

EXPRESSIVE THERAPY AS A TREATMENT PREFERENCE FOR ABORIGINAL TRAUMA

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ABSTRACT

This article provides the theoretical rationale and overview of the client preference and the best practice approach for counselling Aboriginal people and offers the expressive therapies as a treatment option for trauma. Aboriginal peoples have used expressive therapies including art, dance, music, drama, and storytelling throughout their history including pre-European contact. The expressive therapies involve a strong experiential element that provides holistic healing that the verbal therapies are less able to offer. This article explores the links between the expressive therapies, experiential education, healing traumas, and Aboriginal culture. The traumas specified in this article are related to the negative effects of colonialism and residential schools. Examining these and related dynamics with consideration of best practices, ethics, preference effect, historical traumas, colonialist attitudes, and social justice yields some strong conclusions and recommendations. These findings should be of interest to Aboriginal communities and those engaged with Aboriginal people including policy makers, governments, counsellors, funding bodies, academics, healers, and health professionals.

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Tell me and I'll forget. Show me, and I may not remember. Involve me, and I'll understand. First Nation teaching.

BACKGROUND

Recently, there has been an increased use of the expressive therapies in the counselling profession. In 2004, the American Counselling Association formed a new division, *The Association for Creativity in Counselling*, which began publishing the *Journal of Creativity in Mental Health*. Davis (2010) noted an increase in counselling journals paying more attention to expressive therapies, even dedicating entire volumes to the creative arts such as the 1997 volume of the *Journal of Humanistic Education, Counseling, and Development*. Davis also reported the increase in book titles and professional conferences focusing on the effectiveness of expressive arts and creativity related benefits for the counselling profession, and ultimately for the client.

The significance of the client preference effect as a determining factor for treatment outcomes has also been gaining attention in counselling practice. An evaluation of the context, culture, and preferences of the client is necessary in delivering effective therapeutic interventions. The American Psychological Association (APA) (2006) stated that client preferences for therapy conditions are considered essential in current best practice standards. Swift et al. (2011) stated that not only are treatment outcomes improved if the client's preference for treatment type is met but that client preferences are recognized as a core component in evidence-based practice. Swift and Callahan (2009) asserted that when a client is properly matched with their preferred therapy, the preference effect means that the client is significantly less likely to prematurely drop out of therapy and significantly more likely to show improved outcomes compared to a client with unmatched or unconsidered preferences.

The client preference effect has direct implications for culturally relevant counselling practice.

Recommended therapeutic interventions for delivering and practicing culturally relevant therapy in counselling literature are often written from the beliefs and perspectives of the dominant culture. Examining the general beliefs and perspectives of the nondominant culture is a logical starting place for culturally relevant best practices for that specific culture or individual. It is important for the therapist to understand First Nation culture including the history of oppression by a dominant culture often represented in the very professionals offering therapy. To consider how a specific culture acquires knowledge is a clue to determining the treatment preference of that culture. In Aboriginal culture, there is a historical understanding that people acquire knowledge from one another experientially, and that this experiential learning preference remains present in today's world (Stonechild, 2006). The trauma experienced in residential school history included a prolonged exposure to abuse, paired with a perceived inability to escape. This experience yielded a type of post-traumatic stress disorder (PTSD) characterized as "complex" or "C-PTSD" as originally identified by Herman (1992). For the purposes of this paper, "trauma" is defined as an experience or experiences that create a sustained and substantial psychological impact on a person of any age. A traumatizing event may be a singularity experienced first-hand or an observed event such as witnessing an injury. Experiencing trauma involves an attack on all of the senses, which I argue requires a subsequent sensory-based experiential therapy to undo. I will explore the notion that the expressive therapies such as music, art, play, movement, drama, sand play, and integrative approaches are a viable treatment option for the Canadian Aboriginal population. I will relate the client preference effect to the Aboriginal history of experiential knowledge acquisition patterns and to the Aboriginal trauma as related to residential schools and colonialism.

The concept of client preference is key to facilitating the empowerment of a nondominant population. Determining the most relevant treatment options for Aboriginal Canadians will make effective treatment more likely. Effective treatment for positive outcomes is not only an ethical responsibility

to the counselling profession, but it is also financially sound since treatment for trauma is a growing issue in the counselling profession (Malchiodi, 2008). I will present a brief history of the nature of Aboriginal trauma, highlight the benefits of client preference, and present the expressive therapies as a viable option for a relevant and effective preference for ethical practice. I will offer limitations as well as recommendations for further research and development as related to these areas.

