

EXAMINING THE LIVED EXPERIENCES OF NATIVE AMERICAN COUNSELORS
WORKING ON THE RESERVATION: AN INTERPRETIVE PHENOMENOLOGICAL
ANALYSIS

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ABSTRACT

The success of mental health counseling partially depends on the professionals who are providing these services, also on the quality of services they provide. To maximize their efficacy, counselors must achieve and maintain their own personal wellness. However, for counselors who work with people who have experienced trauma, there is an increased chance that these counselors will experience adverse effects from this work. In fact, the impact of trauma on counseling professionals is similar to actually experiencing the traumatic event themselves. Native Americans are more likely than any other racial group in the United States to experience chronic traumatization and victimization. As a result of this, Native Americans suffer disproportionate health disparities, including mental health conditions like depression, anxiety, and addiction. The research question of this phenomenological study is, “What are the lived experiences of Native American counselors working in the trauma-intense environment of a Native American reservation?”. In this study, three participants took part in a semi-structured, open-ended, individual interview. Through data analysis, four themes were identified about the participants’ shared experiences: the worth and weight of working on a reservation, the impact of culture and community on counseling, four forms of trauma impacting the counselor and their work, and the effects of personal and professional wellness on counselors. The discussion of these findings are presented, along with implications for future research and policy change. In short, the goal of this study is to assist Native American counselors in maintaining their wellness, so they may continue providing counseling services to a population of people who experience significant trauma.

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CHAPTER I. INTRODUCTION

Native Americans (also referred to as Natives) rank higher than any other racial group in mental health disparities including depression, substance abuse, collective trauma exposure, interpersonal losses, and unresolved grief (Brave Heart, Chase, Elkins, & Altschul, 2011). The physical and mental health disparities between Native and non-Native American people still continue (Sarche & Spicer, 2008). The term ‘health disparities’ refers to the potentially avoidable differences in health or health risks between groups of people who are socially less advantaged (Brave Heart, Elkins, Bird, & Salvador, 2012). Indeed, Native Americans rank highest among ethnic and racial groups in health disparities. For example, Native Americans have the lowest survival rate for all cancers combined and have the highest rates of tuberculosis among all racial groups in the United States (Beals, Novins, Whitesell, Spicer, Mitchell, & Manson, 2005; Simianu, Varghese, Porter, Henderson, Buchwald, & Javid, 2016).

Statement and Significance of the Problem

Large scale research, both short-term and longitudinal, in the area of Native American overall health is lacking. More to the point, research concerning mental health issues specific to Native Americans as a whole is inadequate, and in order to provide robust and empirically supported treatment options, this area needs increased research support, specifically, research concerning mental health treatment combined with cultural healing practices (Sarche & Spicer, 2008). It has been long understood that good mental health research is foundational to good mental health clinical practices. This is especially true for empirical research on appropriate cultural healing practices and their manifestation in sound clinical practice. The fact that Native Americans, who make up nearly 2% of the United States population, remain largely understudied, brings to light many concerns over the direction of future mental health research

(United States Census [U.S. Census], 2010). Taking this into consideration, in addition to the high rates of mental health issues afflicting Native peoples, a call for research is appropriate (Brave Heart et al., 2012).

Mental Health Disparities on the Reservation

There exists a need for health care, specifically mental health care, on reservations across the United States. The rate of suicide in Indian country is 50% higher than the national average (Brave Heart et al., 2011) and Native American males are four times more likely and Native American females are three times more likely to attempt suicide than members of other racial groups (BigFoot & Schmidt, 2010). Recent statistics indicate that Native Americans have the highest rates of suicide for both males and females in 2017 (Curtin & Hedegaard, 2019). Moreover, a 2018 study conducted by Mental Health America found that the rates of depression among older Native American's range from 10-30% (Mental Health America, 2018). This study, however, did not directly indicate that the participants were experiencing depression linked to trauma exposure, interpersonal loss, or unresolved grief.

Effects of Trauma

More than any other racial group, Native Americans suffer the highest per-capita rate of trauma and victimization (Gone, 2009; Sarche & Spicer, 2008). In addition, Native American children are more likely to be exposed to multiple traumatic events than either African American or Caucasian children (Sarche & Spicer, 2008). The high number of traumatic events occurring on reservations highlight the need for mental health services, because exposure to traumatic events is associated with the development of mental health issues. These traumatic experiences may include serious injury, threat of serious injury to one's self or the witness of injury to others, as well as exposure to violent crime and assault. These experiences are compounded by the

chronic poverty, racism, and lack of educational opportunities present on many American reservations. Additionally, a history of traumatic experiences increases the risk of developing substance abuse problems throughout life (Farley, Golding, Young, Mulligan, & Minkoff, 2004).

Indeed, in my professional experience in working with traumatized individuals, consistent exposure to trauma throughout one's childhood often produces an effect of 'pseudo-immunity,' meaning that individuals often present as ambivalent when recalling multiple past traumatic experiences due to trauma's numbing effect. Simply put, it appears that the more experiences with trauma one experiences, the less it externally manifests itself as grief, anger, or other content-appropriate emotional constructs. Perhaps it is because of this pseudo-immunity resulting from chronic trauma exposure, that the Brave Heart et al. (2011) study reports higher thresholds for trauma and post-traumatic stress disorder in Native American youth. Frequently diagnosed conditions among Native youth that require behavioral health services and intervention are anxiety, depression, post-traumatic stress disorder, and alcohol use/dependence (U.S. Department of Health and Human Services, 2011).

Effects of Substance Abuse

The combination of high rates of exposure to traumatic events and an overall shortage of available treatment options and mental health providers for people living on reservations in the United States (Sarche & Spicer, 2008) is further affected by the rates of substance abuse in Indian Country. Rates of alcohol and drug abuse among Native Americans indicate that overall consumption rates and prevalence of addiction varies from Tribe to Tribe (Beals et al., 2005; Duran, Parker, Malcoe, Lucero & Jiang, 2009). However, research has shown that, in terms of gender, Native men have higher rates of alcohol addiction than Native women (Beals et al., 2005).

Additionally, Native American youth are more likely to have issues with substance abuse than youth of other races (Goodkind, Hess, Gorman, & Parker, 2012). For example, early intoxication of Native American youth (by the age of 14) has been associated with higher rates of overall substance use, the development of psychiatric disorders such as mood and anxiety disorders, and deficits in cognitive and executive functioning (Stanley & Swaim, 2015). Native American youth begin drinking alcohol at a younger age and face more negative consequences from using alcohol and drugs than non-Native youth (Goodkind et al., 2012).

For example, a 1998 study found that one out of every two adolescents in a Northern Plains reservation juvenile detention facility had a substance abuse or a mental health disorder (Duclos, Beals, Novins, Martin, Jewett, & Manson, 1998). In fact, it is five times more likely that a Native American will experience death from alcohol-related causes than a non-Native individual (Brave Heart et al., 2011). According to a national survey on drug use and health, Native Americans were more likely than other racial or ethnic groups to be in need of substance abuse treatment. 15% of Native people received chemical addiction treatment for alcohol or drug use; this is compared to 10.2% of the general American population (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Thus, addiction, a common denominator in Native mental health issues, manifests across both generations and genders.

A 2016 study identified 445 programs that provide substance abuse treatment services to Native American communities (Rieckmann, Moore, Croy, Novins, & Aarons, 2016). These are Tribal, State, and Indian Health Service (IHS) substance abuse treatment centers (Rieckmann et al., 2016). Bearing in mind there are approximately 5.2 million Native American people living in the United States (U.S. Census, 2010), this is an alarmingly low ratio of Native people to treatment centers. Even more concerning, there are only 10 treatment centers in the entire United

States dedicated specifically to Native American youth (Indian Health Service [IHS], 2015). The majority (73%) of substance abuse treatment facilities that are operated by a tribal government are located in rural areas (SAMHSA, 2013). Furthermore, the majority of reservations are rural as opposed to urban. For those individuals living in urban areas, there are options for drug and alcohol treatment through privately owned or State/local government-operated facilities, although these are not specifically for Native Americans (SAMHSA, 2013).

The Reservation Healthcare System

The lack of available treatment for drug and alcohol addiction extends to all aspects of wellness and mental health issues. The insufficiency of appropriate and available mental and behavioral health care implicates a systemic failure. The central relationship affecting the operation of Native American Tribal governments, and ultimately, the health and wellness of Native people themselves, is the relationship between the United States Government and Tribal nations as sovereign entities (between a Government and a Government) (Bureau of Indian Affairs [BIA], n.d.). Since first contact with non-Native settlers, tribes have been regarded as independent nations, with the fundamental right and power to self-govern all tribal matters. This history of tribal sovereignty has informed the current tribal political landscape (Brookshire & Kaza, 2013). The United States Census in 2010 indicates that there are approximately 5.2 million Native American people (those identifying only as Native American and those identifying as mixed race, of which includes Native American) living in the United States, in 566 federally recognized Indian Nations, which are commonly referred to as ‘tribes’ (U.S. Census, 2010). There are 326 reservations (reserved federal lands) for these 566 recognized Indian Nations in the United States, with some Nations having more than one reservation and others having none at

all (BIA, n.d.) Similarities exist among North American indigenous people, however each Tribal Nation varies in language, culture, and size.

One of the similarities, however, is the overall poor quality of health of Native American people (Brave Heart et al., 2012). In contrast to the aspects of life that are considered Tribal responsibilities, the physical and emotional care and wellbeing of its members is technically a responsibility of the United States federal government by way of Indian Health Service (IHS). IHS operates through the U.S. Public Health Service, which is under the umbrella of the Department of Health, Education, and Welfare (BIA, n.d.; National Congress of American Indians [NCAI], 2018)

There are 161 Indian Health Centers in the United States. The physical sites of these clinics are divided into 12 regions, according to geographical location in the United States. Each region has a varying number of public health hospitals, Indian health clinics, Indian health hospitals, alcohol treatment facilities, and behavioral health facilities. In fact, Indian health clinics, hospitals, and treatment centers are expected to serve the entire population of Native American people living in that specific area. For example, the Great Plains Area manages service units providing health care to approximately 122,000 Native Americans living in North Dakota, South Dakota, Nebraska, and Iowa (NCAI, 2018).

Lack of Healthcare Professionals

In addition to a lack of resources on reservations nationwide, there are other obstacles to Native Americans accessing behavioral health care. Factors such as a lack of Native American treatment providers, an overall lack of family support, social stigma, and a strong preference for traditional healing practices as opposed to Western mental health treatment options can affect Native people's willingness/ability to access mental health care (Duran et al., 2009; Grandbois,

2005). In a study that examined the counselor preferences of 68 Native American people, Thomason (2012), found that half of these participants believed that counseling with a Native counselor would be more effective than with a non-Native counselor. However, it should be noted that these participants also identified their willingness to also work with culturally competent non-Native counselors. This was partially due to the lack of mental health care providers on the reservation as a whole (Thomason, 2012).

In addition, counselor turnover also affects organizations. As Ducharme, Knudsen, and Roman (2007) reported, the development of meaningful relationships is a cornerstone of the counseling profession. Therefore, when these relationships are prone to sudden change, such as the departure and arrival of different counselors, client care is affected. Furthermore, counselor attrition impacts an organization's financial stability, training resources, organizational efficacy, and causes lower rates of employee morale (Eby, Burk, & Maher, 2010). Research has found that mental health clients respond to therapy more positively when there is consistency and continuity in the counselors they have contact with while receiving treatment (Lamb, Greenlick, & McCarty, 1998)

While there are no figures on the rates of turnover in reservation counseling centers, research shows the rate of clinician turnover within substance abuse treatment facilities is high, nearing the 25% range in some areas. This is important to note because, like reservation counseling centers, the counselors in these centers also experience secondary traumatic stress and vicarious trauma, which contribute to counselor attrition rates (Bride & Kintzle, 2011).

A “perfect storm” of conditions exists on reservations across the United States: high rates of mental and physical health disparities, exposure to trauma, difficulty accessing appropriate health care services, and difficulty recruiting and retaining qualified health care providers. This

complex and multilayered issue has no simple solution; however, one area to study is counselors' ability to access and care for Native American people. Native Americans have had a long and enduring association with trauma. Due to this, there are significant mental health issues among Native Americans (Gone, 2009; Sarche & Spicer, 2008). Addressing these issues is complex and marked by shortages of mental health care providers, especially Native American providers, who are, themselves, a part of the cultural collective of which they serve. One way to impact the quality of mental health services available on reservations is by ensuring that the wellness needs of counselors are met, which may improve provider retention rates.

Counselor Wellness

Professional counselors on reservations are in short supply and the need for their services is high. Therefore, the retention of counselors on the reservation is important. There is little research available on Native American counselors, therefore this is an untapped potential research area. However, general research on counselors providing mental health services to those who have experienced multiple levels of trauma, has found that this work places these counselors at a higher risk for being traumatized themselves (Lawson, Venart, Hazler, & Kottler, 2007). How, then, do counselors keep themselves healthy so they may continue to provide these much-needed services to traumatized clients?

In the counseling profession, an emphasis has been placed on the importance of professional wellness. Ideally, counselors should maintain a reasonable level of mental health themselves; they should be emotionally stable, empathic toward their clients, and be able to separate work issues from their home life. However, given the intense emotional nature of professional counseling, often counselors find that they experience some kind of negative impact from their work. Hearing stories of trauma day in and day out is emotionally and mentally

demanding. Research has found that this constant exposure to another person's traumatic stories can result in the counselor becoming traumatized themselves (Cummins, Massey, & Jones, 2007). This can result in professional burnout, and in some cases, symptoms similar to post-traumatic stress disorder (Beutler, Machado, & Neufeldt, 1994).

Research Question and Scope of Study

Working with Native American people who are living on a reservation requires that counselors develop and maintain effective wellness practices. The reservation setting, however, does not readily lend itself to such practices. Counselors on reservations work with a high percentage of clients who present with impacts from historical trauma as well as present-day trauma. The success of counseling services is impacted by the counselor's ability to provide effective, culturally appropriate, and long-term mental health care (Landrum, Knight, & Flynn, 2011). This is compounded by an environment that boasts high rates of staff turnover, negatively influencing client engagement and satisfaction. Clients often have difficulty forming a working therapeutic alliance when staff turnover is high (Landrum, Knight, & Flynn, 2011). Furthermore, Knight, Landrum, Becan, & Flynn (2012) found that the perception that counselors have of their work demands and the resources available for maintaining wellness positively contributes to their decision on whether to remain in a their professional positions. Therefore, the combination of factors such as work load perception, exposure to traumatic client material, and rates of employee turnover directly affect counselor wellness.

To address the question of how Native American counselors can maintain personal and professional wellness, this study begins by gaining insight into what the experiences are of Native American counselors who provide counseling services to people living on the reservation. The goal is to take these first-hand accounts and examine them through the lens of counselor

wellness, more specifically through Native American counselor wellness; ultimately informing future research and counselor wellness practices.

Definition of Terms

Counselor A mental health professional with the education, training, and licensing of a sanctioned body who provides counseling services to clients. In this study, this refers to Licensed Professional Counselors (LPC, LPCC).

Historical Trauma “[C]umulative emotional and psychological wounding across generations, [emanating] from massive group trauma” (Brave Heart et al., 2011, pg. 283).

Indian Country Native American reservations; Native American communities, Alaska Native villages, rancheros, and all Indian allotments (BigFoot & Schmidt, 2010).

Native American or Native Indigenous peoples of the United States who self-identify as Native American/Native (Garrett & Pichette, 2000).

Reservation Native American communities, Alaska Native villages, rancheros, and all Indian allotments (BigFoot & Schmidt, 2010).

Trauma An event outside of the expected or normal range of an individual’s experience that causes an emotional disruption in an individual’s life (American Psychological Association, 2018; Connolly, 2011; Evans-Campbell, 2008).

Wellness An individual’s intentional approach to a state of health, both physically and psychologically (Day-Vines & Holcomb-McCoy, 2007).

CHAPTER II. LITERATURE REVIEW

In this chapter, a review of the relevant literature is presented. The purpose of the review is to place the study of Native American counselor wellness in the historical and cultural context of trauma among Native Americans who are living on reservations. Specifically, the literature on counselor wellness and burnout, especially in light of working with a high concentration of traumatized clients, is examined.

To determine trends in research concerning Native American trauma and Native American counselor wellness on reservations, a literature search was performed on multiple databases. First, a Science Direct search using the terms *counselor wellness* and *Native American*, provided 2,758 results. After narrowing the search parameters down to research articles and applying a filter for only articles containing the terms “Native American, American Indian” 53 articles were identified. Additional term filters were applied for articles containing a combination of the following terms: reservation, counselor wellness, professional wellness, and provider wellness. The final result included two relevant articles. A similar procedure was applied using the database Academic Search Premier (EBSCO host), which yielded one relevant research article.

Trauma

Trauma is defined by the American Psychological Association (APA) as, “an emotional response to a terrible event” (NCAI, 2018). When events that are considered outside of the expected or normal range of an individual’s experience occur they can cause major disruptions in one’s physical and psychological well-being (Connolly, 2011; Evans-Campbell, 2008).

The effect of trauma is not always limited to one individual at a time; it has a ripple effect. Trauma impacts the individual experiencing it, but it also impacts those who may witness

the event, and the family and friends of those who are traumatized. Trauma's effects often go even further, including the counselors who are in the position to help those who are traumatized deal with the emotional and physical effects of their experience. The World Health Organization (WHO) released the Report on Mental Health, Resilience & Inequalities and stated that, "Levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing" (Friedli, 2009, p. III). This contributes to the idea that the consequence of trauma is often pervasive as well as longitudinal.

Often believed to be limited to childhood events, trauma can occur at any stage in life and research has shown the complex impact it has on survivors. Traumatic life events affect memory, emotional regulation, physiological stress management, and interpersonal skills (Connolly, 2011).

Post-Traumatic Stress Disorder

The aftermath of trauma can be devastating. Carl Jung explained trauma and its effect on the psyche stating: "whole tracts of our being can plunge...into unconsciousness and vanish from the surface for years and decades" (Connolly, 2011, p. 609). Emotional and physical reactions to trauma have been referred to as "the syndrome of the survivor of extreme situations" (Connolly, 2011, pg. 608). This "syndrome" may be better explained as post-traumatic stress disorder (PTSD).

PTSD is a common diagnosis found in individuals who have experienced trauma. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) acknowledges a variety of circumstances that can cause the development of

PTSD, including rape, military combat experience, child abuse, physical attacks, and being threatened with a weapon (Evans-Campbell, 2008). The diagnosis of PTSD conceptualizes the response to traumatic events in a single individual (Evans-Campbell, 2008). According to the DSM-5, the symptoms of PTSD include invasive recollection of the traumatic event, nightmares, flashbacks, and persistent negative psychological and physiological reactions to events or images that trigger memories of the event. For PTSD to be diagnosed in an individual, these symptoms must cause a clinically significant impairment in one's life (American Psychiatric Association, 2013). Research indicates that the rates of PTSD among Native Americans is about double that of the general population and the highest rates observed were among Native American women (Beals et al., 2005).

