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The Impact of Training Indigenous Facilitators for a Two-Eyed Seeing Research Treatment Intervention for Intergenerational Trauma and Addiction

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Abstract

Intergenerational trauma in Indigenous Peoples was not the result of a targeted event, but rather political and governmental policies inflicted upon entire generations. The resultant effects of these traumas and multiple losses include addiction, depression, anxiety, violence, self-destructive behaviors, and suicide, to name but a few. Traditional healers, Elders, and Indigenous facilitators agree that the reclamation of traditional healing practices combined with conventional interventions could be effective in addressing intergenerational trauma and substance use disorders. Recent research has shown that the blending of Indigenous traditional healing practices and the Western treatment model Seeking Safety resulted in a reduction of intergenerational trauma (IGT) symptoms and substance use disorders (SUD). This article focuses on the Indigenous facilitators who were recruited and trained to conduct the sharing circles as part of the research effort. We describe the six-day training, which focused on the implementation of the Indigenous Healing and Seeking Safety model, as well as the impact the training had on the facilitators. Through the viewpoints and voices of the facilitators, we explore the growth and changes the training brought about for them, as well as their perception of how their changes impacted their clients.

Keywords

Post-traumatic stress disorder, PTSD, substance use disorder, intergenerational trauma, blended implementation, Two-Eyed Seeing, Seeking Safety, Indigenous Healing and Seeking Safety, traditional healing practices, Elders, sharing circles, decolonizing methodologies

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The Impact of Training Indigenous Facilitators for a Two-Eyed Seeing Research Treatment Intervention for Intergenerational Trauma and Addiction

It is a known fact that Indigenous Peoples are the most disadvantaged group in Canada. Indigenous Peoples in Canada have generally poorer physical and mental health; are less likely to complete primary, secondary, and tertiary education; and do not have the same employment opportunities as non-Indigenous Canadians (Chansonneuve, 2007; Hart, 2007; Kirmayer et al., 2000, 2009). Furthermore, Indigenous Peoples are affected by high rates of suicide, homicide, substance use disorders, accidental deaths, community and domestic violence, child abuse and neglect, poverty, as well as other complex social problems. Most, if not all, of these issues have been attributed to the impact of ongoing colonization (Waldram, 2008). These factors have strongly contributed to the multigenerational grief and loss associated with intergenerational trauma (IGT; Brant Castellano, 2004; Smith, 1999; Waldram, 2008; Waldram et al., 2006; Wilson, 2008).

For the purposes of this article, the term Aboriginal Peoples refer to First Nations (Status and non-Status Indians), Métis, and Inuit as referenced in the Canadian Constitution. Aboriginal Peoples is used as a way to respect and acknowledge their shared values, historical residential school experiences, and contemporary struggles in the aftermath of colonization and oppression. Indigenous Peoples will also be used interchangeably with Aboriginal Peoples. The former term is most recognizable within international contexts.

To be properly understood, the escalation of mental health challenges and substance use disorders (SUD) in Indigenous communities must be viewed through a historical lens and the unique historical experiences of Indigenous communities (Evans-Campbell, 2008; Kirmayer & Valaskakis, 2009; Linklater, 2010; Macaulay, 2009). In Canada, Indigenous communities exhibit the impacts and symptoms of colonization and the Residential School System—such as SUD; anxiety; violence to self, family, and communities; and youth and adult suicide (Chandler et al., 2003; Marsh, Cote-Meek et al., 2016; Menzies, 2014). Also, the disproportionately high prevalence of mental health problems and SUD in Indigenous communities can be linked in part to a history of cultural disruption, oppression, marginalization, and the impacts of ongoing colonization (Hart, 2007; Menzies, 2014; Waldram, 2008). The complexity of symptoms that accompany IGT and SUD represent major challenges in the treatment of both.

Today, Western medicine is struggling to reduce the death toll from the overdose crisis across all of Canada and elsewhere. Many treatment programs for mental health and SUD lack an understanding of the cultural needs of Indigenous Peoples (Bishop, 1999; Hill, 2009). Stewart (2008) suggested that these contemporary treatment issues exist for Aboriginal Peoples because Western treatments and conventional psychology have failed to understand holistic Indigenous wellness, spirituality, and traditional healing methods (Cote & Schissel, 2008; Evans-Campbell, 2008; Poonwassie & Charter, 2005; Stewart, 2008). Today, many Indigenous Peoples are now turning toward traditional healing and culturally appropriate treatment to help them recover from this deadly disease, which is claiming many young lives. Unfortunately, there are currently few culturally appropriate, evidence-based, and integrative treatments for both conditions available (Kirmayer & Valaskakis, 2009; Menzies, 2014; Stewart, 2008; Thatcher, 2004).