CULTURE

Evidence suggests that clients from a nondominant population are less likely to seek counselling services due to the counselling profession's tendency to be ethnocentric (Bimrose, 1996). Where Western counselling practice is based on the white middle class, it is easy to see how people from a nondominant population could feel alienated before they even enter counselling (Sue and Sue, 1999). The relevance of culture when administering an intervention or treatment is evident when considering the APA (2003) definition of culture which includes in its synthesis, the collection of the following: world view, beliefs, and values; rituals, practices, customs, or norms; social, religious, or spiritual traditions; language, history, ties to geographic locations; and social, economic, or political structures.

This definition of culture is based on the assumptions that every individual is a cultural being learning culture through social interactions and that this culture is constantly in flux (Ho, 1995). The ingredients of this definition of culture are the very topics and themes of counselling content. The fluidity of cultural identity means that an individual or group can have multiple cultural identities at any given time and that these identities may evolve over their lifespan (Arthur and Collins, 2010). Even if a person is from a seemingly distinct culture, (s)he may still identify more strongly with a new, chosen culture. This notion of a unique culture of the individual means that every person possesses such a distinct collection of experiences that (s)he could be considered a unique one-person culture (Arthur and Collins, 2010). Therapists who hold the possibility of clients having a unique and individual culture apart

from an ethnically defined culture may be less likely to assume what any given client may prefer. Quite simply, matching a treatment to a client's preferences based on their culture translates to an effective and ethical practice. The term "culture" can be as broad or specific as the client determines. This shift in assumptions is an adaptation for the therapist and is defined by Bernal et al. (2009, p. 362) as

the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meaning, and values.

The importance of treatment type as a function of client culture is clearly relevant as it directly influences evidence based treatment.

Peavy (2004, p. 33) offered guidelines for multicultural awareness in counselling that can be applied to any intervention. He encourages counsellors to listen from the perspective of the client with a fresh ear while practicing genuine curiosity from a not-knowing stance and exercising patience, respect, and equality, letting the client teach the therapist; he suggests beginning where the client is, not where you expect, assume, or need the client to be; while restraining vanity, self-importance, and the need to assert yourself (p. 33). These guidelines are not a formulaic recipe for practicing in a culturally adaptive way but instead are intended as an over-arching philosophy for culturally relevant practice. Although they can be applied to any intervention, they lend themselves particularly well to the expressive therapies. Similarly, Draguns (2008) identified common themes to consider for cultural adaptation from current literature on cross-cultural psychotherapy. These include the following:

- Therapists must practice flexibly.
- Services must be meaningful within the cultural context that they are delivered.
- Assessments should be conducted prior to implementing treatment.
- Therapists must remain open to what clients bring to therapy.
- Traditional treatments should not be dismissed but rather used as existing resources.
- Therapists must communicate empathy with clients in a culturally appropriate manner.

- Therapists should not interpret cultural differences as deficits.

The above inventory of best therapeutic practices offers current guidelines for counsellors to consider when working with both dominant and nondominant cultures. The urgency to ensure the delivery of effective therapy practices for Canada's Aboriginal population is increased by the importance of not furthering the power imbalance that created the trauma in the first place.

THE CANADIAN ABORIGINAL EXPERIENCE

The Canadian Aboriginal people, including First Nations, Inuit, and Métis, vary widely across geography and their respective historical experiences. Canada's Aboriginal people number about 1.2 million (Statistics Canada, 2006), making up about 4% of the country's total population. Although it is difficult to make generalizations about such a large group of people, Aboriginal people can be characterized as having a history of interacting with the world through an understanding of interconnectedness which stems from land-based values and gaining knowledge through experiential learning (Stonechild, 2006). Castellano (2002, p. 25) wrote about Aboriginal knowledge that

[it] is said to be personal, oral, experiential, holistic, and conveyed in narrative or metaphoric language.