In addition to the event itself, the intensity and duration of the trauma impacts the severity of the response (Evans-Campbell, 2008). Some traumatic events occur on only one occasion, for example, a natural disaster such as a flood or tornado, while other traumatic events continue to occur throughout someone's life time, for example domestic abuse.

Similarly, certain stimuli can trigger or cause one's existing PTSD symptoms to reemerge and these can also be acute or chronic in nature. Acute stressors and triggers are those that occur on only one occasion and are time-limited. However, chronic stressors and triggers are refers to those that continue to occur throughout one's life. These psychological triggers are defined as neutral stimuli (ex., sensory information such as sights, smells, or sounds) that an individual will associate with related images of past trauma (Mental Health America, 2018a). Research indicates that chronic stressors are more significantly related to incidents of avoidance, emotional numbing, repression, and regression. However, acute stressors are more associated with intrusive memories, somatization, and hypervigilance (Evans-Campbell, 2008).

The diagnostic criteria for PTSD captures a number of symptoms that are experienced by trauma survivors, however it is limited in its recognition of the additional effects of traumatic events that affect multiple generations (Evans-Campbell, 2008). The diagnosis of PTSD does not specifically include the phenomena of intergenerational transmission of trauma, rather, it is focused more on the individual's direct experience of trauma or directly witnessing a traumatic event.

Historical Trauma

Throughout history, there are incidents of groups of people experiencing the same traumatic event (i.e., civil wars or natural disasters). The traumatic response to these large-scale events are known as historical trauma. Historical trauma is defined as, "cumulative emotional and psychological wounding across generations...which emanates from massive group trauma" (Brave Heart et al., 2011, p. 283). Historical trauma can span a lifetime and stretches across multiple generations (Brave Heart, 1998). Historical trauma is also referred to as collective trauma, intergenerational trauma, and multigenerational trauma (Brave Heart, 1998). For the purposes of this paper, the term historical trauma (HT) will be used.

Many groups have experienced HT, for example, Jewish Holocaust survivors of World War II, the ancestors of African slaves brought to North America, and the indigenous peoples of the South Pacific (Estrada, 2009). Studies on the descendants of Holocaust survivors have found that the rates of mental health disorders among this group is not usually higher than the general population, however though the symptoms may not meet criteria for a DSM-5 diagnosis, these individuals do, indeed, experience symptoms of depression, anxiety, somatization, and anger management issues (Evans-Campbell, 2008; Whitbeck, Adams, Hoyt, and Chen, 2004).

Some children of Holocaust survivors have displayed a pattern of vulnerability in stressful situations. Research found that when these children experience present-day trauma, they are more likely to develop PTSD than others. Similar findings have been observed with other groups, such as Japanese Americans after internment and victims of the Turkish genocide of Armenians (Evans-Campbell, 2008).

Many of these responses are psychological in nature, however some are physically-based. For example, one study found that lifelong hormonal changes occurred in WWII Holocaust survivors who suffered from PTSD. In addition, it was found that the children of these survivors were also affected. A “high percentage” of the adult children of Holocaust survivors have shown similar hormonal changes (Connolly, 2011). The tragedy of intergenerational group trauma was captured by Perel Wilogwicz, who wrote, “the child of [trauma] survivors becomes imprisoned in the parents’ trauma...condemned to repeat what they themselves have not experienced” (Connolly, 2011, p. 611).

Native American Historical Trauma

In the approximately 500 years since North America was invaded by non-Native explorers, Native American people have experienced one traumatic event after another (Markley, 1994). In fact, Whitbeck et al., (2004) notes, “American Indians experienced one of the most systematic and successful programs of ethnic cleansing the world has seen” (p. 121). However, this attempt at cultural genocide did not stop at the point of military defeat or with the occupation of a territory. Instead, it persisted for generations, and, to this day, continues to persist. In many ways, Native Americans are reminded on a daily basis, just by simply living on a reservation, what exactly was taken from them. In order to fully understand the uniqueness and extent of Native American mental health issues, it is necessary to include the concept of historical trauma

and how this phenomenon has immeasurably and dramatically shaped the lives of Native Americans as a whole (BigFoot & Schmidt, 2010).

To understand historical trauma (HT), there must be an understanding of the course that HT takes. There are three stages of HT: 1) an event takes place that is considered a mass trauma, 2) there are common trauma responses present within the first generation of survivors, and 3) these maladaptive trauma responses are transmitted to subsequent generations (Estrada, 2009).

Additionally, to be classified as historical trauma, there are three shared characteristics of the traumatic event(s). First, the traumatic event is widespread, second, it causes significant distress, and finally, it is due to human-initiated actions that may be considered genocide or ethnocide (Evans-Campbell, 2008).

Overall, Native American historical trauma fits these classifications as the traumatic events are widespread, between multiple communities. Also, the effects of the group trauma appear to grow with time; even though these events may have occurred over different time periods, they “come to be seen as parts of a single traumatic trajectory” (Evans-Campbell, 2008, p. 321). Men, women, and children from different families, who may be members of different clans or bands of within Tribal communities, can all be impacted by the trauma. The number of people who experience the actual traumatic event can indeed be high – however, this number is not all-encompassing, as it does not account for all of those who have been left in trauma’s wake. The aftermath of these traumatic events permeates throughout families, communities, and Tribes (Evans-Campbell, 2008).

Also, Native American HT was as a result of the purposeful, destructive motives of outside individuals and groups. In fact, the descendants of trauma survivors will often avoid

sharing personal problems to other family or community members so as not to emotionally burden an already-taxed community. (Evans-Campbell, 2008).

The transmission of historical trauma occurs at two levels: interpersonal and societal. Within the interpersonal transmission of HT, it occurs either directly or indirectly. The direct interpersonal transmission of HT can occur, for example, when a child has the vicarious experience of a trauma because of oral or written stories that describe their parent's or their grandparent's traumatic experiences. The exposure to familial traumatic material can cause a child to suffer emotionally as a result. However, the indirect interpersonal transmission of trauma refers to trauma that occurs as a result of the parent's or grandparent's associated psychological problems due to the traumatic event. Often this is observed as abusive, ineffective, or neglectful parenting; experiences that also can cause a child to suffer emotionally (Evans-Campbell, 2008). Following a collective group trauma, such as genocide or the forced removal of racial minorities, there exists an elimination of the group's traditional way of life and spiritual freedom. Therefore, by merely living in a reservation community, for example, Native people continue to experience the ripple effects of their ancestor's forced relocation trauma (Evans-Campbell, 2008). Furthermore, Evans-Campbell (2008) notes, "in a community that has lost its spiritual compass...people might be more susceptible to drugs, or children raised in families that have lost their ability to parent might experience increased levels of abuse and neglect" (pg. 328).

The events that cause HT usually become destructive at a physical as well as an emotional level (Evans-Campbell, 2008). Because HT is intergenerational and is compounded from generation to generation, these events can occur at varying time periods to a single person or persons. However the consequences of the trauma and the subsequent reactions to that trauma is passed down from grandparent to parent, then from parent to child, and so on (Evans-

Campbell, 2008). The descendants of trauma experiencers emotionally identify with the suffering of their ancestors (Evans-Campbell, 2008). At its core, historical trauma represents a macro-level "...profound, unsettled bereavement" (Brave Heart, 1998, p. 288). For example, research has shown that the Lakota Sioux people, as a whole, have suffered from, "impaired grief of an enduring and pervasive quality" (Brave Heart, 1998, p. 287). Individuals can experience what is called historical unresolved grief, which is explained as continued and complex grief that results from a generational experience of unresolved grief (Evans-Campbell, 2008).

Among the Lakota people, this unresolved grief is displayed through three primary channels: somatization, depression, and substance abuse (Brave Heart, 1998). Historical trauma contributes to rates of depressive symptoms, self-destructive behaviors, chemical addictions, and an overall fixation on the trauma itself (Estrada, 2009).

A study by Whitbeck et al., (2004) indicated that one fifth of respondents thought about the loss of their people's indigenous land at least one time per day. In addition, more than one third thought about the loss of their native language on a daily basis. Furthermore, nearly half of respondents thought daily about the effects that alcoholism has on their community (Evans-Campbell, 2008). This way of identifying with and, in some ways, experiencing the suffering of one's ancestors can have significant effects on an individual. There is greater tendency for individuals to experience a number of corresponding symptoms of trauma (i.e., PTSD) when one continues to think about or relive the traumatic events (Ehlers, Gizer, Gilder, Ellingson, & Yehuda, 2013). For many Native Americans, "...ancestral losses are often mourned as though they are recent" (Brave Heart et al., 2012, p. 178).

Symptoms of Historical Trauma

Various responses have been observed from those who experience historical trauma; these are referred to as “historical trauma response”. Research has found that historical trauma can cause symptoms akin to PTSD. At an individual level, responses to historical trauma may cause symptoms of depression and anxiety (Evans-Campbell, 2008). In addition, survivor guilt, intrusive thoughts and dreams, anger, self-destructive behaviors, addiction, and an over-identification with the dead are common (Brave Heart et al., 2012).

Examining diagnostic requirements, it is clear there are limitations in the symptom criteria of PTSD in relation to historical trauma. First, the diagnosis of PTSD was not developed to specifically include intergenerational trauma. PTSD does not address the unique response to compounding, multiple stressors in the way that historical trauma presents itself. In addition, PTSD fails to account for the ways past and current traumas interact, or how a present-day trauma may be interpreted within the context of historical events (Evans-Campbell, 2008). This has implications in the real world in terms of insurance and billing requirements. For example, an individual suffering from the effects of historical trauma may not meet criteria for PTSD, and therefore, the cost of certain treatment modalities may not be covered.

The focus of PTSD is different from the focus of historical trauma response. PTSD focuses on the individual, whereas historical trauma response affects the group or community as a whole. Impact from historical trauma is understood at three levels: individual, family, and community. Because these are all interrelated, as each has the ability to impact the other levels (Evans-Campbell, 2008). As previously noted, responses to historical trauma for an individual may manifest as mental and physical health issues. However, within family and community systems, more broad communication issues arise such as difficulty with family dynamics and

negative impacts on parenting efficacy (Brave Heart et al., 2012). Furthermore, the Native American community response to historical trauma has included a decrease, or in some cases cessation all together, of traditional cultural practices, as well as an increase in the rates of chemical addiction and physical illness. Historical trauma response to the individual, family, and community have the potential to affect many generation's mental and physical health, and may completely alter the way that someone interacts with his or her family and community (Evans-Campbell, 2008).

Historical losses are associated with one's view of self and one's own cultural identification. Individuals who suffer from chemical dependency are more likely to experience distress because of historical losses than those without addiction issues (Ehlers et al., 2013). In order to identify the level of historical loss that an individual may face, the Historical Trauma and Unresolved Grief Intervention was developed, in part, to examine and quantify historical trauma. This is a culturally appropriate intervention for grief counseling and trauma counseling that has been used alongside a number of other coping interventions (Brave Heart et al., 2012).

An example of the aftermath of traumatic group events is subsequent mental illness diagnoses. The most common diagnoses for Native Americans are alcohol dependence (now referred to as substance use disorder in the DSM-5), post-traumatic stress disorder, and major depressive episode. This population has comparable, and in many cases greater, mental health service needs than those in the general population of the United States (Beals et al., 2005). In fact, the annual rate of violent crimes among Native Americans is more than 2.5 times the national average (BigFoot & Schmidt, 2010). Native people have the highest rates of homicide in the United States and Native women experience more domestic violence than women from any other race (BigFoot & Schmidt, 2010). In fact, it is two times more likely that a Native woman

will be physically or sexually abused by their partner (BigFoot & Schmidt, 2010). Additionally, rates of PTSD are higher among Native American people than members of the general population. The repeated exposure of violence will ensure that this pattern will continue (BigFoot & Schmidt, 2010).

When counselors are faced with a multitude of clients with trauma and subsequent mental health diagnoses, the impact on professionals as a whole is tantamount to experiencing a traumatic event themselves. Individuals exposed to trauma are at a higher risk for developing stress-related diseases. The time in one's life when traumatic events occur can have an impact. The diathesis-stress model explains that exposure to stress and/or trauma at critical developmental periods can result in a hyper reaction to the stress response of the body. When this is repeated, the systems involved in stress management (e.x., neural and endocrine systems) become a catalyst for an individual's predisposition to develop a number of stress-related illnesses. Therefore, not only are some stress-related diseases genetic, they can also appear as a result of an individual's exposure to traumatic life events (Neigh, Ritschel, & Nemeroff, 2010).

Adverse Childhood Experience (ACE) has been an area of focus in the world of trauma counseling. Numerous studies over many disciplines have found a link between adverse childhood experiences and poor mental health outcomes (Lee & Chen, 2017). When experiencing early life stress, individuals often see an increase risk for changes in the central nervous system and this can increase one's vulnerability to stress later in life (Neigh et al., 2010). Neigh (2010) found that individuals who experienced childhood physical or sexual abuse experience health issues in adulthood. These include somatic symptoms, actual medical symptoms (i.e., heart disease), psychological and emotional issues, and substance abuse (Neigh et al., 2010). In addition to victims of domestic violence, there are ethnic and racial groups that

have experienced intense widespread trauma, for example, Jewish Holocaust survivors and Japanese internment camp survivors (Mohatt, Thompson, Thai, & Tebes, 2014). In addition, Native people indigenous to the United States, have also experienced intense group trauma. All three groups, Holocaust survivors, Japanese internment camp survivors, and Native Americans, may carry the risk of passing historical trauma on to future generations (Mohatt et al., 2014). Furthermore, the trauma experienced by Native Americans over the last 500 years is compounded. For example, the descendants of those at the Wounded Knee Massacre feel the effects of this large, Tribal-based trauma today. In this case, “trauma continues to roll forward over generations leaving an array of effects in its wake” (Evans-Campbell, 2008, page 329). Whole groups of people can, indeed, experience a specific kind of trauma.

While not all individuals and potential clients living on a reservation experience trauma, there is evidence of widespread intergenerational group trauma, and resulting individual trauma, that is unique to Native American people (Brave Heart et al., 2011). Present-day descendants of Indigenous peoples of North America suffer from high incidents of psychological distress. Indeed, Native American individuals are at a greater risk for experiencing trauma. Therefore, when one is working on a reservation, there is a greater chance of working with individuals who have experienced trauma at some level than those working off-reservation (Gone, 2009).

Treatment of Historical Trauma

It is important that mental health counselors continue to progress in terms of the treatment of historical trauma in Native Americans. In order to fully accomplish that, understanding the cultural implications of treatment options is vital. As Brave Heart (2011) noted, the treatment of historical trauma “must be developed with the involvement of the indigenous community” (pg. 287).

It is inappropriate to generalize Native American culture, as there are over 500 federally recognized Tribes in the United States (Brave Heart et al., 2011). Each tribe has diverse beliefs, languages, customs, and traditional practices. However, among these tribes, commonalities do exist, including an overall emphasis on balance, the belief in animal and ancestor spirits serving as guides, and an overall kinship to all creation (Brave Heart et al., 2011).

Traditionally, grief and emotional distress were treated through healing ceremonies that had been in place far before the arrival of non-Native people to the North American continent (Brave Heart, 1998). An example is the healing of grief and emotional distress due to loss by the Lakota Sioux people. The Lakota believe that the hair on one's head holds strength and identity. As a show of honor and respect, the bereaved individual would cut their long hair short. The bereaved would also give away their possessions and refrain from celebrating and dancing with their family and community. Spirit keeping ceremonies allow the bereaved to mourn for a year after the death of a loved one. During this time the deceased's soul is kept with the mourner until the "releasing of the spirit ceremony" which is followed by the "wiping of the tears ceremony". This symbolizes the end of the mourning period and the return of the bereaved to normal society.

However, in 1881, these ceremonies and practices were officially banned by the United States government (Brave Heart, 1998). The result was an increase in feelings of helplessness and hopelessness among Native people. Therefore, historical trauma intervention and its goal of reducing emotional suffering among Native people for present-day losses, as well as historical losses (Brave Heart et al., 2011).

Culturally appropriate mental health interventions have been developed to address this (Brave Heart et al., 2011). Brave Heart (1998) found a number of possible solutions to dealing with this cumulative trauma including psycho-educational groups, affective exploration, and

traditional Lakota ceremonies/references that assist in grief resolution. In one study, Joseph Gone interviewed nineteen Native Americans regarding historical trauma and Native American mental health issues. Four themes emerged: emotional burdens, cathartic disclosure, self-as-project reflexivity, and the impact of colonization (Gone, 2009). Therefore, the culturally therapeutic healing process moves through the action of facing one's own traumatic experiences and emotional burdens. Often, the weight of trauma is carried along with the individual for years, and even decades. These emotions must be dealt with in order for healing to begin (Gone, 2009). Cathartic disclosure refers to the idea that Native people can find relief from their pain through discussing past traumas with a mental health professional. That weight can be lifted from the act of verbally disclosing the events and, with that, the accompanied emotional release from having opened that wound up and processed it with another (Gone, 2009). The healing process is life-long. Self-as-project reflexivity refers to the lifetime "project" that is healing. There is a longitudinal aspect to healing; it does not take place in a matter of hours or days. When one is able to gain personal insight into the real cause for one's problems, they are able to shift their perspective and focus on transformation (Gone, 2009). Finally, the healing process includes acknowledging and expressing the personal pain that is often a part of the impact of colonization. Many find that the sharing and processing of feelings surrounding the loss of the culture and identity of Native American peoples is beneficial for them in the healing process (Gone, 2009).

The practical side of healing involves many factors such as government involvement, cost, location, and accessibility. Indeed, it is a unique experience, living on a federally recognized Indian reservation (Baca, Alverson, Manuel, & Blackwell, 2007). Overall, the treatment structures in place for treating mental health problems on the reservation are deficient and navigating treatment options can be overwhelming. Those that are already in place are

complex and consist of an often times confusing maze of Tribal, Federal, State, local, and community-based services (BigFoot & Schmidt, 2010). Furthermore, treatment does not always come from a proactive source; in fact, Native American children and adolescents are more likely to receive mental health and addiction treatment through the juvenile justice system and inpatient facilities, than in outpatient settings (BigFoot & Schmidt, 2010).

Both historical and present-day trauma causes a multitude of intense mental and emotional problems. It is imperative that we treat these with effective, culturally appropriate, and long-term solutions mental health solutions. In order to do that, mental health providers serving on the reservation must be equipped to handle the personal and professional strain that can result from working with highly traumatized populations.

Counselor Wellness

Wellness is defined as a person's intentional approach to a state of health, both physically and psychologically, that aids them in coping with life stressors, and wellness can result with an individual living up to his or her potential. It is a way to maximize personal potential through positive and healthy lifestyle choices with the goal of achieving intrapersonal balance (Day-Vines & Holcomb-McCoy, 2007). For the purposes of this paper, wellness is examined through the lens of mental health, and of those who provide these services: the counselors themselves.

