Working in the Midst of Ideological and Cultural Differences: Critically Reflecting on Youth Suicide Prevention in Indigenous Communities

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ABSTRACT

Many non-Aboriginal practitioners are interested in working effectively with Aboriginal youth, families, and communities. Honouring Indigenous ways of knowing and being informed by a critical consciousness regarding the influence of history, politics, and social forces in the emergence of suicidal behaviour among Aboriginal youth are central to this work. By uncovering assumptions and locating suicide prevention practice within specific discourses, this article demonstrates the relevance and value of critical reflection. Qualities of curiosity, collaborative meaning-making, joint knowledge construction, and ethical engagement are valuable resources for counsellors practicing at the clinical or community level.

RÉSUMÉ

Plusieurs praticiens non autochtones sont intéressés à travailler avec des jeunes, des familles, et des communautés autochtones de la façon la plus susceptible d'être efficace. Le respect des manières autochtones de connaître et d'être informé par une conscience critique de l'influence de l'histoire, de la politique, et des forces sociales dans l'émergence du comportement suicidaire chez les jeunes Autochtones se situe au centre de ce travail. En dégageant des à-priori et en localisant des pratiques de prévention du suicide dans des discours précis, le présent article démontre la pertinence et la valeur de la réflexion critique. Les qualités de curiosité, de création de sens en collaboration, de construction conjointe des connaissances, et d'engagement éthique sont des ressources valables pour les conseillers pratiquant au niveau communautaire ou clinique.

High rates of youth suicide and suicidal behaviour continue to be a disturbing reality for many Indigenous[1] communities in Canada. Specifically, rates of suicide among Aboriginal youth are estimated to be five to six times higher than among non-Aboriginal youth (Health Canada, 2003), but it is also important to acknowledge that variations in suicide rates across First Nations communities are common and many have very low to non-existent rates of youth suicide (Chandler & Lalonde, 1998).

Factors associated with elevated risks for suicide among Aboriginal youth include male gender, previous suicidal behaviour, mood disorder, substance misuse, social isolation, school problems, and work problems/unemployment (Health Canada, 2003; White & Jodoin, 2004). Many of the factors associated with suicide among Aboriginal youth are similar to those of non-Aboriginal youth. However, certain risk factors for suicide among Aboriginal youth need to be understood within a sociocultural, political, and historical context that explicitly recognizes

the negative effects of colonization on Aboriginal health and well-being. These include economic marginalization, forced assimilation, and cultural discontinuity (Health Canada; Poonwassie & Charter, 2001; Weaver, 2007).

Concerned about suicide and suicidal behaviour among youth and eager to make a positive difference, many non-Aboriginal human service providers (myself included) are interested in working with Aboriginal youth, families, and communities in ways that are most likely to be effective. Honouring Indigenous ways of knowing and being informed by a critical consciousness regarding the influence of history, politics, and other social forces in the emergence of suicidal behaviour among Aboriginal youth are central to this work. Culturally respectful approaches to working with Indigenous clients have been described elsewhere (McCormick, 1997; 1998; Poonwassie & Charter, 2001; Vicary & Bishop, 2005; Weaver, 2007), and Aboriginal counsellor education programs that emphasize Indigenous worldviews, values, and cultural imperatives have recently been developed (Morrissette & Gadbois, 2006).

The purpose of this article is to demonstrate the relevance and value of critically reflecting on everyday youth suicide prevention practice when working with Indigenous youth and communities. Youth suicide prevention practice is understood as a broad and comprehensive set of overlapping activities encompassing population-level preventive interventions, individual clinical interventions, and "postvention" (intervening *after* a suicide death). Through critical reflection, I hope to call attention to some of the ways that our taken-for-granted approaches to knowing and understanding structure how the problem of suicide among Aboriginal youth is seen, made sense of, and ultimately responded to. By posing questions, uncovering assumptions, and locating contemporary suicide prevention practice within specific discourses, this article is designed to demonstrate the relevance and value of critical reflection for enhancing wise, ethical, and collaborative action within and across diversities. While the focus is on those ideas and practices designed to benefit Aboriginal youth and communities, I believe that the comments and questions that are included here are equally relevant to the practice of youth suicide prevention generally.