Draguns (2008) noted that "traditional treatments should not be dismissed but rather used as existing resources," and I would argue that Aboriginal people have been employing the expressive therapies long before anything resembling modern psychology existed. Perry (2008) suggested that we look at Aboriginal cultures for the expressive therapies in their beliefs, rituals, and principles on how to heal traumas. Trauma has occurred in all cultures over human history; however, when levels of trauma are sustained in a specific culture over a long period of time, the long-term effects of trauma will become evident.

The history of Aboriginals in Canada is rife with struggle since sustained European contact, spe-

cifically since the mid-1800s when the Canadian Government introduced the residential school system. Under federal government policy, children were forcibly removed from their homes and placed in residential schools as a means of assimilating Aboriginals into Canadian society, the strategy being to “kill the Indian in the child” (Chansonneuve, 2005, p. 44). The government’s strategy towards the goal of assimilation was to isolate Aboriginal children in the residential schools in order to “civilize and Christianize” (Chansonneuve, 2005), or as Sochting et al. (2007, p. 321) described,

the residential schools focused on the supremacy of the English language and on Christianity as the only acceptable spiritual belief system. In many cases, Aboriginal students received corporal punishment for speaking their own language rather than English.

The children were denied access to their families during the school year and sometimes during the school breaks, thus severing familial connections for several years. Beyond the trauma of the children’s forcible removal from their communities, families, and homes, many children were further abused physically, sexually, and emotionally at these schools. In the communities where the children were removed, there was a sense of hopelessness and a disconnection to the heirs of traditional and cultural knowledge. Chansonneuve (2005, p. 39) reported that

policies, such as those in Canada that supported the aggressive assimilation of Aboriginal children through residential schooling, are now considered as examples of ethnocide or as genocide..

The traumas of the residential schools have created a ripple effect that will take what Aboriginals consider to be seven generations to heal (Poonwassie and Charter, 2001). The direct survivors of residential schools as well as their descendants who have suffered the intergenerational effects of the trauma and the unresolved trauma share a common pattern of characteristics which have been specified as Residential School Syndrome (Brasfield, 2001). The last residential school closed in 1996, and the legacy of traumas which endured for over 150 years at these institutions has created an overwhelming

need for healing (Chansonneuve, 2005). Resolving the impacts of the massive direct childhood traumas as well as the resulting intergenerational traumas requires a serious consideration of the cultural context of Aboriginal people apart from the dominant culture’s preference for treatment. Facilitating the healing of these traumas requires including the perspectives and preferences of the Aboriginal people.

PREFERENCE EFFECT AND TRAUMA

The importance of matching client preference to an appropriate treatment is related to a core ethic of the counselling profession; that is, to respect the dignity of the client (Sinclair and Pettifor, 2001). Taking this a step further, Smith et al. (2011) argued that matching culture preferences for best practice treatment options is recommended. In their meta-analysis including 8620 participants, they determined that

mental health services targeted to a specific cultural group were several times more effective than those provided to clients from a variety of cultural backgrounds. (p. 166)

They also recommended that

a series of research-supported therapeutic practices that account for client’s culture, with culture-specific treatments being more effective than generally culture-sensitive treatments. (p. 166)

The American Psychological Association (2003) published “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,” which asserted that therapists are responsible to employ culturally appropriate skills, while constantly considering the cultural context of the client. Swift et al. (2011) reported that treatment outcomes are improved if the client preference for treatment type is met. In 2006, the American Psychological Association asserted that client preferences for therapy conditions are considered essential in current best practice standards. Swift and Callahan (2009) concluded that when a client is adequately matched with their preferred therapy, the preference effect means that the client is significantly less likely to prematurely drop out of therapy and significantly more likely

to show improved outcomes compared to a client with unmatched or unconsidered preferences. Three main client preferences were identified by Swift et al. (2011), including role preferences, therapist preferences, and treatment preferences. Swift et al. (2011) stipulated that these three client preferences converge to create one of the main components of evidence-based practice, alongside clinical expertise, and using the best available research.