One factor that affects the quality of mental health services relies, in part, on the counselor's wellness (Beutler et al., 1994). Passengers on an airplane are reminded that, in case of an emergency, they are to put their own oxygen mask on before helping someone else do the same. Similarly, in order for counselors to help others become healthy, they themselves must to be healthy.

In fact, professional organizations (e.g., American Counseling Association [ACA], American Mental Health Counselors Association [AMHCA]; National Board for Certified Counselors [NBCC]) have acknowledged this by placing increased emphasis on the importance of counselor wellness. The ACA has created a specific taskforce to identify the needs of professional counselors in relation to wellness and self-care (American Counseling Association, 2002). Additionally, the ACA (2014) Code of Ethics addresses counselor impairment by stating that, “counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired” (ACA, 2014, p. 9).

When an individual experiences a traumatic event, it causes significant, and often long lasting, devastating effects. However, the destruction does not end there. Retelling the story of the traumatic event to others can, and does, affect those who are listening. In fact, research has supported this, finding that counseling high-risk or highly traumatized client populations may compromise a counselor’s wellness (Lawson et al., 2007).

Providing counseling services to those who have experienced high levels of both personal and group trauma can be overwhelming. Counseling the traumatized can result in emotional exhaustion, higher levels of stress, and a reduced quality of life (Cummins et al., 2007). In fact, research has shown that repeated exposure to the traumatic stories of others has both short and long-term effects on the wellness of counselors (Beutler et al., 1994).

When counselors work consistently with individuals who have suffered traumatic events, the trauma can be “passed on” to the counselor (Cummins et al., 2007). Certain clinical settings and client populations may increase the likelihood of counselor contact with various psychological pathologies. For example, counselors working in a domestic violence shelter will

frequently deal with individuals who have experienced high levels of trauma. Similarly, counselors who provide mental health services to Native Americans residing on reservations are also more likely to come in contact with traumatized individuals, and, as a result, are at an increased risk for experiencing residual effects of other people's traumatic stories; this is called secondary traumatic stress (STS) or vicarious trauma (VT) (Mohatt et al., 2014). STS and VT has a significant effect on the mental health of counselors over the course of their professional life, and these effects result in symptoms similar to that of post-traumatic stress disorder (PTSD). These include symptoms such as re-experiencing the traumatic event, invasive and intrusive thoughts, avoidance of any reminder or trigger of the event, hyperarousal, increased irritability, a loss of hope, and anxiety (Crumpei & Dafinoiu, 2012).

Though the discussion surrounding professional wellness is not new, and wellness specific to counselors has been researched in the past; specific research regarding the demands placed on counselors who provide services to traumatized populations is limited. Previous research has examined the effect of STS and VT on counselors in an overall sense; however, research on how counselor wellness is affected by working in the trauma-concentrated environment of Native American reservations is scarce. Additionally, there is limited research available addressing issues surrounding Native American counselors as a whole, or Native American counselor's wellness.

Counselors on reservations throughout the United States often work in trauma-intense environments and under generally poor conditions, and therefore, these professionals are at a higher risk of experiencing negative effects from their work with traumatized Native American clients (Beals et al., 2005). Previous research found that counselors who have a personal history of trauma displayed more negative effects from their work with traumatized clients than those

who did not. One reason may be due to repeated exposure to clients' traumatic material, which becomes a trigger for their own traumatic histories (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2011).

Unresolved personal issues, life stressors, and a history of personal trauma can influence how, and to what extent, a counselor manages their own stress. Counselors experiencing a personal trauma are at a higher risk for developing STS and, ultimately, in leaving their professional positions (Cummins et al., 2007). Counselors indicate that if they endure these personal difficulties and setbacks, they believe that their work with traumatized clients is related to those experiences (Cummins et al., 2007). This can take the form of emotional exhaustion, stress, and a general lower reported quality of life (Lawson et al., 2007).

Understanding counselor wellness is a vital aspect of providing the best possible care to Native people living on the reservation. One factor that stands out is empathy. The importance that empathy plays in the counseling process has been researched and is widely accepted. "Empathy reduces the psychological distance between therapist and client and may enhance the impact of the vicarious experience and increase the need for accommodation of schema. The accommodation process can be a negative one (such as in the case of vicarious trauma), but it also opens the door for a positive one" (Brockhouse, Msetfi, Cohen, & Joseph, 2011, p. 741). When a counselor experiences STS or VT, they will respond by suppressing empathic responses toward their clients in an attempt to conserve their own self-empathy (Connolly, 2011, p. 617).

To fully understand these concepts, this paper will examine occupational stress syndromes and discuss their impact on counselor wellness.

Occupational Stress Syndromes

Vicarious trauma (VT), secondary traumatic stress (STS), burnout, and compassion fatigue comprise a group of psychological conditions referred to as occupational stress syndromes. According to Galek, Flannelly, Greene, & Kudler (2011), there are five factors common among these: “(1) frequent intense encounters with clients; (2) physical and mental fatigue states; (3) challenges to values, beliefs and world view; (4) exposure to traumatized clients; and (5) expectable stress responses” (p. 634). Individuals from other helping professions are also at risk to experience these occupational stress syndromes. For example, professional chaplains may experience STS from their work with families and individuals who have undergone significant emotional distress due to grief and loss. Other professionals, such as social workers, domestic violence agency staff members, nurses, physicians, and rescue workers often experience occupational stress syndromes as well (Choi, 2017; Christodoulou-Fella, Middleton, Papathanassoglou, & Karanikola, 2017; Galek et al., 2011; van Minnen & Keijzers, 2000). Though these professions differ in many ways, the individuals providing these services share a common experience of consistently dealing with other people’s emotional and/or physical trauma. In fact, research has supported this, Culver, McKinney, & Paradise (2011), found that repeated exposure to another person’s traumatic story may be related to significant adverse effects on those in these helping professions.

Vicarious Trauma

Counseling people who have experienced past trauma, or who are currently experiencing trauma, is often challenging and complex. The term vicarious trauma (VT) was developed in the 1990s as a way to describe the how counseling and psychiatric care can cause distress in mental health providers (Chouliara, Hutchison, & Karatzias, 2009). Vicarious trauma refers to the

mental and emotional effects of direct clinical practice with victims of trauma (Deville, Wright, & Varker, 2009). For example, when a client shares with their counselor an experience of sexual assault he/she previously went through, the counselor can experience some parts of the event empathetically. Over the course of many years of exposure to this type of client trauma, this counselor may build up a vicarious history of trauma themselves. Often these changes are so gradual that the counselor does not see it in themselves until the symptoms are well-established (Brockhouse et al., 2011). PTSD is a condition that manifests because of actual, or threatened, emotional and physical trauma, dissimilarly, VT is tied to the *empathetic* experience of trauma. Vicarious trauma often results in changes to a counselor's whole worldview, such as cognitive disruptions in a counselor's beliefs about such things as safety or intimacy. It is through this process that a counselor's inner experiences are traumatically transformed due to repeated empathetic engagement with traumatic client material (Deville et al., 2009; Jenkins et al., 2011; Newell & MacNeil, 2010). In fact, research finds that mental health providers who repeatedly hear stories of trauma can actually develop a skewed view of their own self, which affects their interactions with others in their world (Cummins et al., 2007).

How VT develops depends on a number of factors. It is important to note that nearly all counselors are exposed to client trauma throughout their professional lives, but not every single one develops VT. A factor that affects the degree and intensity of a counselor-experienced VT is due, in part, by their own history of trauma. As opposed to counselors who have undergone their own personal therapy, counselors who have untreated trauma, may have a different, and often more difficult, experience with working with traumatized clients (Jordan, 2010).

For example, one counselor working with a sexual assault survivor might remain relatively unaffected by the client's stories; however, another counselor might have a strong

response to that client. These responses, such as intrusive thoughts, flashbacks, distorted cognitions, and hypervigilance mimic the same responses found in PTSD (Sommer, 2008). Counselors report that they find trauma-related sessions more difficult than non-trauma-related sessions. Additionally, some report that, during difficult sessions, they can experience effects such as dissociation and emotional numbness (van Minnen & Keijers, 2000). Dissociation refers to the experience of an involuntary change of consciousness that occurs as a reaction to traumatic stimuli (Serrano-Sevillano, González-Ordi, Corbí-Gran, & Vallejo-Pareja, 2017). It is considered a form of self-preservation and self-defense during which an individual will mentally and emotionally separate themselves as a way to protect the psyche from a perceived threat, in this case, the threat being a clients' traumatic material (Ensink, Berthelot, Bégin, Maheux, & Normandin, 2017).

An important, if not vital, aspect to successful counseling involves empathy, specifically, a counselor's empathic and compassionate responses to client material. Empathic response refers to the extent that a counselor tries to reduce the suffering of their client through the expression of empathy (Figley, 2002). These expressions of empathy benefit the client, however, it can also have a negative impact on a counselor's wellbeing, namely their ability to provide the same, or similar levels of empathy to other's they counsel. Therefore, counseling is indirectly affected by the capacity of the counselor to protect or guard themselves against the pain and trauma discussed in a given session (Hernández, Engstrom, & Gangsei, 2010).

Increased awareness of professional VT has resulted in an effort to detect and treat the symptoms more effectively. If VT is undetected and therefore untreated, the negative effects of it can last for multiple years (Chouliara et al., 2009). Therefore, the detection of VT is the first step in treatment and can be achieved through the use of self-assessment scales (Jordan, 2010). An

assessment tool, the a 29-item scale called the “Vicarious Traumatization Questionnaire (VTQ)”, was developed to aid in the assessment of counselor VT (Culver et al., 2011). Another, the “Trauma Symptom Inventory (TSI)”, is a widely used scale that was originally intended to examine and assess an individual’s symptoms of PTSD. The TSI uses a 100-item self-report scale to quantify and measure the experience of PTSD in an individual (Snyder, Elhai, North, & Heaney, 2009).

Secondary Traumatic Stress

When a counselor is vicariously traumatized, this opens the door for them to experience the corresponding negative emotional responses, which have been categorized as secondary traumatic stress (STS) symptoms. STS is thought of as a natural result of the nature of caring between two people, when the first person has been traumatized and the other person becomes affected by the their traumatic experiences (Figley & Kleber, 1995). In counseling, STS occurs when a trauma, discussed in the confines of a counseling session, is transferred from the client to the clinician. After time, this can result in the counselor experiencing symptoms of post-trauma symptoms similar to those of PTSD (Galek et al., 2011; Killian, 2008).

Like PTSD, STS can be treated using psychotropic medication to address specific symptom profiles (e.g. depressive or anxious symptoms) and through personal counseling. These treatment options used to lessen the effects of STS include time-sensitive stress debriefing (interviews occurring shortly after the exposure to traumatic client material), peer group intervention, and one-to-one counselor supervision sessions (Killian, 2008).

It is logical then, that when counselors experience symptoms of STS, this interruption can affect their clients through either disrupted or distorted therapy. In addition, these disruptions could also affect mental health care structures as a whole. At a systemic level, this occurs when

there is an increase in drop-out rates due to declines in counselor emotional health. Thus, the relationship between the counselor and the client play important roles in both the therapeutic process and the health of the profession.

Therefore, researchers, educators, and clinicians all place an emphasis on the emotional energy expended by the clinician in the counseling room (Figley, 2002). The counselor should remain emotionally available to their clients during a session, and when their time has concluded, this counselor must be able to emotionally detach from the client and from the material being discussed. Then, the counselor should regroup and direct the same emotional response (empathy) to the next client in the waiting room. However, when this repeated engagement and subsequent disengagement involves the discussion of traumatic material, there is a potential for the counselor's wellbeing, and the therapeutic relationship itself, to be at risk (Cummins et al., 2007). In fact, a study by Ting, Jacobson, & Sanders (2011) found that counselors who reported higher levels of STS and who had a recent encounter with a client who was suicidal or committed suicide, reported higher levels of perceived stress within themselves.

Thus, it is necessary to address the negative impact that trauma counseling can have on the practitioners, as it often affects both their job performance, as well as their personal lives (Hernández et al., 2010). The presence of VT and the subsequent development of STS in helping professions is a reminder that counselors who provide services to high-trauma populations are at a very real risk of experiencing lasting psychological harm from their work (Hernández et al., 2010). Indeed, their whole worldview may be affected when they experience STS, including their basic ability to “have fun, to enjoy themselves alone and in the company of others, to laugh, and to renew their faith in the goodness of most humans” (Figley, 1995, p. 141).

The prevalence and intensity of STS in a variety of professional settings has not been specifically addressed through research; it is unclear how professionals from varying fields differ in their response to VT (Manning-Jones, de Terte, & Stephens, 2016). Additionally, research on VT and STS has not been examined through the specific experiences of Native American counselors who work with traumatized Native clients. In instances other than those relating to racial and ethnic trauma, there has been an increase in research studies regarding the vicarious trauma experienced by counselors who provide mental health services to combat veterans. The result of the secondary trauma is often similar, however, counselors in this field, specifically, are often members of the military themselves, and subsequently experience the secondary trauma in a unique way (Jordan, 2010).

Burnout

Burnout is a term referring to the experience of fatigue and disconnection that is caused, in part, by psychologically demanding professional work (Chouliara et al., 2009). It is a serious issue that can occur at different points in one's professional life, and has been described as a physical, emotional, and spiritual collapse (Newell & MacNeil, 2010; Ohrt & Cunningham, 2012). Burnout describes a condition that results in significant levels of emotional exhaustion, depersonalization, and a reported reduced sense of accomplishment (Newell & MacNeil, 2010). Counselor burnout, in particular, occurs in response to demanding work environments, interpersonal stressors, management of consistently challenging and difficult client material, large caseloads, and deficient employee resources (Landrum et al., 2011). This response to occupational stress may result in decreased job performance and lower job satisfaction (Cummins et al., 2007; Galek et al., 2011). When a practitioner's emotional state has become

affected by the needs, demands, and expectations of their clients, coworkers, and employers, this emotional exhaustion or decline often takes place (Newell & MacNeil, 2010).

Note that burnout, secondary traumatic stress, and vicarious trauma are not the same principles in counseling. They do all involve a counselor's repeated exposure to difficult client material, (Boscarino, Adams, & Figley, 2010), however, there are also notable differences among them. First, burnout has an association with occupational conditions, such as employee workload. Whereas secondary trauma is related to an actual experience of trauma by-proxy (Jenkins et al., 2011). Next, vicarious trauma results from the onset of symptoms that occur suddenly and can have a more widespread effect on an individual and agency. Additionally, burnout occurs when a counselor works with traumatized clients, but also they also have to deal with specific occupational frustrations and feelings of powerlessness which results in the counselor feeling as if they are unable to achieve their professional goals (Jordan, 2010).

Mental health organizations that are focused on serving traumatized individuals may see higher burnout rates among its employees. When these employees experience burnout, it affects their physical and mental health, and their job performance. The experience of burnout can impact employee's perceptions of satisfaction in their position, and ultimately, may sway their intentions to quit this challenging work altogether (Landrum et al., 2011).

Additionally, age, or the number of years in the profession, is shown to have an impact on rates of burnout among counselors. Burnout is more common among younger professionals than those who are 40 and older. When new professionals feel overloaded with work and perceive themselves as having a lack of support from others, their level of burnout is often higher and more intense than professionals who have been practicing for 10 or more years. Specifically, perceptions of professional support can also influence rates of burnout. In fact, one study found

that the mere belief that a new professional does or does not have access to supportive people in their lives can affect stress and, ultimately, burnout (Devilley et al., 2009).

Counselors who have themselves have experienced trauma may face unique professional challenges, such as difficulty in maintaining an appropriate emotional distance from the clients trauma and their own trauma (Jenkins et al., 2011). In 1995, research by Pearlman and Mac Ian found that therapists having a history of traumatic life events, who worked with traumatized individuals reported higher rates of negative beliefs about themselves and about their clients. This may be because the counselor's traumatic memories had resurfaced and caused them internal distress.

Many times, counselors who have a history of trauma, pursue the field of counseling themselves because they feel motivated to share their stories of resilience with others struggling with similar issues. Inversely, others may find themselves attracted to the field of mental health because of a failing to adequately process their own trauma and may feel that helping others with their trauma will resolve their own emotional issues. In fact, a study done by Jenkins et al. (2011), found that trauma counselors who had experienced their own personal trauma noticed positive changes in themselves when working with traumatized clients. However, encouraging this finding seems, it should be noted that this same group rated themselves higher on symptom scales for PTSD and depression, suggesting that while they notice positive changes in their work, they may also be experiencing negative symptoms simultaneously.

There are multiple commonalities found in burnout, and three distinct dimensions have been identified. First, when an individual is experiencing burnout, they often find themselves in a state of overwhelming exhaustion. This includes feeling depleted of the necessary emotional and physical resources used in counseling. Second, burnout causes strong feelings of cynicism

toward the work itself and an overall detachment in general. Finally, there exists a tendency for individuals suffering from burnout to feel disappointed in their work as a whole, or feel a lack of accomplishment or fulfillment (Devilley et al., 2009).

Compassion Fatigue

In her book, *That Was Then, This is Now*, S.E. Hinton wrote that “nothing can wear you out like caring about people” (Hinton, 1998, p. 144). Indeed, most mental health providers know this statement to be true. There exists a “burden of care” due to the constant outpouring of emotional support that counselors provide to others (Boscarino, Figley, & Adams, 2004). The term compassion fatigue refers to a “reduced capacity or interest in being empathic or bearing the suffering of clients” (Boscarino et al., 2004, pg. 2).

The experience of compassion fatigue is not limited to counselors, but also psychologists, child-protection workers, nurses, physicians and social workers. In fact, research has found that those working in helping professions are likely to experience some kind of negative consequence resulting from direct exposure to the mental health needs of others (Boscarino et al., 2004).

Counselor Turnover

Research has shown that organizations that experience high rates of staff turnover also report less client engagement and client satisfaction. In addition, clients have reported increased difficulty in bonding with clinicians at organizations where staff turnover is high (Landrum et al., 2011). There are several factors that play into an organization’s clinician turnover rate. For instance, researchers have found that when clinicians carry large and difficult caseloads, they have a higher incidence of reporting a more stressful work environment and less job satisfaction (Knight et al., 2012). It is important to note that stress itself can have various interpretations dependent upon how individuals measure personal stress and dissatisfaction.

Furthermore, Knight et al., (2012) found that counselor's perceptions of work demands and the resources available for wellness positively contributed to their decisions on whether or not to leave a job. According to the Knight et al., (2012) study, there is a significant interaction between the perceived needs of a program and whether or not change can, or has the potential to, occur. Therefore, the probability of employee turnover decreases when counselors feel that warranted organizational change that is taking place. Conversely, counselors are more likely to cease their employment with an organization if they feel that the changes occurring at an administrative level are either unnecessary or unwarranted. Individuals who identified experiences of low job satisfaction were, predictably, more likely to leave that job position. Furthermore, according to the research by Knight et al., (2012), when an organization is change-oriented, employees are less likely to cease employment in favor of another organization.