The article begins with an introduction to critical reflection. Next the everyday practice of youth suicide prevention is described. Two prominent practice discourses in the published suicide prevention literature are examined and critiqued: evidence-based practice (EBP) and community capacity-building. The values, assumptions, and principles underlying these particular approaches to youth suicide prevention are highlighted, including a consideration of their respective strengths and limitations for addressing suicide among Aboriginal youth. Tensions and questions that emerge for counselling practitioners who are practicing in the midst of what are often incompatible traditions and conflicting values will be illuminated. The article concludes with a discussion of how counsellors might utilize concepts like curiosity, collaborative meaning-making, joint knowledge construction, and ethical engagement when practicing at the clinical or community level.

CRITICAL REFLECTION

Critical reflection as it is being used here draws from social constructionism, discourse analysis, and critical pedagogies (Gergen, 2000; Mezirow, 1998; Phillips & Jorgensen, 2004; Taylor & White, 2000). Critical reflection is more than introspection—it is predicated on the notion of constructed knowledge (as opposed to knowledge as "given"). Critical reflection makes it possible to explicate and call into question the assumptions upon which knowledge claims are based and allows the contexts of knowledge generation to be exposed and analyzed (Mezirow).

Reflexivity

Reflexivity, which others have described as a process of "destabilizing taken-for-granted ideas and professional routines" (Taylor & White, 2000, p. 6), is an important quality in a critically reflective practitioner. When I am writing from a reflexive position (i.e., being conscientious of, and transparent about, the impact of my own history, biases, and assumptions on what and how I know, think, and write), I become much more sensitized to the limits of language and I become increasingly aware of the problematic and often crude ways in which we speak and write about differences.

For example, I have already recognized that many "non-Aboriginal" practitioners (myself included) want to make a difference in this area of youth suicide prevention. While perhaps conveying my intention to address the "cross-cultural" nature of this work, this way of characterizing myself is unsatisfactory and in many respects it continues to perpetuate problematic "us and them" characterizations. One way out of this binary is to adopt richer, less static, more deeply contextualized language that minimizes essentializing practices and prepares the ground for more active and relational engagement (Bird, 2004). For example, instead of using limiting language like "non-Aboriginal" when describing myself, it might be more fruitful for me to give a more detailed and emerging account of myself.

I am a fourth-generation Canadian of Irish, Scottish, and German descent. I grew up in a middle-class home in an urban, western Canadian city, where I lived until the age of 18. I have worked in the field of youth suicide prevention for close to 20 years, and I have had extensive experience working with a diverse array of communities, including many First Nations' communities. My knowledge of the day-to-day realities faced by Aboriginal people in this country and my understanding of the emergence of suicide as a social problem among Aboriginal youth, while limited, has been informed by direct experience working with Aboriginal communities as a guest/outsider; formal professional knowledge; ongoing dialogues with suicide prevention practitioners and researchers; and, perhaps most significantly, my cherished relationships with Aboriginal colleagues and friends. It is based on this experience that I understand that Indigenous peoples in Canada represent a broad range of diverse and distinct cultures. Each is characterized by different languages, customs, and traditions, and there is no such thing as a "singular" Aboriginal culture. At the same time, I recognize that many Aboriginal

people in Canada share a common cultural, political, and historical experience (i.e., colonization, cultural disruption, multi-generational losses) that is relevant for understanding suicide risk among youth.

This more detailed and contextualized account of myself serves at least two functions. First, it hints at the power of language in shaping social meanings. Second, it qualifies my knowledge as local, contingent, and partial. When we socially locate ourselves as scholars and practitioners in this way, we directly challenge the myth of the neutral observer. The process also invites us to give up our expert positions in exchange for more open, relational, collaborative, and accountable practices (Madsen, 2006).

