
Disrupted Attachments:

A Social Context Complex Trauma Framework and the Lives of Aboriginal Peoples in Canada

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PART 1 — THE SIGNIFICANCE OF A COMPLEX TRAUMA FRAMEWORK FOR UNDERSTANDING THE LIVES OF ABORIGINAL PEOPLES IN CANADA¹

INTRODUCTION

The idea of “disrupted attachments” speaks to both levels on which the historic and contemporary assaults on Aboriginal peoples in Canada have resonated. Not only have the policies of colonialism expressly aimed to sever the attachment of Canada’s First Nations to their land, customs, culture, modes of self-governance, languages, and ways of life, but the traumatic impact of these disrupted attachments have reverberated through both the communities and through the individual lives of Aboriginal peoples in this country. The relatively new and more expansive conceptualization of “complex trauma” in the mental health field has, as one of its core and defining features, alterations (better expressed as harms) in relationships with one’s sense of self, as well as alterations (more aptly described as harms) to relationships with others. These harms to relationships can be usefully conceptualized as “disrupted attachments.” In this way then, the idea of “disrupted attachment” eloquently speaks to the myriad and fundamental ways in which the individuals and the communities comprising the Aboriginal peoples in Canada have been traumatized.

There has been a relative explosion in the field of trauma and trauma studies in recent years. Most of this work has taken place in the traditional fields of psychology, psychiatry, neuroscience, and medicine. Significant developments in these fields have helped us better understand the ways in which traumatic events can have far reaching and pervasive effects on people’s lives and, in particular, have shed light on the way in which traumatic events in early childhood can seriously and negatively affect human development across cognitive, psychological, neurological, and physical dimensions.

Given that the Aboriginal peoples of Canada have been subjected to centuries of genocidal state policies and continue, in great numbers, to live in conditions characterized by relative deprivation and contexts of abuse

(Health Canada, 2009), the insights of a trauma framework can help to illuminate the ways in which these traumatic events have shaped the lives of Aboriginal peoples at the individual and community levels.

A traditional trauma framework is not broad enough, however, to grasp the complexities and dimensions of these experiences. Instead, an expanded trauma framework that explicitly attends to and integrates an analysis of social context, including the social relations of inequality — race and ethnicity, socio-economic status, gender and sexuality, and abilities and disabilities — is necessary.

We describe this kind of approach as a trauma framework that necessarily attends to social context, thereby moving beyond an inherently individualistic focus. More

specifically, given the emergence of the new and important diagnostic category of complex post-traumatic stress, which describes the impact of traumatic events which are often ongoing and chronic, we discuss what we call a “social context complex traumatic stress framework” to analyze some of the dimensions of the lives and experiences of the peoples of Canada’s First Nations.

In this paper, we explicate the contours of a social context complex trauma framework, building from the insights of the fields of psychology and neuroscience that are beginning to provide a fuller understanding of the pervasive and developmental impacts of trauma. We engage the important literature on historical trauma in relation to Aboriginal peoples, which seeks to identify the collective harms of trauma on entire communities and the ways in which these harms can be “transmitted” intergenerationally. Nevertheless, the dynamics of “intergenerational transmission” are inadequately described and explained in this literature. Rather, we argue that a social context complex trauma framework better fills in the gaps and provides a more complicated and multi-levelled way of understanding collective trauma in communities.

In developing our conceptualization of a social context complex trauma framework, we draw on the foundational constructs from trauma theory, from attachment theory, and from the insights of the literature on historical trauma, as well as the interdisciplinary research literature on the health and well-being of Aboriginal peoples in order to advance a developmental perspective. We further discuss some of the important ways in which this expanded conceptual framework can help to understand the ways in which experiences of trauma have shaped and harmed so many Aboriginal individuals and communities in Canada, and point to some directions for healing and transformation efforts.

Conceptualizing Trauma Contextually: Integrating the Social and the Individual Levels

Trauma refers to the range of possible, typical and normal responses people have to an extreme and overwhelming event, or series of events. Many traditional approaches, particularly in the mainstream disciplines of psychiatry and psychology, tend to view the issue of trauma, and how people experience trauma, at a highly individualized and decontextualized micro-level. This view, while important for understanding how any individual’s experience might be affected by the impact of trauma, disengages from a broader awareness of the ways in which people’s individual experiences are inextricably connected to their broader social contexts. Put differently, traditional psychiatric and psychological approaches to the study of trauma often

tend to ignore or minimize the relevant and broader social contexts and social relationships in which people’s experiences are shaped and lived.

Others in the field have noted both the utility and the limits of a traditional trauma framework. In their words,

...like any partial truth, the metaphor of trauma also has limitations and unwanted connotations... Current trauma theory and therapy tend to focus on the psychiatric disorder of post-traumatic stress disorder and give insufficient attention to the other dimensions of experience that may be profoundly transformed by massive trauma and abrogation of human rights. These include issues of secure attachment and trust, belief in a just world, a sense of connectedness to others, and a stable personal and collective identity (Kirmayer, Tait & Simpson, 2009, p. 27).

As the writers of a background report for the Royal Commission on Aboriginal Peoples note, “clearly, social problems have much wider and more substantial origins in social and economic circumstances. Social problems may themselves be the cause of psychiatric disorders” (Kirmayer et al., 1994, p. 4). Along these lines, Armstrong (1993) has argued that “chronic stresses of daily life rather than diagnosable psychiatric disorders, account for Native Indians’ high rates of arrest, homicide, suicide, incarceration, wife and child abuse and violent death” (p. 224). Both individual and social perspectives therefore have something to contribute in understanding the origins and alleviation of psychological suffering.

An essential and defining element of a more comprehensive approach to understanding trauma in people’s lives, especially in the lives of Aboriginal peoples in Canada, is an attention to and integration of an analysis of the social and the individual levels on which trauma and its effects are lived. An exclusively individualized approach fails to account for the ways in which social injustice, discrimination and colonialism have systematic and far-reaching effects on entire communities. In other words, an individual focused approach to understanding trauma in the context of the peoples of Canada’s First Nations misses the fact that traumatic impacts are rooted not only in the specific experiences of any individual’s unique life story and experiences, but also that traumatic impacts are structured by the historical legacy and contemporary realities of social inequalities. A more adequate and complete trauma framework, then, needs to focus on the ways in which traumatic stress is experienced by individuals, while also attending to the relevance of the social contexts which shape this very experience.

A Multi-Dimensional Complex Trauma Lens: Conceptualizing the Impacts of Trauma on the Health and Well-being of Aboriginal Peoples of Canada

It is well known, yet perhaps still significantly under acknowledged and misunderstood in mainstream society, that the Aboriginal peoples in Canada have experienced histories of colonialism and sharp systematic injustices; the pervasive effects of which continue to echo today.³ In a sharp embarrassment to Canada, Prime Minister Stephen Harper saw fit to make a declaration on September 25th, 2009, at the most recent meeting of the G20 Summit in the United States, denying the history of colonialism in this country. In his words, “we also have no history of colonialism” in Canada, a denial of rather astonishing proportions (Barrera, 2009; Atleo, 2009).

This denial aside, the injustices and colonialism in the lives of Canada’s First Nations peoples are not merely relics of a distant or even a recent past. Instead, these injustices continue to be found and are even entrenched in the contemporary social conditions of inequality in which a great many of Canada’s First Nations peoples live.⁴ Many aspects of the lives of Aboriginal peoples, therefore, are *continuously traumatic*. This is a fundamental insight which cannot be over emphasized, and which must be foregrounded in any discussion of the impact of trauma on Aboriginal peoples of Canada.

These ongoing traumatic events relate to: the loss of culture, language and identity related to forced assimilation policies; the loss of land and disruption of traditional forms of governance; the decades of incarceration of Aboriginal children in state-run residential schools and its impact on many generations; the high levels of child sexual abuse, sexual assault and domestic violence in many Aboriginal communities; and the epidemics of alcohol and substance abuse also facing so many Aboriginal communities. All of these factors have had, and continue to have, profound effects on the health and well-being of the peoples of Canada’s First Nations.⁵ Moreover, they are compounded by a widespread social denial about these traumatic events and an evasion of a sense of social responsibility for effecting the kind of political, social and economic change required to remedy this situation.

An emphasis on the traumatic impacts of these social and continuous realities is an important corrective to the tendency to think of trauma as an exclusively individual experience. That said, the ways in which trauma responses shape people’s lives at the individual level must also be understood and recognized. Especially when speaking of the lives of Aboriginal peoples and even more broadly,

the individual and social levels must be simultaneously apprehended, along with how these levels are almost always inextricably interconnected.

The emerging and widely accepted category of complex traumatic stress, now also described as “developmental trauma disorder” in relation to children (van der Kolk, 2005), when expressly situated within a social context framework, is a new and important way of conceptualizing the traumatic impacts of a range of harmful events on the Aboriginal peoples of Canada. This is the focus of the analysis of this paper, one which seeks to integrate the insights of the dynamic and expanding field of trauma studies with the more sociological, anthropological and theoretical insights of historical trauma and social theory. An expanded and more integrated understanding of the nature and impact of trauma in Aboriginal communities is undoubtedly necessary for the construction of more effective interventions, programs and agendas for change.

At the level of individual psychological responses, some of the key elements of complex post-traumatic stress (elaborated in detail in later sections of this paper) include:

- Feelings of sadness, hopelessness and depression (possibly suicidality).
- Disruptions in attachments, relationships.
- Affect dysregulation, or difficulties regulating emotional states.
- Impairment of the ability to trust.
- Alteration in self-perceptions.
- Sense of stigmatization, isolation and marginalization.
- Use of alcohol or drugs to soothe or numb overwhelming feelings.
- Loss of meaning.

These traumatic stress responses are often related to abuse experiences in childhood or adulthood, and are exacerbated by conditions of captivity, vulnerability and helplessness. These conditions, however, cannot be understood at only the micro-level of individual experience(s). On the contrary, these conditions are also at the macro-level in many cases, as is evident in the social conditions in which many of the Aboriginal peoples of Canada live. These social conditions include:

- Ongoing experiences of loss and hopelessness.
- Childhoods characterized by abuse (physical or sexual).
- Childhoods characterized by neglect and/or abandonment.

- Poverty and inadequacy of resources.
- Lack of stability and safety.
- Social undervaluing, denigration related to inequalities of racism, sexism, colonial dispossession, etc.
- Social and economic discrimination.

Trauma in childhood elevates the likelihood of traumas later in adulthood. This increased vulnerability flowing from childhood trauma relates to the pervasive developmental impacts of trauma, which are explained in greater depth in Parts II and III of this paper.

One of the expressions of the histories of traumatic events and contemporary conditions of inequality and deprivation facing so many Aboriginal communities is the fact that the Aboriginal peoples in this country face a range of daunting health issues and problems. In fact, research has demonstrated that, for a variety of reasons, Aboriginal peoples tend to have the poorest levels of physical and mental health and well-being in Canada (MacMillan et al., 1996). Many of these health issues are related to and express trauma histories, both individual and collective. A trauma informed approach, then, must be taken to understand the complex interconnections between traumatic events, social conditions, health and well-being, and traumatic stress.

