLIS

Email: agfe45@gmail.com

Abstract

This paper is a review of research in 2010 and then updated in 2019 which reflects the considerations given to the Medicine Wheel during an Indigenous person's healing process. While at City University of Seattle in Edmonton, Alberta doing my Master's in Psychology Counselling I was curious as a Gwich'in woman as to how Indigenous values, beliefs, and spirituality were and are being considered in therapeutic practice. The limited and now growing academic research over the past ten years speaks to integrating traditional Indigenous spirituality, such as the medicine wheel teachings into one's healing journey. However it does not address any applications with respect to methodologies or practices — the medicine wheel is simply a concept. Through reconciliation many Canadians are learning how Indigenous people in Canada were denied their cultural practices and it is my intent to find a way for Indigenous people to introduce their own values and healing into what is defined as traditional therapeutic practices. My research I hope will open more doors to understanding how Indigenous people heal and grow over a lifetime and how that process continually shapes the person on their healing journey.

Keywords: medicine wheel; healing; healing journey; Indigenous healing; Indigenous values, Indigenous beliefs, Indigenous ceremony, self-care

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Cultural teachings that integrate physical, emotional, social and spiritual teachings of the Medicine Wheel are beginning to be considered in traditional therapeutic practices and research – including Aboriginal (Indigenous) spiritual values such as smudging and listening to our Elders. Over the course of my career, and while completing my Master’s Psychology counseling program, I have been curious as to how Indigenous values, beliefs, and spirituality were/are being considered in healing and therapeutic practices.

As an Indigenous woman, my psychological and spiritual pain is a result of the deep-rooted social and emotional trauma passed on through the generations of my First Nations ancestors, the personal experiences and teachings within my family, and sadly, the political decisions that are outside of my control. Whenever I sought medical attention as a child and young adult, any depth or breadth of inquiry halted at the mention of my “Indian” heritage, coupled with being raised in an alcoholic environment. Hence, I have continually questioned the effectiveness of the medical profession in assisting me to overcome the pain of my past. My personal journey and the strong influence of my mother’s life and death have brought me to this point of needing to understand why Western medical services do not fully address the healing of Indigenous peoples, and how, with a holistic approach to healing, Indigenous peoples have had the inner courage to persevere and overcome the atrocities of their past.

The limited academic research available speaks to integrating traditional Indigenous spirituality such as Medicine Wheel teachings into healing practices, but it does not speak to its application with respect to methodologies or practices. The foundational paper that supports Indigenous people in moving forward and challenges the historical treatment of Indigenous people is *The Royal Commission on Aboriginal Peoples Report* ([*The Report*], 1996). Then, in 2008 the Truth and Reconciliation Commission (TRC), which was mandated by the *Indian Residential Schools Settlement Agreement* of 2006, started its work on addressing the Indian Residential School (IRS) system, survivors’ experiences, and the traumatic impact left on generations of Indigenous people. In addition to the over 400 recommendations of *The Report* (1996), the *Report of the Truth and Reconciliation Commission of Canada* ([*The TRC Report*], 2015) has 94 Calls to Action for all Canadians.

This research will examine the consideration given to cultural teachings and the Medicine Wheel during an Indigenous person’s healing process. *The Report* (1996) and *The TRC Report* (2015) validates what Indigenous people have said for years, namely that when the

Indigenous perspective is missing, Indigenous culture is not being valued within the dominant society. It is my intent to review the limited current body of knowledge and methodologies, and then provide a personal reflection of my Medicine Wheel learning, reflecting on teachings and counseling sessions with Indigenous clientele.

Literature Review

An exploration of all psychology and related databases within City University’s library yielded a limited number of academic papers related to the Medicine Wheel. Beyond the main academic databases, other sources for research (e.g. medical, social work and nursing) related to Indigenous health matters included a general research of University of Victoria website, Health Canada website, Aboriginal Healing Foundation ([AHF], 1998), and the University of Toronto, Center for Indigenous Studies. The academic research available on Indigenous health issues by Indigenous authors is sparse. My strategy was simply to find research that included any mention of, discussion about, or information associated with the following key words: Indigenous, Medicine Wheel, and traditional therapeutic models / practices.

In general, research that reflects Indigenous perspective and culture is relatively new, and, over the course of this project, I did not find documented research that speaks to Indigenous values being considered in therapeutic practice. What I did find was a discussion recommending that, when dealing with Indigenous clientele, Indigenous values should be considered in therapeutic practice. This body of research includes a variety of studies that merely mention the use of Indigenous traditional healing or medicinal practice. Any mention of the Medicine Wheel is through an overview of introducing or considering the Indigenous perspective, culture, or values in Indigenous people’s healing in traditional therapeutic practice.

I see the overarching issues as follows: a systemic barrier of non-trust that does not allow Indigenous people to heal using their traditional ways, denial of the Indigenous perspective and culture in traditional therapeutic practice, and a need to continuously educate professionals around cultural sensitivities. It would be beneficial to see the research in chronological order in order to determine how it builds over time. All of the studies I examined initially were from 2004 - 2010, with three being from the United States (US) and the rest from Canada, and follow the creation of the AHF (1998) and recommendations from *The Report* (1996). Through a comparative analysis of Canada versus the US, it seems that while the thematic issues are similar, Canada is behind the US in documenting its research on Indigenous health-related issues.

The most comprehensive research documenting the historical trauma impacting Indigenous people is the research conducted by Wesley-Esquimaux and Smolewski (2004). It is an extensive and thorough investigative paper which is most similar to cultural ethnography, a type of methodology used in qualitative research. It is a linear historical account of significant events going back 400 years. Their research is significant because it speaks to the trauma in Indigenous people's lives and how they return to their cultural and traditional ways of living. Although Wesley-Esquimaux and Smolewski (2004) do not specifically mention the Medicine Wheel approach, the principles of the Medicine Wheel are formatted throughout their research. They also speak to the importance of the Medicine Wheel principle of interconnectedness and to the need for Indigenous people to find their way back to that interconnection and spiritualism.

Prior to research by Wesley-Esquimaux and Smolewski (2004), McDonald, Morton, and Stewart (1992) wrote an informative paper on the Indigenous perspective in therapeutic practices in the US. Their concerns from 20 years ago point to the similarities between Indigenous issues and perspectives in both Canada and the US. In addition, they also advocate for recognizing the history of Indigenous people's unique cultures, languages, and ceremonies. McDonald et al.'s (1992) ideas from 20 years ago were considered innovative and were published in *An Innovation in Clinical Practice*, which is a resource collection of papers that provide innovative ideologies related to clinical therapeutic practices in the US. The authors, McDonald et al. (1992), are of Indigenous ancestry and belong to a First Nation or tribe in the US. Their research does not specifically address the Medicine Wheel, however they do examine clinical practices and suggest ways to consider the Indigenous culture in a clinician's practice. All of the researchers are academics working in a health profession and/or conducting research on Indigenous issues within the field of either counseling or psychology (p. 451). Their research draws attention to the uniqueness of Indigenous people's social context and the importance of integrating a holistic approach into a therapist's chosen method of practice. Within their clinical experiences and published materials, McDonald et al. (1992) identify similar issues in many Indigenous cultures and provide suggestions on how to address Indigenous clientele using a holistic approach to supplement whatever traditional therapeutic model is preferred. They recognize that consideration of traditional Indigenous healing values and beliefs is important to working with Indigenous people in a clinical practice of counseling or therapy.

