Coloniality of Pain and Decolonial Pain Care:
Examining the Effects of Colonial Violence on Chronic Pain Through Kwakwa̱ka̱'wakw Women's Experiences

By

Hiroko Sakai

B.S.W., University of Victoria, 2004
M.A., Yorkville University, 2009

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We acknowledge with respect the Lekwungen peoples on whose traditional territory the university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.

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Supervisory Committee

Dr. Mehmoona Moosa-Mitha (School of Social Work, University of Victoria)

Supervisor

Dr. Cindy Holmes (School of Social Work, University of Victoria)

Committee Member

Abstract

Recently, pain studies have begun to acknowledge the biopsychosocial nature of chronic pain with an increased emphasis on the social and structural factors contributing to pain. In particular, studies have identified relationships between chronic pain and intersecting structural oppressions such as systemic violence and racism created by heteropatriarchal settler-colonialism. However, few research studies on pain have examined how systemic colonial violence affects Indigenous women's experiences of chronic pain, and its correlation to pain care inequities. Centring the experiential knowledge of five cisgender Kwakwa̱ka̱'wakw women participants and situated within Indigenous decolonial feminist theories, this qualitative community-based participatory research study addressed the questions: how does colonial violence and trauma interact with physical pain? What were participants' recommendations for decolonizing pain care? The participants described reciprocal interactions between pain and colonial violence and trauma; emotional pain; fatigue; and substance use. Their stories illustrated how their experiences of systemic gendered and racialized violence were closely connected to the onset and development of chronic pain. Participants also explained how chronic pain experiences were exacerbated by anti-Indigenous racism and the white-centric healthcare practices that discredited and pathologized their narratives of pain. Participants recommended decolonizing pain care by addressing structural injustices and care inequities. Cultural revitalization was considered foundational to decolonizing pain care by fostering healing that affirmed Indigeneity and the right to self-determination at multiple levels, while enhancing relational approaches to health and healing. Addressing anti-Indigenous racism is an urgent step towards decolonial pain care. Finally, decolonial pain care should encompass biopsychosocial as well as cultural and spiritual aspects through multidisciplinary care provisions.

Table of Contents

Supervisory Committee ii
Abstract iii
Table of Contents iv
Acknowledgement vi
Dedication vii
Introduction 1
About This Research 3
My Relationship to This Topic 4
Clarifying the Terms Used in This Thesis 7
Overview of Chapters 11
Chapter One: Literature Review 13
- 1.1 Coloniality of Pain 13
  - 1.1.1 Gaps in the Current Research on Pain Among Indigenous Women 13
  - 1.1.2 Comorbidity Between Pain and Psychological Conditions 16
  - 1.1.3 Pain as Stress Response 18
  - 1.1.4 Colonial Gendered Violence Against Indigenous Women 20
  - 1.1.5 Care Inequities: Indigenous Women's Experiences of Accessing Pain Care 24
  - 1.1.6 Epistemological Violence 28
- 1.2 Decolonizing Pain Care 30
  - 1.2.1 Colonial Trauma and Current Trauma Therapies 31
  - 1.2.2 Culture 32
  - 1.2.3 Equity Oriented Healthcare: EQUIP 35
  - 1.2.4 Culturally Safe Care 37
  - 1.2.5 Trauma- and Violence-Informed Care 39
  - 1.2.6 Contextually Tailored Care for Rural Communities 41
- 1.3 Conclusion 43

Chapter Two: Research Methodology 45
- 2.1 Theoretical Framework 45
- 2.2 Research Design: Community-Based Participatory Research (CBPR) 49
- 2.3 Ethical Considerations 52
- 2.4 Community Engagement and Consultation 55
- 2.5 Research Permission Seeking Process 57
- 2.6 Recruitment Methods 58
- 2.7 Data Gathering Methods 59
  - 2.7.1 Storytelling, Talking Circle, and Witnessing 59
  - 2.7.2 Art-Based Approach: Body Map 62
- 2.8 Data Analysis 63
- 2.9 Strengths 64
- 2.10 Limitations 65
- 2.11 Conclusion 66

Chapter Three: Coloniality of Pain 67
3.1 Participants... 68
3.1.1 Elder Sharon.. 68
3.1.2 Elder Maggie... 70
3.1.3 Zoe 71
3.1.4 Maggie 71
3.1.5 Stephanie... 72
3.2 Embodied Effects of Colonization: Relationship Between Trauma and Pain 73
3.2.1 Trauma is an Outcome of Life-Long Exposure to Colonial Violence and is Intergenerational 74
3.2.2 Pain Develops Through Stress Responses to Colonial Trauma 81
3.2.3 Racism in Healthcare Aggravates Stress Responses and Pain …………………84
3.2.4 Neoliberal Policies Result in Insufficient Pain Care for Rural Communities..... 88
3.2.5 Reciprocal Interactions Between Trauma, Stress, Fatigue, and Substance Use . 91
3.3 Discussion 94
3.3.1 Colonial Violence is Gendered, Intersectional, and Ongoing............................ 95
3.3.2 Pain is a Natural Response to Colonial Trauma.. 99
3.4 Conclusion 103
Chapter Four: Recommendations for Decolonizing Pain Care 106
4.1 Revitalization of Culture as Integral to Healing and Decolonial Pain Care 108
4.1.1 Restoring Wholistic Connections.. 109
4.1.2 Self-Determination..113
4.1.3 Lifestyles Informed by Cultural and Traditional Practices 116
4.2 Decolonial Pain Care Practices 118
4.2.1 Decolonizing Pain Care by Enhancing Indigenous Cultural Safety 118
4.2.2 Decolonizing Pain Care Practice by Promoting Self-Determination............... 130
4.3 Discussion 136
4.3.1 Biopsychosocial Approaches to Pain Care 137
4.3.2 Cultural and Spiritual Care 140
4.4 Conclusion 143
Conclusion 146
References 154
Appendices... 199
Appendix A 199
Appendix B 205
Appendix C 208
Appendix D 209
Appendix E.. 210
Appendix F...211

Acknowledgements

The topic of chronic pain treatment for Indigenous women has been evolving for me over the past decade. This thesis is not in any sense a complete product, nor an end to a learning journey. At the same time, I acknowledge that this is an opportunity for me to reflect on the relational nature of this learning process. I wish to acknowledge how this thesis became possible only because of precious relationships, some new and some old.

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Finally, to my family and friends, you are the source of my dreams, inspirations, confidence, resilience, and joy. My husband, Dick, without trusting your unfaltering support for the endless process of editing, debriefing, and listening to my questions, I would not have even thought of starting this study. My friends, Oonagh and Tracy, I am deeply grateful for your unconditional support, listening to my questions, brainstorming ideas, and editing my writing. Finally, my parents, you were with me throughout this thesis process reminding me of your unconditional love. It gave me the confidence to face the challenge and walk through it.

Dedication

I dedicate this study to all Indigenous women who live with chronic pain.

I hope this study will inspire settler healthcare providers to join the journey of decolonization.
We can challenge our colonial healthcare practices by first examining how we listen and judge.
I hope that together we create trustworthy and respectful pain care that confronts
anti-Indigenous racism and violence against all Indigenous women.

Introduction

Chronic pain is commonly defined as pain lasting longer than three months accompanied by both emotional distress and functional disability in the absence of another diagnosis (Canadian Pain Task Force, 2019). It is a prevalent health condition around the world, and it is estimated to affect one in five Canadians (Canadian Pain Task Force, 2019). Living with persistent pain can lead to many challenges. In addition to emotional distress, people can experience functional challenges such as being unable to work, to care for themselves or others, or to have meaningful engagement in their home and community (Mathur et al., 2022). Such challenges can deeply affect a person's sense of stability and wellness (Thanh et al., 2022). Because of these extensive and debilitating effects of pain, chronic pain is considered "a major physical and mental health care problem" (Gatchel et al., 2007, p. 581).

Pathways of chronic pain are complex. Biological, psychological, and social factors all contribute to people's pain experiences (Canadian Pain Task Force, 2019; Gatchel et al., 2007). Current biomedical research explains the neurological mechanisms through which overlapping central and peripheral neural networks lead to the development of chronic pain (Abdallah & Geha, 2017; Cohen et al., 2021; Yang & Chang, 2019). In addition, research reports high comorbidity between chronic pain and psychological experiences such as anxiety and depression (Gatchel et al., 2007), and post-traumatic stress disorder (Abdallah & Geha, 2017; Hemsing et al., 2016; Outcalt et al., 2015; Siqveland et al., 2017; Timmers et al., 2019), as well as substance related challenges (Velly & Mohit, 2018).

More recently, the field of pain studies has begun to address the social and structural factors affecting chronic pain by examining how intersecting forms of structural inequity contribute to people's pain experiences through biological and psychological processes (Mathur et al., 2022; Moosa-Mitha et al., 2025). A number of studies have reported that people who experience discrimination and challenging socioeconomic conditions, including Indigenous women among others, are disproportionately affected by chronic pain (Allan & Smylie, 2015; Canadian Pain Task Force, 2019; Cohen et al., 2021; Craig et al., 2020; Holmes et al., 2024; Mills et al., 2019; Moosa-Mitha et al., 2025; Wallace et al., 2021). There is also a growing awareness of how multiple forms of violence, as well as trauma and substance use as outcomes of violence, intersect with chronic pain adding complexity to the pain experiences among people who face socioeconomic disparities (Craig et al., 2020; Canadian Pain Task Force, 2020; Ford-Gilboe et al., 2023; Holmes et al., 2024; Wallace et al., 2021).

A number of studies have acknowledged that settler-colonization, in particular, is at the root of violence against Indigenous women in present-day Canada while continuing to generate health inequity (Allan & Smylie, 2015; Browne et al., 2016; Craig et al., 2020; Holmes et al., 2024; Loppie & Wien, 2022; Turpel-Lafond, 2020; Varcoe et al., 2019; Wallace et al., 2021; Wylie & McConkey, 2019). Colonial violence against Indigenous women is highlighted in the reports of intimate partner violence and the missing and murdered Indigenous women inquires (Holmes & Hunt, 2017; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Ogden & Tutty, 2023; Razack, 2016). In addition, anti-Indigenous racism, another form of colonial violence, remains prevalent in colonial systems including healthcare while creating barriers for Indigenous peoples to access effective and respectful pain care in a timely fashion (Allan & Smylie, 2015; Turpel-Lafond, 2020). At the same time, little research is found which specifically addresses the effects of structural colonial violence, past and present, on experiences of chronic pain among Indigenous women.

Current common treatments for pain continue to remain within the scope of biomedical interventions such as medications and surgery augmented by psychotherapies to manage anxiety and depression which may occur in response to prolonged pain experiences (Canadian Pain Task Force, 2019; Healthlink BC, 2022; Government of Canada, 2023). Insufficient understanding about the effects of colonial violence on Indigenous women's pain experiences results in inadequate responses to address the structural factors contributing to their chronic pain and a lack of cultural safety in healthcare for Indigenous women seeking support and care related to chronic pain. Viewing Indigenous women's pain only as personal biomedical pathology not only leads to insufficient and ineffective pain care, but also overlooks and thus perpetuates current racist and discriminatory care practices that contribute to structural injustices.

About This Research

This qualitative study explored chronic pain experiences among Indigenous women of Turtle Island, also known as Canada, focusing specifically on the experiences of Kwakwa̱ka̱'wakw women living in their territories located in Northern Vancouver Island, British Columbia. It inquired about their experiential knowledge of pain and their perception of its relation to gendered and racial violence in settler-colonial systems. Through their lived experiences and embodied knowledge of pain and colonial violence, this study intended to deepen the understanding of how trauma, resulting from structural violence created by colonization, profoundly interacts with Indigenous women's pain experiences. Two questions guided this research: how does trauma, as an outcome of gendered and racial colonial violence, interact with chronic pain in Kwakwa̱ka̱'wakw women's lives; and what elements and approaches facilitate healing and decolonizing pain care for Kwakwa̱ka̱'wakw women living in a rural community?

I explored these questions with five cisgender Kwakwa̱ka̱’wakw women in the district of Port Hardy, a rural community in British Columbia, where I have been practicing social work as a mental health clinician for over two decades. Grounded in Indigenous decolonial feminist frameworks, this community-based participatory research project was developed in consultation with Kwakwa̱ka̱’wakw community partners, who formed a community advisory group and guided each phase of the research process. This project was inspired by the Indigenous practice of storytelling and Kwagu’ł methodology of witnessing (Hunt, 2018) as well as practices of settler solidarity and accountability (Hunt & Holmes, 2015). Kwakwa̱ka̱’wakw women were invited to share their stories of pain where I positioned myself as a witness to their stories. Drawing on their knowledge of pain, this research aimed at fostering contextual understandings of physical pain among Kwakwaka’wakw women at the intersections of Indigeneity and gender. It further aimed to offer healthcare providers in the community an increased understanding about the colonial nature of chronic pain experienced by Kwakwa̱ka̱’wakw women and to provide recommendations for decolonial equity-oriented pain care.

My Relationship to This Topic

This project has personal importance to me both as an uninvited settler living on the Kwakwa̱ka̱’wakw territory and as a racialized social worker practicing in the white-dominant healthcare system. Being a first-generation immigrant from Japan, I have been an uninvited settler in the ancestral and traditional Kwakwa̱ka̱’wakw territory over the past three decades. Kwakwa̱ka̱’wakw means “the people who speak Kwak̓wala” (U’mista Cultural Society, 2025, Our Language section). From the northern coast of Vancouver Island, southeast to the middle of the Island, surrounding islands, and the adjacent coastal areas of British Columbia, the Kwakwaka’wakw Nations created rich cultural traditions rooted in the natural environment of their homelands. Although sharing similar traditions and spiritual beliefs, each Nation has their own history and culture that are transmitted through ceremonies, songs, dances, and stories (U’mista Cultural Society, 2025).

I have come to know Kwakwa̱ka̱’wakw women mostly through my social work practice in mental health services in their traditional territory. Many women believe that their strengths are in their family networks, cultural ceremonies, and connections to the territory. They generously shared with me their knowledge of the land and how to harvest plants in the marshes and clams and seaweed off the beach at certain times of the year. They also taught me how their rich culture, political structure, and spirituality are expressed through art, the big house, and ceremonies such as potlatch (U’mista Cultural Society, 2025).

Many of the women I met through the mental health service also spoke about their extensive experiences of gendered colonial violence through relocation from their traditional villages to federal reserve lands, loss of connections to lands and resources, abuse at residential schools, violence in their homes and communities because of intergenerational trauma, and grief from losing many family members because of illness, violence, suicide, and toxic drugs. They also shared with me their daily experiences of racism and oppressive colonial practices in healthcare, child welfare, criminal justice, and social service settings in their communities. Trauma was an ongoing experience for many women, and it created deep emotional and spiritual pain among them. Many women also suffered from physical pain, and that further affected their emotional wellbeing, ability to engage in work and life tasks, and their connections to their culture and families.

Recognizing the prevalence of physical pain in the community and people seeking more effective pain treatment, a small group of community healthcare providers including myself developed a community-based multidisciplinary chronic pain program and provided a community self-management education program. During this process, however, I became increasingly aware that our curriculum assumed a universal approach to pain without acknowledging how intersecting structural factors such as colonization, violence and trauma, and gender contribute to and interact with physical pain. Failing to address structural factors of pain in our self-management course could contribute to viewing Indigenous women as being personally responsible for managing their pain and further deepen structural injustices. Decolonization requires a continual process of becoming aware of and challenging assumptions embedded in the practice which perpetuates structural oppression (Pierre, 2019). I acknowledged my settler responsibility to deepen my understanding about physical pain experienced by Kwakwa̱ka̱'wakw women and to support efforts to decolonize community pain care practices.

In addition, validating the embodied experiential knowledge of Kwakwa̱ka̱'wakw women helped me examine my own white normative assumptions as a racialized female social worker practicing in a white-dominant hierarchical healthcare setting. DiAngelo (2006) explained that whiteness normalizes multidimensional and often invisible processes that enforce its domination. Neoliberal white-centric healthcare practices view physical and mental health as "personal health management challenges even as they embody neoliberal socio-economic developments in society at large" (Sparke, 2016, p. 237). Marketizing health, neoliberal biomedical approaches to mental health reinforce white-centric views of trauma as an individual pathology to be treated according to the choices made by the individual "consumer" (Tseris & Jamieson, 2023, p. 4).

While examining current white-centric approaches such as psychotherapy models to treat harmful psychological outcomes of colonization, Wendt et al. (2022) warned that practicing psychotherapy can function as a "subtle assimilative agent" (p. 808). Assimilative outcomes of psychotherapy not only effect Indigenous peoples seeking healing but also impact racialized settler mental health workers such as myself who are trained to treat the outcomes of colonization as individual psychological pathology using white-centric treatment modalities. Centring my inquiry on Indigenous women's knowledge offered me an opportunity to engage in my own process of decolonizing my mind and practice. It created space where I acknowledged how my beliefs, assumptions, and practice have been formed in the context of current Canadian healthcare practice governed by white-centric, biomedical, and market-driven neoliberal policies.

Clarifying the Terms Used in This Thesis

Through this research process, I have become increasingly aware that the words I use bear political power that can either conform to or resist colonial oppression. I describe my assumptions embedded in the terms I used in this thesis.

- **Abuse**: Feminist theories examine how intersecting structural factors such as gender, race, sexuality, age, ability, and class, contribute to perpetuating violence while maintaining heteropatriarchy and cisnormativity (Hooks, 2025). Intersecting forms of structural violence are particularly evident in the experiences of Indigenous women, trans women, and women outside of cisgender and heterosexual identities including Two-Spirit people (Holmes et al., 2024; Holmes & Hunt, 2017; Hunt, 2016). Women are frequently held responsible for the outcomes of male violence resulting in blaming the victims of gendered and sexual violence (Hooks, 2025). Being informed by this intersectional structural understanding of abuse, I use the term to describe structural violence by misuse of power, eroding autonomy of the persons or groups and resulting in a wide range of harmful outcomes.

- **Chronic pain:** it is commonly specified as pain lasting longer than three months accompanied by both emotional distress and functional disability in the absence of another diagnosis (Canadian Pain Task Force, 2019). However, at the very beginning of this research project, I received feedback from the community advisory group that such a narrow definition of chronic pain does not encompass the vast experiences of pain among Kwakwa̱ka̱'wakw women. Honouring this recommendation, the term chronic pain used in this research refers to all recurring physical pain unattached to the time frame.
- **Coloniality:** this term refers to the settler-colonial policies, practices, and sociopolitical structures including structures of governance and ongoing racism and discrimination (Moosa-Mitha et al., 2025). Coloniality also depends on and reinforces heteropatriarchy and cisnormativity (Holmes et al, 2024) as well as Eurocentric knowledge systems which devalue Indigenous ways of knowing (Josewski et al., 2023).
- **Indigenous:** I use this term for all people who self-identify as the First Nations, Inuit, and Métis of Turtle Island regardless of their status as specified in the Indian Act of Canada (Government of Canada, 2024).
- **Kwagu'ł**: different spellings exist such as "Kwagu'ł" (U'mista Cultural Society, 2025), "Kwakiutl" (Kwakiutl Band Council, 2024), and "Kwagiulth" (Hunt, 2018) referring to the Indigenous people whose ancestral and traditional territories are located on the northeastern coast of Vancouver Island (Kwakiutl Band Council, 2024). I was informed by one of the community advisory group members of this project that "Kwagu'ł" is the more traditional spelling of the

Nation than “Kwakiutl”, and that “Kwakiutl” is used more colonially such as for the registration of the Nation with the colonial government. Dr. Sarah Hunt, a Kwagu’ł scholar, used a different spelling, “Kwagiulth”, when describing her Nation. This spelling is also the closest to how the name of the Nation is pronounced. While respecting Dr. Hunt’s choice of spelling her Nation’s name, I use “Kwagu’ł” consistently in this thesis to respect the local knowledge held in the advisory group and to avoid confusion.

- **Rural:** this term commonly refers to communities outside of population centres. Census (Statistics Canada, 2021) defines population centres as areas with the core population of 10,000 people or higher. However, I use this term mainly to distinguish rural from more populated areas to address specific characteristics of rural communities.
- **Trauma:** this term is commonly used in the colonial knowledge system of psychology and psychiatry referring to “the lasting emotional response that often results from living through a distressing event” (Centre for Addiction and Mental Health, 2025, heading). However, applying a biomedical definition of trauma to understand the vast psychological outcomes of colonial violence experienced by Indigenous women shifts the attention from the colonial system that creates trauma to the individual who experiences trauma (Clark, 2016; de Finney, 2017; Holmes & Hunt, 2017; Million, 2020). Viewing trauma only within the individual context has resulted in “victim-blaming” (de Finney, 2017, p. 13) while leading to the development of a “trauma industry” (Clark, 2016, p. 2) by which the colonial system profits from the outcomes of colonial violence. Acknowledging such

injustice perpetuated through the colonial discourse on trauma, this study views trauma experienced by Indigenous women as a natural human response to colonial violence. Further discussion is provided in Chapter 3 section 3.3.2 on the issues associated with the colonial definition of this term.

- **Women:** while sex is based on biological attributes and is assigned at birth, gender, such as women, refers to socially and culturally molded identities, expressions, and roles beyond biological factors (Trans Care BC, 2025). Cisgender refers to gender experiences of a person whose gender aligns with their assigned sex (Trans Care BC, 2025). Colonialism is based on a binary gender system (Clark, 2016; de Finney; Hunt, 2016; Holmes & Hunt, 2017), that does not reflect the diverse ways in which people experience gender (Trans Care BC, 2025). For many Indigenous Nations, there is a history of gender and sexual orientation existing in ways that differ from colonial norms seen today (Trans Care BC, 2025). Terms such as Indigiqueer and Two-Spirit reflect some of this diversity today (Trans Care BC, 2025). The pain experiences of Indigenous people who are trans, Two- Spirit, and non-binary gender identities should not be assumed to be the same as the experiences of cisgender Indigenous people. Attention should be paid to specific experiences of pain among women with diverse gender identities including cisgender, transgender, and non-binary such as gender-fluid, gender-queer, and Two Spirit. At the same time, I was unable to recruit Indigenous women who identified as trans, Two-Spirit, or non-binary to participate in this study. In addition, none of the literature specifically mentions that their women participants are cisgender, which normalizes cisgender as the universal gender. This study acknowledges that complex sociopolitical oppression exists behind gender distinctions. The term “women” used in this study reflects the experiences of cisgender women unless further descriptions are provided.

- **Wholistic**: this term is commonly spelled as “holistic” meaning “relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts” (Merriam-Webster, 2025). Indigenous scholar, Minogiizhigokwe, Kathleen Absolon (2022) uses the spelling “wholistic” while explaining, “I bring wholism into how we search to restore a wholistic lens in re-search” (p. xv). Informed by Indigenous research methodologies grounded in Indigenous ways of knowing, I use “wholistic” when I referred to the whole as opposed to separatable parts.

Overview of Chapters

This thesis is organized into four chapters. Chapter one provides an overview of current research on chronic pain from the biopsychosocial perspective. I also review scholarship that examined connections between physical pain, colonial violence, and trauma and stress, I address this ‘coloniality of pain’ by analyzing the intricate relationships between Indigenous women’s physical pain and the colonial systems. The latter half of this chapter provides a review of literature relevant to my second question regarding decolonizing pain care and enhancing care equity. I discuss challenges specific to rural pain care in the current neoliberal context.

Chapter two explains my research methodology. This research was developed using a decolonial feminist theoretical framework drawing on Indigenous feminist methodologies such as storytelling and witnessing as well as the practices of settler solidarity and accountability that highlight embodied experiences of Indigenous women in the intersection of Indigeneity and gender in the colonial system. I describe the process of developing this community-based participatory research and discuss ethical considerations, strengths, and limitations as well as lessons learned from the process.

Chapter three responds to my first research question: how does trauma, as an outcome of gendered and racial colonial violence, construct and interact with chronic pain in Kwakwa̲ka̲’wakw women’s lives? Centring the experiential knowledge of pain in relation to colonial violence and trauma shared by the five cisgender Kwakwaka’wakw women who participated in this study, I assert that chronic pain among Kwakwaka’wakw women is a natural human response to colonial trauma and is exacerbated by persistent anti-Indigenous racism in healthcare.

Finally, Chapter four proposes decolonizing approaches to equity-oriented pain care for Kwakwa̲ka̲’wakw women based on the recommendations of the participants. I explore the profound and catalytic roles culture plays for Kwakwa̲ka̲’wakw women’s health, wellness, and healing. I argue that improving Indigenous cultural safety while addressing persistent anti-Indigenous racism should be a priority of decolonizing pain care. Furthermore, Indigenous women’s self-determination should be enhanced at multiple levels of care. Finally, decolonizing pain care should nurture wholistic wellness through biopsychosocial as well as cultural and spiritual approaches to healing.

Chapter One: Coloniality of Pain and Decolonizing Pain Care

In this chapter, I provide a review of recent literature inquiring into Indigenous women's pain experiences. Two questions, based on the aims of my research study, structure this review of the literature. First, how do colonial and gendered violence interact with chronic pain in Indigenous women's lives; and second, what elements and approaches facilitate healing and decolonizing pain care for Indigenous women living in rural communities?

This review is divided into three sections. In section one, I discuss the gaps in the current understanding of pain among Indigenous women. I address the biopsychosocial nature of chronic pain, and that it is an embodied colonial trauma for Indigenous women. I describe comorbidity of trauma and pain and their overlapping biological and psychological mechanisms. I also explore how different types of colonial violence, such as gendered violence, racism, and epistemological violence, contribute to trauma.

In section two, I review literature envisioning decolonizing pain care. Recognizing the limitations of applying Eurocentric trauma therapy modalities to the healing of Indigenous peoples, I assert that revitalization of culture should be at the centre of healing. I also discuss care equity being another essential element of decolonizing care. Reviewing the research on the EQUIP (Research to Equip Primary Healthcare for Equity) framework, I explore three equity-oriented care principles: culturally safe care, trauma- and violence-informed care, and contextually tailored care for rural communities.

1.1 Coloniality of Pain

1.1.1 Gaps in the Current Research on Pain Among Indigenous Women

Chronic pain is a complex and often debilitating experience encompassing the person's cognitive, behavioural, emotional, and functional aspects of everyday life (Mathur et al., 2022).

A person living with severe chronic pain frequently experiences functional challenges such as being unable to work, to care for themselves or others, or to have meaningful engagement in their home and community (Mathur et al., 2022). These functional challenges further negatively affect the person's sense of stability and wellness (Mathur et al., 2022). The person may experience emotional distress (Thanh et al., 2022) such as anxiety and depression, and suicidal ideation (Canadian Pain Task Force, 2019; Petrosky et al., 2018; Racine, 2018; Velly & Mohit, 2018). In fact, chronic pain itself is reported to be an independent risk factor for suicide (Racine, 2018).

There is a growing shift in the field of pain studies recognizing chronic pain as biopsychosocial experiences rather than solely as a biological disease (Canadian Pain Task Force, 2019). The biopsychosocial model of pain acknowledges that pain manifests through compounding interactions among the person's biological, psychological, and social factors (Gatchel et al., 2007). Social factors include a variety of conditions encompassing geographic, economic, spiritual, as well as the outcomes of structural injustice such as colonialism (Holmes & Hunt, 2017). People who identify as women, Indigenous, or a person who faces various discriminatory and challenging socioeconomic conditions (Allan & Smylie, 2015; Canadian Pain Task Force, 2019; Cohen et al., 2021; Mills et al., 2019) such as being homeless, a recent immigrant, a refugee, a person of colour, and/or LGBTQ2S (Craig et al., 2020) are disproportionately affected by chronic pain.

Canadian Pain Task Force (2020) reported that Indigenous people are disproportionately affected by chronic pain; however, gaps exist in research to fully understand the impact of chronic pain among them. It further noted that pain is conceptualized differently among Indigenous peoples, and physical pain is often closely tied to emotional pain. Various forms of trauma and abuse, as well as mental health and substance use issues, can contribute to both emotional and physical pain. In addition, Indigenous peoples experience barriers to accessing culturally safe and trauma informed care because of ongoing colonialism and persistent and prevalent racism in society (Canadian Pain Task Force, 2020).

Women are found to be more commonly affected by chronic pain than men (Canadian Pain Task Force, 2019; Canadian Pain Task Force, 2020; Velly & Mohit, 2018). A variety of biopsychosocial conditions including pain sensitivity, beliefs, susceptibility to medications, sexual orientation and gender roles may contribute to women's pain experiences (Canadian Pain Task Force, 2019; Canadian Pain Task Force, 2020; Mills et al., 2019; Rice et al., 2024). Women, particularly those who identify themselves as lesbian, gay, bisexual, queer, or Two-Spirit (LGBTQ2S), may be more likely to experience gender-based violence and trauma including intimate partner violence (Canadian Pain Task Force, 2020; Heidinger, 2021; Holmes & Hunt, 2017). Women are more frequently affected by pain which accompanies fibromyalgia, irritable bowel syndrome, rheumatoid arthritis, chronic pelvic pain, and migraine headaches (Canadian Pain Task Force, 2019).

Marginalization based on sexual orientation and gender identity may further compound women's pain experiences. Lesbian and bisexual women, in comparison to heterosexual women, are reported to be at a higher risk of arthritis (Canadian Pain Task Force, 2019). Two-Spirit, Indigenous trans and non-gender binary people more frequently experience health conditions that are associated with chronic pain compared to cisgender and heterosexual people (Holmes et al., 2024). Among people who are older or diagnosed with disability, transgender people may be more likely to experience chronic pain than those among cisgender people (Craig et al., 2020). A Canada-wide survey found that Indigenous trans and non-gender binary people frequently experience various types of harassment such as verbal (79% of responders), sexual (54%), and physical (52%) harassment (Trans PULSE Canada, 2021). Discrimination and unsafe care including physical violence by healthcare providers create barriers for trans and non-gender binary people to access safe healthcare (Holmes et al., 2024).

Medical conditions which accompany pain and are frequently experienced by women, such as fibromyalgia and myalgic encephalomyelitis/chronic fatigue syndrome, are poorly understood as they do not fit the current biomedical understanding of pain (Rice et al., 2024). Women suffering from these conditions can face the skepticism of care providers without receiving a diagnosis or treatment (Canadian Pain Task Force, 2020; Rice et al., 2024). Indigenous women further reported "experiences of misogyny" (Canadian Pain task Force, 2020, "Indigenous Peoples" section) when accessing pain care.

Research points to the sociopolitical nature of pain and how intersecting structural injustice shapes Indigenous women's pain experiences. There is an emerging awareness in the field of pain research recognizing chronic pain experienced by socially marginalized people as a manifestation of their traumatic experiences because of structural violence and discrimination (Chae & Walters, 2009; Holms et al., 2024).

1.1.2 Comorbidity Between Pain and Psychological Conditions

Research indicates intimate connections between physical pain and certain psychological conditions. Anxiety and depression, for example, are commonly reported in chronic pain research although comorbidity rates vary widely among studies (Burke et al., 2015; Velly & Mohit, 2018; Yang & Chang, 2019). Velly and Mohit (2018) further noted that people who live with more severe anxiety disorders are found to be at a higher risk of developing chronic pain compared to those with less severe anxiety. In addition, while pain increases the risk of developing anxiety disorders, anxiety disorders also increase the risk of chronic pain. Similarly, depression is found to increase the risk of developing chronic pain. The effect of chronic pain on depression is not clearly stated in this study.

Comorbidity is also found between chronic pain and substance use disorders (Velly & Mohit, 2018; Vogel et al., 2017). The overall comorbidity rates of pain and substance use disorders range between 1% and 15% and the opioid dependency rate between 8% and 12% depending on the definition of disorder, study methodology, and population. Associations are found between opioid dependence and factors such as age, history of opioid use and dependence, depression, and psychotropic medication use. Similarly to anxiety and depression, pain and substance use disorders seem to affect each other reciprocally, although this requires further investigation (Velly & Mohit, 2018).

Furthermore, comorbidity of chronic pain and Post Traumatic Stress Disorder (PTSD) is well documented (Abdallah & Geha, 2017; Hemsing et al., 2016; Outcalt et al., 2015; Siqveland et al., 2017; Timmers et al., 2019). Siqveland et al. (2017) estimated that 9.7% of people with chronic pain also suffer from PTSD although the rate of such association ranges between 2% and 28.3%. PTSD and depression contribute to increased functional disabilities and decrease quality of life (Siqveland et al., 2017). Functional somatic syndrome is poorly understood in medicine, and it includes chronic widespread pain, fibromyalgia, and irritable bowel syndrome (Afari et al., 2014). These conditions are often accompanied by pain, fatigue, sleep disruptions, and functional challenges (Afari et al., 2014). Experience of any type of trauma is found to increase the risk of functional somatic syndrome by 2.7 times (Afari et al., 2014).