The indicia of the states of health in Aboriginal communities are measured in terms of higher rates of abuse in childhood, higher rates of domestic violence, shorter life expectancies, lower birth rates, more violent and accidental deaths, higher infant mortality rate, higher suicide rates, higher rates of substance abuse, and higher rates of a range of other chronic health conditions (MacMillan et al., 1996, pp. 1571-1577). Given that the social and economic conditions of so many Aboriginal people's lives are shaped by inadequate housing, substandard sanitation conditions, a lack of clean water, inadequate nutrition, lower education levels, unemployment and poverty, and racism, poorer health in Aboriginal communities is not surprising.⁶ Exacerbating these circumstances is the lack of adequate state accountability for ameliorating these situations. As the World Health Organization (2008) has noted,

[I]nequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. *The conditions in which people live and die are, in turn, shaped by political, social, and economic forces* [emphasis added] (p. i).

While relatively more, if still insufficient, attention has been paid to the structural elements of the health and well-being of Aboriginal communities in recent years, less attention has been paid to the role of trauma in the collective and individual histories of Aboriginal peoples. While there is an emerging body of literature in this field, more work is necessary to document and analyze the role of trauma in the lives of Canada's First Nations peoples. This critically important psychological dimension functions at both the individual and community levels.

Through a complex trauma lens, or complex trauma framework, some of the powerful forces at play in the lives of Aboriginal peoples can be more effectively brought to light. At the individual level, a trauma framework, which takes into account post-traumatic stress as well as complex post-traumatic stress, can help to understand, in a non-pathologizing way, the range of coping and adaptation strategies that abused and traumatized individuals adopt in order to adapt to and survive their life circumstances.

At the structural and community levels, shaped by the historical legacy of colonialism, community and family disruption and dislocation, a social context complex trauma framework, may bring to light the psychosocial conditions that cause and perpetuate ongoing "intergenerational traumas." Intergenerational trauma refers to the idea that the effects of and responses to traumatic events can be "transmitted" across generations, as is elaborated upon in subsequent sections of this paper.

The work of conceptualizing lifespan trauma responses is critically important and necessary not only for a better understanding of the nature and effects of trauma in the lives of Aboriginal peoples, but also for the purposes of designing and delivering more effective and culturally appropriate treatment approaches and community interventions. Developing culturally appropriate models of healing from trauma requires approaches that build upon the capacities of Aboriginal peoples, while also fostering and strengthening resilience. It must be a project that, while drawing on the skills and expertise of others where needed, is centrally informed by Aboriginal peoples themselves.

The Importance of Language: Avoiding Deficit Based Descriptors

The language of traditional psychological, psychiatric and medical accounts of trauma and victimization is replete with pathologizing and stigmatizing terms. These include the idea that traumatic responses are best characterized as "disorders," and use of descriptors like dysfunction, maladaptive and pathological. While these terms can

be useful in some contexts, they can also be utilized in a manner which is not productive and can instead be harmful.

This replication of problematic language even occasionally occurs within research and writing that expressly aims to adopt a stance which acknowledges injustice and inequality. The dominant pathologizing terms are so common in the literature and in the language of the traditional mental health professions, and are therefore so easy to use. Given how pervasive and taken for granted this kind of language is in the field of trauma studies, it is difficult but nevertheless necessary to be vigilant in our attempts to avoid language and terms which stigmatize people who are coping and attempting to cope with traumatic events and their responses to them.

To illustrate, the effects of abuse and harm are often called “symptoms,” evoking a disease-based conceptualization or medical model of understanding a socially produced yet individually lived experience. The term “symptoms” is more suited to medical discussions of physical diseases of the body. Instead of speaking of “symptoms” when referring to abuse and trauma, the terms “adaptations,” “effects” and/or “responses,” more usefully capture the ways in which people cope with abuse and other traumatic events in their lives. This is the approach taken in the social context complex trauma framework advanced and discussed within this paper.

Furthermore, the difficulties facing so many Aboriginal individuals and communities are often described as “pathologies,” or “dysfunctions.” Even the foundational concept of the trauma field, post-traumatic stress disorder, describes the condition of experiencing the effects of trauma as if it were a personal trait or problem of the individual, a personal “disorder.” Instead of viewing the effects of trauma as representing a mental “disorder,” it is more useful to grasp the consequences of traumatic events as responses to, or as impacts or effects of trauma.

One of the important contributions of a social context complex traumatic stress model, then, is a more subtle attention to the politics and impact of language within psychological, psychiatric and medical accounts of trauma. While it may not be possible to be entirely successful in eliminating potentially problematic language from analyses of abuse and trauma, especially when citing the mainstream research in this area, it is important to endeavor to use terms which both de-stigmatize the experiences being described, while also more accurately and respectfully capturing and reflecting their essence. This is part of the broader project of developing respectful analytical and practical approaches to describing effective responses to healing the effects of

violence, abuse and practices of oppression — and the resulting traumatic effects of these experiences — in people’s lives. In the context of Aboriginal people’s lives, this is all the more imperative.

Trauma, Healing and Resilience

The study of trauma in relation to the Aboriginal peoples of Canada is not an academic exercise. Instead, it is necessarily a project infused with a social justice vision of healing, recovery, equality, and transformation. Part of this vision necessarily includes attention to the conditions of wellness and resilience, and attention to directions for healing from trauma. In the latter sections of this paper, therefore, we discuss some of the key issues and findings pertaining to the conditions which best facilitate wellness, health and resilience.

Structure of the Paper

This paper is divided into a number of inter-related parts. Part I of the report provides an overview of the relevance of a trauma framework and how this framework helps to further understand Aboriginal people’s lives. Part II addresses the two key models of trauma, simple and complex, and explicates the crucial distinction between these two trauma responses. Part III articulates a framework for understanding complex trauma from a developmental perspective, and provides the six-part diagnostic criteria which define complex trauma. Part IV foregrounds the significance of attachment in complex trauma, and provides a brief overview of attachment theory, along with the negative impact on attachment associated with abuse, neglect and deprivation.

Part V discusses the literature on collective and historical trauma, and, in particular, the literature in relation to the experiences of Aboriginal peoples of Canada. This part further includes a discussion of some emerging research findings from the studies of trauma and Aboriginal peoples, with a particular emphasis on identifying the impacts of historical trauma, or collective trauma.

Part VI identifies some of the gaps in the literature on historical trauma in explaining dynamically how it is that trauma responses are “transmitted” generationally, and argues for the expanded social context complex trauma framework as a more comprehensive approach for capturing multiple levels of trauma responses, individually and within communities. In this section, we elaborate on this expanded social context complex trauma framework and the enhanced understanding it offers of the impact and dynamics of trauma in Aboriginal communities in Canada today.

Finally, Part VII briefly points to some of the important directions for working towards healing from trauma, at both the individual and community levels, and also makes some broad recommendations flowing from our analysis.

PART II — CONCEPTUALIZING TRAUMA: KEY PSYCHOLOGICAL MODELS

Understanding Trauma and Its Effects:

Introduction

People who endure severe and chronic abuse in many cases develop what might seem like a bewildering array of problems and difficulties throughout their lives. These difficulties can appear, at best, to be incomprehensible to those who do not understand the ways in which abuse and trauma can impair a person's capacities, and, in turn, can limit that person's opportunities in life. At worst, these difficulties are seen as self-inflicted to those who fail to understand abuse, trauma and its reverberating effects throughout a person's life. As Judith Herman (1992) observes, "social judgment of chronically traumatized people can tend to be extremely harsh" (p. 115).

People who are abused and neglected in childhood often experience a range of long-term effects, both psychological and physical. It is well established in the literature and from clinical experience that abuse survivors tend to experience significantly more depression, sexual dysfunction, dissociation, anger, suicidality, self-harm, drug addiction and alcoholism than any other people experiencing mental health problems (Briere & Jordan, 2004).

The traumatic effects of abuse are especially acute when the violence is ongoing, when it begins in childhood, and when it is perpetrated by someone the person should have been able to trust. All of these factors speak to the all too common experience of many Aboriginal peoples of either physical or sexual assault perpetrated in the family of origin by an adult relative, and/or physical or sexual abuse perpetrated in a residential school context (Paletta, 2008; Samson, 2003).

Compounding these harmful effects of the abuse is the sense of stigma which too often attaches to abuse survivors; a stigma which flows from a society prone to victim blaming, to denying or minimizing the extent of child abuse and in which there is a general failure to understand trauma and its impacts. The very traumatic effects of the abuse, then, can be a further source of alienation and difficulties in maintaining social and intimate relationships. Difficulties with and in relationships are perhaps among the most

fundamental and pervasive harms associated with complex abuse-related trauma, as is further elaborated in later sections of this paper.

The chronically abused person's apparent helplessness and passivity, [his or] her entrapment in the past, ... intractable depression and somatic complaints, and... smoldering anger often frustrate the people closest to [them] (Herman, 1992, p. 115).

This quotation also speaks to the intolerance and contempt that many people express in relation to people who have chronic difficulties in their lives as a result of their traumatic experiences. This kind of contempt can be expressed in the form of victim-blaming and as hostility to those who are in need or who are perceived to be powerless.

The Importance of Recognizing Post-Traumatic Stress

Understanding the effects of traumatic stress helps to provide a framework in which people's responses to abusive or neglected experiences begin to become intelligible, and the underlying functions of typical trauma responses become more clear. Furthermore, the post-traumatic stress construct helps remove the stigma and self-blame from women and men who have been abused and who are coping with trauma reactions in their lives. Instead of seeing a set of "symptoms" or "problems," the various yet patterned responses to trauma are seen as a person's best efforts to cope with the effects of harmful external events. The external events of abuse and violence are the core problem, not the subsequent post-traumatic responses that develop in reaction.

Abuse victims and those who have endured other traumatic events often cannot explain or even recognize their own psychological responses as trauma-related. Furthermore, they often do not relate their difficulties in adulthood to much earlier traumatic life experiences, especially neglect and deprivation. Even more than abuse in childhood, which is often denied or minimized because it is such a painful experience, the presence of neglect and deprivation are very often difficult to name.

Traumatized people may not recognize the role of abuse-related trauma in the development of some of their own ways of managing and coping in their everyday lives. This points to the critical importance of psycho-education at both the individual and community levels concerning the nature of trauma and its effects.

Contextualized information about traumatic stress shifts the focus away from perceived flaws in the “personality” or “character” of the abuse survivor, and instead understands his or her behaviours as normal and typical human responses to trauma imposed from external sources. This reframing is a crucial contribution of the traumatic stress framework and one of its most crucially important aspects. Moreover, when integrated with a social context analysis, this reframing allows for an expanded, deepened and more dynamic appreciation of the ways in which trauma responses are fundamental aspects of human experience in the all too common experience of abuse, violence, neglect, and deprivation.