Determining the client's preference includes methods ranging from a discussion-based treatment interview, which assists the client to focus treatment into one of three domains: roles; therapists; and treatments (Vollmer et al., 2009), to more empirical rating scales and questionnaires. A battery of questions developed by Berg et al. (2008) assisted clients to focus on a preference type chosen from four possible intervention and behavioural domains: outward orientation, inward orientation, support, and catharsis (focusing on the expressive therapies). If the time is taken to truly determine what the client prefers, then a tailored treatment can be planned with the client and this act in itself offers dignity and fosters empowerment. Smith (2010) asserted that the most appropriate therapy for the culture and context of the client is not only what is popularly known as "best practice" but is also the best *ethical* practice. The consideration of culture in assessing client preference is lowest in ethnic minorities (Gonzalez et al., 2010). The lack of proper therapy-client matching has created a lowered engagement in the therapeutic process amongst these minorities (Dumas et al., 2008) as well as a reduced relevance of available treatments (Miranda et al., 1996). The significance of matching treatments to the client's preference could be described as a social justice issue when it is evident how the preference effect shows such strong positive outcomes in evidence-based practice.

The oppression that colonialism has inflicted on Canada's Aboriginal population stems from a philosophy that disregards the vulnerable. To stop the perpetuation of the colonialist philosophy that disempowers individuals, therapists should not assume what is best for Aboriginal trauma healing. To ask people of any culture, whether a visible minority or

not, what they prefer as an intervention or treatment modality is best practice for multicultural therapy, and especially for those who have been traumatized by the foreign values of a dominant culture.

TRAUMA

Sustained exposure to neglect or abuse, and the loss of home, possessions, and family would characterize chronic trauma experiences (Malchiodi, 2008), and are directly related to the Canadian Aboriginal residential school experience as detailed above.

The American Psychiatric Association's Revised Fourth Edition of the Diagnostic and Statistical Manual (DSM -IV-TR) (2000) defined Post-Traumatic Stress Disorder symptoms in three clusters: intrusive recollection, avoidant/numbing symptoms, and hyper-arousal symptoms. An individual must have at least two symptoms from each of these three clusters of symptoms to meet the requirements for a PTSD diagnosis. By examining the duration and severity of symptoms, further criteria can specify if the PTSD is acute or chronic, with delayed onset or not. In the proposed revisions for the fifth edition of the DSM, the delayed versus chronic specification is proposed to be eliminated entirely. Although proposals include age-specific criteria for children and adolescents and a new preschool subtype of PTSD, there is little mention of adaptations for cultural applicability in the DSM-5. This is counter to statistics showing that cultural minorities are more susceptible to traumatic events (National Child Traumatic Stress Network, 2006). Young and Johnson (2010) suggested that the PTSD section of the DSM 5 draft specifically neglects cultural sensitivities. Young (2010) suggested that this oversight has implications for both the diagnoses and the treatment of PTSD in these nondominant cultures. With this lack of acknowledgement for the context of an Aboriginal client presenting with traumatic symptoms, an accurate diagnosis or effective intervention is compromised. Sue and Sue (2003, p. 8) stated firmly that

counselling and psychotherapy have done great harm to culturally diverse groups by invalidating their life experiences, by defining their cultural values or differences as deviant and pathological,

by denying them culturally appropriate care, and by imposing the values of a dominant culture upon them.

The importance of client preference becomes stronger when combating colonialist philosophies. In the best interests of the cultural context of Aboriginal clients, I propose that expressive therapies should be recognized as a relevant and readily available treatment option.

EXPRESSIVE THERAPY FOR TRAUMA

Reactions to trauma are both psychological and physiological (Malchiodi, 2008). The effect of trauma manifests itself in the body in a range of symptoms, from visible posture to decreased energy levels or a heightened fear response. A person's emotions are interconnected with hormonal fluctuations, cardiovascular effects, and neurological processes (Perry, 2009). The neural systems affected by trauma, neglect, and maltreatment originate in the brainstem and midbrain which can be best accessed by the primary somatosensory experiences, or the senses: visual, tactile, rhythmic auditory, and movement (Perry, 2008). A traumatic event is experienced by the senses, and the expressive therapies employ the senses in the expulsion of that experience from the self to positively transform the event (Malchiodi, 2008). Throughout history, traumatic events have been described as "unspeakable" and thus difficult to process in traditional talking-based therapy. In Herman's (1992) foundational book, *Trauma and Recovery*, she stated,

The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word unspeakable. Atrocities, however, refuse to be buried.... Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims. (p. 1)