Evidence from a recent study demonstrates benefits from the blending of Indigenous traditional healing practices with a Western treatment model called Seeking Safety (Marsh, Cote-Meek et al., 2016; Marsh, Young et al., 2016; Najavits, 2002). The blended model was called Indigenous Healing and Seeking Safety (IHSS). This integration of Western and Indigenous approaches can enhance the health and well-being of Indigenous people with IGT and SUD (Marsh, Cote-Meek et al., 2016; Marsh, Young et al., 2016). One of the key components of the IHSS implementation was the presence of trained Indigenous facilitators who facilitated the IHSS Sharing Circles. This component was important because, according to the *First Peoples, Second Class Treatment* reports (Allen & Smylie, 2015), coupled with the release of the Truth and Reconciliation Commission of Canada's (TRC, 2015) Calls to Action, there is an urgent need to bridge the gap between Indigenous clients and non-Indigenous health care providers. Across the board, many First Nation, Métis, and Inuit people have reported being ignored, discriminated against, mocked, and belittled by mainstream Canadian health care providers (Allen & Smylie, 2015; Kirmayer et al., 2009). While the broad set of Indigenous healing practices utilized in the study of IHSS are described elsewhere (Marsh, Coholic et al., 2015; Marsh, Cote-Meek et al., 2015; Marsh, Cote-Meek et al., 2016), this article explores the six-day training provided to Indigenous facilitators on the implementation of IHSS and the impact on these Indigenous facilitators. Also, through the viewpoints and voices of the facilitators, we will explore the growth and change the facilitators experienced through the training, as well as the healing that took place.

Literature Review

There is a strong relationship between childhood stressors and SUD (Anda et al., 2002), and many individuals who experience traumatic events or are under chronic strain turn to alcohol or drugs to self-medicate their pain and distress (Carpenter & Hasin, 1999). Among Indigenous Peoples, those with a history of childhood neglect, sexual, and physical abuse; violence victimization; or family substance use consistently show higher levels of SUD (Brave Heart, 1999, 2003; Chansonneuve, 2007; Duran, 2006; Marsh, Young et al., 2016). There is also a cyclical nature to this relationship, as prospective studies have indicated that individuals who abuse alcohol are also more likely to encounter a range of stressful events (Lukassen & Beaudet, 2005).

Many different terms have been used to describe the multigenerational nature of distress in Indigenous communities, including collective trauma, IGT, multigenerational trauma, and historical trauma. Intergenerational trauma is most often used by the Indigenous Peoples in Canada and this term is conceptualized as a collective complex trauma inflicted on a group of people who share a specific group identity or affiliation, such as that based on ethnicity, nationality, or religious affiliation (Hill, 2009; Kovach, 2010; Marsh, Coholic et al., 2015)). The legacy of traumatic events includes numerous losses experienced by a community over generations and encompasses the psychological and social responses to such events (Brave Heart, 1998, 1999, 2000).

The Western treatment model, Seeking Safety is an evidence-based, manualized counseling model originally developed in the United States as an integrated treatment for PTSD and SUD (Najavits, 2002). It is also now used for any form of trauma and/or addiction (i.e., for either issue or for those with no formal diagnoses). The model is present focused and designed to teach coping skills to attain safety from trauma and/or addiction in an optimistic, inspiring way. It can be conducted in group or individual modality and does not require any formal training or certification, making it the lowest cost evidence-

based¹ PTSD model available. It can be conducted by anyone, including professionals, peers, paraprofessionals, advocates, and case managers. The evidence base for Seeking Safety includes over 40 published empirical articles (Najavits & Hien, 2013). The treatment has shown positive results and is the only model for PTSD and SUD thus far to improve both PTSD and SUD compared to a control (Najavits & Hien, 2013). Also, Seeking Safety has been implemented with Indigenous Peoples in Canada and showed positive results (Marsh, Young et al., 2016). The perspective of Seeking Safety is convergent with Aboriginal traditional methods. Because of the content and delivery method of Seeking Safety, the program complements traditional teachings such as holism, relational connection, spirituality, cultural presence, honesty, and respect (Gone, 2008; Lavallée, 2009; Menzies, 2014). Specifically, this model was chosen because it offered an individually empowering approach to the treatment of trauma and SUDs (Najavits, 2002).

The Seeking Safety model includes an inspiring quotation at the beginning of each session (Najavits, 2007; Najavits & Hein, 2013), as well as discussions about safety, gentle language, and teachings about the genesis of IGT and SUD (Najavits, 2002; Najavits & Hein, 2013). It is a highly culturally sensitive model that encourages adaptation based on culture, age, setting, gender, etc. Seeking Safety addresses behavior, thinking, and relationships as well as a focus on case management, including utilization of community resources. These are all the strengths that the Western model brings.

