

A Compendium of Aboriginal Healing Foundation Research



The Aboriginal Healing Foundation Research Series

© 2010 Aboriginal Healing Foundation

Published by:
Aboriginal Healing Foundation
75 Albert Street, Suite 801, Ottawa, Ontario (Canada) K1P 5E7
Phone: 1-613-237-4441
Toll-free: 1-888-725-8886
Fax: 1-613-237-4442
Email: research@ahf.ca
Website: www.ahf.ca

Design & Production:
Aboriginal Healing Foundation

Printed by:
Trade Publishing Co. Ltd. (Honolulu, HI)
Dollco Printing (Ottawa, ON)

Print version:
ISBN 978-1-897285-94-7

Electronic version:
ISBN 978-1-897285-96-1

Unauthorized use of the name "Aboriginal Healing Foundation" and of the Foundation's logo is prohibited.
Non-commercial reproduction of this document is, however, encouraged.

This project was funded by the Aboriginal Healing Foundation,
but the views expressed in this report are the personal views of the author(s).

**A Compendium of
Aboriginal Healing Foundation
Research**

2010

Recueil des documents de recherche de la Fondation autochtone de guérison

Liste de sommaires

| | |
|---|----|
| Introduction..... | 1 |
| La délinquance sexuelle chez les Autochtones au Canada | 3 |
| Profil de la santé mentale d'un échantillon d'Autochtones de la Colombie-Britannique survivants du régime canadien des pensionnats..... | 5 |
| La violence familiale chez les Autochtones au Canada | 7 |
| Peuples autochtones, résilience et séquelles du régime des pensionnats..... | 9 |
| Syndrome d'alcoolisation fœtale chez les peuples autochtones du Canada : Examen et analyse des répercussions intergénérationnelles liées au régime des pensionnats | 11 |
| Violence contre les aînés au Canada | 15 |
| Traumatisme historique et guérison autochtone | 17 |
| Les guerriers-soignants : Comprendre les difficultés et la guérison des hommes des Premières nations : Un guide ressource | 19 |
| Bref compte-rendu du régime des pensionnats pour les Inuits du gouvernement fédéral du Canada... | 21 |
| Décolonisation et guérison : Expériences des peuples autochtones aux États-Unis, en Nouvelle-Zélande, en Australie et au Groenland | 23 |
| Retisser nos liens : Comprendre les traumatismes vécus dans les pensionnats indiens par les Autochtones..... | 27 |
| Rapport final – Fondation autochtone de guérison..... | 29 |
| Histoire et expérience des Métis et les pensionnats au Canada | 33 |
| Comportements de dépendance chez les Autochtones au Canada | 35 |
| Suicide chez les Autochtones au Canada | 37 |
| Projet de recherche sur le paiement forfaitaire compensatoire : le cercle se referme..... | 41 |
| De la vérité à la réconciliation : Transformer l'héritage des pensionnats | 45 |
| La guérison autochtone au Canada : Études sur la conception thérapeutique et la pratique..... | 49 |
| Réponse, responsabilité et renouveau : Cheminement du Canada vers la vérité et la réconciliation..... | 53 |
| Pensionnats, prisons et VIH/sida au sein de la population autochtone du Canada : à la recherche de liens d'interdépendance..... | 57 |
| Paiement d'expérience commune, composante de l'Accord de règlement relatif aux pensionnats indiens, et guérison : une étude qualitative exploratoire des incidences sur les bénéficiaires..... | 59 |

Introduction

The Aboriginal Healing Foundation was created in 1998 as a vehicle to fund community-based healing initiatives that address the legacy of physical and sexual abuse suffered in Indian residential schools in Canada. As part of the original funding agreement signed between the Government of Canada and the Aboriginal Healing Foundation (AHF) on 31 March 1998, a portion of monies were to be spent on research related to developing the necessary knowledge base for effective program design/redesign, implementation, and evaluation or public inquiries.

The AHF is committed to building effective and sustainable capacities for healing the legacy of physical and sexual abuse in the residential school system, including the intergenerational impacts (the Legacy). AHF's research goals recognize the commitment to encourage effective healing practices at the community level that address this legacy. Within this context, the AHF undertook operational and applied research essential to the AHF's mission of promoting community-level healing related to residential school abuse. The research goals are to gather, analyse, and make available information that can:

- ✦ contribute to effective program design/redesign, implementation, and evaluation;
- ✦ promote holistic healing and identify the best healing practices of community projects;
- ✦ provide information on substantive issues that supports healing practices and enhances capacity-building in Aboriginal communities;
- ✦ contribute to the national healing legacy of the Aboriginal Healing Foundation; and
- ✦ encourage a more informed and supportive public environment.

Following the research objectives, issues were identified based on selected indicators—rates of physical and sexual abuse, children in care, incarceration, and suicide. The research included:

- ✦ discerning best healing practices in treating sexual offenders, treating physical abuse, and studying how abuse passes through families;
- ✦ determining the specific healing needs of Inuit and Métis affected by the Legacy;
- ✦ investigating and examining what constitutes intergenerational impacts;
- ✦ addressing the lack in existing program knowledge regarding what constitutes greatest need;
- ✦ utilizing funded projects in a larger research effort to determine the extent of the problem in their respective regions;
- ✦ sharing research on culturally appropriate community-based healing approaches that reflect local differences, needs, geography, and other realities relating to the healing process;

- addressing existing shortfalls and gaps in the knowledge regarding victimization, offending behaviours, appropriate healing strategies, and what constitutes best and worst healing practices;
- making recommendations regarding the healing needs of children, youth, Elders, women, men, the incarcerated, two-spirited people, disabled peoples whose bodies, minds, hearts, and spirits have been affected by the Legacy;
- assessing the need for additional resources to continue the healing process;
- fostering and promoting an understanding and an appreciation of the nature and effect of the Legacy, including the intergenerational impacts on the victims, their families, and their communities; and
- identifying options on the kind of national legacy the Aboriginal Healing Foundation should leave behind for future generations.

The research undertaken by the AHF contributes to community healing programs in the short-term and strengthens the long-term healing capacities of Aboriginal communities. AHF's research approach is grounded in Aboriginal knowledge and the experience, wisdom, and authority this knowledge represents. This approach requires a participatory process in which Aboriginal people determine how the AHF can most effectively respond to their healing needs. This approach also recognizes the value of holistic healing, the importance of forming partnerships with other service providers, and the need for interdepartmental cooperation in achieving the goals of research and evaluation. The AHF Research collaborated with stakeholders to:

- identify the information and knowledge needed for effective programming;
- design and implement methods for gathering pertinent information; and
- present research findings to stakeholders in understandable and useful ways.

To accomplish these goals with the approach taken above, the AHF sought after Aboriginal and other professionals expert in their field of research. The following summaries are a compilation of the major research undertaken by these individuals on behalf of and published under the Aboriginal Healing Foundation.

Aboriginal Sexual Offending in Canada

Dr. John H. Hylton
With the Assistance of:
Murray Bird
Nicole Eddy
Heather Sinclair
Heather Stenerson

2002

Sexual assault is a serious problem in Canada. Most perpetrators are men, while most victims are women or children. Contrary to popular belief, most sex offenders are family members, acquaintances, or friends of those they victimize and risk of victimization also varies from community to community.

As many as 600,000 sexual offences will occur in Canada each year, and 90 per cent or more are never reported to the police. Although the justice system has been dealing more harshly with sex offenders, it is estimated that only one in 100 sex offenders is apprehended and sent to jail, and the proportion could be much smaller. Most serious sexual offenders average a sentence of about four years; thus, the justice system's impact on the problem of sexual abuse is, and likely will remain, quite limited.

Aboriginal people are overrepresented in Canada's correctional systems. The many reasons for this have been well-documented in numerous commissions and public inquiries that have examined Aboriginal justice issues over the past 30 years. Despite decreases in crime and incarceration rates generally, Aboriginal people continue to be incarcerated in disproportionate numbers, and they make up an ever-increasing proportion of all those behind bars in Canada. Between 20 and 25 per cent of convicted sex offenders in Canada are Aboriginal, and there may be as many as 150,000 Aboriginal sex offenders in Canada. A small number of these offenders are responsible for committing many offences, sometimes over long periods of time.

Past attempts to reform the justice system to better address the needs and concerns of Aboriginal offenders, victims, and communities have largely been unsuccessful, as it is unclear if there have been any deterrent or rehabilitative effects on the majority of Aboriginal offenders. The justice system has often failed to address either the needs of Aboriginal victims or the goals of Aboriginal communities.

The most promising undertaking to improve access to effective, culturally appropriate services are those carried out by Aboriginal communities themselves. These programs recognize and respect the Aboriginal right of self-determination and provide opportunities and resources for Aboriginal communities to design and put into practice their own solutions.

Canada is a world leader in the relatively new field of sex offender treatment; yet, there are few programs, and little information is available about their effectiveness. Although Aboriginal sex offenders are known to be much more disadvantaged than other offenders, and while the numbers being processed through the justice system have grown, there are surprisingly few specialized treatment resources of any kind available in Canada. The number of programs that make use of any sort of culturally appropriate programming

are rarer still. As a result, most Aboriginal sex offenders return to their communities without receiving any treatment, much less any culturally appropriate treatment.

While the scarcity of Aboriginal-specific treatment programs is a serious concern, it is also clear that the most meaningful strategies for addressing Aboriginal sexual offending lie beyond the justice system. Even major efforts to stop, deter, or rehabilitate Aboriginal sex offenders will likely have little appreciable impact on victimization rates; rather, there is a need to invest in community-based solutions, including early intervention programs, crime prevention programs, and restorative justice programs.

Meaningful, long-term strategies to address Aboriginal sexual offending will require the coordinated efforts of many partners. Communities must become more informed, but they must also be provided with the resources that will allow them to take ownership of the problem. Making the effort to help strengthen the family and community are also key. In addition, there must be an increased commitment to develop adequate and appropriate programs for offenders and victims.

There is an urgent need for research to more fully determine the extent of offending and victimization, for program development to provide effective solutions, and for development of Aboriginal human resources to deal with these and other related needs in Aboriginal communities throughout Canada.

Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System

Dr. Raymond R. Corrado, Ph.D.
Dr. Irwin M. Cohen, Ph.D.
Corrado Research and Evaluation Associates Inc.

2003

Through an analysis of case files of a sample of 127 Aboriginal Survivors of the residential school system who have undergone a clinical assessment, a study was conducted to examine the abuse, mental health, and health profiles of these Survivors. The study looked at the profiles of Survivors and their families before, during, and after residential school; the residential school experiences of the sample; the number of occurrences of post-traumatic stress disorder (PTSD) and the number of occurrences of PTSD with other mental disorders; and the treatment needs of Survivors.

All of the subjects are Aboriginal adults who made legal claims against the federal government of Canada, the United Church of Canada, the Anglican Church, and/or the Roman Catholic Church for abuses they suffered while students at residential school. Most of the subjects are male with a mean age of 48.5 years old. The mean age when subjects arrived at residential school was 8.5 years old, and they usually came from intact families. Upon leaving the residential school system at age 15, only a small number returned to intact families. The majority of the subjects did not continue with their education after leaving the residential school, and only one-quarter indicated they attended post-secondary institutions. Employment history was equally divided between jobs that required no formal training or education and those requiring more extensive training or education.

No valid or direct comparisons across the time periods of pre-residential school, during residential school, and post-residential school could be done; however, there appeared to be a dramatic increase in alcohol consumption by the subjects between the pre-residential school period and the later time periods that cannot be completely accounted for solely by differences in age. More than three-quarters of the subjects report having abused alcohol in the post-residential school period. As expected, the number of case files that provide information about sexual, physical, and emotional abuse increased overwhelmingly for the time period when subjects were attending residential schools and then declined for the post-residential school period. One hundred per cent of the case files reporting abuse during attendance at residential school indicate that the subjects had been sexually abused, and nearly 90 per cent of the case files report physical abuse.

Nearly half of the case files that provide information about the subject's criminal history report convictions mainly for assault and sexual assault. While there were multiple victims mentioned for many of these criminal incidents, most involve intimate partners and family members. However, about one-third also involve police officers and one-fifth involve strangers.

Mental health information was present in three-quarters of the case files. In only two cases did the subjects not suffer from a mental disorder. The most common mental disorders were post-traumatic stress disorder, substance abuse disorder, and major depression. As expected, half of those diagnosed

with PTSD had other mental disorders, including substance abuse disorder, major depression, and dysthymic disorder. Only a small number of the case files mentioned the new, but unofficial, clinical category: residential school syndrome. The residential school syndrome is a sub-type of PTSD that focuses on intense feeling of fear and anger and the tendency to abuse alcohol and drugs.

The development of a detailed code book used in this study was a necessary step in developing a useful database regarding the mental health, health, and social problems of residential school Survivors in Canada. This code book will also help to make cross-national comparisons with residential school Survivors in other countries. This could provide mental health workers with a more complete understanding of residential school Survivors and may assist them in the development of more specific treatment interventions.

Aboriginal Domestic Violence in Canada

Four Worlds Centre for Development Learning

Michael Bopp, Ph.D.

Judie Bopp, Ph.D.

Phil Lane, Jr.

2003

Aboriginal family violence and abuse are a social disease or syndrome involving many factors and not simply undesirable behaviours that reside within Aboriginal individuals, families, and community relationships as well as within social and political dynamics. Domestic violence shows itself as a practice of one person dominating or overpowering another or others through violence, fear, and a variety of abusive methods. It is not a one-time event or pattern, and it is most often rooted in intergenerational abuse and almost always linked to the need for healing from trauma. Aboriginal family violence is allowed to continue and grow because community dynamics allows it to happen. This amounts to a serious breach of trust between the victims of violence and abuse and the whole community. The entire syndrome has its roots in Aboriginal historical experience that must be understood in order to restore wholeness, trust, and safety to Aboriginal family and community life.

Key factors of family violence and abuse in the community include: absence of remorse and taking ownership of own actions, poor attitude and beliefs of males regarding women, past history of domestic abuse, levels of personal and community wellness, professional support services, community leadership, public policy, policing and the justice system, poverty and unemployment, community awareness and vigilance, geographical and social isolation, and spiritual and moral climate. These factors do not usually operate in isolation, but as a mutually reinforcing system of factors. No two communities are alike, so the ways in which these and other factors combine to impact the phenomenon of family violence and abuse in any community needs to be carefully and thoughtfully mapped. Factors from outside Aboriginal communities that hinder their capacity to work effectively to address family violence and abuse include present-day government policies and programs, the marginalization of Aboriginal people in society as a whole, and the national and global trends in society and mass culture. These put them at risk of a whole host of social issues that are associated with family violence and abuse, and thus undermine the values and dynamics that distinguished Aboriginal communities and sustained them in traditional times.

Responses to Aboriginal family violence and abuse are reviewed by examining the nature and scope of fifteen community-based or regional programs, as well as the primary lessons from their many years of experience operating transition housing, counselling, referrals, and many other types of support to women and children seeking sanctuary from abusive situations. Some of the programs also carry out public relations and outreach activities in local communities. Several programs focus on outreach, healing, and rehabilitation services for perpetrators of violence, and several of the shelters also sponsor men's healing and support groups. Services related to domestic violence and abuse are offered through justice, social services, and mental health agencies.