Beyond being unspeakable, trauma can also be terrifying, mentally and physically exhausting, and generally confusing (Malchiodi, 2008). The inability for many trauma survivors to speak the unspeakable therefore limits expression to less verbal or nonverbal therapeutic modalities. Human mem-

ory is stored both explicitly, with greater capacity for verbal recall, and implicitly, as is common with traumatic events. Implicit memory is sensory and more difficult to verbally recall, therefore traditional talk therapy can be less effective (Malchiodi, 2008). Rothschild (2000) speculated that PTSD occurs when the implicit memory of trauma is stored separately from the explicit memory storage, making the context for the sensations associated with the traumatic event difficult for the individual to access when engaging in talk therapy. Accessing the unconscious, implicit memory related to a trauma requires an expression of the very senses that experienced the trauma. Expressive therapy is useful for processing the parts of trauma which language could not make sense out of. Malchiodi (2005, p. 11) stated,

All expressive therapies focus on encouraging clients to become active participants in the therapeutic process. The experience of doing, making, and creating can actually energize individuals, redirect attention and focus, and alleviate emotional stress, allowing clients to fully concentrate on issues, goals, and behaviours. Finally, in addition to promoting active participation, expressive therapies are sensory in nature. Many or all of the senses are utilized in one way or another when a person engages in art making, music playing or listening, dancing or moving, enacting, or playing.

The neural pathways in the lower part of the brain which are altered by trauma can only be effectively accessed with therapy through rhythmic, somatosensory experiences like rhythmic auditory (music), tactile (art), dance, and repetitive visual or tactile activity (Perry, 2008). Hundreds of Aboriginal cultures have practiced this sort of expressive healing of trauma for thousands of years (Archibald and Dewar, 2010; Perry, 2008). Indeed, the solution to the exploitation by the dominant culture already lies within the Aboriginal culture: storytelling, music, dance, art, movement, and supportive family relationships and connections all converge as the optimal culture-based healing program for Aboriginals. The realization that people require culture-specific treatment is embraced by British Columbia's Round Lake Treatment Centre whose motto is "Culture is treatment." The expressive therapies used as effective treatment for Aboriginal trauma are not new

as Aboriginals acknowledge in the holistic medicine wheel model of health (Chansonneuve, 2005). Stuckey and Nobel (2010) clarified the term “holistic” when describing the healing effects of expressive therapies on diagnosable conditions. They determined that employing expressive therapies in healing practices is aligned with the medical perspective of integrating the emotional, somatic, artistic, and spiritual dimensions of learning. They also contended that:

Through creativity and imagination, we find our identity and our reservoir of healing. The more we understand the relationship between creative expression and healing, the more we will discover the healing power of the arts. (p. 261)

The experiential nature of the expressive therapies, paired with the history of Aboriginal culture valuing these holistic tenets of healing make the client preference for expressive therapy an increasingly relevant option for Aboriginal people.

EXPRESSIVE THERAPY AND EXPERIENTIAL LEARNING

The similarity between experiential learning and expressive therapy is important because of the larger body of research linking the former as a preference for Aboriginal culture. The dominant culture’s disregard for the preferences of Aboriginal culture in the education system parallels that in the counselling community where available expressive therapy practitioners are a minority. O’Connor (2010) presented evidence that in the current education system, even though it is known that Aboriginal cultures are characterized by experiential learning patterns, the most common mode of educational delivery is didactic, at a disservice to Aboriginal students. In 2005, the Assembly of First Nations described the current state of education for Canadian Aboriginals as unacceptable. Grande (2004) identified the lack of traditional Aboriginal knowledge and perspectives in the public school system as a significant factor in the high failure rates of Aboriginal students. Aboriginal success and failure rates in the education system are well documented, and I mention it here because the parallel is so strong with the less documented subject of expressive therapies in Aboriginal treatment.

The Association for Experiential Education (2009) defined experiential learning as being very holistic, and included many identical descriptors and benefits as the expressive therapies.

An extensive review of the literature on expressive art therapy by Kerr et al. (2008, p. xiv), yielded their observation that “art interventions can reduce defensiveness and may unlock deeper levels of experiential understanding for both individuals and families in treatment.” Based on the premise that creative expression is an abstract method of communication, the expressive therapies access the unconscious. Malchiodi (2003, p. 1) described this as having the potential to “change your state of being and tap your intuitive and creative powers.” This experientially rooted method of therapy pairing movement with meaning-making is life-enhancing, healing, and a legitimate communication of the thoughts and feelings despite being a nonverbal modality (Kidd and Wix, 1996). The advantages of expressive therapy were described by Malchiodi (2007, p. 12) as being able to

Encourage personal growth, increase self-understanding, and assist in emotional reparation and has been employed in a wide variety of settings with children, adults, families, and groups. It is a modality that can help individuals of all ages create meaning and achieve insight, find relief from overwhelming emotions or trauma, resolve conflicts or problems, enrich daily life, and achieve an increased sense of well-being.