Questions

Despite my knowledge, experience, genuine concern, and desire to make a difference in the area of youth suicide prevention, several challenging questions persist. Good intentions aside, I am left to wonder whether practitioners like myself, who often have no direct understanding of the realities of day-to-day life for Aboriginal youth living on-reserve or in urban centres, can offer anything of value to Aboriginal communities in the area of youth suicide prevention. Such questions include

1. As a non-Aboriginal practitioner with a specific interest in and knowledge about youth suicide prevention, can I make a useful contribution to addressing youth suicide in Aboriginal communities?
2. To what extent is the knowledge and experience that I bring to understanding this complex problem even relevant for Aboriginal communities, or does it inadvertently perpetuate historical colonizing practices?
3. Why am I interested in addressing this issue and what does this interest in working with Aboriginal youth and communities say about me?
4. Are there specific circumstances under which I could be considered a helpful ally?
5. What criteria or guidelines could I use for deciding how I might engage with Aboriginal youth, families, and communities in ways that are ethical, respectful, and honouring of diverse knowledge?

While it is not my intention to provide answers to all of these complex questions, in the final section I do offer some tentative criteria for guiding ethical engagement and collaborative meaning-making when working with Aboriginal youth and communities. It is also my hope that the questions I ask will have some resonance for others, prompting them to critically reflect on their own everyday practices in the area of youth suicide prevention.

By taking the time to locate myself as a practitioner and scholar and by articulating the questions that have prompted this exploration, I begin the process of practicing an important form of critical reflexivity and accountability. Among other factors, this combination of curiosity and transparency serves to contextualize my perspective "as a view from somewhere," one that clearly has a history. It

also introduces a level of contingency and subjectivity that enables others to see my questions and claims as one perspective among possible others (Phillips & Jorgensen, 2004). When we critically reflect on our own practices in open dialogue with the clients and communities we serve, we begin to develop a new form of accountability. As others have argued,

> our accountability to the people we serve will come not from efforts to prove the authority of our knowledge, nor from efforts to dismantle it and prove it groundless. It will come instead from a more reflective and dialogic engagement with our knowledge, and with the people served through it—an engagement that seeks constantly to problematize our knowing, to probe and critique it, to trace its origins and assumptions, and explore its implications, to open it to inquiry and transformation. (McKee Sellick, Delaney, & Brownlee, 2002, p. 493)

youth suicide prevention discourses

Of specific interest here is the way in which contemporary discourses in suicide prevention serve to construct the problem, orient attention, frame the tasks, and limit some actions while facilitating others (Estefan, McAllister, & Rowe, 2004; Fullagar, 2003; Gubrium & Holstein, 2001; Scheurich, 1994). Discourses "act as forms of containment of knowledge, setting parameters and limiting the ways in which a practice can be thought or spoken about and consequently experienced" (Estefan et al., p. 27). The discourses of EBP and community capacity-building, with their embedded notions of truth, goodness, and reality, each convey certain ideas and values about how youth suicide prevention work ought to be conceptualized and enacted.

Concepts like EBP and community capacity-building, despite their broad appeal and popularity, are not entirely unproblematic. The discussion that follows is designed to show how discourses like EBP and community capacity-building can be subject to critical analysis in order to highlight their historical, contingent, and socially constructed character (Taylor & White, 2000). Recognizing the potentially limiting effects of certain concepts and discourses—rather than advocating for their abandonment—is the aim of this critique. According to Phillips and Jorgensen (2004), critique is a "positioned opening for discussion [and it] always contains an invitation to the reader to enter the discussion herself and carry it further" (p. 209).

Evidence-Based Practice

The youth suicide prevention field has a strong emphasis on using the ideas and findings from science to better understand and respond to this complex and troubling social problem (Berman, Jobes, & Silverman, 2006; Macgowan, 2004). EBP is an approach that is historically rooted in medicine and emphasizes the contributions of science in determining what actions should be taken to reduce risks and effectively treat individuals who are contemplating suicide. Quite simply, EBP means that practitioners are applying the best currently available research evidence in the provision of services (Waddell & Godderis, 2005).

The findings generated through carefully conducted empirical studies provide an important foundation for thinking about how to tackle this complex problem from both a prevention and an intervention perspective. Even though there is a dearth of any conclusive research evidence (and little of what does exist pertains to Aboriginal youth, families, and communities), there are varying degrees of empirical support for specific suicide *prevention* strategies. These include social support enhancement and problem-solving interventions for high-risk youth, youth skill building, education of health professionals, peer recognition training, school gatekeeper training, means restriction, media education, and facilitating community self-determination and strengthening cultural identity for First Nations youth (Gould, Greenberg, Velting, & Shaffer, 2003; Kirmayer, Boothroyd, Laliberte, & Simpson, 1999; White, 2005). Meanwhile, reviews of the *treatment* literature suggest that the following approaches hold the most promise for addressing suicidality among youth: developmental group psychotherapy, family communication and problem-solving, short-term interventions in outpatient settings, involvement of family members in treatment, and using some form of cognitive behavioural therapy (CBT) (Macgowan, 2004).