Women who have experienced intimate partner violence face elevated risks for anxiety, depression, and a number of health issues that contribute to chronic pain: arthritis, migraine headaches, pelvic inflammatory disease, and functional gastro-intestinal disorders (Ford-Gilboe et al., 2023) as well as fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome and premenstrual syndrome (Hemsing et al., 2016). These conditions may lead to an increased risk and vulnerability to opioid prescription dependence (Hemsing et al., 2016).

In addition, adverse childhood experiences (ACE) are recognized to increase the risk of developing chronic pain. Nelson et al. (2018) reported that over 80% of youth living with chronic pain have experienced at least one incident of ACE. Exposure to three or more ACE incidents is associated with an increased risk of developing more severe anxiety and depression. Sansone et al. (2013) reported that all types of ACE, particularly emotional and sexual abuse, show a strong correlation with pain severity. Similarly, Prangnell et al. (2020) found that emotional abuse shows a moderate and severe association with pain interference later in life, including the use of illicit drugs. Finally, ACE can create intergenerational effects. Not only the child's adverse childhood experiences, but also their parents' adverse childhood experiences contribute to the child's later experiences of chronic pain (Christensen et al., 2021). These comorbidity studies point to the intimate connections among violence, mental health, and chronic pain.

1.1.3 Pain as Stress Response

In the biomedical field, chronic pain is recognized as a central nervous system disorder involving multiple neural networks in the nervous system (Yang & Chang, 2019). The neural network regulates pain perception through both the corticolimbic system in the prefrontal region and the limbic system, which are connected to emotions, memory, learning, motivation, decision making and behavioural responses (Abdallah & Geha, 2017; Yang & Chang, 2019). Unlike acute pain, neuroplasticity and sensitization of pain pathways contribute to the development, maintenance, and exacerbation of chronic pain (Cohen et al., 2021; Yang & Chang, 2019). Chronic pain repeatedly activates the corticolimbic system. This leads to anatomic alteration and functional changes such as difficulty with erasing pain memory and regulating fear behaviours (Yang & Chang, 2019). Furthermore, various neurotransmitters involved in transmitting pain signals affect moods, which may explain the high comorbidity of chronic pain and depression (Yang & Chang, 2019).

Similarly to the pain process, stress response creates anatomic and functional changes through neuroplasticity (Bak et al., 2021; Hunter et al., 2015). Prolonged exposures to fear triggering events can facilitate cascading and compounding effects and alterations in the neuroendocrine system and immune function. These changes may contribute to the development of depression and PTSD (Kovner et al., 2019) as well as a number of pain related disorders such as inflammatory diseases (Gupta, 2013; Hannibal & Bishop, 2014).

Stress and pain are found to share overlapping biological and psychological mechanisms while bidirectionally interacting with each other (Abdallah & Geha, 2017). Both exposure to stress and chronic pain can activate a stress response (Hannibal & Bishop, 2014; Kovner et al., 2019; Timmers et al., 2019). In fact, pain can be viewed as a type of stressor (Hannibal & Bishop, 2014). Repeated exposure to acute stress can also increase pain severity as stress response can lead to inflammation and pain. (Hannibal & Bishop, 2014). In addition, both chronic pain and stress response involve assessment of threat and the triggering of fear (Hannibal & Bishop, 2014; Kovner et al., 2019; Timmers et al., 2019) and may lead to psychological experiences such as increased severity of depression and anxiety, and decreased capacity for memory and learning (Timmers et al., 2019).

Stress also interacts with pain through epigenetic processes. Epigenetic studies explain how exposure to even a single stressful event may alter gene expression through a variety of mechanisms (Doewes et al., 2021; Hunter et al., 2015; Gupta, 2013). Such epigenetic changes may contribute to increased intergenerational and gender-specific risks of physical and mental health challenges (Christensen et al., 2021).

These overlapping and interactive biological and psychological mechanisms pose an alternative conceptualization of pain and trauma as the “two sides of the same coin” (Abdalla & Geha, 2017 p.1). A study by Krieger (2005) argued that human bodies are “active and engaged entities” (p. 351) which tell stories of their lived experiences even beyond their awareness. Ehrkamp et al. (2019) asserted in their study of PTSD among refugees that trauma should be perceived as a body-mind experience for the individual in the particular political geographies rather than a psychological and mental health diagnosis. Stilwell and Harman (2019) further described the wholistic and embodied nature of pain and how pain develops through a “dynamic sensorimotor loop” (p. 645) within the body, which is deeply embedded in the geopolitical and socioeconomic environment. Johnson-Jennings et al. (2014) postulated that pain among Two-Spirit people “may serve as the embodiment of discrimination” (p. 1667).

Articulating the close connections among pain, stress, and trauma, these studies describe interactive biopsychological processes in response to the person’s sociopolitical environment. Chronic pain among Indigenous women may also be conceptualized as an embodiment of their trauma from intersecting forms of structural violence.

1.1.4 Colonial Gendered Violence Against Indigenous Women

The literature indicates that chronic pain for Indigenous women may be viewed as an embodiment of structural violence, a manifestation of biopsychosocial conditions in response to their sociopolitical environment. In order to fully address this concept, it is essential to grasp the extent of violence against Indigenous women built into the colonial system and how it continues to shape their lives.

Canada is a settler-colonial state, which was built and has been maintained by multifaceted violence in order to displace Indigenous peoples from their territories (Coulthard, 2014). Built on racism as its foundation, systemic colonial violence has paved the road to the present-day settler-colonial state of Canada. The Indian Act of 1876 was developed by consolidating two previous assimilation policies: the Gradual Civilization Act of 1857 and the Gradual Enfranchisement Act of 1869 (Allan & Smylie, 2015). The Indian Act remains in effect today granting the power to the federal government to limit and control identity, access to resources, and sovereignty among Indigenous peoples (Allan & Smylie, 2015; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Assimilation policies and systems led to the development and operation of residential schools, TB hospitals, sixties scoop, and today's child welfare system. Colonial systems continue to perpetuate the harmful effects of historical, intergenerational, and multigenerational trauma among Indigenous peoples, which manifest as health and social disparities (Latimer et al., 2018).

Colonization relies on heteropatriarchal values in order to be enacted (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019) and targets Indigenous women and girls in a specific way. The colonial system forced Indigenous peoples to comply with a heterosexual and patriarchal family system (Allan & Smylie, 2015; Clark, 2016; de Finney, 2017; Holmes & Hunt, 2017). Section 3 of the Indian Act of 1876 defined “Indian” to be: “first as any male person of Indian blood, reputed to belong to a particular band; second, any child of such person; and third, any woman who is or was lawfully married to such person (Stevenson, 2020, pp. 39-40). Up to 1985, Indigenous women who married non-Indigenous men lost their Indian status under the Indian Act, although non-Indigenous women who married Indigenous men were granted Indigenous status (Coulthard, 2014). The Gradual Enfranchisement of Indians Act drastically limited the rights of Indigenous women including their participation in political actions. It also removed the right for Indigenous women to receive inheritance (Coulthard, 2014). Clark (2016) wrote that “Colonization required the silencing of Indigenous women, as the matriarchal and co-operative societies did not fit within the individualistic and patriarchal ways of the colonizer” (p. 3). Bill C-31 in 1985 was aimed at addressing gender inequalities among Indigenous women and men. However, rather than restoring the rights of women to give status to their children, it instead equally limited the capacity to bestow Indigenous status to their children for both status men and status women (Allan & Smylie, 2015).

Two-Spirit people in North American Indigenous cultures include a wide range of non-binary gender and sexual identities reflecting their spirituality and worldviews (Hunt, 2016). Two-Spirit people in traditional Indigenous cultures played significant roles and had responsibilities as teachers, healers, and knowledge keepers (Hunt, 2016). However, the colonial system enforced heterosexuality and cisnormativity over Indigenous peoples, and this has contributed to violence, discrimination, and social marginalization against Two-Spirit people (Holmes et al., 2024; Holmes & Hunt, 2017; Hunt, 2016).

Thus, colonization, as a cisheteropatriarchal racist system, has generated sexual exploitation and gender-based violence against Indigenous women (Daoud et al., 2013; de Finney, 2017; Morton, 2018; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Ogden & Tutty, 2023). Heidinger (2021) reported that physical and sexual violence affects Indigenous women more frequently than non-Indigenous women. In addition, Indigenous women more frequently experience childhood physical and sexual abuse by an adult (Heidinger, 2021).

Indigenous women face intimate partner violence much more frequently than non-Indigenous women. The Public Health Agency reported in their 2018 survey that 61% of Indigenous women as opposed to 44% of non-Indigenous women had experienced intimate partner violence since they were 15 years old. Heidinger (2021) reported that 86% of Indigenous LGBTQ2S women experienced intimate partner violence as opposed to 59% of non-Indigenous LGBTQ2S women.

Intimate partner violence leads to more serious outcomes for Indigenous women. 51% of Indigenous women as opposed to 39% of non-Indigenous women reported being injured by their intimate partners (Department of Justice Canada, 2022). Daoud et al (2013) described how intimate partner violence against Indigenous women is influenced by various sociopolitical and economic factors resulting from colonization and structural injustice, such as violence and trauma, disrupted connections to culture and kinship, heteropatriarchal gender roles, financial stress, and lack of social support.

Violence against Indigenous women is found to be more lethal. Indigenous women are about six times more likely to be murdered than non-Indigenous women (Statistics Canada, 2023b). In addition, Indigenous women are eight times more likely to be killed by intimate partner violence than non-Indigenous women (Department of Justice Canada, 2022).

Racism, sexism, homophobia and transphobia create targeted violence against Two-Spirit people (Hunt, 2016). Two-Spirit people report various types of violence and trauma (Holmes & Hunt, 2017). Two-Spirit women are reported to be even more likely to experience sexual and physical violence than heterosexual Indigenous women and white lesbian women (Hunt, 2016).

The settler-colonial state of Canada not only fails to address such violence against Indigenous women but rather continues to inflict colonial violence. Indigenous women experience a higher rate of police violence (Palmater, n.d.; National Family and Survivors Circle, 2022). Police interventions are often reported to be either violent and abusive or indifferent (Cunneen & Tauri, 2018).

In addition, the criminal justice system and child welfare system replaced residential schools and the reserve system while continuing to reinforce assimilation and segregation policies (Chartrand, 2019). Chartrand (2019) argued that “the penitentiary has been central to a project of modern colonialism in Canada in establishing settler domination” (p. 78). 2021 census data showed that 53.8% of children in the child welfare system were Indigenous although only 7.7% of all children under the age of 14 were Indigenous (Public Health Agency of Canada, 2018). Health disparities, poverty, and a high rate of intimate partner violence which are the outcome of the colonial system justifies child protection while advancing the assimilation policy (Humphreys & Absler, 2011). Being disguised as serving “the best interests of the child” (Cassidy, 2006, p. 125), the current Canadian child welfare system, just like the residential school system and the Sixties Scoop, continues to perpetuate colonial violence against Indigenous children and families (Clark, 2016). It fulfills the colonial agenda of assimilating Indigenous children while disrupting Indigenous kinship and violating women’s right to parent (Stevenson, 2021). These reports vividly portray how the structural violence of assimilation continues to affect Indigenous women’s lives in present-day Canada.

1.1.5 Care Inequities: Indigenous Women’s Experiences of Accessing Pain Care

In addition to physical violence, racism is a type of colonial violence (Cunneen & Tauri, 2018). Contributing to the sociopolitical aspect of pain (Bailey et al., 2023; Goodman et al., 2017; Letzen et al., 2022; Mathur et al., 2022), racism moulds people’s pain experiences (Allan & Smylie, 2015; Nelson & Wilson, 2018; Turpel-Lafond, 2020) while forming their meanings of pain (Wallace et al., 2021). Exploring the effects of racism in relation to colonization reveals the nature of interactions between trauma as a result of colonial violence, and Indigenous women’s pain experiences.

Racism is at the root of colonization which legitimizes the settler-colonial dominance over Indigenous peoples (Allan & Smylie, 2015). Quijano (2000) argued that the concept of race in the Americas developed through the colonial context. Race has played a central role in establishing and maintaining the colonial social order for the purpose of advancing the colonial capitalist agenda. ‘Whiteness’, which encompasses all of the systems associated with Western-Europe, has become privileged creating the modern Eurocentric capitalist world as we know it today (Quijano, 2000).

Racism thus works in multiple ways in Canada to secure settler-colonial domination. An inquiry into Indigenous specific racism in healthcare in British Columbia (Turpel-Lafond, 2020) reported that derogatory and misogynistic labels such as “squaws” are specifically used against Indigenous women and attempt to devalue Indigenous women’s bodies. Such stereotypes perpetuate racist and sexist prejudice against Indigenous women as being sexually promiscuous while justifying and sustaining sexual violence against them (Turpel-Lafond, 2020).

Anti-Indigenous racism in healthcare continues to shape Indigenous women’s pain experiences. It justifies stereotyping, thus contributing to minimizing the severity of self-reports and refusing to provide treatment and culturally safe care. It trivializes the effects of colonial violence on health by viewing them as personal pathology or the outcome of poor personal choices (Allan & Smylie, 2015; Brown et al., 2018; Canadian Pain Task Force, 2020; Goodman et al., 2017; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019). Turpel-Lafond (2020) reported that Indigenous people frequently experience stereotypes such as “drunken Indian”, “drug seeking”, “non-compliant”, and “frequent flyer” (p.19) in current Canadian healthcare settings. Following from these racist stereotypes, chronic pain among Indigenous women is also frequently viewed as the consequences of their poor lifestyles, risky behaviours, and treatment noncompliance (Yu et al., 2019).

These stereotypes and assumptions reveal and shape care providers’ biases about their Indigenous patients. They contribute to poor quality care (Wylie & McConkey, 2019), including delayed diagnosis, treatment, or referrals to specialists, insufficient or denied access to pain management medications, rough treatment, negligence, and death (Nelson & Wilson, 2018; Turpel-Lafond, 2020). Indigenous people suffering from rheumatoid arthritis received between 36 and 51% fewer visits to a specialist and on average two fewer surgeries compared to non-Indigenous people (Loyola-Sanchez et al., 2017).

Studies have documented Indigenous peoples’ frustration and distrust towards the current colonial healthcare system. Nelson and Wilson’s study (2018) based in Prince George, British Columbia, described several care issues such as delayed or misdiagnosis, refusing to provide pain management medications, lack of treatment, long wait times at emergency, long waitlist for routine care, limited time available at each appointment, and perceived discrimination when Indigenous patients interacted with care staff.

In addition, Indigenous patients seeking healthcare frequently report healthcare staff being reluctant to provide sufficient pain management medications on the assumption that Indigenous patients have addiction issues (Barnabe et al., 2019; Goodman et al., 2017; Wallace et al., 2021). Some healthcare providers are reported to quickly fill out pain management prescriptions without listening to the patients or addressing their concerns properly (Barnabe et al., 2019).

Indigenous peoples' experiences of racism in healthcare create compounding outcomes to their pain experiences. Because of loss of trust in the healthcare system, Indigenous people may minimize or ignore their own pain (Barnabe et al., 2019) and they are less likely to seek timely treatment (Craig et al., 2020). Inflammatory arthritis such as rheumatoid and spondyloarthritis are reported to be twice as common among Indigenous people as among non-Indigenous people. Delayed intervention for these conditions can result in increased severity and a higher hospitalization rate (Barnabe et al., 2019).

Secondly, damaged relationships between Indigenous people and healthcare workers lead to internalized stigma (Canadian Pain Task Force, 2020), psychological distress, and increased pain (Brown et al., 2018). Stigma is often created through pain care when a care provider disapproves, dismisses, and minimizes the person's pain reports (De Ruddere & Craig, 2016). Repeated exposure to care provider's disbelief and lack of compassion can lead to internalized stigma (Perugino et al., 2022) resulting in self-doubt, decreased sense of self-worth (De Ruddere & Craig, 2016), and a lower sense of personal agency and control over pain (Perugino et al., 2022).

Finally, people's experiences of racism, discrimination, and stigma not only contribute to poor pain management because of insufficient or absent care, but they also directly exacerbate pain through the neurobiological response (Brown et al., 2018). Racism in fact functions as "a chronic stressor" (Allan & Smylie, 2015, p. 13) triggering and reinforcing stress response. Patients' experiences of discrimination are found to be associated with the severity of pain as well as their decreased capacity to perform daily living tasks (Ziadni et al., 2020). In addition, psychological distress due to accumulated exposure to racism and perceived discrimination throughout life positively correlates with pain severity (Brown et al., 2018).

Addressing care equity requires organizational commitment to on-going care provider education and monitoring, as well as initiating policy and organizational change. However, regardless of the increasing attention to the harmful effects of anti-Indigenous racism, the healthcare system has not shown sufficient commitment (Yu et al., 2019). Wylie and McConkey (2019) reported that the healthcare workers' understanding of Indigenous health issues is mostly informed by popular media. More than half of Indigenous healthcare workers reported experiencing racism in their workplace (Turpel-Lafond, 2020). Indigenous specific interpersonal racism is frequently viewed as "cultural difference" (Allan & Smylie, 2015, p. 28) without being recognized as a structural oppression.

Through both individual care provider's biases and organizational policies, racism provides justification for health disparities and care inequity affecting Indigenous women while shaping their pain experiences. Addressing racism and discrimination is an essential element of care access (Allan & Smylie, 2015; Browne et al., 2016; Canadian Pain Task Force, 2020). A further review of the current literature on care equity issues is provided in section 1.2.3.

1.1.6 Epistemological Violence

Epistemological violence refers to the "denial of Indigenous knowledges and viewpoints" (Cunneen & Tauri, 2018, p.351) by viewing "the knowledge of one racialized group as superior to another" (Allan & Smylie, 2015, p.5). Epistemological violence is another type of colonial violence which shapes and interacts with Indigenous women's pain experiences. Canada has been denying Indigenous knowledge systems, spirituality, and worldviews to advance colonization (Cunneen & Tauri, 2018). Walter Mignolo (E-International Relations, 2017) articulated that “Modern epistemology was built precisely to make sense of, justify, and legitimize coloniality” (p. 3). Epistemological violence has been evident in Canadian policies through criminalizing Indigenous cultural practices, language, and laws and governance systems while reinforcing the Eurocentric knowledge system (Truth and Reconciliation Commission of Canada, 2015).

Epistemological violence is visible in present pain care, which relies on the Eurocentric and biomedical understanding of pain as the single truth while dismissing and minimizing Indigenous people’s pain reports (Bailey et al., 2023). Care providers’ lack of awareness about how pain is shaped by biopsychosocial factors negatively influences Indigenous women’s pain experiences in multiple ways. It reduces Indigenous women’s pain experiences to their individual pathology. Women continue to experience being doubted and brushed off about their pain experiences (Turpel-Lafond, 2020). In addition, it denies that culturally based pain beliefs exist outside of the Eurocentric knowledge about pain. Relying solely on biomedical knowledge of pain fails to embrace the idea that health is culturally defined, and culture informs approaches to healing and care (Goodkind et al., 2012; Oulanova & Moodley, 2017). Furthermore, relying only on the biomedical understanding of pain fails to capture Indigenous women’s expression of pain. Currently available Eurocentric pain assessment tools are not effective or adequate to capture their personally felt pain experiences (Latimer et al., 2020).

There is an emerging awareness of the harm of epistemological violence in pain care and the need for developing culturally appropriate pain assessment methods (Bailey et al., 2023). Storytelling, for example, is recognized as a culturally appropriate method for capturing pain experiences among Indigenous peoples (Bailey et al., 2023; Latimer et al., 2018; Latimer et al., 2020). Latimer et al. (2020) asserted that pain among Indigenous people can be experienced not as a mere biomedical disease but rather as cultural and spiritual pain. Pain can be expressed non-verbally and care providers must be attentive to both verbal and non-verbal expressions of pain (Latimer et al., 2020).

Built on an awareness of the harm of epistemological violence, the present study directly sought Indigenous women's knowledge of pain, its interactions with colonial violence and trauma, and the essential elements for decolonizing pain care guided by culturally appropriate methods such as storytelling and Two-Eyed Seeing (Bailey et al., 2023; Latimer et al., 2018; Latimer et al., 2020). Further information about these cultural methods is provided in section 1.2.2.

1.2 Decolonizing Pain Care

This section addresses the current research related to my second question: what elements and approaches facilitate healing and decolonizing pain care for Indigenous women particularly in rural communities? Although awareness is emerging in the field about the relationship between colonization and chronic pain among Indigenous peoples (Oliveira et al., 2023), Canadian Pain Task Force (2020) reports that current pain care in the healthcare system remains predominantly Eurocentric. Recognizing pain among Indigenous women as an embodied colonial trauma points to the need to decolonize pain care by actively addressing the coloniality of pain.

Len Pierre, a Coast Salish educator and activist from the Katzie Nation, defined decolonization as a "process of disrupting, dismantling, and deconstructing culture and colonial barriers that separate us, suppress us, and often oppress us" (2019, p. 21). At the same time, Tuck and Yang (2012) argued that decolonization must always be grounded in "repatriation of Indigenous land and life" (p.1). The health of Indigenous peoples is deeply rooted in their territories. It cannot be addressed while ignoring the fact that Canada is built on colonial violence both to Indigenous peoples and their territories. Being aware of the political responsibility and everyday practices called forth with the word "decolonization" (Hunt & Holmes, 2015), the remainder of this section reviews studies which inform elements of decolonizing care such as "culture-as-treatment" (Wendt et al., 2022, p. 809). I also report on studies which examined improving care equity promoted by culturally safe and trauma- and violence-informed care practices. I further discuss factors specific to rural communities and the necessity to contextualize care grounded in the local knowledge.

1.2.1 Colonial Trauma and Current Trauma Therapies

Trauma is deeply intertwined with Indigenous women's pain experiences. Trauma in the Euro-colonial framework refers to a broad range of psychological, neurobiological, and cognitive responses to single or multiple events often involving overwhelming psychological responses such as fear, stress, hopelessness (Isobel, 2021) and accompanied by behavioural outcomes and daily functional challenges (Bargeman et al., 2022). However, criticism has been made against applying such Western medical conceptualization when understanding Indigenous peoples' trauma experiences (Clark, 2016).

Urrieta (2019) argued that colonial trauma creates collective and multigenerational effects for Indigenous peoples over their social, cultural, and spiritual domains. The effects of colonial trauma on Indigenous peoples thus stretch far beyond their biological, psychological, or behavioural aspect. Duran (1990, as cited in National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019) asserted that colonial trauma creates "soul wounds" (p. 112) and trauma healing for Indigenous peoples is fostered through reconstructing traumatic experiences in relation to colonization and structural oppression (Duran et al., 2008). Duran et al.

(2008) warned that well-intentioned helping professionals may perpetuate “psychological oppression” (p. 288) without a critical awareness about how structural oppression continues to generate colonial trauma among Indigenous peoples.

Applying Eurocentric approaches and interventions for trauma to Indigenous women thus risks perpetuating and compounding colonial trauma. It fails to address the social justice nature of trauma. Clark (2016) argued that trauma has become an “umbrella term” (p. 4) encompassing all types of trauma ranging from “car accidents to genocide” (p. 4). Failure to acknowledge the colonial nature of trauma for Indigenous peoples leads to reinforcing the Eurocentric definition of trauma as a psychiatric pathology leading to “the individualized and medicalized approach to trauma” (Clark, 2016, p. 2) while eroding Indigenous people’s resilience. In addition, little is known about the efficacy of Eurocentric approaches for Indigenous peoples due to lack of evidence on therapy approaches for trauma treatment for Indigenous people in North America (Wendt et al., 2022). Furthermore, concepts of health and well-being are culturally defined. Fundamental differences exist about wellness between Indigenous and European cultures. Recognizing such differences leads to the need for radical reconstruction of therapy goals, approaches, and applications. However, cultural adaptations made to conventional approaches often remain at the surface level while therapy models continue to be specific to a disorder (Wendt et al., 2022). Rather than seeking cultural adaptations to Eurocentric models, increasing attention is paid to viewing “culture-as-treatment” (Wendt et al., 2022, p. 809), centering healing in revitalization of culture.

1.2.2 Culture

Studies have begun to address how culture directly and indirectly informs healing for Indigenous peoples. Culture is “a dynamic and adaptive system of meaning that is learned, shared, and transmitted from one generation to the next and is reflected in the values, norms, practices, symbols, ways of life, and other social interactions of a given culture" (Krueter & McClure, 2004, as cited in National Collaborating Centre for Aboriginal Health, 2016, p. 1). Oliveira et al. (2023) further described culture as "the web of meanings and the lenses through which these people understand, explain, and interpret the world" (p. 1). Wellness is a culturally defined concept rooted in collectively held identity and values (Clark et al., 2022; Duran et al., 2008; National Collaborating Centre for Aboriginal Health, 2016).

Significant differences exist between Indigenous and Eurocentric beliefs about wellness and healing practices. Although differences do exist among Indigenous Nations, Indigenous cultures often share a common view about the wholistic nature of health and wellness (Yu et al., 2019). Rather than viewing a human body as an amalgamation of separate parts, wellness is achieved through maintaining harmonious relationships within the person, with families and communities, and with the territory (Dumont & National Native Addictions Partnership Foundation, 2014). Healing is a process of restoring such wholistic relationships (Yu et al., 2019).

As previously discussed, chronic pain among Indigenous peoples can be experienced as much more than bio-neurological disorders but rather experienced as psychological, spiritual, and cultural pain in response to colonial trauma (Latimer et al., 2020). Goodkind et al. (2012) wrote that "If social injustice is one of the root causes of distress, healing must be explicitly guided by transformative social change efforts that build on individual, family, and community strengths" (p. 1019). Decolonizing healing must be rooted in the strengths, resistance, resilience, and resurgence of the Indigenous peoples as a collective (Mitchell, 2017).

Revitalization of culture fosters self-determination, personal and collective agency, and autonomy, and it plays a critical role for Indigenous women's wellness and healing (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Centering healing in cultural revitalization counteracts colonial violence by fostering a collective identity, empowerment, and resilience. Fostering individual and collective agency can facilitate each woman seeking knowledge about their pain and determining the course of treatment even if they chose conventional Western medicine over traditional healing methods (Cidro et al., 2018).

Psychological resilience is nurtured through the process of cultural revitalization where personal and collective identities are reconstructed in the relationship with self, community, society, and beyond (Kirmayer et al., 2011). The study by Varcoe et al. (2019) affirmed that rebuilding a sense of self and identity separate from trauma is essential for healing from trauma. This process can be facilitated through cultural practices such as Talking Circle and support from Elders. Elders' support is reported to be one of the essential elements of healing through which participants become reconnected to their culture. Similarly, participating in the practice of Talking Circle as a safe and trusting environment enhances participants' connections to others and to self.

Latimer et al. (2020) advocated that the FIRST approach for care providers should be: engaging the family and community, being attentive to how culture shapes communication, nurturing relationships by listening, creating a safe-space, and utilizing Two-Eyed Treatment, which offers both Indigenous and Western treatment choices. Two-Eyed Seeing is a cultural concept introduced by Mi'kmaq Elders, Albert and Murdena Marshal, allowing values of both Indigenous traditional medicine and Western medicine in pain treatment. While traditional activities to manage pain are valuable when supported by wide family connections, conventional care is also useful when grounded in compassionate care relationships.

Finally, research reports that care providers' awareness about the colonial nature of pain and the role of culture in healing is essential for building trust in care relationships. Loyola-Sanchez et al. (2020) articulated that trust is fostered when the care provider shows empathy and respect for the patients' knowledge about pain, acknowledges cultural factors affecting pain, and promotes personal agency and collaborative decision making for treatment of pain. In the remaining sections of this review, I discuss the current knowledge about the essential elements to improving care equity.

1.2.3 Equity Oriented Healthcare: EQUIP

Decolonizing pain care must address the current care inequities based on racism and intersecting forms of structural violence and discrimination. The EQUIP (Research to Equip Primary Healthcare for Equity) Health Care Research team offers promising directions for improving care equity by addressing structural inequities, racism, discrimination and stigma, and barriers to healthcare access experienced by people who are most affected by these inequities (Browne et al., 2016; Browne et al., 2018; Ford-Gilboe et al., 2018; Varcoe et al., 2019; Wallace et al., 2021).

EQUIP promotes three principles: trauma- and violence-informed care, culturally safe care, and contextually tailored care (Browne et al., 2016; Browne et al., 2018; Ford-Gilboe et al., 2018; Varcoe et al., 2019; Wallace et al., 2021). Ford-Gilboe et al. (2018) defined these principles:

- Trauma- and Violence-Informed Care (TVIC) extends beyond trauma-informed practice to explicitly acknowledge and address the intersection and cumulative effects

> of interpersonal (eg, child maltreatment, intimate partner violence) and structural (eg, poverty, racism) forms of violence on people's lives and health.
>
> - Culturally Safe Care (CSC) moves beyond culturally sensitive approaches to explicitly address inequitable power relations, racism, discrimination, and ongoing effects of historical and current inequities within health care encounters.
> - Contextually Tailored Care (CTC) expands the individually focused concept of patient-centred care to include offering services tailored to the specific health care organization, the populations served, and the local and wider social contexts. (p.640)

These principles foster care providers' understanding about health disparities rooted in sociopolitical and economic issues as well as their awareness about stigma and discrimination. In addition, EQUIP promotes institutional changes by providing continuing staff education and monitoring practice, designing a welcoming space, and developing collaboration with Nations and community partners (Browne et al., 2016).

Wallace et al. (2021) applied the EQUIP framework to pain research. This study highlighted how care inequity shapes pain experiences among people who face broad intersecting socio-economic issues such as being Indigenous, LGBTQ2S, refugees and newcomers. It reported that care providers must develop an awareness about their own power in care relationships. They also must understand how people's beliefs about pain are shaped by their experiences depending on their social locations, and that each person may identify themselves with multiple aspects of social locations. This study further argued that it is essential for care providers to actively address their assumptions which result in discriminatory practices. Finally, care should be tailored to each person "while avoiding judgement and expressing compassion for the dignity of each person" (Wallace et al., 2021, p. 10).

Browne et al. (2018) evaluated the effects of staff education on implementing the EQUIP framework of care at four primary care clinics over 8 to 12 months. This study reported increased awareness among care staff and leadership of the relationship between social marginalization and its contribution to health disparities. It also improved their knowledge about the relationship between chronic pain, violence, trauma, and mental health and substance use issues. Care staff's understanding about the colonial nature of pain increased their empathy and facilitated a shift in their communication both with their patients and care staff. Harm reduction approaches were more actively applied within pain management.

EQUIP intervention was further found to improve health outcomes of their patients. A study by Ford-Gilboe et al. (2018) measured patients' evaluations of care equity, confidence to manage their health issues, and quality of life. Out of 395 participants, over 40% identified themselves as Indigenous. Patients reported increased comfort and trust in care and greater confidence to manage their health issues. They further reported decreased symptoms of depression, PTSD, and chronic pain. Patients' experiences of discrimination on the other hand were found to negatively affect these care outcomes. The rest of this section examines each of the EQUIP principles to clarify current understanding about factors associated with care equity.

1.2.4 Culturally Safe Care

EQUIP addresses culturally safe care as one of the essential elements of equity-oriented care (Browne et al, 2016; Wallace et al., 2021). The term, cultural safety, has attracted attention globally in the healthcare field (Hardy et al., 2023). Originally proposed by Indigenous care providers in New Zealand (Anderson et al., 2003), cultural safety addresses power dynamics in care, specifically how care provider assumptions and discrimination contribute to health disparities (Anderson et al., 2003; Gerlach, 2012; Hardy et al., 2023; Nelson & Wilson, 2018;

Wallace et al., 2021). Culture in this context refers to broader and intersectional categories contributing to care equity encompassing ethnicity, gender and sexuality, disability, and socioeconomic status (Gerlach, 2012). Brown et al. (2011) argued that rather than women's personal choices or lack of adherence to care, unsafe care derives from "erosion and dismissive practices and contexts that impacted women's power, choice, and control" (p. 113). Care providers are responsible to actively challenge the care inequity as a result of structural injustice such as racism, discrimination, marginalization and other impacts of colonization (Browne et al, 2016; Wallace et al., 2021).

A number of cultural safety courses are available across Canada. San'yas, for example, has offered Indigenous cultural safety (ICS) training courses in Canada since 2008 to health, education, social services, and business sectors (Provincial Health Services Authority, n.d.). Up to 2020, over 120,000 people have accessed San'yas training (Provincial Health Services Authority, n.d.). Participants have reported significantly increased awareness of their assumptions about Indigenous patients, which led to shifting their beliefs and attitudes (Hardy et al., 2023).

The efficacy of ICS programs requires further research. Hardy et al. (2023) reported that very few studies have examined the efficacy beyond care providers' self-reports. No studies have evaluated patients' experiences, changes within care practice, health outcomes or a shift at the organizational level. Smylie et al. (2024) examined the effects of San'yas ICS training in terms of change within care providers' practices. 58 non-Indigenous physicians and nurse practitioners in Ontario received 8-to-10-hour ICS and an hour-long anti-bias training. Then clinician-patient interactions and adherence to cultural safety were rated. The study did not find a statistically significant result due to a small sample size. However, it found that the clinicians who took ICS training were more likely to be recommended by patients suggesting that ICS training could improve patient care quality.