A good example of Indigenous values being considered in therapeutic ideology is an article by Roberts, Harper, Bull, and Heideman-Provost (1998), which provides a comprehensive discussion on the comparison of one type of Medicine Wheel, which is directional in design, with individual psychology theory. The authors themselves are Indigenous and are graduate students. The study by Roberts et al. (1998) compares common themes between Individual Psychology, a growth model of Alderian's theory and the Native American Medicine Wheel. The relevance of the study is its focus on the Medicine Wheel and, theoretically, its significance in therapeutic healing. The researchers found that the Medicine Wheel is a universal element in Indigenous cultures; it speaks to the core of Indigenous peoples' way of life. Ultimately, Roberts et al. (1998) suggest that the focus of a Medicine Wheel is on a person achieving wholeness through understanding their place in the Universe.

By contrast, in Canada Indigenous people's voices were not being heard until *The Report* (1996) was finalized and it confirmed what was being said by Indigenous people, namely that Indigenous health matters and research related to Indigenous health issues should be researched and published by Indigenous people. Established in 1998, the AHF had a mandate for facilitating Indigenous research by Indigenous people. Subsequently, in 2000, the National Aboriginal Health Organization (NAHO) was established and, through its organization, the *Journal of Aboriginal Health* was created for the publication of health-related Indigenous research in Canada.

Arising out of this, Lemchuk-Favel and Jock (2004) research is a synthesis of their 2002 research, culminating in an extensive review of health systems within Indigenous communities in Canada. Their research is published in the *Journal of Aboriginal Health*, which is a peer reviewed publication of research completed on Indigenous health issues within Canada. Lemchuk-Favel and Jock (2004) analyzed the successes and challenges in First Nations communities, Inuit communities, and Métis settlements. This includes factors affecting Indigenous health as well as challenges and successes with current health systems. Lemchuk-Favel and Jock's (2004) research is based on nine case studies of Indigenous health centers in Canada. The relevance of their research is that it supports the holistic practice of medicine and promotes multi-disciplinary medical professions working together. The Medicine Wheel is not mentioned as a traditional resource for any of the nine Indigenous health centers, however a common theme that emerges in all of the Indigenous health centers identified within Lemchuk-Favel and Jock's (2004) case studies is the integration of

specific Indigenous group cultural healing practices.

There are many successful programs identified within Lemchuk-Favel and Jock's (2004) research, and each of the health systems they studied was unique to a community of Indigenous people. The obvious message is that success cannot be attributed to one specific method or program, as there is a need for many approaches tailored to many communities with varying needs and resources. Again, there was no specific mention of the Medicine Wheel, however it seemed that the higher the level of cultural self-reliant factors of involvement, the greater the success in integrating traditional and modern-day Western healing practices.

In contrast to Lemchuk-Favel and Jock (2004), Coyhis and Simonelli (2005), who are Americans, base their paper on Coyhis's personal and professional experiences. They also built a business, White Bison Inc., based on Coyhis's personal experience. They write about hope and speak to the value and importance of Indigenous teachings being part of an Indigenous person's healing and Indigenous community's wellness. The relevance of Coyhis and Simonelli's (2005) article is its direct integration of the Medicine Wheel's principle of interconnectedness (p. 327). White Bison Inc., business promotes healing programs to First Nations communities across the US. The programs and teachings are based on Indigenous traditions, and this particular article, which details the Wellbriety Movement, focuses on the wisdom of Elders in blending the knowledge of the Medicine Wheel with the 12 steps of Alcoholics Anonymous in order to provide culture-specific addiction recovery help for Native Americans. Their teachings are based on Coyhis's personal journey with sobriety, and his personal story is a connection he now has with many Indigenous people who are seeking healing from alcoholic abuse (p. 323-24). Coyhis and Simonelli's (2005) learnings and teachings acknowledge many Indigenous beliefs and practices. Their use of the Medicine Wheel and its integration into their programs helps Indigenous people understand themselves and promotes healing from their various addictions.

Within Canada's academic world, Stewart (2009) and Ball (2005) are two Indigenous researchers who look at the Indigenous perspective in academic research. Stewart's (2009) research is a narrative study and it provides suggestions regarding the introduction of Indigenous traditional values and ethics. Ball's (2005) research found that traditional models have built their teachings on rigor and evidential success with clientele, however traditional therapeutic practices have not considered historical socioeconomic realities. They both

address the issue of Indigenous ethics and values in academic research and, more specifically, why Indigenous ethics and values are not addressed. Ball's (2005) and Stewart's (2009) research has significant relevance to my own research question as a mechanism for changing the contemporary perspective to be inclusive of Indigenous teachings in therapeutic practice and in research.

Like Coyhis and Simonelli (2005), Stewart (2009) shares a personal journey, and both Coyhis and Stewart use their personal journeys to reach out to other Indigenous people on similar journeys. Stewart's (2009) research of her personal journey is mostly reflective and relevant to my own question of integrating the Medicine Wheel into traditional therapeutic practices. She does not mention the integration or use of the Medicine Wheel until she addresses a changing research methodology. Stewart (2009) believes that traditional teachings in Native communities based on the Medicine Wheel create an epistemological paradigm that employs a holistic foundation for human behavior and interactions; it informs a framework for mental health through a discussion of its four quadrants (p. 64).

Unlike the previous Indigenous authors, Rupert Ross is a non-Indigenous lawyer and has more than 25 years of experience working with Indigenous people in remote Northern communities. Ross (2006) wrote a discussion paper based on his personal and professional experiences with Indigenous people in Northern remote communities. His description of the traumatization of Indigenous people is an excerpt from his book *Dancing With a Ghost: Exploring Aboriginal Reality* (2006). Throughout his legal career, Ross (2006) found internal and community systems broken down beyond repair, with children raising each other, parents and kin incarcerated for violating and killing each other. Ross's (2006) professional experiences support the belief that these breakdowns have multiple impacts on individuals' physical, mental, emotional and spiritual wellness. Ross's (1999, 2006) writings are relevant to the research question because he offers a solution of hope for Indigenous people which involves returning to their traditional cultural practices.