Being familiar with the empirical evidence in youth suicide prevention is an important cornerstone of practicing wisely. Doing things that are consistent with the best research evidence about "what works" also makes sense to most practitioners, community members, and clients. On the surface, the task of preventing youth suicide from an EBP perspective appears straightforward. For example, read the literature, attend conferences and training workshops, consult with experts and trusted colleagues to become familiar with empirically validated approaches, and then implement those programs that have been rigorously evaluated and proven effective. The reality, of course, is much more complex.

First, most recent evidence-based reviews of the youth suicide prevention research literature suggest that there is insufficient and inconclusive evidence regarding the effectiveness of interventions for preventing youth suicide (Guo & Harstall, 2002; Macgowan, 2004; White, 2005). Second, EBP is historically predicated on a hierarchical approach to appraising knowledge whereby certain forms of research-based findings (i.e., quantitative data emerging from randomized controlled trials) are typically privileged over others (i.e., qualitative data). Third, definitions of what is to count as evidence are highly contested (Lawler & Bilson, 2004; Tannenbaum, 2003; Waddell & Godderis, 2005). Fourth, many of the knowledge utilization models through which EBP is designed to be transmitted are highly problematic, typically reflecting one or more of the following assumptions: (a) only experts possess relevant knowledge; (b) only a single, typically empirical basis for knowledge exists; (c) this knowledge is best transferred from the "top" down to the target audience; and (d) learning is simply a matter of instruction by establishing pipelines for communication (Broner, Franczak, Dye, & McAllister, 2001). Fifth, many proponents of EBP appear to regard the types of knowledge generated through scientific experiments to be value-free or neutral, and thus equally applicable to all contexts and clients, irrespective of

their particular background, culture, or experience. This assumption has been seriously called into question by those in the mental health and social care fields (Burton & Chapman, 2004; Issacs, Huang, Hernandez, & Echo-Hawk, 2005; Tannenbaum).

Recognizing the limits of a narrowly constructed, hierarchical definition of evidence, many authors have called for a re-conceptualization of EBP (Issacs et al., 2005; Waddell & Godderis, 2005), one that recognizes the place of culture, context, values, and relationships in everyday practice and one that admits qualitative research findings as legitimate sources of knowledge (Gilgun, 2006). By recognizing that practice is more than the application of expert knowledge, it becomes increasingly evident that more culturally sensitive and complex approaches to supporting the emergence of "knowing communities" are required. Such approaches might include, for example, the facilitation of "reflexive conversations" (Lawler & Bilson, 2004), the construction of "practice-based evidence models" (Issacs et al.) and the development of more participatory approaches to knowledge generation (Broner et al., 2001; Taylor & White, 2000).

At the same time that calls for more research-informed approaches are being advanced, there is a parallel focus in the literature on the processes of community engagement—on the *hows* of our work. Specifically, there appears to be collective agreement that understanding the particular social, cultural, and political history of Aboriginal peoples is a necessary ethical foundation for doing the work of suicide prevention at the individual or community level (McCormick, 1998; Strickland, Walsh, & Cooper, 2006; Vicary & Bishop, 2005; White & Jodoin, 2004). Having an astute sensitivity to and respectful appreciation for local traditions and protocols are important considerations. The discourse of community capacity-building responds to many of these interests.

Community-Capacity Building

A community capacity-building approach typically refers to strengthening a community's ability to respond to its own health issues (Chino & DeBruyn, 2006). Other related notions such as community empowerment, local ownership and control, and self-determination are often incorporated under the broad banner of community capacity-building. This approach, when applied to the prevention of youth suicide among Aboriginal communities, is typically guided by a strong set of values and ideas including youth participation, local ownership, strengths-based and context-sensitive practices, and the recognition that youth well-being and family and community well-being are inextricably linked (Health Canada, 2003; Kirmayer et al., 1999; Mussell, Cardiff, & White, 2004).