Finally, inconsistencies in cultural safety training are reported within healthcare education, and a coordinated approach is warranted to create a mandatory and on-going cultural safety training across healthcare disciplines (Turpel-Lefond, 2020). For example, different terms have been used among training programs referring to cultural safety such as cultural awareness, security, respect, competency, or humility (Hardy et al., 2023). Perceiving cultural safety as cultural awareness, competency, or sensitivity dismisses the political nature of culture and fails to address the power differences which normalizes whiteness (Pon, 2009). Cautions are raised that cultural safety could easily be turned into colonial jargon obscuring the role of coloniality at the root of discrimination and biases among care providers (Pon, 2009). Failure to centre cultural safety on power differences would further perpetuate colonial violence (Gerlach, 2012). Keeping these warnings in mind, cultural safety provides a pathway towards decolonizing pain care for Indigenous women.

1.2.5 Trauma- and Violence-Informed Care

Trauma- and violence-informed care (TVIC) provides another essential perspective on care equity. TVIC is grounded in the understanding that people who are marginalized in society may frequently be faced with structural violence which results in trauma and a variety of health issues including chronic pain as well as mental health and substance related challenges (Browne et al., 2016). TVIC fosters the care providers' shift in their view of trauma among marginalized people from personal pathology to the outcome of systemic and structural violence.

Acknowledging the close associations among structural violence, trauma, and pain, TVIC is considered to be one of the essential components for chronic pain care for marginalized populations (Browne et al., 2016; Ford-Gilboe et al., 2018; Wallace et al., 2021). By building respectful relationships and a sense of safety, TVIC strives to minimize retraumatization of patients and improve their access to care (Bargeman et al., 2022). TVIC promotes a patient-centred approach to enhance autonomy and empowerment (Ades et al., 2019) by actively sharing information, providing options, and collaboratively developing intervention plans (Raja et al., 2015). TVIC further draws attention to care staff's knowledge and awareness about themselves, such as their own trauma history, beliefs, and values, as these factors contribute to the care staff's responses and assumptions (Raja et al., 2015).

TVIC implementation involves a multifaceted approach beyond individual care providers including collaboration at system, organization, and community levels (Bargeman et al., 2022). Infrastructural changes require adequate funding for staff training as well as obtaining screening and assessment resources. Organizations need to develop interdepartmental coordination to strengthen TVIC implementation across care while incorporating and monitoring routine trauma screening.

Large variations are reported among current TVIC training programs particularly across disciplines (Jackson & Jewell, 2021). TVIC training can be a one-hour information training, frequently for physicians and nursing staff (Niimura et al., 2019; Powers et al., 2023). It can also be a multi-day training with follow up for child welfare and mental health staff (Jackson & Jewell, 2021).

Reviews of multi-day programs have found positive outcomes both for care providers and the well-being of children in the child welfare system. These TVIC trainings build knowledge about trauma and about TVIC implementations among care providers. They improved communication and collaboration among care staff. They also increased the well-being of children in care with respect to emotional regulation and behavioural and functional outcomes (Jackson & Jewell, 2021).

Brief trainings are also reported to increase care providers' knowledge about trauma and their sense of comfort in providing care. However, studies have not addressed the effects of brief trainings with respect to either the care providers' change within their practices or patients' health outcomes (Jackson & Jewell, 2021). Additional research is warranted to address care outcomes of brief TVIC trainings.

1.2.6 Contextually Tailored Care for Rural Communities

This section discusses the need for community-specific interventions instead of applying a universal approach to pain care for Indigenous women. Contextually tailored care in the EQUIP framework highlights the individual and groups' specific interests and needs in their local and community context (Browne et al., 2016; Wallace et al., 2021). It promotes developing specific policies, procedures, and practices which address unique local needs (Browne, 2016; Wallace et al., 2021). Communities and organizations are viewed as complex and evolving entities with their own unique history, culture, and ways of operation grounded in their specific local factors. Rather than adopting generalized and standardized approaches, it promotes interventions founded on these unique contexts.

Rural communities in Canada in general possess different demographic and socio-economic characteristics in comparison to urban centres. According to the report by Canadian Institute for Health Information (2006), rural areas are found to have larger proportions of children, youth and aging populations as well as lower education, income, and higher unemployment rates. Chronic health presentations are found to be more complex depending on the specific illness and gender. Among them, arthritis and rheumatism were more prevalent in rural communities. Furthermore, a recent study by Audet et al. (2024) reported that in Quebec, people living in rural areas are more likely to use pain medications and cannabis to manage pain compared to people who experience chronic pain in urban areas.

Many rural communities have a higher proportion of Indigenous Peoples (Statistics Canada, 2023a). Indigenous peoples in rural communities face barriers to accessing care, and geographic challenges are magnified among Indigenous people. During 2015 and 2018, only 35% of Indigenous women and girls living in very remote areas had regular access to primary care compared to 87% of those living in more accessible areas. Among non-Indigenous women, the percentages were 55% and 88% respectively (Amini, 2022).

The Canadian Pain Task Force (2020) noted that the general lack of access to pain management resources across Canada resulted in poorer health outcomes. Neoliberal policies prioritize cost effective care based on market-driven economic values while placing responsibility on individuals for their own health and welfare (Brown et al., 2012). Such policies have deepened health inequity between rich and poor and particularly for Indigenous people who live in rural communities needing to travel long distances to access specialized care (Brown et al., 2011; Canadian Pain Task Force, 2020; National Collaborating Centre for Indigenous Health, 2019).

For example, an early diagnosis of lower back pain combined with access to physiotherapy care is found to decrease the need for opioid pain management by 89% (Crockett et al., 2022). However, rural Indigenous people receive inconsistent, limited, or no access to primary and specialised care (Bailey et al., 2023). With the exception of care through virtual platforms, access to specialized pain care requires a long journey to urban centres. Receiving care away from their community disrupts Indigenous peoples’ connections to family, supports, and culture. In addition to the physical burden, traveling long distances to access specialized care can create a financial burden. Although Indigenous people with status are eligible for a travel allowance, the permitted allowance may be insufficient to cover the cost of travel (Brown et al., 2011). Virtual care may also not be readily available in remote communities (Canadian Pain Task Force, 2020). Limited care availability, longer wait times, and greater distances to access specialized pain care contribute to delayed diagnosis and intervention, which compounds health disparities (National Collaborating Centre for Indigenous Health, 2019).

Pain research has not yet sufficiently explored how such rural community-specific factors interact with Indigenous women's pain experiences. Despite the apparent deficits, unique community-based resources also exist in rural communities. For example, residents in rural communities report a stronger sense of community and belonging (Canadian Institute for Health Information, 2006). Dassieu et al. (2021) described social networks as one of the protective factors for pain. Further research is warranted to develop contextualized pain care for Indigenous women outside of urban centres.

1.3 Conclusion

Research has documented that historical, intergenerational, and on-going gendered colonial violence creates traumatic experiences throughout Indigenous women's lives. Chronic pain develops in interaction with these traumatic experiences through stress response and epigenetics. Racism and epistemological violence further fuel care disparities and exacerbate pain. At the same time, little research is found that directly addresses Indigenous women's lived experiences of pain in relation to colonial violence and trauma.

In addition, the literature asserts that decolonizing pain care for Indigenous women should be rooted in the revitalization of culture as the foundation of wellness. Care inequity can be addressed by organizational change and increased awareness among individual care providers. Implementing EQUIP principles of cultural safety, trauma- and violence-informed care, and contextualized care would help improve care equity. Consultation with communities and Indigenous women is essential to the process of increasing care equity and culturally safe community pain care (Canadian Pain Task Force, 2020).

Building on these research findings, this present study explored a deeper understanding of Indigenous women's chronic pain experiences and the nature of interactions between pain and trauma as a result of colonial violence. It also sought directions towards decolonial pain care for rural communities which are informed by the healing effects of the revitalization of Indigenous culture. Acknowledging the harm of epistemological violence, this study directly asked Indigenous women using culturally aligned approaches for their experiential knowledge of pain and recommendations for decolonizing pain care. The next chapter examines the research methodology and the process of research development.

Chapter Two: Research Methodology

This study explored Kwakwa̱ka̱'wakw women's knowledge about chronic pain on Kwagu'ł territory, in Port Hardy, British Columbia, where I have been working as a community social worker for two decades. I specifically asked how colonial and gendered violence, as a form of trauma, shaped and interacted with each participant's chronic pain experiences. In addition, I sought participants' recommendations about essential factors for future pain care that address coloniality of pain and care equity.

I developed a qualitative research study guided by Indigenous decolonial and feminist theories. In this chapter, I elaborate on my chosen methodology (Section 2.1). I used a community-based participatory research framework, which promotes equity and social justice both as an outcome and throughout the research process (Section 2.2). Ethical considerations were made to minimize the risk of harm and exploitation of the participants and the community (Section 2.3). Through the community consultation (Section 2.4) and upon receiving research permissions from two Kwakwa̱ka̱'wakw Nations (Section 2.5), five participants were recruited using convenience sampling and community advertisement (Section 2.6). Data was gathered using Indigenous methods of storytelling, Talking Circle, and witnessing aligned with practices of settler solidarity and accountability (Section 2.7.1). In addition, body mapping, an art-based method, provided a supplementary tool to facilitate storytelling (Section 2.7.2). Four themes were developed using reflexive thematic analysis (Section 2.8). Finally, I discuss strengths and limitations found in this research (Section 2.9 & 2.10).

2.1 Theoretical Framework

This research used a decolonial feminist framework, drawing specifically on Indigenous feminist theories and methodologies. Decolonial feminist theories focus on the way intersecting systems of oppression such as gender, sexuality, race, and class in the settler-colonial system create complexity and diversity among women's experiences (BlackDeer, 2023; Dibavar, 2023; Figueroa, 2020; Lugones, 2010; Wagner, 2021). Currently the Eurocentric biomedical perspective remains dominant within Canadian pain research (Canadian Pain Task Force, 2020). Focusing only on the neurophysiological perspective, the biomedical model of pain assumes the universality of pain experiences among all people while failing to address how sociopolitical and cultural factors affect people differently and shape diverse pain experiences (Gatchel et al., 2007). Pain research has started to acknowledge such a biopsychosocial aspect of chronic pain and the need for pain research to examine how various oppressions contribute to people's pain experiences (Canadian Pain Task Force, 2020; Mathur et al., 2022). This study was based on a foundational belief that pain develops differently among people in relation to their specific and multiple forms of intersecting oppression. This study specifically focused on Indigenous women's pain experiences and explored how intersecting systems of oppression such as settler-colonialism, race, and gender together contributed to their unique experiences of physical pain.

Secondly, Indigenous decolonial feminist research methodologies are founded on the self-determination of Indigenous communities (BlackDeer, 2023). Smith (2012) argued that colonial research has objectified Indigenous people while dehumanizing them. Decolonizing research must be centred on Indigenous peoples' self-determination at all levels (Smith, 2012). Being a settler researcher inquiring about Indigenous women's experiences of colonial violence and pain, I sought ways in which my research supported community and participants' self-determination rather than repeating colonial practices when undertaking this research. I consulted the community to discuss my concerns about engaging in this inquiry and how it could serve community needs. I placed myself as a facilitator to create a space for Indigenous women to share their wisdom, beliefs and insights about pain and care, and to help mobilize community resources towards change.

Thirdly, in the decolonial feminist research process, it is essential for a researcher to contribute to restoring respectful, harmonious, and wholistic relationships (BlackDeer, 2023). Figueroa (2020) described relationality as “a methodology of complex coalition-building, of learning one another’s histories, and of understanding why difference can fragment communities in search of liberation” (p. 223). The process of this research was guided through forming respectful partnerships with the community. My interactions with the participants and the community were informed by the Indigenous values of respect, reciprocity, responsibility and Deep Listening (Hart, 2010). I regularly sought participants’ permission, feedback, suggestions, and guidance to navigate the research process. Being accountable to the relationships that I, as the researcher, created through this research process, I intend to continue advocating for decolonizing pain care for the community. The process of community engagement is discussed further in section 2.4.

In addition, decolonial feminist research methodologies pay attention to the embodied gendered colonial knowledge of the people in the margins, while promoting the process in which “devalued or othered knowledge comes to be understood and valued as other ways of knowing” (Figueroa, 2019, p. 221). This study highlighted Indigenous women’s embodied knowledge of pain. It was grounded in a strength-based perspective, which focuses on “the inherent strengths of individuals, families, communities, and organizations” (Data Sub-Working Group, 2021, p. 34) while honouring their wisdom and resilience. This research was built on the belief that Indigenous women themselves are the knowledge holders, and that they would guide this inquiry.

Furthermore, Indigenous decolonial feminist research avoids a pan-Indigenous approach while paying attention to the diversity among the Nations, their specific history and experiences grounded in their territory (Quintessential Research Group, 2022). Stepping away from “white saviourism where white outsiders to the community parachute in to save the individuals or communities they deem in need of saving” (BlackDeer, 2023, pp. 621-622), Indigenous decolonial feminism focuses on the specific localized context and “how multiple intersecting forces of race, class, gender, and sovereignty are operating in our own backyards” (BlackDeer, 2023, p. 622). Kwagu’ł feminist scholar Sarah Hunt/Tłaliłila’ogwa wrote in her co-authored article (Hunt/Tłaliłila’ogwa & Farrales, 2024) that knowledge is always formed “in relation to one another, in relation to the specific genealogies of our own families and communities, in relation to radical coalitional scholarship, and in relation to the lands where we are currently situated and to which we are ancestrally connected” (p. 433). This research explored Kwakwa̱ka̱’wakw women’s experiences where I have worked as a community social worker for 20 years. I sought Kwakwa̱ka̱’wakw specific knowledge about pain grounded in their language, history, and territory, and the role of culture in pain care. Being informed by the concept of Two-Eyed Seeing (Latimer et a., 2020), attention was paid to the roles of both traditional knowledge and current Eurocentric pain care.

This study was inspired by the Kwagu’ł feminist methodology of witnessing. Hunt (2018) explained that Kwagu’ł witnessing methodology is to create a space where the silenced voice is heard, and discarded knowledge becomes validated. Researchers using this methodology are bound by a duty to recall and retell the stories being told. Witnessing can be a community practice for strengthening relationships and collectively challenging the harmful colonial policies and practices (Hunt, 2018). Being in solidarity with Indigenous peoples and to challenge colonial violence and structural injustice, this research was developed to create a safe space where Kwakwa̱ka̱'wakw women's stories and experiences of pain become validated and amplified. By entering this study, I formed a specific bond with the community and the participants. As a witness to their stories, I am responsible to present participants' knowledge about the coloniality of pain and their recommendations for decolonizing pain care.

Finally, critical reflexivity is essential for decolonial feminist social work (BlackDeer, 2023). It enables researchers to "critically examine the power dynamics and coloniality of knowledge and knowledge production" (Dibavar, 2023, para. 16). Practicing "multidimensional reflexivity" (Rowe et al., 2015, p. 303) further allows researchers to explore how their positionality, emotional and intuitive reactions, beliefs and assumptions influence the process of research. As a non-Indigenous researcher and a racialized community social worker, I found critical reflexivity to be crucial for me to examine how my own contextual and situational positionality influenced the research process (Gooden & Hackett, 2012; Mehrotra, 2010). Practicing critical reflexivity guided me through this interactive process of inquiry in which I learned to listen to and amplify Kwakwa̱ka̱'wakw women's knowledge about chronic pain. It made me examine what knowledge I was choosing to listen to and what to discard, and how I made sense of their knowledge in relation to my own social locations and cultural worldview. This process helped me to navigate my inquiry through expected and unexpected challenges while critically examining my reactions and assumptions, remaining accountable to the community, and being committed to seeking ways to decolonize community pain care.

2.2 Research Design: Community-Based Participatory Research (CBPR)

This research was built on a community-based participatory research framework (CBPR). CBPR explicitly addresses structural oppressions and power relations both as a research goal and process (Moosa-Mitha & Wallace, 2021). It offers a framework within which local and community knowledge becomes mobilized, and researchers and the community engage in a longer-term effort to foster “emancipatory social change” (Cornish et al., 2023, p. 1). Given my theoretical framework that emphasized partnerships with participants throughout the research process, the CBPR framework provided a suitable structure for this research.

CBPR invites the community to address the issues that are of their interest and to facilitate change through the research process (Jull et al., 2017; Moosa-Mitha & Wallace, 2021; Smith, 2012). Research is “a process for generating knowledge-for-action and knowledge-through-action in service of goals of specific communities” (Cornish et al., 2023, p. 2). Knowledge must facilitate liberation for the community, organization, and society (Cornish et al., 2023; Morrow et al., 2022; Moosa-Mitha & Wallace, 2021). CBPR provided this research a framework geared for community change through creating a space and mobilizing community resources to address coloniality of pain and care. The community was consulted at an early stage of this project and affirmed that this pain research was meaningful for the community. The community consultation process is discussed in detail in section 2.4.

In addition, CBPR relies on the expertise of those who are most affected by the particular structural issue (Cornish et al., 2023; Morrow et al., 2022; Moosa-Mitha & Wallace, 2021). Dominant Western feminism has been criticized for their assumption about universality of women’s experiences (Smith, 2012). Morrow et al. (2022) argued that research on women’s health issues must be centred on their lived experiences while also addressing how various power structures contribute to inequity. Self-determination is also found at the centre of the Indigenous and decolonizing research (Smith, 2012). This research was built on the belief that both individual and collective voices of Indigenous women living with chronic pain must be at the centre when addressing the structural issues embedded in pain and care.

CBPR further offers a framework in which power is shared throughout the research process among the Indigenous women, their community, and the researcher. Smith (2012) cautioned that the power held by researchers enables them to "distort, to make invisible, to overlook, to exaggerate and to draw conclusions, based not on factual data, but on assumptions, hidden value judgements, and often downright misunderstandings" (p. 229). The CBPR framework minimizes such risks by inviting the community to take an active role in research while fostering collaborative knowledge production (Cornish et al., 2023; Furman et al., 2019; Jull et al., 2017). Establishing and maintaining working relationships with the community is essential for the co-creation of knowledge (Cornish et al., 2023). Critical awareness is warranted, however, as such a process may remain merely superficial to satisfy institutional and funding requirements while failing to address structural inequity and facilitate social change (Morrow et al., 2022). I worked closely with the community advisory group and the participants through this research. Further discussion is provided in Section 2.4.

CBPR has been applied as a framework for recent studies both on chronic pain and trauma. A pain study by Wallace et al. (2021), for example, focused on the pain experiences among people who face social marginalization. This study was developed in partnership with an organization, local communities, and researchers. It highlighted how participants' experiences of pain are intertwined with a variety of issues relative to their social locations, structural injustice, and care inequity. Thematic analysis was shared among the research team, organizations, participants, and care providers and their feedback was incorporated into the final analysis.

Another CBPR example was found in the study by Moosa-Mitha and Wallace (2021) exploring the need for trauma research among refugee newcomers. Centring on the voices of the refugees, this research reported the essential role of research as social change and CBPR as a suitable framework for this type of research. Researchers hold specific responsibilities when engaging in such research. While they should have sufficient knowledge about trauma and the culture of the participants, they also need to "take a learner role and ask their participants advice" (Moosa-Mitha & Wallace, 2021, p. 33).

Considering these factors and examples, CBPR was found to be a good fit for this present study which examined colonial violence, trauma and pain centring on the community and participants' knowledge. Through meaningful engagement with the community and mobilizing community resources, CBPR offered a framework for community change promoting decolonizing care and care equity. Each research participant was envisioned to be a project partner, consultant, and advisor in this collective process.

2.3 Ethical Considerations

Considering the political nature of research, critical attention to ethical considerations is paramount throughout the research process, particularly when involving human participants and marginalized communities. Settler researchers have often perpetuated colonial violence through their research on Indigenous communities using Eurocentric research methodologies (Kovach, 2015). Tuck and Yang (2014) argued that research is a system of settler invasion to produce colonial knowledge. Bearing these warnings in mind, several strategies were used to minimize the risk of exploitation of Indigenous peoples through this research.

First, it is paramount that communities are consulted for the planning, implementation, and data analysis (Goodman et al., 2017; Latimer et al., 2018; Varcoe et al., 2021; Wallace et al., 2021). In addition to the University of Victoria Human Research Ethics Board, I requested research permission from the three Kwakwa̱ka̱'wakw Nations. Attention was paid to the quality and frequency of engagement with the community to avoid both tokenistic consultation (Morrow et al., 2022) and creating a burden for the community with insufficient resources (Wallace, 2005). Balancing the ethical need for consultation and the concerns about the capacity of the community, consultation with the advisory group was requested with specific attention to how much consultation at what stages would be most beneficial.

Secondly, individual consent was sought before both the individual and the group sessions. Nations and community agencies which were interested in participating in this research were informed about the research purpose, activities, and questions using posters and newsletters. More detailed information was provided to organizations and potential participants directly by the researcher and advisory group members. Participants were reminded that they may share only what they wish to share about pain without feeling obligated to disclose details that may trigger a trauma response. Participants were also reminded that they may withdraw their consent at any point during the research. The consent form for the individual session is found as Appendix A and for the group session as Appendix B.

Thirdly, reflexivity played an essential role in uncovering my assumptions, working through my dilemmas, learning from challenges, trusting the collaborative process, and being willing to adjust the process as research moved forward. Conversations with the research team were helpful both during the planning process and analysis to articulate my assumptions and to ascertain what I was avoiding, ignoring, or dismissing. For example, thematic analysis used for this research is a subjective process where I deliberately assign meanings to women's stories to be able to organize data into themes (Tuck & Yang, 2014). Feedback was sought from all who were directly involved in this research to critically examine the themes.

Furthermore, confidentiality is paramount in a small community where people are closely connected in multiple ways. Individual and group sessions were conducted at North Island Building Blocks, which offers a variety of wellness programs, during the time when the agency was closed. Interviews with two Elders were conducted at their homes upon their request considering their ease and comfort. Participants at the group session were requested to practice confidentiality about the personal information shared during the session.

Asking participants to remember and talk about traumatic experiences could result in retraumatizing both the storyteller and the witness. Provisions were made to minimize the risk of retraumatization throughout the data gathering phase. Participants were required to have either previous or current engagement in healing activities so that they were equipped with coping strategies. In addition, participants were invited to bring their own support person(s) to their individual session. Pain stories were primarily gathered in individual sessions as sharing traumatic stories requires a sense of trust between the storyteller and the witness (Martin, 2018). Furthermore, participants were invited to take breaks, break the interview into multiple sessions, or end their participation at any time. Participants were offered a list of community resources before and after the interviews. I also provided a follow-up by phone with some of the participants to ensure their emotional stability.

Finally, the research team including the principal researcher, thesis supervisors, and the community advisory group discussed Indigenous data sovereignty and whether the raw data should be shared with the Nations which agreed to participate in this research. Indigenous data sovereignty is an inherent Indigenous “right of a sovereign group to govern the collection, ownership and application of its own data" (Data Sub-Working Group, 2021, p. 17). While ensuring protection of the citizens' wellbeing, Indigenous Data Sovereignty acknowledges the Nation's jurisdiction to use the data for the purpose of governing (Data Sub-Working Group, 2021).

The essential point here was balancing individual women's rights to their own privacy and their Nation's rights to the data. After reviewing relevant information on Indigenous Data Sovereignty such as Anti-Racism Data Legislation (Quintessential Research Group, 2022) and the 2021 National Action Plan Data Strategy (Data Sub-Working Group, 2021), the priority was given to the research participants who have survived violence by respecting their privacy and safety living in a small community. Each woman was invited to choose whether they wished to share with their Nation the raw data from the individual session. Similarly, group participants discussed whether they wished to share the data from the group session. The group agreed to share the final report with anonymized data with the two Nations which granted their permission for this research.

2.4 Community Engagement and Consultation

This research has been guided by a community advisory group throughout the process. Developing a community advisory group became my first step in determining the need for this research and to review and refine the purpose, goals, and methods. Considering potential logistical challenges with a larger group such as coordinating a meeting time and making decisions for this project, I intended to invite about five members including an Indigenous Elder, a youth and a healer. As I began the consultation process, however, I immediately received an invitation from North Island Building Blocks (NIBB), a local community organization funded and administered by Gwa'sala-'Nakwaxda'xw Nations, to host this project. This agency worked closely with me to create the advisory group. Four Indigenous women from three Kwakwa̱ka̱’wakw Nations as well as two non-Indigenous women agreed to form a community advisory group to guide this project. Five members are currently working for the health services for these Nations and one member is a retired health director for one of the Nations.

The group had its first meeting in May 2023. Feedback was sought about the purpose and value of this project, research design and methods, roles of the advisory group, and communication methods with the group. Group members affirmed the value of this inquiry. The members shared their knowledge that chronic pain is a very common experience among Indigenous women. It is often associated with other psychosocial challenges such as depression, financial issues such as the cost of medications, and barriers to accessing care. Members further acknowledged the growing awareness of and an interest in the role of traditional medicine for pain management.

The group further addressed the importance of decolonizing research and that this project must have a clear purpose and benefits for the participants and the community. The group agreed that first and foremost, this project should create a space where women’s stories would be heard and validated. It should also foster women’s understanding about connections between pain and trauma while reframing their experiences as their way of coping with pain. The group questioned the conventional definition of chronic pain within the colonial knowledge and advised instead to explore what pain meant for each woman. In addition, a caution was provided about inquiring into women’s experiences of violence and trauma. The members felt confident to proceed with this project considering all the safeguards built into the research and my experience as a mental health counsellor providing support for Kwakwa̱ka̱’wakw women. The group advised me to incorporate traditional healing practices after sessions if available. In addition to interviewing individual women, the group recommended mother and daughter pairs, which would help highlight intergenerational connections while providing comfort for women in sharing their stories.

NIBB agreed to provide the space for interviews, refreshments, and a $50 grocery card for each participant to promote health and wellness of the participants. The advisory group was consulted throughout the research especially during the permission seeking process from the Nations and participant recruitment. The advisory group has agreed to continue working towards community change following the recommendations generated by this research.

2.5 Research Permission Seeking Process

This research was conducted on Kwagu'ł territory. Initially I hoped to invite Kwakwa̱ka̱'wakw women from all three Nations located near Port Hardy. Permission was sought from each of the three Nations, Kwagu'ł, Quatsino, and Gwa'sala-'Nakwaxda'xw, to be able to invite their members. Letters requesting permission were delivered in May 2023. Quatsino Nation immediately provided consent. Kwagu'ł and Gwa'sala-'Nakwaxda'xw Nations did not respond and were contacted 2, 4, and 8 weeks later to follow up. The advisory group provided close guidance and directions in this process. I received written permission from Kwagu'ł Nation three months after the initial request was sent.

Gwa'sala-'Nakwaxda'xw Nation, however, declined to participate in this research at this time. Nations often become weary given the number of requests for research and data collection. Ambivalence toward research and 'research fatigue' are documented as "we've been researched to death" (Blair, 2016; Castellano, 2014; Maar et al., 2011; Maar, Sutherland, & McGregor, 2007; Noojmowin Teg Health Centre, 2003, as cited in Peltier, 2018). This process offered a reminder that relationship building is an on-going process. I hope to develop trust and interest in the community through community presentations of the research findings.

2.6 Recruitment Methods

Originally, I planned to recruit eight adult Indigenous women who were recommended by the advisory group through convenience sampling. Advisory group members were requested to recommend women who lived with chronic pain and who have engaged in healing practices. Being consistent with Indigenous values of relationships, this approach relied on the pre-existing trusting relationships between the advisory group members and the community. Considering the nature of the research involving personal experiences of trauma, this preselection step was considered as a safeguard to minimize the potential risk of unwarranted retraumatization of participants during the research. Each advisory group member was requested to provide information about this research to potential participants to obtain their permission for me to contact them to explore their interest in participation. To minimize undue pressure on the participants, the advisory group was not to be informed of the identities of the final participants.

However, this process faced a challenge as none of the potential candidates responded to my calls. The lack of familiarity and pre-existing relationships between these potential participants and myself was assumed to contribute to this challenge. The advisory group strongly recommended that I actively invite participants while advertising this research in the community.

Upon receiving the ethics approval from the University of Victoria, this project was advertised in electronic community newsletters. Posters were also delivered to the health centres of the two Nations and community social service organizations. At each agency, I explained the purpose, goals, and activities involved in this project. Within the following several weeks, five women, including two Elders and three women working in the field of healthcare, agreed to participate in this project. Developing a trusting relationship was found to be essential for the recruiting process and it could be fostered even during a brief encounter explaining this research. The community poster is attached as Appendix C.

2.7 Data Gathering Methods

Data was gathered both through individual sessions and a group session using a form of storytelling. During the individual session which lasted from one to two hours, each participant shared their knowledge about chronic pain in relation to violence and trauma. Participants were invited to create their own body maps to identify, describe, explore, and reframe their experiences of pain. The group session lasted for two and a half hours. Using a Talking Circle format, the group explored collective understanding about pain and recommendations about future care. The group reviewed and discussed themes generated from individual sessions. Feedback was solicited about the process of the research. The group agreed on community presentations as the next step after this research was completed. With participants' consent, both individual and group sessions were audio-recorded, and body maps were photographed to assist analysis.

2.7.1 Storytelling, Talking Circle, Witnessing, and Practices of Settler Solidarity and Accountability

Storytelling used in critical and Indigenous methodologies is a tool for creating counter-stories against systemic injustice while highlighting resistance and liberation of marginalized peoples (Qwul'sih'yah'maht, 2015; Solórzano & Yosso, 2002). Using Talking Circles (Goodman et al., 2017), focus groups (Wallace et al., 2021), and individual interviews (Varcoe et al., 2021), studies present people's resistance and resilience in the face of systemic racism and colonial gendered violence. Storytelling in group settings in participatory research fosters validation, reduces self-blame (Varcoe et al., 2021), nurtures community connections, and sets a stage for future community actions (Wallace et al., 2021). Being a reciprocal, relational, and collective process between the storyteller and the audience, storytelling can create a collective commitment towards decolonization (Brearley & Hamm, 2013). Storytelling was considered to be a suitable tool for this research project in order to create a space where women's stories were validated, and a sense of collective agency was fostered to facilitate community change.

The Indigenous practice of Talking Circle offers a safe and respectful listening and sharing space (Brown & Di Lallo, 2020; Hanson & Danyluk, 2022; Mehl-Madrona & Mainguy, 2014). Participants are invited to speak from their heart and listen with their heart (Mehl-Madrona & Mainguy, 2014). Talking Circle enhances a non-hierarchical place for learning (Hanson & Danyluk, 2022), healing (Mehl-Madrona & Mainguy, 2014), relationship building, and community building (Di Lallo et al, 2020).

Researchers bear specific responsibilities as a witness in storytelling. Witnessing through Deep Listening, observing, and remembering functions as validation of the storyteller's experiences (Hunt, 2018). Deep Listening in Indigenous cultures requires using all senses with specific attention to connections within the person and as a collective (Brearley & Hamm, 2013). A Kwagu'ł scholar, Sarah Hunt (2018) wrote that "Witnessing is about the affective, embodied, spiritual role that emerges from sitting among your relations in the context of a sacred place of cultural business" (p. 290). In the Kwakwa̱ka̱'wakw potlach system, witnesses bear a role in remembering the transactions being made during the potlach (Hunt, 2018).

This research was guided by the practice of settler solidarity and accountability involving an everyday practice of decolonization, "unsettling power relations and taken-for-granted assumptions" (Hunt & Holmes, 2015, p. 156) through "relational knowledge production, conversation, dialogue, and personal storytelling" (Hunt & Holmes, 2015, p. 156). Bassel (2017) further argued that it is important for settler activists to learn to listen before taking an action when addressing issues involving Indigenous peoples, who have full agency to form and take a political stance. Listening to Indigenous women's stories required reflexivity and critical attention to my positionality as a settler researcher and a racialized woman as this colours the filters through which I hear, experience, and interpret stories.

As a non-Indigenous researcher using an Indigenous methodology that is specific to the Nations which participated in this study, I acknowledge that my practice of witnessing methodology is different from that of Dr. Hunt (2018). My practice was instead guided by settler solidarity and accountability during both individual and group sessions while holding the space where women's stories were honoured and validated. During individual sessions, I broadly asked the participants to share their experiences and knowledge about pain attached to specific body locations. I also inquired about what triggered pain and how they coped with pain. I asked questions sparingly, primarily to clarify the meanings in their stories or to inquire further about a topic.

A Talking Circle format was used during the group session with the participants' agreement. Participants took turns and shared their insights, beliefs, knowledge, and wisdom. I placed myself as a facilitator throughout this group process while acknowledging and honouring each person's knowledge. I asked participants to review the themes that are generated from the individual interviews. Participants created collective knowledge of pain and pain care built through the sharing of their beliefs, thoughts, and experiences in the group. The group discussed the next step, community presentation of the research findings, to foster care providers' awareness about coloniality of pain among Indigenous women and to improve care equity. A list of questions for the individual and group sessions is attached as Appendix D.