Overall, there are many well-researched factors that affect the quality and availability of mental health care services. Broadly speaking these are policy and legislation hurdles, problems with finding and allocating adequate funding for mental health services, and issues surrounding appropriate training and supervision. While previous studies have focused on barriers to mental health service access, including economic barriers, informational barriers, and insufficient resources, it should be noted that, in addition to these well-known barriers, the specific factor of counselor wellness is an emerging, understudied area of interest (Lawson et al., 2007). Indeed, little is known about how counselors who work in trauma-dense settings view the work they do, their sense of purpose in this work, their preparation for this type of work, or their personal wellness strategies. It stands to reason, then, from what we know about clinician turnover in general, that clinicians who work in trauma-dense settings may be more susceptible to burnout.

This, in turn, will affect how clinics are able to staff counselors, which then, negatively affects the availability of mental health services.

Large scale research, both short-term and longitudinal, in the area of Native American overall health is lacking. More to the point, research concerning mental health issues specific to Native Americans as a whole is inadequate, and in order to provide robust and empirically supported treatment options, this is an area in need of increased research support. Specifically, research concerning the mental health care of Native American people combined with factors specific to Native American counselors must be examined more closely (Urban Indian Health Institute, 2012). It has been long understood that good mental health research is foundational to good mental health clinical practices. This is especially true for empirical research on appropriate cultural healing practices and their manifestation in sound clinical practice. The fact that Native Americans, who make up nearly 2% of the United States population, remain largely understudied, brings to light many concerns about the direction of future mental health research (U.S. Census, 2010). Taking this into consideration, in addition to the high rates of mental health issues afflicting Native peoples (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012), it is quite clear that a call to action is appropriate.

The goals of this study are to further the discussion of counselor professional wellness (specifically of Native American counselor wellness), to gain insight into the experiences of Native American counselors delivering mental health services on reservations, and to call attention to a population of individuals (Native Americans) in the United States that are in need of counseling services, but who, historically, do not have access to consistent and quality mental health care. As a result, this information and awareness may better equip Native and non-Native mental health providers who work on reservations in avoiding secondary traumatic stress,

vicarious trauma, and burnout. In addition, the hope is to inform future counseling research and practice regarding counselor retention in Indian Country, and also to help provide stable, consistent care for individuals living on reservations nationwide.

CHAPTER III. METHOD

This research utilized a qualitative design, specifically Interpretative Phenomenological Analysis (IPA). Qualitative research aims to provide in-depth examination of how the world around us is structured and how it operates (Morse & Field, 1996). Qualitative research is utilized when a problem or issue, one that cannot easily be measured or captured, needs more exploration. Furthermore, qualitative research can be empowering, as it encourages the participants themselves to share their stories by using their own voices (Creswell & Poth, 2018).

Society is complex and multifaceted and inherently encompasses both the individual and the collective psycho-social aspects of human beings, such as language, rituals, beliefs, and ethics (McLeod, 2011). For research to fully capture the depth, complexity, and experience of an individual, there must be space in the research process for people to share their thoughts and emotions. Ultimately, this combination of subjective and objective elements may be accomplished through the use of qualitative research (Allan & Eatough, 2016).

Qualitative studies in the fields of counseling and psychotherapy provide rich information on client and practitioner experiences (Smith, 2011). Flynn and Korcuska (2018) draw the comparison between counseling and research, noting that both researcher and counselor aim to uncover and understand the essence of an individual's experience. In fact, those who engage in counseling and psychotherapy research are often therapists themselves (McLeod, 2011). This benefits the profession, narrowing the gap between research and application. Qualitative research in the field of counseling may offer a better understanding of ways in to integrate the information gathered in a research study to the therapeutic practice (McLeod, 2011). For example, Duarte, Fischersworing, Martínez, and Tomicic (2017) used qualitative analysis to examine the psychotherapeutic change of a patient with Borderline Personality Disorder (BPD). In this study,

researchers examined both the patient and the practitioner's subjective experiences. The information was then analyzed and participants' narratives were used to inform further research, but also to inform further clinical procedure for practitioners working with individuals with BPD (Duarte et al., 2017).

Purpose of the Study

The purpose of this study utilizing Interpretive Phenomenological Analysis (IPA) was to understand the lived experiences of Native American counselors who work or have worked on reservations. This study asked Native counselors to share their experiences in practicing counseling in a trauma-dense setting, such as the reservation, with a population of individuals who experience disproportionate amounts of trauma. The goal was to identify themes that may emerge regarding Native counselors' shared experiences. An additional goal was to contribute to research and literature on counselor wellness, specifically the wellness of Native American counselors working on reservations.

Research Question

The research question forming the basis of this study was, "What are the lived experiences of Native American counselors working in the trauma-intense environment of a Native American reservation?". IPA research questions are designed to be broad and open-ended. Because there is no predetermined hypothesis in IPA, participants are given the opportunity to share their thoughts and reactions relating to the phenomena in question.

Method

An Interpretive Phenomenological Analysis (IPA) was used in this study. According to Pietkiewicz & Smith (2014) IPA is theoretically connected to phenomenology, hermeneutics, and ideography. IPA research aims at understanding an event in its own terms, through the

perspective of those who have lived it (Smith, 2011). Because a direct sample of an experience cannot be taken from the individual's memory, IPA utilizes interpretation. This, as Smith (2011) notes, is the process of a double hermeneutic, "whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (p. 10). IPA is idiographic in its focus on analyzing each participant's narrative in detail. Often, IPA studies present shared themes among participants and takes that a step further by investigating the ways these themes play out for individuals (Smith, 2011). To examine the nuanced, lived experiences of research participants, IPA uses a "sequential set of interpretive readings of the data" (Chamberlain, 2011; McLeod, 2011, p. 148). Additionally, IPA is organized around semi-structured interviews with participants, which are then transcribed and discussed by the researcher (McLeod, 2011).

To improve credibility and rigor in qualitative research, the process of data collection is important. Collection of IPA data is commonly completed through participant interviews (Allan & Eatough, 2016) and this study utilized individual interviews to gather this data from participants. Because IPA research aims for a first-person account of the phenomena being investigated, one-on-one interviews are the most common method to collect data. In addition to gathering information, one-on-one interviews also allow the researcher and participant to engage in real-time conversation, which often results in more rich, detailed data.

Pietkiewicz & Smith (2014) note that IPA researchers must have well-developed interviewing skills. This includes active listening skills, the ability to formulate and pose questions that are open-ended, yet do not guide or sway the participants in any way and establishing a therapeutic level of trust from the participant. In order to establish this rapport and allow the participant to become more comfortable prior to being asked emotionally sensitive or difficult questions, it is recommended that the researcher and participant engage in a 'warm-up

discussion' (Pietkiewicz & Smith, 2014). A warm-up discussion commonly occurs at the beginning of each interview, as this allows the researcher to build rapport with the participant and also provides the participant time to ease any pre-interview tension they may have (Pietkiewicz & Smith, 2014). Semi-structured interviews provide the researcher with a set of questions on an 'interview schedule' and the course of the interview is ultimately guided by the schedule, but not mandated, or dictated, by it (Smith & Osborn, 2015). With semi-structured IPA interviews, it is important that the researcher build rapport with the participant (Smith & Osborn, 2015).

Procedures

Sampling Methods

The sample size in IPA studies are intentionally small (e.g. 3-6 participants), as this allows the researcher to provide a detailed report on the perceptions and understandings of a particular group, rather than making broad, general claims (Smith & Osborn, 2015). Additionally, a small sample size is preferred for IPA because of the intense amount of post-interview activities, including the transcription and case-by-case analysis that are required to adequately carry out successful research (Smith & Osborn, 2015; Smith, 2011). In fact, it is recommended that new IPA researchers, such as doctoral students, maintain a small sample size, as one of the concerns is that if a sample size becomes too large, a first-time IPA researcher may become overwhelmed by the large amounts of data, leaving space for the analysis to lose power (Smith & Osborn, 2015)

As opposed to random sampling strategies, a homogenous sample is preferred in IPA studies. The purpose of utilizing a sample selection based in specific qualifications is to identify a well-defined group of individuals for whom the research question will be significant (Smith &

Osborn, 2015). In this study, the participants were Native American counselors who provide, or previously provided, counseling services to Native individuals living on a reservation.

Recruitment

To gain a homogenous participant pool, a sampling procedure known as ‘snowball sampling’ was used in this study. This method of sampling involves the researcher identifying informants through contact information that is provided by other informants. Basically, the ‘snowball effect’ refers to the repetitive process of informants referring the researcher to other informants, who are contacted by the researcher, and are then referred to yet another informant, and so on. In fact, snowball sampling is often believed to be the most widely used method of sampling in qualitative research, across disciplines (Noy, 2008).

Data collection

After approval from the IRB, potential participants were identified by contacting the directors of behavioral health departments on various reservations. Potential participants were identified using the snowball method of sampling, whereby the researcher reached out to known contacts who have the opportunity to provide the names of known individuals who would meet the study’s participant criteria. The necessary licensing credentials for potential participants include those who possess either a Licensed Professional Counselor (LPC) or a Licensed Professional Clinical Counselor (LPCC) license.

Interview Questions

The methods of data collection commonly used in phenomenological research are semi-structured interviews, focus groups, and artifact collection. Based on the objectives of this study, examining the lived experiences of Native American counselors working on reservations, data collection was achieved through semi-structured, open-ended, individual interviews. Because the

participants were from various locations in the Upper Plains, consistency across participants was maintained by completing all of the interviews via phone. Each interview was recorded, allowing the researcher to focus on the interviewee. If video was available, the researcher made note of the participants' body language and non-verbal cues during the interviews. Each participant completed 30 to 45 minute long interviews. Each interview began with the researcher obtaining verbal permission from the participant to proceed with audio recording the interview. Each participant was asked if they understand the consent form and, if so, asked to provide oral consent to proceed with the study. By verbally agreeing to participate in the study, participants waived the need for a consent signature.

To establish rapport that will allow a participant to become comfortable with the researcher prior to being asked any potentially emotional or sensitive questions, it is recommended that the researcher and participant engage in a 'warm-up discussion' (Pietkiewicz & Smith, 2014). In this study, the warm-up discussion consisted of researcher-participant introductions as well as a brief discussion about the interview process. For example, participants were given a brief outline of the interview schedule, including an overview of questions that were asked, at which time the participant will be allowed to ask questions and clarify, if necessary.

Participants were asked the interview questions (see Appendix E), which invited participants to share what it is like to work as a counselor on a reservation and how they maintain personal and professional wellness. Participants were encouraged to expand on these questions as they saw fit. Clarification statements such as, "explain that more for me" and "give me an example" were used by the researcher as needed.

Data Analysis

The researcher collected the data and transcribed each participant interview. The transcribed documents were stored on North Dakota State University's OneDrive cloud/Electronic files, audio and text, were password protected and available only to the researcher. The researcher kept hard copies in a secure, locked filing system. All digital and hard copies of research data will remain in a locked cabinet for five years, after which all hard copies will be destroyed, and electronic data will be deleted. Participants were informed that after approximately two weeks, a follow-up interview via Skype or phone will be conducted allowing the researcher to ask follow-up or clarification questions and also to allow participants to add comments or information to the data from their first interview.

Smith, Flowers, and Larkin (2009) note that IPA researchers attempt to gain knowledge of “what it *might mean for participants to have these concerns, in this context*” (p. 79, emphasis added). As Allan & Eatough (2016) note, IPA is not meant to be limited to a rigid, prescribed set of steps, rather there are guidelines that serve as a model for how to engage in phenomenological research. Importantly, each case is analyzed separately before moving forward with a comprehensive analysis. Specifically, I analyzed the data utilizing the following steps associated with IPA:

- 1. Reading and re-reading.** In order to enter the experiential world of the participant, researchers must read the transcript of the interviews a number of times (Allan & Eatough, 2016). This includes several transcript readings, and also multiple audio/video recording viewings, if applicable. This allows researchers to become immersed in the data and to recall the atmosphere and setting of each interview. Multiple exposures to each interview may also provide new insights (Pietkiewicz & Smith, 2014)

- 2. Initial noting.** At this stage, researchers can make notes of anything that strikes them as significant or interesting in the transcript (Allan & Eatough, 2016). This may include specific content, the language used by participants (e.g., metaphors, symbols, pauses). Additionally, researchers can also make note of their own observations and reflections about the interviews, including comments relating to personal reflexivity (e.g., how personal characteristics of the researcher themselves such as age or gender may have impacted participants) (Pietkiewicz & Smith, 2014).
- 3. Developing emerging themes.** At this stage, researchers set aside the transcript and recordings to work more closely with his or her notes (Pietkiewicz & Smith, 2014). Specifically, researchers work to identify general themes that may have emerged and to discuss any implications based on the information provided by the participants (Allan & Eatough, 2016). While the purpose in identifying thematic information is to “formulate a concise phrase at a slightly higher level of abstraction”, it is important that these interpretations remain grounded in the participant’s account (Pietkiewicz & Smith, 2014, p. 12).
- 4. Searching for connections across emergent themes.** Since the researcher has identified themes from the full transcript, they now begin delving in further in an attempt to identify thematic connections and clusters (Pietkiewicz & Smith, 2014). Researchers then determine whether superordinate themes and subthemes may be identified based on conceptual similarities of identified themes (McLeod, 2011). Any themes that do not fit well with the emerging structure or those that do not have a strong base of evidence may be dropped at this stage (Pietkiewicz & Smith, 2014).

Trustworthiness Procedures

Traditionally, the terms ‘reliability’ and ‘validity’ are used to indicate stable and consistent research results. However, in a qualitative research design, such as IPA, the term ‘trustworthiness’ is more appropriate in capturing the importance of high quality qualitative work (Rodham, Fox, & Doran, 2015). To achieve this, varying strategies and principles are used that demonstrate procedural consistency and congruence within the research design (Flynn & Korcuska, 2018).

In qualitative research, there are six procedures designed to enhance trustworthiness in a study: epoche/bracketing, auditing, triangulation, member checking, reflexivity, and thick and rich descriptions. Of these procedures, the most commonly used are reflexivity and member checking (Flynn & Korcuska, 2018). Member checking, or respondent validation, involves the return of data or results to the participants for them to verify the accuracy and resonance with their experience. Member checking encompasses a variety of activities including the return to transcripts, member check interviews, member check focus groups, and member check of analyzed data (Birt, Scott, Cavers, Campbell, & Walter, 2016). Because the sample size of this study was relatively small, it was appropriate to ask participants to return to the transcripts of their interviews.

This study utilized the methods of reflexivity and triangulation of investigators in order to achieve trustworthiness in the data and analysis. Reflexivity in research emphasizes the impact the researcher will have on their own research process. It is this critical self-awareness that requires a level of mindfulness throughout the research process (Barry, Britten, Barber, Bradley, & Stevenson, 1999; Finlay, 2014). Simply put, reflexivity is the acknowledgement that the researcher will inevitably have an impact on the interpretation of the data because they,

admittedly, are viewing the data through their own view (Rodham et al., 2015). The purpose of reflexivity is to improve the quality of the research. This is achieved through self-examination by way writing a statement of reflexivity, keeping field notes and/or research journals, and by continuing to have an open and curious stance toward the data (Barry et al., 1999; Rodham et al., 2015).

Triangulation of investigators refers to the use of additional researchers' involvement in analyzing the data of a particular study. The inclusion of other researchers in qualitative research strengthens the design and builds confidence in the findings (Hays & Singh, 2012). This study included the use of an additional analytical investigator to review the presented data and provide feedback. This feedback was used to procure the final data analysis results.

Quality of research results in IPA can be strengthened through the following four guidelines: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance (Rodham et al., 2015). It is important that research demonstrate an awareness of the culture and varying perspectives of participants (Brown, Webb, Robinson, & Cotgreave, 2018). Yardley (2017) indicated the importance of the language used by participants. Semantics, specifically the words used by participants matters. For example, the use of slang words by participants and the subsequent interpretation of these words by the researcher may impact the outcome of the research. Rodham et al., (2015) tracked these contextual influences by keeping a research journal that highlighted any prior assumptions and ideas the researcher may have on the research topic. Additionally, a research journal gives the researcher an opportunity to document emotional reactions they may have to the data and analysis. A study shows commitment and rigor when the researcher's engagement with the topic is apparent and when it has been demonstrated that the population sampled was appropriate for the goal of the research. One way

this is done is through the process of documenting the data collection and analysis procedures (Brown et al., 2018; Yardley, 2017). In addition to verifying rigor, this process also ensures transparency, as the reader should be able to plainly see how the interpretation was derived from the data (Brown et al., 2018; Yardley, 2017). The steps taken to ensure this quality of research further bolster the impact and importance of the data and analysis (Brown et al., 2018).

Researcher Reflexivity Statement

In order to improve the quality of this study through critical self-awareness, I reflected on my experiences, background, and assumptions, in order to discuss how these may affect this study.

I am a 38-year-old Caucasian and Native American female living in central North Dakota. I am a descendant of the Standing Rock Sioux Tribe of Lakota, where my father, an enrolled member of the Tribe, was born and raised and where he presently lives. I have Native American family members, some of whom live on the reservation, while others live off the reservation. To my knowledge, no members of my family are or were employed as mental health providers on any reservation. At the time of this study, I am a doctoral candidate in Counselor Education and Supervision at North Dakota State University. I am a Licensed Professional Clinical Counselor and a National Certified Counselor providing clinical counseling services to individuals in an urban healthcare setting. My scholarly interests are in the areas of counselor wellness, trauma counseling, and Native American mental health.

Through the process of phenomenological analysis, it is important that the researcher has awareness of their judgments and assumptions so they may remain objective and impartial (Barry et al., 1999). However, this does not require that the researcher be ignorant about their beliefs, rather they should become aware of their preconceived notions in order to gain insight on

their impact on the study (Rodham et al., 2015). This process, called bracketing or epoche, should be continued throughout the progression of the research (Murray & Holmes, 2014). I will describe my research assumptions and biases below and will continue to examine them throughout the research process.

I have a number of assumptions about counselor wellness, trauma counseling, and Native American mental health. The first assumption was that historical trauma, when coupled with recent personal trauma has a negative effect on Native American people and on the Native American counselors who work with them. Due to my own experiences as a Native American counselor, there was an assumption that other Native counselors would report experiences of connectedness with their Native American clients. This connectedness is assumed to exist, partially, because of cultural and spiritual values among many Native peoples. It is assumed that participants would report personal effects due to experiencing trauma themselves, and by hearing the traumatic stories of other Native people.

I have life experiences that extend outside of academic and professional pursuits. Naturally, I have accumulated certain biases that may impact the interpretation and analysis of the data. I have a connectedness to Native American people, more specifically to the Lakota Sioux people, to our culture, our language, and our beliefs. I was raised by a Caucasian mother and a Lakota father, both of whom instilled in me the importance of family, heritage, and culture. Many members of my family and friends live on the Standing Rock Sioux Reservation, as well as other reservations throughout the United States. This impacts my view on the importance of understanding and caring for Native people. I possess a unique worldview, that of a Native American and White professional counselor, which drives my academic and professional motivation in this helping profession.