The language of community capacity-building is appealing because of its explicit focus on the values and principles of collaboration, respect for Indigenous knowledge, attention to community strengths, and locally developed and owned solutions. At the same time, it is important to resist the temptation to romanticize community capacity-building. It is no panacea for singularly resolving all of the complex historical, social, political, and cultural circumstances and conditions

that have led to elevated rates of suicide and suicidal behaviour among Aboriginal youth.

Despite the clear emphases on community empowerment, inclusive practices, and local participation and control, many contemporary understandings and applications of community capacity-building remain firmly rooted in Western intellectual traditions. As a result, it is problematic to assume that all community capacity-building approaches are always relevant to, applicable to, and respectful of Indigenous realities and contexts (Chino & DeBruyn, 2006; Kral & Idlout, in press).

For example, many mainstream approaches to community capacity-building make too many assumptions about the availability of specific resources and skills within Aboriginal communities, too often concluding that it is just a matter of identifying and defining these resources on the community's own terms. The amount of time needed for trust-building, healing from past wounds, and addressing multi-generational losses is often underestimated in many mainstream approaches (Chino & DeBruyn, 2006).

It has been suggested that a more promising approach to community capacity-building is one that is clearly developed "from the inside" by and for Indigenous people. These "ground up approaches" typically reflect community values (e.g., direct experience, interconnectedness, relationships, meaningful involvement of Elders) and Indigenous ways of knowing (Chino & DeBruyn, 2006; Kral & Idlout, in press). By understanding community control as an important form of decolonization and by heightening community members' critical consciousness regarding the systemic and institutional barriers that threaten Indigenous health and wellness, many community capacity-building efforts have the potential to transform existing power relationships between communities and government funders and policy-makers (Chino & DeBruyn). Given this emphasis on local control and self-determination, many questions remain about whether non-Aboriginal outsiders can make a valuable and meaningful contribution to this process.

Attempting to implement strategies that are informed by empirical research while at the same time honouring local and traditional Indigenous knowledge through capacity-building approaches can be an extraordinarily difficult tension to live and work with. Some have even suggested that two discourses might be fundamentally incommensurable—"a colliding of worldviews" (Issacs et al., 2005). Brief examples of how these tensions might show up in clinical and community contexts are described next.

TENSIONS IN PRACTICE

Western views of suicide are typically rooted in a biomedical context, which emphasizes individual risk factors and pathology (e.g., mental disorders). In this view, mental health problems like depression or suicide ideation are often understood in isolation from other concerns (e.g., spirituality, culture, physical health, relations of power). Suicidal individuals are often referred to mental health experts

to receive empirically validated treatments (e.g., cognitive behavioural therapy, dialectical behavioural therapy, pharmacological treatments) (Goldney, 2005; Macgowan, 2004).

Keeping their rich diversity in mind, Aboriginal views of health and wellness tend to include more holistic, cultural, and spiritual dimensions (McCormick, 1998; Poonwassie & Charter, 2001; Vicary & Bishop, 2005). Individual mental well-being cannot be separated from family, community, cultural, and spiritual well-being (Strickland et al., 2006). Depression and suicidal behaviours are often understood to be signs of overall imbalance, disconnection, or lack of harmony, conditions that can often be traced back to intergenerational trauma, poverty, unemployment, and lack of housing (Smye & Mussell, 2001). Spiritual practices, participation in ceremonies, community connectedness, involvement of Elders, and the recovery of specific cultural traditions are considered important components of prevention and healing for First Nations youth (McCormick, 1997; Mussell et al., 2004; Poonwassie & Charter; Strickland et al.).

Clinical Contexts

When faced with an Aboriginal youth who is plagued by persistent suicidal thoughts, counsellors who work in mainstream mental health settings are often expected to practice in an evidence-based way. In the absence of any clear, empirically supported treatments for working with Aboriginal youth who are suicidal, clinicians are faced with difficult questions. For example, should they practice a form of cognitive behavioural therapy (CBT) or dialectical behavioural therapy (DBT), as these approaches have been the most rigorously evaluated and show the most promise according to evidence-based reviews (Berman et al., 2006; Macgowan, 2004)? What unspoken assumptions about "good mental health" and "appropriate/healthy client behaviours" do these approaches implicitly convey (James & Prilleltensky, 2002)?