2.7.2 Art-Based Approach: Body Map

Arts-based research methods facilitate expressions of complex lived and embodied experiences (Furman et al., 2019; Gaete et al., 2023). For example, a study presented by Latimer et al. (2018) demonstrates an innovative arts-based approach in which both oral storytelling and arts-based narratives were used to facilitate expressions of wholistic and deeper pain experiences among Indigenous youth.

Originating in art-therapy, body mapping is used as an arts-based method in participatory research uncovering embodied emotions, thoughts, and knowledge (Boydell, 2021; Furman et al., 2019). Body mapping offers a unique tool to explore the complex and contextual nature of people's experiences embedded in interlocking oppressions (Boydell, 2021; Furman et al., 2019). Externalization is used in therapy to separate the problems from the person (Combs & Freedman, 2012). Body mapping can help participants externalize their experience of trauma and reconceptualize their embodied experiences while moving towards healing (Boydell, 2021).

At the same time, cautions were raised by the advisory group that participants facing their own body on paper may trigger their past trauma. Following the violence and trauma-informed approach, participants were invited to use body mapping as a tool only if they wished to do so. Three participants engaged in this activity while two participants declined. For those who were interested in this tool, I traced the outline of each person onto poster paper. Participants marked and articulated locations, texture, and characteristics of pain using materials such as pens, yarn, glitter, stickers, shells, plants, and pebbles. The body map was used as a supplementary tool for storytelling and participants marked the locations on their body maps as they shared stories attached to each location. With consent, completed body maps were shared at the group session among the participants acknowledging each person's unique experience. Upon the group's agreement, body maps were transformed with fire after the group session. An example of a body map is attached as Appendix E.

2.8 Data Analysis

Reflexive thematic analysis (TA) was used to analyze the data and generate themes. TA is a method used for a wide variety of both quantitative and qualitative research to identify patterns and themes within rich and complex data (Braun & Clarke, 2021). TA provided a valuable method for this research because of its flexibility with the sample size (Braun & Clarke, 2017). In addition, TA allowed this research to capture lived experiences of the participants in the context of their sociocultural and political environment (Braun & Clarke, 2006). Four themes were generated to capture the information provided through individual sessions.

Methods within TA vary widely depending on the theoretical foundations of the research (Braun & Clarke, 2006). In particular, 'reflexive TA' used for this research explicitly pays attention to the role of the researcher and "emphasises the importance of the researcher's subjectivity as analytic resource, and their reflexive engagement with theory, data, and interpretation (Braun & Clarke, 2021, p. 330). Within this method, themes do not necessarily reflect the prevalence in the data but rather capture particular meanings in relation to the research question (Braun & Clarke, 2006). Researchers' subjective views and interactions with the data play essential roles in theme development. The process of coding requires researchers' "immersion in the data, reading, reflecting, questioning, imagining, wondering, writing, retreating, returning" (Braun & Clarke, 2021, p. 332). Themes are actively generated instead of being discovered by researchers in relation to their questions and data (Braun & Clarke, 2006). It involves both inductive and deductive analysis in relation to research questions (Braun & Clarke, 2021).

The analysis process during this research was non-linear, intuitive, reflective, and explorative. Transcribing interviews myself provided an opportunity for me to become familiar with the data. Data was first coded according to my research questions such as violence, trauma, pain, healing, care, and additional individual themes. Originally ten themes were developed and collapsed into four primary themes: relationships between violence, trauma, and pain; systemic racism and pain; role of cultural revitalization for healing; and recommendations for decolonial pain care. Viewing research as cocreation of knowledge, all who took part in this research were requested to review the themes. During the group session, participants were invited to discuss, add, and modify primary and secondary themes. These discussions provided additional insight and knowledge to enrich the findings. Thematic maps are attached as Appendix F.

2.9 Strengths

Critical research methodologies such as feminist decolonial approach used for this research address structural issues while rejecting objective and universal positivist views of knowledge (Rowe et al., 2015). Founded on the epistemology, ontology, and axiology of critical research, this study inquired into the sociopolitical nature of pain among Indigenous women while challenging the current biomedical view based on Eurocentric and colonial knowledge.

The community-based participatory research framework addresses power inherent in the research process (Moosa-Mitha & Wallace, 2021). My research attempted to minimize the power imbalance between the researcher and the participants by meaningfully engaging the community advisory group throughout the research process. In addition, the participants were invited to review and edit the research findings. The outcome of the research will be shared with the community in consultation with the advisory group and participants.

This study highlighted Kwakwa̲ka̲'wakw women's knowledge of pain grounded in their culture, language, and territory. Informed by Indigenous storytelling, the Kwagu'ł feminist method of witnessing, and practices of settler solidarity and accountability with the art-based method of body mapping, this research respectfully sought women's embodied knowledge of colonial violence, trauma, and pain. Positioning myself as a witness to the women's stories, it intended to validate and amplify women's experiential knowledge of the healing while valuing each woman's individual unique connections to Kwakwa̲ka̲'wakw culture and spirituality.

2.10 Limitations

One of the limitations in this research was that it did not explore the pain experiences among Indigenous women with diverse gender identities and sexual orientations. Research studies show that the heteropatriarchal colonial system reinforces violence against Two-Spirit people and Indigenous people with diverse gender and sexual identities (Holmes & Hunt, 2017). Similarly, research shows that trans and non-binary people experience stigma and discrimination because of transphobia and cisnormativity. Further research is needed to address intersecting effects of sexuality, gender, and race in relation to colonial violence and how they manifest as different pain experiences among Indigenous people with diverse gender and sexual identities.

In addition, this research aimed to highlight specific knowledge among the three Kwakwa̲ka̲'wakw Nations. However, I was unable to obtain permission from one of the Nations. In addition, this study did not invite other Kwakwa̲ka̲'wakw Nations closely connected to this region. Both permission seeking and recruiting processes reminded me of the importance of respectful and trusting relationships, which require on-going effort to nurture. Future studies should expand invitations to all Kwakwa̱ka̱'wakw Nations in the community.

2.11 Conclusion

Built on the decolonial feminist intersectional methodology, this community-based participatory research shed light on relationships between chronic pain and colonial and gendered violence and trauma through Kwakwa̱ka̱'wakw women's lived experiences in Kwagu'ł territory in the district of Port Hardy, British Columbia, Canada. In consultation with the community advisory group, five cisgender Kwakwa̱ka̱'wakw women shared their pain experiences through individual interviews with storytelling and body mapping. Using thematic analysis in collaboration with the advisory group and participants, four themes were generated to address coloniality of pain and decolonizing pain care.

Ethical considerations were made to minimize the harm of settler colonialism during this research including meaningful engagement with the community, confidentiality in a small community, and provisions to minimize re-traumatization. Reflexivity enabled critical attention to my positionality as a racialized settler-researcher and how this interacted with the research process.

The limitations of this research were the focusing only on cisgender and heterosexual Indigenous women's pain experiences, and that only two Kwakwa̱ka̱'wakw Nations participated. Despite these challenges, this study contributed to social work research by targeting coloniality of pain while highlighting Kwakwa̱ka̱'wakw women's wisdom through their lived pain experiences. Through this collective community process of knowledge production, it envisioned decolonizing community pain care founded on care equity and honouring Kwakwa̱ka̱'wakw knowledge.

Chapter Three: Coloniality of Pain

This chapter explores my first research question, how trauma, resulting from colonial and gendered violence, interacts with chronic pain in the lives of Kwakwa̱ka̱'wakw women in rural communities. This study was situated within Indigenous decolonial feminist theories, which draw attention to how intersecting oppression such as Indigeneity, gender, sexuality, and class in the settler-colonial system create diverse experiences among women (BlackDeer, 2023; Dibavar, 2023; Figueroa, 2020; Lugones, 2010; Wagner, 2021). It was built on the belief that physical pain among Indigenous women cannot be sufficiently addressed within a narrow biomedical perspective, which assumes universality of pain (Gatchel et al., 2007). Instead, this study was informed by and aligned with scholarship that recognizes that physical pain develops differently among different people in response to various intersecting forms of systemic inequity including structural violence (Craig et al., 2020; Holmes et al., 2024; Mathur et al., 2022; Moosa-Mitha et al., 2025; Wallace et al., 2021). It particularly examined the coloniality of pain and the relationships between Kwakwa̱ka̱'wakw women's physical pain experiences and racial and gendered violence as a form of intersecting oppression in the neoliberal political environment.

This research was also inspired by the Kwagu'ł feminist methodology of witnessing (Hunt, 2018) along with practices of settler solidarity and accountability (Hunt & Holmes, 2015) while honoring participants' lived experiences and embodied knowledge of trauma and pain. The knowledge shared in this study should be properly attributed to each participant. All participants also wished to be named in this thesis and their names attached to their insights and recommendations. At the same time, some participants shared their concerns about the negative effects which their stories may create in their relationships with family and care providers. Respecting both the participants' wishes and concerns, their comments shared in this chapter remain anonymous as they contain sensitive information. The comments are attributed to each participant in the next chapter when discussing recommendations for decolonizing care.

In addition, Indigenous and decolonizing research seeks wholistic and relational knowledge grounded in the person's locations (Absolon, 2022). Each participant of this study shared their rich life experiences beyond their experiences of chronic pain. To honour their lives rooted in their ancestry and territory, I introduce each participant with their name, ancestry, and brief description of their life experiences and beliefs.

This chapter is organized in four sections. I first introduce the participants (Section 3.1) followed by description of their experiences and insights about how trauma caused by colonial violence reciprocally interacted with pain and other conditions associated with pain (Section 3.2). Building on this knowledge, I discuss how chronic pain among Kwakwaka'wakw women cannot be fully understood outside of colonial trauma (Section 3.3). A summary is provided at the end of this chapter (Section 3.4).

3.1 Participants

Five cisgender Kwakwa̲ka̲'wakw women agreed to participate in this study: Elder Sharon, Elder Maggie, Zoe, Maggie, and Stephanie. Each woman shared their heritage and unique life story and experience beyond just their narratives of chronic pain. Indigenous research methodology centres on the embodied knowledge formed through individual connections to the territory, ancestry, and social positionality (Absolon, 2022). To honour each woman's life journey and individual insights into pain and healing, I introduce them by describing their ancestry and social positionality followed by a brief description of their pain experiences and beliefs about healing.

3.1.1 Elder Sharon

I met Sharon in her apartment where she lived with her granddaughter, her beloved dog Jasper, and two cats. Sharon is a Kwagu'ł Elder. She has strong family connections to both Kwagu'ł and Gusgimukw Quatsino Nations. Her grandparents came from the families of chiefs.

Growing up with her grandparents, Sharon learned wholistic connections to the territory, harvesting food, and serving the community. Hard work and generosity are two of the principles Sharon learned from growing up with her grandparents. Harvesting food such as cleaning and processing fish sometimes continued until late into the night. Sharon's grandmother was so generous and caring that their home pantry was always empty. However, they were never out of food as her generosity was a two-way street with the community reciprocating. After graduating high school, Sharon engaged in post-secondary education. She spoke about completing her studies while overcoming her learning challenges by a commitment to hard work and perseverance. Sharon spent her adult life supporting others. She worked in women's shelters in Vancouver and as a house parent in a youth shelter after returning home.

Sharon spent several childhood years at the Nanaimo Indian Hospital where she experienced severe abuse by healthcare providers, which created trauma. She also spoke about experiencing intergenerational trauma while being reared by her parent who was a Residential School survivor. She shared her knowledge about the connections between chronic pain and trauma from her childhood. I elaborate on her experiences in section 3.2.

Sharon has been on a healing journey for over 50 years. She spoke about anger as one of the outcomes of colonial violence and trauma. Anger created negative outcomes for her health. She explained that letting go of anger was essential for healing as it lightened the load of the negative outcomes of trauma in her life. She also spoke about healing from trauma through the daily practice of unlearning harmful colonial teachings and learning and relearning nurturing relationships with herself and others around her. Her recommendations for healing are presented in the next chapter.

3.1.2 Elder Maggie

Maggie is a Kwagu'ł Elder. She is well known in the community for her healing work. She has a bachelor's degree in nursing and a master's degree in counselling. She is also a grandmother and regularly provides childcare for her grandchildren. I met Maggie at her house. She explained that she and her spouse, Scotty, lived together for 55 years. They traveled the world and lived overseas for some years while experiencing different cultures. After losing Scotty several years ago, Maggie lives with one of her granddaughters, who was present at the interview and wished to remain anonymous as "granddaughter". Maggie's granddaughter also lives with chronic physical pain caused by complex health issues.

Maggie grew up speaking Kwak'wala, the language spoken among Kwakwa̱ka̱'wakw, as her primary language until she attended an Indian Day School where she learned English. She spoke about her childhood memory of being unable to communicate in English. She experienced violence at St. Michaels' Indian Residential School which she attended as a Day School student because her family lived in the community. She spoke about the harmful effects of violence at St. Michaels' to both her later health and Indigenous communities.

Maggie and her granddaughter explained that the relational worldview expressed through Kwak'wala fosters deep spiritual connections to the territory and people around them. Maggie further spoke about her belief that wellness can be fostered by utilizing both traditional and Western knowledge of healing. She contributed to a study published in 1982 about the healing properties of the Kwakwa̱ka̱'wakw cultural medicine, Ooligan grease. To manage her chronic pain, Maggie utilizes both traditional medicines such as Ooligan grease and western medicines including cortisone shots.

3.1.3 Zoe

Zoe is a mother who works at a social service agency in the community. She is connected to Kwagu'ł Nation through her grandparents. I met Zoe at North Island Building Blocks (NIBB). Although pain flare-ups have disrupted her life and her ability to function, Zoe continues to seek meaningful engagement with the community as a Kwakwa̱ka̱'wakw woman. She has an excellent academic record and was completing another diploma for working in the healthcare field at the time of this interview.

Zoe experiences extensive pain throughout her body. She came to understand the wholistic nature of the human body, and how her pain related symptoms in different parts of her body were often caused by an over-reactive auto-immune response to trauma. She spoke about her challenging experiences in accessing healthcare in the community, and how these challenges exacerbated her pain. She became her own advocate to navigate through the colonial healthcare system.

Zoe manages her symptoms now by working closely with a rheumatologist using pharmaceutical medications, monitoring her stress, exercising, and being mindful of her diet. She shared her insight about decolonizing pain care and how revitalization of culture is the foundation for the health and wellbeing of the Kwakwa̱ka̱'wakw.

3.1.4 Maggie

Maggie is known in her community as Aunt Maggie. I met Maggie at NIBB. She is a mother and a grandmother. Her father is a hereditary chief. She was offered this role when she was in her late teens. She declined this offer, however, as she expected that taking on this responsibility would be too stressful for her at that time. She instead left the community and attended post-secondary education and studied public administration and community development. She believed that to achieve community change, the whole community including people of all ages, gender, position, or ability must be invited to participate. She has been a dedicated worker at school, at the community health centre, and in a logging operation as a dump truck driver. Maggie is also a great baker. She takes pride and great care in what she does and creates.

Maggie has survived severe violence throughout her life. Her physical pain is tied to injuries from assaults by her stepparents and intimate partners. She talked about learning not to feel her pain sensations in order to survive through violence and to fight back. She has first-hand experiences of living on the street and being exposed to severe racial and sexual violence. Eventually, she returned home to take back custody of her children. However, her son died in an accident about 12 years ago. Of all the losses she endured, the loss of her son has hurt her the most. In her story, Maggie shared her embodied knowledge about the close connections between substance use, violence and trauma, and emotional pain.

Maggie's stories conveyed her commitment to life and to caring for her children. She commented on the power of jokes and laughter, which have given her strength and helped her to stay alive. She also believes that the spirits of her son and relatives remain around her. She acknowledged that this awareness creates a sense of comfort for her as it confirms to her the unbreakable connections that exist with those who now live beyond this life.

3.1.5 Stephanie

Stephanie's ancestry is rooted in the Kwakwa̱ka̱'wakw Nations in the coastal communities: Wuikinuxv Nation and Musgamagw Dzawada'enuxw Nation, which is formed by four tribes, Gwawa’enuxw, Kwikwa’sutinuxw, Haxwa’mis, and Dzawada’enuxw (Musgamagw Dzawada̲’enux̲w Fisheries Group, 2017). Her band was transferred to the Kwagu’ł Nation, and she became registered as a Kwagu’ł band member.

Stephanie had worked in the social services field for most of her adult life. She is a coordinator for a community agency providing a variety of wellness programs. She was working towards her master’s degree in leadership at the time of this interview.

Stephanie’s parents attended Residential Schools, and she experienced and witnessed violence from a young age both at home and in the community. She grew up taking care of her siblings. She continues to be the caregiver for her family. Stephanie described that since her adolescence she had developed a number of health issues accompanied by painful symptoms. She shared her knowledge of the close relationships between her pain and stress. She also talked about how her pain flare-ups continue to affect her emotional, physical, and spiritual health, and her ability to engage in daily tasks.

Stephanie emphasized the importance of managing stress, staying active, and maintaining a healthy diet. She also commented on the healing power of the revitalization of culture. She further spoke about her memories of her grandmother. She believes that unconditional love, which she received from her grandmother, continues to give her a sense of peace and strength. She emphasized the foundational role of compassion for healing and care.

3.2 Embodied Effects of Colonization: Relationship Between Trauma and Pain

In this section, I analyse participants’ narratives as they speak to how trauma, resulting from intersecting oppression in the form of gendered and racial violence against Indigenous women in the colonial system, interacts with chronic pain. Their narratives revealed how life-long exposure to gendered and racial violence shaped their physical pain through the multifaceted and reciprocal interactions between pain, trauma, stress, fatigue, and substance use. Participants also reported how racism in healthcare, which is another form of colonial violence, exacerbated their physical pain. In addition, insufficient healthcare resources further compounded their experiences of colonial violence when they sought pain care.

I present these participants' insights using the following five subthemes: 3.2.1 Trauma Is an Outcome of Life-Long Exposure to Colonial Violence and is Intergenerational; 3.2.2 Pain Develops Through Stress Responses to Colonial Trauma; 3.2.3 Racism in Healthcare Aggravates Stress Responses and Pain; 3.2.4 Neoliberal Policies Result in Insufficient Pain Care for Rural Communities; and 3.2.5 Reciprocal Interactions Among Trauma, Stress, Fatigue, and Substance Use.

3.2.1 Trauma is an Outcome of Life-Long Exposure to Colonial Violence and is Intergenerational

Participants shared their extensive experiences of physical, sexual, and emotional violence throughout their lives. These racial and gendered violence incidents happened in a variety of settings including at colonial institutions such as Indian Residential Schools, inside the homes, workplaces, and in communities. Participants explained that all these incidents were directly connected to the settler-colonial policies and practices. Being exposed to such systemic violence throughout their lives created a deep sense of trauma among them.

Both Elders in this study spoke about repeatedly experiencing abuse when they attended colonial institutions such as Indian Schools or Indian Hospitals. Residential Schools for Indigenous children, also places of violence, operated for over a hundred years across Canada, and a minimum of 150,000 Indigenous children were estimated to have gone through this system (Truth and Reconciliation Commission of Canada, 2015). In addition to Residential Schools, Indian Day Schools also operated to enforce assimilation of Indigenous children whose families lived in the same community where the schools were located (University of British Columbia, n.d.). All forms of abuse took place both at Residential Schools (Truth and Reconciliation Commission of Canada, 2015) and Day Schools (University of British Columbia, n.d.). Extremely abusive punishments, such as strapping until bleeding, were commonly used as a disciplinary measure (Truth and Reconciliation Commission, 2015). One of the Elders experienced such punishment as a Day School student while she attended St. Michaels' in 'Ya̲lis, which is also known as Alert Bay, British Columbia. She spoke about the traumatic effects of physical abuse she experienced as a student:

> I got hit on the head by the choir teacher ... because I was 13 and I refused to sing. Bang Bang. She hit me on the head. ... So the other time was when I wasn't scrubbing the kitchen floor right and the cook came over and she hit me on the head with a bread pan. ... It developed a little leak or weaken some blood vessels. But in ... 1984 I had a grand mal seizure.

Violence and abuse did not end at these schools but continued when children were admitted to Indian Hospitals to be treated for Tuberculosis (TB). TB was extremely common at Residential Schools due to the poor living conditions such as overcrowded residences, insufficient heating, and inadequate nutrition (Truth and Reconciliation Commission of Canada, 2015). The main purpose of the establishment of Indian Hospitals was to segregate Indigenous TB patients from the settlers, responding to the settlers' concerns about TB spreading to the settler society (Lux, 2010). As in Residential Schools, children who were admitted at Indian Hospitals received inhumane treatment including "segregation, inadequate standards of care, medical, pharmaceutical and surgical experimentation with limited opportunities for informed consent" (Carrigg, 2020, para 14). In addition, children at Nanaimo Indian Hospital in the 1950s received abusive treatment such as being tied to a bed for most of the time spent at the hospital lasting from several months to several years (Sterritt & Dufresne, 2018). An Elder participant of this study spoke about her personal experience of such violence, and how this experience created a deep sense of trauma:

> we had a nurse that walked up and down the hall to make sure we ate what was on our tray. And if you didn't, she would strike you in the hand. ... And so I took a bite, a mouthful of the turnips, and I threw up on my tray. I had to eat every[thing], my puke and all, off my tray. … With all this trauma that I've been through, I felt like I was just existing…

Being repeatedly exposed to such systemic childhood violence inflicted by the colonial system creates intergenerational trauma (Bombay et al, 2014; Wilk et al., 2017). Intergenerational trauma is found to negatively affect the health and wellbeing of families and communities of the people who attended these colonial institutions across multiple generations (Wilk et al., 2017). Intergenerational trauma, as an outcome of colonial violence, can affect a person in profound ways. One participant spoke about how her harmful experiences of intergenerational trauma started even before her birth and continued throughout her childhood:

> I definitely had a really traumatic upbringing since I was born. ... My mom was only 20 when she was pregnant with me. My dad didn't want me. She ... went to Residential School. ... And so even from the time of conception I wasn't wanted. ... I had sexual abuse at a really young age and then just witnessed, you know, a lot of domestic violence on a regular basis. ... By the time I was nine, I was ... pretty much mom to my sister. ... I was

> already cooking and babysitting at 9 and 10 [years of age], and then I would have my younger cousins too.

Research explains the biological mechanisms through which intergenerational trauma can be transferred over generations. For example, Coussons-Read (2013) reported how parents' experiences of stress can influence the development of endocrine and immune systems of the child before and after their birth. Another participant stressed the importance of the families and communities understanding intergenerational trauma as an outcome of colonial violence such as the violence which Indigenous children and families experienced at Residential Schools and Indian Hospitals. This realization will shift the blame from individual Indigenous parents to the colonial system at the root of intergenerational trauma:

> what I went through with my mother, who was a victim survivor. ... So many different things affect the children. ... I've been through it, I didn't wanna put my children through it. But without going through my healing, I ended up being my mother and ... being overbearing and abusive to my children and my cousins. ... We need … this generation to understand, you know, where we are, where we need to go to change that.

For some participants, violence and trauma did not end with their childhood but continued throughout their adult lives. Racist and heteropatriarchal colonial policies and practices have perpetuated gendered violence against Indigenous women while disrupting their traditional values, culture, and spirituality, as well as their access to resources, education, and healthcare (Daoud et al., 2013; Godard et al., 2017; Native Women's Association of Canada, n.d.; Ogden & Tutty, 2023; Stevenson, 2020). Participants spoke about traumatic experiences of intimate partner violence at homes, sexual violence on streets, and racial and gendered violence at workplaces.

Intimate partner violence affects Indigenous women more frequently than non-Indigenous women (Department of Justice Canada, 2022; Heidinger, 2021) and can lead to more severe harm among Indigenous women than non-Indigenous women (Government of Canada, 2017). Intimate partner violence which Indigenous women experience is closely associated with colonization and intergenerational trauma, which has disrupted Indigenous peoples' connections to culturally defined relational ways of being such as their kinship networks (Holmes & Hunt, 2017). A participant's story described life-threatening intimate partner violence and her desire and attempt to shelter her children from violence:

> My boys were ... six and eight. And I told my friend … to take them out of the room. Please, I don't want them to hear this. And my boyfriend was beating me and beating me, and he ended up sitting across my chest pinning my arms and choking me. And when you're dying, the world ... it just gets smaller and smaller. ... I knew another four seconds, ... I'm gone. And then the cops walked in. And he jumped off. (I was) back again.

Current colonial policies and practices exacerbate gendered violence against Indigenous women. Intimate partner violence is perceived as an individual problem in the current health and social services (Godard et al., 2017). In addition, disclosing intimate partner violence which happened in the presence of a child to any helping institutions, such as police, healthcare, or child welfare system, could result in Indigenous women losing custody of their children (Humphreys & Absler, 2011). Thus, the patriarchal colonial system forces Indigenous women to choose between their safety and their right to parent, compounding their trauma experiences when facing intimate partner violence (Godard et al., 2017). A participant explained how Kwakwa̱ka̱'wakw women are retraumatized by the colonial system when asking for help:

> It's systemic violence that perpetuates [trauma] like the child protection system, from the police, ... MCFD [Ministry of Children and Family Development]. ... a lot of First Nations women [feel] ... a real hesitance to be involved or talk to the police or talk to hospital staff. ... We were doing a mother's mental health series for younger moms. ... If I was a young mom, I wouldn't wanna come here and tell you about my mental health problems because I would be afraid that you would tell somebody, you report that to somebody. ... it's real. Do I want to reach out for help if I'm having problems? Because my kids could be taken away?

In addition to intimate partner violence, Indigenous women are targeted for severe gendered and sexual violence on the streets (Lavallee et al., 2018), and a disproportionate number of Indigenous women are severely injured, missing, or brutally murdered (Department of Justice Canada, 2022). The settler-colonial system is developed on heteropatriarchal and racist values, and it continues to generate sexual exploitation and gender-based violence against Indigenous women (Allan & Smylie, 2015; Daoud et al., 2013; de Finney, 2017; Holmes & Hunt, 2017; Morton, 2018; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Ogden & Tutty, 2023; Razack, 2016). Razack (2016) argued that brutal and lethal sexual violence against Indigenous women, such as seen in Cindy Gladue's murder and the legal proceedings following her death, reflects how Indigenous women in the settler-state of Canada are viewed as expendable and disposable. A participant of this study also spoke about observing many Indigenous women disappearing off the streets. In addition, she personally experienced brutal gendered sexual violence herself by both white and racialized men, and she suffered multiple physical injuries. Some of the violent encounters were quite severe and she narrowly escaped death. Living everyday faced with brutal gendered violence and trauma, she expected that her life could end any day:

> I think I've rebroken my ribs a few times. These ones have been at least three times, and these one by two various beatings. ... I fought for my life more than once. I always thought I'd end up in a dumpster. Unidentified female in a dumpster I really thought of that's how I was going out.

Furthermore, racial and gendered violence against Indigenous women extends to workplaces. Racialized women, compared to both racialized men and white workers, are reported to face a higher incidence of workplace discrimination (Zou et al., 2022). Experiences of workplace racial and gender discrimination can affect the mental health of Indigenous and racialized female workers (Zou et al., 2022). One participant shared her experience of racism at her workplace and the emotional toll it took. Her experience of racism was further compounded by gendered violence:

> at the beginning, ... they supported me and believed in me. ... They hired all these men. ... One of my first meetings with them, he was just telling me that he didn't feel that First Nations had it so bad comparatively to other Indigenous peoples. ... Of course he's a bit of like a colonizer mindset. ... He bullied me so hard. ... And I would complain to my manager about this treatment that I was receiving. And then, you know, he would talk to the guy and then the guy would retaliate against me. ... I just stopped complaining and just left it because ... there was nothing I could do. I worked so hard. I gave up so much time with my kid to be in this place, to make it a success because I thought it was going to go somewhere.

Participants recounted their experiences of life-long exposure to racial, gendered, institutional, and intergenerational forms of colonial violence. One participant described her experience as “living in fear ... all my life”. Trauma developed in response to their experiences of violence at colonial institutions and homes, in intimate relationships, at workplaces, and on the streets. While childhood exposure to violence through intergenerational trauma created early trauma experiences among participants, current colonial policies and practices deepened their trauma by failing to create safe supports for them even when they are faced with severe violence.

3.2.2 Pain Develops Through Stress Responses to Colonial Trauma

Participants of this study shared their insight into different ways in which trauma caused by colonial violence generated and interacted with their physical pain. Studies show comorbidity between chronic pain and experiences of trauma (Abdallah & Geha, 2017; Craig et al., 2020; Ford-Gilboe et al., 2022; Hemsing et al., 2016; Holmes et al., 2024; Moosa-Mitha et al., 2025; Outcalt et al., 2015; Timmers et al., 2019; Wallace et al., 2021). People who have experienced adverse childhood incidents such as childhood trauma are particularly more likely to experience severe pain later in life than people without such experience (Nelson et al., 2018; Prangnell et al., 2020; Sansone et al, 2013). Participants of this study echoed these findings and shared their insight about how their pain was deeply connected with childhood trauma such as being exposed to childhood abuse, witnessing violence, and feeling unsafe as a child. For example, one participant explained her understanding about the close relationship between her childhood trauma and chronic pain later in her life:

> I would say every joint in my body [hurts]. ... what we went through as children that's causing us pain. [The doctor] explained the cause for me having rheumatoid arthritis. And that's what I feel that it stemmed from being in a TB hospital, going through the trauma

> that I went through. And I think that is probably the same for people who went through Residential School, all the trauma that they endured.

In addition, some participants of this study reported that emotional pain such as anger and hurt was closely connected with their physical pain. Literature indicates that Indigenous people often report physical pain being closely tied to their emotional pain (Canadian Pain Task Force, 2020; Latimer et al., 2018). Emotions such as anger and fear are also common responses to trauma (National Centre for PTSD, n.d.). One of the participants spoke about her emotional pain when she was faced with intergenerational trauma, which disrupted nurturing familial connections (Bombay et al., 2014). Yearning for a nurturing connection with her parent, she said, “there's a little girl in me hoping my mom wanted to see me. But no. Not at all. So I'm really mad at them for hurting me, for having the ability to hurt me”. Both experiencing and suppressing emotions such as anger exacerbate chronic pain (Yarns et al., 2022). Another participant explained the direct connection between her emotional and physical pain. She stated, “I was angry at so many people, no wonder why I was feeling the pain”.

Participants further spoke about their insight into the close relationships among trauma, stress, and pain. While trauma commonly triggers stress responses (National Center for PTSD, n.d.), stress creates cascading and compounding effects in neuroendocrine systems and immune function, and these changes can lead to the development of chronic pain inducing conditions such as inflammatory diseases (Gupta, 2013; Hannibal & Bishop, 2014). Many participants of this study reported that inflammatory diseases are one of their major causes of pain. These conditions often started as a localized and sporadic symptom such as allergies and skin reactions at a young age. Over the years, they spread throughout their body: in joints, skin, digestive tract, spine, and reproductive organs. One participant explained such a progressive development of pain symptoms associated with inflammatory diseases:

> I have been struggling for years … with these symptoms [pain]. … I have had psoriasis since I was 10 years old. … I think I have psoriatic arthritis, too. … I can't get out of bed in the morning without extreme stiffness for several hours.

Stress can also trigger and exacerbate existing pain symptoms (Hannibal & Bishop, 2014). Another participant explained her insight about such relationships between stress and pain and how stress led to pain flare-ups:

> I realized that stress was a big factor in how my body reacts and how my body feels. … I was having to relive all that trauma of what had happened to me. And then I've got sick again. … that's when I realized the stress from that caused these symptoms.

Colonial violence is systemic and the intergenerational effects of trauma resulting from colonial violence extends beyond the person to their entire families and communities (Bombay et al., 2014; Cunneen & Tauri, 2018). A participant spoke about how her vicarious trauma experiences triggered stress and pain flare-ups when witnessing her family and community members experience trauma. Studies indicate that particularly helping professionals, who themselves have previous trauma experiences, could be more severely affected by witnessing their clients experience trauma (Henderson et al., 2024; Roberts et al., 2022). She explained how her stress response was also triggered when vicariously experiencing trauma through her family members and clients:

> I definitely know it's related obviously to my stress and my childhood stuff. ... in my 30s ... if I have a really stressful day or there's vicarious trauma that happens within my

> job or my children, ... I can't even move my neck ... or I'll have to use the bathroom right away. ... it's like my body reacts a lot faster now that I'm older.

Participants reported their insight about how trauma as an outcome of colonial violence interacted with pain. They believed that emotional pain was a response to experiencing colonial and intergenerational trauma, and that emotional pain led to physical pain. They also acknowledged the close relationships between pain and stress. Their physical pain developed in an interaction with stress caused by trauma in their childhood and adult lives. They believed that stress response played a key role in the development of their inflammatory diseases as well as causing pain flare-ups.