By sharing this, I am making my cultural identity and my experiences, assumptions, and biases known. This is done so the data collected and analyzed throughout the research process will benefit from researcher insight and objectivity. This was incorporated as the research study progressed, as I continued to reflect on how my experiences, biases, and assumptions played a role in the findings. To achieve this, a researcher journal was kept, in which I reflected on my thoughts and experiences throughout the research process. The ultimate goal in this study, as with IPA research in general, was to accurately represent the participants' voices and experiences through thoughtful, insight-motivated, and rich qualitative data (Smith, 2011).

CHAPTER IV. FINDINGS

Presented here are the findings of this study. Interpretive Phenomenological Analysis (IPA) was utilized to understand the lived experiences of three Native American counselors who have worked or are currently working on a reservation located in the Upper Plains. In accordance with IPA, research participants' experiences are presented so that readers have an understanding of the research participants' lived experiences. Thus, direct quotations from participants provide an in-depth view of participant perspectives. The purpose of this chapter is to present the broad themes and corresponding sub-themes that capture the essence of Native American counselors working on the reservation.

Method

Participants

The purpose of this study was to explore the lived experiences of Native American counselors working on reservations. Prior to the collection of data, Institutional Review Board (IRB) approval was secured by North Dakota State University. Approval was additionally secured from two Upper Plains Tribal IRB entities.

A homogenous sample is preferred in IPA studies since the purpose is to identify a well-defined group of individuals for whom the research question will be significant (Smith & Osborn, 2015). There were three participants. Demographic information was intentionally not collected or reported in this study to avoid any possible identification of participants. Because the target population is relatively small and the communities where they work tightly-knit, this lack of identification was important to ensure the anonymity of participants. All participants met the specified criteria for participation. All participants were over the age of 18, identified as Native American, were Licensed Professional Counselors (LPC) or Licensed Professional

Clinical Counselors (LPCC), and had obtained a master's degree or higher from an accredited counseling program. Additionally, participants were currently working on or have worked on a Native American reservation in the United States.

To gain a homogenous participant pool, a sampling procedure known as “snowball sampling” was used in this study. Snowball sampling is believed to be the most widely used method of sampling in qualitative research (Noy, 2008). In this study, the researcher identified informants through contact information that was provided by other informants. Potential participants were then contacted via email by the researcher. The necessary qualifications of each participant were confirmed, all participants were given consent information, and verbal consent was provided by all participants.

Each participant took part in a semi-structured, open-ended, individual interview. All interviews were completed by telephone. Each participant provided verbal permission for the researcher to proceed with audio recording. The interviews lasted from 30 – 45 minutes. At the end of their interview, participants were informed that they would be contacted via e-mail by the researcher, when they would be provided with a transcription of their interviews. In addition, participants were given an opportunity to review transcripts, and clarify if necessary. All participants reviewed their respective transcripts and confirmed, via e-mail, that the transcription was to their satisfaction. The participants, Mary, Lisa, and Lilli chose their pseudonyms to be used in this study.

Applied research methodology

Interpretative Phenomenological Analysis (IPA) is not limited to a prescribed set of steps; therefore, the following sequence was used in the analysis for this study. Each case was analyzed separately, on its own merits, before the researcher moved forward with the comprehensive

analysis (Allan & Eatough, 2016). Analysis of data was managed by using coding and sorting techniques. This information was then analyzed by applying the process indicated by Alase (2017).

The sequence of data analysis for this study included:

1. The researcher completed transcriptions of individual participant interviews.
2. Initial reading and subsequent re-reading of each transcript was done by the researcher. Additionally, audio of each interview was reviewed twice. These measures were taken by the researcher in order to enter the experiential world of the participant (Allan & Eatough, 2016).
3. The preliminary noting of each transcript was done via a color-coding process, identifying significant emerging themes in the data.
4. The color coded transcripts allowed the researcher to identify “chunky statements” (Alase, 2017, p. 16), that were extracted from the transcript and placed in a table. This was done to aid the researcher in breaking down the respondents’ statements to a more condensed and manageable format (Alase, 2017). An example of this process is found in Table 1.
5. An additional column was added to the table, where the reduced versions of the extracted, chunky statements were identified. This was done to reduce large sections of the transcript down to the core essence of participants’ responses (Alase, 2017). Again, see Table 1.
6. Emerging themes across participant data were identified in order to establish tentative themes and establish any patterns or similarities in the data (see Table 1).

7. Finally, the emerging themes were analyzed and categorized into one of the four final themes that emerged from the data (see Table 1).

Table 1

Sample Analysis Table

Extracted (chunky) statements	Reduction of chunky statements	Emergent themes	Tentative category	Final category
“I would say working with the clients is very rich and you always get, you always, you often get complex cases.”	The experience is rich and the cases often are complex	Description of work	Complexity of work	The worth and weight of working on a reservation
“So you drive an hour on the reservation and you spend time with that one person because you’re the one person that they trust, um, and it so, it impacts, it absolutely impacts your work. It does.”	The physical distance on the reservation impacts the work, as does singular trust of clients.	Challenges and impacts	Community and barriers	The impact of culture and community on counseling
“...we all struggle and we all have our struggles in life and I’m just here to help facilitate healing, and the person in front of me helps me heal as much as I help them.”	By helping others, the participant is also finding a benefit in that. There is an element of by-proxy healing, or experiential healing.	Healing through intervention	Counselor wellness	The effects of personal and professional wellness on counselors
“[The work] can be challenging at times because of the significant level of trauma, or multiple traumas that people have.”	The work becomes challenging due to the high amount of trauma.	Client trauma, impact on counselor	Trauma’s impact	Four forms of trauma impacting the counselor and their work

Note: Adapted from Allan, R., & Eatough, V. (2016). The use of interpretive phenomenological analysis in couple and family therapy research. *Family Journal*, 24(4), 406–414.

The Lived Experiences of Native American Counselors Working on the Reservation

The research question, “What are the lived experiences of Native American counselors working in the trauma-intense environment of a Native American reservation?” served as the lens through which the data was analyzed. Analysis of the data led to the creation of the

following four themes: “The worth and the weight of working on a reservation,” “The impact of culture and community on counseling,” “Four forms of trauma impacting the counselor and their work” and “The effects of personal and professional wellness on counselors.” In the following section, data are organized and presented in accordance with the four main themes relating to the experiences of working on the reservation. Additionally, identified sub-themes for the main themes are included.

Theme 1: The Worth and Weight of Working on a Reservation

Both positive and negative experiences for counselors working on the reservation were reported in this study. Participants explained that they found worth in the work they were doing on the reservation. For example, all three participants used the adjective “rewarding” to describe their work. Further, participants noted that this work was valuable and their roles in the communities in which they serve was important. Lisa described this saying, “[the work] is difficult and it’s rewarding, and it’s beautiful and it’s hard, and it’s everything in between.” Such a sentiment was echoed in a variety of participants’ statements.

Conversely, analysis of the data revealed another side to this rewarding experience: the difficult nature of the work. When asked to share her experiences providing counseling on the reservation, Lisa almost immediately became passionate, using poetic descriptions of her experience. Through the use of metaphor, Lisa was able to capture her lived experience and paint a picture of the emotional heaviness that is present when working on a reservation. She described this emotional toll as a, “blanket of weight on you when you work [on the reservation], it’s so hard to take a deep breath and ground yourself.” She went on to describe her experience of becoming enveloped in the trauma saying:

It feels like you're just swimming in trauma and it's like in a swamp. And the moment that you feel you're kind of stepping out of a swamp, something else happens because our communities are so small and the amount of trauma is just in your face all the time so you can't escape it.

Lisa's statement provides a moving example of the inescapability of the experience of trauma. This inescapability is one of many difficult aspects of this work.

Having a large number of clients to manage was noted as being an additional difficult variable in counseling on the reservation. Two participants remarked that they felt that having a caseload with large numbers of clients was a significant challenge. Lilli noted that the high number of clients on her caseload was partially due to a lack of counselors on the reservation, and said, "There's such a need up here that it's, it's really not funny. They've advertised for a long time. They can't get anyone to go." In addition to the large work load, Mary noted that there are also the expected challenges that counselors, in general, face such as the pressure to keep up-to-date with client electronic health records.

Evidence for the "weight" of the work was further identified through shared responses of boundary confusion. For example, Lisa referred to an intersection that she felt existed between the counselor as a person and as a professional. At this cross point, the professional and personal roles of the individual would occasionally become blurred or misconstrued. Lisa explained, "at times, when we're looked at as a professional, um, versus a person. So that's something that I had to really work on is like, my initials behind my name do not define who I am, I'm a human being." Lisa discussed this in relation to her experience with some community members, who knew her prior to her becoming a professional counselor. Lisa felt they would pass judgment on

her or express that she *must* be thinking as if she were better or at a higher social standing than they.

In addition, the evidence for the heaviness and weight of the work was found in participant discussions of substance abuse present on the reservation. Mary found that substance abuse occurs, not only with the client, but often with the client's family members who also abuse drugs and alcohol. Through counseling, it was Lisa's hope that the work she has done within her community will help change the cycle of addiction and poverty she feels is present among her people. Lisa elaborated on this by saying, "I grew up in poverty and abuse and alcoholism and I'm trying to change the cycle." Clearly, the repeated patterns of addiction and psychological pathology was a feature that can be found in reservation communities and counselors working there believed they were part of the solution.

For participants, the line between the person and the professional was further obscured due to three factors: collectivist culture, perception of a shared trauma experience, and closeness and familiarity within reservation communities. A collectivist culture exists within Native American communities (Galbraith, C., Rodriguez, C., & Stiles, C., 2006) and this has an impact on the way trauma is perceived and processed. Portman & Garrett (2006) noted the importance of "relation", both family and community, as being central to Native traditions. Xia et. al (2019) stated that a culture of collectivism focuses on the interests of the group as a whole, as opposed to priority being placed mostly on individual interests. All three participants noted that when a traumatic event happened to one person or to one family on the reservation, it is as if everyone in the community shared and felt it. Conversely, this culture of collectivism can also be seen as a source of strength among reservation communities. Participants discussed how this collective experience also results in community unity and Lilli explained:

When something happens, you notice the community all comes together. I notice that they go to the schools immediately to be there for the kids, to be there because they...most of them have a connection. So we all kind of band together, I noticed that, support each other.

Lisa echoed this saying, Native American communities, as a whole, grieve together. She noted, “that’s where I see this beauty of the community healing.” In Mary’s view, the shared experience of trauma and emotion can result in the challenge of compartmentalizing the work she is doing from the community in which she lives. She went on to explain that because she provides counseling to such a small population of people, she will frequently see her clients in the community, and that there is a propensity for the work to invade her personal life.

Difficulty incorporating formal therapy techniques

Further analysis indicated a subtheme relevant to the weight of the work. All participants discussed challenges they have experienced in using traditional therapy techniques in their work. Participants noted that it is difficult to plan a singular, theory-based treatment modality for clients, one reason being the high number of clients on their caseloads. Mary expanded on this saying:

If I’m seeing many clients, you know, and sometimes I’m seeing seven clients a day at one point in time I was seeing seven or eight or nine clients a day. It’s hard for me to be really planful [sic] in terms of like, what skill am I working with specifically? Am I following a DBT outline? Or am I following a trauma, trauma narrative outline or am I following a mind/body/medicine modality?

The significant amounts of trauma existing among clients also impacted counselors’ abilities to utilize a formal treatment plan. For example, Lisa said she often felt unable to apply

specific techniques that she learned in her training and would struggle to create a traditional therapy space that is necessary in a trauma-dense setting. Participants indicated that the frequency of crisis events in their clients' lives was an obstacle that prevented counselors from applying any therapeutic treatment plans. Lisa stressed that her work was primarily, "crisis management over therapy". Mary also discussed this, saying that she often deals with a client's "crisis of the week", which made it difficult for her to introduce a consistent treatment modality. Lilli went on to say that, for her, she finds that she does "a lot of crisis overtime" in her work.

Because of the elevated volume of crisis, it is difficult to practice within a specific counseling modality. Participants reported that it was more effective for them to have a toolbox of a variety of interventions and techniques available to use in their practice. Mary emphasized the importance of basic attending skills, focusing on client strengths, and incorporating aspects of Native healing into her work. Lilli noted the difficulty of motivating her clients to change, adding that the presence of dual mental health and addiction diagnoses can often add other layers to the complexity of her clients' cases. In order to address these complex client issues, Mary explained that she will, "[ask] the client sometimes, in a very simple way, to just breathe with me, you know? That's all we need to do together. And because sometimes the emotion is so high in the room." For her, Mary felt that teaching mindfulness and meditation skills to her clients had a positive impact on their wellness.

Overall, the weight and the worth of counseling on a reservation is multilayered and steeped in emotions. Further, this is impacted by the tendency for counselors to manage crisis situations, the impact of consistently high caseloads, and the difficulty that arises with personal and professional role boundaries.

Theme 2: The Impact of Culture and Community on Counseling

In addition to the rewarding and sometimes difficult nature of practicing counseling on a reservation, all participants used the word “unique” to describe their personal experiences. Indeed, counseling on a reservation with Native American clients does present a unique opportunity in that it allows the counselor to incorporate Western counseling techniques and theories with Tribe-specific healing practices. All three participants emphasized the importance of how their counseling processes included the use of some aspect of cultural healing. Participants shared their inclusion of healing ceremonies in counseling, such as taking part in a sweat lodge ceremony (*inipi*) or attending female-centered ceremonies. Daily customs are also used in counseling sessions, such as smudging, which is the purification and cleansing of the spirit achieved through the burning of sage while engaging in prayer and reflection. This is a distinctly Native American way of healing that incorporates individual practices with the shared healing experience of a larger community.

Culture

Through data analysis, the culture of these reservation communities was noted. Native American cultures and beliefs can vary from Tribe to Tribe, and each Tribe is unique in how personal and Tribal healing is attained and maintained. Mary was raised in the same community that she now practices counseling. For her, this provides an assurance that her chosen profession is a good fit:

Because I grew up on this community and lived in this community most of my life being able to give back to it in a good way is really important to me. And so it feels, to me, like a real natural fit. In terms of living and working in my community and providing services to people that I, you know, consider relatives.

In the literal sense, Lilli explained that she is related to many people on her reservation and, because of this, she personally knows nearly everyone who lives there. Due to the strong connection between the community members and the Native American counselors, they share the experiences and emotions resulting from the same losses, tragedies, and successes. Mary exemplified this by saying that, for her, “community healing is also part of my own healing.” All participants discussed the distinct advantage for a counselor working in a reservation community is that they can, essentially, heal right alongside their community. Additionally, Mary noted that she felt this advantage added an element of trust to these therapeutic relationships.

Community

In addition to the cultural underpinnings on a reservation, physical and sociological factors were reported as well. Multiple small communities, or villages, make up many Federal Indian Reservations and the land size among them varies. For some reservations, there are vast expanses of land sprawling for miles. For example, the size of the Standing Rock Indian Reservation is over 3,000 square miles and has largest population in the United States; the Navajo Nation, covers over 27,000 square miles (U.S. Census, 2010). Through data analysis, two relevant sub-categories emerged which included aspects of community such as rurality and institutional policy.

Rurality

Lisa and Lilli identified the rural and isolated nature of their reservations and how it caused unique challenges in their work. Lisa indicated that a substantial amount of her work day involved driving long distances across the reservation in order to see one client. These participants indicated that they felt this was unique among counselors and indicated that this influenced the way that counseling services are transmitted on the reservation. Because of the

extended travel time necessary between client sessions, these participants noted that there was a reduction in the number of clients they had time to see in a given day.

Participants also reflected on how the rural location of their reservations affected the presence of external influences on the people of the community. Lilli asserted that many mental health issues often go untreated on her reservation, and she felt that this led to people in her community turning to methods of self-medication, such as the abuse of drugs and alcohol. She added that she feels that many people on her reservation have become desensitized or accustomed to a 'drug life' because of the common presence drugs have in the community. One participant, Lilli, noticed that these outside influencers (i.e., individuals coming from outside the reservation) seem to take advantage of communities' rural and isolated location. Specifically, drug dealers and drug manufacturers will come to her community to make and sell illegal substances and seemingly assume that their activity will go unnoticed on the reservation. She added, "It's really disheartening. How many drugs have...have gotten in up here." She expanded on this experience:

Because it's so remote people think that they can just come up from Chicago and Minneapolis, and they can find places that...because it's so remote, they can build meth labs anywhere. And that's what we were finding that lots of meth labs are coming up. And they shut them down as fast as they were found but then they would just start another one up. So then...the drugs come in from Mexico they go to Chicago and Minneapolis then they come up here. And you know, it's easy to get [residents of the reservation] addicted.

In addition to these external influencers, participants also believed that the rurality of the reservation impacted the amount of Native American counselors who would be willing to move

back to their reservations to work. Lilli noticed that many people leave the reservation to get an education, possibly with the intention of returning, but do not follow through with that. She believed this was, in part, due to the isolated locale of many reservation towns and she noted it is difficult for various Tribal agencies and Federal health programs to attract and/or retain Native American counselors.

Institutional policy

Through the process of data analysis, it became clear, in addition to the challenges resulting from the rurality of reservations, there were issues with the way Tribal policy and procedures affected various aspects of mental health care. Lilli and Lisa felt that their work was impacted by politics and bureaucracy. Lisa said that the institutions providing mental health care on her reservation could occasionally serve as barriers to counselors feeling confident with their place in the larger system, and this could impact the counselor's interpretation of their role, and possibly, the quality of care they provide.

Additionally, a concern raised by Lisa related to the lack of training and experience of some of those in decision-making and leadership positions. She explained:

But, let's say a manager of a mental health system who has no degree, has no clue of treatment planning, can come in and make these decisions for our clients that are not based on any evidence, it's based on emotion and maybe some family tie. It is this confusion. It's this confusion.

Lilli shared a similar sentiment, that she felt this was not helpful to community members who were seeking counseling services due to the way that Tribal politics and policy could interfere with the process. Due to this, participants reported feeling as if a system of "red tape" served as a

barrier in the disbursement of therapy services in their communities, which suggested the need for change in this area. Lisa expanded on this:

Tribal politics is huge. You have this oppression that is on the reservation that people can often feel but they can't name it. ...It is so oppressive and when you're out and realize what you were working in and knowing Tribal politics and knowing [that it] changes every two years.

Additionally, Lilli discussed the way in which support programs and policies on her reservation had inadvertently caused people to become dependent upon it. She theorized that this had created a cycle of dependence on Federal or Tribal assistance. Further, she found it frustrating that this system was enabling people, saying that she felt that many of these people are fully capable of working to support themselves, but, "some of them are dependent...the reservation has made some of the people dependent."