Different Kinds of Post-traumatic Stress — Simple and Complex

“Simple” and “complex” post-traumatic stress are related but distinct descriptors (or diagnoses) of responses to traumatic events. Most fundamentally, *simple post-traumatic stress* (simple PTSD) typically results from a one-time traumatic event, which might take the form of an accident (for example, a car accident), or an assault (for example, a stranger attack). *Complex post-traumatic stress* (complex PTSD), on the other hand, is a form of a traumatic stress response flowing from more chronic and protracted traumatic experiences.

It has become clear that simple post-traumatic stress resulting from a one-time incident, such as, for example, being raped by a stranger or a serious car accident, is markedly different from the complex set of responses that follows chronic, multiple and/or ongoing traumatic events. Such events include chronic childhood abuse or prolonged experiences of assault and violence in an intimate relationship, as, for example, violence perpetrated by a spouse or caregiver.

Complex post-traumatic stress is multidimensional and pervasive because it is often the result of ongoing damaging and neglectful experiences, which are sometimes compounded by childhoods that lack consistent, predictable and attuned parenting. People experiencing complex post-traumatic stress have most typically experienced chronic and ongoing abuse, often in the context of intimate relationships.

Individuals who have experienced severe and frightening events as either children or adults may have complex post-traumatic stress and yet not have simple post-traumatic stress. More typically, however, they suffer from both kinds of post-traumatic stress (Luxenberg, Spinazzola & van der Kolk, 2001).

Diagnostic Criteria for Simple Post-traumatic Stress

Simple PTSD is primarily a neuro-physiological disorder. There are three sets or categories of psychological responses which define PTSD (identified under criteria B, C and D in the sections which follow). In order to meet the diagnostic criteria for simple post-traumatic stress, an individual must meet criteria A, and the designated responses under Criteria B, C and D. It is not unusual for people who do not fully meet all the criteria to still be considered to experience partial post-traumatic stress.

Criterion A:

Simple post-traumatic stress results from exposure to a traumatic or extremely emotionally and psychologically distressing event (or events). The person exposed to this event must have experienced intense fear, helplessness or horror in response.

Traumatic experiences have traditionally been defined as those perceived in some way as being life-threatening. However, many people who have experienced post-traumatic stress may not believe that the traumatic event threatened their lives. Furthermore, the traditional definition does not capture the experiences of countless women and men who have survived not only past or present physical and sexual abuse, but also neglect and emotional abuse as children.

A more complete definition of a traumatic event recognizes the traumatic nature and long-term effects of events which might not have been perceived to be life-threatening.

A traumatic experience is an event that continues to exert negative effects on thinking (cognition), feelings (affects) and on behaviour, long after the event is in the past.

People respond to traumatic experiences very differently. Some trauma responses are detectable and obvious, such as intrusive memories or flashbacks. On the other hand, some trauma responses, such as feeling numb and empty, are less detectable and more difficult to recognize.

“Symptom” Clusters of Simple post-traumatic stress

There are three “clusters” or categories of responses which define simple post-traumatic stress, each of which has a number of elements or possible expressions.

Criterion B (a diagnosis requires one or more of the following responses):

- Re-living the event/extreme distress, emotional or physiological. After the traumatic event is over, it is experienced as if it is being “relived.” This can occur through flashbacks, nightmares or other intrusive thoughts or images that seem to suddenly “pop” into the traumatized person’s mind.
- Experiencing extreme emotional and physiological distress, such as uncontrollable shaking, or panic when faced with reminders of the event.

Criterion C (a diagnosis requires three or more of the following responses):

- Avoiding reminders of the event, including places, people, thoughts, or other activities associated with the trauma.
- Experiencing a diminished interest in friends, family and everyday activities.
- Becoming emotionally numb and having feelings of detachment.

Criterion D (a diagnosis requires two or more of the following responses):

- A sense of being on guard or hyper-aroused at all times. This can include irritability or sudden anger.
- Difficulty sleeping.
- Lack of concentration.
- Being easily startled, and constantly scanning the environment for danger.

In summary, the criteria which must be present to meet a clinical diagnosis of post-traumatic stress disorder, or (simple) PTSD, include:

- An event in which the life, physical safety or physical integrity of the person was threatened or actually harmed, and the person experienced intense fear, helplessness or horror in response to the event.
- Continuing to re-experience the traumatic event after it is over.
- Seeking to avoid reminders of the event.
- Exhibiting signs of persistent arousal.

What is Complex Post-Traumatic Stress?

Unlike simple post-traumatic stress, which results from a single traumatic event, complex post-traumatic stress results when a person suffers a series of ongoing overwhelming events or “blows,” or extreme events or absences of necessary and fundamental consistent and safe parenting, most often in childhood. Very often, these events take the form of interpersonal abuse in childhood (often in the family of origin), and usually occur in the context of inadequate social, psychological and emotional support in the child’s life more generally.

In one of the groundbreaking works elucidating the links between abuse and trauma responses, Judith Herman (1992) explains that prolonged and repeated trauma occurs in situations where a person is captive, unable to flee, or is under the control of the perpetrator. These conditions render the person powerless, and allow the perpetrator ongoing coercive control. Such conditions may be found in situations varying from prison camps, religious cults and conditions of war, in addition to some families or institutions such as residential schools.

Captivity can be achieved by physical force, as with prisoners of war, or by a combination of physical, economic, social, and psychological means, as is typically the case for battered women and abused children, including those compelled to leave their families and attend residential schools. The result of this ongoing coercive control is psychological trauma that differs greatly, both in complexity and in range of effects, from that resulting from a one-time traumatic event. As a result, the diagnosis called complex post-traumatic stress was developed to encompass this broader range of psychological alterations (Herman, 1992). More recently, in terms of children and adolescents, this category has subsequently been reconceptualized as “Developmental Trauma Disorder.” This reconceptualized category captures the pervasive and ongoing traumatic impacts of interpersonal abuse in the lives of children and adolescents (D’Andrea, Spinazzola & van der Kolk, 2009).

Judith Herman (1992) outlines three broad areas of psychological disturbance that distinguish complex PTSD from simple PTSD.

- The first area involves the types of responses or effects which are more complex, widespread and persistent in complex PTSD due to the prolonged nature of the trauma.
- The second area involves characteristic personality changes that accompany complex PTSD, including difficulties with relationships and identity.

- The third area relates to the survivor's increased vulnerability to further victimization, in the form of both self-harm and harm perpetrated by others.

Even with a traumatic experience such as sexual assault, if the experience is a single event, if the individual has adequate support afterward, and if there is little or no history of trauma, the individual, although destabilized for a period of time, can expect this condition to eventually diminish and to be able to move towards a resolution. Simple post-traumatic stress is therefore potentially more easily resolved and settled than the more complicated and pervasive set of effects associated with complex post-traumatic stress. In part, this is because the breadth and range of the effects of complex traumatic stress are less easily identified, especially to those not educated or knowledgeable about this specialized topic.

The very pervasiveness of the effects of complex post-traumatic stress, then, can make the impact seem, to those who are not aware of what complex post-traumatic stress is, invisible. This, in turn, too often leads to the failure to recognize the problem, lack of proper treatment, support and intervention, and a tendency to fault the trauma survivors for their "problems."

Although the new diagnoses of complex post-traumatic stress and developmental trauma disorder have not yet been officially recognized in the DSM-IV (the fourth and current edition of the Diagnostic and Statistical Manual of Mental Disorders, the most used guide to diagnosing mental health problems), complex trauma is currently captured under the general DSM-IV category of "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS). This is an important development in understanding and treating trauma. The specific category of complex PTSD is expected by the leading experts in the field to be included in the DSM-V.⁷ There has been, however, some controversy within the mental health field about this specific category, as there is often political resistance to new diagnostic categories. It is therefore not clear whether the committee which makes the final decision will accept the diagnosis, even in the face of a consensus of national experts in the field (Pine, 2009).

Why is it so Important to Understand Complex Traumatic stress?

Many of those who seek treatment in mental health clinics or other services have histories of long-term emotional, physical and sexual abuse. Many mental health professionals, especially those lacking specialized education and training, have previously not well understood that prolonged abuse

experiences can cause a person to develop a spectrum of complex psychological trauma responses.

Simple post-traumatic stress responses (PTSR) include intrusive re-experiencing of the trauma, numbing and hyperarousal (excessive physiological arousal such as insomnia, startle reactions and irritability). Individuals who have histories of prolonged abuse or multiple traumas experience not only the effects of simple PTSR, but also a variety of other psychological difficulties, which are characteristic of *complex* post-traumatic stress.

These additional effects associated with complex post-traumatic stress can include:

- Depression and self-hatred.
- Significant difficulties dealing with emotions and impulses (also known as affect dysregulation), including aggression expressed against themselves.
- Dissociative responses (such as depersonalization).
- Self-destructive behaviour (such as substance abuse problems and eating disorders).
- Inability to develop and maintain satisfying personal relationships.
- A loss of meaning and hope.

It is often these problems, rather than the effects of simple post-traumatic stress, that create the most psychological distress for many traumatized people. Moreover, it is often these issues, which may not even be connected to the originating traumatic events in their awareness, that prompt them to seek help.

Complex post-traumatic stress is also associated with various biopsychosocial changes. When an environment is chronically traumatizing, as are most childhood traumatic environments, the survival response system will become chronically activated, resulting in long-term effects on the developing brain and body. These effects of complex trauma, as we elaborate in more depth in the following sections of this paper, can influence attachment, working memory and other areas of functioning and psychological life.

The neurobiological and psychological effects of a hyperactivated autonomic nervous system and disorganized attachment patterns associated with complex post-traumatic stress will often become well-entrenched, familiar and habitual responses. Consequently, the effects of complex post-traumatic stress typically have far-reaching and often damaging impacts in most aspects of everyday living.

Despite the growing awareness of trauma, it is still too often the case that traumatic effects, particularly relating to abuse, are insufficiently understood and under recognized

within the mental health system. In particular, while there is increasing knowledge about post-traumatic stress disorder, there remains insufficient knowledge about the new conceptualization of complex post-traumatic stress. Since the more pervasive effects of complex traumatic stress, especially when associated with chronic abuse, are manifested over a long period of time, these effects are often not recognized as such. This is especially the case given the relative newness of this trauma conceptualization, along with the lack of widespread knowledge about it.

The Failure to Recognize Complex Trauma and the Tendency to Misdiagnose

Many trauma survivors who have sought mental health services have been given more than one diagnosis (at the same time) to describe their difficulties. These multiple diagnoses include bipolar disorder, schizophrenia–paranoid type and borderline personality disorder. These diagnoses, however, are descriptive labels for individual symptoms and behaviours, and emphasize pathology. Traditional psychiatric diagnoses therefore do not consider the context in which a person may have developed these responses, and instead focus on the individual alone. In other words, many of these “symptoms” that people exhibit represent their attempts to cope with and adapt to traumatic stress. In fact, research conducted on a sample of people diagnosed with complex traumatic stress found that those who sought treatment typically had histories of prolonged and/or multiple traumatic experiences (van der Kolk, 2005). The above diagnoses, however, focus on what is “wrong” with the person, rather than on what traumatic events have happened to the person.

