Advanced Skills Workshop: Indigenous Cultural Safety, Humility, and Anti-Racist Practice

Operationalizing the CHCPBC Standard Through a Non-Pathologizing Lens

Workshop Synopsis

The CHCPBC Indigenous Cultural Safety, Cultural Humility, and Anti-Racism Practice Standard is not a supplementary professional development recommendation — it is a mandatory ethical requirement, enshrined in the *Health Professions and Occupations Act* and effective across all regulated health professions in British Columbia as of April 1, 2026. For psychotherapists preparing for regulation under CHCPBC, this standard demands more than cultural sensitivity or diversity awareness training. It demands a structural reckoning with the ways psychotherapy itself — through its history, its medical model foundations, its diagnostic frameworks, and its clinical language — has functioned as a site of colonization. This workshop provides the theoretical foundation, the ethical grounding, and the practical clinical tools to meet this standard — and argues that the non-pathologizing framework is uniquely positioned to operationalize it, because Indigenous cultural safety and non-pathologizing psychotherapy share the same foundational commitments: that the client is the expert on their own life, that distress is always contextual and adaptive, that dominant narratives must be examined and not imposed, and that the therapist's first obligation is to honour the dignity of the person in front of them.

Why This Workshop Cannot Wait

The CHCPBC's own evidence base for this standard is unambiguous. The *In Plain Sight* report — commissioned to address Indigenous-specific racism and discrimination in BC health care — documented that Indigenous-specific racism negatively affects access to healthcare and health outcomes, contributing to lower life expectancy, higher infant mortality, and the increased presence of chronic health conditions among Indigenous peoples in BC. The standard adopted by CHCPBC was developed in collaboration with Indigenous Knowledge Keepers and leaders, adapted from standards initially created by the BC College of Nurses and Midwives and the College of Physicians and Surgeons of BC, and guided by eleven health profession regulatory colleges. Its inclusion in the CHCPBC Ethics and Practice Standards is not symbolic — it is a legally binding professional obligation.

For psychotherapists, the stakes are particularly high. Psychotherapy's long history within the medical model means that standard clinical practices — diagnosing, naming pathology, constructing treatment plans, writing case notes — have all been vehicles through which the dominant Western, colonial narrative has been applied to Indigenous clients without their consent, without cultural relevance, and without acknowledgment of the structural conditions that shape their lives. What has been called *resistance* or *treatment non-compliance* in the

clinical record may in fact be a client's entirely reasonable refusal to have their experience pathologized and overwritten. This workshop names that history directly, and then provides practical tools for doing something different.

The CHCPBC Standard: Six Core Concepts

The standard is organized into six core concepts, each carrying specific clinical obligations:

1. Self-Reflective Practice — It Starts With Me
Cultural humility begins with a self-examination of the healthcare professional's values, assumptions, beliefs, and privileges embedded in their own knowledge and practice. Therapists must reflect on, identify, and not act on any stereotypes or assumptions they hold about Indigenous Peoples; reflect on how their privileges, biases, values, belief structures, behaviours, and positions of power may impact the therapeutic relationship with Indigenous patients; and evaluate and seek feedback on their own behaviour towards Indigenous Peoples. This is not a one-time orientation — it is an ongoing professional discipline.

2. Building Knowledge Through Education
Therapists must undertake ongoing education on Indigenous healthcare, determinants of health, cultural safety, cultural humility, and anti-racism; learn about the historical and current impacts of colonialism on Indigenous Peoples and how this may impact their healthcare experiences; and learn about the specific Indigenous communities located in the areas where they work, recognizing that languages, histories, heritage, cultural practices, and systems of knowledge may differ between communities.

3. Anti-Racist Practice — Taking Action
Therapists must take active steps to identify, address, prevent, and eliminate Indigenous-specific racism — including intervening when they observe colleagues acting in racist or discriminatory ways, supporting patients and colleagues who report acts of racism, and reporting acts of racism to leadership and relevant regulatory bodies. This standard makes anti-racism a professional active obligation, not merely a passive commitment to non-discrimination.

4. Creating Safe Healthcare Experiences
Therapists must treat patients with respect and empathy by acknowledging the patient's cultural identity, listening to and seeking to understand the patient's lived experiences, and being open to learning from the patient. They must care for patients holistically — considering physical,

mental/emotional, spiritual, and cultural needs — and acknowledge and incorporate into the plan of care Indigenous cultural rights, values, and practices, including ceremonies and protocols related to illness, birth, and death. They must also facilitate the involvement of the patient's family, community, Elders, and cultural navigators as needed and requested.