3.2.3 Racism in Healthcare Aggravates Stress Responses and Pain

Many participants in this study spoke about their pain being exacerbated by racism in healthcare. They reported frequent occurrences of having their pain experiences overlooked, underassessed, and unacknowledged by healthcare providers, which resulted in delayed or denied care. Racism is a form of colonial violence (Cunneen & Tauri, 2018). Research indicates that persistent anti-Indigenous racism in the healthcare system continues to shape Indigenous peoples' pain experiences (Allan & Smylie, 2015; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021). One of the participants reported an experience with a healthcare provider who stereotypically assumed that the pain and discomfort she was experiencing was due to alcohol use. She reported how her concerns were repeatedly dismissed even when she was in a critical medical condition:

> I ended up with a staph infection with MRSA [methicillin-resistant Staphylococcus aureus] and they put me on this double dose of antibiotics, and I went home. ... I'm allergic to them, we found out. I puked for 12 hours straight, ended up in the hospital, and

> I told them ... I'm sick. [A healthcare provider responded] “And really, I think you're just hungover. ... I don't think you're that sick.” Took them 45 minutes to get an IV because I was so dehydrated they couldn't find my veins and I ended up in quarantine. ... My organs were shutting down.

Wylie and McConkey (2019) argued that healthcare providers generally lack awareness about how they routinely discriminate against Indigenous peoples and that their practice is usually based on unacknowledged racism. When seeking pain care, Indigenous people frequently face racially-based prejudice and stereotyping such as being viewed as drug-seeking (Browne et al., 2016; Browne et al., 2018; Craig et al., 2020; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019). One of the participants spoke about needing to seek a white person to accompany her to the emergency room at a local hospital so that her pain symptoms and her request for pain treatment were validated:

> I had to go into the hospital to emergency on Thanksgiving of 2021, ... when I got really sick and I was like, I don't know what to do. I had to bring a white person with me, like come with me, because I was about to ask for drugs, right? Because I was in so much pain. And so, thankfully, I had a friend that was a nurse that could come with me and be there and advocate for me.

Healthcare providers are reported to frequently minimize Indigenous women’s chronic pain experiences, blaming these health outcomes on their poor personal choices and decision-making (Yu et al., 2019). While people who suffer from chronic pain often experience being doubted about their pain, people who are “othered” in society even more frequently receive such doubt (De Ruddere & Craig, 2016). Being disbelieved about their severe pain can create stigma while resulting in compounding negative effects on the person’s physical and emotional wellbeing (De Ruddere & Craig, 2016). A participant spoke about such an experience when her healthcare provider minimized her unresolved life-long health challenges into a “poor hygiene” problem or a “lifestyle choice” because she is Indigenous. This experience created a deep sense of stigma:

> So, the symptoms have definitely been throughout my entire life. And then I've had really poor care. ... a doctor said that [for] First Nations’ [people], everything's linked because we have poor hygiene, and so I've always felt in my head really dirty.

Indigenous people frequently report experiences of anti-Indigenous racism when seeking healthcare (Allan & Smylie, 2015; Turpel-Lafond, 2020). This can be seen in cases of health providers’ automatically discrediting Indigenous women’s pain experiences while assigning derogatory stereotypes because they are Indigenous. In Plain Sight (Turpel-Lafond, 2020) reported:

> Submissions by patients, family members, health care workers and third-party witnesses recounted patients being treated poorly simply because they are Indigenous. Comments and actions attributed to health care providers suggested Indigenous patients were perceived as a homogenous group that was less entitled to care and respect, including describing or treating Indigenous peoples as living in poverty, being dirty, sexually promiscuous and inclined to criminal behaviour. (p. 39)

Another participant spoke about how healthcare providers’ racist assumptions manifested in care settings when the healthcare provider did not explain to her about her medical issues or treatment options. She felt invalidated and disrespected, which created a sense of distrust towards the healthcare provider. Such distrust resulted in ineffective treatment as she found the recommended medication was neither effective nor appropriate to manage her pain and she discontinued it after a short period of trial. In addition, her negative experience with the healthcare providers contributed to her reluctance to seek further medical care, thus exacerbating her experience of pain:

> For many years I just didn't open up to anybody about anything. And that got me heading down the wrong path. And then with the doctors ... instead of telling me I was depressed, gave me antidepressants. And I'm asking, well, why are you giving this to me? Instead of saying, well you're depressed and this is why, ... they would turn around and say, well with Native people, we find that this medication works better for arthritis. ... I took that for about a week and found it just made me feel sick.

In addition, Indigenous women can be retraumatized, particularly when the healthcare provider has insufficient understanding about the effects of ongoing colonial violence and trauma-informed approach to care (Reid et al., 2023). A participant shared her experience in which healthcare providers' lack of awareness about colonial and gendered violence against Indigenous women exacerbated her feeling of being unsafe when accessing care:

> I don't trust the system and ... when they're saying that about my hygiene and how dirty and gross it makes me feel. Same with a pap. Like, it's just so retraumatizing. We didn't have sexual abuse in our communities until Residential School. And then exponentially it's gone up ... So you think about when we go in for physicals, it's traumatizing.

Thus, healthcare providers' lack of awareness about both their racist assumptions and about ongoing colonial violence and trauma against Indigenous women resulted in ineffective care or care being denied. This in turn created among the participants distrust of care and reluctance to access care. Delayed access to care could not only prolong and increase their suffering, but it may also cause irreversible medical conditions (Nelson & Wilson, 2018; Turpel-

Lafond, 2020). One of the participants commented that when she fell down the stairs, she did not seek care for several weeks until she was unable to walk. At another time, she experienced severe numbness in her legs but did not promptly seek care. She stated: “clearly this isn't normal, but again, when am I going to the doctor and get brushed off?” This participant found out later that her condition could have led to a permanent loss of function in her body.

Participants’ stories illustrated how the current healthcare system reinforced colonial violence and trauma in care settings while exacerbating their pain and suffering. Many participants explained how racism manifested through current healthcare practices. Healthcare providers frequently lacked awareness about their own racist assumptions. They also had insufficient understanding about the connections between colonial trauma and pain. These issues contributed to the healthcare providers’ dismissing and minimizing participants’ concerns while refusing to provide them appropriate care. In another incident, a healthcare provider did not offer an explanation about the participant’s health issues or treatment options. Furthermore, healthcare providers’ general lack of awareness about colonial trauma created situations where participants felt unsafe to access care. These manifestations of racism in healthcare practices created a deep sense of distrust among the participants. Many participants of this study have avoided seeking care in a timely fashion, which could have created potentially irreversible medical conditions. Lack of safe and respectful care, particularly when experiencing unresolved and debilitating pain, further triggered stress and exacerbated their emotional and physical pain.

3.2.4 Neoliberal Policies Result in Insufficient Pain Care for Rural Communities

Research studies report that a general shortage of pain care resources contributes to Indigenous people’s negative pain experiences (Bailey et al., 2023; Canadian Pain Task Force, 2020). Particularly Indigenous peoples living in rural communities often do not have access to consistent care, and they are also frequently required to travel to urban centres to access diagnostic procedures and specialized care (Bailey et al., 2023). Experiences of long wait times and delayed access to care contribute to Indigenous peoples' frustration and distrust of the colonial medical system (Nelson & Wilson, 2018).

Neoliberal policies prioritize market-driven economic growth while placing responsibility on the individuals for their own health and welfare (Brown et al., 2012). Since 1990's, Canada introduced budget caps to control and reduce healthcare spending, and this has resulted in decreased healthcare resources and longer wait times for treatment (Tyson & Karpowicz, 2012). Such policies have also deepened health inequity between rich and poor, particularly for people who live in rural communities needing to travel long distances to access specialized care (Brown et al., 2011; Canadian Pain Task Force, 2020; National Collaborating Centre for Indigenous Health, 2019). In addition, neoliberal approaches to health focus narrowly on the biomedical causes of disease symptoms within the individual (Tseris & Jamieson, 2024) while disregarding a nuanced biopsychosocial understanding of pain. Furthermore, driven by a cost-benefit approach, neoliberal policies promote a brief treatment for a specific acute ailment, thus advancing "medical colonialism" (Brown et al., 2012, p. 48) while disregarding Indigenous values of wholistic health (Brown et al., 2012).

Multiple participants commented on such negative effects of neoliberal policies on their health and pain care. They regularly experienced long waits for their medical appointments both with a primary care provider and for medical testing. Delayed access to primary care exacerbated their emotional distress and pain. A participant reported that she could only book an appointment with her primary care provider six to eight weeks in advance. Another participant commented on her frustration about a long wait for diagnostic procedures for pain. She stated that “(I) had to basically (wait) for a good six months just lying in bed”.

Long wait times to access primary care result in increased visits to the emergency room (Canadian Institute for Health Information, 2024). Moreover, communication does not routinely occur between primary care and emergency medicine (Beamon et al, 2021). Insufficient communication creates fragmented treatment which negatively affects particularly patients with chronic conditions (Joo, 2023). One participant pointed out that lack of communication between healthcare sites caused fragmented care while creating stress and worsening her pain. Such an experience further contributed to her frustration and distrust of healthcare:

> I have all this shit on my file. They should be able to look at my thing, see that I have a history of disease and prescribe me something to take home because I'm not going to suffer anymore needlessly because I have in the past and it hasn't done me any good.

This participant further contrasted the differences of the care quality between a First Nation’s and non-First Nations’ clinic while attributing the care quality differences to the colonial system:

> if I call [a First Nation’s clinic], I can get in to even just a phone appointment the next day, which is crazy because up there [a non-First Nation’s clinic], you're like waiting for a month. ... I'm not feeling sick anymore. So, why am I coming to the doctor? ... I've taken my aunt to the doctor here and they're like, oh, well, we can only discuss one thing at a time. Because of their billing, you know? So now she's going to wait another month to talk about ... XYZ. ... it's really frustrating.

Also, effective medications may not be readily funded under their medical plan. To be approved for the coverage of preferred and often more expensive medications, patients must first try less expensive alternatives to demonstrate their need for the particular medication (Government of British Columbia, 2024). Such a process causes prolonged suffering for patients:

> They [physicians] give you the methotrexate because it's cheap. ... It wasn't working, and it clearly hadn't been working for some time. But because the biologic medication is $2500 a shot, they really have to prove that ... the medication they're giving you isn’t working. ... thankfully I was [approved], because it just changed my whole life.

In addition to systemic racism, participants expressed how in the neoliberal political environment, they face additional barriers to access timely and effective pain treatment. Limited pain care resources available in rural communities created long waits to access primary care and diagnostic procedures. Delayed access to pain assessment and treatment exacerbated participants’ emotional distress and physical pain. Lack of communication between healthcare sites further fragmented care and contributed to participants’ increased frustration and distrust of the colonial healthcare system.

3.2.5. Reciprocal Interactions Between Trauma, Stress, Fatigue, and Substance Use

Participants in this study reported that severe fatigue often accompanied their pain. Fatigue is a common experience among people who live with chronic pain (Van Damme et al., 2017). Comorbidity of pain and fatigue is evident in conditions such as chronic fatigue syndrome and fibromyalgia (Mense & Schiltenwolf, 2010) as well as arthritis (Norton et al., 2024). Living with severe fatigue creates debilitating outcomes as it exacerbates pain intensity, sleep disruption, emotional distress, and challenges to day-to-day functioning (Boggero et al., 2017). Multiple participants of this study spoke about their struggles to live with fatigue. One of the participants described such challenge:

> it drains my energy. I know there are things I would like to do, and I just don't have the will, desire to do it. Sometimes I feel like I just need somebody to come in and just be [here] for me to talk to or for them to encourage me. Come on, you can do it, you know ... I know my feet hurt a lot. I mean, like even just to stand up. It hurts but I do, otherwise I will just sit here and wallow in self-pity. I don't wanna go there.

Participants' struggles were further compounded by lack of family support because of intergenerational trauma. Intergenerational trauma, as an outcome of colonial violence, can interrupt relationships within Indigenous families (Bombay et al., 2014). Many participants of this study reported growing up faced with challenging family dynamics because of the harmful legacies of Residential Schools over generations. This participant described her day-to-day challenge of living as a single parent without a supportive family particularly when she experienced extreme fatigue associated with pain:

> I had to stop working and it was painful. It was to the point where I would lay in bed. I would get my daughter off to school. I would go back to bed. I would get up. I would, you know, try to do some dishes. I would try to do a load of laundry. I would be exhausted from doing any of that stuff. I would have to lay down and have a nap. And you know, it wasn't a good situation. And of course, because I'm so sick all the time, I'm like not doing the best parenting I can do. I'm not doing the best self-care I can do. Because, you know, when you're sick you don't want to cook for yourself.

The stress of living with severe fatigue was further aggravated by intergenerational effects of colonial violence. This participant explained how growing up with intergenerational trauma and childhood abuse contributed to her struggles during her pain flare-ups:

> I'm so tired all the time because my immune system is overactive, right? It's continuously on all the time. And so of course I'm exhausted. ... it was ingrained in me since I was little… if I'm sleeping in or I'm not getting up and doing all of this stuff, I'm lazy, you know?

Living with unmanaged pain can lead to depression and suicidal ideation (Canadian Pain Task Force, 2019; Petrosky et al., 2018; Racine, 2018; Velly & Mohit, 2018). Chronic pain is found to be an independent risk factor for suicide (Racine, 2018). A participant shared her experience of starting to lose hope when living with unmanaged severe pain and fatigue:

> I was sick when you physically don't look sick you know. But I was really sick. ... I have a lot to live for. I love living. I love my life. But it was starting to feel like it would be better if this suffering would stop. ... how much longer could I have continued to live with this pain?

In addition, research indicates reciprocal interactions between living with chronic pain and substance use (Velly & Mohit, 2018; Vogel et al., 2017). A participant talked about how being dependent on prescription pain medications, alcohol, and substances when attempting to manage pain deepened a sense of trauma for both the person and their friends and family:

> My uncle used to steal pain meds. At the end, he quit taking them, quit the doctor to quit giving him, and he got drunk, self-medicated. ... We gave him weed, smokes, bought him weed, bought him beer. I tried to help. He committed suicide. ... I don't like thinking about that. I don't like thinking of the repercussions, the ripple effects.

Participants' stories illustrated multifaceted interactions between colonial violence, intergenerational trauma, stress, emotional and physical pain, fatigue, and substance use. These interactions were found to be bidirectional while exacerbating one another in compounding ways. Participants found that colonial violence and intergenerational trauma created stress, and this resulted in emotional and physical pain. In addition, intergenerational trauma disrupted nurturing family support when they struggled to cope with pain and fatigue. It further contributed to unhelpful expectations towards self while deepening a sense of struggle to manage life with pain and fatigue.

Participants also explained how living with pain created stress and this exacerbated pain. Similarly, their physical pain deepened emotional pain, depression, a sense of hopelessness, and sometimes thoughts of suicide. Losing loved ones to suicide further increased a sense of loss, trauma, stress, and pain. Participants' stories highlighted these complex and compounding effects of colonial violence and intergenerational trauma that interacted with their experiences of physical pain.

3.3 Discussion

Informed by the Indigenous decolonial feminist theories, this study examined the coloniality of pain through five cisgender Kwakwa̱ka̱'wakw women's pain experiences. Indigenous decolonial feminist theories draw attention to intersecting forms of oppression in the context of colonial systems, and how they create diverse, inequitable, and hierarchal experiences among women globally (Dibavar, 2023; Figueroa, 2020; Lugones, 2010; Wagner, 2021) and in Canada, as well as among Indigenous women of Turtle Island (BlackDeer, 2023; Craig et al., 2020; Holmes & Hunt, 2017; Holmes et al., 2024).

This study explored physical pain experiences among cisgender Kwakwa̱ka̱'wakw women specifically in how their pain manifests at the intersections of Indigeneity and gender in the settler-colonial system. Participants' stories highlighted multifaceted effects of colonial violence and trauma on their physical pain. In the next section, I discuss further how various forms of structural violence shape Kwakwa̱ka̱'wakw women's lives today (3.3.1) and articulate how their chronic pain develops as a response to the trauma and stress from being repeatedly exposed to racial and gendered colonial violence (3.3.2).

3.3.1 Colonial Violence is Gendered, Intersectional, and Ongoing

Despite the popular myth among settler Canadians that colonial violence occurred only in the past (Midzain-Gobin & Smyth, 2020), participants' stories articulated how gendered colonial violence against Kwakwa̱ka̱'wakw women is current and continues to erode safety throughout their lives (Allen & Smylie, 2015; Daoud et al., 2013; de Finney, 2017; Holmes & Hunt, 2017; Holmes et al., 2024; Morton, 2018; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Ogden & Tutty, 2023; Razack, 2016).

The colonial policies and practices of assimilation and elimination by the settler state of Canada has inflicted violence against Indigenous people while attempting to erase their existence (Allan & Smylie, 2015; de Finney, 2017; Holmes & Hunt, 2017; Truth and Reconciliation Commission of Canada, 2015; Wolfe, 2006). The settler-colonial logic of elimination, as Wolfe (2006) explains, enabled the settler-colonial government's "breaking-down of native title into alienable individual freeholds, native citizenship, child abduction, religious conversion, resocialization in total institutions such as missions or boarding schools, and a whole range of cognate biocultural assimilations" (p. 388). Truth and Reconciliation Commission (2015) called this cultural genocide, referring to the settler-colonial state's attempt to "cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada" (p. 1). Million (2020) further asserted that regardless of the term, culture, these are the settler-state's attempts at genocide of Indigenous peoples as "killing a people's cultural context is equivalent to killing their bodies and their future generations" (p. 413). As all participants of this study expressed, violence at Residential Schools and Indian Hospitals created profound and multigenerational outcomes among Indigenous families (Allan & Smylie, 2015; Latimer et al., 2018; O'Neill et al., 2018).

Gendered colonial violence has never ended. Colonization continues to reinforce the heteropatriarchal racist system while generating gender-based violence against Indigenous women (Daoud et al., 2013; de Finney, 2017; Holmes & Hunt, 2017; Morton, 2018; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Ogden & Tutty, 2023; Razack, 2016). Clark (2016) wrote, "colonization required silencing of Indigenous women, as the matriarchal and co-operative societies did not fit within the individualistic and patriarchal ways of the colonizer" (p. 3). Morton (2018) asserted that "violence is made possible and understandable by normalizing the sense that a particular population segment (in this case Indigenous women) is "less-than" and therefore the violence against them is neutralized" (p. 260). Razack (2016) further argued, "sexualized violence [against Indigenous women] is key to disposability, and flesh is the site at which racial and sexual power are both inscribed" (p. 285). Brutal, extreme, and lethal sexual violence against Indigenous women's bodies is current, and this is evident in the ongoing national issue of missing and murdered Indigenous women and the settler-state's lack of commitment to act on the recommendations made by the National Inquiry into Missing and Murdered Indigenous Women and Girls (Carreiro, 2023; de Finney, 2017).

In addition, intimate partner violence affects Indigenous women more frequently than non-Indigenous women (Daoud et al., 2013), and it is more likely to result in severe injury and death (Heidinger, 2021). Present-day settler colonialism perpetuates intimate partner violence against Indigenous women by failing to recognize how violence is exacerbated by the current colonial policies and practices through child welfare, healthcare (Godard et al., 2017), police

(Palmater, n.d.; National Family and Survivors Circle, 2022), as well as the criminal justice system (McBride et al., 2020). Women's choice for seeking safety is influenced by many socioeconomic and safety factors including safety after separation, economic factors such as income and housing, custody of their children, and mental health consequences of violence such as depression and anxiety (Heron et al., 2022). Rather than addressing these socioeconomic and safety factors which are rooted in colonization and affecting women's decisions, the patriarchal colonial system makes Indigenous women individually accountable for such violence (Godard et al., 2017). A psychiatric diagnosis such as borderline personality disorder is often assigned to the mental health outcomes of women being exposed to violence and trauma, and Eurocentric mental health diagnostic procedures continue to individualize and pathologize women who experience violence while utterly failing to acknowledge the profound effects of trauma on the person (Clark, 2016; de Finney, 2017; Holmes & Hunt, 2017; Hunt, 2016; Shaw & Proctor, 2005).

Furthermore, a participant in this study addressed how the current child welfare practice perpetuates colonial violence by creating barriers for Kwakwa̱ka̱'wakw women to seeking safety when they experience intimate partner violence. In British Columbia, intimate partner violence in the presence of a child is required to be reported to the child welfare system (Province of British Columbia, 2017). Despite their stated mission, child welfare systems contribute to the structural violence by exercising their power to pathologize, discredit, and silence Indigenous women's voices. Godard et al. (2017) wrote:

> The harm occurs when systems elide the historical and social-political contexts in which violence against women occurs, when they fail to address or even name the social inequalities that exacerbate women's distress, and when they overlook the capacities and

> resourcefulness of women to survive and support themselves and their children productively despite tremendous ongoing adversity. (p. 415)

A disproportionate number of Indigenous children are in state custody (Humphreys & Absler, 2011; Matheson et al., 2022; Public Health Agency of Canada, 2018) and the proportion of Indigenous children in foster care is increasing (Hahmann et al., 2024). Risks of losing their children create fear and a barrier for Kwakwa̱ka̱’wakw women to seeking help when they face intimate partner violence until the situation reaches a crisis point (Fiolet et al., 2021).

Canada as a settler state fails to recognize and address colonial policies and practices and their outcomes which are reflected in the health disparities (Allan & Smylie, 2015; Brown et al., 2018; Canadian Pain Task Force, 2020; Goodman et al., 2017; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019). Kwakwa̱ka̱’wakw women’s safety continues to be undermined by these patriarchal and racist colonial policies and practices through the child welfare and mental health systems.

In addition, colonial violence is not just gendered but it is also racist (Cunneen & Tauri, 2018) as is evident in the healthcare system that results in Indigenous peoples’ health concerns being dismissed and minimized, and the care being refused, delayed, or insufficient (Allan & Smylie, 2015; Brown et al., 2018; Canadian Pain Task Force, 2020; Goodman et al., 2017; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019). Participants of this study expressed that their health concerns were routinely brushed off or minimized through stereotypical racist assumptions held by healthcare providers who interpreted pain experiences as reflective of poor lifestyle or poor hygiene issues because of their race. Participants reported that these experiences of racism created a deep sense of distrust with healthcare, increased stress and hopelessness, and delayed access to care.

A number of studies have documented similar Indigenous patients' experiences of racial discrimination in care settings leading to their distrust of and delayed access to care (Barnabe et al, 2019; Browne et al., 2018; Craig et al., 2020; Nelson & Wilson, 2018; Wallace et al., 2021). Studies also have reported that racism in healthcare contributed to internalized stigma and increasing psychological distress (Browne et al., 2018; Canadian Pain Task Force, 2020). In British Columbia, In Plain Sight (Turpel-Lafond, 2020) has documented Indigenous healthcare providers' frequent experiences of Indigenous specific racism both against them and towards Indigenous patients in healthcare settings. Furthermore, a study in Alberta by Roach et al. (2023) captured physicians' lack of awareness about their racial bias against Indigenous patients. It reported that physicians in general held a moderate level of implicit racial bias against Indigenous peoples. In addition, 10% to 25% of the physicians who participated in this study were found to hold explicit bias against Indigenous peoples. This study further reported a lack of awareness and unwillingness at the leadership level to address Indigenous-specific racism in their care settings. Moreover, Indigenous culture as a source of meaning-making and healing from experiences of pain is entirely overlooked by healthcare providers. Training solely based on Western medicine results in discrediting and devaluing culturally based knowledge of wellness and the practice of healing (Roach et al., 2023).

Thus, racial and gendered violence against Indigenous women is a current, structural, social, and equity issue (Godard et al., 2017). Various forms of violence against Indigenous women continue to shape their lives today. Failing to address colonial violence as an intersecting sociopolitical structural issue within the colonial system perpetuates such violence and its harmful health outcomes (Holmes & Hunt, 2017).

3.3.2 Pain is a Natural Response to Colonial Trauma

Absolon (2022) wrote that for Indigenous people, “trauma is a consequence of colonial violence” (p. 71). Colonial discourse perceives trauma only within individualized biomedical and psychological frameworks devoid of the colonial context (Moosa-Mitha, 2021). Indigenous and non-Indigenous feminist scholars of Turtle Island have argued against such conceptualization of Indigenous people’s collective experiences of colonial violence as individual psychiatric pathology (Clark, 2016; de Finney, 2017; Holmes & Hunt, 2017; Million, 2020). A bio-medical approach to understanding trauma shifts the focus from settler-state violence towards Indigenous communities and constructs Indigenous women as helpless trauma victims in need of the colonial system’s intervention to address trauma (Clark, 2016; de Finney, 2017; Million, 2020). Million (2020) further articulates how focusing on trauma has come to represent “humanitarian efforts to reconcile victims of colonial violence to settler states” (p. 412). “Trauma industry”, as Clark (2016, p. 2) describes it, developed as the capitalist and neoliberal settler-colonial state’s response to reconciliation while reabsorbing its ongoing violence against Indigenous peoples into their system and turning healing into a profitable business (Million, 2020).

Thus, discourse about trauma experienced by Indigenous women must be grounded in the understanding of racist heteropatriarchal neoliberal settler-colonial state practices and its ongoing effects (Clark, 2016; de Finney, 2017; Holmes & Hunt, 2017; Million, 2020). Colonial trauma develops when being repeatedly exposed to colonial violence both individually and collectively, and it is a human response to the violence perpetuated by historical and current colonial policies and practices (Mitchell et al., 2019). Cumulative effects of stress from such prolonged, pervasive, and intergenerational trauma can lead to a variety of negative physical and mental health outcomes (Bombay et al., 2014; Mitchell et al., 2019; O’Neill et al., 2018).

In addition to the individual and familial trauma experiences, Indigenous women who are in helping professions, which was the case for all participants in this study, are even more frequently exposed to trauma in the community through their work. Being repeatedly exposed to trauma without sufficient support in the context of complex and overlapping relationships is likely to contribute further to stress and negative outcomes of perpetual stress (Roberts et al., 2022).

Pain and stress from trauma share overlapping biomedical and psychological processes while interacting with each other in a feedback loop (Abdallah & Geha, 2017; Hannibal & Bishop, 2014; Kovner et al., 2019; Timmers et al., 2019). Abdalla and Geha (2017) described how pain and trauma are the "two sides of the same coin" (p. 1). Overlapping and interactive mechanisms of stress and pain suggest that chronic pain among Kwakwa̱ka̱'wakw women cannot be fully understood without a comprehensive understanding of the effects of colonial trauma created and maintained by the ongoing structural violence. Rather than personal pathology or an outcome of maladaptive coping and poor personal choices (Allan & Smylie, 2015; Brown et al., 2018; Canadian Pain Task Force, 2020; Goodman et al., 2017; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019), pain among Kwakwa̱ka̱'wakw women should be understood as a human response to colonial trauma.

Indigenous people may conceptualize pain differently and physical pain can be closely connected to emotional pain (Canadian Pain Task Force, 2020). One of the participants of this study stated that her emotional pain felt as strong as her physical pain. Physical and emotional pain share overlapping neurobiological mechanisms (Frumkin et al., 2020). There is a high comorbidity between chronic pain and depression (Burke et al., 2015; Velly & Mohit, 2018; Yang & Chang, 2019), which can be felt as emotional pain (Frumkin et al., 2020). Emotional pain and distress are common responses to trauma, and they are associated with an increased intensity of physical pain (Outcalt et al., 2015). Therefore, both physical and emotional pain among Kwakwa̱ka̱'wakw women can better be understood as interactive human responses to colonial trauma.

In addition, fatigue is frequently associated with pain (Van Damme et al., 2018). Bartley et al. (2018) found that among Fibromyalgia patients, a higher level of fatigue corresponded with a greater pain intensity. Participants of this study reported similar experiences of severe fatigue associated with pain, and this contributed to increased difficulty in managing their life tasks. Challenges caused by severe fatigue associated with pain can be further compounded by the effects of intergenerational trauma which shifts one's views and expectations of oneself (O'Neill et al., 2018). Patriarchal gender roles rooted in the colonial system also contribute to overloading Indigenous women with household labour and childcare (McKinley et al., 2021).

Pain, fatigue, and depression are all associated with stress created by traumatic incidents (Afari et al., 2014). Childhood traumatic experiences are found to increase the risks of conditions caused by inflammatory responses, which will last well beyond childhood (Dube et at., 2009; Song et al., 2018). In addition, research has found inflammatory immune responses within the nervous system, such as seen in autoimmune disorders, are linked to fatigue and depression (Lee & Giuliani, 2019) as well as chronic pain (Lacagnina et al., 2021). These studies suggest a strong link between colonial violence and trauma, and pain and fatigue through the autoimmune response. Severe fatigue can be perceived as another human response to colonial violence.

Finally, alcohol and substance use can best be understood in the context of coping with colonial violence, trauma, and pain. Comorbidity between substance use and pain is well documented (Alford et al., 2016; Hemsing et al., 2016; Holmes et al., 2024; Velly & Mohit, 2018; Vogel et al., 2017; Wallace et al., 2021). Self-medication of pain is reported among people who use illicit substances (Alford et al., 2016). Studies also describe comorbidity between substance use and PTSD (Belfrage et al., 2023; Dell'Aquila & Berle, 2023; Hemsing et al., 2016; Holmes & Hunt, 2017; McCauley et al., 2012). Experiences of interpersonal trauma, such as sexual and physical abuse, may contribute to people's attempt to manage their challenging trauma response symptoms with alcohol and substances (Dell'Aquila & Berle, 2023). In addition, Belfrage et al. (2023) reported a high prevalence of both childhood and lifetime trauma experiences among the group of people who currently use substances and who used substances in the past. Women who currently use substances were more likely to have experienced childhood trauma and physical neglect than those who used substances in the past (Belfrage et al., 2023).

In a review of literature about Indigenous family violence, Holmes and Hunt (2017) articulated how substance use is frequently framed as a personal health issue contributing to the risk of violence and trauma. Such discourse promotes individualizing and pathologizing views of trauma experienced by Indigenous women while failing to recognize that both trauma and substance use exist in the context of heteropatriarchal colonial systems generating structural violence. These studies clearly suggest that alcohol and substance use among Indigenous women living with pain must be reconceptualized in a broader context of structural violence in the colonial system. This realization urges pain care to develop more comprehensive and non-pathologizing approaches to address substance use, chronic pain, and trauma, all as linked and interactive outcomes of colonial violence (Holmes et al., 2024; Wallace et al., 2021).

3.4 Conclusion

Situated within the Indigenous decolonial feminist theories of intersectionality (BlackDeer, 2023; Dibavar, 2023; Figueroa, 2020; Lugones, 2010; Wagner, 2021) and informed by the Kwagu'ł methodology of witnessing (Hunt, 2018) and practices of settler solidarity and accountability (Hunt & Holmes, 2015), this chapter explored five cisgender Kwakwa̱ka̱'wakw women participants' embodied knowledge of how colonial and gendered violence and trauma generate and interact with chronic pain in their lives. First, ongoing gendered and racial violence in the settler colonial system in Canada today continues to shape Kwakwa̱ka̱'wakw women's safety and trauma experiences. Canada as a settler-colonial state has been built on the policies and practices of assimilation and elimination of Indigenous peoples (Allan & Smylie, 2015; de Finney, 2017; Holmes & Hunt, 2017; Truth and Reconciliation Commission of Canada, 2015; Wolfe, 2006). Indigenous women are targeted with more severe gendered violence as an outcome of colonial and patriarchal policies and practices. Colonial institutions such as healthcare and child welfare systems create barriers for Kwakwa̱ka̱'wakw women to access care and supports while pathologizing them, undermining their capacity, and silencing their voices. Being repeatedly exposed to colonial and gendered violence without having reliable and safe help creates colonial trauma as both an individual and collective experience. Examining the coloniality of pain allows a deeper understanding of Kwakwa̱ka̱'wakw women's experiences of pain manifesting at the intersections of gender and Indigeneity in the neoliberal settler-colonial context. It is far beyond a personal health concern, and is rather a physical manifestation of colonial, gendered, and racist structural oppression collectively experienced in the context of the settler colonial system.

Current colonial healthcare practices add to participants' experiences of colonial trauma. The Healthcare system fails to acknowledge coloniality of pain while pathologizing Kwakwa̱ka̱'wakw women's pain experiences. Participants of this study frequently experienced discrimination in healthcare settings. They pointed out that healthcare providers' lack of knowledge about the coloniality of pain contributed to disrespectful and ineffective pain care. In addition, insufficient funding and resources because of the neoliberal economic agenda resulted in extended wait times for primary care, diagnostic procedures, and pain treatment. These factors in turn deepened participants' sense of distrust, hopelessness and delayed access to care while exacerbating pain. Self-medication with substances was a way of coping with pain and colonial trauma in the absence of respectful, safe, and trustworthy care.

Examining the coloniality of pain reveals the need for decolonizing pain care in order for care to be effective. Decolonizing pain care is a social justice issue, and it must be built on the understanding about how colonial violence, trauma, and ongoing racism and discrimination intersect with Kwakwa̱ka̱'wakw women's pain experiences. In the next chapter, I discuss and analyze participants' recommendations on decolonizing pain care.