Outside of qualitative research, Cook's (2005) quantitative research approach addresses the use of Indigenous traditional medicine and Western medicine with the Mi'kmaq First Nations people. At the time of publication, Cook (2005) was a medical student at Dalhousie Medical School in Halifax, Nova Scotia. Cook's (2005) study is relevant because it is a quantitative study in which she surveyed over 100 participants using a survey of eight simple questions to determine whether

Mi'kmaq people used traditional Mi'kmaq medicine. Cook (2005) did find that the Mi'kmaq in Eastern Canada were using both Western medicine and traditional Indigenous medicine, but there were no results in her research that address the effectiveness of either model. Although both were respected and relied upon, neither healing model integrated the values and views of the other, which would imply that the ethical considerations of each medical model were not fully considered by the other.

Cook's (2005) study is the only quantitative research approach that questions the use of traditional Indigenous medicine / treatment in healing its people, but it does not specify the use of the Medicine Wheel or outline any traditional practices. Cook (2005) found that according to *The Report* (1996), the appropriate use of traditional medicine and healing will assist in improving outcomes, and that the integration of traditional healing practices and spirituality into medical and social services is the missing ingredient needed to make those services valuable for Indigenous people (p. 96). Her study does not validate or reject the success of traditional healing, rather it simply reinforces the belief that traditional healing is a choice for Indigenous people.

Nadia Ferrara, like Ross and Cook, is also non-Indigenous and, among many professions, she is a professional art therapist and Professor of Anthropology. In her book, *Healing through Art: Ritualized Space and Cree Identity* (Ferrara, 2004), she connects with her young clients, who are from Northern Quebec Cree communities, through art and play therapy. Ferrara (2004) shares how, as a therapist with Indigenous clients, the process of listening, building trust, and developing a relationship is necessary for helping young Indigenous children heal. The young children, as well as many parents and Elders, will learn to understand their own pain and find their voice through a spiritual process expressed in their art. Often a child's pain would be passed down from parents or grandparents who are survivors of unfathomable abuse. Ferrara (2004), like Ross (2006), listened to many Elders share their experiences of residential schools. She also witnessed the impacts of intergenerational trauma in her young clients, and through it all she writes of their resiliency (Ferrara, 2004).

Furthermore, Thurston et al. (2012), through a multi-stakeholder partnership, worked on a project addressing intergenerational trauma prevention. This project produced the following report: *Intervention to Address Intergenerational Trauma: Overcoming, Resisting, and Preventing Structural Violence* (2012), which is a review of 16 papers and documents that may be contributing to the intergenerational trauma in children of parent and

grandparent survivors of Indian Residential Schools. The major finding in Thurston et al.'s (2012) project was that there are minimal practices for addressing intergenerational trauma when dealing with Indigenous youth. In addition, they wrote two solid recommendations, which include better holistic evaluation and reliable funding and resources to continue meaningful work with youth and community healing.

Another study recognizing the use of art as a medium for healing with youth can be found in *Because We Have Really Unique Art: Decolonizing Research With Indigenous Youth Using the Arts* (Flicker et al., 2016). Flicker et al. (2016) writes that Indigenous peoples are holistic in their healing, and that art, as healing, is a form of aesthetic and spiritual connection they have with the land and with their communities. This holistic approach is seen in worldviews, which are broader and more holistically inclusive of the whole person than what is perceived as the norm in Western therapeutic teachings.

The Eight Ujarait (Rocks) Model: Supporting Inuit Adolescent Mental Health with an Intervention Model Based on Inuit Knowledge and Ways of Knowing (Healey, Noah, & Mearns, 2016) is a fascinating study and a recommended model for assisting and supporting youth in addressing their personal mental health and wellness. Healey et al. (2016) suggest that this model is designed to look at many parts of a person such as self-esteem, physical activity, stress, relationships, resiliency capabilities, identity, and effect of intergenerational trauma on youth. Healey et al. (2016) state that programs which include reclaiming traditional practices, relearning on-the-land skills such as hunting or gathering, and learning one's language are significant to holistic and meaningful healing.

Gaudet and Chilton (2018) also share the importance of healing from a holistic approach and returning to the land for healing in their study, *Milo Pimatisimu Project: Healthy Living for Mushkegowuk Youth*. Their study identified two objectives: to "foster intergenerational exchange of knowledge" (p.26) and increase community support. A statement similar to a quote by Shannis Gray, "with intergenerational trauma comes intergenerational wisdom" (as cited in Zavarise, 2018). Gaudet and Chilton's (2018) article is the first study I have read suggesting that trauma in young indigenous people can be learned like the wisdom of our Elders and ancestors. Healing intergenerational trauma, as indicated by Gray in this article, is through our spiritual beliefs with Elders and our ancestors, who provide intergenerational wisdom (Zavarise, 2018).

These studies are a starting point for advocating the use of the Medicine Wheel and, more generally, Indigenous traditional healing, as a focal point for healing that takes place with Indigenous people and/or in Indigenous communities. In addition to these studies, and since the initial work from the TRC, there is progress towards genuine inclusiveness of Indigenous cultural teachings.

Methodological Analysis

The majority of research approaches considered here are qualitative. The qualitative approach is an in-depth inquiry that starts with a panoramic holistic view, with detailed information that is within the researcher's natural setting. By contrast, quantitative research is primarily scientific and based on whether predictive generalizations of one's theory are true. Since qualitative research can be classified into a variety of methodological approaches with numerous permutations, it allows complex social concerns to be studied globally (Creswell, 2007). The qualitative research paradigms reviewed include: investigative cultural study or ethnography, case studies, comparative analysis, narrative, and discussion/information papers. In addition, there is one example of quantitative research that is a survey. As the research is sparse, there is no one preferred methodology.

All of the research papers reviewed spoke to their respective research question or the purpose of their research surrounding the Indigenous perspective in Western medical / healing practices. They all included an inquiry into a particular issue affecting Indigenous people, and through their research they examined the social context of the particular questions being asked, with the exception of Cook's (2005) quantitative research. For example, McDonald et al. (1992) gathered relevant information highlighting the historical perspective, social concerns, and the Indigenous perspective within the US. Wesley-Esquimaux and Smolewski's (2004) historical review provides a linear focus on the number of events that had a significant negative impact on Indigenous people. Stewart (2009) used a personal narrative approach with five participant narratives woven together, speaking to the lack of Indigenous perspective in academic research and therapeutic practices, and concluding that Indigenous healing traditions such as the Medicine Wheel need to be woven into research and therapeutic practices. Using individual case studies as a follow-up to their 2002 paper, Lemchuk-Favel and Jock (2004) examined the challenges and successes of Indigenous health centers in Canada. The qualitative approaches' used by these researchers allow them to express their ideologies in a method that appears to best suit their research question.