The similarities between the above descriptions of expressive therapies and experiential learning are strikingly similar in that both offer deep personal understanding through guided, non-verbal, physical processing of information including the element of creativity and growth through movement. I want to explicitly state here that the large body of existing literature connecting experiential education with Aboriginals also supports the relevance of the expressive therapies for Aboriginals.

EXPRESSIVE THERAPY AND ABORIGINAL CULTURE

The “increased sense of well-being” described above, which Malchiodi (2007) attributes to the expressive therapies, is aligned with improvements in

health similar to those described by the Association for Experiential Education: physical health, social health, emotional health, and spiritual health. These elements of holistic health are not an exhaustive list but they do appear across North American Aboriginal cultures on the medicine wheel as the broad titles of the four quadrants (Poonwassie and Charter, 2001). An imbalance in the wheel indicates an area to be corrected for the creation of a whole self. The notion of health in First Nations culture includes these quadrants, or “four directions” and the medicine wheel model for balanced health includes expanded versions depending on specific Aboriginal cultures. An elaborate description of the holistic and interconnected nature of the medicine wheel by Poonwassie and Charter (2001) concluded with the notion that the model be a starting point for counsellors working with Aboriginal people, perhaps even before counselling begins. This aligns with the notion of awareness around client preferences. As the medicine wheel is a template for cultural philosophy about health and life, it should follow that it is highly relevant for a counsellor to be familiar with the medicine wheel when counselling Aboriginal clients. Aboriginal understanding of human complexity is described by Blue et al. (2010, p. 269) as follows:

In all traditional societies, an indigenous psychology exists that describes, from a slightly different perspective, the same phenomena as does European-based psychology. The [interconnectedness principals] underscore the core understandings that guide beliefs and values for First Nations people. These include a unity and connectedness of the spiritual world, the importance of the unconscious, the meaning of dreams and the integration of art and creativity into First Nations belief systems.

The importance and value that Aboriginals hold for experiential learning, art, the unconscious, and the wholeness of the self provide an excellent environment for the expressive therapies. The above reference shows evidence for the strength of this connection. Euro-Western psychology values cognitive-behavioural processing and the verbal therapies, whereas the expressive therapies go beyond cognitions and behaviours by including and capitalizing on

creativity, the unconscious, spirituality, and physical movement into the client’s therapeutic and healing process. The expressive therapies involve physicality by means of touch, movement, drama, music, or dance, whereas therapies of the behavioural or cognitive domain are more psychoeducational, including tasks like homework and goal-setting. Kazdin (2001) described behavioural therapy as focused on observable behaviour, which translates in therapeutic practice to talking about the determinants, root causes, assessment, and evaluation of these behaviours and how to change them in a cause-and-effect manner. The expressive therapies can be integrated with nonexpressive therapies; for instance, Saunders and Saunders (2000) have reported that treating behavioural problems with expressive therapy has proven efficacious. Several effects of trauma have been successfully treated with expressive therapies (Eaton et al., 2007). These include suicidal ideation and depression (Harnden et al., 2004). Using integrative techniques allows a therapist to practice in their strongest method while including various expressive techniques at their comfort. As evidenced above, the expressive therapies are especially useful when working with trauma and with those less verbal such as children.

The effects of intergenerational trauma appear in children and they must have the opportunity to express these traumas through expressive play, art, music, dance, or combinations of integrative approaches. The magnitude of assisting in this multigenerational healing journey requires constant consideration of the preferences of the client base. If Aboriginal culture is known to be characterized by expressive or experiential preferences, then offering this corresponding therapeutic modality as a sole or a blended treatment option follows the counselling profession’s best practices. Researchers have suggested establishing new therapies, specific to each individual cultural group, that are clearly aligned with that culture’s values, beliefs, and practices (Comas-Diaz, 2006; Gone, 2009); however, Castro et al. (2004) suggested that an integrated model of cultural adaptation that takes into consideration best fit and long-term applicability would be preferable. In order to follow best and ethical practices, coun-

sellors should consider cultural values and treatment preferences.