These multiple diagnoses have serious consequences for treatment and intervention. In specific, therapy and other treatments can rarely be successful when the underlying issues of trauma, abuse and neglect are not identified or addressed. This is highly relevant both to mental health professionals and to those whose lives are affected by the impact of complex trauma.

Overlooking this history of abuse in people’s lives often results in the pathologizing of those with mental health difficulties. Instead of appreciating the role of abuse and abuse-related trauma, an average of four Axis I diagnoses from the DSM-IV are inappropriately ascribed in individual cases (Cloutre, Koenen, Gratz, & Jakupcak, 2002). Some of the misdiagnoses are often attributed to people whose issues are actually flowing from abuse-related trauma, and include: Schizophrenia, Delusional Disorder, Bipolar Disorder, Major Depression, and Substance-Induced Psychotic Disorder.

Female trauma survivors are even more likely to suffer from misdiagnosis in the traditional mental health system. This is related both to a well-documented tendency to discount women’s experiences in the traditional mental health system, along with a tendency to stigmatize and pathologize women’s ways of coping in relation to gender stereotypes.⁸ This can include receiving medical diagnoses that include personality disorders, resulting in diagnoses that span both Axis I and Axis II categories. These diagnoses may include: Personality Disorders, Borderline Personality, Antisocial Personality, Narcissistic Personality, Dependant Personality, and Schizoid Personality (Herman, 1992).

In people’s lives, where a fundamental issue is abuse-related trauma, these multiple diagnoses are counterproductive and ineffectual. More importantly, they interfere with effective treatment approaches to healing. Instead, these diagnoses are descriptive labels for symptoms and behaviours, and emphasize individual pathology. They fail to recognize that many symptoms trauma survivors exhibit are their best attempts to cope and adapt with overwhelming experiences (Herman, 1992).

More generally, and as is discussed further below, entire communities of Aboriginal peoples have been stigmatized by racist stereotypes which blame them for their ways of coping. If it is understood, for example, that it is trauma that so often drives substance and alcohol abuse within Aboriginal communities, then the deeply problematic and racist (mis)characterizations of Aboriginal peoples in relation to these issues become starkly revealed.

Abuse survivors suffer tremendously as a result of these kinds of misdiagnoses, mistreatment and the absence of appropriately integrated services, along with the lack of a voice in their own treatment. Trauma survivors may cycle in and out of mental health and substance abuse systems over long periods of time, using a tremendous number of services without experiencing any improvement. Given this situation, it is not surprising that many people dealing with complex post-traumatic stress feel mistrustful of the mental health system’s ability to offer help, which, in turn, keeps them further isolated and without necessary support and treatment.

Therefore, as a result of the failure to understand trauma and its effects, there is a propensity to blame the abuse survivors for the harms and abuse that were done to them. Equally problematic, the trauma survivors often do not receive the help and treatment they require. Educating people, including service providers and abuse survivors, about the nature of complex post-traumatic stress is essential in order to ensure that abuse survivors are properly diagnosed, and therefore properly treated and supported.

PART III: COMPLEX TRAUMA: A DEVELOPMENTAL AND LIFESPAN FRAMEWORK FOR UNDERSTANDING TRAUMA RESPONSES

Complex Trauma: An Emerging Framework and Consensus Among Experts

Much of the literature documenting the harms and psychological difficulties experienced by Aboriginal people has been largely atheoretical. Accordingly, this literature has resulted in a pathologizing exposition which does not effectively contribute to a greater understanding of the etiology and developmental progression of many of the long-term psychological harms associated with complex post-traumatic stress.

Typically, complex trauma results when a child is chronically abused or neglected, but it can also be caused by other events, such as witnessing domestic violence, genocide or war. Exposures to ongoing threats, such as these events, along with the dissolution of one's community or family are forms of trauma for both children and their parents. Clearly, a complex post-traumatic framework is relevant to developing a more sophisticated and complete understanding of the conditions of the lives of Aboriginal peoples of Canada.

An exposition of the diagnostic criteria for what has become known as complex post-traumatic stress follows in the next section. In the chart below, the six major areas of effects identified with complex post-traumatic stress are outlined, with examples of the kind of psychological issues and responses associated with each area. In brief, the six major effects of complex post-traumatic stress are:

1. Affect dysregulation and impairment in regulating emotion and impulses.
2. Changes in consciousness and attention (dissociation).
3. Alterations in self-perception (harm to one's sense of self).
4. Alterations in relationships with others.
5. Somatization (complaints of physical pain and physical problems).
6. Alterations in systems of meaning (a sense of hopelessness).

Very briefly, affect dysregulation refers to difficulties in modulating emotion and impulses. Changes in consciousness points to the ways in which traumatized

people can, at times, detach from immediate reality or "dissociate." Alterations in self-perception are very often expressed as a deep sense of shame, guilt or, conversely, an exaggerated sense of responsibility. Alterations in relationships with others denotes difficulties in establishing and maintaining intimate emotional connections with others, often because of a difficulty in trusting. Somatization refers to the body's manifestation of psychic pain in physical illness, often expressed as diffuse physical pain. Alterations in systems of meaning points to a loss of a sense of purpose in life, which is often expressed as overwhelming hopelessness.

More detail and some specific examples under each of the criteria for complex post-traumatic stress are provided in the chart below.

Diagnostic Criteria for Complex Post-Traumatic Stress Response

- (I) Alteration in Regulation of Affect and Impulses
(A and one of B-F required):
 - A. Affect Regulation
 - B. Modulation of Anger
 - C. Self-Destructive Behaviour
 - D. Suicidal Preoccupation
 - E. Difficulty Modulating Sexual Involvement
 - F. Excessive Risk Taking

- (II) Alterations in Attention or Consciousness
(A or B required):
 - A. Amnesia
 - B. Transient Dissociative Episodes and Depersonalization

- (III) Alterations in Self-Perception
(Two of A-F required):
 - A. Ineffectiveness
 - B. Permanent Damage
 - C. Guilt and Responsibility
 - D. Shame
 - E. Nobody Can Understand
 - F. Minimizing

- (IV) Alterations in Relations With Others
(One of A-C required):
 - A. Inability to Trust
 - B. Revictimization
 - C. Victimizing Others

- (V) Somatization
(Two of A-E required):
- A. Digestive System
 - B. Chronic Pain
 - C. Cardiopulmonary Symptoms
 - D. Conversion Symptoms
 - E. Sexual Symptoms
- (VI) Alterations in Systems of Meaning
(A or B required):
- A. Despair and Hopelessness
 - B. Loss of Previously Sustaining Beliefs

Some of the most fundamental and complicated ways in which complex trauma affects development, including brain development, in addition to how disruptions to attachment are part of the complex trauma response, are discussed in the sections which follow.

Childhoods Shaped by Neglect, Deprivation and Abuse, and Complex Trauma

The impact of trauma depends on many factors. In cases of abuse, neglect and deprivation in childhood, the overall impact depends on developmental issues such as: the age at which the abuse began; the nature, severity and duration of the abuse; the relationship to the perpetrator; and the nature of the child's attachment to her or his parents/parental figures.

The impact of trauma also depends on whether the abuse took place in a larger context of severe neglect and emotional invalidation. *Emotional invalidation* occurs when a person's feelings or emotional states, such as anger or hurt, are not attributed to the harmful or abusive events. Instead, the feelings are minimized or denied, or in other words, invalidated. At times, to compound this emotional invalidation, the person who is upset is also accused of being "over-sensitive" or "paranoid" because they experience these feelings of upset, meaning that they are both invalidated and then criticized.

Chronic neglect, deprivation and/or abuse in childhood — on its own or combined with a lack of emotionally connected parenting — profoundly shapes and negatively affects a person's cognitive, emotional and psychosocial development. These negative effects are worsened when childhood abuse occurs in an environment where a child is also deprived of essential emotional needs including safety, constancy and emotional validation.

Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and other difficulties, such as psychiatric and addictive disorders, chronic medical illness, and legal, vocational and family problems. Moreover, chronic abuse in childhood, physical and/or sexual, has been repeatedly demonstrated to increase vulnerability to developing substance abuse problems, a range of mental health difficulties and other physical health problems later in life.

Adults who experienced these types of childhoods characterized by ongoing abuse, neglect and deprivation are most likely to develop complex post-traumatic stress. They will typically experience a host of psychological problems, including:

- Low self-esteem.
- A sense that they are bad or not worthy.
- Difficulty forming and maintaining relationships.
- Out-of-control emotional responses.
- A tendency to become easily overwhelmed and disorganized by relatively small stressors.
- Engaging in self-destructive behaviour, such as substance abuse and other self-harming practices.

In particular, women with histories of childhood physical, sexual or emotional abuse may develop complex post-traumatic stress when faced with an additional trauma later in life, such as sexual assault, abuse by a partner, divorce, or loss of a loved one. Given the high incidence of sexual abuse in childhood and domestic violence in intimate relationships facing so many Aboriginal women in Canada, it seems clear that many Aboriginal women are dealing with the effects of complex traumatic stress in their lives.⁹

Affect Dysregulation and Complex Trauma

Since affect dysregulation is a central feature of complex post-traumatic stress, it is important to understand its development in chronically abused people's lives. The term "affect dysregulation" refers to the acute difficulties some people experience when managing their emotions. This difficulty is one of the most significant effects of psychological trauma, and, as such, is an important aspect of complex post-traumatic stress.

Some of the key elements of affect dysregulation include:

- Overreacting to minor stresses.
- Becoming easily emotionally overwhelmed.
- Becoming easily cognitively overwhelmed.
- Having difficulty calming or soothing oneself.

- Possibly relying on self-harming behaviours (such as cutting or slashing oneself).
- Drug use, alcohol use; addictions.
- Problems with eating.
- Compulsive sexual activities.

Each of these elements represents different ways of modulating a dysregulated nervous system. For example:

- Self-injury and planning suicide both induce adrenaline and endorphin responses.
- Self-starvation and overeating each induce numbing.
- Addictive behaviours and substance abuse can be tailored to induce either numbing or increased arousal, or a combination of both.

Research has illustrated that when people are chronically traumatized, the narrative memories are connected to intense states of autonomic arousal (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). Chronically traumatized people tend not to have any baseline state of physical calm.

In attempts to calm themselves, individuals will often rely on coping measures that are self-destructive, such as self-injury, drug use or eating disorders. They can also exhibit suicidal thoughts and difficulty modulating sexual impulses, along with heightened risk-taking behaviour.