Ross (2006) used a discussion paper methodology to address serious issues affecting Indigenous people in Northern communities. Within Ross's (2006) discussion paper, he used profound examples to stir emotions in people to act on a serious problem, and his writings also include a message of hope. From an ethical standpoint, he discloses some fairly horrific behaviors, but it is done with respect and the intention of revealing the realities of how Northern community-living truly effects the human experience. Similarly, Ferrara (2004) shares her experience of not being able to connect with her young clients initially and through silence and drawing, art became the medium for connecting. It is through the spiritual connections of self-play and art therapy as well as with listening with one's heart in silence that allowed Ferrara to learn from her many Indigenous clients. There is also the understanding of connecting therapy back into the culture practices learned through anthropological knowledge. Ferrara (2004) makes a direct link that Northern Quebec Cree people, her clients, are able to initiate healing through their way of knowing and not necessarily through Western therapeutic constructs alone.

A study in arts-based learning and research with Indigenous youth, led by community and university researchers Flicker et al. (2016), explores the links between their community, culture, colonization, and HIV. The purpose of the study was to imagine new approaches for health promotion with Indigenous youth through the use of arts-based workshops in their communities across Canada. Flicker et al. (2016) concluded that there were several benefits: mainly that it was fun and helped build self-esteem, and also that engaging in art allowed for the transference of cultural practices and skills. The youth participants found value in both the process and the products of arts-based methods. Flicker et al.'s (2016) arts-based research agrees with Ferrara's (2004) art therapy in that the methodology may differ but the end result is that allowing Indigenous youth to make art contributes significantly to what they are doing and how they think about life.

Wesley-Esquimaux and Smolewski's (2004) methodology is an intensive investigative review of 400 years of history affecting Indigenous people, including their traumatic experiences, and concludes with providing a new model to deal with these intergenerational traumas as well as a message from Elders. Wesley-Esquimaux and Smolewski's (2004) research reflects the Medicine Wheel teachings.

Like Ross (2006) and Wesley-Esquimaux and Smolewski (2004), McDonald et al.'s (1992) methodology is an informative paper that speaks positively of American

Indigenous perspectives through their personal lens as academics in the health profession, providing insights for practicing clinicians. Overall, McDonald et al.'s (1992) strength in their research is that they identified five common themes that are reflective of many Indigenous cultures. They prepared a review of demographics based on the American 1990 Census and they compared assessment and treatment between Indigenous people and mainstream psychologies. Their research is authentic because they are Indigenous people.

Interestingly, Roberts et al.'s (1998) methodology is a comparative analysis. Comparing the Medicine Wheel to Aldrian individual psychology theory is a good match as they view the person holistically. In addition to the analysis, a comparison as to how the principle teaching of the Medicine Wheel of interconnectedness and holistic approaches would have been good to read. As well as, it would have been useful to see how the Medicine Wheel compared to other therapeutic theories such as psychoanalytic theory or cognitive behavior theory. Lastly, the research is such that the process appears unstructured; the Medicine Wheel is seen, in general, as a life-long process.

Gaudet and Chilton's (2018) research is a reflection of the Moose Cree First Nation's Youth Center initiative that re-centers the Cree philosophy of 'milo pimatisiwin', which means "good and healthy living" [Abstract]. Both Gaudet and Chilton (2018) used their personal experiences in their loss of connection to the land and life-stage teaching to share and help others learn life-knowledge bundles in current social context. The philosophy of 'milo pimatisiwin' is found in many First Nations' way of living. Gaudet and Chilton's (2018) literature review shares those First Nations using the same or similar concept of 'milo pimatisiwin' in community programming. The Moose Cree First Nation's Youth Center project involved integrating local resources and land-based knowledge, along with teachings of the Medicine Wheel of emotional, spiritual, physical, and social constructs.

Coyhis's and Simonelli's (2005) research is based on Coyhis's personal journey, and how his personal experience led to a movement and the development of a therapeutic intervention that assists Indigenous people with addiction disorders for alcohol and drugs. Lastly, Cook (2005) is the only researcher to use a quantitative study, which addresses the use of traditional Indigenous values in healing versus the use of Western medicine. The research referenced throughout this paper is authored by individuals of Indigenous ancestry, with the exception of Ferrara (2004), Cook (2005), and Ross (2006).

Research is often collected within very tight geographical boundaries which can result in the misrepresentation of a cultural group of people, as the information is not necessarily from a representative sample. Cook's (2005) study has been used in Health Canada reports and it may have credibility with the medical community, however it may not be as credible in the Indigenous community. In this case, Cook's (2005) credibility would be dependent on being well known and accepted as a non-Indigenous person within the community.

The process that Lemchuk-Favel and Jock (2004) used for their methodological approach is an excerpt from their 2002 research. Their data collection involved visiting communities and interviewing health administrators. They also reviewed various Census reports, Health Canada documents, and other reports/documents relevant to the health centers under review. They did not address archival information or traditional practices. Their participants were identified as workers at community Indigenous health centers which were located on reserves, in remote locations, and in urban centers. The nine case studies used in the 2004 research were in-depth reviews and comparative analyses of strengths, weaknesses, opportunities, and threats that these health centers faced as they partially or fully employed Western, Indigenous and/or both medical practices. Their 2002 research looked at the whole community, including its infrastructure, social needs, and economic viability. The reliability of this research is significant in that nine Indigenous health centers were reviewed. They provide an approach and model for many Indigenous communities moving toward becoming self-reliant. Health system models that are working are scaled down or added onto based on multiple resource factors, the size of the community, geographic location, land claims or settlement agreements signed, and a vision of the community moving forward. The statistical information is reliable and cross-referenced between census data and new data captured (Lemchuk-Favel & Jock, 2004, p. 28-32). The strength of health care services available within and controlled by an Indigenous group demonstrates significant successes, i.e. collaboration between various stakeholders, partnership with various health or medical professionals, and the empowerment of communities towards self-governance. Their research reflects all Indigenous groups: First Nations, Inuit, and Métis principles and values across Canada, including all the provinces, regions, and territories. The success of these health systems comes from a multifaceted approach and has the commitment of all parties involved, with the primary success being cultural involvement.

Lemchuk-Favel and Jock's (2004) information is reliable, credible, and in demand, however there is a need to include multi-year reviews to monitor the continued and/or changing successes and challenges. It is my opinion that when something is successful for Indigenous people, it is deemed a one-time success, and is not often considered for a follow-up. One significant weakness of this research will be in validating or replicating the same research in a reasonable period of time (i.e. approximately five years). Lemchuk-Favel and Jock's (2004) research studied many health centers across Canada in many Indigenous communities, at a time when funding was available and public interest was high.

Thurston et al. (2012) worked with a variety of partners. They reviewed and analyzed sixteen papers and reports addressing intergenerational trauma in the context of youth, and they met with many communities to discuss their findings. Through discussions, Thurston et al.'s (2012) recommendations were valid with emphasis on better communication between agencies, especially when dealing with youth and their overall health/wellness. Elders did recommend that a more holistic approach be attached to the evaluation, monitoring, and reporting of youth-related intergenerational trauma initiatives.