Chapter Four: Recommendations for Decolonizing Pain Care

This study explored five cisgender Kwakwa̱ka̱’wakw women’s experiences and knowledge about the coloniality of pain. Their stories illustrated how chronic pain among them manifested at the intersections of Indigeneity and gender as a result of coloniality. They described how physical pain is deeply intertwined with colonial trauma, which developed in response to ongoing racial and gendered violence. They further explained how trauma resulting from colonial violence created a variety of outcomes such as stress, fatigue, emotional pain, and substance use, all of which reciprocally interact with one another while creating compounding effects on physical pain.

Canada, as a settler-colonial state, is built on assimilative policies and practices which are based on the colonial logic of elimination (Wolfe, 2006). Racist, gendered, and sexual violence against Indigenous women continues in present-day Canada, and it is evident in the large number of missing and murdered Indigenous women and girls (Allan & Smylie, 2015; de Finney, 2017; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019), intimate partner violence against Indigenous women (Allan & Smylie, 2015; Holmes & Hunt, 2017), and violence against Two-Spirit people (Holmes et al., 2024; Holmes & Hunt, 2017; Hunt, 2016). Neoliberal settler colonial policies fail to address the colonial nature of racial and gendered violence while individualizing the outcomes of colonial violence as personal trauma, a biomedical and psychiatric pathology, to be intervened in and healed by the colonial system (Cark, 2016, de Finney, 2017; Holmes & Hunt, 2017; Million, 2020).

In addition, many studies report that persistent anti-Indigenous racism continues to exacerbate health disparities experienced by Indigenous peoples today (Allan & Smylie, 2015; Brown et al., 2018; Canadian Pain Task Force, 2020; Goodman et al., 2017; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019). Similarly, participants of this study recounted their personal experiences of anti-Indigenous racism when seeking pain care. Racism is another form of structural violence (Cunneen & Tauri, 2018). Similar to the use of a pathologizing discourse that constructs the effects of colonial violence as individual trauma, the colonial health system minimizes indigenous women’s pain as being reflective of their personal pathology and as outcomes of poor personal choices (Allan & Smylie, 2015; Turpel-Lafond, 2020). Anti-Indigenous racism also manifests through healthcare providers labeling Indigenous women seeking pain care as drug-seeking while refusing to provide sufficient pain medications (Turpel-Lafond, 2020). Participants reported that anti-Indigenous racism resulted in prolonging their suffering and in turn triggered more pain. Long waits to access diagnostic procedures and pain management resources in the current neoliberal environment further compounded their pain and suffering.

Participants’ stories clearly indicate that physical pain among Kwakwa̱ka̱’wakw women could not be sufficiently addressed when it is treated only using a biomedical approach. They point to an urgent need for healthcare practitioners to decolonize pain care by actively addressing how intersecting structural factors, such as colonial violence and racism, contribute to Indigenous women’s pain experiences. This realization leads to my second research question: what elements and approaches facilitate decolonizing pain care? What do frontline healthcare providers, agencies, and communities need to change to provide them with “respectful, just, and effective care” (Wallace et al., 2021, p. 9)?

This study was informed by Indigenous decolonial feminist research methodologies centring on the participants’ embodied knowledge grounded in their specific local context. This research was also inspired by the Kwagu’ł feminist methodology of witnessing in which participants’ voices, experiences, and knowledge are validated, remembered, and amplified (Hunt, 2018). Guided by these principles while also practicing settler responsibility to challenge coloniality, I sought the answers to my second research question grounded in the participants’ beliefs and recommendations honouring each participant’s contribution to this inquiry.

Participants’ comments articulated that the revitalization of Kwakwa̱ka̱’wakw culture plays profound and catalytic roles for health and wellbeing of Kwakwa̱ka̱’wakw women, and for this reason, it is integral to decolonizing pain care. In this chapter, I first analyse participants’ comments by exploring their beliefs about how cultural revitalization enhances wellness and healing. I then highlight the participants’ recommendations on decolonizing pain care practices which are explicitly built on their beliefs about the roles of cultural revitalization for healing. In section 4.1, I report three key outcomes that result from cultural revitalization for wellness for Kwakwaka’wakw women: wholistic and respectful relationships, self-determination, and culturally defined activities. In section 4.2, I discuss the implications and application of this knowledge for the decolonial pain care practice. I assert that increasing cultural safety while addressing persistent racism is a priority for decolonizing community pain care. In addition, pain care needs to promote Indigenous women’s self-determination at multiple levels of care. In section 4.3, I offer a discussion of the findings where I argue that decolonial pain care should foster wholistic wellness and healing which requires both biopsychosocial as well as cultural and spiritual approaches to pain care. I end the chapter with a conclusion in section 4.4.

4.1 Revitalization of Culture as Integral to Healing and Decolonial Pain Care

Revitalization of Indigenous cultures facilitates collective wellbeing founded on shared identity, values, norms, and ways of life deeply rooted in their territory (National Collaborating Centre for Aboriginal Health, 2016). Contesting narrow biomedical pain treatments, many participants of this study believed that revitalizing Kwakwa̱ka̱'wakw culture is foundational for both their collective and individual wellness and healing.

Yet, the logic of cultural and corporal elimination, as Wolfe (2006) argued, is at the foundation of settler colonialism and Canada as a settler colonial nation-state. Cultural genocide of Indigenous peoples has and continues to deny their existence through forced dislocation while dismantling their political, cultural, societal, and spiritual practices rooted in their territory, and replacing them with colonial systems (Wolfe, 2006). Revitalization of Indigenous cultures in the settler-colonial system is, thus, a political act of reclaiming the very right to be Indigenous (Loong et al., 2023). Corntassel (2012) describes how the daily practices of "peoplehood" (p. 89), which renews and revitalizes culturally guided ways of being, should be at the centre of decolonization. Zoe, one of the participants of this study, described the catalytic, profound, and overarching effects of cultural revitalization. She stated, "I think that culture is not just defined by dancing and language and singing and all, it's actually just, I mean, who we are as people".

Participants of this study echoed such foundational roles of cultural revitalization for the health of Kwakwa̱ka̱'wakw women. Their comments pointed to three essential factors which are facilitated by cultural revitalization and foster health and wellness among them. In section 4.1.1, I discuss restoring wholistic and respectful connections, as reflected in their cultural worldview, being central to their health. In section 4.1.2, I address self-determination as the essential element of health facilitated by cultural revitalization. In section 4.1.3, I examine how revitalization of culture enhances health and healing through restoring cultural ways of life including traditional diet, physical movement in traditional activities, and humour.

4.1.1 Restoring Wholistic Connections

Health is a state that is not just about an absence of disease (World Health Organization, 2024). Rather, meanings of health and wellness are informed by each culture according to their collectively held beliefs, values, and worldviews (Clark et al., 2017; Duran et al., 2008; National Collaborating Centre for Aboriginal Health, 2016). Health and wellness in Indigenous cultures are often attained by maintaining and restoring a web of harmonious and respectful connections (Dumont & National Native Addictions Partnership Foundation, 2014; Yu et al., 2019). Participants of this study affirmed such a relational nature of health and how revitalizing their culture fosters the restoration of wholistic relations essential for their wellbeing. Zoe described a collective identity of Kwakwaka'wakw centred on the respectful and harmonious relationships to one another:

> It [culture] is about who we are as a collective group, and as a collective people how we interact and [how] we treat each other. I think that is part of what is taken away [by] colonization… not just the culture like singing, dancing, language aspect of it, but like how we've treated each other and how we interact and love one another as a family and as a community.

The healing power of relationships also extends to being connected to ancestors, those who have moved beyond this life (Dumont & National Native Addictions Partnership Foundation, 2014; Yu et al., 2019). Maggie spoke about how spiritual connections to her ancestors and loved ones who passed away continue to nurture healing. She said:

> he [her deceased son] checks on my family because I was with my cousin …next door and her granddaughter … was giggling looking down the hallway. And we're like, what are you laughing at ? Uncle … is making a funny face. Oh, he is visiting.

Elder Sharon also shared her belief about her ancestors guiding her healing journey. She said, “I also believe that the ancestors bring certain people into your life that you need at the moment. And it’s being able to accept that”. Sharon further explained her belief that the healing journey for a person does not end in this world but continues even after their death. She reflected on her memory of her mother and spoke about her belief that the spirit of her mother continues to heal from colonial trauma even after her spirit left her body. She said, “she [Sharon’s mother] is here and she is healing. She is not quite there yet, but she's healing”.

Wellness of Indigenous peoples is often founded on living harmoniously not only with human relatives but also with non-human relatives within the territory (Dumont & National Native Addictions Partnership Foundation, 2014; Lees & Bang, 2023; Yu et al., 2019). Josewski et al. (2023) wrote, “Indigenous people, though deeply heterogeneous and greatly varied, are in and of place, anchored in a connection to homelands, even if separated from those homelands upon which their kinship and genealogical being stretch back beyond time itself” (p. 3). Stephanie shared a similar belief of wellness founded on such deep interconnectedness and kinship to all that exist in their territory:

> we believe that spirit lives in our water, and our rocks are our oldest grandfathers. It goes back to our mountains, goes back to our origin stories, and our place names since time immemorial. … one of our connections for all people is nature, that’s where we lived.

In addition, language and culture are deeply connected, and the language of a culture conveys its specific worldview (Chilblow & Meighan, 2022). Relational worldview of the Kwakwaka’wakw culture is expressed through their language, Kwak̓wala (Rosborough et al., 2017). Elder Maggie’s granddaughter explained:

> It’s [Kwak̓wala is] such a deep language. So when you say something, it's never translated to just that thing. There are so many layers that come with it. So yeah, it does make you feel different. It makes you feel more connected to the land or whoever you're talking to … everything is so deep in Kwak̓wala.

Assimilation policies enacted by the settler-colonial state of Canada included a prohibition of the use of the Indigenous language (Allan &Smylie, 2015; Mitchell et al., 2019; Truth and Reconciliation Commission of Canada, 2015). Thus, language revitalization is a political act against the colonial system to reclaim Indigenous collective identity expressed through their language (Greenwood & Jones, 2018; Kirmayer et al., 2011; Whalen et al., 2022). Importantly, language revitalization promotes wellness against the harmful effects of colonial violence (Shea et al., 2019). Studies report that language revitalization initiatives create a broad range of health promoting outcomes including decreased rates of suicide (Chandler & Dunlop, 2018; Whalen et al., 2022) and alcohol use as well as improved mental health (Whalen et al., 2022) and decreased chronic health issues such as diabetes (Oster et a., 2014; Whalen et al., 2022).

Both Elder Maggie and her granddaughter spoke about the cultural meanings of pain, “T’sa̱xa̱la”, which means pain in Kwak̓wala, being viewed as “a natural thing” in life. The granddaughter shared this story about her great grandmother having her first child:

> So my great grandmother … was one of the people that raised me. And I think about her going to have her first child. She was 14, I believe. And … that [pain during childbirth] is one of the biggest pains your body can go through, but her thought was to go up to the back of the woods up against the cedar tree and have the baby herself. I wish I could ask her what she thought about pain back then. But you just dealt with it.

She further spoke about how Kwakwaka’wakw culture fosters accepting pain even at the time of death:

> Even when people were dying, they [families] would have them at home in the middle of all of their families and everybody would come and visit them to say their last words to them. It wasn't like we need to fix this pain because your body needs to feel it.

The cultural meaning of pain as being a part of everyday life helped the granddaughter commit to living well with pain. She stated:

> I remember saying to my grandmother, Ohh this hurts. I don't feel very well. Well, you're alive, is what she would say to me. [You] feel it because you're alive. … I get the headaches as well. I have a tumor … sometimes … my eyes swell up, back of my neck swells up and that causes a lot of … issues, loss. Yeah, we're just dealing with it day by day.

Health and wellbeing are culturally defined, and they encompass larger concepts beyond absence of disease. Participants explained that health in the Kwakwaka’wakw culture is nurtured through restoring and maintaining harmonious kinship connections in their territory. Kinship connections extend beyond humans to the land and waters of the territory. It also encompasses spiritual connections with their loved ones as they continue to heal after their spirits leave their body. Revitalization of Kwak̓wala further fosters a relational worldview as expressed in their language. Accepting pain as a natural experience in life, Kwak̓wala revitalization enhances living well with pain.

4.1.2 Self-Determination

Participants of this study explained that revitalizing Kwakwa̱ka̱’wakw culture affirms their collective resiliency and agency to resist assimilation (Kirmayer et al., 2011). Being

Indigenous is an everyday practice to “reclaim and regenerate one’s relational, place-based existence by challenging the ongoing, destructive forces of colonization” (Corntassel & Bryce, 2012, p. 152). Stephanie explained that revitalizing Kwakwa̱ka̱’wakw culture is to reject harmful labels which the colonial system attempted to impose on them, and instead claim their collective identity as healthy, resilient, and self-sufficient people rooted in the territory. Such identity is foundational for the wellness and healing of the Kwakwaka’wakw:

> it is the system that has brought us this way. Nothing is wrong with us. … We had sustainability. We treated each other with love and kindness. We didn't need this type of [colonial] system. We went to our plants and our herbs and our traditional ways.

Reclamation of culture consists of “daily acts of embodying and living Indigeneity” (Hunt & Holmes, 2015, p. 157). Stephanie explained that this continuous process of decolonization means to her “everyday [being] committed that we’re human”.

Revitalization of culture promotes self-determination and taking back control of healing (Chioneso et al., 2020). Zoe spoke about becoming her own advocate to receive more effective treatment in a timely manner:

> You really have to learn how to advocate for yourself, which has been a process for me in my healthcare and my health journey… being able to just say to my doctor … this is how I’m feeling like. … I can’t dictate to him [doctor] what the best course of treatment is. I’m not a doctor but I can advocate for myself. … I also got into learning how to describe pains in my body…throbbing pain, sharp pain, dull ache, on a scale of one to 10, what does it feel like?

Self-determination fosters “psychological liberation” from colonial trauma (Duran et al., 2008, as cited in National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 289). Elder Sharon stated her commitment towards such liberation. She encouraged others to join this collective healing journey:

> I wanna know what it is to live and not just exist. As to me, with all this trauma that I've been through, I felt like I was just existing. Wanna be able to know the freedom, being free from that trauma, free of the anger, free of the fear, and just be able to enjoy life. And that's my prayer for everyone who has gone through what we've gone through. Let's start with each individual to make that choice. … we are becoming a united people fighting a battle for justice, equality.

Two-Eyed Seeing approach can further promote Indigenous women's self-determination. Challenging the universality of Western biomedical knowledge, Two-Eyed Seeing can support healthcare providers to facilitate conversations with Indigenous women to create care plans utilizing diverse knowledge traditions (McFadden et al., 2023). At the same time, Broadheald and Howard (2022) caution against an uncritical application of Two-Eyed Seeing as a universal approach which could underestimate the fundamental differences between Indigenous and Western knowledge systems. However, within the context of this study, participants clearly recommended that different approaches to healing should be available when developing care plans as long as they are grounded in the person's personal values, beliefs and preferences and being tailored to the community context. Elder Sharon spoke about actively choosing to learn from both traditions to create the best course for the future:

> we can't go back to how our ancestors lived. What we can do is take the best of both worlds. I know there's a lot of things about colonialism that I don't agree with, but you know, they are here. They are here to stay and there is nothing we can really do about it.

> But learn their education, learn their way of life, accept what's gonna work. But that doesn't mean we have to accept what's not going to work. It's knowing the difference.

Participants of this study articulated that revitalizing culture was to reclaim their identity which the colonial system has attempted to erase. Affirming their resiliency and agency, strengthening Kwakwa̱ka̱'wakw culture fostered self-determination, which allowed them to take control over their own healing, as reported by participants. Through this process, cultural reclamation encouraged Kwakwa̱ka̱'wakw women who participated in this study, to become their own advocate and to direct their care by utilizing the best of both Western pain medicine and traditional healing.

4.1.3 Lifestyles Informed by Cultural and Traditional Practices

Revitalizing Kwakwaka'wakw culture enhances health and wellness by promoting traditional culturally based lifestyles rooted in their cultural practices. Elder Maggie spoke about how the traditional diet provides an abundance of minerals from the coast. She said, "[eating] fish two or three times a week … crabs, clams, cockles, that was part of the diet. So there's a lot of minerals in the cockles and clams". In addition, Oolichan grease produced in the territory offers an additional source of minerals. It has been treasured as cultural medicine by many First Nations on the coast and beyond (Cranmer Webster, 2001). Elder Maggie spoke about this cultural medicine:

> there's a few families that go up to Dzawadi in Knight Inlet. … You line the pits with like cedar boughs or hemlock bows and then just let it ripen. … [her spouse] said let it rot. No, you let it ripen! And then you put it in a big vat with the glacial water and boil it, boil it. And then the oil comes out of it. And up and down the coast, it's pretty near the same method that they used. It's really amazing how they found this.

She explained that Oolichan grease was traded with other Nations, and it created “grease trails” on the West coast of Vancouver Island and the interior. She further spoke about the negative effects of colonization through the residential schools by which the Indigenous traditional diet was taught to be shameful:

> I believe with the residential school … when I used to bring fish sandwiches to school, it was ohh you got fish, it stinks. So the young people are made to feel ashamed of their diet. Even Oolichan oil and stuff like that, ohh, I wouldn’t taste that. … They don’t realize how good it is for them. So, they’ve gone away from our traditional foods. If you start a child early enough with our Oolichan oil and with the fish, they would develop a taste for it.

In addition, many participants believed that staying active is critical for wellness and managing pain. Exercise activates pain regulation mechanisms and is found to modulate the pain sensation among people who do not have chronic pain (Hodges & Smeets, 2015). Stephanie explained how movement, when engaging in traditional activities, enhances wellness:

> I know that movement is medicine. It's when I'm not moving that I get more of my ailments … I've had three knee surgeries and a sprained ankle, … a fractured ankle. … I think we need to go back to our ancestral ways … I think that because our ancestors, we were warriors. … that's how we had to live on the canoes and hunting …

Furthermore, Maggie shared her belief about laughter and humour as medicine. Laughter and humour can create a safe space to transform hurtful outcomes of colonialism (Copage, 2019). Maggie explained how humour helped her survive the emotional pain experiences of trauma and grief:

> if I don't laugh, I'm gonna cry and I'm tired of crying. So, I laugh about pretty much everything. Yeah, I'm sorry. I'm the one that's gonna laugh at a funeral. But you know what? I think they[deceased]'d be happy if we were happy.

In addition to restoring wholistic and respectful relationships and strengthening self-determination, participants believed that cultural revitalization promotes health and wellness through restoring traditional lifestyles inherent within their culture. Wellness can be fostered through restoring traditional diet of their territory, enhancing movement in line with their cultural ways of life, and stimulating humour and laughter as cultural medicine.

4.2 Decolonial Pain Care Practices

In this section, I explore decolonizing pain care in the Canadian rural community context which explicitly addresses the coloniality of pain referring to various ways in which colonial structures and practices manifest in and perpetuate physical pain among Indigenous women (Moosa-Mitha, 2025). Situated within an Indigenous decolonial feminist framework, I discuss decolonizing pain care practices drawing on the embodied knowledge of the Kwakwaka'wakw women participants. Participants of this study believed that revitalizing Kwakwa̱ka̱'wakw culture is integral to their health and wellbeing because it counteracts colonial violence and trauma while fostering their culturally defined identity and self-determination. I discuss two fundamental ways by which settler healthcare providers can implement decolonizing pain care practices. The first of which is enhancing Indigenous cultural safety (4.2.1) and secondly, by promoting self-determination (4.2.2).

4.2.1 Decolonizing Pain Care by Enhancing Indigenous Cultural Safety

As discussed in the last chapter, many participants of this study have routinely experienced incidents of anti-Indigenous racism when seeking pain care. Multiple participants reported that they were automatically assumed by healthcare providers to be drug-seeking or intoxicated because they are Indigenous. These racist assumptions resulted in healthcare providers dismissing the participants' pain experiences and refusing to provide either necessary assessment or treatment.

Healthcare providers also held assumptions about pain being a solely biomedical issue and overlooked structural inequities and systemic violence that contribute to Indigenous women's experiences of physical pain. Lack of this structural understanding of pain, in addition to anti-Indigenous racism and disrespectful assumptions about Indigenous women, justified healthcare providers viewing Indigenous women as responsible for pain while minimizing their experience as an outcome of their poor hygiene and poor personal choices.

Routinely experiencing anti-Indigenous racism in healthcare, participants reported a deep sense of distrust towards the healthcare system. In addition to exacerbating pain and prolonging suffering, anti-Indigenous racism resulted in delayed care, potentially causing permanent damage and even death. Although Indigenous cultural safety (ICS) training programs are widely available, anti-Indigenous racism continues to exist throughout Canadian healthcare settings (Allan & Smylie, 2015; Brown et al., 2018; Canadian Pain Task Force, 2020; Goodman et al., 2017; Nelson & Wilson, 2018; Turpel-Lafond, 2020; Wallace et al., 2021; Wylie & McConkey, 2019).

First Nations Health Authority (2025a) defines ICS as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system" (Framework for Cultural Safety and Humility section, para 1). ICS training combined with additional anti-bias training has shown some positive change within patients' self-reports (Smylie et al., 2024); however, efficacy of ICS trainings requires further research (Hardy et al., 2023). Turpel-Lafond (2020) also reported that inconsistencies were found among ICS trainings. Particularly when ICS is perceived as multicultural awareness and competency, the structural nature of anti-Indigenous racism can become obscured while failing to address white normativity or the inherent power differences in healthcare (Pon, 2009; Gerlach, 2012).

In addition, trauma- and violence-informed care (TVIC) trainings can enhance healthcare providers' understanding about how both structural and interpersonal forms of violence manifest in Indigenous women's experiences of pain. Extending previous models of trauma informed care, Equity-Oriented Care studies (Browne et al., 2016; Browne et al., 2018; Ford-Gilboe et al., 2018; Holmes et al., 2024; Moosa-Mitha et al., 2025; Varcoe et al., 2019; Wallace et al., 2021) brought attention to violence in addition to trauma which often contributes to the pain experienced by people who are affected by systemic inequities. TVIC promotes patient safety in healthcare by recognizing the pervasive effects of trauma and violence in people's pain experiences, being attentive to the power held by healthcare providers, and actively building trusting and respectful care relationships.

In the following section, drawing on the participants' stories, I discuss the practice of decolonizing pain care through addressing anti-Indigenous racism and enhancing ICS. First, I argue that healthcare providers need to develop a better understanding of the relationships between colonial violence, trauma, stress, and pain and to actively address them through pain care (4.2.1.1). I assert that ICS and TVIC programs should assist healthcare providers in this learning process. Next, I explore the process in which healthcare providers engage in the ongoing practice of decolonizing their beliefs and assumptions based on white-centric values (4.2.1.2). I explain how cultural humility and critical self-reflexivity would guide healthcare providers in this process. Finally, addressing the power imbalance inherent within healthcare relationships is an essential component within both ICS and TVIC (Browne et al., 2016; Browne et al., 2018; Ford-Gilboe et al., 2018; Varcoe et al., 2019; Wallace et al., 2021). Through exploring Indigenous listening practices, I discuss how respectful listening practices would facilitate shifting the power balance and promoting decolonizing healthcare relationships (4.2.1.3).

4.2.1.1 Decolonizing Pain Care by Addressing Coloniality of Pain

Given the findings of this study, decolonizing pain care requires healthcare providers' sufficient understanding of coloniality of pain, how colonial gendered and racial violence continues to create trauma among Indigenous women both in healthcare and in their communities, and that anti-Indigenous racism as colonial violence repeatedly exacerbates Indigenous women's pain experiences. Both ICS and TVIC trainings should introduce healthcare providers to the concept of structural violence, the "broader historical and economic conditions shaping patients' health issues" (Browne et al., 2018, p. 8).

Stephanie stressed the importance of settler healthcare providers' commitment to learning about colonial violence and trauma and how they have created health challenges among the Kwakwa̱ka̱'wakw. She believed that healthcare providers' critical knowledge about the region-specific colonial history could help foster non-judgemental and compassionate attitudes towards their Kwakwa̱ka̱'wakw women patients. Such an understanding could contribute to a shift among the healthcare providers from viewing chronic pain as individual pathology to viewing pain as an outcome of colonial violence and trauma:

> knowing the history of where we come from and if the doctors are working on our lands, then acknowledging that … (by) showing up with more love and empathy and compassion versus the opposite … and not trying to pathologize us or fix us, but meet us where we're at.

Considering that colonial violence is at the root of trauma experienced by Indigenous women, TVIC training should be incorporated into ICS trainings (Tujague & Ryan, 2021). Coordinated training would help enhance healthcare providers' understanding of the impacts of colonial violence, including anti-Indigenous racism in healthcare, on the physical pain of Indigenous women.

In addition, a participant of this study stressed the importance of healthcare providers explicitly addressing through pain care the coloniality of pain, how sociopolitical and economic systems in neoliberal settler-colonialism contribute to Indigenous women's physical pain through gendered colonial violence, ongoing racism and discrimination, which is also colonial violence, and intergenerational trauma as a result of experiencing colonial violence. Elder Sharon spoke about her experience of her healthcare provider explaining the connections between colonial trauma and physical pain. This knowledge opened the door to her healing journey:

> The first doctor that diagnosed me with rheumatoid [arthritis] asked me all kinds of questions, and I thought at that time that was none of his business. … After we did all the test and got the results back … he explained the cause … stemmed from being in a TB [Indian] hospital going through the trauma that I went through. … He was the only one that knew and understood the cause of and the process of rheumatoid arthritis … So that year when I had him as my doctor, I really worked at … not allowing somebody to make me angry, not allowing that experience to traumatise me, and I really felt the difference in how I was feeling.

Placing women's pain experiences within the context of colonial violence, a collaborative inquiry by the healthcare provider and the Indigenous woman patient would validate their experiences while shifting the blame away from the individual who suffers from pain. It would further help identify and address various harmful outcomes of colonial violence which contribute to Indigenous women's pain experiences.

4.2.1.2 Decolonizing Pain Care by Challenging Anti-Indigenous Racism

Challenging the ongoing persistent racism while improving ICS in healthcare is an urgent task. Addressing persistent racism in present pain care practice requires attention to multiple factors reinforcing racism. First, white settler healthcare providers need to recognize how white privilege is often invisible and how white superiority is sustained also by the white people who consider themselves to be "non-discriminating towards racialized people" (Weinberg & Fine, 2022, p. 103). DiAngelo (2006) explained how Eurocentric white normativity forms "internalized racial dominance" (p. 51), which often operates outside of the person's conscious awareness or intention. White-centric values such as individualism are frequently upheld as a universal truth. Such a value perpetuates racism by disregarding historical and current structural inequity based on race and viewing individuals as responsible for the outcomes of such structural inequity (DiAngelo, 2006; Holmes et al., 2024; Moosa-Mitha et al., 2025). White dominance is protected by white solidarity often shielding white settlers from examining their own racial biases, which can trigger uneasiness (DiAngelo, 2006). DiAngelo (2016) called this white fragility:

> a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. (p. 247)

Addressing anti-Indigenous racism involves healthcare workers' remaining in discomfort and working through their own white fragility to acknowledge their settler privilege, white-centric beliefs, values, biases, and assumptions.

In addition, non-Indigenous racialized-settler healthcare workers also need to examine how they contribute to sustaining anti-Indigenous racism. Racialized-settler workers may experience institutional and interpersonal racism themselves in their daily experience (Badwall, 2014; Elkchirid et al., 2021; Wineberg & Fine, 2021). Elkchirid et al. (2021) argued that racialized workers may view themselves as being innocent while positioning themselves outside of the "Settler/Indigenous binary" (p. 290), thus taking the role of silent observers that reinforces Indigenous specific racism. Their daily encounters of racism may also lead them to attempt gaining status "by performing whiteness" (Badwall, 2014, p. 6) rather than confronting anti-Indigenous racism in the white hierarchical healthcare practices. It is critical that racialized healthcare workers situate anti-Indigenous racism within the context of settler-colonization and diligently examine their "embodied colonialism" (Elkchirid et al., 2021, p. 291) as both colonizer and colonized, and their "complicity in the ongoing project of colonization" (Lawrence & Dua, 2005, p. 122).

Furthermore, white dominance is woven through capitalist and neoliberal policies of settler-colonialism (Allan & Smylie, 2015; Quijano, 2000). Current neoliberal policies have created chronic insufficiency of healthcare resources (Tyson & Karpowicz, 2012) which more severely affects people living in rural communities (Bailey et al., 2023). Participants of this study expressed their frustration and distrust of the healthcare system when they routinely experienced severe pain without timely access to primary care, diagnostic procedures, or effective medications. Healthcare providers may also find it challenging to remain committed to anti-racist care with insufficient care resources which forces them to provide only brief and acute biomedical treatment (Tseris & Jamieson, 2024). Zoe pointed out the challenges for healthcare providers in the neoliberal political environment to stay committed to providing reflexive care. She posed this question:

> To really understand it [connections between colonial trauma and pain] from care perspective … when … it is the 50th First Nations person that is telling them their story about the same thing that's happened. … How do you really take that person's story in? You can understand it but how do you, as a person, as a healthcare provider, put that into practice and really understand it in a way that is going to give them the best care possible, especially when you're not First Nations?

Addressing anti-Indigenous racism thus requires each healthcare provider to diligently engage in their own decolonizing process, which can be guided by cultural humility. Cultural humility refers to "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts from an examination of her/his own beliefs and cultural identities" (Yeager & Bauer-We, 2013, as cited in Logie, 2021, p. 63). Critical self-reflexivity is an essential element of cultural humility. The practice of critical self-reflexivity can enable individual healthcare providers to recognize their own values, beliefs, and assumptions while "disrupting colonizing mind frames and enabling decolonizing interactions" (Baikie, 2020, p. 333). Questions such as "how Whiteness is produced or how colonialism shapes their sense of self as White settlers" (Hunt & Holmes, 2015, p. 165) can be explored both individually and collectively through everyday conversations including outside of workplaces (Hunt & Homes, 2015). Critical self-reflexive inquiry can further help healthcare providers challenge the power imbalance (Logie, 2021) which is inherent in healthcare relationships.

It is essential that this reflexive process addresses the structural nature of personally held values and assumptions, and how they are created in the context of the white-centric socioeconomic structures through internalized racial dominance as well as internalized oppression (DiAngelo, 2006). If kept within one's familiar knowledge, self-reflexivity can become another colonial practice to reinforce white dominance (Tang Yan et al., 2022). It can turn into a personal confession rather than addressing the structural nature of the white dominance on which personal beliefs and assumptions are based (Tang Yan et al., 2022). Critical, or "uncomfortable reflexivity" as Tang Yan et al. (2022) described it, should help settler healthcare providers to acknowledge "White power as a structure of racial dominance" (p. 1673), and how their personally held values and assumptions are created to maintain the white-centric socioeconomic structures.

Finally, exploring one's own privilege, power, and oppression could trigger emotional responses, and it is crucial that the worker remains aware of their emotions even when it provokes discomfort (Wong, 2018). Participants of the study emphasized that Kwakwa̱ka̱'wakw cultures believe that health and wellness are facilitated through cohesive and harmonious relationships within the person and between the person and the environment. Challenging the colonial assumption which views mind and body as separate entities, decolonial learning processes should enhance integration of body, mind, emotions, and spirit (Batacharya & Wong, 2018). Mindfulness, for example, may help in decolonizing the practice of critical reflexivity. Wong (2018) described the practice of mindfulness:

> Mindfulness is about being present with the unity of body, heart, and mind to the full

> range of experience and the fullness of life in the moment. It is an open and direct awareness of the fluidity of the experience of the present moment. It disrupts the habit of the mind to react, categorize, and control our experience of the world and of life. (p. 254)

Through strengthening wholistic connections of mind, body, heart and spirit, mindfulness practices may assist each worker to engage in non-judgmental inquiries into their beliefs and actions perpetuating white dominance and anti-Indigenous racism. At the same time, racism and white dominance can be perpetuated when mindfulness is practiced by each person only to self-manage the negative effects of structural oppression and injustice without at the same time acting on our individual and collective responsibility to bring about change (Clarke & Yellow Bird, 2021). Strengthening wholistic connections within the person and between the person and the community, society, and the environment, a decolonizing mindfulness practice should rather be used to actively challenge and transform colonial and white dominant beliefs, emotions, and actions both individually and collectively (Clarke & Yellow Bird, 2021).

4.2.1.3 Decolonizing Care Relationships with Respectful and Deep Listening Practices

Healthcare providers can challenge and shift the power imbalance inherent in colonial healthcare relationships through respectful listening practices. Many participants of this study recounted their experiences of unsafe pain care when their pain reports were doubted and dismissed by their healthcare providers, which led to the provision of care being delayed or refused. Healthcare providers' willingness to respectfully listen to Indigenous women patients and to believe in their experience can enhance ICS while reducing the power imbalance between healthcare providers and patients (First Nations Health Authority, 2025a).