Jiwa et al. (2008) examined the development of cultural and community-based programs for First Nation peoples to address SUD. They found that the key components of success in SUD treatment for this population appeared to be community engagement and strong leadership from Chief and Council. They noted the importance of viewing SUD through a sociocultural lens and advocated for a traditional cultural component in the treatment of SUD. Along these lines, several researchers agree that culturally sensitive assessment tools and interventions are needed to enhance healing from SUD in Indigenous Peoples (Duran & Duran, 1995; Kirmayer et al., 2000; Whitbeck et al., 2004). It is also important to consider treating SUD and the effects of trauma concurrently, since they are so closely connected (Kirmayer, et al., 2000; Whitbeck, et al., 2004).

Two-Eyed Seeing is a decolonizing methodology that blends Aboriginal and Western research methods, knowledge translation, and program development (Bartlett, 2005; Bartlett et al., 2012; Iwama et al., 2009). According to Stewart (2007), blending Aboriginal and Western treatment methods involves the incorporation of Aboriginal traditional healing practices and traditional healers; the presence of Elders in treatment programs; the involvement of local communities, drumming, smudging, and sweat ceremonies; and the participation of non-Aboriginal treatment providers in community events and ceremonies (see also Gone, 2008; Menzies, 2014; Stewart, 2008). Creating a blended model of care has the potential to increase the rate at which Aboriginal Peoples access mental health services and decrease program dropout rates. Furthermore, a blended approach could encourage cultural understanding and strengthen relationships between Aboriginal and non-Aboriginal service providers (Gone, 2008; Menzies, 2014; Poonwassie & Charter, 2005; Robbins & Dewar, 2011).

The Two-Eyed Seeing framework was utilized in this research because it recognizes Indigenous knowledge as a distinct epistemological system that can exist side by side with mainstream (Western)

¹ Based on published outcome research.

science (Bartlett, 2009; Bartlett et al., 2012; Iwama et al., 2009). The application of the concept of Two-Eyed Seeing advocates for inclusion, trust, respect, collaboration, understanding, and acceptance of the strengths that reside in both Western and Aboriginal worldviews (Iwama et al., 2009). Two-Eyed Seeing encourages Aboriginal Peoples, healthcare providers, and researchers to develop a relationship of mutual cultural respect, wherein the benefits of both worldviews are acknowledged as beneficial in the healing process (Bartlett, 2009; Bartlett et al., 2012; Iwama et al., 2009).

Currently, Indigenous workers, helpers, and clinicians know about the many obstacles that stand in the way of Indigenous Peoples' healing journey (Linklater, 2010). Linklater's (2010) research, which explored healing and wellness within Indigenous communities on Turtle Island, showed that Indigenous workers and Indigenous strategies for helping and healing are vitally important to trauma work. As IGT continues to increase, these communities are confronted with complex health issues, including high rates of violence, sexual abuse, substance abuse, addiction, suicide, unresolved grief, and poverty. Workers are not just dealing with past traumas but also with the traumas that happen on a daily basis (Tousignant & Sioui, 2009). Mehl-Madrona (2009) pointed out that the overall sense of community "is hampered by deteriorating social structures, thereby forcing its members to look after their own individual needs and survival, which undermines traditional values and stories that put the needs and survival of the group above that of the individual" (p. 21). As a result, many Indigenous people, including workers, experience extreme stress and multigenerational trauma with little or no support. It was clear as I embarked upon this research project using a blended approach based on Two-Eyed Seeing to help Indigenous Peoples heal from IGT and SUD that there had to be a place where the facilitators could receive the help, training, and support (Marsh, Coholic et al., 2015; Marsh, Cote-Meek et al., 2015, 2016; Linklater, 2010).

Methods

Background

In past research, IHSS was found to be feasible, suitable, and beneficial for the treatment of IGT and SUD in Indigenous women and men (Marsh, Cote-Meek et al, 2016; Marsh, Young et al., 2016). The results of research looking at the qualitative and quantitative outcomes of IHSS among clients are described in prior papers (Marsh, Cote-Meek et al., 2016; Marsh, Young et al., 2016). Close attention and respect to cultural ethics and protocols guided the mixed-methods approach, utilizing both quantitative and qualitative inquiry to evaluate IHSS implementation (Marsh, Cote-Meek et al., 2015).

This article draws from the qualitative interviews conducted with the Indigenous facilitators who were recruited and trained to implement IHSS Sharing Circles. A holistic view of mental health and SUD includes connection to community so many Indigenous protocols were incorporated into the sharing circles. Elders are the key to the healing process, as they are considered wise and responsible for educating the people (Colomeda & Wenzel, 2000). Elders' skills, knowledge, and ability in helping individuals restore balance in their lives have earned them significant roles within Aboriginal communities (Menzies et al., 2010).