Theme 3: Four Forms of Trauma Impacting the Counselor and Their Work

All three participants discussed the role that trauma has on the work they do as counselors. Through analyzing the data, a thread appeared that connected the four themes across participants. There is a large amount of trauma that occurs on reservations. Participants' reflected this by sharing a significant amount of statements about trauma. In phenomenological study, it is important to use the participants' own words to fully understand their experiences, therefore, the participants' statements about trauma in their entirety are presented in (Table 2).

Table 2

Participant Trauma Statements

Mary	Lisa	Lilli
“trauma exists everywhere it seems like.”	“Our communities are so small and the amount of trauma is just in your face all the time so you can’t escape it	“There’s definitely some trauma ... they’ve been given, this generation at least, this younger generation, and then, the next.”
“[The work] can be challenging at times because of the significant level of trauma, or multiple traumas that people have.”	“I did work with some adults as well, but it was all trauma.”	“We just had a woman commit suicide and kill her children. And we worked with her. I worked every day with her. ... It happened and it hit everybody really hard and ... it’s taken its toll on the workers as well as the clients and the surrounding people ... It’s hard.”
“So for me... I’m aware of [the traumas], because I live here and I experience them. I experience the deaths, or the losses or the fires or whatever they happen to be in the same way that an individual that might be affect[ed] by it does.”	“So [trauma] is just ongoing and it keeps going and well, I have these family secrets”	“That is what I’m kind of working with is trauma.”
“[There is] lots of domestic violence [on the reservation].”	“...cause you’re from the same community, [people] flood you.... what’s going on and they’re all traumatized as well.”	
“Suicide is a real risk in the sense that many people that I’ve worked with have had that ideation since childhood ... It seems like it’s present all the time.”	“I did work with some adults as well, but it was all trauma.”	
“The most taxing part of my counseling work would be the level of suicide ideation that people have.”	“this thing keeps popping up is... a ton of sexual trauma that isn’t talked about.” “... I had a 15-year-old student that had come to me, who was traumatized over the weekend, she was sexually assaulted.” “I would really like to inspire our people ... heal over the educational trauma that’s there.” “As a mental health counselor on a reservation you’re dealing with trauma, trauma, trauma.” “... the amount of childhood sexual abuse that isn’t talked about and the secrets and all of that makes it very difficult to get to the root of problems.”	

By analyzing these finding statements in the data, it became clear that one way in which trauma impacted counseling on reservations was how trauma had reduced the number of clients that a counselor was able to see in a day. There is already a need for counselors on reservations and when a significant amount of the counselor's time is spent providing support to one person who recently experienced a trauma, the quality and quantity of client-care is negatively impacted.

In addition to the administrative side of how trauma effects counseling, the frequency of exposure to clients' trauma was found to effect participants' personal lives. Participants noted that, by living and working within the same community, they experienced a heightened level of awareness about events occurring in the community, including the traumatic events. The impact that this community awareness has on the participants is worth noting. For example, when a tragedy occurs to a person in the community, it is almost as if everyone else in that community could feel it as well, this is the phenomenon of a shared experience. One participant talked about a difficult experience that occurred in which one of her clients had tragically taken the lives of her own children, then committed suicide. This participant elaborated, saying:

I worked every day with her. And it happened and it hit everybody really hard and so it's taken its toll on the workers as well as the clients and the surrounding people you know. It's hard. And it's close, because everybody knows everybody. It's not like a big city or anything. So when something happens it happens to everyone. And they feel it.

This exemplifies the way that a traumatic event on a reservation is experienced on a micro and macro level. In this story, the tragedy happened to one family, but the resulting trauma was shared with a larger circle of family and friends. And this ripple continued in waves until it reached a point when the negative effects of one trauma was felt by everyone in the community.

Forms of trauma

There are different ways in which trauma can be experienced. In this study, the participants discussed various kinds of trauma they had experienced directly or indirectly throughout their counseling careers. After reviewing the data in more detail, four forms of trauma emerged: (1) sexual trauma and domestic violence, (2) generational trauma, (3) suicide, and (4) educational trauma. A discussion of each form of trauma is provided below.

Sexual trauma and domestic violence

Trauma stemming from sexual abuse and domestic violence on the reservation was significant. Lisa reflected on the impact of a culture of silence that existed surrounding sexual trauma: “I look at the amount of childhood sexual abuse that isn’t talked about and the secrets, and the family, and all of that makes it very difficult to get to the root of problems.” For many victims of sexual trauma, disclosing the details of the event is an overwhelming prospect. However, in order to process the painful event in a counseling session, it starts with the counselor’s knowledge of the occurrence. Whether or not a counselor will be privy to this information depends on the client’s openness and willingness to reveal these traumatic parts of their past, and for many clients, this topic is off-limits.

Across interviews, participants discussed the impact that domestic violence had on their clients and communities. Some participants reported domestic violence is commonplace on their reservations and that it resulted in various pathologies. For example, Lilli talked about one outcome of trauma relating to domestic violence; she noted that this type of trauma seems to frequently cause the victims to self-medicate by abusing drugs and alcohol to help them cope with the trauma.

Lisa pointed out that she had known of other professionals who had been experiencing domestic violence within their homes, but she questioned whether these victims were adequately treating their own mental health. Basically, there exists a sequence in which a victim of domestic violence goes to work, provides counseling and support to another victim of domestic violence, to then return home to dysfunction and violence. It is clear, then, that there are people who have committed their professional lives to helping others that are in need of help as well.

Generational trauma

There is a ripple effect pertaining to the transmission of trauma's effects from one generation to the next. The results of a systematic oppression that an entire generation of people experience negatively impacts future generations. Lilli discussed this, saying:

Because their lives are so difficult, lots of poverty on the reservation, lack of motivation I think because they've come up through generations of-of being, um, ugh, it's just, it can be really hard cause it's generations, maybe three generations you go back I would say to find people that aren't so...they've always been oppressed, but, but the last three generations I think have turned to more like the drugs and alcohol. Their parents, then their parent's parents, I can look back at some of the grandparents are even selling drugs up here.

Reservation counselors face the compounding stress that occurs in the wake of the trauma and have a sense of responsibility to alter or stop the cycle of trauma. However, participants noted that this was a difficult, but necessary, element of counseling that aims to address the wellbeing of the community as a whole.

Suicide

The trauma that surrounds events related to suicide ideation, suicide attempts, and suicide completions is another facet to the dysfunction occurring on reservations. Mary talked about this saying:

But the most taxing part of my counseling work would be the level of suicide ideation that people have. That's the most taxing part of my work. Um. Because, you know, keeping a person safe or doing safety plans, um, and exploring that with an individual is ... I mean that's something for me that doesn't leave me. When that person leaves the room, I still carry that person with me.

Reservation counselors report having a keen awareness of the risk for their clients, and others in the community, committing suicide. One participant, Lisa, discussed how suicide and sexual violence had affected her. She shared a story about how a series of tragedies affected her one of her clients (see Appendix F). Through this story, Lisa was able to provide a poignant example of the domino effect that trauma has within a single family and within the larger community. At one point, Lisa reported that she was becoming aware of an increase in her feelings of anxiousness when retelling this story, however she did not indicate that this was causing her significant stress or that she was in need of counseling intervention at that time.

Educational trauma

A form of oppression that exists on the reservation is related to the quality and overall lack of educational opportunities. Lisa shared what she considers an educational trauma that exists on her reservation. She discussed how she believed that a lack of higher education options, as well as pay disparities, negatively affected the rate at which young people who leave the

reservation to further their education and training, will end up not returning to their communities to live and work.

Theme 4: Counselor wellness and strategies for self-care

Finally, all three participants discussed the importance of counselor wellness and factors that affected it. When counselors lived and worked in the same community, it effected their personal wellness. This experience was not specific to counselors alone, as participants indicated that there were other professionals in their communities who may have been experiencing the interplay between work and wellness.

Additionally, any personal trauma experienced by a professional was an important facet of wellness. For example, one participant discussed that she had observed other agency employees and administration members who had been affected by their personal trauma. This participant felt that the emotional and behavioral results of these traumas were being manifested through the use of unhealthy coping skills, such as increased social media use, nicotine use, and lack of exercise. She felt that it seemed as if some of her professional peers were likely not addressing their own issues head-on.

For Lilli, she shared her feelings that had resulted from her work and how she eventually began to question herself. She explained that she found herself at a point in where she was beginning to have serious doubts whether or not the counseling services she provided people had a positive impact on them. However, she said that this may have been partially due to the large number of mandated clients on her caseload. She suggested that clients who were required by the court system to attend counseling were often times unwilling to fully participate in their treatment, which resulted in her own doubts about her professional efficacy. Further, Lilli acknowledged that there were times when she questioned whether or not she was doing enough

to help her community. She said, “then some [clients] do come in and they’ve told me, I get feedback that I’ve helped. But you know, there’s always that feeling that you could do more.” These moments of doubt resulted in periods of time when she was unsure if she would be able or willing to continue in the counseling profession.

Participants reported that there were times when they felt they had to make a choice between their wellness and their work. Lisa offered her experiences of these self-imposed expectations, stating, “I guess what I want to say is that, I can speak for others and for sure myself, is that there’s many of us that want to be [on our reservations], working with our people, um, and we’re choosing not to because sometimes you have to choose your mental wellness and your physical wellness over that.” This suggests that there is a point at which a counselor must take an honest look at the sacrifices they are willing to make in order to help everyone else but themselves.

The counselor’s personal life

Participants indicated that there were times, throughout their careers, that their work as counselors negatively impacted their lives. Lisa shared a moment when she felt that her work life had crossed over into her personal life, and how this potentially altered the course of an important relationship in her life, her marriage. She reflected on a specific moment from her past where she realized that her work was enveloping her:

I remember having my baby in my arms and I was putting her in her crib, she must have been 4 months old, as my phone was between my ear and my shoulder taking a call. And it was a moment I stepped back. And I was like. ‘[Lisa] what, what are you doing? This is overtaking you.’ I was realizing this wasn’t a life that I wanted. And there was [sic]

moments like that where I'm like, 'I am actually jeopardizing my family time and my own wellness and time with my husband'.

This story exemplifies how a counselor's personal life and relationships can slowly become overshadowed by the intense demands of work.

Additionally, Lilli discussed how her personal and professional lives had collided in the past, and it was at this intersection that she felt her ability to continue working as a counselor was in serious jeopardy. In her story, Lilli shared about her adult child and how they had been dealing with chronic drug and alcohol addiction. As a mother, this took an emotional toll on her and eventually became a barrier in her ability to continue counseling others. This deep and personal involvement with her child's addiction issues, had been coupled by her professional responsibilities to provide counseling to her clients' addiction issues, resulted in a combination of overwhelming experiences. Lilli described the difficult decision she had made to suspend her work as a counselor so that she could focus on her family, and eventually how she did return to work later on, at a point when she felt she was emotionally ready.

Another participant discussed how her family members had experienced the tertiary effects of her work. Lilli noted that her husband had to learn to accept that her self-care was a vital part of her overall health. She described this saying:

[He] has really allowed me the opportunity to do whatever I need to do to take care of myself. And that means, whether that means [cough], saying I won't be home 'til 8 this evening cause I'm going to go here after work. Never having to question or never having to justify my reason for participating in community events. That's really been, really good for me.

It is evident that, in addition to the counselor navigating the effects of working a demanding job that causes considerable stress, their family members are faced with a process of adaptation as well.

Strategies for self-care

Through the data analysis process, three types of self-care emerged: (a) mental and emotional self-care, (b) physical self-care, and (c) cultural self-care. Each of these categories of self-care often occur in conjunction with one another, however, when examined individually it is clear that they are also quite unique.

Mental and emotional self-care

During their interviews, both Lisa and Lilli disclosed that they were utilizing counseling services for themselves. They shared how this had proven to be an effective way for them to address their own mental and emotional wellness. In fact, Lisa argued that therapy should be a part of self-care for everyone. She firmly stated, “I think that everyone should be in therapy if you’re working on a reservation. If you don’t have problems, then there’s a problem.” She then shared her own experiences with counseling by noting that she was continuing to see a counselor for many years now and believed that it was through this process that she gained insight on herself and on the triggers that had been impacting her mental health.

For Lilli, she came began using counseling as self-care, but credited the persistence of a fellow health care professional in her deciding to take action. Lilli had been encouraged, multiple times, by a medical provider at her community’s Indian Health Service (IHS) clinic to attend counseling. This provider had cited the pressure and stress that Lilli had regularly reported in their appointments as a case for counseling. Lilli said:

And now, believe it or not, I never thought I would do it but I'm actually seeing a therapist myself. I've had two sessions with her. I just broke down and [went to therapy]. I've just been stubborn. I can do it myself. [laughs] It's stupid, it's like a doctor trying to treat themselves. It's silly, you can't.

She admitted that it took a fair amount of time for her to be convinced, but she finally agreed to begin seeing a counselor, and she attributed this shift in her self-care paradigm to the consistent, but gentle, urging of her IHS provider. Lilli believed that her provider was able to see her from an objective point of view and could see how the pressures of her job were affecting her mental and physical health.

In Mary's experience, emotional and mental self-care consisted of her carving out small pockets of time between client sessions when she would use a combination of her Christian teachings as well as more traditional Native American ways of healing. Mary had incorporated these smaller self-care practices, such as prayer or meditation, while driving in her car during her commute to and from work. While the mental and emotional part of self-care was being addressed, participants also indicated there were other ways in which they would focus on their wellness.

Physical self-care

For self-care to be successful, participants noted that it was important for them to consider how to incorporate the physical aspect of self-care. For example, Lisa emphasized a holistic approach to self-care, stating, "I need to take care of my body and myself and my mind." She elaborated on this by describing her method of physical self-care that consisted of regular and intense exercise, such as running. She found that this provided her with some relief from the

stressors of work. For Lisa, exercise also served as a cathartic experience where she could physically release emotions that had been building up within her.

The importance of physical self-care was something that participants indicated was being recognized at an institutional level as well. They described how employers had begun to acknowledge the importance of counselor self-care by establishing protocols to address these needs. For example, some of the participants' employers began offering all of their employees a specific amount of protected time, either once a day or time allotted per week, that was to be used for self-care practices of their own choosing. One participant noted that for counselors at her agency this included exercise, but for others, this involved professional growth through continuing education opportunities.

Spiritual self-care

The final type of counselor self-care is related to spiritual wellness and the role it has on one's personal wellness. Participants were able to make a connection between the way their communities experienced trauma and the way that trauma manifested itself in the counselors within that community. Among many reservation communities, there is a spiritual element in which the community of people move toward healing together, and this was reported by participants to be a significant aspect of counselor healing. Lisa offered her experiences of utilizing teachings that were passed on to her:

So I feel like I got teachings from my elders of, you know, just take tobacco before you see a client and all of their stuff, you can hold that. That's part of your job. That's part of your calling. That's an honor to be able to listen to somebody's story but you cannot hold on to it, you take some tobacco and put it by a tree and take it.

Through this practice, Lisa discovered the importance of finding a balance between the responsibilities she had to help her people and the awareness needed to manage her own wellness.

Part of the uniqueness of counselors who are Native American is that, for many, providing counseling to other Native American people results in a shared cultural experience occurring between the client and the counselor. Mary acknowledged this aspect of professional self-care by saying:

The other benefit, or the other uniqueness is, is that I can write into the treatment plan, and be able to carry out, participation in community ceremonies with my clients. So taking them to a language circle or taking them to a healing ceremony or taking them to a pipe ceremony. That if I include that in the treatment plan, you know, pulling from the diagnostic that culture is important, that we use it as far as treatment, into the treatment plan and then into the daily, um, or weekly visit that I can actually meet with a client in a healing ceremony and use it as part of a therapy session.

By sharing this, Mary had suggested that by helping others, counselors can also experience a benefit.

Through analysis of the data, it became evident that there is a shared experience of healing that occurs between a counselor and their client. This process of ‘healing alongside’ or ‘healing by association’ occurs when a counselor leads the client in a therapeutic method of healing, and, as a result, is able to find relief in it as well. An example of this was given by Lisa, who noted that she would often bring her clients to a sweat lodge ceremony, or *inipi*, as a part of their therapy. Adding that she would also participate in the *inipi* with them.

Shared healing between a Native American counselor and a Native American client has become an important aspect of counseling. For some, the use of some cultural practices occurred within the confines of the counseling session, but participant's noted that there were times when, outside of the regular session time, they would extend the session by taking part in a ceremony alongside the client.

While this is a helpful method of healing for Native American counselors and clients, Mary asserted that these shared experiences must only be utilized while maintaining professional and ethical boundaries. She discussed the importance confidentiality in these instances. She reported that she was always mindful to never reveal anything confidential about a client during any ceremony. These boundaries also extended to the counselor as well. Mary explained that she found it important for her personal wellness to she attend traditional Native ceremonies without any of her clients in attendance. Lisa echoed this sentiment, saying, "so then I would make sure I was able to go to a full moon ceremony or a sweat or something without any clients so that I could take what I kind of, whatever I take in, that I was able to release, and then also release my own stuff as well."

There are specific Native American ceremonies that are specific to women, and Mary noted that these ceremonies had provided an environment for her to heal alongside her Native sisters. She furthered this point by sharing her experiences with this:

I participate in a woman's, a traditional woman's moon ceremony once a month. Just going there being around women that I trust. Women that I can share what I'm carrying, without, you know, disclosing anything confidential about any clients, but just like the number of, or level of stress that I've been feeling over the last month. And it's done in a traditional circle process, so it allows me to be, um, to share whatever I have to share and

then, um, release some of it as part of the ceremony in terms of putting in, putting my prayers into the fire and asking for, um, making my tobacco tie and then asking just for healing and ongoing courage to do the work that I'm doing.

For Mary, she felt that female-centered healing practices provide a great opportunity for the female counselor's self-care.

In addition to these traditional methods of healing, Mary mentioned other therapeutic self-care strategies such as meditation, journaling, drawing, and mindfulness practices that she would teach her clients, and then take part in along with them in the session. She was able to sum this all up by saying, "community healing is also part of my own healing." There is an importance placed on, not only individual wellness, but also the wellness of the community as a whole. These ceremonies create a space for Native American counselors to utilize their traditional teachings to help them spiritually heal from all of the intense emotions they often experience.

Summary of Chapter IV

Chapter four reported the findings of this phenomenological study of three Native American counselors' experiences working on a reservation. The interview data was coded to identify common themes. This analysis revealed that participants had several shared experiences and these were reflected in the following four themes:

- 1. The worth and weight of working on a reservation.** Participants expressed both positive and negative experiences in working on a reservation. Participants stated that they found satisfaction through the services they were providing to their communities, this was interpreted as the "worth" they found in doing their work. However, they noted

that there were significant difficulties as well. These difficulties, interpreted as the “weight” of responsibly in providing counseling on a reservation was classified.