A generic framework for intervention to reduce and eventually rid widespread family violence and abuse from Aboriginal communities is proposed. The first category of intervention within this framework involves

building an adequate community response system. An important step would be to establish and train of a community response team made up of representatives from community agencies and leadership, as well as community volunteers and professionals with extensive experience in counselling. The purpose of the community response team would be to provide safety, healing, and long-term support for victims and their extended families and contain, monitor, and supervise abusers as they undertake healing and rehabilitation. Establishing a protocol in collaboration with justice and social service agencies for intervening in family violence and abuse situations is another crucial step. Finally, an alternative program for community-based healing and reconciliation needs to be created to support the needs of both victims and abusers.

A second category of intervention relates to healing the root causes of family violence and abuse. This work relates to breaking the cycle of intergenerational trauma by assisting the present generation of parents to see the roots of their own pain and to learn how to stop the cycle of abuse and by assisting children now living within abusive relationships to receive the care necessary to heal from the trauma they have already experienced. Equally vital is to bring the community together to envision healing and to interrupt power dynamics that create barriers to this work.

The third category of intervention involves transforming the family and community systems that enable and perpetuate abuse. This task requires systematic work in two key areas: identifying and mapping the dynamics of key determinants of family violence and abuse and acquiring an adequate understanding of how each determinant plays out with the particular community system in question; and identifying key community capacities needed to bring about change relative to the determinants of violence and abuse, to develop those capacities, and to apply them strategically and systematically to the work of shifting the status of key determinants.

The fourth and final category of intervention deals with building adequate support and service systems for long-term healing and community development. In this regard, general principles are offered to guide the work that should be done within Aboriginal communities to build a comprehensive response to family violence and abuse and would incorporate the following components: early detection and intervention, safe houses and emergency shelters, protection of victims, including children witnessing violence, confrontation and containment of abusers, healing and long-term support for both victims and abusers, prevention-oriented education and public relations, maintenance and supervision of at-risk households, healing and reconciliation work with extended families, and integrating the family violence initiative within a wider community healing movement.

Important issues external to the Aboriginal community that need to be addressed in support of comprehensive healing of Aboriginal family violence and abuse are: funding, public policy implementation, support for the development of Aboriginal civil society, and the status of Aboriginal people in society as a whole.

Aboriginal People, Resilience and the Residential School Legacy

Madeleine Dion Stout
Gregory Kipling

2003

Resilience, along with its practical applications, has been studied and debated since the 1970s. The concept is most often defined as the capacity to spring back from adversity and have a good life outcome despite emotional, mental, or physical distress. Risk factors, such as poverty or parental alcoholism, increase the probability of a negative outcome. Risk can reside in the individual, family, or wider environment and vulnerability to a negative outcome increases exponentially with each additional risk factor. This process is known as “risk pile-up.” Protective factors or defenses such as average intelligence or nurturing parents help to counteract risk and decrease individual vulnerability to adverse conditions. Children who experience wide-ranging protective factors generally have good life prospects as adults, although positive coping strategies are difficult to sustain against major or ongoing trauma. Breaking with the past and disrupting negative chain reactions are, therefore, critical steps in desisting from such negative strategies.

At a more theoretical level, resilience enhancement initiatives require longitudinal research for tracing the outcomes of cognitive abilities, emotional competence, and physical health over individual lives. Interventions are more likely to be successful if “keystone” risk factors are isolated, the cumulative effects of multiple risk factors are identified, and risks that emerge in later life are recognized.

Culture and resilience intersect and help shape traditions, beliefs, and human relationships. Traditional Aboriginal societies have placed great emphasis on fostering resilience for children and youth, but an oppressive colonial experience has often cut off Aboriginal parents from such cultural moorings. Notwithstanding, the resurgence of Aboriginal beliefs and practices, accompanied by traditional resilience promotion strategies, has given rise to promising interventions.

Status Indian, Métis, and Inuit children had varied residential school experiences, both in intensity and duration. Although status Indians formed the majority of attendees at any given time, many Métis children were accepted, often to boost school enrollment figures. Meanwhile, the number of Inuit children grew quickly in the 1950s when a network of schools was built across the North. Despite the manner in which they found themselves enrolled, status Indian, Métis, and Inuit Survivors have all had to contend with risk factors related to the residential school experience, which have spilled over to their descendants. In many cases, Survivors suffered long-term consequences, especially in how they perceive themselves and interact with others because of the high degree of risk associated with the schools’ disciplinary regimes, corporal punishments, and estrangement from families. Still, Survivors report protective factors, including pre-school supports from parents and families, as many children also benefited from the positive relationships they developed with other students or adult relatives. They also gained strength from competitive sports, prayer, religious beliefs, and anticipated reunions with their families.

Detachment, reinterpretation, accommodation, and resistance were the general coping strategies in residential schools, although some of the attitudes and behaviours learned in residential school proved to

be destructive for Survivors. However, their resilience is evident in the steps they have taken to counteract negative outcomes. Many former students have found support in Elders, Alcoholics Anonymous, and healing circles. They have also opted to share memories and stories with other former students, pursue further education, relearn Aboriginal languages, and follow spiritual paths to reinforce Aboriginal identity.

In order to foster resilience and promote healing, it is suggested that implementing initiatives to open up educational, career, or growth is needed where there is a significant Survivor population.

Fetal Alcohol Syndrome among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools

Caroline L. Tait

2003

In the past three decades, fetal alcohol syndrome (FAS), and alcohol-related birth effects (ARBEs) more generally, have emerged as health concerns for Aboriginal people in Canada. At the heart of this concern are two issues: the devastating effects that substance addiction has had on Aboriginal people and their communities and the difficulties faced by those individuals, families, and communities affected by FAS and ARBEs. The necessary contributing factor in this discussion is alcohol use by pregnant women, as FAS and ARBEs are found only in offspring where in-utero alcohol exposure has occurred. However, while in-utero alcohol exposure is a necessary factor, debate exists as to whether it is a sufficient variable to produce FAS/ARBEs or that other mitigating factors need to be present for effects to occur; for example, a pregnant woman's overall physical and mental health status, her nutritional intake during pregnancy, and other social and historical factors. Strong evidence exists that these secondary factors can play a significant role in birth outcomes where alcohol exposure in-utero has occurred. Intergenerational links between residential schools, particularly with regard to sexual and physical abuse experienced by children who attended the schools, mass adoption of Aboriginal children in the 1960s and 1970s, and the introduction of alcohol by Europeans into Aboriginal communities have collectively contributed to high rates of FAS and other related illnesses among Aboriginal people.

FAS is marked by prenatal and/or post-natal growth, central nervous system dysfunction, and characteristic cranio-facial malformations. The severity of the illness can vary greatly among individuals, and specific markers of the illness, such as facial features, can change over time or manifest themselves differently in the same individual. Since the first description of FAS in the medical literature, ongoing progress has been made in developing specific criteria for delineating this syndrome. However, controversy remains in key areas, including the relative boundaries of the diagnosis as well as the markers that should be used to define those boundaries. Diagnostic criteria vary from study to study and, along with other methodological factors such as the method of case ascertainment and the population surveyed, this has meant that estimates on the prevalence of FAS and ARBEs vary widely.

FAE was originally used to refer to behavioural and cognitive problems occurring in offspring exposed to alcohol in-utero without typical FAS diagnostic features. FAE was understood to be generally less severe than the full-blown syndrome; however, some authors have stressed that FAE involves central nervous system dysfunction as severe as that occurring in FAS. Others suggest that the precision of the term FAE, which has never been very exact, has been gradually reduced because of the difficulties found in measuring exposure to alcohol, coupled with the difficulties inherent in quantifying or demarcating behavioural and cognitive problems. Due to a lack of standardized diagnostic tools and many physicians in Canada not being trained in FAS/ARBE referral and assessment, it is difficult for a patient to receive a medical assessment for FAS/ARBEs in most regions of Canada. Confounding factors, such as specific phenotypes (e.g., typical facial features, height, head size) among certain Aboriginal groups that are similar to those found in persons with FAS/ARBEs, have meant that the potential for mis-diagnosis or over-diagnosis of FAS/ARBEs in some Aboriginal communities exists.

Standardized psychological testing for central nervous system dysfunction may also be inappropriate for Aboriginal children who do not speak English or French as their first language or who live in remote communities. Cultural characteristics of the specific community as well as consideration of other local factors (e.g., community integration or dysfunction) must be considered in the development of appropriate assessment tools.

Epidemiology studies suggest that rates of FAS/ARBES, especially among Aboriginal people in North America, may be increasing. However, this claim, along with suggestions that FAS/ARBES are more prevalent among Aboriginal groups than non-Aboriginal groups, is questionable based on the available research data. For example, researchers selected some of the Aboriginal communities surveyed because alcohol abuse was endemic and FAS/ARBES were thought to be a major public health problem. Furthermore, while there are few epidemiological studies on FAS/ARBES among Aboriginal people in Canada, there is even less research on the prevalence of FAS/ARBES in non-Aboriginal populations. This makes it difficult, if not impossible, to make a valid comparison of the prevalence rates between Aboriginal and non-Aboriginal people in Canada.

In relationship to intergenerational links to substance abuse and pregnancy and to FAS/ARBES, it is clear that the residential school system contributed not only to the central risk factor involved—substance abuse—but also to factors shown to be linked to alcohol abuse, such as child and adult physical, emotional, and sexual abuse, mental health problems, and family dysfunction. The impact of residential schools can also be linked to risk factors for poor pregnancy outcomes among women who abuse alcohol, such as poor overall health, low levels of education, and chronic poverty.

Child abuse is an important factor when considering intergenerational links between the residential school system and current rates of substance abuse during pregnancy among Aboriginal women. Research shows that child abuse is linked to a number of mental health problems, including adult alcohol abuse. Severity and multiple episodes of abuse increase the risk for these problems. Child sexual abuse in some Aboriginal communities in Canada and the United States is believed to be significantly higher than national averages. Some research suggests that Aboriginal women may experience higher levels of certain symptomatology following childhood or adult sexual abuse, such as somatic symptoms, alcohol abuse, mental health problems, sleep disturbances, and sexual difficulties.

Aboriginal victims of abuse and their families may face numerous barriers that prevent them from reporting the abuse. Furthermore, they may have limited support if they do report abuse, and it is likely that their perpetrators will not be prosecuted or, if convicted, will not receive appropriate sentencing. Studies involving pregnancy and substance abuse have failed to fully address the question of violence, even though women at high risk of producing alcohol-affected children report high rates of child and adult abuse. Some studies report that violence may increase in some instances during pregnancy and that violence has been linked to poor pregnancy outcomes, such as low birth weight babies.

Institutional child abuse occurs within an institutional setting where children are placed in the care of a group of people who control almost every aspect of the children's lives. Within this setting, children are made particularly vulnerable to acts of violence, including sexual abuse, because they are cut off from family supports and there are generally few or no avenues for them to report abuse. The residential school system was identified by the Law Commission of Canada as causing the most amount of damage to a

group of children than any other institution in Canada. The residential school system was unlike other institutions as it was intended to undermine a culture. Because of this, Aboriginal children suffered in a way distinct from children placed in other types of institutions.

Before it can be concluded that Aboriginal children are at an increased risk of being born with FAS/ARBEs, important questions should be addressed. Research examining how demographic, socio-economic, and socio-cultural factors may be related to an increased risk of FAS/ARBEs for some Aboriginal groups needs to be conducted. However, studies may not account for environmental and cultural factors, especially where minorities are concerned, which may cause an overrepresentation of affected individuals and, thus, higher prevalence rates. While FAS/ARBEs are a serious health problem, Aboriginal people should be critical of claims that suggest they are at greater risk and should be cautious in applying prevalence rates found in specific high-risk communities to other Aboriginal groups.

Alcohol and pregnancy studies have, in many instances, focused on Aboriginal women as a sub-group in North America who are particularly at risk for producing alcohol-affected children. In a review of the literature, however, it becomes clear that methodological problems exist in many of the studies arguing that Aboriginal heritage is a risk factor for FAS/ARBEs. Chronic poverty and social marginalization appear to be variables that are more important in identifying women at risk than ethnic identity. Because Aboriginal women are the poorest and most marginalized group in Canada, these factors, rather than their Aboriginal culture or heritage, situate them among women at risk. In the delivery of FAS/ARBE prevention and intervention services, Aboriginal women may present certain challenges for service delivery. Although the research literature is limited, services targeting high-risk Aboriginal women provided by Aboriginal organizations or have a strong Aboriginal component and involvement of Aboriginal service providers are seen to be most effective in meeting the needs of Aboriginal women. Increasingly, the involvement of traditional practitioners and Elders is seen as a positive and often necessary inclusion in best practice programs.

Aboriginal women experience numerous barriers and gaps in service that prevent them from accessing prenatal and addiction treatment services. Barriers range from long waiting lists at treatment centres to a woman being afraid to lose custody of her baby when it is born if she admits to needing help when pregnant. The geographical location of a community, the range of services available, and the level of community integration of services all contribute to whether or not women access prenatal and addiction treatment services. Some Aboriginal communities have begun to integrate traditional practices related to pregnancy and parenting into prevention strategies with the involvement of traditional practitioners, such as mid-wives.

Alcohol-affected persons who are Aboriginal may be at risk of multiple environmental insults that could further exaggerate their illness, such as multiple foster placements, poverty, family dysfunction, and long-term separation from family members. Aboriginal communities may also lack the range of services needed to address the needs of alcohol-affected children, which may result in the children being removed from the community, despite there being care givers who could provide a stable and loving home environment.

Widespread substance abuse, particularly alcohol abuse, among those who attended residential schools has been identified as both an outcome of the residential school experience and a contributing factor

to other negative health and social problems among this group and among subsequent generations of Aboriginal people. Although no research studies exist that specifically examine the ways in which residential school experiences contributed to current rates of FAS/ARBES among Aboriginal people, the residential school system did contribute to high rates of alcohol abuse among those who previously attended the schools and among significant numbers of parents and community members who had their children removed from their care because of the school system.

The residential school system further contributed to alcohol abuse among subsequent generations of Aboriginal people, including women of child-bearing ages. Despite the negative impacts of the residential school system and other forms of colonization, it should be pointed out that not every former student responded in the same way to their experience and, for various reasons, some individuals and communities fared better than others. Because of this, alcohol abuse among Aboriginal people in Canada varies and it should be understood as a problem of certain individuals and subpopulations, rather than a problem of all Aboriginal people. In relation to FAS/ARBES, this suggests that programming and services should target those particular populations who are at risk, rather than targeting all groups regardless of their alcohol use levels.

There is limited written information about the response of Aboriginal communities in dealing with alcohol-affected persons. Recognition of the diversity of cultures and histories found among and between First Nations, Métis, and Inuit communities is important in understanding how communities respond to FAS/ARBES. Aboriginal communities face different challenges, depending on whether they are rural or urban-based, the degree of substance abuse in the community, and the range of other issues confronting them. These include those related to substance abuse during pregnancy and FAS/ARBES. Aboriginal communities, with the involvement of national Aboriginal political and professional organizations, are better equipped than government ministries to identify the priorities to be addressed within their communities.