Counsellors may experience additional tensions if they work in a mental health system where problems such as suicide are individualized and medicalized through the language of diagnosis and symptom management (James & Prilleltensky, 2002). Social, historical, and political factors that contribute to the problem's emergence—like racism, economic marginalization, and oppression—often remain obscured from view and clients' spiritual understandings often remain underexplored.

When faced with these tensions in clinical settings, some questions might stimulate deeper critical reflection. How might ideas from Western-based empirically supported approaches co-exist with Indigenous practices (i.e., involvement of Elders, traditional ceremonies, spiritual practices)? What assumptions are being made about the emergence of suicidal behaviour from each of these perspectives? Where do these assumptions lead? How does the therapeutic approach position the client in relation to the therapist, that is, is the client required to enter the therapist's "expert" knowledge or does it require the therapist to enter the "world" of the client (Freedman & Combs, 1996)?

Community Contexts

Practicing at the community level also introduces ideological tensions and practice challenges. As one example, consider the non-Aboriginal counsellor who has been asked to assist with the facilitation of a safe and effective postvention response for a school or community following a youth suicide. On the one hand, there is some evidence to suggest that following a suicide in a small community, certain conditions, including those "interventions that focus dramatic, communal attention on an individual tragedy" (Browne, Barber, Stone, & Meyer, 2005, p. 237), might inadvertently create risks for imitative or copycat suicidal behaviours. This has led to strongly worded cautions from suicide prevention experts *against* any large-scale, emotionally charged communal gatherings. Meanwhile, many Aboriginal communities respond to the loss of one of their community members by organizing large community gatherings as a way to facilitate healing and honour the person who has died, based on their own unique traditions, beliefs, mourning rituals, and spiritual practices. Where, then, does this leave the practitioner who is faced with the task of facilitating a process that is effective, safe, and culturally meaningful?

Questions for deepening critical reflection in this context could include: Who has initiated this healing process? What does it mean to be an insider or outsider in this particular situation? Which/whose knowledge should be privileged? Whose protocols should prevail? What might compromise or integration look like? What are the risks and opportunities? Does the approach divide and isolate people or give them a sense of community and collaboration (Freedman & Combs, 1996)?

Practicing in the midst of these complex cultural and ideological differences and competing discourses, many counsellors and other human service providers wonder how it might be possible to go forward in ways that are effective, therapeutically sound, and culturally respectful. In the absence of empirical or ethical certainty, where might we stand? And, importantly, what do we stand *for*?

SOME POTENTIAL WAYS FORWARD

In this final section, I would like to put forward three tentative criteria that have the potential to enhance critical reflection and promote ethical and respectful engagement when working with Aboriginal youth, families, and communities. Brief examples from my own clinical and community experience that have been modified to preserve confidentiality convey how these ideas might get taken up in practice. It is important to clarify that the ideas offered here are not intended as techniques, but, taken together, they represent an overall stance that is informed by social constructionism, narrative therapy, discourse analysis, and critical pedagogy (Bird, 2004; Freedman & Combs, 1996; Gergen, 2000; Mezirow, 1998; Philips & Jorgensen, 2004).

Curiosity and Questions

Throughout this article I have posed a number of questions that have been intended to provide a platform for discovery and critical reflection. Learning to

ask generative questions is an important skill in becoming a critically reflective practitioner. In a therapeutic context, staying curious and asking good questions can introduce new preferred storylines, transform perspectives, and reacquaint individuals and communities with their existing resources. Questions are most likely to be useful when they move from being passive devices for gathering information to becoming prompts for *generating* experience (Freedman & Combs, 1996).

In my own experience working with Aboriginal youth, I have found that when I ground my approach in a stance of curiosity, I am able to cultivate a much richer understanding of the meaning of suicide in particular young people's lives. I recall being very captivated by one young man's elaborate description of how, to him, suicide represented a breach in the contract with the Creator. Unprompted by me, he began to draw this relationship on a piece of paper as a way to teach me about this important belief system. As he talked and drew, I asked him questions about the history of these ideas, about what these ideas meant in his life, the life of his family and community, and in the lives of his ancestors. I also asked him about some of the specific ways that these ideas brought him closer to reclaiming his relationship with hope. By privileging his cultural meaning system and by using my own specialized knowledge and skills to facilitate an ongoing therapeutic dialogue, new conversational spaces were opened. The process enabled him to rediscover a vast array of untapped resources and capacities, and it had the effect of strengthening the bonds he had with several extended family members and his community.