Children who experience abuse or neglect are likely to have problems with emotional regulation, self-concept, social skills, and academic motivation. Studies have demonstrated that severe depression, substance abuse, impulsiveness, hyperactivity, and aggression are long-term outcomes of abuse.

Not only is dealing with this childhood abuse or neglect difficult, but also it is difficult to cope with the diminished ability to deal with the stresses and challenges of everyday life. *This is a pervasive and important impact of complex post-traumatic stress.* In fact, this limitation of capacities is one of the most challenging yet little appreciated long-term effects of abuse and trauma. The diminished coping capacities associated with the abuse or neglect can affect functioning across a wide spectrum of life's activities, including, perhaps most importantly, maintaining intimate relationships with partners, children and other family members.

The psychological outcomes of inability to both regulate emotions (feeling and acting overwhelmed by intense emotions) and feel secure in relationships results in the need to develop adaptations in order to survive. The adaptations that traumatized people develop are their attempts to solve

psychological distress. For example, self-harming behaviour and substance abuse function as solutions to deal with affect dysregulation.

Most chronically abused people develop extreme coping strategies to manage the effects of overwhelming traumatic stress. These maladaptive coping strategies are often not understood as comprehensible responses to underlying disrupted core self-capacities, and as a result there is often harsh judgment about people who self-harm or abuse substances.

Dissociation as a Trauma Response

One of the key dimensions of complex post-traumatic stress is dissociation. Traumatized people who dissociate learn to alter an unbearable reality by developing an ability to go into a trance state or a state of disconnection from their bodies or thoughts. This is the "dissociative state." Dissociation is defined as the failure to integrate information and experiences. As a result, thoughts and emotions can be disconnected, physical sensations can be unrecognized and repetitive behaviour often happens without conscious awareness.

When dissociating, many report feeling like a spectator, as if floating above the scene. They may have gaps in memories for significant portions of their experience, as if they are on "automatic pilot." They have a restricted emotional range, and will have difficulties tracking information. For people experiencing this dissociative state, the present is experienced as hazy and dulled, while the intrusive memories of abuse are intense and clear.

Dissociation describes changes in consciousness characterized by a sense of estrangement from the self or from the environment. Dissociation, therefore, is a way of warding off the overwhelming emotional effects of traumatic experiences and traumatic memories. As such, dissociation is best understood as a defence against these effects (Cardeña, 1994).

Dissociation is a defense in which an overwhelmed individual cannot escape what assails her or him by taking meaningful action or successful flight. The individual instead escapes by altering his or her internal organization by taking inward flight (Kluft, 1992).

Some of the signs of dissociating include the following:

- Staring blankly into space.
- Feeling/being in a daze.
- Feeling numbness.
- Feeling as if dead.
- A clouding of perception.

Dissociating also involves experiencing events, sensations and emotions at a distance, and can involve a sense of being detached from one's body.

Although dissociation begins as a self-protective mechanism, it often develops into a chronic problem on its own because trauma survivors develop an over-reliance on dissociation, and will often utilize this coping mechanism to deal with everyday stressors. Dissociation has also been found to create vulnerabilities for further re-victimization (van der Kolk, 1994). If an individual learns to automatically dissociate in the face of overwhelming threat or other danger, this dissociation prevents her or him from taking effective protective action.

Dissociation is a problem insofar as it potentially blocks effective coping with danger and everyday stressors. Furthermore, it also blocks the resolution of trauma. Accordingly, dissociation is a form of coping that must ultimately be overcome in the work to heal traumatic effects.

Abuse and Trauma in Childhood and Brain Development

One of the most significant developments in the field of studying and understanding trauma is our ability to better recognize the ways in which early experiences of abuse and trauma actually affect brain development. This important development in the field is captured and described by the newly constructed diagnostic category of "Developmental Trauma Disorder." As two researchers in this field note,

All experiences change the brain. But not all experiences have equal 'impact' on the brain. Because the brain is developing and organizing at such an explosive rate in the first years of life, experiences during this period have more potential to influence the brain – in positive and negative ways. Traumatic experiences and therapeutic experiences impact the same brain and are limited by the same principles of neurophysiology. Traumatic events disrupt homeostasis in the multiple areas of the brain that are recruited to respond to the threat (Perry & Pollard, 1998, p. 33).

Studies have shown that children who are abused and neglected tend to have impaired cognitive functioning (Schore, 2002). Additionally, children who experience abuse or neglect are likely to have problems with emotional regulation, self-concept, social skills, and academic motivation. Early experiences of stress establish a lower set point for a child's internal stress system. Such a person becomes stressed more easily than normal throughout life,

and is, as a result, more easily overwhelmed and less adept at responding to the stressors.

Abuse and Neglect in Childhood: The Neurobiological Alterations

Humans are biologically wired to have a "fight or flight" response when in danger or when experiencing conditions of acute stress. The fight-flight response is essentially adaptive and includes a change of activity in the autonomic nervous system. In a moment of danger or threat the amygdala in the brain evaluates the threat and then signals the hypothalamus to "activate" the sympathetic nervous system. The adrenal glands release a cascade of more adrenaline and cortisol into the blood stream. This speeds up the heart and breathing rates, and increases blood pressure and metabolism. This adrenaline stress response results in high levels of physiological arousal, and helps a person react quickly and effectively under pressure. Non-essential organ systems are "turned off," including the frontal cortex, the area of the brain associated with reason, problem solving and planning.

When fighting or fleeing are not options, the parasympathetic nervous system also offers two other survival alternatives: freeze and submission. People who are captive (for example, battered wives, prisoners of war and Aboriginal children forced into residential schools) are almost entirely dependent on freeze and submission responses in order to survive.

Following a traumatic event, a person's hippocampus (part of the limbic system) is responsible for organizing the experience into chronological order and encoding it to verbal memory areas. However, the hippocampus is disabled under intense and chronic threat, and, as a result, the mind is unable to make meaning of the event. Without the ability to make meaning, the individual is left with an inadequate memory of both what has happened and how it was endured.

In cases of parental neglect or abuse, the child develops brain connections and chemical responses that are highly sensitive to danger. These brain connections or chemical tendencies laid down in a perilous environment from early life become entrenched. So, even after the danger is over, anything that even remotely reminds the person of the traumatic event activates the amygdala. As a result of this over activated amygdala, the danger or threat is experienced as ever present rather than in the past. This is related to the sense of being hyperaroused, of always being on guard and of needing to be hypervigilant, which many abuse survivors experience.

Even if an individual eventually finds her or himself in a safe and secure adult environment, her or his brain is conditioned to stay on constant lookout for signs of danger. The amygdala sorts experience to identify threat, based on earlier experience. For example, a person who has been severely betrayed as a child may interpret intimacy as dangerous later in life, although in fact the later experience poses no real threat.

A brain conditioned to be easily triggered into a stress response is likely to become highly responsive to substances and behaviours that provide short-term relief. Put more simply, this helps to explain a neurological and psychological basis of many traumatized people's dependence on alcohol and drugs. Studies have, in fact, demonstrated that severe depression, substance abuse, impulsiveness, hyperactivity, and aggression are long term outcomes of abuse-related trauma (van der Kolk, 2009).

As the price for surviving the traumatic experiences, the individual is left with unmetabolized neurobiological responses. *Thus, the same neurobiological responses that preserve our physical and psychological integrity under threat can drive the symptoms of complex traumatic stress for years.*

Experiences of childhood neglect or abuse, or of parenting compromised by depression or substance abuse, influence a child's development often in profound ways. The child is not just dealing with the abuse or neglect per se, but also the diminished ability to deal with the stress and challenges of everyday life. Early stress establishes a lower set point for a child's internal stress system; such a person becomes stressed more easily than normal throughout life.

A child who is stressed early in life will also become more overactive and reactive. She or he will be triggered more easily, be more anxious and distressed. Early trauma has consequences for how human beings respond to stress all their lives, and stress is connected with addictions. The failure to develop core self-capacities therefore leaves the individual vulnerable to developing substance abuse problems.

Additionally, other responses develop that represent valiant neurobiological attempts to cope with the trauma. These can include:

- Self-injury and suicidality.
- Risk-taking and re-enactment behaviour.
- Caretaking and self-sacrifice.
- Re-victimization and addictive behaviour.

The brain and nervous system are essential for regulation of all other systems. Excessive or prolonged levels of stress hormones — one of the consequences of

childhood abuse and neglect — lead to damage of biological systems, tissues and organs, resulting in long-term chronic mental and physical illnesses. Exposure to high levels of stress hormones (cortisol) in development may alter or kill neurons in the hippocampus and other limbic structures. The result of high levels of cortisol in the brain therefore affects health, well-being and the ability to cope throughout life.

These difficulties with coping, along with the limitations of capacities and problems associated with affect dysregulation, are a central component of complex trauma. These difficulties are, in turn, intricately tied to the disruptions of attachment (alterations with relationship to self and with others), which are a part of complex trauma. It is the centrality of attachment to which we now turn to in the next section.

PART IV — THE ROLE OF ATTACHMENT IN COMPLEX TRAUMA RESPONSES

The Effects of Abuse, Neglect and Deprivation on Attachment: A Developmental Perspective

Trauma is best understood from the perspective of human development. This perspective focuses on the origins and on the individual pathways to adaptation and “maladaptation,” or ways of coping which ultimately interfere with a traumatized person's mental and physical health and well-being.

Jon Allen (2001), a leading theorist and clinician whose work focuses on understanding attachment, makes the important point that, “this perspective not only covers the full lifespan of the individual but also takes into account multigenerational processes” (p. 10). Allen argues that trauma effects psychological development at any age, but attachment trauma in childhood has a particularly devastating effect because of its dual consequences. These early childhood experiences of abuse and neglect in early attachments not only create extreme distress, but also, and more importantly, undermine the development of the capacities to regulate that distress. *This dual liability is at the heart of developmental trauma disorder (the new diagnostic category proposed for the DSM-V to describe the impact on children), and complex trauma (which describes the impact on adults).*

Developmental trauma occurs in an attachment relationship, and is especially detrimental because it undermines the primary function of attachment, which is to provide the child protection while she or he is developing (Allen, 2001). It is essential to understand that the primary

purpose of attachment is “the provision of emotional security and protection against stress” (Rutter & O’Connor, 1999, p. 824). This places attachment at the center when coping with trauma. *It means that disrupted attachment is a core feature of complex trauma responses.*

The pioneer in the field of attachment theory is Dr. John Bowlby. As part of his work as a psychiatrist in a children’s hospital, John Bowlby (1982) witnessed the effects of prolonged hospitalization or institutionalization of toddlers separated from their parents. Additionally, as part of his work commissioned in 1949 by the World Health Organization, he studied the emotional effects of World War II on children made homeless as a result of losses in the war. Bowlby found that separation and losses had catastrophic impacts on the delinquent, homeless and hospitalized children he observed. Bowlby documented that their reaction to traumatic separation was protest, followed by despair, that later turned to detachment. He concluded that children are traumatized not only by the dislocation of war, but also by chronically inadequate parenting. Bowlby (1982) further observed that attachment not only helps with security in childhood, but also plays a key role in well-being and mental health throughout a person’s lifespan.