Research into the testing-retesting of the reliability and validity of FAS/ARBE diagnostic classifications and assessment tools should be undertaken in order to determine how consistent FAS/ARBE diagnostic classifications are in identifying Aboriginal individuals with alcohol-related birth effects over the lifespan. Testing-retesting could involve independent reassessment (the clinician is blind to previous diagnosis) of patients at different intervals over the lifespan to see if these patients still warrant the diagnostic label. The example of substance abuse and pregnancy, and FAS/ARBES more generally, illustrate how federal and provincial governments continue to set priorities in Aboriginal health. While substance abuse during pregnancy and FAS/ARBES are health concerns for Aboriginal people, there is a need for a cautious approach, including critiquing the scientific and policy literature and the importance of taking a broad-based perspective that situates the issue within a larger historical and social context.

Aboriginal Elder Abuse in Canada

Claudette Dumont-Smith, RN BScN, MPA

2002

Global statistics on the abuse of elders are lacking and known to be grossly under-reported in several countries, including Canada. In Canada, the most common form of abuse against the mainstream elderly population is emotional abuse, followed by financial abuse. Elder abuse can take on many forms, which could include abandonment, physical abuse, psychological/emotional abuse, financial or material abuse, sexual abuse, neglect and, spiritual abuse. Factors that contribute to the causes of elder abuse could include dependency, stress, and structural factors such as age, gender, race, ethnicity, and class. There is much controversy about whether or not these factors contribute to elder abuse; however, some experts do agree that stress and society's attitude toward aging are contributing factors.

In the general Canadian population, seniors or elders are the fastest growing age group. Since 1981, the number of seniors has grown by two-thirds to reach nearly four million. In 1996, Aboriginal people 55 years of age or older accounted for 8.3 per cent of the total Aboriginal population of 799,010. Life expectancy is shorter in the Aboriginal population than the Canadian population in general, which is why some governments and other agencies consider age 55 as senior for Aboriginal people. It is expected that the number of Aboriginal persons who are 65 years and older will triple during the period 1996 to 2016, and this does not take into account those reaching age 55 to 65 years will also increase. Therefore, Aboriginal people will become dependent at an earlier age than their non-Aboriginal counterparts.

No statistical data exists on the incidence and prevalence of elder abuse in the Aboriginal population; however, violence in Aboriginal communities is higher than in the general population. Aboriginal elders may be more susceptible to becoming victims of elder abuse because of various factors such as overall poor health status, loss of traditional role and respect in the immediate and extended family structures, and lack of community elder-specific health and social services. These factors are linked to the colonization process and its strategies and policies that were developed to subjugate, dis-empower, and assimilate Aboriginal people. The establishment of one such policy that continues to negatively impact on the overall health and well-being of Aboriginal people was the residential school system. Survivors of these institutions and their families continue to experience losses, such as cultural, spiritual, familial, and traditional practices or lifestyle. As a result, individual family members, most notably elders, have lost the respect they once held and, as a consequence, have been or are at risk for abuse and neglect.

Research on the abuse of elders must be initiated to determine with accuracy the extent of this problem and to develop strategies to come to the aid of those Aboriginal elders who are being abused and neglected.

Historic Trauma and Aboriginal Healing

Cynthia C. Wesley-Esquimaux, Ph.D.

Magdalena Smolewski, Ph.D.

2004

Aboriginal people have experienced unremitting trauma and post-traumatic effects since Europeans reached the New World and unleashed a series of contagions among the Indigenous population. These contagions burned across the entire continent from the southern to northern hemispheres over a 400- year timeframe, killing up to 90 per cent of the continental Indigenous population and rendering Indigenous people physically, spiritually, emotionally, and psychically traumatized by deep and unresolved grief.

This study proposes a model to describe the intergenerational transmission of historic trauma and examines the implications for healing in a contemporary Aboriginal context. The purpose of the study was to develop a comprehensive historical framework of Aboriginal trauma, beginning with contact in 1492 through to the 1950s, with a primary focus on the period immediately after contact.

Following Judith Herman's 1997 work, *Trauma and Recovery: The Aftermath of Violence, from domestic abuse to political terror*, a new model is being introduced for trauma transmission and healing, which cites the presence of complex or endemic post-traumatic stress disorders in Aboriginal culture that originated as a direct result of historic trauma transmission (HTT). A variety of disciplines, including history, anthropology, psychology, psychiatry, sociology, and political science are called upon to illuminate the model of historic trauma transmission and provide different perspectives and information on how historic trauma can be understood as a valid source of continuing dis-ease and reactivity to historical and social forces in Aboriginal communities.

Purposeful *universalization* of the Indigenous people's historic experience is proposed as a means to explain the basis for creating a nucleus of unresolved grief that has continued to affect successive generations of Indigenous people. The process of the *universalization* of trauma is purposefully placed in direct opposition to the *particularization* of Aboriginal cultural and social suffering. The stage for this theory is set with a comprehensive review of the historical records of the diseases, violence, and depopulation of the Americas during influenza and smallpox epidemics from 1493 to 1520, which also triggered successive epidemics until at least the nineteenth century. An estimated 90 to 95 per cent of the Indigenous population died within two generations of contact in 1492. These epidemics are viewed as the point of departure for the cumulative waves of trauma and grief that have not been resolved within the Aboriginal psyche and have become deeply embedded in the collective memory of Aboriginal people.

Examples of the waves of colonization: cultural transition (early period); cultural dispossession (middle period); and cultural oppression (late period) are provided as evidence of the genocidal nature of what befell Indigenous people in the Americas. Familiar stories of genocide from Australian, Polish, and Tasmanian experiences illustrate the similarity in the characteristics of genocide in the Americas.

A variety of healing models and First Nations' therapeutic interventions aimed at healing Aboriginal communities through facilitating specific aspects of Aboriginal knowledge and traditional values such

as balance, interconnectedness, intraconnectedness, and transcendence are reviewed. Also, a new model of HTT is proposed to create a better understanding of the etiology of social and cultural diffusion that disrupted Aboriginal communities for so many years. Historic trauma is understood as a cluster of traumatic events and as a disease itself. Hidden collective memories of this trauma, or a collective non-remembering, is passed from generation to generation, as are the maladaptive social and behavioural patterns that are symptoms of many social disorders caused by historic trauma. There is no single historic trauma response; rather, there are different social disorders with respective clusters of symptoms. HTT disrupts adaptive social and cultural patterns and transforms them into maladaptive ones, which manifest themselves into symptoms of social disorder. In short, historic trauma causes deep breakdowns in social functioning that may last for many years, decades, and even generations.

The connectedness of Aboriginal people to their lands, their natural and spiritual environments, and their systems of social and cultural action and economic practice are addressed throughout this study. One of the main considerations for this study relates to the interconnectedness and intraconnectedness of Aboriginal people and how that connectedness contributes not only to their ability to maintain cultural and traditional values in the face of pressures from colonial and assimilationist tactics, but also makes Aboriginal people more susceptible to the deeper feelings of grief and trauma in their day-to-day lives. Therefore, the voices of Elders and their views on Aboriginal memory, tradition, and healing are important in understanding how the past intersects with the present, and it shows the importance of keeping traditions alive in Aboriginal homes and hearts.

Warrior-Caregivers: Understanding the Challenges and Healing of First Nations Men — A Resource Guide

W.J. (Bill) Mussell

2005

Decimated populations, much smaller land bases upon which to make a living, and major changes in family composition in the home because of the removal of children to residential schools and the introduction of single family dwellings are major forces over which First Nations people had no control. The consequences of these experiences, especially the reduced human and material resources in their lives, strongly affected the roles of males. Many First Nations men have suffered from sexual and physical violence as children, youth, or adults within their families, at residential school, and in their communities. Being a victim of violence has many direct and hidden effects, such as addictions, depression, difficulties in relationships, parenting, practicing safer sex, and so on. In some cases, men become part of the cycle of violence by hurting others. Power and sexuality expressed as violence are harmful to everyone, and active healing through treatment programs, healing ceremonies, and health centres is needed. Relatively few have sought assistance to help them work through the process of trauma so as to become able to move forward in their overall growth and development. Most men have not healed themselves and continue to behave in ways that show the effects of unresolved personal issues.

The purpose of this guide is to assist caregivers, parents, leaders, consultants, advisers, educators, and community-based health, education, and social development workers to reach and inspire more men in First Nations contexts to address the effects of loss and trauma in their lives; to influence more boys, youth, and men in First Nations contexts to overcome their resistance to engagement with others of both sexes of different cultural backgrounds, and to discover the joys of personal growth, genuine care, and rewards connected with supporting and assisting others in effective ways; to work more effectively with parents and other caregivers to prepare and equip young boys and youth with abilities required to find a place and make a personal space in a range of social situations, to enjoy self-care, to learn how to learn, and to be of assistance to others; and to provide practical reference materials.

Children and youth in the residential schools were not able to learn anything about their family and community history or culture. Methods employed in the classrooms were not designed to facilitate learning how to learn; instead, remembering what the teacher taught as facts was emphasized. When these young people returned to their community, nurturing relationships and tools to facilitate sharing of information were mostly absent. Conditions for the transmission of culture from family and community to the young people were impossible to create in these circumstances. Similar constraints limited transmission of culture between family and young people when the residential school system ended for most status Indian children in the nation. Mediated learning could not take place and continues to be a desired process that is not yet fully known to most First Nations families.

Roles and responsibilities of First Nations adult males and females were modified by the intergenerational institutionalization. The family structure was further fractured with modern housing, and chances of building and rebuilding relationships between parents and children in the residential schools were reduced because of social isolation and language difficulties. The effects of residential schooling included

disruption of family relations, especially rights of parents to transmit their identity to the next generation, violation of trust inherent in colonial oppression, and withholding of communication and silent suffering. The ways of the Western world have found a home in First Nations where there are strong evidence of male superiority and use and abuse of power by males and by some females.

It appears discontinuity in male roles and responsibilities has persisted so long that distinctive male characteristics have become blurred and even forgotten. Some families and communities seem to define maleness by stressing the negative of femaleness. At the same time, most First Nations live by traditions, habits, and beliefs that perpetuate male superiority and privilege without the social and emotional responsibilities that underpin family health and wellness.

There is strong confusion about the place of maleness in First Nations. This confusion is identified with colonization for over the span of four and five generations, that is, setting aside of reserves, establishment of, and administration by, a bureaucratic branch of government, residential schooling, and modern child welfare practices. More recently, exposure to images and values easily available and accessible in the media has been a source of negative influence and destructive role modelling. Aggression is touted highly in movies, some television programs, popular songs, and popular magazines and is also experienced directly by First Nations young people in their communities, sometimes in their families, and especially between siblings. When they are told aggressiveness is not acceptable and bad, they revert to imitating the familiar in the absence of positive role models.

A clear and positive sense of cultural identity in institutions that allow for collective self-control, along with strong bonds of love and mutual support in the family and community, can act as a protective force against despair, self-destructiveness, and suicide. Language, land, and colonial legacy lie at the heart of culture for First Nations people and should, therefore, be targeted in all work connected with grieving, healing, and prevention.

A community is more likely to find healing and experience successful change if solutions are based on its world view, traditional practices, and good cultural ways. Traditional approaches for providing support and healing include storytelling, sharing circles designed to promote intentional learning, discussion circles, purposeful play, participation in ceremonies, and role modelling. In communities where there is a mix of world views, efforts should be made to identify what world views are in common and to build upon them. Focusing upon identification of shared principles and values often facilitates movement by the community in the desired direction.

A Brief Report of the Federal Government of Canada's Residential School System for Inuit

David King

2006

From 1955 to 1970 the Department of Northern Affairs ran the federal government's northern education system. Prior to 1947, education was provided by the churches through its missionaries and with financial support of government. When government implemented the day school building program in 1947, churches no longer received money to build schools but only to manage them, which led to competition and hostilities among the churches. By 1970, control of education was handed over to the new Northwest Territories government. First Nations and Inuit youth who attended these federal day schools stayed in small or large hostels built near the schools, and there were also some students who attended part-time or while in hospitals. In 1955, less than 15 per cent of school-aged Inuit were enrolled in schools, and this increased to 75 per cent about a decade later. Low school attendance and government pressure to fill empty spaces probably encouraged threats in individual cases to suspend family allowance that began in 1944 to the families of Inuit who did not attend. Low attendance also suggests that many Inuit families did not support this system.

Before the federal government built the education system in the North, only one out of 15 Inuit could read English, although most could read their own language in syllabics. The federal government believed that Inuit who knew English would find jobs as the Southern economy moved north. As a result, federal policy emphasized teaching English, often ignoring or under-valuing Inuktitut and limiting it to religious instruction and social activities. Most teachers came from Alberta universities and colleges, but no specific curriculum was followed other than what each individual teacher offered. The government would not allow Inuit Elders as teachers of traditional knowledge into the education system, and there were no academic courses that could teach the teachers about the Inuit.

The diet at the schools consisted of both traditional and Western foods. However, by 1961, with allegations of smaller caribou herds and increased attendance, traditional foods were eventually banned from the schools.

It was not until 1995 when sexual assault allegations came to national attention. Out of 86 investigations, 13 sexual abuse charges against three Catholic priests and 41 civilian staff members were laid. In addition to sexual abuse, other abuses were inflicted on Inuit students. There were reports of students being neglected, supplied with alcohol, food, and pornographic material to lure them into entering a staff member's room, female students getting pregnant, prostitution, and the spread of sexually transmitted diseases among the students. The federal government took measures to protect students against exposure to alcohol by limiting contact between students and the community. The government conducted many investigations on reports of sexually transmitted diseases, pregnancies, and prostitution but claimed these were false.

The federal government had separated what is now northern Quebec from the Northwest Territories in 1912 without Inuit consent. Because neither government wanted responsibility for the education of

Quebec Inuit, responsibility was then undertaken by the Anglican Church and its mission schools. By 1935, the government of Quebec began relinquishing fiscal responsibility for Inuit, legally forcing the federal government to assume responsibility. The federal government continued to hold responsibility for Inuit schooling until the 1960s, when Quebec began to focus on the economic resources in northern Quebec.

The schools may have provided a rudimentary education but the loss of culture and family bonding, self-esteem as a result of government and staff paternalism and prejudice, and sexual and physical abuse at the hands of a minority of staff who caused a negative impact on the lives of many former residential school students are all part of the legacy left behind.

Decolonization and Healing: Indigenous Experiences in the United States, New Zealand, Australia and Greenland

Linda Archibald

2006

The physical and sexual abuse suffered by many generations of children in Canada who were sent to government-sponsored residential schools run by the Roman Catholic, Anglican, United, Presbyterian, and other churches between 1892 and 1969—along with the imposed alienation from families, communities, and cultures—left scars that have been passed on from generation to generation. Sadly, Canada was not alone in its attempts to assimilate Aboriginal people through the education system. While policies and criteria under which children were removed varied, many thousands of Indigenous children in the United States and Australia were taken away from their families and placed in boarding or mission schools.