5. Person-Led Care — Relational Care
Therapists must respectfully learn about the patient and the reasons they have sought health services; engage with patients and their identified supports to identify, understand, and address health and wellness goals; actively support the patient's right to decide on their own course of care; and communicate in ways that give the patient necessary time and space to share their needs and goals.

6. Strengths-Based and Trauma-Informed Practice — Looking Below the Surface
Therapists must work with the patient to incorporate their personal strengths in support of health and wellness goals; recognize the potential for trauma — personal or intergenerational — and adapt their approach to be thoughtful and respectful, including *seeking permission before engaging in assessments or treatments*; recognize that colonialism and trauma may affect how patients view, access, and interact with the healthcare system; and recognize that Indigenous women, girls, two-spirit, queer, and trans Indigenous Peoples are disproportionately impacted by Indigenous-specific racism and that gender-specific trauma may shape the healthcare encounter.

The Connection to Non-Pathologizing Philosophy

The workshop's central argument is that the non-pathologizing framework does not simply *accommodate* this standard — it *embodies* it. The alignment runs through every dimension of the clinical work:

Colonialism as the original pathologizing structure
The medical model's dominance in psychotherapy is not culturally neutral. It emerged from the same Western European intellectual tradition that produced colonization — a tradition premised on the authority of expert knowledge over lived experience, on the classification and correction of behaviour that diverges from the dominant norm, and on the erasure of contextual and communal knowledge in favour of universalized categories. When psychotherapy applies diagnostic frameworks to Indigenous clients without acknowledgment of this history, it participates in that tradition. The non-pathologizing framework begins with the recognition that distress is always contextually shaped, that the client's experience is never reducible to a disorder, and that the therapist's knowledge can never supersede the client's. This is not only a therapeutic philosophy — it is an anti-colonial posture.

Experiential Authority as a clinical form of colonization
One of the central theoretical concerns of the textbook (Non-Pathologizing Approach to Counselling) is what is termed *Experiential Authority* — the dynamic in which the therapist's experience, framing, or interpretation is substituted for the client's own meaning-making, typically without either party recognizing it. In transcripts throughout the textbook, this dynamic

appears when therapists name the client's values before the client has done so, when they apply diagnostic constructs to normalize the client's experience, or when they redirect the client's protest language toward the therapist's preferred therapeutic conclusion. With Indigenous clients, this dynamic carries an additional and more serious dimension: Experiential Authority in a colonial context is not simply a misattunement in the therapeutic relationship — it reproduces the historic structure in which Indigenous peoples' self-understanding, meaning-making, and knowledge systems have been systematically overwritten by Western expert authority.

Protest language as a colonial response
The CHCPBC standard observes that colonialism and trauma may affect how Indigenous patients view, access, and interact with the healthcare system. Through the protest language framework, this means that behaviours which might present in a clinical context as guardedness, withdrawal, lateness, one-word answers, refusal of certain interventions, or non-engagement may be forms of entirely legitimate and historically grounded protest — the client saying *no* to a system that has historically harmed them. The clinical task is not to motivate compliance with a healthcare encounter; it is to understand what the client is saying *no* to, and to create the conditions under which the client can shape the terms of their own care.

Social constructionism and Indigenous knowledge systems
The textbook (Protest Language) situates social constructionism as one of the foundational ideas of the non-pathologizing approach — the recognition that knowledge is constructed through social interaction, that no single framework holds a privileged claim on truth, and that dominant narratives must be examined rather than assumed. The CHCPBC standard explicitly requires therapists to recognize and respect Indigenous laws, protocols, and knowledge systems, and to ensure that information shared in any professional context may include *Indigenous or other recognized knowledge systems that are relevant, ethically grounded, and consistent with patient safety*. Social constructionism is the philosophical bridge between these two commitments: it is what makes it possible for a non-pathologizing therapist to hold Western psychological frameworks and Indigenous knowledge systems alongside each other without forcing the client to choose.