By closely examining the social context of the lives of Aboriginal people in Canada, it is evident that many Aboriginal children face similar traumatizing events — from abuse and neglect, to persistent community violence, to being attended to by caregivers who are themselves harmed and impaired by trauma responses, including mental illness, alcohol addictions, and/or depression. This inadequate parenting often results in neglect, which is the most common form of childhood maltreatment. In fact, developmental trauma in childhood is understood to be mainly construed as abuse and neglect.

A broad definition of neglect includes any failure to provide for the basic needs of the child. Neglect can occur in several forms, but physical and emotional neglect are the most common (Perry, Colwell & Schick, 2002). Physical neglect accounts for the majority of cases, and includes failure to provide health care, child abandonment, inadequate supervision, rejection of a child leading to expulsion from the home, and failure to adequately provide for the child’s safety, and physical and emotional needs. Physical neglect, often in combination with emotional neglect, can severely impact development by causing failure to thrive, malnutrition, untreated serious infections and diseases (e.g., pneumonia), and physical harm in the form of cuts, bruises and burns due to lack of supervision.

Furthermore, the long-term emotional, social and cognitive problems may be more serious and difficult to treat than these physical problems. Emotional neglect, another related form of neglect includes spousal abuse in the child’s presence, allowing a child to use drugs or alcohol, failure to provide necessary psychological care, constant belittling, and withholding of affection. This pattern of behaviour can lead to poor self-image, alcohol or drug abuse, destructive behaviour, and even suicide. Severe neglect of infants can result in the infant failing to grow and thrive, and may even lead to infant death.

How does abuse and neglect influence attachment?

It is logical that neglectful parents most likely experienced neglect in their own childhoods. Abuse and neglect are often transgenerational, meaning that parents pass on the way they were parented. Caregivers who were abused or neglected in their own childhoods may have deficits in their ability to take care of themselves, which clearly often leads to difficulties in caring for others, including children. These neglected caregivers also often lack adequate childrearing information and parenting skills to care for the needs of an infant or small child. This neglect is especially probable in households with parents that live chaotic and disorganized lives as a result of substance abuse, depression, dissociation, or a general lack of adequate emotional and material resources.

These experiences mirror current and historical circumstances in Aboriginal communities. In the recent past, Aboriginal children were forcibly separated from their parents when they were placed in residential schools. As well, many Aboriginal communities struggled with substance abuse, poverty and domestic violence. These experiences often resulted in serious developmental traumas.

One of the possible consequences of this ongoing neglect and forced separation is impaired attachment between children and caregivers. Attachment is the capacity to form and maintain healthy emotional relationships. A primary attachment relationship between a caregiver and child provides the healthy emotional matrix for development. When a caregiver and a child are separated, it is impossible to form and maintain a healthy emotional relationship.

The systems in the human brain that allow us to form and maintain emotional relationships develop during infancy and the first years of life. Experiences during this early vulnerable period of life are critical in shaping the capacity to form intimate and emotionally

healthy relationships. Empathy, caring, sharing, happy, and productive personality traits are related to the core attachment capabilities that are formed in infancy and early childhood. This capacity to form intimate and emotionally healthy relationships is greatly impeded when a child experiences traumatic and neglected events early in her or his development.

Attachment and Physiological Regulation

Attachment is a biological need and the mother-infant, or primary-caregiver-infant, interaction plays a central role in neurobiological development. The mother/primary caregiver establishes emotional attunement with the infant, and this psychobiological synchrony facilitates early brain development.

Secure attachment describes the ideal form of attachment developed by the infant. The five basic elements of secure attachment are as follows:

1. **Collaboration** — attuned communication builds a coherent core and autobiographical sense of self.
2. **Reflective dialogue** — share internal experiences.
3. **Repair** — when attuned communication is disrupted, as is inevitable, repair of the rupture is important in re-establishing the connection. Prolonged disconnection has a negative effect on a child's sense of self.
4. **Coherent narrative** — allows integration of experiences.
5. **Emotional communications** — reduces, regulates and soothes negative emotional states (Siegel, 2001).

The essence of emotional communication for secure attachments is that parents can share and amplify positive emotional states in a child, such as joy and excitement, and they can share and soothe negative emotional states, such as fear, anxiety and anger. The important feature of emotional communication is that parents share these emotional states with their children; they don't just mirror them. The parents actually experience these emotional states within themselves and thereby help the child regulate their emotional state.

To foster healthy development in infants, John Bowlby (1982) theorized the infant and young child should experience a warm, intimate and continuous relationship with her or his mother (or permanent mother substitute), in which both find satisfaction and enjoyment. Children who experience interpersonal trauma as the result of abuse and neglect show a disrupted ability to regulate their emotions,

behaviour and attention. Other research illustrates that much of children's later ability to think clearly and solve problems in a calm, non-impulsive manner stems from their experiences in the first five to seven years of life (van der Kolk, 2005).

Additionally, reported traumatic childhood experiences, such as sexual and physical abuse, and later episodes of depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, and domestic violence, have been found to lead to severe physical health problems. The more adverse childhood experiences a person reports having had, the more likely she or he is to develop life-threatening illnesses such as heart disease, cancer and stroke later in life. Given the very high levels of child sexual abuse in many Aboriginal populations, it is not surprising that these sexual abuse histories have been correlated with a range of negative health outcomes in adulthood including, perhaps most perilously, HIV infection, a set of issues and long-term consequences of abuse which is further elaborated later on in this paper.

Abuse and Pervasive Emotional and Psychological Long-Term Effects: The Effects of Trauma on Development and Attachment

Cognitive, affective and psychosocial levels of development can be profoundly shaped and affected by a combination of chronic abuse, lack of emotionally connected parenting and/or the deprivation of basic childhood needs, such as safety, parental constancy and emotional validation. *In order to survive these overwhelming experiences, children are compelled to make complex adaptations.* Indeed, this point can hardly be overstated, because a traumatized child's very survival requires it. This fundamental point, however, remains relatively under recognized and inadequately understood in general. It is even under recognized within some mental health circles and professions, especially those that have not kept abreast of the latest and significant developments and breakthroughs in this field.

The coalescing of these trauma-related processes, and the adaptations developed in response, typically results in inadequate self-capacities. Self-capacities can be described as the inner abilities that allow individuals to manage their intrapersonal worlds, and allow people to maintain a coherent and cohesive sense of self (McCann & Pearlman, 1990). These developmental effects can span the lifetime of many trauma survivors.

Put differently, abuse, neglect, chronic deprivation, and other traumatic experiences deprive children of the opportunity to develop themselves, including their cognitive

and affective (emotional) worlds, in a full and healthy way. Additionally, one of the most significant and profound harms associated with abuse, neglect and deprivation is the absence of the opportunity to develop secure attachment. These difficulties with attachment reverberate throughout a traumatized person's entire life, and affect her or his relationships with self and with others.

A child's capacity to handle psychological and physiological stress is completely dependent on the relationship with her or his parent (or parent figure/primary caregiver). Infants have no ability to regulate their own stress apparatus; they acquire this capacity gradually as they mature, or do not mature, depending on their childhood relationships with caregivers (Maté, 2008).

A core developmental experience children require in order to learn to manage their own emotional experiences is to be calmed when their emotional arousal is too high, and to be stimulated when arousal is too low. In the absence of learning this developmental capacity, a child will not learn to regulate her or his affect (emotional states). In other words, traumatized children most often do not learn the skills necessary to effectively relate to their own emotions. For example, traumatized children typically do not develop the capacities to comfort or soothe themselves, and this lack of ability to regulate affect (emotional states) persists into adulthood. The lack of ability to regulate affect, or affect dysregulation, is at the core of a range of trauma responses, many of which can cause significant further harm to traumatized peoples, including, in many cases, substance and alcohol abuse. Affect dysregulation and disrupted attachment, then, are intimately related consequences of the traumatic experiences of abuse, neglect and deprivation in childhood.

Attachment, Complex Trauma and Historical Trauma

In this paper, we have foregrounded the critical importance of understanding attachment in human development and of understanding the impact on the development of attachment which form part of the complex trauma response. What we have described as "disrupted attachments" are core elements of trauma responses, and are central to the definitional elements of complex trauma. These problems with attachment profoundly affect a traumatized individual's relationship to her or his self, and to others.

At the collective level, disrupted attachments can also speak to the disconnect between traumatized peoples and their sense of belonging to a community, to their sense

of cultural identity. The general and mainstream trauma literature has yet to focus sufficient attention on explicating the dynamics at play on this level. In relation to Aboriginal peoples, however, there is important literature on historical trauma which attempts to grapple with the collective harms and impacts of traumatic events on entire communities, and the ways in which this traumatic impact spans generations.

In the following sections of the paper, we engage some of the key literature, much of it sociological and some psychological, which analyzes the phenomenon known as "historical trauma" in the lives of Aboriginal people. Primarily, this literature has been developed disconnected from and parallel to the much more extensive and exploding field of mainstream trauma studies in the psychological, psychiatric and medical fields reviewed above. To the extent that this literature aims to recognize the impact of collective trauma on individuals and communities, the literature is an important contribution to trauma studies, and one which we cover in order to weave some of its insights into our final sections of the paper. In that final section of the paper, we integrate what we argue is a more expansive, comprehensive and dynamic explanatory theoretical approach to understanding key features in the current lives of Aboriginal peoples of Canada — a social context complex traumatic stress framework.

PART V – THE IDEA OF HISTORICAL TRAUMA

Historical Context for the Trauma of Aboriginal Peoples: A Brief Overview of Trauma and Impacts on Health and Well-being

Trauma has been known, even in industrialized countries, to disproportionately affect the most marginalized members of society (Karmali et al., 2005, p. 1007).

Trauma affects people's health and well-being in profound and pervasive ways. Health, in the sense we are using it here, refers not only to physical wellness and the absence of disease in the body, but more expansively includes well-being in general terms, including mental health and a person's ability to develop and express their range of capacities. As the World Health Organization defines it, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Preamble to the Constitution of the

World Health Organization, 1946). One of the pervasive deleterious effects of traumatic events on the peoples of Canada's First Nations then, is the multi-leveled harm to the health and well-being of Aboriginal individuals as well as to Aboriginal communities in general.

At the time of European contact, the communities of Aboriginal peoples in Canada were thriving and in good health. Over centuries and through the multiple practices of colonization, however, the state of good health of the Aboriginal peoples of Canada has gradually eroded, and ultimately degenerated into the state of relative ill health which characterizes certainly not all, but so many Aboriginal people and communities today (UNPFII, 2006).