Colonialism took different forms in New Zealand and Greenland: if judged by the lower socio-economic and health status of Indigenous people compared to non-Indigenous citizens, the consequences of colonialism were equally damaging. Colonization has been described as being a social process characterized by five distinct but interconnected phases: denial of Indigenous culture; destruction of all physical symbols of culture; denigration of Indigenous belief systems and ceremonies; tokenism, in which the remnants of culture are tolerated as folklore; and exploitation of aspects of traditional culture such as music and art that refuse to disappear. Various characteristics and permutations of these phases of colonization can be recognized in the history of the United States, New Zealand, Australia, and Greenland—although not necessarily chronologically and not all phases are evident in every country.

Decolonization is a process that involves addressing historic trauma and unravelling the tragic after-effects of colonization. Historic trauma theory argues that individuals can be traumatized by events that occurred before their birth. Thus, a relationship exists between history and the social, economic, and political environments and individual experiences. It follows that therapeutic approaches to healing that incorporate Indigenous history will more effectively address root causes. At the same time, many individuals need therapeutic help to heal from deeply personal wounds or to address depression, addiction, or the effects of physical and sexual abuse. The experience of being colonized involves loss of culture, language, land, resources, political autonomy, religious freedom, and, often, personal autonomy. These losses may have a direct relationship to the poor health, social, and economic status of Indigenous people. Understanding the need for personal and collective healing from this perspective points to a way of healing, one that combines the socio-political work involved in decolonization with the more personal therapeutic healing journey.

Groundbreaking research and theoretical work on treating the effects of intergenerational and historic trauma have emerged during the past decade, and these help to open the door to new approaches to healing that are especially relevant to working with survivors of residential and boarding schools. Learning about the history of colonization, mourning the losses, and reconnecting with traditional cultures, values, and practices are becoming recognized stages of the healing process. Indigenous people in the United States, Australia, New Zealand, as well as Canada are all addressing historic trauma, both at a theoretical level

and within therapeutic practice. This supports an early finding of the Aboriginal Healing Foundation: education about residential schools is not only an effective way to dismantle denial, but it also acts as a catalyst for individuals to engage in healing.

Also, cultural intervention plays a vital role in health and healing. At the same time, pan-Aboriginal approaches and the sharing of Indigenous healing traditions across cultures are growing phenomena. Even ceremonies, which tend to be culturally and geographically specific, are being exchanged and shared. However, a danger exists in assuming that when healing programs work well in one context they can be successfully transported to an entirely different social, cultural, or political milieu. In fact, no single approach is applicable across all nations or communities.

While adaptations and sharing of Indigenous practices take place across cultures, an increased resistance to viewing Aboriginal people as having a homogeneous set of traditions and practices is evident. At a global level, efforts are required to maintain and support the cultural diversity that currently exists. At the community level, there is some evidence that culturally appropriate healing interventions are most effective when rooted in local practices, languages, and traditions. At the same time, urbanization and the cumulative effects of assimilation policies have left many Indigenous people alienated from their land and culture and, sometimes, their family. Specific strategies are needed to meet the needs of Indigenous people who do not have strong cultural ties.

Many healing programs incorporate, adapt, and blend traditional and Western approaches. Traditional ceremonies, medicines, and healing practices are being incorporated into the therapeutic process while Indigenous values and world views are providing the program framework. Some core values such as holism, balance, and connection to family and the environment are common to Aboriginal world views across cultures, while others are clearly rooted in local customs and traditions. The variety of therapeutic combinations in use suggests a powerful commitment to the values of adaptability, flexibility, and innovation in the service of healing. This is consistent with the holistic approach to healing common to Indigenous value systems. For Indigenous people, the concept of holism extends beyond the mental, physical, emotional, and spiritual aspects of individual lives to encompass relationships with families, communities, and the physical environment. Such approaches challenge governments that compartmentalize funding through departments (health, education, housing, and so on), but they are natural to Indigenous service providers. A holistic approach also challenges many Western medical practitioners who separate physical and mental health and do not deal with the spiritual dimension. Culturally sensitive screening and assessment tools that complement holistic and relational world views are required.

The existence of treaties recognized and respected by government and incorporated into government policy provide an environment conducive to the development of healing programs designed, delivered, and controlled by Aboriginal people. This is evident in New Zealand where the *Treaty of Waitangi* is referenced in government policy. From the Australian experience, failure on the part of governments to formally recognize and affirm Indigenous rights and to accept responsibility for past policies aimed at assimilating Indigenous people is an impediment to healing, both symbolically and with respect to the development of policies and programs that support individual and community healing. In the United States, policy fluctuations in the 1930s and 1970s resulted in periods where more progressive attitudes prevailed toward Aboriginal culture, including ceremonial and religious practices. Also, the emphasis

on extra-curricular activities in American schools allowed team sports and Native American art, music, drama, and dance to flourish.

While the Canadian and Australian governments made arrangements with churches to run their institutions, most of the American schools were administered by the Bureau of Indian Affairs. Reports of sexual abuse certainly exist, although the issue is not raised by former students as persistently and pervasively as in Canada or in Australia. What remains unclear is whether sexual abuse was less common in schools administered by government rather than churches or if the issue has not yet fully entered the American discourse. Further research is required to clarify this issue and to explore a possible relationship between church involvement in boarding schools and sexual abuse.

The Western practice of documenting and evaluating therapeutic approaches and publishing the results of studies can complement traditional healing practices by providing an alternative means of knowledge transmission. This is especially effective when the researchers and authors are Indigenous people, as in the case with New Zealand; there is a growing number of Maori with professional qualifications. This is also an indication that Maori knowledge about health and healing is gaining respect in its own right. The involvement of local Indigenous researchers in research and evaluation may lead to greater accountability to the community with respect to protecting traditional knowledge and following rules governing how, when, and to whom it may be transmitted. Certain Western skills applied in a culturally appropriate way are especially effective if the Western-trained professional is an Aboriginal person. The central lesson learned is that there is immense value and efficacy to incorporate history and culture into holistic programs based on Indigenous values and world views.

Reclaiming Connections: Understanding Residential School Trauma among Aboriginal People

Deborah Chansonneuve

2005

This manual was created as a learning and reference tool for groups and organizations providing services to Aboriginal people. Its focus is trauma recovery for Survivors of residential school abuse as well as for their descendants who suffer from the intergenerational impacts. It provides a culture-based approach to trauma recovery in the context of residential school abuse for front line workers and can be used as an educational tool to raise awareness of Aboriginal culture and history in Canada.

Population estimates for the Americas prior to sustained European contact in 1500 were as high as 112.5 million people speaking an estimated 2,200 languages. In what is now Canada, the population is estimated to have been anywhere from 500,000 to over 2 million people using agriculture, pottery, and complex social and economic systems. There were many hundreds of diverse nations, tribes, languages, and dialects within six major cultural regions: the Woodland First Nations in the east, the Iroquois First Nations of southeastern Ontario and Quebec, the Plains First Nations of the prairies, the Plateau First Nations, the Pacific Coast First Nations, and the First Nations of the Mackenzie and the Yukon River basins. The economic base was primarily fishing, hunting, and agriculture for which was traded among the many Indigenous nations, including the Inuit. The first Europeans who came to the Americas traded among the many tribes and even adopted agricultural practices and medicine preparation. Although racial “mixing” began from the time of first contact with Europeans, a distinct Métis identity did not emerge until early in the eighteenth century when the fur trade was well established.

The European notion of discipline for children was virtually non-existent in Indigenous cultures. Children learned proper behaviour by modelling adults or experiencing the consequences of their misbehaviour. The steadfast refusal of parents to *spare the rod or spoil the child* later became one excuse for the Church to remove children from their families and communities in order to *civilize them*. Residential schools were established in all provinces and territories, except for Prince Edward Island and New Brunswick, as a means of assimilating “Indian” children into Canadian society. For over a century, under the authority of Indian agents and enforced by the Royal Canadian Mounted Police (RCMP), Aboriginal children were taken from their families and incarcerated in residential schools. There was no recourse for the parents, families, or communities in this process. In residential and day schools, Inuit, Métis, and First Nation children were instructed in a foreign language and punished for using their own languages and customs. Unfamiliar foods, clothing, and forms of worship were forced upon them in settings that were, at best, cold, institutional, and comfortless and, at worst, unremittingly cruel and inhumane.

Many generations of Inuit, Métis, and First Nation children spent the greater part of their childhood in residential schools. The abuse and neglect they suffered while there left its mark on their adult lives as well as the lives of their descendants whose families have been characterized by further abuse and neglect. As adults, many Survivors of residential school abuse found themselves struggling alone with the pain, rage, and grief of unresolved trauma. Those who sought escape through marriage or domestic partnerships were often overwhelmed by the complex demands of intimacy, parenting, and family life without previous

experience of it or preparation for its demands. Some were also re-victimized by domestic violence or became, themselves, the abusers of their partners, children, or parents.

Aboriginal people are overrepresented in all risk-groups associated with preventable social and economic problems, such as homelessness, poverty, addictions, violence, chronic illness, and diseases that include tuberculosis, HIV/AIDS, and diabetes. Yet, providers offering prevention and intervention programs fail to draw Aboriginal people to their services. One reason is the paternalistic and prejudicial attitudes that continue to exist toward Aboriginal people in mainstream society. This is directly related to a lack of knowledge about Aboriginal culture and history and underscores the urgent need for culture-based training and educational resources. This has created a service system that has become badly fragmented and over-specialized. An uncoordinated service system leaves many Aboriginal clients feeling re-traumatized by numerous disclosures required for multiple intake and assessment procedures without finding the respect, compassion, and practical support so urgently needed. Although the range of services run by and for Aboriginal people is expanding, they often lack the resource capacity to fully meet the level of need.

The Canadian educational system too often neglects the important contributions of Aboriginal people to society as we know it today, and it is a shared understanding of the lives, strengths, customs, and beliefs of Indigenous people prior to European contact that is crucial in order to fully grasp the scope of the impacts of assimilation strategies such as residential schooling. A greater understanding of pre-contact history may prevent Aboriginal people from being defined solely as victims of colonizers, which comprise only a small part of their overall histories. It was Canadian government policies that first led to Indian residential schooling and then to the so-called 60s Scoop where thousands of Inuit, Métis, and First Nation children were forced into foster care and adoption. This system was responsible for abuses to children and their families that, in many cases, were much worse than the initial living conditions from which authorities decided the children needed protection.

Trauma can be a one-time event or a series of ongoing experiences over the lifespan of an individual as well as across generations. Knowledge of contemporary theories about post-traumatic stress disorder in the context of ethno-genocide and historical trauma can help bring a shared focus to the work with Aboriginal trauma Survivors in the context of residential school abuse. An Aboriginal approach to maintaining healthy, balanced people and organizations in the course of trauma recovery work is most appropriate. Work with trauma survivors has a profound influence on the physical, emotional, mental, and spiritual health of front line workers and helpers. Because Aboriginal front line workers are often personally impacted by the trauma of residential school abuse and its intergenerational impacts, self-care is a crucial component of effective service delivery. Three areas requiring special attention in terms of impacts of this work relate to counter-transference, burnout, and vicarious or secondary trauma. Aboriginal counsellors and front line workers should have a basic understanding of these impacts, so that effective strategies for self-care can be incorporated into their work.

Although colonization interrupted the passing along of traditional teachings and practices, Indigenous people worldwide are now making significant strides toward reclaiming and revitalizing them. Non-Aboriginal counsellors and therapists must be open to seek guidance from respected Aboriginal Elders and traditional people and to refer Aboriginal clients to culturally based services as needed.

Aboriginal Healing Foundation Final Report

Marlene Brant Castellano (*Volume I: A Healing Journey: Reclaiming Wellness*)
Kishk Anaquot Health Research (*Volume II: Measuring Progress: Program Evaluation*)
Linda Archibald (*Volume III: Promising Healing Practices in Aboriginal Communities*)

2006

Between the 1800s and 1990s, over 130 government-funded church-run industrial schools, boarding schools, and northern hostels operated in Canada for Aboriginal children. Many First Nations, Métis, and Inuit children attending residential schools suffered physical, sexual, and other abuses. They experienced a loss of childhood, family, community, language, and culture. The impacts of residential schools have been felt in every segment of Aboriginal societies. Communities suffered social, economic, and political disintegration. Languages were attacked and continue to be threatened. Families were wrenched apart. The lives of individual students were devastated. Many of those who went through the schools were denied any opportunity to develop parenting skills and lost the ability to pass these skills on to their own children. They struggled with the destruction of their identities as Aboriginal people, the loss of personal liberty and privacy and memories of abuse, trauma, poverty, and neglect.

In 1996, the final report of the Royal Commission on Aboriginal Peoples stressed the urgency of addressing the impacts of residential schools. On 7 January 1998, then Minister of Indian Affairs and Northern Development Honourable Jane Stewart issued a *Statement of Reconciliation* and unveiled the government's response to the RCAP report, *Gathering Strength-Canada's Aboriginal Action Plan*. The response included a one-time grant of \$350 million for community-based healing of the physical and sexual abuses that occurred in residential schools. On 31 March 1998, the Aboriginal Healing Foundation (AHF) was established as an Aboriginal-managed, not-for-profit corporation and was given a \$350 million healing fund and an 11-year mandate to support community-based healing initiatives. These initiatives must address the legacy of physical and sexual abuse suffered in Canada's Indian residential school system, including intergenerational impacts, and to promote reconciliation between Aboriginal people and Canadians. A further commitment of \$40 million was budgeted in 2005 to enable the AHF to support healing projects for an additional two years and to continue promoting public awareness and understanding of healing issues.

The AHF funds healing projects across Canada for Inuit, Métis, and First Nations individuals and groups, on- and off-reserve, whether located in urban, rural, or remote communities. The types of projects funded by the AHF ranged from healing services, community services and life skills support, prevention and awareness education, and traditional activities to training and gatherings of Survivors. Through the course of researching and evaluating the impact of its projects in communities, the AHF found that approximately 86,000 Survivors were alive, with 80 per cent First Nations, 9 per cent Métis, 5 per cent Inuit, and 6 per cent non-status First Nations. It was then estimated through extrapolation that there were 204,564 participants in AHF-funded healing projects and 49,095 participants in AHF-funded training projects, with only 33 per cent who had engaged in prior healing activity. Within the total number of participants, there were 37 per cent of individuals having special needs, that is, severe trauma including alcohol abuse, suicidal behaviour, and so on.

Evaluation found that 36 months is a minimum time to move through needs identification, outreach, and initiation of therapeutic healing, and it should be noted that there were less than one-third of all projects receiving AHF funding for 36 months or longer. When looking at the estimated number of participants, it was found that 56 per cent of AHF-funded projects could not meet healing needs and 36 per cent maintained a waiting list. In conclusion it was estimated that it would require \$140,855,595 to address project needs, including associated costs.

At a macro level, intergenerational impacts that undermined Aboriginal languages, cultures, spirituality, traditions, and belief systems; loss of family and community members through war and disease; loss of political autonomy, land, and resources; loss of children to residential schools; and widespread physical and sexual abuse of children in residential schools can all be seen as root causes of the dismal social, economic, and health status of Aboriginal people. Healing is a long-term process and occurs in stages. Impact of AHF-funded activities in the communities such as level of understanding and awareness of the Legacy, level of team capacity, and number of participants in healing showed that 20 per cent of communities are just beginning their healing, about 66 per cent of communities accomplished a few goals, and 14 per cent of communities accomplished many goals, but much work remains. The conditions that influence both the need for healing and the success of the healing process include: individual experiences, strengths, resources, motivation, and relationships within the family; community-level social, political, and economic conditions; community culture, traditions, language, history, resources, and governance; the degree of leadership support for healing; and community capacity and access to skilled healers and therapists.