Healey et al. (2016) conducted a literature review on community-based youth programs. The review was presented to parents, youth, and Elders for discussion and consultation on developing a community-based camp program for northern Nunavut communities. The camp program was designed to help and support Inuit youth in healthy living through the integration of traditional cultural practices and land-based knowledge. Healey et al. (2016) concluded that intervention in the northern Inuit communities do well when they implement evidence-based, community-driven models in youth programming.

Academic research regarding the use of the medicine wheel in therapeutic practice is sparse. The qualitative methodological approaches are a best methodology because they provide an thorough in-depth inquiry and analysis of the research question. The disadvantages of the qualitative approaches, especially from an Indigenous perspective, revolve around gaining credibility and proving reliability and validity. However, the disadvantages could change in time as the research related to Indigenous values increases and as Indigenous values gain credibility through Indigenous healers practicing their traditional ways.

Ethical Considerations

The Codes of Conduct for provincial or federal psychologists provide guidelines on being culturally sensitive to clients of varying cultures, but there is no accountability process in place that ensures that these guidelines are followed. Following a procedure does not necessarily address accountability. The AHF (1998) and the NAHO (2000) are both fundamental resources for research related to Indigenous health issues. They have created their own standards for the scholarly peer review process which are very similar to other academic processes, however the Indigenous perspective is the primary consideration in Indigenous research.

The ethical considerations within the presented research include: adapting academic research to appropriately reflect Indigenous cultural variances and their cultural ethical considerations, and the lack of available Indigenous clinicians, researchers, and academics. The available research questions the lack of action, it provides solutions and practices that are yielding positive results, and it raises the awareness of non-Indigenous audiences to the importance of giving consideration to the Indigenous perspective in their therapeutic practices. Indigenous healing practices include Elders, ceremonies, smudging, praying, sharing circles, storytelling, acceptance of all people, and the Medicine Wheel. For example, Wesley-Esquimaux and Smolewski (2004) use the Medicine Wheel principles throughout their research. Elders are invited to speak in the research, as evidenced by Coyhis and Simonelli (2005), who invited Indigenous Elders to join them in healing ceremonies throughout the US. Both Ball (2005) and Stewart (2009) speak to research ethics taking into account Indigenous values. Instead research by Indigenous authors reflects non-Indigenous professional standards.

At the macro level, Wesley-Esquimaux and Smolewski's (2004) research considers the societal responsibility of addressing Indigenous cultural values. In their research, Wesley-Esquimaux and Smolewski (2004) have Elders give messages of Indigenous people's historical-social trauma, as the Elders hold a memory bank of information that is passed down through generations. Unlike non-Indigenous academic researchers, Elders are honored and valued simply for their spoken word and wisdom. An Elder is not questioned or given parameters from which to speak. It is a high honor for an Elder to participate in an individual's research, and the researcher would be viewed as disrespectful if he/she were to question such a resource. By contrast, a non-Indigenous researcher may have the need to understand the details or specifics, which is in sharp contrast to the Elder who speaks to how the part impacts the whole.

Within their research, Wesley-Esquimaux and Smolewski (2004) address the Medicine Wheel as one spiritual resource available to Indigenous people. In comparison to Western ideology, the Medicine Wheel looks at the whole person. When a person is not well, the Western approach is to fix the part that is broken. The ethical dilemma, when considering the Medicine Wheel, is not to diagnose based on observed or spoken symptoms but rather to listen to what is impacting the person, resulting in particular behaviors.

Similar to Wesley-Esquimaux and Smolewski (2004), McDonald et al. (1992) gathered information from multiple sources to demonstrate the need for clinicians to become more sensitive to and aware of Indigenous values. As an ethical dilemma, the Indigenous perspective is talked about but not necessarily practiced. To deal with such conflicts, any healing of Indigenous clientele should address their specific history of political and social impacts, as well as acculturation. An extension of ethical consideration in cultural sensitivity is that not all Indigenous people understand their own culture or history and the impact it has on them, particularly with how intergenerational trauma can be passed down through generations. It would be helpful and respectful if clinicians worked in partnership with an Elder when treating their Indigenous clientele, as many Indigenous traditional healing practices can be used – e.g. the Medicine Wheel, healing circles, ceremonies, and burning sage/sweet-grass. It is important to recognize that clinicians who are not familiar with Indigenous teachings need to be appropriately trained or know where to redirect their Indigenous clientele when engaged in Indigenous healing.

Ball (2005) and Stewart (2009), as Indigenous academic researchers, consider how traditional methodologies can be modified to incorporate Indigenous values and ethics into existing qualitative research approaches. When it comes to cultural differences, specifically universal Indigenous cultures, Ball (2005) found that researchers are ill-prepared to negotiate research agreements with Indigenous people, to follow cultural protocols, and to respond knowledgeably and usefully to Indigenous people's concerns regarding research (p.1). These ethical dilemmas are consistent in many unpublished Indigenous writings. Ball's (2005) research supports McDonald et al. (1992) and the macro ethical consideration that most research and therapeutic practices with Indigenous people do not acknowledge the socio-historical context that negatively impacts many Indigenous groups.

According to Truscott and Cook (2004), ethical considerations for traditional values, community and

family involvement are outside the therapist's ability to be inclusive. On a macro level, Indigenous ethical considerations are very rigorous and similar to non-Indigenous therapeutic ethical considerations. For example, gift-giving in many Indigenous cultures is mandatory, as it demonstrates respect for the gift being received, be it information, knowledge, or fee for services (McDonald et al., 1992).

Stewart's (2009) narrative approach questions how Native counsellors understand the intersection of traditional Indigenous cultural concepts of mental health and contemporary counseling practice (p. 57). The micro ethical considerations that Stewart (2009) addresses include: issues of bias, generalization, and Indigenous ways of knowing. In addition, a common struggle for Indigenous academics and professionals is the challenge of walking between the two worlds of Western ideologies and Indigenous ways (p. 57). It is not uncommon for an Indigenous person to feel the need to prove themselves and their worth in both worlds. Stewart (2009) addresses her personal and academic conflicts through storytelling in her research. Storytelling in peer-reviewed academic research supports the Indigenous perspective and gives it consideration in therapeutic counseling practices.

Lenchuk-Favel and Jock's (2004) research had many macro ethical considerations as they reviewed Indigenous community health systems in Canada, including provincial and federal commitments and responsibilities, cultural values, jurisdictional boundaries and responsibilities, and partnerships with multiple stakeholders. In a few of the case studies, there was the consideration of internal versus external resources, such as recruitment of various health professionals, existing community resources, and, ultimately, the long term sustainable resource of educating and training internal community members. Common themes were: self-empowerment, holistic approach, primary care, integrated health service delivery, and bringing together Western and traditional philosophies. Elders were involved and their approach to healing was based on a phased holistic treatment, with each phase focusing on the person, their spirit, mind, physical well-being, and their place in their community. As Indigenous communities are integrating traditional practices and working closely within their community, autonomy and trust is being built, allowing them to move forward with their blend of Western and traditional Indigenous healing practices.