The assaults on the health and well-being of Aboriginal communities are multilevel. Canada's historic Report of the Royal Commission on Aboriginal Peoples (1996a) describes the ways in which Aboriginal peoples' health worsened further as traditional economies collapsed and once-mobile peoples were confined to small plots of land where resources and opportunities for natural sanitation were limited. Aboriginal health levels declined again as long-standing norms, values, social systems, and spiritual practices were undermined or outlawed by increasingly problematic colonial policies (RCAP, 1996a).

The Royal Commission reports that, at the time of its research, the perilous state of most Aboriginal housing in Canada posed an "acute threat to health" (RCAP, 1996a, p. 372). The problems of inadequate housing for many Aboriginal peoples in Canada persist unabated over a decade and a half later. The Royal Commission report also documented that 84 per cent of Aboriginal households on reserves did not have sufficient income to cover housing costs (RCAP, 1996a, p.180). This problem of inadequate housing and economic resources persists today, and greatly compromises the health of Aboriginal peoples so affected (Waldram, Herring & Kue Young, 2006; INAC, 2005; Macmillan et al., 1996).

In terms of contemporary research, there are myriad studies documenting the fact that Aboriginal peoples suffer disproportionately high adverse health effects relative to the general population, including higher levels of what has been described as "severe trauma." For example, one set of Canadian researchers found that Aboriginal Canadians had nearly a 4-fold greater risk of severe trauma than the non-Aboriginal population. These severe traumas included things like motor vehicle crashes, assaults and self-inflicted injuries, including suicide. The same researchers found that "Aboriginal Canadians had a 10-fold greater risk of injury secondary to assault and a 3-fold greater risk of traumatic suicide," (Karmali et al., 2005, p. 1010). These findings speak

to the need for an expanded and more nuanced view of the ways in which traumatized peoples, perhaps to a large extent as a complicated consequence of that traumatization, tend to suffer higher rates of injury producing accidents and other harms than those in the general population (MacMillan et al., 1996).

Making Trauma Visible: The Paradox of Denial

One of the more insidious ways that marginalization and relative social powerlessness get reinforced and further entrenched is through the mainstream tendency to deny any social responsibility for producing the very conditions producing this marginalization and powerlessness, while simultaneously holding those so affected responsible for their own situation. This kind of victim-blaming and social denial represents a pernicious additional layer which peoples who have been disenfranchised, as the Aboriginal peoples in Canada have been disenfranchised through generations of colonialism, must endure. It is embedded and expressed in the still too widespread ignorance of the history of the Aboriginal peoples of Canada, the persistent circulation of racist stereotypes about Aboriginal peoples, and the often heard attitude that Aboriginal peoples need to "fit in" to mainstream society and stop getting "special treatment." In this kind of sentiment, we see the simultaneous erasure of colonialism with the blaming of those negatively affected by the colonial injustices.

Paradoxically, then, one of the problems facing Aboriginal communities is a dominant view that holds Aboriginal peoples responsible for the negative effects of the traumatic events they have endured. This view is not only expressed in racist attitudes and stereotypes, but it also reveals a failure (or refusal) to apprehend the factors creating the health problems, including the mental health problems and addictions facing so many Aboriginal peoples today. Moreover, it fails to grasp the connection between the state of health of Aboriginal peoples and the many levels of neglect of basic health needs facing so many Aboriginal communities, such as the failure to provide clean drinking water, safe housing, adequate school buildings, and medical care.¹⁰

This is not a new theme. Indeed, it was articulated in the Final Report of the Royal Commission in the chapter dealing with "A New Beginning." There, the Commissioners observed the ways in which a "formal equality" model, premised on the idea that everyone should now be treated in the same manner, decontextualized the history and present circumstances of Aboriginal peoples of Canada, while denying the role of injustice in creating these circumstances. In the Commissioners' words:

First, there has to be a sincere acknowledgement by non-Aboriginal people of the injustices of the past. Widespread ignorance of the history of dispossession has made it increasingly difficult for non-Aboriginal people to admit the need for restitution. Unfortunately, as Aboriginal people have gained strength in the struggle for their rights there has been a rising tide of opposition among non-Aboriginal people with an interest in maintaining the status quo. Their watchword is 'equality': everyone should be treated the same, regardless of deprivation and disadvantage or the origins of these conditions. Acknowledgement and a genuine desire to make reparations are essential prerequisites of a renewed relationship of fairness and mutual respect (RCAP, 1996a).

Historical and Intergenerational Trauma: Grasping the Harms to Entire Communities

In addition to understanding the ways in which post-traumatic stress affects the lives of individuals, the ways in which traumatic events, particularly those that are ongoing, affect entire communities has begun to be addressed in the scholarly literature through the concept of historical and intergenerational trauma. Within the trauma field more generally, an important and specialized literature, though still relatively small, has emerged mainly from within the psychological, psychiatric, sociological, and anthropological disciplines. This literature attempts to grapple with the transmission of the traumatic impact of gross injustices and harms inflicted on targeted groups of peoples across generations. This literature conceptualizes the trauma inflicted on entire communities of peoples who have been subject to abuses on the basis of their ethnicity and group identity, and explores the ways in which the children of those people also carry the traumatic effects, even though those children did not directly experience the traumatic events themselves.

The concept of historical trauma in fact can act as a model for understanding the cumulative, long-term effects of multiple traumatic events on individuals, families and communities (Evans-Campbell, 2008). There are many terms that have been used to describe this phenomenon, including intergenerational trauma, intergenerational PTSD, collective trauma, historical grief, multigenerational trauma, and historical trauma (Denham, 2008). Historical trauma, however, is the term most commonly used by scholars in the Aboriginal context (Evans-Campbell, 2008; Pearce et al., 2008; Palacios & Portillo, 2009).

Historical trauma has been conceptualized as "a collective complex trauma inflicted on a group of people

who share a specific group identity or affiliation – ethnicity, nationality and religious affiliation. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events" (Evans-Campbell, 2008, p. 320). Put slightly differently, historical trauma is "the collective emotional and psychological injury over the lifespan and across generations" (Pearce et al., 2008, p. 2186).

Some of the state perpetrated war atrocities of the twentieth century were the impetus for this scholarship. The unspeakable violence perpetrated against the Jewish people during the Holocaust of WWII, and the internment of the Japanese during this same historical period, have acted as the early major sources of studies attempting to analyze the effects of historical trauma.¹¹ This concept has since been applied to other groups who have suffered collective harms, including Armenians and Aboriginal peoples.

Part of the goal of this scholarship is to grasp the collective impact of historical abuses, as well as to explore the intergenerational transmission of the knowledge, memories and effects of these traumas. This concept identifies the link between the present and the past, as a writer on the topic of historical trauma observes:

Connecting the past with the present is inherent in many cultural traditions. Historical trauma theory contextualizes "time and place." It validates and aligns itself with the experiences and explanatory models of affected populations and recognizes issues of accountability and agency. It creates an emotional and psychological release from blame and guilt about health status, empowers individuals and communities to address the root causes of poor health and allows for capacity building unique to culture, community and social structure (Sotero, 2006, p. 102).

As discussed below, this literature, some of which is specialized in focusing on the experiences of the Aboriginal peoples in North America and Australia, adds an important and necessary dimension to the typically individualized focus of traditional psychological and psychiatric approaches to the study of trauma.

Emergence of the Idea of "Historical Trauma" and Its Relationship to Aboriginal Peoples

Central to the idea of historical trauma is the existence of unresolved grief relating to the abuses perpetrated against the group, and the idea that there is an intergenerational transmission of traumatic effects from one generation to the next (Palacios & Portillo, 2009). Teresa Evans-

Campbell (2008), a professor at the Washington School of Social Work who is a citizen of the Snohomish Tribes of Indians, has published some important work delineating the nature and impact of historical trauma in Native American communities. Evans-Campbell argues that the events giving rise to historical trauma, though varied, can be seen to share three broadly defining features.

These three distinguishing features of the kinds of events associated with historical trauma in Aboriginal communities are events that:

1. Are widespread amongst the Aboriginal community.
2. Generate high levels of collective distress in contemporary communities.
3. Are perpetrated by outsiders, typically with destructive intent (Evans-Campbell, 2008, p. 321).

In the context of the Aboriginal peoples of Canada, historical trauma flows from an unfortunately long list of events, including colonialism, residential schools, the 1960s “adoption sweep” where Aboriginal children were taken from their families of origin, loss of land, massacres, racism, and the loss of cultural practices and language. These events creating legacies of historical trauma are devastating and have pervasive and life changing effects (Palacios & Portillo, 2009).

One group of researchers describes the issue of trauma in Aboriginal peoples of North America in especially apt and unflinchingly stark terms. In their words:

After military defeat, American Indians experienced one of the most systematic and successful programs of ethnic cleansing the world has seen. They were relocated to what amounted to penal colonies, starved, neglected, and forbidden to practice their religious beliefs. Their children were taken from them and reeducated so that their language, culture, and kinship patterns were lost to them. There are several aspects pertaining to the attempted continental decimation of numerous cultures over the period of 400 years that the analogy to the Holocaust may not sufficiently convey (Whitbeck, Adams, Hoyt, & Chen, 2004, p. 121).

They continue to elaborate upon the specificities of the Aboriginal experiences of North America as follows:

First, there was no safe place to return to or immigrate for American Indians. All were forced to relocate to

areas that had no economic value to Europeans. Some were force-marched or loaded on trains and relocated to completely foreign areas of the continent. Reservations were initially very much like large concentration camps or penal colonies. The “more civilized” general population of Europeans often held the reservation people in disdain. Leaving the reservations was illegal. The residents were dependent on the government representatives for food, shelter, and health care.

Second, traditional means of survival were eradicated and the people were forced to learn new ways of surviving (e.g., farming) that often were culturally distasteful or impossible given the quality of the lands they now occupied. Third, there was no specific end to the ethnic cleansing. It was ongoing and legally sanctioned. Practicing traditional religion became illegal, hunting off the reservation was illegal, and children were legally taken from parents and placed in boarding schools that broke up extended family systems and outlawed traditional language (Whitbeck et al., 2004, p. 121).

The writers conclude by emphasizing the specificity and scale of the particular abuses inflicted upon Aboriginal peoples in North America. In their words:

The important point here is that the ethnic cleansing did not end with military defeat and occupation of territory. Rather, it persisted for generations. This means that American Indian people are faced with daily reminders of loss: reservation living, encroachment of Europeans on even their reservation lands, loss of language, loss and confusion regarding traditional religious practices, loss of traditional family systems, and loss of traditional healing practices (Whitbeck et al., 2004, p. 121).

These writers importantly emphasize that it is the daily nature of the reminders of ethnic cleansing and the persistence of discrimination that are essential to any adequate conceptualization of historical trauma and how it is experienced by the Aboriginal peoples of North America. This recognition, in turn, is essential for understanding the dynamics and mechanisms of the transmission of traumatic impacts through generations.