Furthermore, this research was conducted in an honest, respectful, and humble manner. Knowledge Keepers and Wisdom Carriers from various Indigenous communities (Elders, an Indigenous advisory group, Indigenous scholars, and facilitators) were invited into this process as consultants and experts.

The study was approved by Laurentian University Research Ethics Board in May 2013. Written informed consent was obtained from all participants (both clients and facilitators).

Data Collection

While the detailed methods used in the IHSS study are reported elsewhere (Marsh, Coholic et al., 2015), the approach used for generating qualitative data on the training of the facilitators is briefly described below. As part of a study evaluating the IHSS approach in the treatment of IGT and SUD, 25 sharing circles were offered over a 12-week period to gender-specific groups of 12 men and 12 women. The Elders advised that the facilitators should be Indigenous, have experience working with Indigenous people, and that groups should be divided by gender to ensure that participants felt comfortable and safe during the sharing circle sessions. All six facilitators had previous experience working with women and men who experienced IGT and SUD. Four facilitators and two students were selected to lead the IHSS Sharing Circles. Each of the sharing circles was co-facilitated by two Indigenous healthcare workers and one student. For the male circle, we had one Métis male and two female facilitators, one Métis social worker and one Indigenous social work student. Unfortunately, we could not find three Indigenous male facilitators. All of the women who facilitated the female sharing circles were from the Anishinabek Nation in Sudbury. Three of the women were recruited from the N'Swakamok Native Friendship Centre and one was a social work student and a frontline worker.

This study explores the impact of facilitator training and implementation of the IHSS Two-Eyed Seeing approach. The facilitators offered 5 to 6 hours weekly to facilitate these circles, and Elders and the Indigenous Advisory Group provided supervision and interaction to the facilitators. The Indigenous Advisory Group consisted of one Indigenous physician, three Elders, two intake workers from the N'Swakamok Native Friendship Centre in Sudbury, two Indigenous social workers, an Indigenous social work student, and one Indigenous university faculty member.

An Elder was present every second week for the sharing circles, which provided connection to important healing practices as part of Two-Eyed Seeing. Aboriginal Peoples have long recognized the role of the Elder as integral in the healing process. The Elder's presence in the sharing circles was reflexive and culturally adaptive. They taught about Two-Eyed Seeing, while also focusing on the positive identity of each person in the circle. They also helped to develop a connection to the spiritual world through their teachings.

Each sharing circle was opened and closed with smudging, ceremonial drumming, and singing. Tobacco, a plant recognized in Indigenous culture for its healing powers, was prepared in bundles in advance of the sharing circles. It was offered to each participant for protection and healing. Participants were also invited to participate in three sweat lodge ceremonies held in Weeks 3, 9, and 12 of the intervention period.

All six facilitators entered the training with different but experienced backgrounds in mental health and SUD, as well as an understanding of and personal experiences with IGT. They all reported histories of trauma and a few were in recovery from SUD during their interviews. Also, most expressed that they felt anxious because this experience could activate and trigger their past traumas. They were reassured that they would receive support from the first author. It was thus possible to build on their existing knowledge and insight and introduce them to the knowledge they would require for the implementation

of the IHSS intervention. Both male and female facilitators received the same training, but at different times. Most of the facilitators had an excellent understanding and knowledge of Indigenous traditional healing practices. Facilitators understood that they were expected to use an Indigenous decolonizing methodology and teach cultural practices. The first author, who had several years of experience delivering and providing training in the Seeking Safety approach, trained all the facilitators over a period of six days for eight hours per day.

Choice of Outcome Qualitative Tools for the Facilitators

The Indigenous decolonizing approach of Two-Eyed Seeing was interwoven through the selection of tools and during the data collection phase for facilitators. Numerous discussions were had with the Indigenous Advisory Group, Elders, and the research committee about appropriate measures for the facilitators. The post-treatment semi-structured instrument was presented, and teachings were provided about how to make this process culturally safe.

Initial individual 90-minute meetings were conducted with the six facilitators in their place and time of choice. During these meetings, facilitators received information about Seeking Safety, traditional healing, sharing circles, the process, and the program details. They had lots of time to ask questions and tell their stories. For example, some of the facilitators would start off the interview through storytelling about their families, communities, ceremonies, and cultures. Some meetings spanned several hours, as respect and listening to stories are part of the decolonizing approach in Two-Eyed Seeing. Also, during this period, facilitators shared many painful stories about their own trauma and the impact of substance use on their lives. All facilitators signed a consent form that outlined their responsibilities. They were informed about their weekly supervision sessions as well as an end of treatment semi-structured interview with the first author. These individual meetings and supervision sessions with the facilitators occurred twice monthly over three months. We also met as a group with the Elders present at least once a month. At the end of the training, all the facilitators completed an end of treatment semi-structured interview with the first author.