Studies report a number of positive outcomes facilitated by the practice of respectful listening including actively challenging the hierarchy inherent in the colonial system (Hanson &

Danyluk, 2022), validating the person's perspective and agency (Bassel, 2017), fostering trusting relationships (Di Lallo et al, 2020; Jagosh et al., 2011), and nurturing healing (Jagosh et al., 2011; Mehl-Madrona & Mainguy, 2014). It can strengthen partnerships between patients and care providers while facilitating collaborative treatment planning (Davis et al., 2008). Being listened to with respect and a non-judgemental attitude validates Indigenous women's voices and supports their self-determination counteracting the harmful effects of colonial trauma (Brown & Di Lallo, 2020; Varcoe et al., 2021).

Zoe reflected on the value of such respectful listening in her personal experience. She shared this story in which her doctor's willingness to listen respectfully about her pain symptoms created an instrumental change for her pain care:

> I have had psoriasis since I was 10 years old. … And the doctor just brushed me off. … He wouldn't even consider getting my bloodwork done. … I ran into my doctor thankfully just by chance. … I said … I'm having the symptoms, and this is the situation. And he was listening, and he [said] … we have a rheumatologist coming next week. How about I order you some bloodwork and we'll get you in to see her because it sounds like that's what it is. … I had a diagnosis within the week basically when I saw the … rheumatologist. I've been struggling with these symptoms for about probably 15 years at that point.

Respectful listening practices require healthcare providers to focus on listening rather than forming a response or expressing their own thoughts (Hanson & Danyluk, 2022). Respectful listening invites care providers to engage in listening with their heart while sharing the reflections from their heart (Mehl-Madrona & Mainguy, 2014). For example, Indigenous practices of Deep Listening are relational practices for developing respectful and reciprocal relationships to self, others, and environment (Brearley, 2014). Deep Listening involves:

> taking the time to develop relationships, listening to stories, to what is said and what is not said, and to deeply understanding what is contained within the silences and spaces. Deep Listening is best describes as involving all the senses, not just listening with your ears. It is a search for understanding and meaning in a manner that invites collaboration and reciprocity. (Banff Centre for Arts and Creativity, 2015, para. 3)

In addition, Indigenous methodologies of storytelling and witnessing built on practices of settler solidarity and accountability also offer decolonizing approaches to respectful listening. Fostering validation, reducing self-blame, and promoting community connections, storytelling can generate a collective commitment towards decolonization (Brearley & Hamm, 2013). Furthermore, witnessing as a Kwagu'ł methodology assigns the listener the role of witness to validate, remember, and amplify the women's stories (Hunt, 2018). Healthcare providers who take on the role of witness would create a space where the women's silenced voices become heard and validated (Hunt, 2018). Being accountable to the settler responsibility, healthcare providers would also actively challenge the dominant pathologizing views of trauma while shifting their attention to the colonial system which perpetuates gendered colonial violence (Hunt, 2018).

Respectful listening and validation of Indigenous women's experiences of pain is foundational for decolonizing pain care. Centred on Indigenous women's voices, Deep Listening, storytelling, and witnessing built on practices of settler solidarity and accountability can facilitate decolonizing pain practice while shifting power dynamics and promoting culturally appropriate approaches to foster culturally safe, anti-racist, and relational care.

4.2.2 Decolonizing Pain Care Practice by Promoting Self-Determination

Self-determination is a human right (Coalition for the Human Rights of Indigenous Peoples, 2021) and is acknowledged as being foundational to the health and wellbeing of Indigenous peoples (Halseth & Murdock, 2020; Turpel-Lafond, 2020). The colonial system has repeatedly disrupted Indigenous peoples' rights to self-determination. Particularly Indigenous women's rights to self-determination have been violated in the heterosexual patriarchal and racist settler-colonial system, which manifests as health and socioeconomic disparities as well as the high incidence of gendered violence against Indigenous women (Allan & Smylie, 2015; Holmes & Hunt, 2017; Hunt, 2016).

Participants of this study expressed that revitalizing culture strengthens their self-determination while supporting them to actively direct their healthcare and healing. For this reason, promoting self-determination should be one of the core principles for decolonizing pain care. Pain care founded on each Kwakwa̱ka̱'wakw woman's self-determination can be promoted in multiple contexts in addition to direct patient care. They include community and agency levels (Browne et al., 2016) as well as within healthcare systems (Halseth & Murdoch, 2020). In the following section, I explore decolonizing pain care practice which promotes self-determination within: direct patient care (4.2.2.1); teams (4.2.2.2); and community-based healthcare delivery models (4.2.2.3).

4.2.2.1 Promoting Individual Women's Self-Determination

Settler-colonial policies and practices have repeatedly violated Indigenous women's rights to consent to and direct their medical care. A number of examples are known revealing systemic violations of Indigenous peoples' and women's rights to self-determination. For example, in the 1930s, newborn children, infants, and school age children on the Qu'Appelle reserve in Saskatchewan were given experimental trials of a tuberculosis vaccine (Blackburn, 2013). In addition, children at Indian Residential Schools across Canada became subjects in nutritional experiments to test the efficacy of vitamin supplements, and during these experiments, schools withheld essential foods from children to obtain baseline data for the sake of the experiment (Canadian Broadcasting Corporation, 2013). Furthermore, abusive treatments without consent frequently occurred at Indian Hospitals (Sterritt & Dufresne, 2018; Turpel-Lafond, 2020; Carrigg, 2020)

To this day, many Indigenous women continue to experience anti-Indigenous racism in healthcare, and they are targeted by misogynistic stereotypes that label Indigenous women as sexually promiscuous and inadequate parents in their role as parents (Turpel-Lafond, 2020). Healthcare providers' racist and sexist prejudice against Indigenous women has also manifested in medical treatments without consent such as coerced sterilization (Turpel-Lafond, 2020). These non-consensual medical procedures continued to occur even as late as in 2018 (Zingel, 2019) and in 2019 (Cheng, 2023).

Thus, consent to care is critical in decolonizing pain care practices. Elder Sharon shared her experience in which healthcare provider prescribed her an antidepressant for managing pain without explaining the reasons for prescribing that particular medication or providing other treatment options. She expressed her frustration and emphasized the importance of healthcare providers seeking consent from their Indigenous patients while informing them about their health issues and treatment options, and collaboratively developing treatment plans:

> if I'm depressed, explain that to me and explain what depression is. Maybe I could just work it out myself or with the help of a counselor or whatever, but don't just give me something and lie to me. … ask me for permission.

Both ICS and TVIC practices aim to promote self-determination through collaborative and safe person-centred care relationships while validating patients' experience and enhancing their choices and control over their care (Elliott et al., 2005). Person-centred care approaches can facilitate creating respectful care relationships where each patient is treated as "an equal partner" (Coulter & Oldham, 2016, p. 114). The patient-centred approach fosters healthcare providers to listen with respect while discussing and developing treatment approaches with their patients (Coulter & Oldham, 2016).

At the same time, critical self-awareness is required when practicing person-centred care. Smith et al. (2022) argued that personhood in the context of person-centred care is assumed to be "a white, colonial, cisheterosexual, and able-bodied consumer" (p. 4), who is rational, independent, and capable of negotiating and making informed decisions while advocating for their rights. Such a notion of personhood disregards structural oppression and can justify dehumanization of Indigenous women when healthcare providers lack the critical awareness about who is seen as a human worthy of care (Smith et al., 2022).

Thus, decolonizing person-centred care requires that non-Indigenous healthcare providers are committed to ending anti-Indigenous racism. This includes diligently examining their own assumptions rooted in the current white-centred neoliberal healthcare system, their positionality, and internalized dominance and oppressions. As discussed earlier, coordinated ICS and TVIC trainings would help increase healthcare providers' self-awareness about their assumptions and judgment while promoting Indigenous women's self-determination and collaborative pain care (Brooks-Cleator et al., 2018; Browne et al., 2016; Browne et al., 2018; Ford-Gilboe et al., 2018; Gerlach, 2012; Varcoe et al., 2019; Wallace et al., 2021).

4.2.2.2 Promoting Self-Determination within Care Teams

Not only the clinical healthcare providers, but all staff involved in pain care must become knowledgeable about the harmful effects of colonial violence and anti-Indigenous racism. Healthcare staff includes workers outside of clinical care such as front-desk staff at clinics (Browne et al., 2018) as well as housekeeping and security staff at hospitals (Varcoe et al., 2019). Increased team-based awareness of structural violence will help develop an understanding of the need for coordinated approaches to improving safety in care and care equity. Team-based approaches include creating a welcoming environment, adopting flexible approaches to lower the barriers for care access, and actively soliciting and incorporating patient feedback to improve care (Ford-Gilboe et al., 2018). Zoe spoke about the importance of educating staff at all levels of pain care:

> It's … really tiring, retraumatizing to relive that and tell people all over again like this is what happened, … this is why … I don't feel comfortable being touched like that … including the people who are there to bring your food when you're sick in the hospital or the people that … aren't maybe necessarily caring for you in the medical field but are part of your care. … those people still need to be educated.

She also shared a story about how staff as a team at a primary care clinic where she worked developed an innovative strategy to create a safe space for all patients when a patient became triggered by trauma. Rather than refusing to provide care, a coordinated approach such as the one described in this story would foster culturally safe TVIC:

> we don't turn people away. … we have a person that came in who has a history of violence and it's like, OK, how do we provide them care, access to care, without putting anybody else [at risk]. So … we'll put them in this room. The door can be open, we'll

> have someone standing by the door, but we'll still make sure that people aren't walking by, so they have privacy. …[because] people are carrying all this trauma with them.

In addition, the practice of ICS and TVIC requires ongoing education (Wylie et al., 2021). Zoe believed that ongoing team-based discussions would support staff to learn from each other about the history of the local community:

> especially for people who are really not from here to have that understanding … of First Nations culture would be maybe really beneficial to them and their patients, right? Because I was overhearing one of the (care staff) talking to (another care staff) here explaining the history … the reasons why people are struggling the way they're struggling … even if maybe they've learned some of it in school, they're not gonna know until they come [here] and they have this dialogue.

Research indicates how ICS training should be provided over time while utilizing different learning approaches such as online lectures, team discussions, and listening to the Indigenous peoples’ lived experiences (Wylie et al., 2021). Although there are similarities among the Kwakwa̲ka̲’wakw Nations, each Nation has its own unique history and culture (U’mista Cultural Society, 2025). Ongoing team-based learning with Elders and Knowledge Keepers would help gain deeper understanding of the effects of colonial violence on each Nation. Such collaborative learning would help create team-based understanding while enhancing their commitment towards decolonizing care and developing unique approaches to improving care equity.

4.2.2.3 Promoting Self-Determination as a Community

Studies report Indigenous political self-determination as being integral to the health and wellbeing of Indigenous peoples both within Canada and internationally (Garces-Ozanne et al., 2016; Halseth & Murdoch, 2020). Increased self-determination by Indigenous Nations helps address ongoing structural inequities, such as racism and violence against Indigenous women, which are clearly reflected in current health disparities (Allan & Smylie, 2015; Halseth & Murdoch, 2020; Holmes & Hunt, 2017).

Indigenous-led healthcare partnerships advance Nation-based health governance ensuring control over the delivery of culturally determined and respectful healthcare built on the knowledge of the Elders, healers, and Knowledge Keepers (Allen et al., 2020; First Nations Health Authority, 2024a; First Nations Health Council, 2023). These initiatives nurture Indigenous cultural beliefs about the wholistic nature of health while actively addressing a range of social determinants of health in a multidisciplinary team-based approach (First Nations Health Authority, 2024a). In addition, the Two-Eyed Seeing approach fosters utilizing both traditional and Western knowledge of health while offering individually tailored quality care (First Nations Health Authority, 2024a). These initiatives further offer close-to-home and timely access to culturally safe care developed through collaboration with Indigenous and non-Indigenous healthcare resources (First Nations Health Council, 2023).

Examples of Indigenous-led health partnerships are increasingly found across Canada today (Allen et al., 2020). In British Columbia, First Nations Health Authority provides leadership and support for Nations to develop Nation-led health initiatives (First Nations Health Authority, 2013). Lu’ma Medical Centre in Vancouver and All Nations Healing House in Williams Lake offer Indigenous-led healthcare practices (First Nations Health Authority, 2024a). In addition, each of the Kwagu’ł and Quatsino Nations, which participated in this study, provide multidisciplinary healthcare and social services authority (Kwakiutl Band Council, 2024; Quatsino First Nation, 2024) in collaboration with First Nation’s Health Authority and Island

Health, their regional health authority (Vancouver Island Regional Caucus, Island Health, & First Nations Health Authority, 2022). In addition, the Kwakwa̱ka̱'wakw Primary Care Initiative was recently developed to provide multidisciplinary primary care in the territory as directed by the Nations (First Nations Health Authority, 2024a). Zoe appreciated the timely access provided by one of the First Nations clinics:

> I'm thankful that I have been a patient because we have our own doctors' office in Alert Bay. … I'll always have a doctor at the health centre there. And so after I saw that doctor that didn't listen to me [at a local clinic] … I just started going to the [health centre] in Alert Bay. … I don't know if I'm on a list of people getting really fast [access], but usually if I call, I can get in to even just a phone appointment the next day, which is crazy because up there [a local clinic] you are waiting for a month. … It's really wonderful that I have such good healthcare there and I'm able to talk to my doctors there. … You know, they actually listen.

These Kwakwa̱ka̱'wakw Nation-led primary care programs advance the Nations' right to self-determination and control over the planning and delivery of their primary care. In collaboration with health authority and community partners, they offer Kwakwa̱ka̱'wakw women improved access to respectful and wholistic pain care grounded in their cultural identity, values, and beliefs on health and wellbeing.

4.3 Discussion

Participants of this study described the coloniality of pain, how their physical pain is intricately interwoven with trauma, stress, and emotional pain in response to multifaceted gendered colonial violence. The coloniality of pain suggests that physical pain among Kwakwa̱ka̱'wakw women cannot be addressed sufficiently when treated only within the biomedical approach to pain. Decolonial pain care should foster a wholistic approach while acknowledging their physical pain in the broader context of colonization. Emotional pain, fatigue, and substance use, which may accompany physical pain, should also be addressed as outcomes of trauma in response to colonial violence.

In the next section, based on the narratives of Kwakwa̱ka̱'wakw women participants, I discuss how decolonial pain care should be built on the biopsychosocial, cultural and spiritual perspectives to address broader factors contributing to their pain experiences. In section 4.3.1, I explore decolonial biopsychosocial approaches to pain and the roles of multidisciplinary teams using a harm reduction approach to pain treatment. In section 4.3.2, I address the need for developing decolonial pain care which is centred on Kwakwa̱ka̱'wakw cultural approaches to healing.

4.3.1 Biopsychosocial Approaches to Pain Care

The biopsychosocial model of pain acknowledges that physical pain is compounded by multifaceted interactions among biological, psychological, and social factors (Gatchel et al., 2007). One of the enduring biopsychosocial issues identified in this study is the way in which colonial violence creates collective, cumulative, and intergenerational trauma experiences among Indigenous women profoundly impacting their health, wellbeing, and experiences of pain (Mitchell et al., 2019). Stephanie spoke about the need for healthcare providers to educate themselves about trauma and physical pain experienced by Indigenous women:

> they need to educate themselves more on trauma as well. You know, I've been told that a lot of doctors … don't get any education on trauma and it's like that needs to be built in the system because they're correlated. It's not just all … physical. What about our mental health and how does that affect us?

To effectively respond to and acknowledge the pervasive and interconnected outcomes of colonial violence that result in trauma, pain treatment should involve multidisciplinary teams (Gkiouleka et al., 2022). For example, physical and occupational therapies can help address strategies and supports for living with pain, fatigue, and mobility issues while psychological and mental health therapies can support people to cope with colonial trauma and the stress of living with physical pain. In addition, advocacy and intervention to increase income, access to safe housing, food security, and personal safety should become readily available as part of pain treatment. Particularly for mothers who experience pain and face intimate partner violence, coordinated intervention should be developed through discussion with the mothers. They should be honoured as experts on their own lives who hold crucial knowledge of their support systems (Godard et al., 2017). Healthcare providers also should pay attention to various factors affecting the mothers' decision to seek safety. These include pain, fatigue, and depression, as well as external supports, income, and housing (Heron et al., 2022).

Trauma, physical pain, and substance use reciprocally affect each other and create compounding effects (Velly & Mohit, 2018). Decolonizing pain care should consider taking a harm reduction approach when an Indigenous woman self-manages pain with unregulated drugs. Many Indigenous lives have been lost particularly during the ongoing crisis of toxic drug poisoning (Lavalley et al., 2024). Indigenous women are disproportionately affected by toxic drug poisoning (First Nations Health Authority, 2024b). Harm reduction-based interventions target minimizing the adverse effects of substances on a person's health (Beck et al., 2024). Harm reduction interventions include providing information and education, safe supplies, opioid agonist therapies, and overdose death prevention tools (Beck et al., 2024) such as the distribution of naloxone kits (Government of British Columbia, 2025). It provides life-promoting person-centred pain care through non-judgemental and compassionate attitudes while reducing the use of stigmatizing labels such as drug-seeking against people who seek pain care (Wallace et al., 2021).

In addition, Indigenous and decolonial harm reduction practitioners and scholars have critiqued the way many harm reduction approaches are colonial and insufficient. They have argued that harm reduction strategies must actively address the broader harm created by past and present colonialism (Canadian Aboriginal Aids Network & Interagency Coalition on AIDS and Development, 2019). First Nations Health Authority (2025b) defines Indigenous approaches to harm reduction:

> Indigenous harm reduction means undoing the harms of colonialism, which place Indigenous people- First Nations, Métis and Inuit – at higher risk of harmful substance use. This means a decolonized, Indigenized approach to harm reduction that re-connects people to culture, and rebuilds relationships with the interconnected spiritual, human and natural worlds. (para. 2)

Indigenous harm reduction steps away from focusing on individual's behaviours and promotes a relational approach to safety while honoring their self-determination and "meeting people where they are at" (Canadian Aboriginal Aids Network & Interagency Coalition on AIDS and Development, 2019, p. 10).

The loss of many Indigenous lives by toxic drug poisoning is another outcome of colonial violence and trauma (First Nations Health Authority, 2024b; Levalley et al., 2024). Maggie expressed her grief at losing many people both by suicide and toxic drug poisoning. She stressed the importance of healthcare providers offering compassionate and non-judgemental care focused on safety to those struggling with substance use as a way to cope with trauma:

> our kids need help. They don't need judgement. They don’t need to be kicked out. That's just gonna make it worse. … They still are our people. They're hurting, obviously. Look at what they're doing to get rid of their demons. Like you're just gonna ostracize them, make them feel alone, alienate them. What are they gonna do when they're alone? … We should be treating them with love.

Healthcare providers should be aware of the stigma attached to accessing harm reduction services. This is reflective of society’s negative view towards substance use, which creates barriers for people to access harm reduction supports (Beck et al., 2024). A study by Lavalley et al. (2024) asserted the need for harm reduction services for Indigenous peoples to be built on the foundation of cultural safety. Culturally safe harm reduction services can create safe spaces for people to engage in meaningful care (Lavalley et al., 2024). In addition, Indigenous harm reduction programs offered by Indigenous-led health partnerships could form the foundation for community-based culturally safe and culturally guided harm reduction supports. Designed, developed, and implemented by Indigenous Nations, Indigenous-led harm reduction programs would strengthen decolonizing and Indigenizing approaches to substance use while integrating Kwakwa̱ka̱’wakw specific values, protocols, and healing practices.

4.3.2 Cultural and Spiritual Care

In addition to biopsychosocial factors, it is essential for decolonial pain care to promote wholistic health rooted in Kwakwa̱ka̱’wakw cultural values and actively incorporate cultural healing practices into pain care. The Truth and Reconciliation Commission (2015) stated:

> We call upon those who can effect change within the Canadian health-care system to

> recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. (p. 163)

Decolonial pain care for Kwakwa̱ka̱’wakw women should enhance their cultural values of wholistic and relational wellbeing through building harmonious relationships within the person, with their family and community, and in their territory. Wellness can be nurtured through engaging in everyday cultural activities including speaking Kwak̓wala or connecting to the creator and ancestors through prayers (Corntassel, 2012). In addition, traditional practices such as Talking Circle (Brown & Di Lallo, 2020; Goodman et al., 2017; Hanson & Danyluk, 2022; Mehl-Madrona & Mainguy, 2014; Varcoe et al., 2019) and storytelling (Qwul’sih’yah’maht, 2015; Solórzano & Yosso, 2002), as well as Kwagu’ł witnessing practice (Hunt, 2018) can be incorporated within pain care which can nurture collective healing through building respectful relationships within care relationships.

In addition, land-based practices would offer Kwakwa̱ka̱’wakw women wellness centring on their cultural values while strengthening spiritual connections to the territory (Milligan, 2019). Enhancing movement through traditional lifestyles and activities, land-based healing offers women opportunities to engage in cultural activities such as harvesting traditional foods of the territory (Assisted Living Registry, 2024). Elder Sharon spoke about how learning these essential life skills from her grandparents nurtured a sense of confidence throughout her life. She commented, “we'd never go hungry so long as we knew how to do that and know how to work on it and how it's done”.

As Sharon commented, Elders play essential roles in cultural transmission and continuity (Viscogliosi et al., 2020). Cultural continuity refers to “the ability to preserve the historical traditions of a culture and carry them forward with that culture into the future” (Krieg, 2016, p. 29). It affirms the collective identity of the Indigenous peoples and is foundational for their wellbeing to resist the settler-colonial state’s attempts at assimilation (Krieg, 2016).

Elders also provide nurturing connections within the family while strengthening the protection for their grandchildren (Viscogliosi et al., 2020). Stephanie shared her memories of her grandmother. These memories created a sense of strength throughout her life:

> I have her pictures all over my house. I think my favorites would be sleeping with her. She would roll up a big blanket … and her bathing me, pouring water in my hair, … and baking … and watching her knit. She would often sit in silence. She was very humble and quiet. … I cherish those [memories].

Cultural healing approaches facilitated by Elders, Knowledge Keepers, and peers can strengthen Kwakwa̱ka̱’wakw women’s wholistic and respectful connections to the territory, which are central to being Kwakwaka’wakw. Elders play essential roles in nurturing wellbeing, and they should be integral to planning and delivery of wholistic cultural healing programs (Viscogloisi et al., 2020).

It is important to note that traditional healing practices must always be guided by Elders, healers, and Knowledge Keepers, as without their guidance and leadership, non-Indigenous people may perpetuate cultural appropriation. Cultural appropriation refers to “taking possession of specific aspects of someone else’s culture in unethical, oppressive ways” (Kadi, 1996, as cited in Batacharya, 2018, p. 171). Cultural appropriation is structural violence as it disregards the larger colonial oppression under which appropriation occurs. It also ignores Nation-specific, complex cultural and spiritual knowledge in which cultural healing practices are rooted while turning them into another Western “New Age spirituality” (Batacharya & Wong, 2018, p. 12).

Settler healthcare providers, including social workers should always seek permission and guidance from Indigenous Knowledge Keepers and ideally, the specific Nation, when considering incorporating cultural healing practices into pain care.

Attention is also warranted when incorporating culturally based healing programs for individual pain treatment since each woman has a unique relationship to their culture. For example, Maggie spoke about her complex relationships with her culture which led her to decline the opportunity to accept the role of Chief. As discussed in the previous section, intervention plans should be developed through collaborative discussions with each Kwakwa̱ka̱'wakw woman while respecting their self-determination. In addition, Two-Eyed Seeing promotes contextual applications of diverse cultural traditions for pain treatment. Consultations with Elders, healers, and Knowledge Keepers would provide further guidance for developing culturally based pain care practices tailored to each woman with their unique interest in and relationships to their culture.

4.4 Conclusion

This chapter explored decolonizing pain practices which address the coloniality of pain. Participants of this study explained that their physical pain is closely connected to gendered colonial violence, which reciprocally interacts with other harmful outcomes of colonial trauma. Participants provided recommendations towards decolonizing pain care built on this broader understanding of pain in the context of colonization. They articulated how revitalizing Kwakwa̱ka̱'wakw culture is central to their health and healing. Revitalizing culture fosters a collective identity as a healthy, resilient, and self-sufficient people in their territory. Health is nurtured through respectful relationships to all that exists in the territory. Healing continues beyond life through spiritual connections. In addition, revitalization of Kwak̓wala enhances the

Kwakwa̱ka̱'wakw teachings of living well with pain. Furthermore, revitalizing culture fosters self-determination and control over their own health, which is another crucial condition for human health. Finally, revitalization of culture fosters health and wellness through traditional diet and medicines, movement in cultural activities, and humour and laughter transforming pain.

These critical elements of health, which are informed through revitalization of culture, must be at the centre of decolonial pain care. First, it is essential for non-Indigenous healthcare providers to learn about the multifaceted effects of colonial violence and respond to Indigenous women's physical pain in this context. Settler healthcare providers need to increase their awareness that the power imbalance in healthcare relationships becomes amplified when Indigenous women seek care in colonial healthcare settings. Cultural safety and cultural humility combined with trauma- and violence-informed care offer frameworks for healthcare providers to engage in ongoing learning and a reflective journey examining their white-centric values, assumptions, and unsafe practices. Critical reflexivity and a decolonized mindfulness practice would assist them in this learning process. Respectful and Deep Listening practices and Indigenous methodologies of storytelling and witnessing aligned with practices of settler solidarity and accountability can also help shift the power imbalance and increase Indigenous cultural safety.

Decolonial pain care also needs to promote Indigenous self-determination at all levels of care. Informed consent is essential when developing care plans. Coordinated ICS and TVIC trainings should foster both individual staff and care-teams' awareness of colonial violence and their white-centric assumptions contributing to the dehumanizing of Indigenous women. Team-based strategies can improve care equity. Indigenous-led health partnerships can further increase Indigenous women's access to effective, safe, timely, and equitable pain care.

Furthermore, pain treatment should address the biopsychosocial and spiritual outcomes of colonial trauma which interact with physical pain while promoting wholistic relational wellness and healing. Multidisciplinary pain treatment should be available to target various physical, mental, emotional, and spiritual outcomes of gendered colonial violence associated with physical pain. Indigenous harm reduction strategies are built on the conceptualization of harm as an outcome of colonization. Using a relational approach, Indigenous harm reduction promotes the safety of Indigenous women by helping them reconnect to their culture and cultural healing practices.

Finally, it is crucial for decolonial pain care practice to promote wholistic wellness through cultural healing approaches guided by Indigenous Elders, healers, and Knowledge Keepers. Land-based healing promotes Kwakwa̱ka̱’wakw women’s connections to the territory while engaging in cultural activities, movement, and harvesting of traditional foods. Elders are an integral part of developing healing programs as they play essential roles in cultural continuity and healing. Facilitating relational conversations, Two-Eyed Seeing can further support each woman to utilize the best of both traditional and Western approaches in their pain care. Decolonizing pain care by incorporating these research participants’ recommendations will help shift norms towards anti-racist, safe, and equitable pain care for Kwakwa̱ka̱’wakw women.

Conclusion

Situated within Indigenous decolonial feminist theories, this qualitative community-based participatory research study explored chronic pain experiences among cisgender Indigenous women. Two questions were asked: how does trauma, as an outcome of gendered and racial colonial violence, interact with chronic pain in Indigenous women's lives; and what elements and approaches facilitate healing and decolonizing pain care for Indigenous women living in a rural community?

Informed by the Indigenous practice of storytelling, Kwagu'ł methodology of witnessing (Hunt, 2018), and practices of settler solidarity and accountability (Hunt & Holmes, 2015), this research explored these questions through the lived experiences and insights shared by five cisgender Kwakwa̲ka̲'wakw women living in a rural community in their territories located in Northern Vancouver Island, British Columbia, Canada. This study contributes to equity-oriented pain care research by examining the coloniality of pain and increasing the understanding of the effects of structural violence in the development and persistence of chronic pain among Indigenous women. Grounded in the experiential knowledge of the Kwakwaka'wakw women participants, it envisioned decolonizing approaches to equity-oriented pain care by acknowledging and addressing the coloniality of pain to promote effective and socially just care for Indigenous women.

Despite a common belief among settler Canadians that colonial violence occurred only in the past (Midzain-Gobin & Smyth, 2020), participants narrated how the settler-logic of elimination (Wolfe, 2006) manifests through various forms of gendered colonial violence against Indigenous women in present-day Canada. Indigenous women are targeted with more severe gendered violence because of patriarchal colonial policies and practices (Allen & Smylie, 2015;

de Finney, 2017; Holmes & Hunt, 2017; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Razack, 2016; Ogden & Tutty, 2023). Participants' stories illustrated their repeated life-long experiences of colonial violence not only at Indian Day School and Indian Hospital, or during childhood because of intergenerational trauma, but also in their adulthood in the form of intimate partner violence, workplace discrimination, and sexual and gendered violence on the streets.

Participants reported that their chronic pain developed in close connection to colonial trauma. Emotional pain, also an outcome of colonial violence and trauma, often accompanied physical pain. Severe fatigue frequently occurred with physical pain, and pain combined with fatigue created debilitating challenges for participants to manage their life tasks. Their challenges were further amplified by the negative outcomes of intergenerational trauma that disrupted nurturing familial and community connections (Bombay et al., 2014). Lack of family support contributed to additional challenges for participants to manage household and parental tasks during pain flare-ups, and it exacerbated their experiences of stress, emotional pain, and physical pain.

Instead of addressing the structural and colonial nature of violence, trauma, and pain, current neoliberal healthcare exacerbates health disparities by assuming that Indigenous women's experiences of physical pain are an outcome of their poor personal choices (Brown et al., 2012). Furthermore, as has been noted in previous studies, persistent anti-Indigenous racism is another form of colonial violence (Cunneen & Tauri, 2018) that compounds Indigenous women's pain experiences. Participants reported their frequent experience of anti-Indigenous racism when they sought healthcare. They expressed frustration and anger towards healthcare practitioners who discredited their experiential accounts of severe pain. Healthcare providers' unwillingness to listen to and believe the participants' pain reports led to insufficient and delayed treatment. Not having access to respectful and trustworthy healthcare contributed to participants' colonial trauma while triggering stress and both emotional and physical pain.

These participants' stories described the coloniality of pain at the intersections of gender and Indigeneity in the neoliberal settler-colonial contexts. Recognizing the coloniality of pain points to an urgent need for decolonial pain care which addresses physical pain as an outcome of the multifaceted colonial structural violence. This study confirms that physical pain and associated features including trauma, fatigue, emotional pain, stress, and substance use should all be understood within this colonial context. This leads to the second research question: what elements and approaches facilitate healing and decolonizing pain care for Indigenous women living in a rural community? Participants of this study provided several recommendations for decolonizing and equity-oriented pain care.

A foundational recommendation of the participants was centred on the importance of enhancing Indigenous cultural revitalization, which they understood as facilitating profound and overarching positive effects on the health of Indigenous peoples. Participants believed that cultural revitalization nurtured the health of Kwakwa̱ka̱'wakw women by affirming their Indigenous identity as a healthy, resilient, and self-sufficient people rooted in their territory and ancestral knowledge. In addition, participants also believed that cultural revitalization enhanced Kwakwa̱ka̱'wakw women's culturally-based understandings of health as a relational concept that is the result of strengthening harmonious relationships with self, others, ancestors, and kinship to all that exists in their territories. Furthermore, participants expressed that cultural revitalization fostered self-determination and enhanced Kwakwa̱ka̱'wakw women's control over their own health. Finally, participants explained how cultural revitalization supported Kwakwa̱ka̱'wakw women to live well with pain by engaging in healthy cultural lifestyles such as traditional diet and activities rooted in their territory. It also strengthened humour and laughter, which are cultural medicine, and they created transformative effects on healing.

These critical elements of health, which are informed by revitalization of culture, should guide decolonial pain care practice. First, non-Indigenous healthcare providers need to increase their knowledge of the multifaceted effects of colonial violence and how they manifest through Indigenous women's physical and mental health. They also need to understand the power imbalance inherent in healthcare relationships and how it becomes magnified when Indigenous women seek pain care. Practices of Deep Listening (Brearley, 2014, Banff Centre for Arts and Creativity, 2015), storytelling (Brearley & Hamm, 2013), witnessing (Hunt 2018), and settler solidarity and accountability (Hunt & Holmes, 2015) may help non-Indigenous healthcare providers actively challenge the power imbalance.

Decolonial pain care should also strengthen Indigenous women's individual and collective self-determination while validating their pain experiences and right to direct their own care (Chioneso et al., 2020). Two-Eyed Seeing can facilitate collaborative and respectful care conversations (McFadden et al., 2023), and it can promote each Indigenous woman's choice to use diverse knowledge traditions for their own healing. Indigenous-led healthcare partnerships can further advance collective rights for Indigenous peoples to shape their healthcare delivery (Allen et al., 2020).