- 2. The impact of culture and community on counseling.** Participants described the experience of providing counseling services on a reservation as being unique, in the way in which there is an incorporation of Western counseling techniques and theories along with traditional Native American healing practices. Four sub-themes emerged in the data – Native American culture, the reservation community, the rurality of the reservation, and institutional policy influence.
- 3. Four forms of trauma impacting the counselor and their work.** Across participant interviews, there was a common thread of trauma that connected their stories. Participants noted that the amount of trauma present on the reservation was significant, and it had a profound influence on their work. Four forms of trauma were identified through participant interviews: (a) sexual trauma and domestic violence, (b) suicide, (c) generational trauma, and (d) educational trauma.
- 4. The effects of personal and professional wellness on counselors.** The importance of counselor wellness and the factors effecting it had been highlighted by all three participants. Participants reflected on their own wellness and how it had been compromised at times. Participants noted that there was an intrusive nature of their work and that this was the primary factor in the decline of their personal and professional satisfaction. To combat this, participants discussed strategies for self-care that they had found beneficial. These strategies were categorized into three areas of self-care, physical, emotional, and spiritual.

Chapter five provides a discussion of the research results which are presented in relation to existing literature and will be introduced as a contribution to the profession of counseling and counselor education and supervision. Additionally, implications for future research are discussed.

CHAPTER V. DISCUSSION

Native Americans rank higher than any other racial group in mental health disparities (Brave Heart et al., 2011) and, in counseling research, the Native population consistently remains largely understudied. Specific research on Native American mental health issues is inadequate, and research on Native American counselor wellness is non-existent. (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012; Williams, 2018). Through this study, I hoped to fill this gap in existing research by exploring what the experiences of Native American counselors are, and how these experiences can be used to inform research and policy change going forward.

In this chapter, I discuss the findings from the present study in relation to the limited available research. The lack of existing research underscores the need for this qualitative study. The following research question formed the basis of this study, “What are the lived experiences of Native American counselors working in the trauma-intense environment of a Native American reservation?” Through the use of Interpretive Phenomenological Analysis (IPA), this study achieved its goal, which was to identify the themes that emerged from interviews with three Native American counselors in order to gain an understanding of the experiences of this unique population of professionals. The implications for counselor education, tribal and reservation administration and policy, research, and the practice of counseling on reservations are provided. Additionally, transferability of the current study and future recommendations are presented.

This phenomenological study resulted in four themes capturing the essences of three Native American counselors’ experiences while working on a reservation. These themes and sub-themes exemplify the dynamic and unique experience of counseling in an environment that is impacted by high rates of trauma, but is also informed by the cultural underpinnings throughout the environment in which it exists. The following themes were identified in the data

analysis and will be discussed below: (a) the worth and weight of working on a reservation, (b) the impact of culture and community on counseling, (c) four forms of trauma impacting the counselor and their work, and (d) the effects of personal and professional wellness on counselors.

The Worth and Weight of Working on a Reservation

Participants shared both positive and negative experiences with respect to their work as counselors on the reservation. There were four finding statements related to positive experiences, for example, feeling as if they were making a difference in the lives of the people they serve and communities in which they live.

In addition to the worth found in counseling on the reservation, participants reported experiencing negative aspects concerning the lack of treatment providers on the reservation. Two participants addressed this in regard to how large numbers of clients on their caseloads prevent them from adequately meeting the needs of everyone. These current findings underscore a fundamental issue that early research reported over fourteen years ago—that a lack of reservation healthcare funding negatively impacts residents' access to mental health care providers (Duran et al., 2009; Grandbois, 2005). The current findings also point out that this treatment provider shortage results in existing providers being overwhelmed by (a) the number of clients on their caseload and (b) the nature of clients' presenting issues. In addition, these findings also confirm longstanding research that shows how counselor turnover rates impact both clients and counselors (Lamb et al., 1998).

Another challenging aspect of their work as counselors relates to the boundary that exists between the Native provider and their own Native community. This is reflected in no less than twelve finding statements related to the challenge of counseling a person who is a part of a culture that typically processes major events in a collective manner. This finding aligned with

previous studies by Galbraith et al. (2006) and Portman & Garrett (2006), both of whom noted the prevalence of Native American communities operating within a collectivist framework. Thus, this movement from a collective process paradigm to an individualist process paradigm sets up a paradox for healing on at least three levels. First, the client, who is part of the collectivist culture, is required to separate from the culture as a whole in order to heal from the trauma both cultural and personal trauma. This creates another fracture in the cohesiveness of the culture, without which the client cannot heal. Second, this practice of individualism sets up a paradox for the Native counselor who is also a part of the community as a whole—requiring the counselor to also “step outside” the community in order to help both the community and the individual. However, this “stepping outside” also cuts off the counselor from those healthy avenues of healing that would ensure the counselor’s personal emotional health. Finally, this paradox affects the community as a whole because without the collectivist participation of both client and counselor, the community cannot heal. This study’s findings display the unique way in which a collectivist paradigm can impact the diffusion of trauma through a community or culture. The results of a singular traumatic event can cast a wide net on a reservation community, and the counselors there are impacted by the increasing amount of counseling work that this requires.

The prevalence of drug and alcohol addiction within reservation communities significantly added to the “weight” of the participants’ work. Two participant statements addressed addiction on the reservation and the effect that it has on the counselors working there. For example, one participant shared the way in which addiction had impacted her on two levels: personal and professional. To treat addiction that has become increasingly common on reservations requires the presence of reservation-based chemical dependency treatment programs. In fact, statements from the United States Substance Abuse and Mental Health

Services Administration [SAMHSA] underscore this, noting that Native Americans are more likely than other racial group to be in need of substance abuse treatment (SAMHSA, 2013). The lack of substance abuse treatment options on reservations affects not only the lives of community members, but also the lives of the mental health professionals treating and managing the social and emotional consequences of substance abuse.

An additional aspect to the weight of the work of a reservation counselor relates to the frequency of clients presenting in a crisis situation. This is reflected in nine separate finding statements relating to the impact crisis has on the experience of counseling on a reservation. Specifically, participants discussed the challenges that frequent client crises have on their ability to incorporate Western therapy approaches with their clients. One participant went as far as to say that often times she found that she was doing, “crisis counseling over therapy.”

The way in which client crises affects counselors has been examined in previous research. For example, research in the field of crisis counseling has focused on the way that frequent contact with clients’ crises effects counselors. Specifically, McAdams III and Keener (2008) reported that counselors will often fail to identify that they too are, in a sense, a survivor of a client’s or community’s crisis event. This study’s findings did not address the emotional effects of crisis counseling specifically, however it should be noted that in a central research study completed in 1999, Foster and McAdams III identify three common responses from crisis counselors’ exposure to client crisis, these are guilt, self-doubt, and anxiety. These responses, combined with the frequent practice of crisis counseling reported by this study’s participants, must be taken into account in discussions about the education and training of counselors working on a reservation.

The Impact of Culture and Community on Counseling

The unique nature of providing counseling on a reservation was discussed by every participant in this study. Through the data analysis process, there were three elements of this experience that emerged, they were: (a) the influence of cultural practices, (b) the role of institutional policy, and (c) the rural location of these reservation communities.

First, there is a distinct blend of culture and community that exists on the reservation. Two participants, Lisa and Mary, reflected on how this intersection has affected them. Between these two participants, there were eight finding statements that addressed the interplay that exists between their Native American cultures and their work as professional counselors. Lisa and Mary both believed that combining Western counseling theories with their traditional Tribal spirituality was positively impacting their clients. My findings indicate that, for counselors to provide the most beneficial and effective services on the reservation, counseling must incorporate elements of traditional healing. This confirmed foundational research that studied cultural healing and Native American mental health outcomes (Brave Heart, 1998). In this study of 45 Lakota service providers and community leaders, Brave Heart (1998) found that participants had reported an overwhelmingly positive response to the incorporation of Lakota ceremonies in managing their symptoms surrounding grief and loss. Ultimately, the Brave Heart (1998) study found that it is to a client's benefit that their counselor includes cultural practices, as well as Western counseling theory, to aid in healing.

Second, multiple participant statements discussed the influence that institutional programming and procedure had on reservation-based mental health care. Between two participants, there were nine finding statements that related to this issue. An example comes from a participant who had discussed her frustration with the lack of a standardized policy relating to

the dissemination of counseling services on the reservation. She felt that the lack of consistency in the administrative management of services resulted in confusion and dissent among providers and agencies over elements of care such as initial paperwork which would ensure the proper financial channels would be incorporated in client care.

Additionally, these participants lamented that there were instances in which Tribal politics negatively influenced institutional decisions that were made, for example, one participant felt that there were cases of nepotism within her agency relating to the promotion process. The structure of administrative policy was found to have an important impact on employee satisfaction in this study. In fact, previous research has examined how employee perceptions can affect many facets of job satisfaction and performance. For example, the results of a study by Knight, Landrum, Becan, & Flynn (2012) found that the likelihood of counselor turnover was, in part, related to whether or not counselors felt that institutional change was warranted and if they felt that this change was even likely to occur. In other words, when counselors believe that their concerns are being disregarded by the administration, it can impact their willingness to remain at their place of employment. This highlights the importance for an administration to provide clear strategies to streamline the dissemination of services and to provide these services in a timely manner.

Third, this study found that the physical location, or rurality, of many reservations has an impact on the transmission of counseling services. Most Native American reservations are located in rural areas (SAMHSA, 2013), therefore, this does not affect only a few Tribes, rather it affects Tribal members across multiple reservations. One way this was expressed in this study was through participant statements about how they were impacted by regularly having to drive long distances to attend counseling appointments or home visits. Simply put, the time a

counselor was spending in their car was time that would be better spent actually providing counseling services. For example, a participant noted that there were instances where she had to drive over an hour to get to a single counseling appointment, drive an hour back to her office, and then drive an additional hour in the opposite direction for another appointment. The rurality of most reservation communities serves as a yet another barrier for Tribal members to receive mental health care. This was discussed in previous research by Katz (2004), noting that one obstacle for Native Americans to access mental health care was due to the distance between hospitals and clinics on reservations. Other studies have concurred, finding that gaining access to mental health care is beyond the reach of most Native American people (Grandbois, 2005). The solutions identified that are needed to adequately provide health care to people living on reservations is to increase funding for additional staff, resources, and programming. However, as Grandbois (2005) pointed out, Indian Health Service (IHS) is the responsibility of the U.S. government to the Native American people that has been underfunded and largely ignored.

Four Forms of Trauma Impacting the Counselor and Their Work

Consistent across participant interviews, was the discussion of trauma. All three participants shared their common experiences with living and working in their reservation communities. Similarly, all participants reported that this experience impacted their counseling practices. The reach of a traumatic event was discussed by Evans-Campbell (2008) who found that men, women, and children who are from different families and different Tribal clans or bands, can all be impacted by the same singular traumatic event. Therefore, it is clear that the role that trauma has on a close-knit community, such as a reservation community, is significant. Through data analysis, it became clear that there are four distinct forms of trauma impacting

counselors: (a) sexual trauma and domestic violence, (b) generational trauma, (c) suicide, and (d) educational trauma.

Sexual trauma and domestic violence

The impact that sexual and domestic violence has on a reservation was evident in this study's findings. Between two participants, there were six finding statements relating to the experiences of treating clients who were sexually traumatized and one finding statement that related specifically to domestic violence. Reservation counselors are exposed to the stories of clients' sexual trauma on a regular basis. The importance of this issue is underscored by the statistics. The National Congress of American Indians Policy Research Center (2018) reported that violence against indigenous women in the United States is incredibly high. In fact, these reports indicate that the majority of Native American women (4 in 5) have experienced some form of violence during their lifetimes, and of these women, more than half identify experiencing incidents relating to sexual violence. Additionally, nearly decade old research found a similar statistic, that Native American women experience more violence than women from any other race (BigFoot & Schmidt, 2010). This suggests that, for Native American women, the odds of them experiencing a sexual trauma are not improving. Therefore, the high rates of sexual trauma occurring on reservations across the country requires an equally significant response to the physical and mental health care of victims and community members.

Generational trauma

There is a forward movement of trauma going from one generation to the next and is an important context in which to view Native American trauma. Central research on this topic indicated that historical trauma compounds through time from generation to generation (Evans-Campbell, 2008). In this study, there were four finding statements relating to trauma's passage

from one generation to the next. Participants discussed how clients are effected, not only by trauma they themselves have endured, but also by the trauma of past generations. In this study, the findings were more specific to the role that an immediate family system has on trauma. For example, Lilli shared how she once worked with a client who was a drug dealer and had come from a long line of drug dealers. Lilli pointed out that, because her client was a third-generation drug dealer, they had been surrounded by the culture of drugs and addiction throughout their whole lives. She went on to share that because this client's parents and grandparents all had histories of selling drugs, it became a normal part of this person's world.

Suicide

Discussion surrounding the topic of suicide was present in all of the participants' interviews and five finding statements related to the high incidence of suicide among Native Americans. This study found that the topic of suicide was a significant source of client and counselor traumatic material. Lilli and Mary both shared specific examples of times in which they were impacted by the suicide of a member of their communities, with Mary admitting that the high rates of suicide and suicidal ideation in her community is, "the most taxing part of [her] counseling work." The clients' stories surrounding the suicide of friends and family were identified as being among the most difficult for these counselors to listen to.

This frequency of contact with suicide in counseling is congruent with the statistics. Suicide among Native Americans continues to be a significant health issue (Curtin, S. & Hedegaard, H., 2019). Past literature has examined the issue of suicide in Indian Country and it is apparent that the rates of suicide among Native American people has long been a consistent health concern (Brave Heart et al., 2011). Further, the current study reports on a specific aspect

of this issue, and that is identifying the way in that a significant trauma such as client suicide, impacts the wellness of counselors working on a reservation.

Educational trauma

Educational trauma was mentioned by only one participant in this study. However, that must not diminish the importance of this issue and the ways in which it has been addressed in previous literature.

Historically, the era of Bureau of Indian Affairs (BIA) boarding schools stretches back to the 1700s. These boarding schools were the product of the Office of Indian Affairs (now known as the BIA) as an attempt to “civilize” Native American children. Essentially, the history of these boarding schools resulted in systematic cultural and educational trauma which has affected generations of Native American people (Brave Heart, M.Y.H. & DeBruyn, L., 1998).

The concept of education is highly valued and there is a great deal of value placed on education among Native American people. This has been established in previous research, for example, in a study done by Grandbois and Sanders (2012) in which a qualitative methodology was employed to understand the experiences of a group of Native American elders. Here, it was reported that there was a strong level of importance placed on education and employment within participants’ Native communities. Additionally, this research notes that this finding is applicable at both an individual and community level (Grandbois & Sanders, 2012).

The Effects of Personal and Professional Wellness on Counselors

The current study examines a specific group of counselors’ experiences in order to adapt a paradigm of counselor wellness that is specific to Native American practitioners. To provide adequate and appropriate mental health care services to people living on reservations, it is imperative that the wellness of the counselors providing these services is ensured. The findings

of this study indicate that providing counseling on a reservation impacts the wellbeing of counselors.

Counselors, like many helping professionals, must have the ability to separate work stressors from their personal lives in order to maintain a system of healthy boundaries. In this study, participants reflected on times when they were not able to successfully separate their work from their personal lives. The way that work impacts the person has been established by previous research. In fact, there is foundational research that has found that the exposure to a client's traumatic material has an effect on the counselor and that this compromises the counselor's own wellness (Lawson et al., 2007). All three participants made a correlation between their work as counselors and the adverse effects it has had on their wellness.

There were several finding statements in this study that addressed counselor self-care. In order to remedy symptoms caused by the occupational stress syndromes, participants in this study identified self-care strategies. Through analysis of the data, three sub-themes of self-care emerged: (a) mental and emotional self-care, (b) physical self-care, and (c) spiritual self-care. This finding echoes the very definition of wellness, that wellness is a person's intentional approach to both a physical and psychological state of health (Day-Vines & Holcomb-McCoy, 2007). The American Counseling Association (ACA) similarly identifies areas of physical, mental, and emotional wellness throughout the ethics code in reference to counselor impairment (ACA, 2014). It is clear that mental, emotional, physical, and spiritual wellness is a vital aspect that must be considered in self-care solutions for counseling professionals.

Participants discussed occupational stress syndromes in this study, but did not formally categorizing them as being secondary traumatic stress, vicarious traumatization, or burnout. However, the resulting pathologies of these syndromes can be inferred. Participants identified,

either with specific examples or broader generalizations, that the five factors of occupational stress syndromes were a part of their experiences. According to Galek, Flannelly, Greene, & Kudler (2011), these five factors are: “(1) frequent intense encounters with clients; (2) physical and mental fatigue states; (3) challenges to values, beliefs and world view; (4) exposure to traumatized clients; and (5) expectable stress responses” (p. 634). The implications relating to these factors were discussed by this study’s participants. Specifically, participant inclusion of trauma stories and examples, how their personal lives were impacted by their work, and the ways in which they found refuge in self-care and wellness.

It is important to note, however, that there has been little, if any, research done on how counselors who work in trauma-dense settings view the work they do, their sense of purpose in this work, their preparation for this type of work, and their personal wellness strategies. However, my study was successful in identifying a bridge for that gap in research, which then provided a starting point to further the discussion of Native American counselor wellness.

Transferability and Trustworthiness of the Data

The credibility and trustworthiness of qualitative data is important when considering its transferability. Of the procedures designed to enhance trustworthiness in a study, this study utilized the two most commonly used trustworthiness measures, reflexivity and member checking (Flynn & Korcuska, 2018).

To improve the quality of this study through critical self-awareness, a researcher reflexivity statement was provided wherein I reflected on my experiences, background, and assumptions to have an awareness of any influence these may have on the data. Additionally, I kept a field journal throughout the research process. In order to continue having an open and curious stance toward the data (Barry et al., 1999; Rodham et al., 2015), I used this journal to

record my thoughts, reactions, and feelings about the study. Additionally, a field journal was used to make note of any contextual data regarding participant interviews, including documentation of pauses in conversation, participant laughter, and any discernable emotional response by participants.

I utilized one aspect of member checking, which involved the return of data to the participants, allowing them to verify the accuracy of their transcripts (Birt et al., 2016). I returned the participant's transcripts to them allowing them the opportunity to review and correct their interview transcript as needed. One participant indicated a spelling error in her transcript, which I then corrected and documented. Additionally, I notified participants of the opportunity to schedule a member check interview, to which all participants declined, indicating that they felt no changes needed to be made in their interview transcriptions. Because participants declined a second interview, in which member checking procedures were to take place, an additional trustworthiness procedure was implemented.

This study included the use of an additional analytical investigator to review the presented data analysis and provide feedback. This feedback was used to procure the final data analysis results. This process, referred to as triangulation of investigators, allows for an additional researcher's assessment of the data. This inclusion of an additional researcher's analysis strengthened the design and builds confidence in the findings (Hays & Singh, 2012).

Lastly, in order to demonstrate this study's commitment and rigor, it has been established that the population that was sampled for the study was appropriate for the goal of the research. Documentation of the data collection and analysis procedures were given to also ensure transparency, as it is clear how the interpretations were derived from the data.