Fifty-seven per cent of participants told AHF that their goals changed over the course of attending AHF-funded activities. Four most commonly cited changes were improved self-awareness, relationships with others, knowledge, and cultural reclamation. The majority felt better about themselves because they found strength, improved their self-esteem, and were able to work through their trauma.

It would take an average of 10 years for a community to reach out, dismantle denial, create safety, and engage participants in therapeutic healing. The progress and duration of healing is affected by the level of community awareness, the readiness to heal in individuals, the availability of organizational infrastructure, and the access to skilled personnel. Responses to surveys indicate healing goals are achieved best through services by Aboriginal practitioners and longer involvement in counselling and therapeutic activities. AHF-funded projects play a pivotal role in partnering with community and service agencies, identifying and filling gaps in services, and engaging Survivors and those intergenerationally impacted by the legacy of residential schools.

Healing needs are conditioned by the history of trauma and dislocation experienced over generations in multiple dimensions of Aboriginal peoples' lives. Trauma is thus a collective as well as an individual legacy. Promising healing practices acknowledge the collective and historical context of needs and develop approaches that incorporate three necessary elements: Aboriginal values and world view; personal and cultural safety; and the capacity to heal that resides in Aboriginal persons and communities. Key methods in promising healing practices include reclaiming history, cultural interventions, and therapeutic healing that draws creatively on traditional healing methods and Western therapies. Individuals proceed along their healing path aided or constrained by their individual strengths and vulnerabilities. The community environment plays an influential role in helping or hindering progress. Aboriginal healers, helpers, and

counsellors have always practised holistic healing, but the intensity and pervasiveness of healing needs deriving from historic trauma and residential school abuse have overwhelmed informal helping networks. Programs introduced from outside agencies are fragmented and most often have narrow mandates that frustrate efforts to implement holistic healing. The most striking example of this is the exclusion of cultural activities from health and healing program funding, with few exceptions. Research on promising healing practices points to evidence that cultural activities are legitimate and successful healing interventions.

There is evidence that supports the case for the funding of culture-based, community-led initiatives to heal the legacy of collective and individual trauma that, to varying degrees, cripples the capacity and undermines the resiliency of Aboriginal individuals, families, communities, and nations. Residential school experience is a major component of the Legacy, but it is only one of the multiple, repeated assaults on cultural continuity and individual identity that have created the need for healing. The case has also been made that healing facilitated by Aboriginal people, including residential school Survivors, is most effective in restoring meaning, connections, and resourcefulness in individual lives that have been damaged by abuse. The risks involved in fundamental personal change make it essential that healing support be sustained over time so that individuals who embark on healing have access to sensitive and skilled therapists who can model and guide healthy identity development.

Métis History and Experience and Residential Schools in Canada

Larry N. Chartrand

Tricia E. Logan

Judy D. Daniels

2006

Métis education was not formal until the Catholic Church began to instruct Métis children in the Red River area by the 1800s. Prior to this time, formal education was rare and, when it did occur, Métis children were sent to Canada or Europe for their education by their European fathers. Education was largely controlled by the Catholic Church, which dictated curriculum based on European values and beliefs. It was not until the 1960s that Métis communities began to demand their educational experiences be more relevant and meaningful to Métis culture and lifestyle and future aspirations.

There is evidence that Métis attended residential schools in considerable numbers. Available statistics indicate at least nine per cent of those who attended residential schools identified as Métis. In the early period, Métis were often accepted into residential schools by church authorities for various reasons and with little resistance from government authorities. As long as they were seen as culturally Indian, it made sense that they should attend residential schools to assimilate them into mainstream society.

Both students and staff considered the Métis as outsiders during their years at the schools. They were considered to be in a different class than everyone else and they were treated as such. There was a lack of consistency in the attendance policies that would surround the Métis, and, in turn, there was no consistency in how they were treated at the schools. Perceptions of racial characteristics, poverty, religion, social rank, and culture could all be used to influence the quality of education that a Métis student could receive. A Métis child was judged by the colour of his or her skin, the community he or she originated from, his or her blood relations, and health condition when he or she arrived at school. In the eyes of staff and administrators, a Métis child in one instance could be seen as better off than an Indian child and in the next could be seen as worse off.

As the federal government began to develop its official policy concerning the rights of Métis, official tolerance of Métis attendance at residential schools dissolved. Since Métis rights were extinguished and Métis were not legally considered Indians, they were therefore not the responsibility of the federal government that funded residential schools and were not allowed to attend. There were, of course, exceptions even after the government's policy of not accepting Métis. Some churches, without federal funding, set up schools for the Métis, such as St. Paul's in Saskatchewan. Still, other churches included Métis in existing Indian residential schools where room permitted or by ignoring official policy altogether. Nonetheless, by the 1930s, most Métis were excluded from formal education because of federal government policy. Also, they were often not included in provincial-operated schools due to social, racist, and economic reasons until well after formal education in the provinces became freely available to all residents without cost or discrimination.

The impact of residential schools on Métis children who did attend was similar to the experiences of Indians who attended such schools. In some cases, those Métis who attended residential schools would

sometimes be treated as second class since the Church did not receive any funding for Métis students. In many cases, stories of Métis indicate their treatment was neither better nor worse than that of their First Nation classmates, but that they did have unique experiences. There are distinct aspects to the admittance, discharge, treatment, and location of the residential schools that would have Métis children in their charge.

All of the personal accounts and histories of course are not stories that ended with the closing of these schools. The intergenerational impacts of these schools affect all generations of Métis today. Credit is due to the generation of people who stepped forward and had the courage to tell their stories about their experiences as a Métis Survivor. Each report opens new doors to this collective history and explores different aspects of the Métis Nation and how it has dealt with the residential school legacy. Carving out a unique niche in the legacy of the residential school system will help the future generations of Métis who may still want to know.

Addictive Behaviours Among Aboriginal People in Canada

Deborah Chansonneuve

2007

Addictive behaviours are a way of coping with emotional pain. Residential schooling brutally severed generations of Aboriginal children's attachments to family and community, placing them in sterile institutions among strangers. Children who expressed their fears and anxieties about this separation were at worst punished and at best ignored. The psychological and social effects of forcibly removing Aboriginal children from their families have passed from generation to generation. Survivors and their descendants report difficulties forming trusting attachments with their family and others, which have contributed enormously to the level of addictive behaviours in the Aboriginal population. Many Survivors of residential school abuse became caught in alcohol and drug addictions or compulsive behaviours in eating, sex, or gambling to numb painful memories or regain feelings of power and control in order to cope with trauma. Two coping mechanisms relevant to addictive behaviours are *dissociation* and *re-enactment*. No other population group in Canada's history has endured such a deliberate, comprehensive, and prolonged assault on their human rights as that of Aboriginal people. Yet, despite growing recognition of past wrongs, many Canadians remain unaware of the full scope of these injustices or their impacts.

The origins of alcohol abuse can be found in early Canadian history with the introduction of liquor by European fur traders in the early seventeenth century. Prior to this, drunkenness and violence were virtually unknown to Aboriginal people. As well as introducing alcohol, trading practices had a dramatic impact on traditional diet; healthy, natural foods readily available through hunting, gathering, and agriculture were gradually replaced with convenience foods.

Federal policies such as the 1869 *Act for the gradual enfranchisement of Indians*, the 1867 *Indian Act*, and the creation of residential schools were deliberate attempts by the Government of Canada to wipe out all traces of Aboriginal cultures including languages, beliefs, customs, and spiritual traditions. The actions carried out under these policies continue to profoundly affect all Inuit, Métis, and First Nation people.

Alcohol and drug abuse are deemed the most frequent or constant problem in Aboriginal communities. Death due to alcohol is two times greater than the rate for the general population, and death due to illicit drugs is approximately three times greater than the rate for the general population. One in five Aboriginal youth reported having used solvents; of these, one in three were under the age of 15 and over half started using solvents before age 11. Alcohol is the primary addiction or substance abuse problem for clients in NNADAP treatment centres. Other drugs such as narcotics and hallucinogens were also identified. Inuit identify alcohol and drug abuse, family violence and abuse, and suicidal behaviour as their most prevalent mental health problems.

Injury and poisoning is the leading cause of death for children through adulthood (accounting for 40% of deaths among males). Suicide and self-injury accounted for 38 per cent of deaths among youth and 23 per cent among adults aged 20 to 44. Studies reveal that the rate of injury and poisoning for First Nations is four times greater than for the general population and suggest that high rates of hospitalization and deaths due to injury and poisoning are linked to alcohol and other drugs. Aboriginal youth are two to six

times at greater risk for alcohol-related problems than their non-Aboriginal counterparts and are more likely at a much younger age to use all types of illicit drugs, tobacco, solvents, alcohol, and cannabis than non-Aboriginal youth. The prevalence of prescription drug abuse accounts for 48 per cent of Aboriginal people using addiction treatment services; of these, 74 per cent use benzodiazepines and over 60 per cent are poly-prescription drug users.

The rate of smoking among First Nation individuals is 62 per cent, almost three times the national rate of about 23 per cent. Inuit have the highest rate at 72 per cent. Sixty per cent of both begin smoking before the age of 16. Although smoking has generally decreased over the past two decades, tobacco-related death and illness rates remain very high, especially among Aboriginal people. First Nation populations on reserves have a 40 per cent higher rate of stroke and a 60 per cent higher rate of heart disease than the general population of Canada. One of the major causes of death—lung cancer—is prevalent among Inuit women who have the highest rate in the world. The problem of gambling is far higher among First Nations and Inuit than the general population. Sexual addiction affects both men and women, heterosexual and homosexual, and it appears to be common among those people who also suffer from other addictive disorders such as drug abuse. Many addictions specialists and front line workers involved with Aboriginal communities believe that the disproportionately high rates of relationship and family conflict arise from the same type of dependencies that characterize addictive behavioural patterns.

Increasingly, evidence shows the most effective addictions prevention and intervention programs for Aboriginal people is grounded in the wisdom of traditional Inuit, Métis, and First Nation teachings about a holistic approach to a healthy life. Aboriginal belief systems have much to teach about a broader approach to recovery because they emphasize all aspects of well-being are equally important and interconnected, including the physical, emotional, mental, and spiritual; balanced well-being is throughout the lifespan; and individual health is an aspect of the health of families, communities, nations, and the environment. An Aboriginal approach begins with the premise that each of these three areas must be addressed in order to sustain improvements over the long term.

The long-term success rate for addictions recovery, regardless of the population group, has not been encouraging. Because of its alternative, holistic health-promoting world view, an Aboriginal approach shows real promise, not only for Aboriginal programs, but for prevention and recovery programs anywhere. Restoring balanced, holistic health in the Aboriginal population requires significant improvements to the social and economic conditions impacting on their health.

Suicide among Aboriginal People in Canada

Laurence J. Kirmayer
Gregory M. Brass
Tara Holton
Ken Paul
Cori Simpson
Caroline Tait

2007

Suicide is a deeply troubling event that challenges our assumptions about the meaning and value of life and leaves a wake of pain and perplexity among the families and friends of those who end their lives. Although suicide is just one indicator of individual and collective suffering, it demands special attention because of its severity and finality.

Aboriginal people in Canada suffer from much higher rates of suicide than the general population. The overall Canadian rate has declined, while in some Aboriginal communities and populations, rates have continued to rise for the last two decades. The overall suicide rate among First Nation communities is about twice that of the total Canadian population; the rate among Inuit is still higher—6 to 11 times higher than the general population. For Aboriginal people, suicide is an affliction of the young. From the ages of 10 to 29, Aboriginal youth on reserves are 5 to 6 times more likely to die of suicide than their peers in the general population. Over a third of all deaths among Aboriginal youth are attributable to suicide, and males are more likely to die by suicide, while females make attempts more often. Despite widespread concern about these alarming statistics, there continues to be a lack of information on Aboriginal suicide, its origins, and effective interventions.

Suicide is a behaviour or action, not a distinct psychiatric disorder, and results from the interaction of many different personal, historical, and contextual factors. Suicide may be associated with a wide range of personal and social problems and have many different contributing causes arising from a complex web of interacting personal and social circumstances. There are risk factors that increase the likelihood of suicidal behaviour and protective factors that reduce it, which include: the physical and social environments; individual constitution, temperament, or developmental experiences; interpersonal relationships; alcohol and substance abuse; suicidal ideation and previous suicide attempts; and co-existing psychiatric disorders. The individual factors that affect suicide in Aboriginal people are no different than those found in other populations and communities, but the prevalence and interrelationships among these factors differ for Aboriginal communities due to their history of colonization and subsequent interactions with the social and political institutions of Canadian society.

Suicide is just one indicator of distress in communities. For every suicide there may be many more people suffering from depression, anxiety, and other feelings of entrapment, powerlessness, and despair. Every suicide has a wide impact affecting many people—family, loved ones, and peers who find echoes of their own predicament and who sometimes may be prompted to consider suicide themselves in response to the event. The circle of loss, grief, and mourning after suicide spreads outward. In small Aboriginal

communities where many people are related and where many people face similar histories of personal and collective adversity, the impact of suicide may be especially widespread and severe.

Risk factors for suicide among Aboriginal youth are similar to those for suicide in the general population of young people. These factors include depression, hopelessness, low self-esteem or negative self-concept, substance use (especially alcohol), suicide of a family member or a friend, history of physical or sexual abuse, family violence, unsupportive and neglectful parents, poor peer relationships or social isolation, and poor performance in school. Two overlapping patterns of vulnerability to suicide can be identified in the existing literature: severe depression is a key contributor to many suicides and life crises, substance abuse, and personality traits of aggressive impulsivity may play an important role in many suicides, especially among youth. Protective factors that contribute to individual resilience include family harmony and cohesion, involvement in family activities, good communication and feeling understood by one's family, good peer relations, and school success.

This information allows for the identification of youth in the community who may be at greater risk for suicide. Providing mental health services, mobilizing social support, and increasing community involvement for these youth and their families should reduce their risk of suicide. Early interventions with families and communities to support the healthy development of infants and children may reduce the prevalence of personality disorders and other mental health problems, which are more difficult to address in adolescents or adults.

Although much of the literature on suicide in the general population is relevant to the experience of Aboriginal people, there are specific cultural, historical, and political considerations that contribute to the high prevalence and that require the rethinking of conventional models and assumptions. Understanding of the role of larger social factors is therefore crucial to identifying the most important contributors to suicide for any specific Aboriginal population, community, or individual. Acculturation stress and marginalization has been repeatedly described as a risk factor for Aboriginal adolescent suicide. Cultural marginalization and associated problems in identity formation may render Aboriginal youth vulnerable to suicide, even in the absence of clinical depression. These processes of marginalization and acculturation stress do not simply reflect individual differences in adaptation, but are largely determined by social and political forces beyond the individual.