Training of the Facilitators

The six days of training on IHSS incorporated all the elements of an integrative, Two-Eyed Seeing blended approach. The training consisted of didactic, experiential, and small-group learning. During the training, the facilitators engaged in IHSS Sharing Circle Sessions on Seeking Safety topics such as PTSD: Taking Back Your Power, Setting Boundaries in Relationships, Healing from Anger, and Taking Good Care of Yourself. During the sharing circles, the Elder offered one of the Seven Grandfather Teachings, Indigenous spiritual and traditional sayings, smudging, and/or prayers during the sessions. The teachings of the Seven Grandfathers, also known as the Seven Teachings, address human conduct toward others including the concepts of Wisdom, Love, Honesty, Respect, Bravery, Humility, and Truth (Benton-Benai, 1988).

The first two training days included topics such as understanding trauma and becoming trauma informed, somatic experiencing trauma work, safety and stabilization during trauma work, and treatment of trauma. Each day began with didactical presentations until lunchtime and in the afternoon the participants would engage in an actual IHSS Sharing Circle facilitated by the lead researcher and an Elder. The Elder would support and teach as well as bringing the traditional teachings to life. For

example, Seeking Safety consists of up to 25 treatment topics, each a safe coping skill (see Marsh, Cote-Meek et al., 2015 for further details on the IHSS intervention). The facilitators had time and opportunity to ask questions and engage in in-depth discourse. Days 3 and 4 focussed on SUD and an exploration of information in the Seeking Safety manual. In-depth discussions helped participants understand how the Seeking Safety sessions are offered as well as how traditional healing practices can be integrated. The last two days of training focussed on vicarious traumatization, practice sessions, planning, and implementation. The practice sessions encouraged the facilitators to explore their strengths and weaknesses in sharing circle facilitation. For example, sometimes the content on intergenerational trauma brought up past painful experiences. All facilitators were encouraged to burn sacred medicines and to place it at the feet of the participant to offer strength. The facilitators understood and valued the ritual of burning sacred medicines as essential to this approach. Discourse on group methods, group processes, therapeutic use of self, and expectations were practiced during these sessions.

A unique outcome of facilitator training was the formation of a community built upon trust, laughter, and feasting. These are respectfully consistent with the Indigenous cultures in this area. During the study, the lead author provided twice-monthly clinical supervision to the facilitators. One-on-one consultations were also available on an ad hoc basis. During supervision and the ad hoc meetings, we focused on their mental wellbeing, the regulation of their nervous systems, the impact of the IHSS sessions on themselves, and how they were doing in the sharing circles. Also, if triggers occurred for them, they had an opportunity to explore and understand how to cope with these triggers. Finally, the supervision focused on support and teachings about their own safety and self-care. This was a very powerful learning time for the facilitators and the first author, as the Seeking Safety content informed them in ways that supported Indigenous ways and teachings.

In accordance with the recommendations of the Elders who guided this study, the sharing circles were offered separately to male and female participants. The men's sharing circles took place at the Rockhaven Recovery Home for Men, located in Sudbury, Ontario. Rockhaven delivers a recovery program that empowers Aboriginal and non-Aboriginal men to develop a personal program of recovery from substance use disorders. Approximately 40 percent of the men served by Rockhaven are of Aboriginal ancestry (Patricia Delyea, personal communication, April 15, 2013). The female sharing circles took place at the N'Swakamok Native Friendship Centre in the same city. The N'Swakamok Native Friendship Centre assists Aboriginal Peoples by providing programs that serve the social, cultural, and recreational needs of the urban Aboriginal community. Each of the sharing circles were co-facilitated by two Aboriginal healthcare workers and one student (now called facilitators). These facilitators organized and led sharing circles twice a week for 13 weeks. Each weekly sharing circle was two hours long.

The facilitators, while covering the Seeking Safety topics (e.g., When Substances Control You, Dealing with Anger, Setting Boundaries in Relationships, and Taking Good Care of Yourself), used the culturally relevant method of storytelling. They incorporated teachings about the history of the Aboriginal Peoples, as well as the Seven Grandfather Teachings that discuss human conduct with an emphasis on Wisdom, Love, Honesty, Respect, Bravery, Humility, and Truth (Benton-Banai, 1988). One Elder was also present at most sessions to help participants develop a connection to the spiritual world through traditional teachings (Menziés et al., 2010). The Elders taught about Two-Eyed Seeing while also focusing on the positive identity of each person in the circle. Two of the facilitators were also traditional

healers at the Friendship Centre. Therefore, their presence as both facilitators and healers was powerful in the sharing circles. Their skills included abilities to promote psychological and spiritual healing and complement the Elder teachings (Gone, 2008; Menzies, 2014; Najavits, 2002; Restoule, 2004).