The ethical considerations of Ross's (1999, 2006) writings reflect the inconsistent approaches to First Nations groups in Canada and the lack of accountability for the psychological problems of Indigenous people in

remote communities. The Canadian justice system is in constant ethical peril because it fails to acknowledge or engage Indigenous legal traditions. The health professions have not supported Indigenous values, which has resulted in unhealthy Indigenous people and communities in remote areas. Specifically, remote Indigenous communities with increased poverty, violence, sexual abuse, chronic drug and alcohol abuse, suicides, and detachment from Indigenous ways maintain states of denial and unhealthy healing practices. A healing tool lies in storytelling, which is an untapped resource outside of the narrative therapeutic approach, as pointed out by Ross (2006) and Stewart (2009). Stories are an integral piece of healing and without them an Indigenous person may not be engaged to share their journey. Lastly, building credibility as a non-Indigenous researcher in an Indigenous community is an ethical consideration within research, particularly for non-Indigenous authors writing of Indigenous issues. Ross (2006) is challenged with balancing his professional legal obligations and meeting the needs of the Indigenous community in which he is practicing. His responsibility toward the justice system and with Indigenous Elders means he must meet the ethical values of both his legal profession and those of the Indigenous people. This ethical consideration is only balanced through time and experience.

Coyhis and Simonelli (2005) look at integrating two therapeutic processes: the Medicine Wheel and the twelve-step program concept. Their paper does reflect the authors' business and primarily references the authors' writings. Coyhis and Simonelli's (2005) article is not based on either a standardized qualitative or quantitative approach; they use a culturally sensitive approach to gathering data and sharing their findings, which could be categorized as a qualitative approach to research. A macro ethical consideration is the social context in which this program is promoted and to what degree it is part of a First Nations cultural healing program. The micro ethical considerations are: enrollment, consent, confidentiality, personal respect, and the commitment to do no harm. Individuals who met the criteria of Indigenous ancestry and desire for recovery from an alcoholic addiction were invited to participate in the program and become its ambassadors. There is no discussion on confidentiality within the program or if there was any process for informed consent once in the program. As the program traveled across the US, groups of participants would gather for meetings where they heard Elders speak. Even though the ultimate goal of Coyhis's and Simonelli's (2005) program was to do no harm and to mitigate the damage caused by alcohol, they could be viewed as unethical because Coyhis was a participant, researcher, and entrepreneur. The powerful relationship roles these

authors had with participants may be questionable. The major question is whether the principle driver was to assist participants or to build a profitable business. Coyhis and Simonelli (2005) would have benefited by partnering with an independent research company to keep their program separate from their business.

Roberts et al. (1998) is a comparison of themes between individual psychology and the Medicine Wheel and its four directions. They did not recruit participants or develop a selection strategy for data collection, as they chose a therapeutic model that resembled the Medicine Wheel and then compared thematic similarities. A possible ethical consideration with Roberts et al. (1998) is that the research is conceptual and does not analyze or assess the researchers' or participants' experiences. A macro ethical consideration is the social context of Indigenous Medicine Wheel principles aligning with Aldrian therapeutic concepts, but only in a theoretical process. An alternative approach, such as the phenomenological approach, would allow each lived experience to compare differences and then identify common themes.

Cook's (2005) study is a straight forward questionnaire. One of the ethical considerations that may have been overlooked has to do with respect for dignity of persons. She did not have her questionnaire translated nor did she have translators available to assist non-English participants who agreed to complete the questionnaire. In addition, the study itself may not be reflective of the whole community, as it targeted the health center clientele only. The community is small compared to the First Nations population in Canada, therefore Cook (2005) would have benefited from seeking the Band Council's permission to survey the whole community through different means – e.g. through a mass mail out, drop in hours at the Band office or health center, an online survey, telephone researchers, and/or in-person interviews. Cook's (2005) ethical considerations are primarily at a macro level: jurisdiction and consideration of Band Council approval. The ethical considerations in Indigenous communities are the importance of researchers, be they Indigenous or non-Indigenous, as well as the approval of the community, generally through the operations of the Band Council. This community level of approval demonstrates cultural sensitivity and respect for cultural governance. Lastly, surveying the whole community and ensuring the questionnaire is translated are also seen as being culturally sensitive and respectful.

Reflection

As I reflect back on my life, I am still confused and I question the purpose of the Canadian government's

Indian Act (1985). Canada is a mosaic of multiple international cultures, people, and ways of life. An important historical event that continues to have an impact today is the proclamation of the *Indian Act* in 1868. The Act initially served to eliminate Indigenous people and their culture in Canada, but it was amended in 1952 to benefit Indigenous people. In 1985, the *Indian Act* was again amended to be inclusive of Indigenous people who had lost their Indian Status. Discussions continue between the government and First Nations groups around whether to keep the *Indian Act* (1985) or repeal it. Whatever the decision, it will heavily impact various Indigenous peoples, infrastructures, health systems, and hundreds of programs and services.

The *Indian Act* (1985) is a controversial subject that continues to hurt and confuse many Indigenous people, for reasons of inclusion, exclusion, and the overall categorization of Indigenous people. Wesley-Esquimaux and Smolewski (2004) have written an excellent historical review of what has happened to Indigenous people and their research, which provided me with a better understanding of my own trauma and the repeated cycles of abuse that continue, both at the individual and community levels. My personal memories of my childhood and adolescent years still affect the multiple decisions that I make for my career, my children's welfare, and myself.

Education became my personal motivator to stop the cycle of abuse in my own life and my children's lives. When I finished university and obtained my degree, I wanted to pursue a Master's program but was unsure as to the area. Fifteen years later, I began City University's graduate program in Psychology / Counseling. Over those 15 years, I continued my education via diploma programs in Human Resources, Massage Therapy and Reflexology.

A significant change in Canada came with the findings of *The Report* (1996). This led to other initiatives, including *The TRC Report's* (2015) calls to action. Programs for studies in Indigenous issues were being developed or enhanced, literacy programs for adults were being developed, and the Indigenous perspective was being seriously considered in many healing and treatment programs. I was thrilled that I now had a focus of interest, and I applied and was accepted into a Master's program. I was cognizant that the three most challenging areas for completion of the program would be my writing skills, my health, and being a single parent to four young children. However, the programming, support, and guidance for teaching traditional therapeutic approaches and integrating Indigenous perspective is often still missing.

Discussion

Following the revised *Indian Act* (1952), Indigenous people spoke out about the failing welfare, education, health care, governance, and economic conditions affecting them as First Nations, Metis, or Inuit peoples. Policies and guidelines were written, however very little was done to monitor or implement change. Finally, the findings of *The Report* (1996) affirmed the voices of Indigenous people. Wesley-Esquimaux and Smolewski (2004) identify post-traumatic stress disorder (PTSD) as intergenerational in Indigenous people, as its impact was continuing to be felt in many subsequent generations. Their findings substantiate the need for Indigenous people's treatment to consider many factors, including the need to integrate traditional healing practices.