Questions can also be used outside the session (including supervision) to help counsellors reflect on specific practice assumptions and discourses. Inviting counsellors to consider the respective limits and opportunities, values and assumptions of their preferred approaches represents an important form of accountability. For example, what does your commitment to this professional discourse reveal about the values, beliefs, hopes, and dreams you bring to your work (Madsen, 2006)? How does your preferred approach "see" persons? How does the approach have them "treat" and "see" and "describe" themselves (Freedman & Combs, 1996)?

Collaborative Meaning-Making and Joint Knowledge Construction

Those who write about culturally sensitive healing strategies for Aboriginal clients place a strong emphasis on recognizing and legitimizing Aboriginal worldviews and cultural traditions (McCormick, 1997; Poonwassie & Charter, 2001). At the same time there is recognition that not all Aboriginal clients will place the same value on reconnecting with traditional practices. It is important for counsellors to stay open to hearing clients' (and communities') understanding of their situation or problem and their preferred realities. Both empirical findings and traditional cultural knowledge, representing different epistemological orientations, can become potentially valuable resources informing the therapeutic work. Vicary and Bishop (2005) suggest that counsellors should consider how current therapeutic

approaches can be modified to benefit Aboriginal clients. They also encourage counsellors to develop and maintain relationships with local First Nations communities (including Elders, professional peers, and colleagues), and they recommend the use of cultural consultants when working with Indigenous clients.

For example, when practicing as a counsellor in an urban setting I worked with a 19-year-old Aboriginal woman who was very interested in learning more about traditional Indigenous healing practices. When I first met her she had just completed an eight-week residential treatment program for alcohol misuse. She had a history of suicide attempts and was struggling with depression and social isolation. Part of our therapeutic work involved helping her to reconnect with a female Elder whom she had met at the treatment program. The Elder agreed to serve as her ongoing mentor and teacher. Along with attending regular sessions with me, she was meeting with the Elder, learning more about sacred traditions, participating in sweat lodge ceremonies, and expanding her overall circle of support. Over time, she became a strong role model for younger Aboriginal women, and she was invited to give talks at the residential treatment centre about her experiences with healing and recovery.

Ethical Engagement

Some have suggested that it is the unexamined practices and assumptions of practitioners—their "ethically unexamined expertise"—that represent some of the greatest threats to ethical practice (Prilleltensky, Rossiter, & Walsh-Bowers, 1996). For example, when we fail to thoughtfully appraise the way that certain discourses actively shape our understandings of our work, we risk becoming uncritically accepting of what *is* instead of challenging ourselves to become active creators of what *is possible*. Critical reflection thus becomes an ethical responsibility (Nakkula & Ravitch, 1998). In everyday practice, this means actively embracing the tensions and uncertainties of suicide prevention practice and continuing to "live/love the questions" in ways that enable us to stay open to and mindful of the sources of our particular ways of knowing. When we ground our work in a clear set of moral values and ethical commitments (including doing no harm, social responsibility, accountability, trust, care, justice, responsiveness, and interdependence) and hold our knowledge with tentativeness and an openness to other traditions and ways of knowing, we discover that we do indeed have somewhere to stand and something to stand for.

In closing, I would like to re-emphasize the value of working at the borders, in the midst, and in the spaces in between. As Giroux (cited in Hargreaves, 1996) tells us, "it is on the borders of our work, where we can explore different cultures and assumptions, that the most interesting and innovative things can often be achieved" (p. 119). By working at the intersection between and across cultural and ideological worldviews, it is possible that a more promising "ethical space" for deliberating about a more hopeful way forward can emerge (Ermine, 2005). Such an "in between" conversational space offers a site for relationship building and mutual transformation, while honouring multiple ways of knowing.

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Note

1. For the purposes of this article, the terms "Aboriginal" and "Indigenous" refer to First Nations ("Status" and "Non-Status Indians"), Metis, and Inuit peoples.

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