LIMITATIONS

Although there is clearly demonstrated value in offering the expressive therapies to experiential learner types, this does not automatically mean that experiential learners could not also benefit from non-expressive therapies, and this is not to say that non-experiential learners could not benefit from expressive therapies. Blue et al. (2010, p. 264) state,

It is difficult to make generalizations about counselling such a diverse group of people.... In Canadian society there are a myriad of mistaken beliefs about First Nations, many of them based on a subtle variety of racism. Racist beliefs are almost always subconscious and as a result it is very difficult for counsellors to rid themselves of these beliefs.

Pare (2008, p. 138) cautions against viewing clients as being “rooted in particular cultures” and reminds counsellors to assess with awareness and an open mind. Related to the notion of assuming what is best for clients and culture, I warn of a possible limitation that may exist whereby using expressive therapy in an individualistic manner with a client from a collectivistic Aboriginal culture may create conflicting feelings about an unbalanced or disproportionate focus on the self. Furthermore, the use of the expressive therapies as an internal, personal experience in any culture that values external values such as community sharing and family may seem counter-therapeutic. Although the expressive therapies can be easily modified to accommodate families and groups, if this is not done, then the preference match of expressive therapies with a collectivist culture like Aboriginals could be inappropriate. Also, if individual preference strength between an expressive therapy and a nonexpressive therapy is marginal, then no significant difference may occur if one client preference were chosen over another. If a therapist is able to culturally adapt their existing expertise in their nonexpressive therapy for a specific client, then this may have better results than trying to conduct an expressive therapy session without the relevant competence to do so.

SUMMARY

Considering the research showing the significance of preference effects for clients, therapists should properly assess the specific individual client's preferences for treatment before treatment begins. Related to this, therapists should not assume the client's preferences. Effective outcomes are directly related to client preference, and when assessment for preferences is lacking or nonexistent, effective outcomes are negatively affected.

Aboriginal cultures are characterized by an experiential learning style, which is aligned with the philosophy and practice of expressive therapies. The importance of art, music, movement, and a sense of interconnectedness all contribute to the relevance of expressive therapies in Aboriginal counselling. The expressive therapies have many nonverbal therapeutic methods, which have also proven relevant for Aboriginal clients. Although the use of this therapy with Aboriginal clients appears to be culturally relevant, there are some limitations to its applicability. If client preference is assessed to be stronger for another intervention, then this should be considered and respected; however, when a therapist believes that a client's preferences are not in the client's best interest, these concerns should be shared to work collaboratively and operate under best practices.

The nature of trauma manifests itself in the entire body: the physical, spiritual, emotional, and psychological systems. These systems are akin to the Aboriginal medicine wheel model of balanced health and Aboriginals have corresponding prescriptions resembling the expressive therapies. Since Aboriginals employed the expressive therapies for healing trauma and building community before European contact, these aspects are already part of their culture. Many traumas have occurred and continue to occur from a history of residential schools and colonialism imposed upon Aboriginals. To prevent further harm from colonialist ideologies, it is essential to consider client preference when counselling Aboriginal clients both as an ethical responsibility and as a social justice issue.

I recommend more research in the area of culturally relevant interventions to more accurately determine the treatment preference range for

Aboriginals. I also suggest more research is required to examine the effectiveness of specific expressive therapies for specific types of trauma on a range of ages. This research may yield results relevant to the healing of multigenerational residential school trauma. In any case, the expressive therapies appear to be an effective treatment option for Aboriginals whether for processing trauma or not.

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- Joseph Graham** has been a practicing counsellor with local First Nations since moving to the Yukon in 2001. His approach has been to notice how people thrive and facilitate their growth through these means. Sometimes this includes the expressive therapies but it can also look like walking in the forest, skiing, and even canoeing. Recognizing and celebrating the sense of interconnectedness that First Nations have with all things is a strength in his counselling practice as it reduces barriers that may otherwise exist. Joseph uses the Aboriginal health model of the medicine wheel which has become a central concept of client assessment. Joseph has attained a Masters of Counselling Psychology with a specialization in Art Therapy and he practices art and play therapy techniques in a studio setting.