Data Analysis

The data analysis approach and results of the IHSS intervention are published in an earlier article (Marsh, Cote-Meek et al., 2016). All discussions from the end-of-treatment sharing circles and the semi-structured interviews with the facilitators were audiotaped and transcribed verbatim. Each facilitator was assigned a number to maintain confidentiality. After transcription, a qualitative thematic analysis was initiated to examine the data. This method was selected to be consistent with cultural data analysis models that require more involvement and interpretation from the researcher (Bernard & Ryan, 1998; Denzin & Lincoln, 2005). First, the text was read and re-read to identify and describe implicit and explicit ideas within the data (Creswell, 2009). Next, codes were developed to represent the identified themes and link the raw data as summary markers. Code frequencies and code occurrences were then compared and the emerging relationships between the codes were graphically displayed. Finally, four emerging themes were identified (Bernard, 1998; Creswell, 2009). Feedback from facilitators was essential to Two-Eyed Seeing and the Indigenous decolonizing methodology; thus, all facilitators received a copy of their transcripts and were encouraged to make additions and deletions. All six facilitators were interviewed at baseline and at the end of the training and also completed a semi-structured interview to elicit their experience of what it was like to facilitate the sharing circles.

Results

Analysis of the Facilitators' Qualitative Responses

The following four core themes were identified: (a) healing through traditional Aboriginal healing methods; (b) impact, education, and knowledge through sharing circles; (c) awareness, understanding, and the link between trauma, substance use, and the impacts of colonization; and (d) integration and application of knowledge. The facilitators are identified below as F1, F2, and F3 of the female group and M4, M5, and M6 of the male group.

Healing Through Indigenous Traditional Healing Methods

The sharing circles and the presence of Elders, Indigenous facilitators, sacred bundles, sacred teachings, sacred medicines, and ceremonies strengthened the experience for the facilitators. All the facilitators reported that the inclusion of traditional healing approaches and the presence of Elders brought them back to their roots and strengthened their own spirituality. M4 noted:

One thing that was very helpful was having an Elder come in to give a teaching. I think those were very helpful along with the topics we were covering with the participants. All the men really enjoyed any traditional knowledge that we as facilitators were sharing. I shared my experiences with them as a facilitator, taught the traditional way, and the men enjoyed all these teachings.

M5 reported:

I believe that part of the reason why these traditional healing approaches were so helpful for me as a facilitator is that it helped us all to reconnect with our identities as Indigenous Peoples. Colonizers have been attempting to remove the identities of Indigenous Peoples for centuries now and in doing so have caused a great deal of damage. This has led to many Indigenous Peoples to not know their own customs and traditions that lead to further issues of identity. Many people believe, including myself, that returning to the traditions and customs is a way of healing Aboriginal people.

There was a consensus amongst all six facilitators about the impact of the traditional healing practices on the lives and health of the participants and themselves.

Some participants indicated that because of the spiritual aspect of the program, they felt more empowered and supported. They shared that they had their own challenges because of their own pain and intergenerational trauma but, as they led the circles and learned more about trauma, it helped them with their own healing. For example, M5 stated:

I greatly appreciated the spiritual aspect of the program as a facilitator. The use of spirituality in social work practice is not widely accepted nor practiced; yet I believe that it is vital in a person's recovery. This strengthened me all the way.

Furthermore, he commented:

I also enjoyed being given the opportunity to be a facilitator while using an Indigenous approach. It was clear to note the changes in the health and well-being of all the facilitators. Although, I've spent quite a bit of time studying Indigenous perspectives in the helping profession, my work experience has been limited to working within conventional models, which confine facilitators to their offices. I feel as though my role has afforded me the opportunity to work more creatively and intuitively. This freedom of these circles has allowed me to feel more effective as a facilitator. For instance, community is an essential facet of the Indigenous perspective and thus I was able to attend community events, such as drumming workshops and Indigenous plays, to connect with the participants in the group.

Here I observed how the facilitation of the IHSS helped this facilitator to feel safe and appreciated. The facilitator's experience highlights the impact of identity and culture loss. This finding is supported by the work of McCormick (2009), who confirms that "one of the roles of therapy for traditional Indigenous society has been to reaffirm cultural values and helping find meaning and identity" (p. 340). M6 stated:

I've learned a lot about the Indigenous healing model, and I really appreciate the teachings around being a human being, as a facilitator. It sounds silly but this was one of the biggest insights for me.

This is a very powerful statement. Yalom and Leszcz (2005) talked about the power of the shared testimonies of traumatized individuals and specifically of the moment when two people compassionately respond to the needs of the other. Yalom and Leszcz agreed with other scholars that trauma destroys

faith, decency, courage, and connection. The power of the sharing circles resulted in a reawakening that can occur through common altruism by others (Brave Heart, 2003; Drake, 2003; Duran, 2006; Herman, 2006; Marsh, 2010; Yalom & Leszcz, 2005).