The impact of the residential school system and other systematic practices of cultural suppression and forced assimilation can be seen at the levels of individual experience, family systems, communities, and whole nations or peoples. Each of these levels has its own pathways that can transmit negative effects across the generations, and these can also contribute to resilience, revitalization, and renewal. The historical roots of current problems must be recognized and addressed to develop effective interventions that can transform intra-familial and intergenerational cycles of suffering. There is evidence of benefits from programs or interventions that restrict access to the means of suicide; provide school-based education to teach coping skills; how to recognize and identify individuals at risk; and how to refer them to counselling or mental health services; train youth as peer counsellors or natural helpers; train other individuals with whom youth come into regular contact (teachers, nurses, primary care providers, clergy, parents) to recognize and refer youth at risk, mobilize the community to develop suicide prevention programs, a crisis intervention team, family support, and activities that bring together youth and Elders to transmit cultural knowledge and values; and ensure that mass media portray suicide and other community problems in appropriate ways.

For individuals already identified to be at risk for suicide or suffering from other mental health problems, it is crucial to ensure that they have access to adequate mental health services. Depending on the severity of the problem, this includes psychiatry, psychology, counselling, peer support, and Indigenous forms of help and healing. Families and friends bereaved by a suicide should also have counselling and other forms of support available. The fact that youth in Aboriginal communities are most obviously affected by suicide tends to keep the focus primarily on youth. Any intervention that reduces suffering and improves the well-being of friends, parents, and families of youth will benefit youth as well as contribute to suicide prevention.

Given the limited state of knowledge about what works in suicide prevention, research must continue to play an important role. In fact, participatory action research may contribute directly to suicide prevention by strengthening communities. To achieve these beneficial effects, research must be conducted collaboratively with communities to ensure relevance and responsiveness to local needs and perceptions.

Lump Sum Compensation Payments Research Project: The Circle Rechecks Itself

Madeleine Dion Stout

Rick Harp

2007

Between 1831 and 1998, at least 130 industrial, boarding, and residential schools, including hostels, operated in all territories and in all but three provinces (New Brunswick, Prince Edward Island, and Newfoundland). In 1991, it was estimated that approximately 105,000 to 107,000 Aboriginal people were alive who had attended residential school. Today, that number is about 86,000. Recent extrapolated figures indicate that approximately 287,350 Aboriginal people have experienced intergenerational impacts. This means there are, at minimum, 373,350 individuals whose lives have been intimately touched by residential schools.

Four different lump sum payment (LSP) options have been offered to Survivors to compensate them for the suffering they experienced at residential school. The first option secured LSPs through civil and criminal lawsuits initiated by Survivors against the Canadian government and the churches. This process began in the 1990s and was criticized by some Survivors as exclusionary, time-intensive, financially and emotionally draining, and less than rewarding. The second option is the alternative dispute resolution (ADR) process and was intended as a less formal, less complicated, and faster alternative to the courts; however, it only dealt with physical and sexual abuse and imposed rigid compensation guidelines for different types of abuses. Similar to court cases, Survivors following the ADR route needed to prove their claims. The third option is the *Indian Residential Schools Settlement Agreement* and includes the common experience payment (CEP) process that offers a common financial package to all Survivors. Using a “10+3” formula, each Survivor alive as of 30 May 2005 would receive \$10,000 for the first year (or part of the first year) of attendance at a residential school and an additional \$3,000 for each subsequent year. The final option is the independent assessment process (IAP), also part of the *Settlement Agreement*, and is meant to replace the ADR process and promises to process any residential school abuse-related claim within a nine-month period.

Under the *Agreement in Principle* announced by the federal government on 20 November 2005, which was then finalized as the *Indian Residential Schools Settlement Agreement* on 8 May 2006, approximately 86,000 former residential school students stand to receive, on average, \$28,000 each in compensation through CEPs, which includes an advance payment of \$8,000. This wave of payments would represent a massive and sudden influx of money into Aboriginal communities across Canada.

In anticipation of imminent LSPs, the Aboriginal Healing Foundation initiated the *Lump Sum Compensation Payments Research Project*. This project offers an impact assessment of past compensation payments on Survivors, their families, and communities as experienced by them. The project consisted of two phases: a first-phase literature review and a second-phase key informant survey. The first phase of the research project revealed that very little research was done about LSP impacts on individuals and not much work had been carried out about the positive and negative uses of such large sums of money. Both the literature review and the survey analysis underscored the urgency of developing a strategy for efficient, culturally appropriate, and accessible supports for LSP recipients. The second phase involved

117 field interviews of recipients and non-recipients of LSPs, which were conducted across western and northwestern Canada. Of the total interviewed, 80 per cent were Survivors, of whom 36 per cent had received LSPs.

Feedback from recipients and non-recipients of LSPs identified a wide range of community impacts stemming from these payments. These impacts began during the application process, which was looked upon negatively by the majority of survey participants who complained of its excessive cost and duration. While a minority found the LSP process beneficial and positive, most saw it as financially inequitable and emotionally draining. However, once the monies arrived, many recipients turned their LSP into a positive financial opportunity to help out family, purchase needed items, clear up debts, and invest. On the negative side, recipients noted that LSPs often led to troublesome increases in problems such as drug and alcohol abuse, pressure from family for money, and encroachment by financial predators. Receiving LSPs also triggered negative residential school memories for Survivors. Some non-recipients linked LSP readiness and general Survivor healthiness to shed light on Survivors' responses to LSPs. While some constructive impacts were recognized, most non-recipients viewed LSPs in a critical light, citing the increased vulnerability of Survivors in general, but particularly if they are elderly, female, ill, or living on the street.

A comprehensive intervention strategic framework for LSPs is proposed in this research project, and it begins with a discussion of the following cross-cutting issues: class, age, gender, religion, geographic location, culture, historic trauma, elder abuse, resources and funding, and research. Undergirding the framework are four strategic principles: the first principle—*Survivors' rights and autonomy are central*—requires that LSP initiatives always respect the ultimate right of Survivors to make their own decisions; the second principle—*Survivors are their own best resource*—urges communities to maintain Survivor involvement in all initiatives; the third principle—*the family has a rightful place at the table*—means that interventions should be ideally tailored to, and inclusive of, an LSP recipient's immediate family members; and the fourth principle—*the community is the natural catalyst*—reinforces the fact that when responses are genuinely developed by and for the community, they nurture and reinforce a sense of local ownership and responsibility over policy and programming. In the interests of inspiring and informing immediate-, medium-, and long-term action, this research project puts forth five strategic goals: reform healing, reframe health, reinforce safety and security, reverse crises, and realign capacity.

To reform healing, it will be important to elevate communal healing and to research and evaluate change over time. Healing reform will require keeping a close eye on the unique and pivotal role of the voluntary/non-governmental sector in Aboriginal communities to the possibilities of private sector involvement in healing initiatives and to exploring key concepts like citizen engagement, social capital, and social cohesion and relating these to home-grown concepts. Prioritizing impact assessments and evaluations will be key, as will training front-line workers on the early detection of risks and impacts of LSPs and collaborating with individuals who have expertise on effective interventions.

To reframe health is to promote holistic health and interventions and link health to wealth. Health disparities, mental health, addictions, and cultural competence have to be considered if health is to proceed holistically and across the spectrum of care. Elders' teachings about self-reliance, productivity, and usage of money have to be embedded into the meaning of culture for the long-term benefit of Survivors, families, and communities. Health can be viewed as an economic resource that can be pressed against

the residential school legacy that has compromised the socio-economic status of Survivors, families, and communities. Therefore, there is a need to mobilize financial and monetary support services through training, along with the provision and promotion of economic and education opportunities, to leveraging the Survivors' money for their own benefit.

To reinforce safety and security is to mediate the risks for the most vulnerable and use the media to the best advantage. LSPs can escalate problems such as domestic violence, frauds and scams, and elder abuse and therefore increase the need for RCMP involvement. One of the important functions for communities is to safeguard the financial well-being of at-risk groups that include elders, women, youth, street people, and the infirm and to provide them with refuge from harm, if necessary, along with children and those who opt out of the *Settlement Agreement*. Elder abuse will have to be addressed on a priority basis as well as the development of disability and injury prevention and awareness initiatives. Public service advertising campaigns can help minimize the negative effects of LSPs, including scams and frauds, by promoting dialogue and hope through Aboriginal languages wherever possible. It will also be important to develop media messages to educate children and youth about the legacy of residential schools and LSPs.

To reverse crises is to focus on crisis management and understand the crushing burden of Survivors' decision making. Crisis response plans, protocols, and practices will need to be set up. Supportive mechanisms like talking circles and specialized treatment programs and centres will have to be made available to Survivors. In addition, Survivors will have to learn the fundamentals of negotiation skills, problem solving, and anger management.

To realign capacity is to build on existing alliances and work with relevant and ready community supports. By offering Survivors the means to act on their own priorities when human resources are at a real premium, LSPs offer them a true stake in delivering their own care supplemented by intercommunity networking and support. Families and youth are critical community supports in minimizing the negative effects of LSPs and in maximizing the benefits.

From Truth to Reconciliation: Transforming the Legacy of Residential Schools

Edited by:
Marlene Brant Castellano
Linda Archibald
Mike DeGagné

2008

Truth and reconciliation are new words in the vocabulary of Canadians speaking about our history and our future in this land. The standard history, which resonates especially with those of European ancestry, is a grand narrative of pioneers and waves of immigrants birthing a peaceable nation from a vast, untamed landscape. The Aboriginal peoples of Canada—First Nations, Inuit, and Métis—tell different stories of ancient origins preserved in legends, of migrations that spanned the continent, of trading networks, treaty making, and sporadic conflicts to establish boundaries between nations, and of prophecies that foretold how their lives would be changed by newcomers to their lands.

Different experiences generate different perspectives on truth. Parallel histories and the world views they support can live comfortably side by side until they intrude on one another and require negotiation of a common understanding. Tense relations and confrontations between original peoples and newcomers have periodically erupted over land since early contact and have led to the signing of historic documents seeking conciliation of differences. Among these are the *Royal Proclamation of 1763*, which is now imbedded in the *Constitution Act* of 1982, and numerous treaties of peace and friendship, which have been given modern force and effect by Supreme Court decisions. “The land question” continues to be the focus of challenge, litigation, and demonstrations across Canada.

Assertion of Aboriginal title is about occupancy of traditional territories and benefit from the resources that support life, but it also refutes the doctrine of *terra nullius*, the claim that North America on discovery by Europeans was empty land, open to occupation and cultivation by civilized peoples without regard to the people already there. Aboriginal peoples were seen to be in a state of nature, possessing neither government nor property. The philosophies that underlay colonization of lands and colonial authority over peoples rationalized the belief that the lands would be better used, that is, more productive, under a system of private property, and the native people would be better off brought into the circle of civilized conditions.

Aggressive civilization to accomplish colonial goals was thought to be futile in the case of adults. Residential schooling was the policy of choice to reshape the identity and consciousness of First Nations, Inuit, and Métis children. The persistence of colonial notions of superiority is evidenced in the fact that residential schooling, which punished the expression of Aboriginal languages, spirituality, and life ways and attempted to instill a Euro-Canadian identity in Aboriginal children, continued from 1831 into the 1970s.

The devastating effects of this program of social engineering were brought into public view in the hearings, research, and *Report of the Royal Commission on Aboriginal Peoples* (RCAP). Its recommendation in 1996 for a public inquiry to examine the origins, purposes, and effects of residential school policies, to identify

abuses, to recommend remedial measures, and to begin the process of healing has taken over a decade to come to realization. A start was made with the federal government's *Statement of Reconciliation* and the establishment of a fund to support community healing. In the interim, the tide of litigation alleging emotional and cultural as well as physical and sexual abuse swelled to include 13,000 residential school Survivors. Court processes and decisions were proving costly to Survivors, churches, and government; the human and financial costs foreseen if litigation were to run its course were insupportable. Several of the churches involved in operating the schools were put under duress financially as a result of compensation orders, but nevertheless made frank and full apologies. The Assembly of First Nations pursued diligent advocacy and mounted international research to bolster the argument that redress for Survivors as a whole, including compensation, was just and practicable.

The *Indian Residential Schools Settlement Agreement* is a court-ordered settlement endorsed by Survivors' legal representatives, churches, and the federal government in 2006 and implemented as of September 2007, which provided for a cash payment to Survivors living in 2005 or their estates if deceased. As well, the settlement provided for an individual assessment process for cases of more serious abuse, the creation of memorials, a five-year extension of funding for the Aboriginal Healing Foundation to support community healing initiatives, and the establishment of a Truth and Reconciliation Commission (TRC) with a five-year mandate consistent with many of the recommendations of RCAP.

The truth-seeking component of the TRC mandate acknowledges the wrong that was done in suppressing the history, culture, and identity of First Nations, Inuit, and Métis peoples through the enforced removal and re-socialization of their children. The healing that is envisaged through a public process of truth-telling touches families, communities, and nations as well as individuals. For Aboriginal peoples, the promise of the TRC is that their truths, as they relate to this tragic chapter of history, will now have a place in the official story of Canada that is accessible to successive generations of Canadians.

Reconciliation—restoring goodwill in relations that have been disrupted—is the second component of the Truth and Reconciliation Commission's mandate. In the course of its work over the past decade, the AHF has encountered many gifted individuals whose life and work have been dedicated to promoting justice and reconciliation in individual, community, and societal relationships in Canada and abroad. AHF invited a cross-section of such persons to consider and submit for publication what they would wish to convey to commissioners appointed to Canada's Truth and Reconciliation Commission. AHF Board members and Aboriginal youth were also offered to express their views on this issue. The collection is organized in four sections.

Section 1: Truth-Telling has a strong historical component. Fred Kelly brings together the perspectives of a boy in residential school trying to make sense of contradictory experiences, an adult political leader and participant in policy deliberations, and an Elder embracing his traditional spirituality and the possibility of reconciliation with those who inflicted harm on children and on peoples. Brian Rice and Anna Snyder elaborate on the history of the relationship between Aboriginal peoples and evolving Canadian society as they provide an overview of the role of truth and reconciliation commissions and the particular challenges of restoring relationship in a post-colonial settler society. Tricia Logan shares her learning as a young Métis person searching out evidence of Métis experience in prairie residential schools in the face of institutional indifference and inconsistent record-keeping. John Amagoalik writes passionately about Inuit efforts to speak their truths to a dominant society that persists in affirming a different reality and

argues that conciliation has to come before reconciliation. Stan McKay writes from the vantage point of a residential school Survivor and a church leader who has spent much of his life trying to build bridges between Aboriginal and non-Aboriginal societies.

Section 2: The Legacy Lives On reveals how injuries suffered in the past are replicated in contemporary circumstances. Beverley Jacobs and Andrea Williams report on the initiative of the Native Women's Association of Canada to bring attention to hundreds of missing and murdered Aboriginal women across Canada, highlighting the research in the Sisters in Spirit project that connects the victimization of Aboriginal women to policies that marginalized and undermined the role of women, making them vulnerable to exploitation and violence. Rupert Ross, a long-serving Assistant Crown Attorney in northwestern Ontario, paints a disturbing picture of the secrets surrounding student victims of abuse who became abusers, of family members traumatized by the lengthy removal of their children who do violence to returnees, and of the emergence in some communities of a generation of damaged children who have never been exposed to models of empathetic, pro-social family relationships and points with cautious optimism to the restorative impacts of community healing initiatives based on traditional values. Cindy Blackstock marshals evidence of the high rates at which First Nations children are being separated from their families, showing that the number of children currently in alternative care exceeds the number in residential schools at their peak and argues for reorientation of child welfare approaches, supported by adequate funding, to ensure that "saying sorry" will not have to be repeated in the next generation. In a moving reflection on resilience, Madeleine Dion Stout shares moments and images that nourished her spirit as a child in residential school and continue to work transformation in her as an adult and a grandmother.