Self-Reflective Practice: The Therapist's Discipline in Cultural Context

The workshop devotes significant attention to the practitioner's internal work — because the CHCPBC standard is explicit that cultural humility begins with the self, and that cultural safety is not a set of techniques applied to a client but a quality of presence and relationship that the therapist either does or does not bring to the encounter.

The textbook's reference to a Multicultural Orientation (MCO) Framework offers a structured approach to this work, built around three pillars: *Cultural Humility* (an open and curious stance, viewing the client as expert on their own cultural experience); *Cultural Comfort* (the therapist's self-awareness and ease in discussing cultural identities); and *Cultural Opportunities* (moments

in therapy when aspects of a client's cultural background emerge and create openings for deeper exploration). The workshop applies these three pillars directly to work with Indigenous clients, examining how cultural humility requires the therapist to remain genuinely curious even — especially — when they believe they share cultural context with the client. The risk of shared cultural identification is that it becomes a license for the therapist to substitute their own cultural understanding for the client's: the non-pathologizing stance requires that this risk be named and actively interrupted.

The CHCPBC standard requires therapists to reflect on how their privileges, biases, values, belief structures, behaviours, and positions of power may impact the therapeutic relationship with Indigenous patients. The workshop uses reflective practice exercises to operationalize this requirement, asking participants to examine their own default clinical assumptions and where those assumptions may carry colonial residue: in how they define a *good* therapeutic relationship, how they understand progress, how they write clinical notes, what language they use to describe guardedness or withdrawal, and how they conceptualize healing.

Person-Led Care and the Triage Model

The CHCPBC's person-led care principle requires that therapists actively support the patient's right to decide on their own course of care, provide time and space for the patient to share their needs and goals, and ensure information is communicated in a way the patient can understand. This maps directly onto the non-pathologizing triage model — with particular urgency for Indigenous clients:

Safety — For Indigenous clients, safety in the healthcare encounter is not abstract. It is shaped by documented systemic racism in the BC healthcare system, by generational experiences of having healthcare encounters produce harm, and by the cultural protocol that relationship precedes treatment. Safety in this context means the therapist understanding and respecting the client's external control mechanisms before attempting to move the work forward — and recognizing that those mechanisms are not resistance but wisdom.

Grief — The triage model identifies grief as the violent or disruptive end of a system of connection. For many Indigenous clients, grief includes the ongoing loss of land, language, family, and cultural continuity produced by colonialism and its ongoing effects. The CHCPBC standard requires therapists to recognize how intergenerational and historical trauma affects Indigenous Peoples during healthcare experiences. The workshop teaches therapists to hold this larger dimension of grief without reducing it to a clinical category — to witness it, honour it, and not rush past it toward processing or problem-solving.

Identity — The non-pathologizing framework's insistence on adjective-based identity work — supporting the client to describe who they are and how they want to be known, rather than organizing identity around diagnosis or externally imposed labels — aligns directly with the standard's requirement to acknowledge the patient's cultural identity and facilitate the

involvement of family, community, Elders, and cultural navigators as part of the care relationship.

Trauma — The standard's requirement to *seek permission before engaging in assessments or treatments* reflects the trauma-sequencing logic of the triage model. Trauma work without adequate safety, grief witnessing, and identity foundation risks re-traumatization — and with Indigenous clients, the risk is compounded by the likelihood that the assessment or treatment tool itself was developed within a framework that does not align with the client's cultural context, uses constructs that are not meaningful to their lived experience, or measures recovery in ways that assume Western individual therapeutic norms.

Anti-Racist Practice in Clinical Language and Documentation

The standard's anti-racist practice component extends beyond the therapy room into the clinical record. The workshop examines how pathologizing clinical language functions as a site of Indigenous-specific harm: when an Indigenous client's guardedness is documented as *resistant*, their absence as *non-compliant*, their protective mechanisms as *avoidance*, or their cultural practices as *unusual behaviour* — the clinical record becomes a document that reproduces the colonial gaze within the healthcare system.

The CORE documentation model is introduced as the anti-racist clinical record — one that makes the client's meaning-making visible in the written account, records the client's relationship to the presenting issue rather than the therapist's interpretation of it, and uses language the client would recognize as their own. The CHCPBC standard also requires therapists to respect Indigenous data sovereignty, consistent with provincial commitments under UNDRIP and OCAP® principles, by being transparent when collecting personal information from self-identifying Indigenous patients — explaining why the information is being collected, how it will be used, who will have access to it, and how Indigenous communities may exercise control over their members' personal information. This is a consent and documentation requirement that has direct implications for how Indigenous clients are identified, recorded, and referred in clinical systems.