Impact of the Education and Knowledge Through Sharing Circles

All of the facilitators appreciated the training and the wisdom the Seeking Safety model offered them, and all agreed that it helped them be better helpers and healers. One of the most outstanding characteristics was the guidance and support the model offered facilitators. As F1 so eloquently stated:

Everything was clearly put out for us, we just had to use ourselves to get the information across. It's an excellent model and I learned and grew so much. This learning and taking in of new wisdom helped me to become more trauma informed and, in this way, I could support myself and the participants to self-regulate.

F3 commented:

I just love Seeking Safety and I learned so much as a student about trauma, addiction, and the connection. Every topic was bang on and powerful.

This connection allows clinicians to tie into their own spirit and helps with vicarious trauma (Pearlman & Saakvitne, 1995). M6 added:

I found the topics to be so practical and grounded in the realities of day-to-day living for those dealing with substance use and trauma. There was so much wisdom in each session, and I would say . . . I think the piece that stands out the most is around self-care, and that being one of the guiding principles . . . is coming back to yourself, and what is healthy for you now, what is safe for you to do now.

Vicarious trauma and burnout are often discussed as an occupational hazard for helpers (Pearlman & Saakvitne, 1995). All the facilitators agreed that the sharing circles helped them with their own self-care and health.

Awareness, Understanding, and the Links Between Substance Use, Trauma, and the Impact of Colonization

Most of the facilitators stated that the 25 Seeking Safety topics added to their existing knowledge about SUD and IGT and helped them understand trauma, the impact of colonization, SUD, and their interrelatedness. They felt that they learned with the participants. Just as the participants expressed their learning and understanding through “aha” moments, so did the facilitators. As F3 stated:

What I found the most helpful about the sharing circle topics was the many different areas of PTSD [and] SUD. Every week we explored a different topic that gave us a different perspective of the depth of PTSD [and] SUD. The actual materials itself [book and handouts] have tools and strategies that are useful in helping people manage their symptoms and substance use issues.

M5 added:

Members of the circle had topics given to them and an emphasis on self-care was provided. I thought that this was important, as many people suffering with PTSD only know how to cope with their symptoms by using substances. The topics that were covered not only shed light on their illness but also gave them the tools to be able to cope with it.

This vicarious learning and healing that happened in these circles remind us as helpers that the helping process is reciprocal (Duran, 2006; Marsh, 2010).

Integration and Application of Knowledge

When facilitators were asked about their experiences in the sharing circles, they valued both traditional healing elements and the Seeking Safety topics. They expressed that they felt confident in talking, practicing, and teaching about their culture as well as informing participants about the connection between SUD and IGT and their impacts. They continued to intimate how much they have gained and healed themselves, and all praised the integration of mainstream and traditional practices. For, example M6 stated:

I really felt that I was healing along with the men. I felt like I knew my role very well, and yet I could see the reciprocal nature of healing. And for all of us, even the other facilitators, we were all in it together. And I can say too that even the experience being with the Elders and the sweat had a profound impact on me. I had experienced tremendous insight, personal and spiritual insights.

Duran (2006) and Herman (2015) validated this statement in their work and research. F3 shared:

Seeking Safety allowed me to do it through some of my own experiences in my life teachings, I guess, and doing the medicine wheel teaching with the women, and how it helps us to look at that, to reflect on how we can better our lives.

F5 concurred:

The passing of the eagle feather signified the sacredness of that person's time to be able to speak. I also enjoyed the smudges before the circles as I believe that it helped people to "cleanse" and ground themselves before they started to speak.

Discussion

This study, as part of a larger study, explored the six-day training and supervision provided to Indigenous facilitators of IHSS, as well as the impact this training and the sharing circles' facilitation had on these facilitators. The larger study identified whether or not Indigenous traditional healing practices implemented with the Seeking Safety treatment model would be a feasible, suitable, and beneficial group implementation project for IGT and SUD in Indigenous women and men (Marsh, Coholic, et al., 2015; Marsh, Cote-Meek, et al., 2015; Marsh, Young et al., 2016).

The IHSS 12-week program and the training, supervision, and support the facilitators received had a tremendous impact on the wellbeing, spirituality, confidence, knowledge, growth, and confidence of the facilitators. There appears to be a scarcity in the literature and research on the impact of training and support for group facilitators and research clinical staff. The work of Carl Rogers (1951, 1992) on the role of the facilitative conditions that placed the therapeutic relationship at the center of the healing process, led researchers to embark on a quest for factors, common to all psychotherapies, that are responsible for the benefits of such treatments (Frank & Frank, 1991; Lambert & Barley, 2001; Lambert & Bergin, 1994; Luborsky, 2000). Emphasis was thus given on the therapeutic relationship as an integrating therapy factor (Yalom & Leszcz, 2005).