When reviewing the findings of this study, it was important to incorporate the spirit of phenomenological inquiry by asking: How does the description of Native American counselors' experiences working on a reservation compare with experiences of other counselors? Additionally, for those with no prior knowledge of this topic, one could ask: Do the findings of this study adequately provide a description of the lived experiences of Native American counselors who work on a reservation? It is the belief of the researcher that the answer to these questions is: yes.

Implications and Future Research

This study sought to add to the existing body of knowledge related to its subject matter and, in many ways, was the first study of its kind. In this study, participants shared their experiences of providing counseling services on a Native American reservation. In doing this, the following distinct elements of these experiences were identified: (a) counselors' perceptions and emotional responses to their work, (b) how the community and its culture collectively impact the counseling process, (c) how counselors are effected by frequent exposure to traumatic client material, and (d) how counselor wellness and self-care is impacted by these collective experiences. In addition, based on the findings of this study, implications are presented in the areas of counseling practice, counselor education and supervision, administration and public policy, and research.

Implications for counseling practice

There are multiple implications for the application of counseling services that can be drawn from this study's findings. First, providing counseling in a reservation setting, with a primarily Native American population, must include the cultural components of healing that are

specific to that tribe and their traditional belief system. This involves the inclusion of Native spirituality and ceremonies alongside Western approaches to counseling.

In addition, incorporating generational elements of healing may be beneficial to Native American counselors and their clients. Specifically, utilizing the teachings and experiences of family and community elders in the healing process is a way in which to find the connection of healing, but across generations.

There is a benefit for Native American counselors to provide services to their own community members, as this can allow for a deeper connection with and understanding of the client population. Additionally, counselors on reservations would find benefit in the utilization of trauma-specific counseling interventions, such as Eye Movement Desensitization and Reprocessing (EMDR), Adverse Childhood Experiences (ACEs) screening tools, and trauma-focused cognitive behavioral therapy (CBT) techniques.

Finally, implications can be drawn in regards to the wellness of counselors who work on reservations. Further development would be beneficial in order to review and establish self-care strategies that are specific to Native American counselors. For example, strategies that involve all three elements of self-care (physical, mental, and spiritual) through the use of tribal teachings.

Implications for counselor education and supervision

Multiple implications of this study are present in relation to the field of counselor education and supervision. For instance, recommendations are made for counselor educators to incorporate the following areas into their counselor training programs: an increased emphasis on counselor wellness and self-care, a more thorough understanding of occupational stress syndromes, specific strategies that may be useful in providing counseling to a largely disenfranchised population such as Native Americans, and the opportunity for counseling

trainees to become more aware of the unique experiences of Native American peoples, such as an understanding of the role that historical trauma plays in the experiences of many Native people.

Additionally, counseling trainees would benefit from increased academic and practical training about tribe-specific Native American mental health issues, as well as real-world examples of what the experience of reservation life is like. This can serve to give non-Native counselors a glimpse into what specific issues affect Native Americans and how they can use that knowledge to adapt their counseling practices going forward.

Furthermore, the education and supervision of counseling trainees would benefit from education about how to incorporate trauma counseling theory, tribe-specific cultural practices, and Western counseling procedures. This can be done by engaging in discussions about topics that relate to the ways in which a collectivist culture processes trauma differently than individualistic culture.

Finally, there is a benefit in equipping counseling trainees with knowledge about the implications of rural counseling and how geographical settings impact both clients and counselors. In order to address the isolation of rural counselors, specifically those working on reservations is through the creation of a Native American counseling professional peer support network. This has the potential to benefit rural counselors from across the country who may be in need of additional support. In fact, Killian (2008) pointed out the importance of this peer group intervention, as well as one-to-one counselor supervision sessions. Providing reservation counselors with an extended support system has the potential to surround a historically isolated and over-worked group of professionals with support from other Native American counselors as well as non-Native trauma counselors.

Implications for administration and public policy

The implications of this study on administration and public policy issues relates the establishment and continued support and promotion of counselor wellness and self-care. This focus on wellness could be accomplished in a variety of ways, such as the development of agency-wide cultural self-care practices (ex: *inipi* or other traditional ceremonies) that would be available to all workers, or through providing an amount of regular, protected time allowing professionals to establish their own methods of self-care.

Additionally, it is important for agencies to actively work towards streamlining the documentation and approval requirements in order to ensure that the distribution of counseling services is provided in an efficient and reliable manner. Finally, an increase in funding through grant programs or other initiatives may provide for additional counselors and other staff members on the reservation and would expand available resources and programming for community and staff. One way in which to expand the availability of services is through the use of technological advancements in distance learning and counseling services for clients, counselors, and all other staff members.

Staff developments and trainings could be more readily available on topics such as crisis counseling and brief counseling interventions that are specific to working with traumatized people. These trainings and educational seminars could be extended to members of the community as well, creating a network of knowledgeable citizens.

Implications for future counselor education research

Native American culture is diverse with many tribes and traditions across the country, therefore research focusing on additional Tribes and reservation communities would lend credibility to the findings of this study. Continuing to examine mental health issues that are

specific to Native American counselors is needed to further the understand the way to adequately meet the needs of this population. Additionally, broadening the research pool would be beneficial to the research. Specifically, future research could examine the experiences of Native American counselors who provide services to Native people in an urban setting, as opposed to a reservation setting. In doing this, a broader interpretation of the data is possible, extending the variables of counselor and client place of residence.

Finally, understanding the experiences of non-Native American counselors who work on reservations is a direction for future research. In order to provide quality and consistent mental health care on reservations, all counselors must be included in this conversation. This study was intentional in its exclusion of non-Native counselors as a way to initiate this field of research. Broadening the scope of experiences to counselors of all backgrounds and ethnicities is necessary in order to provide a comprehensive view of the experiences of reservation counselors.

Apart from this study, research on the topic of Native American counselors who work on reservations is, to my knowledge, nonexistent. The intention of the current study was to highlight the importance of this topic, to provoke counseling researchers to delve further into this topic, and to address the specific needs of counselors who work on reservations. Simply put, the goal of this study was to help the helpers, as they are stationed at the front lines in dealing with a mental health crisis. The current study represented the experiences of Native American counselors who have previously provided or currently provide counseling services on a reservation in the Upper Plains.

Conclusion

Research in the area of mental health issues specific to Native Americans is inadequate. It has been long understood that good mental health research is foundational to good mental health

clinical practices. This is especially true for empirical research on sound clinical practice of providing counseling to the population of Native Americans who are living on a reservation. Native Americans make up nearly 2% of the United States population (United States Census [U.S. Census], 2010) and continue to remain largely understudied. This, in addition to the high rates of mental health issues afflicting Native peoples (Brave Heart et al., 2012), indicates there is a great need for counseling research in this area.

This study's purpose was to explore the lived experiences of Native American counselors working on reservations. An Interpretive Phenomenological Analysis (IPA) approach was utilized to obtain the first-hand accounts of Native American counselors who work on reservations. The findings of this study identified four themes that emerged from the data about the participants' shared experiences – the worth and weight of working on a reservation, the impact of culture and community on counseling, four forms of trauma impacting the counselor and their work, and the effects of personal and professional wellness on counselors.

Additional research is warranted to extend the study to include a new sample of counselors, investigating non-Native counselors' experiences, the use of different methodologies (e.g., case study, ethnography, etc.), and the deliberate application of wellness strategies specific to Native American counselors.

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APPENDIX A. NDSU INSTITUTIONAL REVIEW BOARD APPROVAL



January 28, 2019

Dr. James Korcuska
Counselor Education and Supervision

Re: IRB Determination of Exempt Human Subjects Research:
Protocol #HE19120, "Examining the Lived Experiences of Native American Counselors Working on the
Reservation: An Interpretive Phenomenological Analysis"

Co-investigator(s) and research team: Brynn Luger
Date of Exempt Determination: 1/28/2019 Expiration Date: 1/27/2022
Study site(s): White Earth Reservation
Sponsor: n/a

The above referenced human subjects research project has been determined exempt (category #2(ii)) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, Protection of Human Subjects). This determination is based on the revised protocol submission (received 1/18/2019).

Please also note the following:

- If you wish to continue the research after the expiration, submit a request for recertification several weeks prior to the expiration.
- The study must be conducted as described in the approved protocol. Changes to this protocol must be approved prior to initiating, unless the changes are necessary to eliminate an immediate hazard to subjects.
- Notify the IRB promptly of any adverse events, complaints, or unanticipated problems involving risks to subjects or others related to this project.
- Report any significant new findings that may affect the risks and benefits to the participants and the IRB.

Research records may be subject to a random or directed audit at any time to verify compliance with IRB standard operating procedures.

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.
Sincerely,

A handwritten signature in purple ink that reads "Kristy Shirley".

Kristy Shirley, CIP, Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult http://www.ndsu.edu/research/integrity_compliance/irb/. This Institution has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

INSTITUTIONAL REVIEW BOARD

NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 | ndsu.edu/irb

Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

NDSU is an EO/AA university.

APPENDIX B. SITTING BULL COLLEGE IRB APPROVAL



SBC Institutional Review Board
9299 Highway 24
Fort Yates, ND 58538

February 25, 2019

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James Korcuska, Ph.D.
Counselor Education & Supervision
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RE: IRB Certification of: Examining the Lived Experiences of Native American Counselors Working on the Reservation: An Interpretive Phenomenological Analysis

The Institutional Review Board at Sitting Bull College (SBC) has determined that this project qualifies for an Approval Status in accordance with federal regulations governing human subjects' research (Code of Federal Regulations, Title 45, Part 46, *Protection of Human Subjects*). This determination is based on the protocol version received on 12/20/2018 and approved on 2/22/2019.

An update on the status of this project is required one year from this date (2/23/19 to 2/22/20). If you wish to continue the project beyond this time period, submit a project continuation request. In addition, a copy of any professional articles, research papers, and presentations stemming from this project must be brought to the attention of SBC IRB.

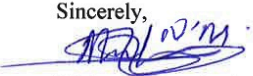
This project must be conducted as described in the approved protocol # SBC212. If you wish to make changes, pre-approval must be obtained from SBC IRB, unless changes are necessary to eliminate an apparent immediate hazard to subjects.

Additional Directions:

- Participants must sign a hardcopy of the consent form for this project
- Prompt, written notification must be made to the IRB of any adverse events, complaints, or unanticipated problems involving risks to subjects or others related to this project.
- Any significant new findings that may affect the risks and benefits to participation must be reported in writing to the participants and the IRB.
- Project records may be subject to a random or directed audit at any time to verify compliance with IRB policies.

Thank you for complying with the SBC IRB policies. Best wishes for a safe and productive project.

Sincerely,


Mafany Mongoh, Ph.D.
IRB Chair
Sitting Bull College/Standing Rock Sioux Tribe

Equal Opportunity Employer

APPENDIX C. WHITE EARTH TRIBE IRB APPROVAL LETTER

PROJECT ORIGINAL SUBMISSION DATE: 1-8-2019

W.E.N.-RRB ORIGINAL REVIEW DATE: 1-15-19

PROJECT TITLE: "Examining the Lived Experiences of Native American Counselors Working on the Reservation: An Interpretive Phenomenological Analysis"

PRINCIPAL-INVESTIGATOR: Brynn Luger CONTACT EMAIL: <brynnluger@gmail.com>

SPONSORING INSTITUTION: NDSU

DATE: 1-15-19

Dear Brynn Luger,

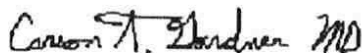
The submission for your requested research project permit on White Earth Nation lands has been reviewed by the White Earth Nation Research Review Board. The Board's conclusion is as follows:

 X Your project is approved as presented in your application and accompanying information; **with one stipulation: You must contact Jeri Jasken, Director of the White Earth Nation Behavioral Health Division, and obtain her agreement to sponsor your research project. A copy of this contingent-approval letter will be sent to her via email, so the two of you can begin communication via email exchange. She will also be provided with a copy of all your application information. Jeri will need to inform the RRB of her decision after consulting with you.**

This letter serves as your research permit. Your approved calendar-date permit period extends from the above-listed Board Original Review Date to and including 365 days. If your project duration will be more than 365 days to completion, you will need to submit a continuation request (see form) *at least one month prior* to reaching the 365-day expiration date. If your project is completed within the 365-day period, you must submit a Project Closeout/Termination Report (see form). If you anticipate making any substantive changes in any part of this approved project protocol, you must submit a detailed letter describing and requesting permission for requested changes/amendments to your project protocol—and receive Board approval before implementing the changes. An exception to this advance-approval requirement is any emergency action that must be taken to protect a project participant's safety or an endangered stewarded-resource. In that event, you still must promptly inform the Research Review Board of the incident, your actions, and your requested ongoing changes.

Please stay in touch with the Research Review Board Code Administrator, refer to the White Earth Nation Principal-Investigator/Sponsoring-Institution Project Guidelines, and comply with the requirements of continued permit use. Feel free to ask any questions.

Sincerely,



Carson Gardner, M.D.

medical director, White Earth Nation Tribal Health Department

medical director, White Earth Reservation Ambulance Service

code administrator, White Earth Nation Research Review Board

Tribal Health Department Building

26246 Crane Road

White Earth, MN 56591

218-983-3286, ext. 1219

carson.gardner@whiteearth-nsn.gov

APPENDIX D. CONSENT SCRIPT



Department of Counselor Education and Supervision
NDSU Dept. 2625, PO Box 6050
Fargo, ND 58108-6050
701-231-7202

Study title:

Examining the Lived Experiences of Native American Counselors Working on the Reservation:
An Interpretive Phenomenological Analysis

Conducted by:

James Korcuska, Ph.D., (701) 231-6296 and Brynn Luger, MA, (701) 471-3300

Oral informed consent script:

Hi, my name is Brynn Luger. I am a doctoral candidate in the Department of Counselor Education and Supervision at North Dakota State University, and I am conducting a research project to examine and understand the experiences of Native American counselors who provide mental health services on Reservations.

You have been invited to participate in this research study. The criteria for participating in this study are that you must be 18 years of age or older, identify as Native American, be a master's or doctorate level graduate in a Counseling or Counselor Education and Supervision program and you must possess either of the following licensing credentials: Licensed Professional Counselor (LPC) or Licensed Professional Clinical Counselor (LPCC).

Your participation is entirely voluntary, and you may change your mind or quit participating at any time, with no penalty; however, your assistance would be greatly appreciated in making this a meaningful study.

In this study, I will ask you to participate in an initial (approximately 45-60 minutes) phone or Skype interview. During this interview, you will be asked questions regarding professional and personal experiences you may have had while providing counseling services on a Reservation. A second interview (approximately 45-60 minutes) will then be scheduled to provide an opportunity for you to participate in member checking for accuracy.

With your oral consent, I will audiotape the interviews and transcribe them into a written document. All data will be stored on NDSU's OneDrive cloud, and electronic files, audio and text, will be password protected, available only to the investigators. Investigators will keep hard copies in a secure, locked filing system.

When writing about the study, your information will be combined with information from other people taking part in the study; we will write about the combined information that we have gathered. You will not be identified in these written materials, rather, you will be asked to provide a pseudonym that will be used in the research writings.

Feel free to ask any questions about the study now, or contact me later at (701) 471-3300, brynn.luger@ndus.edu. You may also contact my advisor, Dr. James Korcuska at (701) 231-6968, james.korcuska@ndsu.edu. If you have questions about the rights of human participants in research, or to report a complaint about the research, contact the NDSU Human Research Protection Program, at (701) 231.8995, toll-free at (855) 800-6717, or via email at: ndsu.irb@ndsu.edu.

Thank you for your participation in this study. If you wish to receive a copy of the research results, please email me at brynn.luger@ndus.edu, or call me at (701) 471-3300.

Documentation of informed consent:

You are freely making a decision whether to be in this research study. Your verbal agreement means that:

1. You have been informed of the consent and purpose of the study
2. You have had your questions answered, and
3. You have decided to participate in the study

APPENDIX E. INTERVIEW QUESTIONS

1. What is it like to work as a counselor on a reservation?
 - a. Follow-up: Discuss what it is like for you to work with traumatized people who are living on a reservation.
 - b. Follow-up: How does this work impact your personal life?
 - c. Follow-up: How does this work impact your professional life?
2. How do you maintain personal and professional wellness?
3. Is there anything else I did not ask you that you would like to add?

APPENDIX F. STORY OF TRAUMA

The following is a story that was told by one of the participants in which she described the experience of dealing with multiple client traumas all within a small circle of people. This story exemplifies the chronic and enduring nature of trauma on the reservation:

Well, I guess the example that comes to mind is when I had a student, a 15-year-old student, that had come to me, who was traumatized over the weekend, she was sexually assaulted. Okay? So there was a trauma. [I] called Indian Child Welfare, called the parents, did all of that. I was supposed to meet the family 20 minutes down the road at the ER. The family was on their way, [but] their vehicle broke down, nobody showed up. Um. You know, it'll traumatize this young girl [to be] there all by herself. I'm there and go over [to the] candy store, and get her a candy, like whatever. [I] put a referral in for mental health, um, mental health services were not able to be given because the paperwork had to be signed. So this is a story that I talk about in what prompted me to get to graduate school. That I was like um. The mom, I knew the mom personally, and like, we need to get her mental help, this is, you know, she needs to see someone. Someone was in the school, wanting to see her but we were waiting for paperwork, but the paperwork had to be done through the case manager through the system so I feel that they could bill for the four-hundred-dollar federal reimbursement rate. Instead of me, who was a contract worker, going to say, here, get some paper work. Cause I see the mom at the gas station or at in school, you know. And I called, she's not being seen yet. I have a referral in. When can we get going, as this person was sitting in their office. Said, well we mailed out the paperwork, we haven't gotten it back, I'm like, 'you're probably not going to get it back, they check their mail like once a month, or you know, I know you

left a message on their cell phone but we got about four people sharing one phone and she probably didn't get the message. Like. We need to go and see her. I see her, can I do this?' 'No. you're blah blah blah'. Long story short, six weeks later that young girl, who wanted the mental health help, who, her family wanted her to have mental health help, committed suicide okay? So. There's a trauma. Then her twin sister found her, okay? So as a mental health counselor on a reservation you're dealing with trauma, trauma, trauma. Well now this young girl that just found her wanted me to go and get her at the house so here I am, you know, she said 'Can I just go to Wal-Mart? Can you bring me to Wal-Mart?' You know? This is my day. So um, 'okay, so you just found your sister last night hanging and so we're going to go to Wal-Mart. Then everyone in Wal-Mart, cause you're from the same community, floods you of like, 'what's going on' and they're all traumatized. It's like. So it is just ongoing and it keeps going and well... So it feels like you're just swimming in trauma and it's like in a swamp. And the moment that you feel you're kind of stepping out of a swamp, something else happens because our communities are so small and the amount of trauma is just in your face all the time so you can't escape it, especially living in the villages...