Building Knowledge: The Educational Obligation

The CHCPBC standard requires ongoing education — not a one-time training — about Indigenous healthcare, determinants of health, and cultural safety. The workshop situates itself as one component of an ongoing educational commitment that participants are expected to maintain as a professional practice discipline. The following knowledge areas are addressed:

- The *In Plain Sight* findings and their implications for BC psychotherapy practice

- The distinct rights, identities, and lived experiences of Indigenous Peoples, including recognition that languages, histories, heritage, cultural practices, and systems of knowledge differ between communities
- The historical and current impacts of colonialism on Indigenous Peoples and how these shape healthcare experiences
- The disproportionate impact of Indigenous-specific racism on Indigenous women, girls, two-spirit, queer, and trans Indigenous Peoples, and the role of gender-specific trauma in the healthcare encounter
- UNDRIP commitments and OCAP® principles as they apply to clinical data collection and documentation

The workshop is explicit that this educational work cannot be completed by a non-Indigenous therapist working alone. Building knowledge through education — as the standard names it — requires ongoing engagement with Indigenous communities, leaders, and knowledge systems, including the specific communities located in the areas where the therapist practices.

Practical Exercises and Reflective Practice Components

The workshop includes four structured practice components that move participants from conceptual understanding to clinical application:

1. The Therapist's Mirror: Locating Colonial Residue in Clinical Practice
Participants examine their own clinical language, documentation habits, and default assumptions using guided self-reflection drawn from the CHCPBC self-reflective practice requirement. The questions centre on: *Where does my clinical language pathologize what is adaptive? Where do my case formulations assume Western norms of individuality, progress, and healing? Where does my documentation reflect my interpretation rather than my client's meaning-making?*

2. Translation Exercise: Clinical Language and Indigenous Experience
Using the 9-step Translation Protocol, participants work with standard clinical phrases and translate them through the lens of the standard's strengths-based and trauma-informed principles. The exercise uses the standard's own language — *looking below the surface* — as the clinical instruction: before deciding that any response is dysfunctional, the therapist must understand what it is protecting, what history it is responding to, and what strength it represents.

3. Protest Language in the Cultural Context
Drawing on the workshop's foundational protest language methodology, participants practise listening for *no* within culturally shaped responses — guardedness, silence, indirect communication, refusal of specific interventions — and apply the triage model to understand these responses as adaptive before considering them as clinical problems.

4. CORE Documentation with Indigenous Data Sovereignty
Participants practise writing CORE notes for fictive client scenarios involving Indigenous clients, applying the transparency requirements of the CHCPBC Privacy and Confidentiality

standard, the data sovereignty requirements under UNDRIP and OCAP® principles, and the person-led documentation philosophy of the CORE model.

Learning Outcomes

By the end of this workshop, participants will be able to:

- Articulate the six core concepts of the CHCPBC Indigenous Cultural Safety, Cultural Humility, and Anti-Racism Practice Standard and translate each into specific clinical obligations for psychotherapy practice
- Identify the structural and historical connections between the medical model, colonial knowledge systems, and the ongoing harm of pathologizing practice when applied to Indigenous clients
- Apply the non-pathologizing framework — including protest language, the triage model, externalization, and not-knowing stance — as clinical tools for operationalizing Indigenous cultural safety in the therapy room
- Recognize Experiential Authority as a colonial clinical dynamic and interrupt it in their own practice through self-reflective discipline
- Use the protest language framework to understand culturally shaped responses — guardedness, silence, refusal, non-engagement — as adaptive, historically grounded, and clinically meaningful rather than as resistance
- Apply the CORE documentation model to produce clinical records that are anti-racist, data sovereign, and consistent with the client's meaning-making
- Meet the CHCPBC standard's active anti-racism obligation — including intervening when they observe racism in clinical settings and supporting colleagues and patients who report it
- Commit to ongoing education about Indigenous healthcare, determinants of health, and the specific Indigenous communities in their practice area as a continuous professional discipline, not a one-time training
- Recognize that cultural humility in this context is not a skill to be achieved but a practice to be maintained — grounded in ongoing self-reflection, relational learning, and the consistent centering of the Indigenous client's own knowledge of themselves