Najavits (2000) described the essential qualities facilitators require to conduct the Seeking Safety treatment: (a) they want to work with this patient population, (b) willingness to use the treatment manual, (c) ability to maintain fidelity to Seeking Safety while also adapting it as needed (e.g., in this study, to apply culturally sensitive material and in this case traditional healing practices). Seeking Safety is an ideal manualized treatment for incorporation into this research study for many reasons, one being that there are no strict criteria about credentials for the therapist selection. Also, the Seeking Safety model's teachings and focus is on stabilization, education, and compassion rather than trauma processing. This approach facilitated safety. It also supported the facilitators' willingness to commit to the training, which required hours of their time during the 12-week intervention period. Seeking Safety incorporates attention to thinking, behavior, and relationships and focuses on optimistic messages toward healing, as well as encouraging utilization of community resources (Najavits, 2002). All the above-mentioned attributes of the Seeking Safety model inspired and facilitated growth and healing for both the sharing circle participants and the facilitators. Lintlater's (2010) research into healing and wellness within Indigenous communities on Turtle Island (i.e., North America) shows that bringing forth Indigenous strategies for helping and healing is a vitally important contribution to the field of trauma work, as well as to the workers' wellbeing. It is well documented that the IGT experienced by Indigenous Peoples is linked to experiences at residential schools (Gagné, 1998; Kirmayer et al., 2000; Menzies et al., 2010; Waldram, 2008). All six facilitators reported a history of IGT and two are in recovery from SUD. The facilitators understood the suffering and struggles of their clients and worked hard to bring forth self-care not just for the participants, but for themselves as well. This was evident in the qualitative data. Najavits (2000) encouraged training for facilitators who lacked knowledge in SUD, PTSD, and cognitive behavioral therapy (CBT). The training offered to the facilitators represented an opportunity for growth, team building, community engagement, and support among community members (Najavits, 2000).

Lambert and Barley (2001) indicated that 40% of the improvement in outcomes among psychotherapy clients could be attributed to extra-therapeutic factors; 30% to common factors, including the client-therapist relationship; 15% to specific interventions; and 15% to expectancy or placebo effects. Also, many researchers have identified converging themes across therapies, such as the significance and importance of the therapeutic relationship, therapist and client variables, specific therapeutic techniques, as well as common mechanisms of change (Beitman, 1992; Goldfried & Davila, 2005; Wampold, 2007). All the facilitators discussed feeling a sense of empowerment, freedom, and satisfaction as they witnessed many positive changes in the participants and themselves. Disconnection and isolation are the hallmarks of trauma and these were clearly counteracted during the sharing circles as the facilitators and participants built interpersonal connections. Some talked about the healing that took place during the

sharing circles. The activated nervous system is often experienced and described by survivors as living in a prison. When people finally begin to heal, a sense of safety and freedom returns (Haskell & Randall, 2009; Herman, 2015; Marsh, 2010). This aspect of healing was beautifully depicted through the viewpoints and voices of the facilitators.

It has been noted that there is a higher percentage of sexual abuse survivors among the population of therapists than is found in the general population (Dunkley & Whelan, 2006; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). The empathic resonance such workers can offer their clients can be a source of hope and validation, and it may also leave counselor-survivors at greater risk of vicarious traumatization (McCann & Pearlman, 1990). All six facilitators reported a history of childhood trauma and therefore the training and weekly supervision played an important role in support throughout the research process. When asked about the impact of supervision, all six facilitators agreed that the education, support, and supervision helped them to function at their best and experience transformation rather than vicarious trauma.

Limitations

The findings in this study have been very positive and healing in a holistic way as reported by the quotes and viewpoints of the facilitators; yet some of the limitations in the education and supervision should be noted. First, our data is solely self-reported. Second, the facilitators are not representative of all Indigenous facilitators. There is a scarcity in the literature on training and supervision of Indigenous research staff; thus, future studies in this area are needed to further shed light on the needs of facilitators and research staff.

Conclusion

The facilitators who attended this training and supported this research project reported profound, empowering, and transformative moving experiences, including spiritual, emotional, and physical growth, and confidence working with clients with IGT and SUD. Furthermore, the training and supervision experiences promoted a deep connection for the facilitators in relation to themselves and the participants. The Seeking Safety material and the Indigenous traditional healing practices enhanced their interactions with each other, themselves, and the participants. The support and teachings by the Elders and the researcher were appreciated by the facilitators throughout the research period. Finally, it was clear that education, support, and supervision are key aspects that enhance empathic engagement with self and recipients of care and treatment. The reclamation process was enhanced through the Indigenous traditional healing practices and the presence of Elders and their wisdom.

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