Section 3: Exploring Paths to Reconciliation presents conceptual analyses and case examples of reconciliation initiatives. Jennifer Llewellyn draws on her experience with the South African Truth and Reconciliation Commission and United Nations consultative groups to set out principles of restorative justice and their application to bridging the gap between truth and reconciliation. Robert Joseph, a Maori professor, elaborates a similar concept of conciliatory justice and presents an insightful analysis of the many forms of denial that impede the acknowledgement of harms and mute the moral demands of reconciliation in democratic societies. Brad Morse provides a thought-provoking examination of the role of authentic apology in reconciling historical wrongs, citing Canada's approach to reparations involving Japanese, Chinese, and other segments of Canadian society and makes the case that apology may decrease rather than increase the risk of liability, contrary to conventional legal opinion. John Bond describes the popular reaction of Australian citizens to the report *Bringing Them Home*, which documented the removal of mixed heritage Aboriginal children from their families for placement in institutions and foster homes and argues that improvement of basic human services and closing the gap in life expectancy is a necessary follow-up to apology. Debra Hocking is one of the Stolen Generation in Australia who was cut off from her family and suffered abuse in foster care and went on to become a leader and spokesperson for human rights and Indigenous reconciliation, an honouree of the United Nations and her home state of Tasmania. She documents her struggle against bureaucracy to restore connection to her family and her identity and Elders who taught her compassion.

Section 4: Journey of the Spirit begins to chart a course of action, from personal reconciliation of a painful past to healing the alienation between Aboriginal people and Canadian society. Garnet Angeconeb, an Anishinaabe and one of the first Survivors who broke silence to disclose sexual abuse in residential

school, retraces his journey from early years, through separation, suppression of memory and feeling, disclosure, and finally to forgiveness. David Joanasie is an Inuk youth who reflects on his good fortune at having been reared with an appreciation for his culture and having fluency in his language and views financial payouts to have a limited effect in healing and reconciliation. Bill Mussell, Sto:lo educator and mental health advocate, reflects on how cultural grounding in a strong family serves to protect individuals from the impacts of destabilizing influences from the surrounding society and emphasizes that respect for Indigenous knowledge and ways of knowing fostered in elementary and secondary curricula is a necessary building block for reconciliation. David MacDonald is a long-term participant in dialogue within the United Church and with the Aboriginal community and puts forward a list of ideas for collaborative action to bring people together, break down stereotypes, and repair the breach that divides us. Maggie Hodgson, another Survivor, has been in the forefront of healing and cultural renewal for a quarter of a century. She cites the undermining and banning of ceremony as a principal cause of current demoralization and calls on her First Nation peers to reclaim their ceremonies and their responsibility for ethical choices. Finally, Marlene Brant Castellano, a member of the editorial team, draws on research of the AHF and the 2006 *Final Report* of the AHF to articulate a holistic approach to reconciliation through the use of graphics to draw parallels between processes of healing at individual and community levels and the stages of acknowledgement, redress, and healing that prepare us for reconciliation. She proposes that the transformation to a state of wholeness and *agency*, in the case of reconciliation, is made possible by asking and offering forgiveness in a climate of safety and an attitude of mutual trust.

Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice

Edited by:
James B. Waldram

2008

Five AHF-funded healing programs were chosen for case studies to develop models and metaphors of mental health and healing in Aboriginal communities. The goals are to provide a valuable tool for future program development, to develop our understanding of the meanings and processes of healing in Aboriginal communities, and to contribute to theoretical understandings of the process of healing and the development of appropriate research methodologies because they speak to the transferability of the findings. Despite the widespread adoption of healing discourse by Aboriginal people and others, what was actually meant by healing is not well-defined but variable and inherently flexible. It made sense to study how clients and therapists/healers understood this key concept and employed it to frame their experiences and to see if it meant something different across the various types of programs and regions represented in this study.

The five programs are located in rural, remote, and urban regions of Canada, from the west coast to the east coast, from urban centre to Subarctic and Arctic, in British Columbia, Nunavut, Saskatchewan, Manitoba, and New Brunswick. Some are residential treatment centres where clients undergo treatment on an in-patient basis, and others are outpatient facilities and even drop-in clinics. Some are located in community contexts allowing for some degree of uniformity in the cultural heritage of the client base, and in other instances, the treatment centre clients came from varied culturally different backgrounds. The two target groups for the research are individual clients engaged in the healing programs at the time of study and program staff (therapists, healers) involved in the delivery of treatment programs.

An important theme that emerges from the case studies is the cultural, age, and gender heterogeneity of the client or patient base that is served by these programs. Of particular note, the researchers found that relatively few research participants had personal experiences as residential school students; however, the legacy of the residential school system has left a deep impact on the social, cultural, and psychological make-up of these individuals. People continue to suffer from the far-reaching impact of the schools, be it within their own families and communities or intergenerationally, because of dysfunctional behaviours passed down from parents or grandparents who did attend. These programs are designed to combat this complex legacy.

One impact of the residential school and substitute care systems for Aboriginal people has been the lack of Aboriginal cultural experiences. These individuals are not culture-less, as many popular accounts of Aboriginal experience might suggest; rather, they simply have had little or no experience in an Aboriginal cultural milieu, especially during initial developmental stages. Effective treatment programs must be able to accommodate a wide variety of Aboriginal people: individuals from different cultural heritages; individuals who have no practical experience in Aboriginal cultural contexts as well as those who have; individuals who do not speak an Aboriginal language and those who do; individuals with no background in the spiritual traditions that underscore such treatment and those who do; and individuals who are avowedly Christian alongside those who practice Aboriginal spirituality and those who simply are

not spiritual. The fact that many of the projects are open to clients from different Aboriginal cultural traditions reinforces the idea that a simple, singular one-size-fits-all model makes little sense. There are nevertheless broad similarities in client profiles across the five programs. Most of the clients are dealing with issues of alcohol and substance abuse, interpersonal violence, homelessness, physical illness, criminality, and a concomitant disruption in meaningful social relations as a result of their behaviour; yet, each was found to be unique.

What clearly emerges from the case studies is the importance of flexibility and eclecticism in the development of treatment models. From the use of the Medicine Wheel to New Age and popular cultural therapeutic modalities, these programs were operating freely to meet the variable needs of their clients. These programs have borrowed liberally from biomedical and psychotherapeutic treatment paradigms and have integrated these with Aboriginal paradigms. Various forms of Aboriginal spirituality, as currently understood in their local contexts, are integral to all programs. For instance, while individual and group therapy are both common, so is the use of sweat lodges. Instruction may occur in the form of workshops, seminars, lectures, and also in more subtle ways through teachings of Elders in the sacred circle or the sweat lodge.

Interestingly, this eclecticism goes beyond simply the borrowing of epistemologies and techniques from non-Aboriginal therapeutic sources, as there were many instances in which a program also borrowed therapeutic or spiritual approaches from other Aboriginal groups. Hence, even a traditional treatment program may involve the incorporation of Aboriginal practices that, historically, were foreign to the area in which the program is found. This has interesting consequences for future understandings of traditionality. It underscores the inherently flexible and pragmatic ethos that governs these treatment programs: a 'whatever works' attitude in which treatment providers do not feel bound to narrowly defined or explicitly cultural or biopsychosocial treatment models. This attitude might be seen as an extension of what cultural ecologists have seen as a long-standing cultural openness characteristic of Aboriginal groups: a desire to borrow and integrate good ideas from others without excessive consternation about cultural contamination and traditionality.

This eclecticism is reflected in the experiences of a diverse treatment staff. While there is an undercurrent of affinity for Aboriginal staff, what mattered was the ability to be empathetic and competent, which was variably defined but suggestive of a demand for knowledgeable and experienced treatment staff. The model of treatment employed in many instances blurs the distinction between healer and patient, as the treatment staff are sometimes on their own healing journey and gain therapeutic benefit from their work with the clients. This means that non-Aboriginal treatment staff are playing an important role in these treatment programs because Aboriginality per se is only one criterion deemed important by clients. In all cases, however, there are always some Aboriginal staff and often a primarily Aboriginal board of directors. Under the right circumstances, a culturally and professionally varied treatment staff can be effective, with Elders working alongside university-trained psychologists and social workers.

There is no singular model of best practice for the psychotherapeutic treatment of Aboriginal people, but there are locally derived models that seem effective for the clients who are likely to be involved. The ideas of flexibility and eclecticism may be the extent of a best practice. There have been no attempts to quantify outcomes of therapeutic efficacy; rather, both practitioners and clients note subjective, behavioural, and attitudinal changes as evidence of positive outcomes. Since many view healing as a lifelong process, those

changes are often subtle, perceptible only to those close to the individual and likely invisible in a clinical assessment of therapeutic efficacy. The lack of an appropriate methodological approach to the question of efficacy of these kinds of programs should not be used as a reason to dismiss them; rather, these should be used as an impetus to design such a new approach. The current method for assessing these programs involves qualitative, case-by-case assessments. Staff often struggle on a daily basis to meet the needs of a large client base with limited funding. In the end, however, the question of whether these programs work well risks taking attention away from the therapeutic process in which clients and therapists are involved. They work well insofar as those involved continue to feel positive about the experience. This simple fact alone should suffice to inform that these programs are doing an important job.

The approaches used in these programs to be Aboriginal in orientation are conceptualized in terms of traditionality; that is, an understanding that these approaches stem from age-old traditions of healing and have been carried forward in time to now deal with very contemporary mental, physical, and social problems. The question of what constitutes a traditional practice is as complex as the question of efficacy, and a too intense search for concrete links with the past may detract from the more important fact that the very idea of traditionality, in the contemporary context, provides an emotional safe place for troubled individuals where they can link their troubles to a historic past. If the clients say that the Medicine Wheel is an age-old model of healing, its actual origin is irrelevant to its use in healing programs as a symbolic representation of a holistic way of life that is promoted as a positive Aboriginal legacy.

Within both public and professional discourse, the idea of healing has become pervasive. Therapists and clients thought about healing as a concept that was difficult to articulate, in part, because most seemed to feel that there is no need to articulate it and/or simply have never been asked to. Healing proved to be variable in meaning, often vague and fuzzy, and very idiosyncratic. Healing is an active, not passive, process: it is something you do, not something you think or that is done to you. In this sense, healing is work, is ongoing, and requires dedication. First and foremost, it requires commitment from the individual. No one can heal you or make you heal. Personal agency is stressed above all else.

The dominant metaphor in this research describes healing as a journey, which has a clear direction toward healing, yet it is a journey fraught with challenges. Falling off the path of healing is common, even expected by treatment staff. There is no shame to temporary setbacks nor are these seen as failures; rather, the individual is welcomed back to continue on his or her journey when he or she feels ready. No one is ever completely healed. No one speaks of being cured in the same way biomedicine uses this concept. Even those who have been on the healing path for many years and who have become therapists themselves must struggle to remain on the path.

Healing is ultimately about the reparation of damaged and disordered social relations. The individual, through outwardly and self-destructive behaviours, has become disconnected from family, friends, community, and even his or her heritage. The reason for undertaking healing is often found in the clients' desire to make amends and to be accepted back into the web of relationships. Healing, then, speaks to a form of Aboriginal sociality that reduces the degree of self-indulgence and self-pity and frames one's problems and the solutions in broader, collective terms. It does not deny historical processes or the legacy of the residential schools, which have created the conditions for social and psychological discontent. It helps individuals understand why they have problems in a manner that allows them to simultaneously see that, while victims of oppression, they retain the necessary agency to change their lives for the better.

The holistic program environment of the various programs encouraged an interaction between therapists and clients that was bidirectional: therapists were simultaneously patients learning from their clients as they continued on their own healing journey; and clients were simultaneously therapists offering their own troubled life experiences as a reflective tool for self-healing by the therapists. The beauty of this synergy is evident from each of the case studies, and this underscores how these healing programs differ in fundamental ways from many non-Aboriginal psychotherapeutic approaches that implicitly or explicitly enforce rigid distinctions between therapists and clients.

Response, Responsibility, and Renewal: Canada's Truth and Reconciliation Journey

Edited by:
Gregory Younging
Jonathan Dewar
Mike DeGagné

2009

Since the release of the Aboriginal Healing Foundation's (AHF) *From Truth to Reconciliation: Transforming the Legacy of Residential Schools* in 2008, numerous milestones have occurred. In February 2008, Canadians watched as Australian Prime Minister Kevin Rudd made a formal apology for past wrongs committed by successive Australian governments on its Indigenous population. He singled out the Stolen Generations of thousands of children forcibly removed from their families. Absent was any commitment to compensation. In Canada, meanwhile, compensation was being administered in the form of the common experience payment and information was circulating about the subsequent individual compensation component, the independent assessment process for physical and sexual abuse claims. The Indian Residential Schools Truth and Reconciliation Commission (TRC) was launched on 1 June 2008. A week and a half later, the Government of Canada made its official apology on 11 June 2008.

So, in the summer of 2008, the AHF decided to commission a second set of articles from Aboriginal and non-Aboriginal individuals in Canada and abroad to continue to promote the truth and reconciliation discourse, particularly on the many challenging issues being raised. However, unexpected developments occurred since this decision. On 20 October 2008, mere months after the TRC was launched and its leaders appointed with great fanfare, Justice Harry LaForme resigned as its chair, followed shortly thereafter by commissioners Jane Brewin Morley and Claudette Dumont-Smith. Subsequently, the TRC entered what may be called a holding pattern. Many noted that some Survivors have passed on from this world in the months since the launch of the TRC, the government apology that followed, and these announcements forcing communities to wait, yet again, for questions to be answered.

Several of the authors featured in this volume have been involved in their communities at the community level, sometimes promoting and sometimes challenging the work ahead of all parties to reconciliation. The commitment to identifying the issues, sharing ideas, making recommendations, meeting challenges, and challenging the status quo is evident here. As with the first volume, we see movement and momentum, possibilities and potential, but also challenges. This collection of articles is divided into three sections.