At the Night Wind Treatment Centre (NWTC) in Northern Alberta the Medicine Wheel model facilitates an integrated approach to healing which is reflected in their mission statement. The four main aspects of therapy used in client treatment are the following: spiritual, milieu, group and individual. Therapy is viewed as a method of healing that allows for the inherent healthy identity to emerge naturally within the individual. In order to enjoy a well-balanced life, clients need to change their ways of thinking, feeling, and behaving that were being demonstrated prior to seeking treatment.

During my practicum at NWTC, I experienced the use of Indigenous healing practices such as the talking circle, smudging, and sweats. For daily living and in group sessions, the use of the Healing and Teaching Wheel Program was practiced. These practices were the focus of their treatment program for Indigenous youth. The Healing and Teaching Wheel was a vision given to the Elder through a Shaking Tent ceremony, when a tent shakes due to the spirits visiting it, giving a vision to the vision questor. The wheel reflects colors, phases in a life cycle, symbols, clans, and animal spirits as life's representation. This Healing and Teaching Wheel is always moving and the colors are interchangeable and interactive within the wheel. A client's healing can occur in any quadrant or phase of his or her life, and at the core of the wheel is love, which is at the core of each client. One's healing can be physical, psychological, spiritual, or emotional. Whatever area is being affected will then effect each and every area of a person's wellness.

By extension, and with any type of Medicine Wheel, Indigenous people's healing will also effect a community. Each Medicine Wheel, as with this Healing and Teaching Wheel, is as unique as the Elder and their specific Indigenous culture and the values being taught. Lastly, the Medicine Wheel is not a replacement for necessary

medical or therapeutic interventions; it is a process that augments holistic healing. For example, at NWTC, I was also engaged with my client's social workers. As I completed psycho-educational assessment testing for all new clients, I read each file for history, medications, and past interventions, and I used a variety of counseling techniques when working with each of my clients.

An important lesson for me during this practicum was the self-care that is expected of staff. All paid and volunteer staff were expected to be engaged in their own healing work, leading by example, and serving as role models for NWTC clients. The teachings of the Medicine Wheel in general and the more focused Healing and Teaching Wheel program are both seen as interactive and a means for connecting people. The energy exuded by one individual is projected on to the clients, and when staff is not upholding the mission of the NWTC, other staff members will bring them to task.

The Medicine Wheel model is not a linear process as there is no clear start or finish. The Medicine Wheel is circular, meaning that whatever we are involved in is both evolving and affecting other areas of our whole being. The clients entering into the NWTC are in treatment because they have been abandoned, neglected, and abused. These actions often result in the potential for a client to perpetuate the next generational cycle of abandonment, neglect, abuse, or self-destructive behaviors. While in care, clients are exposed to staff who care about them as individuals and who show them a healthier way of living. These clients are in daily, sometimes more than once, and are engaged in group sessions as well as individual therapy. During all of these therapeutic sessions, clients engage in healthy thinking – learning to recognize feelings of anger, frustration and betrayal and learning to talk about their feelings, as well as how to address an issue in a safe and positive manner.

Throughout this practicum, I was involved in one-on-one therapy with the client, which included regularly supervised sessions with my supervisor. I applied my learning from previous classes (e.g. family systems). I enjoyed the exercise of preparing my own genogram which is a graphic representation of family members and relationships of family members. I thought this would be a great exercise to use with my clients, however I quickly discovered that genograms with Indigenous youth in treatment is not a valuable exercise for them as they often know very little about their families, including the birthdates of their many siblings. Journaling was another activity that I thought could be a good tool for use between sessions, yet there were clients who could not express themselves in writing.

Each week consisted of a therapy day involving individual sessions with clients, a group session of 1 to 2 hours, and weekly one-hour meetings with staff, including the on-site social worker, registered psychologist, student psychologists, Directors, and Elder. To gain experience, I assumed responsibility for all new client psycho-educational assessments. During my nine months at NWTC, I was able to complete six assessments, which involved using The Wechsler Intelligence Scale for Children – Fourth Edition (WSIC-IV), Wechsler Individual Achievement Test – Second Edition (WIAT-II), Substance Abuse Subtle Screening Inventory (SASSI), and Behavior Assessment System for Children, Second Edition (BASC-2). These assessment tools helped support the potential for future diagnoses using the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR). These assessments identified a client's strengths, weaknesses, and addiction behaviors, and they assisted in the development of the client's treatment plan. The treatment plan itself was essentially each client's personal medicine wheel, their own life plan, which looked at all of who they were, where they came from, and their relationships.

During my practicum, the NWTC had a number of activities that the clients were expected to engage with on a regular basis. These include three daily meals and snacks, which are based on the Canada Food Guide. Between meals and snacks, clients have access to distilled water and herbal teas. There are regular sweats when the Director responsible for cultural learning is on-site. The clients are also involved in daily group sessions that include opening and closing prayers and smudging. It is interesting to note that the NWTC would often be a client's first exposure to Indigenous ceremonies and cultural ways of living, as well as healthy living.

The clients' goals in therapy were generally very basic: to build self-esteem, learn positive social skills for dealing with people, and continue with harm reduction therapy for current addiction(s). I was also involved in family sessions where my supervisor and I would first meet with parents, followed by a meeting with their child. I relied on knowledge from my family systems class to process information such as where a parent or parents were in their own psychological development versus physical development, what they learned as a child and how they projected their teachings onto their child or children. This would only take place with parents who wanted to be involved or who had contact with their child.

Individual sessions brought up many ethical considerations such as confidentiality, namely what was confidential and what had to be disclosed because the

clients were children. With respect to note taking, one had to examine what could be used from notes in court, as well as issues of trust and the setting of strict and appropriate professional boundaries, while always respecting the Code of Ethics for Psychologists and the Code of Conduct for this private business.

The most significant lesson for me during this practicum was around the emotional caretaking that is required of a therapist, ensuring transference and countertransference issues are dealt with immediately. A therapist can work with a particular therapeutic model but needs to be adaptable to work with the client's needs and available personal resources. Each week, I would have a plan for treatment, but each week I rarely followed my plan for a variety of reasons. Some weeks clients were talkative, some weeks clients were silent. I used the exercise "draw me a tree, a house, and a person" to learn about each of my clients. As a result, clients would sometimes want to draw instead of talk.

I had one client who took a long time to trust me, but through game playing I was able to help her build confidence by demonstrating how she intuitively used strategies to maneuver her actions during our game playing. We were then able to transfer this skill into what we did in therapy. There were also times when playing a game helped the client relax. I learned to listen through observation, and actively participate in silence. I learned from the clients and their stories, from the Elder, and, most of all, from a skilled supervisor who allowed me autonomy with the clients but maintained a close connection for support and guidance. I learned a great deal about the colors of the Healing and Training Wheel, and how clients were able to see their life through each color and its representation. All clients had to participate in a process of sharing, encouraging, and supporting each other.