Challenging anti-Indigenous racism is an urgent task for decolonizing pain care. Although cultural safety and trauma informed care trainings are widely available, healthcare continues to be an unsafe place for Indigenous peoples, which indicates that current approaches to addressing anti-Indigenous racism are not sufficient. Settler healthcare workers need to understand how even well-intentioned workers perpetuate anti-Indigenous racism when they fail to recognize the colonial nature of pain and view pain merely as a biomedical issue while disregarding Indigenous women's pain reports. Without sufficiently understanding the structural aspects of pain, and the white-centric knowledge and norms under which current healthcare is practiced, well-intentioned interventions such as person-centred care (Smith et al., 2022), harm-reduction (Canadian Aboriginal Aids Network & Interagency Coalition on AIDS and Development, 2019), psychotherapies (Wendt, et al., 2022), or self-reflexive (Tang Yan et al., 2022) and mindfulness practices (Clarke & Yellow Bird, 2021) could all reinforce white dominance, racism, and the colonial attempt to assimilate Indigenous peoples. Settler healthcare providers should actively acknowledge their white dominance (DiAngelo, 2006) and challenge the power imbalance inherent in care relationships.

Finally, decolonial pain care practice should address the biopsychosocial and spiritual outcomes of colonial trauma while promoting wholistic relational wellness and healing. Honouring each Indigenous woman's knowledge of pain and fostering their self-determination, multidisciplinary pain treatment should target a wide range of negative outcomes of colonial violence. Indigenous Elders, healers, and Knowledge Keepers should be integral members of the multidisciplinary care teams offering Two-Eyed Seeing approach to pain by interweaving Indigenous and Western healing practices.

Through this critical inquiry into the coloniality of chronic pain and decolonizing pain care, several questions emerged in addition to the study limitations discussed in section 2.10, such as the need to explore pain experiences among people with diverse gender and sexual identities as well as women from other Kwakwa̱ka̱'wakw Nations in the region.

First, strategies suggested in this study to address anti-Indigenous racism are insufficient. Future inquiries are necessary to develop community-based approaches that utilize unique community knowledge and resources to shift the persistent systemic anti-Indigenous racism in healthcare. For example, a study by Browne et al. (2016) discussed in chapter one examined the outcomes of implementing the EQUIP intervention during a longer period in the primary care clinics' practices at both their staff and organizational levels. Similar studies can help evaluate anti-Indigenous racism trainings to inform the community about evidence-based and community specific approaches for cultural safety trainings. Such knowledge would benefit not only healthcare but also education and social service agencies when addressing the prevalent anti-Indigenous racism.

This study also did not address the broader socioeconomic outcomes of colonial violence such as limited access to education, housing, childcare, transportation, and employment, and how these issues interact with physical pain through biopsychosocial and cultural processes. Increased understanding in this area could lead to additional supports and resources for the community to reduce the structural inequity contributing to pain.

In addition, this research only briefly examined the harmful effects of neoliberal policies on colonial healthcare services. As discussed in chapter three, neoliberal approaches to health reinforce the biomedical focus on pain while commodifying colonial trauma (Clark, 2016; de Finney, 2017; Million, 2020). Prioritizing cost-effective care based on market-driven economic values, neoliberal policies promote brief and less costly treatment (Brown et al., 2012). Future studies should identify more comprehensively the connections between ongoing colonialism and neoliberal health policies, and their effects on the health of Indigenous peoples.

As this study revealed the close connections between colonial trauma and physical pain, additional inquiry is needed to decolonize Western healing approaches to address colonial trauma as a part of pain care. Studies have pointed out that current psychotherapies for trauma can perpetuate oppression by failing to recognize colonial structural violence at the root of trauma, and instead viewing trauma as individual pathology (Clark, 2016, de Finney, 2017; Holmes & Hunt, 2017; Hunt, 2016; Shaw & Proctor, 2005). A study by Wendt et al. (2022) reported that current cultural adaptations of psychotherapy models remain superficial without addressing the structural nature of colonial trauma. Future inquiry is needed to explore socially just psychotherapy practices.

Finally, I wish to continue examining how my own positionality as a cisgender racialized settler social worker influences my processes of inquiry. Absolon (2022) explained the need for research being anchored in one's wholistic understanding of self:

> All we really have authority to speak about with any truth is ourselves. Self-location is identifying oneself truthfully. … Location anchors responsibility, relevance, and relational accountability. Location speaks to who you are and who you are not. It establishes parameters about what you know and what you do not. (p. 7)

While I did critically examine my positionality when undertaking this study, in the future I would like to continue deepening my awareness of how my cultural worldview and experiential knowledge inform and direct my interests, values, epistemologies, and actions as a social worker practicing in the neoliberal settler-colonial healthcare system.

Grounded in the Kwakwaka'wakw women participants' experiential knowledge and insight, this study examined the coloniality of pain while envisioning decolonizing approaches to pain care informed by the positive effects created through revitalization of Indigenous culture.

Acknowledging the need for future inquiries, it seeks to contribute to current research within and beyond Canada promoting decolonizing, equity-oriented, and socially just pain care.

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Appendices

Appendix A: Participant Consent Form

University of Victoria
Faculty of Human & Social Development | School of Social Work Human & Social Development Building Room B302 PO Box 1700 STN CSC Victoria BC V8W 2Y2
T 250-721-8036 | F 250-721-6228 | socw@uvic.ca

Participant Consent Form

Chronic Pain, Trauma, and Colonialization: Understanding Chronic Pain Through Kwakwa̱ka̱’wakw Women’s Experiences

I would like to invite you to a community participatory research study of chronic pain, trauma and colonization.

I am a community social worker in the North Island and a Social Work graduate student at University of Victoria. This research is used as part of the requirements for me to complete the Master of Social Work degree. This research will be conducted with supervision by Dr. Moosa-Mitha, a faculty member of UVic School of Social Work. If you have any questions about this research, please contact:

Hiroko Sakai, Principal Researcher hirokosakai@uvic.ca
Dr. Mehmoona Moosa-Mitha, Research Supervisor mehmoona@uvic.ca
Stephanie Nelson, Community Advisory Group, North Island Building Blocks at 7305 Market St. Port Hardy 250-949-5101

Purpose and Objectives

This research addresses how violence, trauma, and colonization interact with chronic pain. It seeks this knowledge through the experiences of Kwakwa̱ka̱’wakw women living in and near Port Hardy. By creating a space for women to come together and share their experiences, this study hopes to better understand the connections between colonization, violence, and pain.

Importance of this Research

Chronic pain affects many Indigenous peoples but not many studies have paid attention to the relationship between colonization and chronic pain. Through the resilience and wisdom of Kwakwa̱ka̱’wakw women, this study wishes to show directions for future pain care that promotes equity, respect, and wholistic healing for and beyond our communities.

Participants Selection

At this time, we have gained permission to invite women from Kwakiutl Nation and Quatsino Nation. It is guided by a community advisory group with four Kwakwa̱ka̱’wakw women and two non-Indigenous women. All members have worked to promote health and wellness of the Kwakwa̱ka̱’wakw. As this research requests participants to share stories about trauma, violence, pain, and healing, we invite participants who are:

- 19 years old or older
- Members of Kwakiutl or Quatsino Nation
- Living with chronic/persistent pain
- Engaging/recently engaged in healing activities (cultural healing practices, therapy, healing lodge, or workshops)

- Living with chronic/persistent pain
- Engaging/recently engaged in healing activities (cultural healing practices, therapy, healing lodge, or workshops)
- Have own transportation or can take the bus to attend sessions at Building Blocks

We believe that your stories will offer valuable insight for future pain care.

What is involved

This research involves two activities: individual and group sessions. Both individual and group sessions will happen at North Island Building Blocks.

Individual Session (up to two-hour session, between January and February, 2024)
Creating a body map: you will be asked to create a life size image of your body and articulate the locations and features of your pain (e.g. sharp or dull, hot or cold, etc.) using pens and other available materials (i.e. yarn, shells, rocks, glitter, plants, etc.). Photos will be taken when your body map is completed to be used in analysis.

Stories: You will be asked to share stories about these pain locations. You will be asked additional questions on the relationships between pain, trauma, and colonial and gendered violence. Your stories will be audio-recorded so that they can be transcribed after the interview to explore themes for this study.

You may be asked to share your thoughts:

- Tell me about your experiences of chronic pain.
- What does (chronic) pain mean to you?
- How did the pain start?
- What triggers pain?
- How would you describe some of the strengths that you use to cope with pain?
- How would you describe the care you have received to deal with chronic pain?
- Anything else you would like to share about your knowledge of chronic pain?

Group Session (a four-hour session or two two-hour sessions, April or May, 2024)
You will be asked to attend a group session with all other participants at a time that all participants find convenient. As this session will last for four hours, it may be divided over two sessions if you experience increased pain and discomfort. The group will discuss what chronic pain means and the effects of colonization and violence on chronic pain. You will be asked to review and provide feedback on the themes that I will have identified by listening to your stories. The group will also discuss future pain care grounded in your wisdom and knowledge. The group discussions will be audio-recorded to ensure that I have captured all your insights.

Inconvenience

You will be asked to participate in an individual session (two-hour long) and either one group session (four-hour long) or two group sessions (two-hour long) at North Island Building Blocks. All sessions will take place when it is convenient for you. Bus tickets will be provided if needed.

Risks

This research asks you to share your thoughts around pain and trauma. You may experience discomfort by remembering, focusing on, and talking about your traumatic experiences. In addition, the process of creating your body map may trigger negative emotional and physical responses.

Being mindful of these potential risks, please feel free to bring your personal support person. We will also plan at the very beginning of the individual session how best you will be supported. You will be asked about your familiar and preferred grounding methods and we will practice them together. I will assist you to contact your counsellor, family member, or personal support if needed. A list of other support resources will also be made available.

Benefits

This research creates a space where your stories, wisdom, and insight are heard and honoured. What you have learned, how you understand your experience, and your resilience to continue living as a Kwakwa̱ka̱’wakw woman will be highlighted through your stories. Your experiences and voices will contribute to direct our future pain care in and beyond our communities.

Compensation

To show appreciation for your contribution to this project, North Island Building Blocks will provide you a $50 Save-On gift card at the end of the individual session. You will also receive a gift bag at the end of the group session. Bus tickets will be provided if you take the bus to attend these sessions at North Island Building Blocks.

Voluntary Participation

This research requests you to share your stories and experiences about pain and trauma and it could create difficult emotions. Particularly if you have a preexisting relationship with the research team, you may feel obligated to participate. Preexisting relationships include: being a current or former client, co-worker, a friend or family, or staff being supervised by one of the research team members. In such a case, you may feel pressured to participate in this study. I would like to stress that your participation in this research is completely voluntary. Your decision will be respected without question and there will be no negative consequences if you decide not to participate. If you do decide to participate, you may withdraw at any time without any consequences or explanation. If you do withdraw from the study, information from the individual session will be used anonymously only if you provide permission. Information from the group session will be used in a way that maintains your anonymity. Once the final report is prepared and submitted to the University of Victoria, I will no longer be able to modify the outcome. Your time spent for this research is greatly appreciated even if you decide to withdraw. You will not be asked to return the gift card, the gift bag, or the bus tickets.

On-going Consent

The group session will take place a few months after individual sessions. You will be contacted in April 2024, a few weeks before the group session to plan it at a time that is convenient for you.

Confidentiality

We live in a small community and confidentiality of anyone who participates in this research is very important. Your stories and information shared in this research will be kept confidential. I will store all electronic information on my computer with a password, an encrypted USB memory stick in a locked box, and on the University of Victoria data storage system. All paper copies will be stored in a filing cabinet with a lock.

Anonymity

Please specify how you would like to be acknowledged in the report. You may remain anonymous and identified with a pseudonym (a common name that is not yours) or with your real name.

Dissemination of Results

The final report will be submitted to University of Victoria, School of Social Work, as a requirement to complete my degree. The outcome of this research will also be shared with the communities and it will be discussed at the group session.

Disposal of Data

Data collected during this study will be kept for two years after the final report is submitted and accepted by the University of Victoria in case of receiving further enquiries about this research. In addition, protection of your privacy and safety is most essential as this research requests you to share your personal stories about trauma. The information gathered during the individual session belongs to you. Please inform me if you wish to receive a copy of photos of your body map, audio recording of the interview, a transcript of the recording, and my notes taken during the interview. Respecting that Indigenous data belongs to Indigenous Peoples, please also inform me if you wish to have your data shared with your Nation after personal identifiers are removed from it as it contains health information of their members. Similarly, I believe that the information shared during the group session belongs to the group. We will discuss as a group who may access the data after personal identifiers are removed from it and whether any anonymized data should be shared with your Nation. Finally, please indicate whether you would like your body map stored until the group session to be shared with the group.

COVID-19

Participants will be advised if they have or may have come into contact with an individual who has tested positive for COVID-19. Contact information for participants will be stored in a separate file from research data in the event that follow up is needed.

Contacts

If you have any questions about this study or your consent to participate in this study, please feel free to email either Hiroko, the principal researcher, or Dr. Moosa-Mitha, research supervisor, at email addresses provided at the beginning of this form.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature on the next page indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

______________________________   ______________________________   ________________
Name of Participant   *Signature*   *Date*

Recorded Images/Data

Participant to provide initials, *only if you consent*:

- Photos will be taken of my body map for analysis: ________
- My stories and interviews will be audio-recorded for analysis: ________
- The group discussion will be audio-recorded for analysis: ________

PLEASE SELECT STATEMENT only if you consent:

I consent to be identified by name / credited in the results of the study:

____
(Participant to provide initials)

I consent to have my responses attributed to me by name in the results:

____
(Participant to provide initials)

I consent to be identified by my position (Youth/Mother/Elder/Healthcare Worker): ______________ and/or by Nation: _____________ (Participant to provide initials)

I would like to remain anonymous in the results of the study:

____
(Participant to provide initials)

If I decide to withdraw from this study before completion, I consent to have my data collected up to that point used in analysis only if it remains anonymous: ______________
(Participant to provide initials)

I would like my body map stored at North Island Building Blocks until the group session: ____________
(Participant to provide initials)

I would like to receive a copy of raw data gathered during my individual session: _______________
(Participant to provide initials)
___ Photos of my body map ___ Transcript of the interview ___ Audio-recording of the interview
___ Notes taken during the interview

I would like to share with my Nation (___ Kwakiutl Nation ___ Quatsino Nation) anonymized data gathered during my individual session as specified below: __________
(Participant to provide initials)
___ Photos of my body map ___ Transcript of the interview
___ Audio-recording of the interview ___ Notes taken during the interview

A copy of this consent form will be left with you, and a copy will be taken by the researcher.

Appendix B: Consent Form for The Group Session

University of Victoria

Faculty of Human & Social Development | School of Social Work Human & Social
Development Building Room B302 PO Box 1700 STN CSC Victoria BC V8W 2Y2
T 250-721-8036 | F 250-721-6228 | socw@uvic.ca

Participant On-Going Consent Form

Chronic Pain, Trauma, and Colonialization: Understanding Chronic Pain Through Kwakwa̱ka̱’wakw Women’s Experiences

You are requested to participate in a group session, the second part of this community participatory research study of chronic pain, trauma and colonization.

Purpose and Objectives

This group session intends to create a space where the participants of this research will collectively discuss what chronic pain is and how to address it as a community. You will be asked to review the themes which emerged from the individual sessions. The group will explore:

- How do you define “chronic pain” as a Kwakwa̱ka̱’wakw woman?
- How does colonization and violence interact with your pain?
- What strengths and wisdom do your cultural teachings offer to understand and cope with pain?
- What do you recommend about future chronic pain care for your community?

Inconvenience

This session will take place at North Island Building Blocks and will last about four hours. The session will be planned at the time when all participants of this study are available. You will be contacted in the new year to determine the date and time of this session. This is a long session, and you may experience increased pain and discomfort. We will divide the session into two sessions if you wish. If we decide to have two sessions, we will discuss as a group the date and time of the second session.

Risks

You will be asked to share your experiences and thoughts around pain, trauma, and colonization. You may experience some discomfort.

Benefits

This group session will create a collective space where your stories, wisdom, and insight as a Kwakwa̱ka̱’wakw woman are honoured. Your knowledge and experiences will help direct our future pain care in and beyond our communities.

Compensation

You will receive a gift bag at the end of the group session as a small token of appreciation. Bus tickets will be provided if you take the bus.

Voluntary Participation

This research requests you to share your stories and experiences about pain and trauma and it could create difficult emotions. Particularly if you have a preexisting relationship with the research team, you may feel obligated to participate. Preexisting relationships include: being a client, co-worker, a friend or family, or a staff member being supervised by one of the research team members. In such a case, you may feel pressured to participate in this study. I would like to stress that your participation in this research is completely voluntary. Your decision will be respected without question and there will be no negative consequences if you decide not to participate. If you do decide to participate, you may withdraw at any time without any consequences or explanation. If you do withdraw from the study, the information gathered during the group session up to that point will be used in a way that maintains your anonymity. Once the final report is prepared and submitted to the University of Victoria, I will no longer be able to modify the outcome. Your time spent for this research is greatly appreciated even if you decide to withdraw. You will not be asked to return the gift card, the gift bag, or the bus tickets.

Confidentiality

We live in small communities and confidentiality of anyone who participates in this research is very important but cannot be guaranteed as other people participating in the groups may disclose your identity and participation. All efforts will be made to ensure that the group understands the importance of maintaining confidentiality when participating in this study. Your stories and information shared in this research will be kept confidential by me. I will store all electronic information on my computer with a password, an encrypted USB memory stick in a locked box, and on the University of Victoria data storage system. All paper copies will be stored in a filing cabinet with a lock.

There are limitations to my capacity to keep confidentiality because of my legal professional reporting requirements. I will have to inform delegated agencies if you share information that contains severe and immediate harm to yourself or others, or suspected child or elder abuse.

Anonymity

Please specify how you would like to be acknowledged in the report. You may remain anonymous and identified with a pseudonym (a common name that is not yours) or with your real name.

Dissemination of Results

The final report will be submitted to University of Victoria, School of Social Work, as a requirement to complete my degree. The outcome of this research will be shared with the community and the group will decide how it will be shared.

Disposal of Data

Data collected during the group session will be kept for two years after the final report is accepted by the University of Victoria in case of receiving further enquiries about this research. The information shared during the group session belongs to the group. Respecting that Indigenous data belongs to Indigenous Peoples, we will discuss as a group who will have access to the anonymized data gathered during the group session and whether any anonymized data should be shared with your Nation as it contains health information of their members.

COVID-19

Participants will be advised if they have or may have come into contact with an individual who has tested positive for COVID-19. Contact information for participants will be stored in a separate file from research data in the event that follow up is needed.

Contacts

If you have any questions about this study or your consent to participate in this study, please feel free to email Hiroko, the principal researcher, or Dr. Moosa-Mitha, research supervisor, at email addresses below.

Hiroko Sakai, principal researcher hirokosakai@uvic.ca
Dr. Mehmoona Moosa-Mitha, research supervisor mehmoona@uvic.ca

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in the group session, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

______________________	______________________	__________
Name of Participant	*Signature*	*Date*

Recorded Images/Data

Participant to provide initials, *only if you consent*:

- The group discussion will be audio-recorded for analysis: ________

PLEASE SELECT STATEMENT only if you consent:

I consent to be identified by name / credited in the results of the study: ______________

I consent to have my responses attributed to me by name in the results: ______________

I consent to be identified by my position (Youth/Mother/Elder/Healthcare Worker): _______________
and/or by Nation: ______________

I would like to remain anonymous in the results of the study: ___________________

A copy of this consent form will be left with you, and a copy will be taken by the researcher.

Appendix C: Community Poster

University of Victoria
Faculty of Human & Social Development | School of Social Work Human & Social Development Building Room B302 PO Box 1700 STN CSC Victoria BC V8W 2Y2
T 250-721-8036 | F 250-721-6228 | socw@uvic.ca

Seeking Volunteers for a Chronic Pain Community Participatory Research Project

December 18, 2023

We are seeking volunteers for a community participatory research study to explore how best to support Indigenous women living with chronic pain.

Project Title: Understanding Chronic Pain Through Kwakwa̱ka̱’wakw Women’s Experiences

Chronic pain is very common and affects many Indigenous people but not many studies have paid attention to the relationship between chronic pain and trauma. This project seeks this knowledge through experiences of Kwakwa̱ka̱’wakw women. By creating a space for women to come together and share their experiences, we hope to better understand connections between colonization, violence, and pain. Through the resilience and wisdom of Kwakwa̱ka̱’wakw women, we will explore future pain care that promotes equity, respect, and wholistic healing.

Researchers
The primary researcher is Hiroko Sakai, a community social worker in Port Hardy who is a Master of Social Work Student at the University of Victoria. Her supervisor at University of Victoria, School of Social Work is Mehmoona Moosa-Mitha. This project is guided by a community advisory group of Kwakwa̱ka̱’wakw and non-Indigenous women and hosted by North Island Building Blocks. This study has been approved by Kwakiutl and Quatsino Nations and the University of Victoria’s Ethics Board.

Activities
Participants will be asked to attend a two-hour individual session and a four-hour group session both at North Island Building Blocks. They will be asked to share their personal experiences of pain and their insight as Kwakwa̱ka̱’wakw women about pain, violence, colonization, and healing. The group will create recommendations for future community pain care that is grounded in the Kwakwa̱ka̱’wakw knowledge. The outcome of this research will be shared with the community as determined by the participants. Participants will receive a $50 grocery card after an individual session, a thank-you gift after a group session, and bus tickets to attend these two sessions at North Island Building Blocks.

Participants
We are seeking about **10 volunteers** at this time. As this research asks participants to speak about their experience with violence and pain, we are recruiting women who are:

- **19 years old or older**
- **Members of Kwakiutl or Quatsino Nation**
- **Living with chronic/persistent pain**
- **Engaging/recently engaged in healing activities (cultural healing practices, therapy, healing lodge, or workshops)**
- **Have own transportation or can take the bus to attend sessions at Building Blocks**

If you are interested in participating in this research or have questions, please contact**:**

Hiroko Sakai, principal researcher 250-230-2508 hirokosakai@uvic.ca
Stephanie Nelson, North Island Building Blocks 250-949-5101 stephanie.nelson@gnhfs.com
Caitlin Hartnett, Kwakiutl Health 250-949-6625 hd@kwakiutl.bc.ca
Arlene Clair, First Nations Health Authority 250-710-5634 Arlene.clair@fnha.ca
Mehmoona Moosa-Mitha, Professor, School of Social Work, University of Victoria 250-721-8041 mehmoona@uvic.ca

Appendix D: A List of Questions for the Individual and Group Sessions

Questions for individual sessions

- Tell me about your experiences of chronic pain

- What does (chronic) pain mean to you?

- How did the pain start?

- What triggers pain?

- How would you describe some of the strengths that you use to cope with pain?

- How would you describe the care you have received to deal with chronic pain?

- Anything else you would like to share about your knowledge of chronic pain?

Questions for the group session:

- Do you have feedback on the themes?

- Could you tell me more about your experiences of how trauma, stress response, and pain interact?

- What does wellness and healing mean to you as Kwakwaka’wakw?

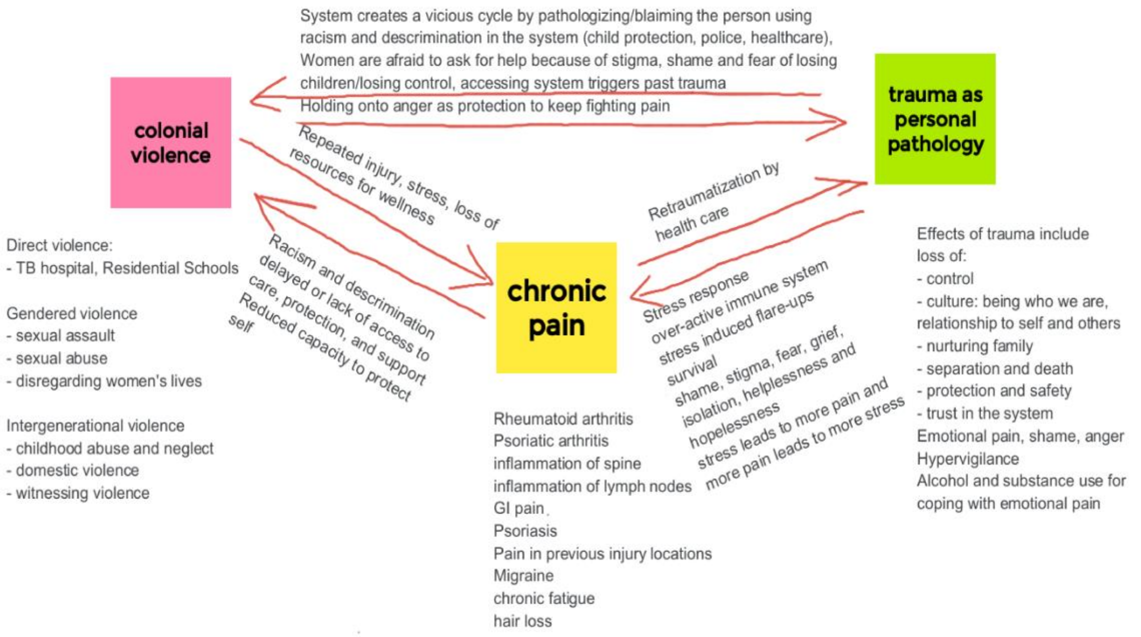
- What does decolonizing health care mean to you?

- What is the next step?

Appendix E: An Example of a Body Map

Appendix F: Thematic Maps

Theme 1 Embodied effects of colonization: Relationship between trauma and pain



System creates a vicious cycle by pathologizing/blaming the person using racism and descrimination in the system (child protection, police, healthcare), Women are afraid to ask for help because of stigma, shame and fear of losing children/losing control, accessing system triggers past trauma

Holding onto anger as protection to keep fighting pain

Repeated injury, stress, loss of resources for wellness

Racism and descrimination delayed or lack of access to care, protection, and support Reduced capacity to protect self

Retraumatization by health care

Stress response
over-active immune system
stress induced flare-ups
survival
shame, stigma, fear, grief, isolation, helplessness and hopelessness
stress leads to more pain and more pain leads to more stress

Direct violence:
- TB hospital, Residential Schools

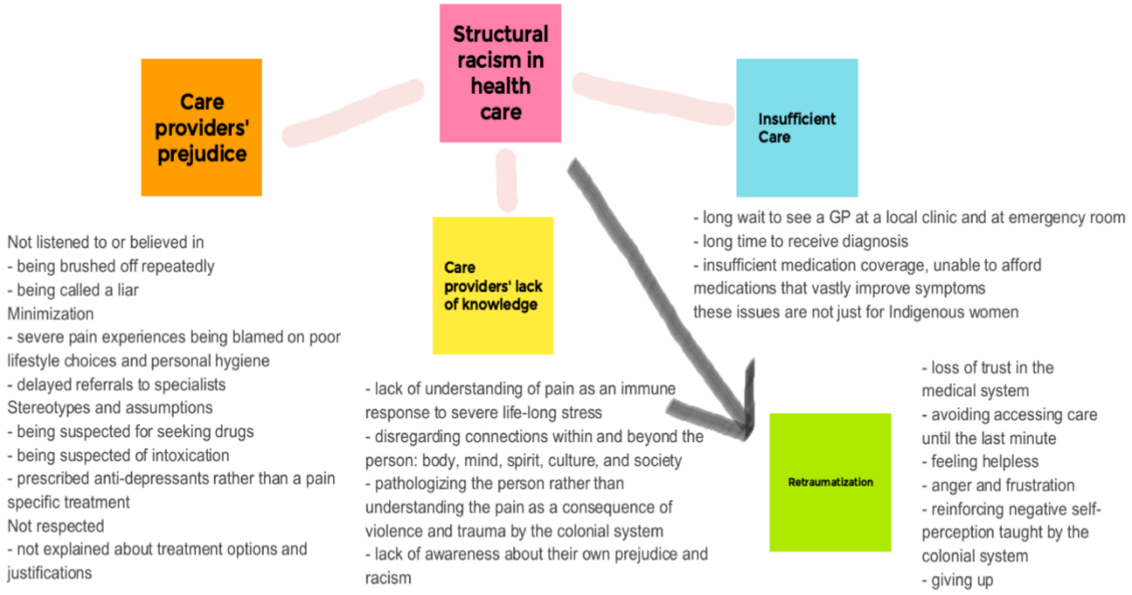
Gendered violence
- sexual assault
- sexual abuse
- disregarding women's lives

Intergenerational violence
- childhood abuse and neglect
- domestic violence
- witnessing violence

Rheumatoid arthritis
Psoriatic arthritis
inflammation of spine
inflammation of lymph nodes
GI pain
Psoriasis
Pain in previous injury locations
Migraine
chronic fatigue
hair loss

Effects of trauma include loss of:
- control
- culture: being who we are, relationship to self and others
- nurturing family
- separation and death
- protection and safety
- trust in the system
Emotional pain, shame, anger
Hypervigilance
Alcohol and substance use for coping with emotional pain

Theme 2. On-going practices of coloniality: Systemic racism and pain



Not listened to or believed in
- being brushed off repeatedly
- being called a liar
Minimization
- severe pain experiences being blamed on poor lifestyle choices and personal hygiene
- delayed referrals to specialists
Stereotypes and assumptions
- being suspected for seeking drugs
- being suspected of intoxication
- prescribed anti-depressants rather than a pain specific treatment
Not respected
- not explained about treatment options and justifications

- lack of understanding of pain as an immune response to severe life-long stress
- disregarding connections within and beyond the person: body, mind, spirit, culture, and society
- pathologizing the person rather than understanding the pain as a consequence of violence and trauma by the colonial system
- lack of awareness about their own prejudice and racism

- long wait to see a GP at a local clinic and at emergency room
- long time to receive diagnosis
- insufficient medication coverage, unable to afford medications that vastly improve symptoms
these issues are not just for Indigenous women

- loss of trust in the medical system
- avoiding accessing care until the last minute
- feeling helpless
- anger and frustration
- reinforcing negative self-perception taught by the colonial system
- giving up

Theme 3. Healing as reclamation of culture: Responses to pain

Kwakwaka'wakw way of life

Ways to treat each other
Connections to self, others and the world
- wholistic connections (language, songs, dances, food, body, mind, spirit, and the world)
- generosity and sharing
- welcoming
- respect
- love and compassion
- responsibility to be a part of the family

Traditional diet
- use of ooligan oil
- seafood and mineral rich diet

Movement
- harvesting and preparing foods
- always in motion

Spirituality
- healing is guided by ancestors
- healing continues after life
- ancestors and loved ones are with us
- meaning of life and life challenges
- acceptance of pain as part of life
- purpose of life as a Kwakwaka'wakw

Intergenerational connections

- Unconditional love and safety, happy memories, and feeling deeply loved
- Intergenerational knowledge transfer about culture, life, and healing (grandmothers, aunties)
- Vicarious healing

Healing through storytelling

- Validation by being listened to and witnessing
- Making sense of the experince
- Increased awareness about self in the context of the world

Healing through humour

Humour as medicine
Laughter as medicine
Being playful

Resilience and Empowerment

Enbracing culture gives strength and stability
- accepting pain
- trusting in healing guided by ancestors
- belonging/being a Kwakwaka'wakw

Empowerment: taking control of my healing
- making a personal commitment to healing
- becoming your own advocate
- breaking the cycle of trauma
- taking from both worlds
- learning, unlearning, and relearning
- learning to forgive self and forgive others
- seeking forgiveness from children
- admitting your mistakes
- letting go of anger or using anger as fuel
- patience
- discipline and commitment
- positive sense of self and feeling important to another
- redirecting your attention
- doing one little thing you can
- singing

Healing is reciprocal

Theme 4. Decolonial trauma-informed pain care

care principles for everyone who are in the care system

Care Quality

readily accessible feedback process

Build a trusting care relationship
- respect the person
- listen to the preson
- seek permission
- be attentive to patients' pain flare-ups
- explain the condition, help patients make connections about factors which affect pain
- provide choices
- complaint/feedback process becoming readily available

Accountability
- read patients' charts, communicate with other care providers
- confidentiality
- acknowledge mistakes

Professionalism
- provide timely intervention: tests, treatment, referrals
- strive towards a better quality of care

Treating the whole person

- Understand connections throughout the body and between body and mind
- Develop more comprehensive treatement plans rather than relying only on medications
- Increase patients' knowledge about pain, trauma, safety, and stress
- Increase knowledge about pain treatments outside of the Western medical system

Becoming an ally

- Stop pathologizing or trying to fix the person suffering from pain
- Explain to patients body-mind connections and how stress affects pain
- Increase self-awareness about your attitudes, beliefs, and behaviours that contribute to racism
- Actively correct the stereotypes against Indigenous peoples among care providers
- Being willing to be flexible
- Advocate for resources (i.e. insufficient medication coverage)

Knowledge about pain and colonization

Care providers' ignorance and indifference strengthens the colonial system
Actively and continue to learn about:
- connections among colonial violence/lack of safety/ trauma/stress response/pain
- accessing health care can be retraumatizing for Indigenous women
- racism and myths about Indigenous peoples

Education must start early and on-going

Listening

- Listen with empathy, interest, respect, and humility
- believe in the patients' reports about their pain experience
- validate their concerns
- understand severity of pain
- stop minimizing medical conditions that require proper diagnosis and treatments
- actively seek feedback