Section 1: History in Our Midst has a strong historical component with an emphasis on its place within our lives today. Jose Kusugak offers a vividly descriptive account of his and his brother's residential school experiences, of being taken and of returning home, and concludes with a thoughtful take on the good times and bad times. In the wake of the 2008 apology, Rene Dussault revisits the report of the Royal Commission on Aboriginal Peoples (RCAP) and the detailed 20-year strategy it proposed to restore the social, economic, and political health of Aboriginal peoples in redefining their relationship with the rest of Canada. Sophie Pierre tells the story of the St. Eugene Mission Resort and a community's determination to change the legacy of residential schools, at least one school in particular, into something positive that would benefit the community for generations to come. James Igloliorte tells the story of

Labrador Inuit and a different, less well-known apology, and he places their experiences within the larger reconciliation discourse. Susan Crean writes about the need to take ownership of our history to truly participate in reconciliation efforts. She highlights her friendship with Métis writer Howard Adams and her own Anglo-Canadian identity and connection to the Northwest Rebellion when her great-uncle went to fight against Louis Riel at Duck Lake. She does this to underscore the personal-within history. Rita Flamand writes about growing up Michif by recounting her day school experience, highlighting the important similarities and distinctions between the Métis experience with residential schools and church and government influences, and calls for a telling of true Métis history. From his position as a founding member of the Centre for Indian Scholars, Ian MacKenzie writes that the time to heal is now, and he promotes the interface of Christianity and First Nations traditional religions. Drew Hayden Taylor takes a humorous approach to the Prime Minister's apology, but asks us to consider some complex questions about apologies and forgiveness and where we all go from here. Mick Dodson offers an Aboriginal Australian perspective on that country's experience with apology, highlights the need to address unfinished business, and closes with a most recent development that may well be yet another fundamental step forward.

Section 2: Reconciliation, Restitution, Rhetoric resembles the volume's title with its three Rs, giving a sense of promise in recent words and deeds but with processes and problems to consider. Heather Igloliorte writes about the power that visual art has in terms of culture and language to speak across the generations and, in this context, gives Inuit art and artists an opportunity to tell their stories to a broad audience and to support the national reconciliation process. Richard Wagamese writes about his experience with the child welfare system and the intergenerational effects of residential schools and stresses the importance of personal reconciliation in dealing with resentment, hatred, and anger for which these truths the TRC will need to hear. Peter Harrison writes about the major challenge facing the TRC, which is coping with ignorance at its most basic levels by dispelling myths about both the history of the policies and the present landscape of settlement agreements and compensation. Scott Serson focuses on Canada's response to the RCAP report, *Gathering Strength—Canada's Aboriginal Action Plan*, highlighting its four objectives to renew partnerships, strengthen governance, develop a new fiscal relationship, and support strong communities, people, and economies. He asks the reader to first consider Canada's words and actions since 1998 and then to consider reconciliation and fiscal fairness. Taiaiake Alfred argues that past actions have done nothing to help Indigenous peoples regain their dignity and strength and calls for a restitution discourse to address the crime of colonialism. Waziyatawin, too, places residential schools within the larger colonial project and calls for bigger solutions. She offers practical steps for addressing crimes of land theft, genocide, ethnic cleansing, and colonization in the Dakota homeland of *Minnesota Makoce*. David Hollinsworth looks critically at Australia's apology and calls upon Australia to make genuine reparations and to ensure healing is available for all those damaged by past policies and practices. Roland Chrisjohn and Tanya Wasacase tackle the rhetoric of Canada's apology and of the TRC mandate, arguing that the TRC will not produce justice even if successful.

Section 3: Tomorrow's History opens with the remarks made by the Most Reverend Fred Hiltz, Primate of the Anglican Church of Canada, in Ottawa, Ontario, on 2 March 2008 during "Remembering the Children: An Aboriginal and Church Leaders' Tour to Prepare for Truth and Reconciliation," pledging to live the words of apology as churches have much to be sorry about. Valerie Galley argues that a commitment to reconciliation must include a commitment to revitalize and protect Aboriginal languages. Mari Tanaka presents her perspective as a new immigrant to Canada and writes of learning

about residential schools and the impact it had on her as she sought to develop her own identity as both Canadian and Japanese. Erin Wolski offers the Native Women's Association of Canada's culturally relevant gender-based analysis framework as a tool the TRC should consider and use as it seeks to serve the needs of Aboriginal women and to represent their unique experiences. Natalie A. Chambers reflects on her experiences as an immigrant woman living on-reserve and urges other settler peoples to engage in critical self-examination as a first step in the process of working through their roles as colonizers in the past so that all may imagine a better future for generations. John Ralston Saul writes of four barriers that stand in the way of reconciliation that the people of Canada collectively need to overcome if they wish it. Finally, Gregory Younging describes his own intergenerational experience with residential schools and his connection to this experience through his mother and her work as well as his own academic and activist work.

Residential Schools, Prisons, and HIV/AIDS among Aboriginal People in Canada: Exploring the Connections

J. Kevin Barlow
Canadian Aboriginal AIDS Network

2009

Residential schools were more than just a place of loneliness for many Aboriginal children who were separated from their parents and community. Attendance at these schools resulted in negative change, seen by many Survivors and Aboriginal communities, as several generations have suffered negative impacts and cumulative losses from the institutional abuse that occurred there. The most devastating types of abuse known are physical and sexual abuse. With the added impact of cultural and language losses, it is easy to understand how so many individuals were so gravely wounded. Multiple losses, poor socio-economic status, and substance abuse are all factors that have slowed the healing process for many Aboriginal people.

While many Aboriginal communities are climbing out of dark pasts, what remains are significant challenges to retain culture, language, and traditional strengths while seeking to be adaptive to a new era. Also, new health issues such as HIV/AIDS, hepatitis C, or injection drug use are increasingly coming into play, especially with those in prison where the most disturbing infection rates are found. Prisons, like residential schools, are complete institutions and far too many Aboriginal people are still spending portions of their lives in institutions where they have little control and are forbidden to leave.

At least one study has shown that it is both plausible and possible that the legacy of residential schools has played a role in the spread of HIV/AIDS among certain segments of the Aboriginal population, perhaps more indirectly than directly. Physical and sexual abuse are common to both male and female injection drug users. Many injection drug users come from troubled homes and childhoods where physical, sexual, mental, and emotional abuse were common factors, which confirms a relationship between troubled childhoods and homes and subsequent self-destructive patterns in adulthood. This self-destructive pattern of injection drug use then leads to high risks for HIV. Unprotected sex, whether heterosexual or homosexual, and, more so, injection drug use account for a large number of HIV/AIDS infections.

Aboriginal people account for only a small percentage of the total Canadian population, yet they account for about one-fifth of the total prison population, both federally and provincially. A small percentage of all persons in correctional services are known to be HIV positive and one-quarter of the federal inmates are diagnosed hepatitis C positive. While the prevalence rates of HIV, hepatitis C, and co-infection are much higher in prisons than in the general public, the rates are believed to be high among the Aboriginal inmates. Also, these infections are more pervasive in Canadian prisons as well as in Aboriginal populations, both inside and outside the confines of the Canadian correctional system.

More information is required on the real extent of the problem of HIV/AIDS, hepatitis C, and co-infection among Aboriginal people. The work to be done should be consistent, practical, and innovative in order to address the care and treatment needs of all Aboriginal people living with HIV/AIDS and/or hepatitis C and to prevent further transmission.

**The *Indian Residential Schools Settlement Agreement's*
Common Experience Payment and Healing:
A Qualitative Study Exploring Impacts on Recipients**

Gwen Reimer
Amy Bombay
Lena Ellsworth
Sara Fryer
Tricia Logan

2010

This study reports on how Survivors have been impacted by the common experience payment (CEP), a component of the 2007 *Indian Residential Schools Settlement Agreement*. This is a qualitative research study with two main objectives: 1) to gather experiential data and to elicit CEP recipients' explanations about the impact of the CEP on Survivors and their engagement in healing; and, 2) to gather insights regarding the roles of support services in assisting them during the compensation process. The findings reported here are derived mainly from interviews with 281 First Nations, Inuit, and Métis Survivors from across Canada, who applied for or received common experience payments. This information is contextualized by an environmental scan based on a review of government services aimed at Settlement Agreement beneficiaries, and on interviews with AHF-funded project staff in the communities where key informants were interviewed. Where possible, the results have been quantified in order to determine the relative priority of impacts, reactions and opinions. The key findings of this study are:

- Most participants had received CEP at the time of the interview; 20% had confirmed receiving their full claim and 32% received only a partial amount.
- Forty per cent of participants found the CEP process difficult or challenging; 26% said the CEP application process was challenging both logistically and emotionally; and for 20%, the long wait time for processing of applications and payments created anxiety and confusion.
- One-third of participants said the CEP application was easy and straightforward. This was mainly the case for applicants under the age of 60 who were fluent and literate in English or French, in communities where Service Canada assistance was made available, or where AHF-funded projects provided form-filling assistance.
- One-quarter of participants were involved in the reconsideration request process at the time of interviews. These applicants were faced with the choice of retelling their story and of trying to prove their years of attendance in the hope that the government would validate their experiences. Survivors said they were made to feel like liars adding that it was not their fault that school records were lost.
- Participants were critical of the omission of some schools, hostels, and group homes from the list of recognized institutions. Decisions around the eligibility of certain schools were not well understood in communities. Questions were raised about why applications from Métis Survivors were denied

because they attended as day-students, albeit at a recognized residential school, or why hostels in which many Inuit children were boarded are not on the list.

- ✦ Participants generally agreed that the compensation process seemed inconsistent, leaving them at the mercy of an outside agency in control of yet another aspect of their lives.
- ✦ For about 10% of the study group, negative experiences during the CEP and reconsideration process influenced their decision not to apply for Independent Assessment payments (IAP) and not to participate in activities related to the Truth and Reconciliation Commission.
- ✦ Over a third of the study group shared that the CEP process triggered negative emotions or traumatic flashbacks. The most common explanation was that completing the applications brought back negative memories and opened old wounds. Survivors described reactions to these memories that ranged from feelings of discomfort and loneliness to reactions of panic and depression, sometimes leading to self-destructive behaviours.
- ✦ More Survivors described positive types of impacts of payments than did those who described negative impacts; however, this *frequency* should not be confused with *magnitude*. The negative impacts described by participants were profoundly destructive for many Survivors and their families, and in some communities greatly outweighed any positive, material benefits of the payments. The general message of Survivors' accounts of negative impacts was that the decision to settle for individual monetary compensation was misguided and insufficient, compounded by a lack of planning on the part of those implementing the CEP to prepare for the triggers, self-destructive reactions, and predatory behaviours. In turn, Survivors' accounts of positive impacts convey a tendency to separate issues of healing from issues of money and hence to simply view the compensation as materially beneficial in its own right. Further, a relatively high rate of positive impacts among participants who received their compensation within six months of the interview suggests that the satisfaction derived from the CEP money was for the most part temporary.
- ✦ Almost half of the study group said that receiving compensation was both a positive and a negative experience. Fundamentally, this dualism characterized CEP as positive because it relieved financial stress and afforded opportunities to share with family or to make necessary and desired purchases, but also negative because these benefits did not outweigh the sense of injustice in the '10 plus 3' compensation formula nor did they alleviate the pain of triggered emotions and memories of trauma from their residential school years.
- ✦ The majority of Survivors in the study group required or wanted some kind of support during the CEP process, whether it was assistance with form-filling or counselling related to triggered emotions and traumatic memories. The over-riding theme in comments about services and supports was the importance of that support being available at the community-level. Over 40% of participants reported that access to services during the application process was a problem. Over 10% commented on the lack of CEP supports in their community, and 7% were unaware of any supports for the CEP process.
- ✦ Over forty per cent of the study group said they relied mainly on non-CEP specific supports such as family, friends, and/or on local resources such as the Friendship Centre, Band office, land-claim office,

or community health centre for support during the CEP process. 16% relied solely on family and friends mainly because they did not trust local services to maintain confidentiality and anonymity. This was particularly the case in smaller isolated and semi-isolated communities.

- ✦ One-quarter of participants said they accessed government services. Service Canada application supports were viewed as helpful when such services were offered in the community or if applicants lived near a Service Canada office. Participants were very critical of the service offered by the CEP Response Centre and most who said they tried the toll-free numbers received little to no help, felt intimidated or frustrated by the operators, or felt the service was insensitive to the emotional effects the CEP process was having on Survivors.
- ✦ Many participants described the benefits of support and assistance they received from AHF-funded community-based healing projects. Participants said that the main benefit of AHF-funded projects' approaches is their focus on residential school trauma, that staff were Aboriginal and/or Survivors themselves, and that traditional Aboriginal activities and wellness practices were viewed as important in healing the legacy of residential schools.
- ✦ An environmental scan of supports and services available to Survivors throughout the CEP process indicates that AHF-funded projects tended to support Survivors by whatever means possible, often providing services that were outside of project mandates. Survivors' statements about lack of services spoke to the increased demand for healing services since the *Settlement Agreement*, which, in the view of community-based service providers, suggests that healing support is currently addressing only the tip of the iceberg. Statements such as this are consistent with a recent evaluation of project activity since the *Settlement Agreement* which concluded that healing from the legacy of residential schools has just begun.
- ✦ About two-thirds of participants were engaged in healing in some form. Survivors who said they were engaged in healing and those who said they were not both reported similar rates of positive and negative impacts of compensation. Survivors who were already on a healing journey before the *Settlement Agreement* were more likely to say that the CEP process and money promoted healing in some way and that, at the very least, it was a small step forward in their personal healing journey. In contrast, participants who indicated they were not engaged in healing were more inclined to say that CEP made no difference or that the process and money was detrimental to their well-being.
- ✦ Almost half of participants in the study said compensation made no difference to their well-being. The main opinion among these Survivors is that there is no connection between money and healing and no amount of compensation can replace what was lost.
- ✦ Participants most commonly defined healing as seeking ways to deal directly with residential school issues in order to cope with traumatic and emotional memories triggered by the CEP process, and to come to terms with the past. This included finding closure for deaths at residential schools, dealing with addictions, or building trust with someone in order to open up and release personal pain. Many defined the term as accessing available traditional, Western, or alternative methods of healing, or as finding personal balance and spiritual strength.

- About one-quarter of participants said that the CEP process promoted healing to some degree, mainly because of what it symbolized: compensation was a tangible acknowledgment of suffering in the residential school system; it revealed to Survivors that they were not alone and prompted them to open up about their experiences; and it provided a sense of closure for what was lost. The symbolic significance of the CEP was often associated with that of the federal government's apology.
- Almost 20% of participants said that the CEP process and money were steps backward on their healing journeys. For these Survivors the CEP process represented a very negative period in their lives and left them feeling worse off than before. They expressed bitterness and resentment toward an inadequate "10 plus 3" formula, anger toward eligibility criteria that deprived compensation to many living Survivors, and grief over the many Survivors who died before the *Settlement Agreement* was implemented.
- About one-third of participants spoke about CEP and compensation from perspectives that took into account the intergenerational impacts of the residential school system. Survivors said that CEP was not enough because the ongoing direct and indirect effects of the physical and sexual abuse that took place at residential schools cannot be compensated, and also that individual compensation is illogical in the sense that the residential school experience is not an individual phenomenon. It is a family and community experience that crosses generations. The intergenerational issues most commonly raised related to family alienation which in turn resulted in a lack of parenting skills; however, participants also said that the CEP process led to increased openness between themselves and their children about the legacy of residential schools.

Aboriginal Healing Foundation
75 Albert Street, Suite 801, Ottawa, Ontario K1P 5E7
Phone: (613) 237-4441
Toll-free: (888) 725-8886
Fax: (613) 237-4442
Email: research@ahf.ca
Website: www.ahf.ca

Helping Aboriginal people heal themselves