The Medicine Wheel model also perfectly fits with the four guiding principles: respecting dignity, responsible caring, integrity in relationships, and societal responsibility of the Canadian Code of Ethics for Psychologists. The Medicine Wheel is grounded in ethics and integrity, whether the participant is an individual, a business, or a community. Its healing remedies reflect First Nations and Indigenous peoples' traditional methods of healing. Like the four guiding principles, the Medicine Wheel integrates four areas of a person's life: physical, spiritual, emotional, and psychological. Self-care is evident in each of these four areas as the business of the NWTC can effect someone's spiritual well-being, their

emotional intuitiveness, and/or their physical and psychological wellness.

The clients are firstly human beings and bring with them a host of issues, some of which are at a subconscious level. The emotions and energy manifested over the course of one day can range from one extreme to another, and emotional volatility is never far from the surface. Self-care impacts the wellness of each therapist and their responsibility towards their clients, colleagues, and practices. Therapy or self-care can include talking to an Elder, medicine man, shaman, counselor, psychologist or doctor to help heal the wounded soul. The benefit of healthy self-care is that the staff can focus care and attention on the client's needs, therefore creating fewer opportunities for counter-transferences to be manifested. Maintaining personal and professional integrity fosters sound judgment in decision making processes and allows the work of the Centre to extend positively into the many agencies and communities working with the NWTC and its clientele.

As I engaged in my practicum, my learning was primarily around the need to have respect for all people, always striving to maintain their dignity. As I study the Medicine Wheel model and use it as my therapy of choice, I am learning to see the ever-intertwined circles of my clients and the many people and external environmental influences that make up the fabric of their lives. The many contributing factors that have brought each of my clients to be at the NWTC are just one small part of the bigger picture affecting each client. The larger picture includes connections between many close and extended family members, the foster care system, as well as the potential for the client to touch many more lives into the future.

One of my past personal biases was to judge adults who abandon, abuse, or neglect their children. As I continue to learn to understand and respect the teachings of the Medicine Wheel, I have a responsibility to acknowledge and respect all the people in my client's life and recognize that their own unhealthy rearing has contributed to my client's current lack of well-being. I cannot judge another person's life as I do not know their experience, their rearing, or how their brain developed and why it currently processes information in the manner that it does. My responsibility is to maintain the dignity of all individuals, not speak ill of others, maintain confidentiality, and have a healthy perspective of each person's reality, which is something I work on daily. My role is not to project my values and beliefs on others; rather it is not to be consumed by other's values and beliefs.

In examining the second principle of the code of ethics, responsible caring, again the Medicine Wheel model is circular and encompasses all areas of our involvement. The ethical decision-making model is a process that looks at who is involved in a process and who is impacted by the decision of a process. The daily choices and decisions that staff at the NWTC make directly affects clients, colleagues, Directors, volunteers, site / labor crews, teachers, and therapists. There can be an indirect impact on the client's co-workers, family members, local businesses, and other agencies involved in the work of the Center. The relevant ethical issues to consider are the protection of clients, privacy of personnel and personal information, and any personal / professional conflicting interests that may become issues. Staff members are held to a high professional standard. Directors are the role models for the staff, while the staff and Directors are role models for clients. As the inner workings of the NWTC exude good energy, the energy moves outward into the local communities and extends beyond into the geographical connections of clients, families, and agencies. This ultimately demonstrates the positive effect of the Medicine Wheel and how one action can affect many areas, be it in a person, place, or community.

With respect to the four principles and the Medicine Wheel model, the third principle of the code of ethics, integrity in relationships, is my inner strength. I am often told that I demonstrate personal integrity in many of my decision-making abilities, both in my human resources position and in my massage therapy practice. I uphold my values and share them openly, not wavering from them when there are difficult choices, and employing a communication style that is direct and to the point. This characteristic worked in my favor with NWTC clientele, as most responded well to my personality type. My personal motto has always been to say what I mean, and mean what I say. I ensure that my values and beliefs are a role model to others and I do not suggest actions that I would not do myself.

The last quadrant of the Medicine Wheel and corresponding guiding principle is responsibility to society, namely how one person impacts or affects society as a whole. From a student psychologist's perspective, we can only change who we are, which then creates the change we want to see. The beauty of the Medicine Wheel is that no one organism, person, or thing is better than another; one has the ability to affect many.

Other considerations within the Medicine Wheel that generally reflect Indigenous cultures is the value placed on Indigenous healers, medicine men/women, and

ceremonies. There is also the value of smudging, the giving of gifts such as the four medicines (tobacco, sweet grass, sage, cedar), cloth, beads, ribbon, drums, rattles, teas and songs for requests. Indigenous values and ethics are as important to Indigenous people as ethics and values are to various non-Indigenous professional associations. Within the professional groups of psychologist/therapists, the Indigenous professional walks two paths. The Canadian Code of Ethics for Psychologists guidelines for cultural sensitivity is based on the premise that, when culture impacts a person's belief system, therapy must respect the client's whole belief system in order for progress to be made.

Conclusion

The research in this paper suggests that there is an obvious desire to integrate, or at least consider, Indigenous cultural practices of healing/traditional medicine into contemporary Western practices. Overall, the research also recommends that health care for Indigenous People be developed with Indigenous communities' involvement. Health systems should be designed, developed, and implemented by Indigenous people. The future for Indigenous health systems or model should be in the Indigenous community and be provided qualified members.

There is information out there, discussions and dialogue are happening; now it is time to capture the experiences for both the academic and Indigenous communities. The strength of the research is in suggesting consideration of traditional Indigenous healing practices, however there is limited access to research with results indicating that traditional healing is actually working. Indigenous cultural and traditional healing concepts involve the use of the Medicine Wheel, along with other traditional Indigenous healing processes, all of which are part of a person's journey. Although traditional therapeutic practices may integrate varying ideologies into their interventions, the Medicine Wheel is not an intervention that can be integrated into another process. Instead, the Medicine Wheel can integrate other concepts, interventions, and models as applicable over the course of a person's lifetime.

My research question focuses on determining how the Medicine Wheel is given consideration in therapeutic practice. In my initial research nine years ago, my preference was to read the academic research progression in this area, and at the time the research only demonstrated that there was a need. Now, the research is showing the use of Indigenous cultural practices in therapy such as art, looking at healing through a holistic lens, and allowing Elders to be part of the process. Through personal

exposure working in an Indigenous treatment center for youth, I experienced the positive effects of practicing Indigenous teachings and using the Medicine Wheel as a model to follow. There are very effective programs that need to be documented or published to demonstrate the wealth of Indigenous practices already in place. Furthermore, as Indigenous therapists are now completing research, clinicians' and authors' future research should include how Indigenous traditional teachings, healing practices, and ethical considerations benefit Indigenous people in their healing.

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