Historical Trauma: Identifying and Measuring The Impacts of Trauma Responses

The effects of historical trauma vary depending on the nature of the events causing the trauma, individual psychological characteristics and the particularities of specific communities. Historical trauma affects the individual, the family and the community, with these three levels interacting and perpetuating the effects onto future generations (Evans-Campbell, 2008).

Since most of the literature on historical trauma focuses on the Holocaust, the studies on the documented effects of historical trauma come largely from studies with Holocaust survivors and their children. At the individual level, these studies indicate that the effects of intergenerational trauma can include symptoms similar to PTSD, including guilt, anxiety and depression. These manifestations are distinct, depending on the individual and the generation being studied. Survivors of the traumatic event may experience many negative mental health consequences, such as depression, agitation, nightmares, anxiety, and dissociation. Some researchers suggest that the future generations may display subtler effects given their greater removal from the original traumatic events.

The levels of effects, such as measurable mental health issues, in the generations following the survivors of the original traumatic event are about the same as in the general population, although they do display more problems displaying emotion, psychosomatization, higher anxiety, and are more likely to have some symptoms of depression, difficulty in interpersonal relationships, violence, and other symptoms (Evans-Campbell, 2008). When the descendants experience contemporary trauma, they are more likely to develop PTSD or sub-threshold PTSD.

Dr. Maria Yellow Horse Brave Heart, one of the leaders in the field of historical trauma, a social worker and an Aboriginal woman in the U.S., has founded the Takini Network, an Aboriginal non-profit organization devoted to community healing from intergenerational massive group trauma among Aboriginal peoples. Dr. Brave Heart has extensively studied the impact of trauma on Aboriginal populations, in particular the Lakota (Teton Sioux), and has observed a phenomenon similar to that observed amongst Holocaust survivor generations. Brave Heart has written extensively on historical unresolved grief theory and on culturally appropriate interventions among American Indians, and her groundbreaking work with colleagues has received international recognition. Brave Heart has identified what she describes as the “historical trauma response” to unresolved grief surrounding traumatic events.

In contrast to the historical trauma literature focusing on individual Holocaust survivors and their children, Brave Heart’s observations of historical trauma in some First Nations groups she studied note the effects not only on individuals, but also on entire communities. As researchers examining the experiences of Aboriginal people note, losses to the community have resulted from generations of traumatic events that have caused the breakdown of family kinship networks and social structures (Shepard, O’Neill & Guenette, 2006). At the familial level, effects of historical trauma can include reduced familial communication and stress around parenting. These effects have also been associated in the literature with increased familial violence and sexual abuse (Pearce et al., 2008). Community responses to historical trauma have also been identified as including the breakdown of traditional culture and values, alcoholism, high rates of suicide, disease and homicide, poverty, internalized racism, and a range of mental health problems (Evans-Campbell, 2008; Palacios & Portillo, 2009).

As important as it is to delineate and analyze the structural and common experiences of trauma, including specifically the idea of historical trauma in the lives of Aboriginal peoples, it is also necessary to pay attention to differences across and within Aboriginal cultures and communities as well as in relation to differences amongst individuals (McCormick & Wong, 2005). As Evans-Campbell (2008) explains,

[T]here is considerable variability in individual responses to traumatic events and exposure does not necessarily trigger symptoms of dysfunction [sic]. Symptomology may be seen in one person after a relatively mild stressor, whereas in another person exposure to a major traumatic event may trigger only mild distress (p. 316).

While for the purposes of this report, we are emphasizing commonalities in experiences of traumatic responses across Aboriginal communities, it is nevertheless important to keep in mind that more research and analysis is necessary to elucidate differences and specificities as these relate to the diverse experiences and contexts of Aboriginal peoples and cultures in relation to complex collective trauma. Put differently, while generalizations are useful to understand the contours of the phenomenon of historical trauma, they should not obscure particularities and diversity in Aboriginal experiences of it.

To illustrate, within the Aboriginal community itself, the traumatic experiences of Aboriginal women may differ from Aboriginal men’s experiences. Aboriginal women,

as a result of their gender, remain doubly disadvantaged in Canadian society, and in Aboriginal communities themselves, by reason of both race and gender. For example, Brave Heart (1999) has documented and discussed gender differences in responses to historical trauma among the Lakota. Her findings from a research study addressing historical trauma are summarized as follows:

The sample of women presented initially with a greater degree of conscious affective experience of historical trauma. In contrast, the men reported more life-span trauma associated with boarding school attendance and appeared to be at an earlier stage of grief. However, at the end of the intervention, women's experience of survivor guilt—a significant trauma response feature—decreased while men's consciousness of historical trauma and unresolved grief increased (p. 1).

As a result of these differences in experiences of historical trauma based on gender, it is necessary for future research and analysis to interrogate the ways in which gender may influence a person's experience of this kind of trauma.

“Measuring” Historical Trauma Responses: Attempts and Challenges in the Research Literature on Aboriginal Peoples

The growing body of recent research addressing historical and contemporary trauma responses in Aboriginal populations has been explicitly aimed at assessing the interconnections between mental health difficulties and substance abuse in relation to trauma, historical loss and current economic deprivation. Some of the leading and most recent empirical research in the area of measurement and what would more traditionally be defined as “diagnosis” of the effects of trauma and mental health, and substance abuse problems in Aboriginal populations has been undertaken by Dr. Les Whitbek and his colleagues, who have included Aboriginal Elders in their research and project design.

Brave Heart has also undertaken important research in this field. In her research on historical trauma among the Lakota, Brave Heart highlights some of the effects of trauma in Aboriginal communities, including ruminations over past events and lost ancestors, survival guilt, numbness in response to trauma, depression, intrusive dreams, and other mental health problems (Evans-Campbell, 2008). The symptoms identified by Brave Heart run from post-traumatic stress to unresolved guilt.

However, other researchers, including Whitbeck and his research associates, have observed that Brave Heart's research has been limited to “theoretically associating psychological symptoms and somatic problems identified among American Indian people indirectly to historical causes” (Whitbeck et al., 2004, p. 121). In other words, Whitbeck and his colleagues argue that Brave Heart has made an important correlation between mental health difficulties and historical trauma without actually documenting that such a connection actually exists. Simply correlating indicators of historical loss with standard stress measures, such as depression and anxiety, does not mean that there is a causal connection between the two. These symptoms might instead be the result of proximal (immediate) rather than distal causes (long-term). Whitbeck and his colleagues contend that we must instead determine the extent to which Aboriginal people associate this emotional distress directly to historical losses (Whitbeck et al., 2004).

For example, in relation to the high rates of suicide among the Aboriginal community, distal factors may include the pervasive historical legacy of colonization over many generations. Proximal factors, on the other hand, may include other immediate causes of suicide, such as a personal crisis, and enabling factors, including availability of alcohol, drugs and firearms, which increase the likelihood of impulsive action and suicide attempts (Kirmayer et al., 2007). One cannot assume that the high rate of suicide among the Aboriginal population is directly attributable to historical trauma without demonstrating the connection. Therefore, future research must find the connection between the psychological symptoms noted by Brave Heart and their historical sources, thereby linking the sense of historical loss to the symptoms (Whitbeck et al., 2004).

In a series of studies with Aboriginal adults, children and youth from First Nation reserves in the U.S. and Canada, studies undertaken by Whitbeck and colleagues have empirically documented the significantly higher rates of mental health and substance abuse problems experienced by the youngest, and therefore possibly the most vulnerable, members of Aboriginal communities. What is significant about this research is that the studies are explicitly framed within an acknowledgement of, and with analytic attention centrally paid to, the historical as well as the contemporary social contexts of colonialism, poverty and disadvantage facing Aboriginal peoples in Canada and the United States. As Whitbeck and colleagues emphasize in relation to their empirical documentation of the link between trauma, discrimination and mental health effects in Aboriginal

communities, the “high rates of mental and substance abuse disorders at these early ages should alarm state and national mental health policymakers” (Whitbeck, Yu, Johnson, Hoyt, & Walls, 2008, p. 899).

In one empirical study of the links between discrimination and the likelihood of American-Indian adults meeting criteria for alcohol abuse, the researchers were able to demonstrate that “alcohol abuse is [in fact] strongly associated with historical loss” (Whitbeck, Chen, Hoyt, & Adams, 2004, p. 413). This is a very significant finding because it delineates a connection between the use of alcohol as a form of coping — numbing — by people attempting to deal with overwhelming current and/or historical traumas.

Whitbeck and colleagues further elaborate on the significance of their finding that alcohol abuse is strongly associated with historical trauma. They suggest that,

Although there is much work to be done to understand the specific mechanisms responsible for this association, the potential relation to stress theory is intriguing. Other findings indicate that historical loss is much on the minds of some American-Indian adults, and they attribute negative emotional responses to it (Whitbeck et al., 2004). Alcohol may serve to reduce intrusive thoughts or feelings related to historical loss and to numb reminders of that loss. Alcohol abuse may also represent anger manifested in self-destructive behaviors (Whitbeck, et al., 2004, p. 416).

This finding indicates the complex interconnections between structural traumas imposed on whole groups and individual coping with trauma responses in Aboriginal communities. As we mention elsewhere in this paper, trauma drives and underpins a great deal of alcohol and substance dependency and abuse.

More broadly, Whitbek and his associates’ research on alcohol abuse and trauma has wider implications for future studies which might seek to delineate further interconnections between trauma and other prevalent issues and problems confronting Aboriginal peoples in Canada today. This research might include, for example, child abuse, domestic violence, lower educational rates, and poverty. This is not to suggest that all of these complex problems are exclusively the product of historical and contemporary trauma. Instead, it is to say that trauma and the effects of complex traumatic stress likely play significant roles in the production and experiences of these social problems at both the micro- and macro-levels. More research and analysis is

necessary to explore and explain these intricacies.

Even more recently, in 2006, Whitbeck and a group of colleagues reported on a study which found that the prevalence of substance abuse, behaviour problems and depression were approximately two times greater for Aboriginal children between 10 and 12 years of age than had been found in a previous study of Indigenous children (Whitbeck et al., 2008). To follow up this research, they tracked the same group of young Aboriginal people, using a sample of 736 children and youth (tribally enrolled in four U.S. and four Canadian reserves), and assessed the prevalence rates of these problems during their early adolescence, ages 13 to 15 years. The data from this study showed significant, and troubling, increases in the prevalence rates of substance abuse, depressive disorders and other mental health problems in this population of Aboriginal young people.

Using comparative data from the prevalence rates of these problems in the general population, Whitbeck and colleagues found that the rates of mental health difficulties and substance abuse problems were dramatically higher for Aboriginal children and adolescents than for the general population. More specifically, these researchers report that rates for a lifetime conduct disorder for Aboriginal youth are “more than twice the highest rates expected in the general population” (Whitbeck et al., 2008, p. 897). For substance abuse problems, the twelve-month rate reported by this study is “nearly three times that of the National Survey on Drug Use and Health” (Whitbeck et al., 2008, p. 897).

The researchers connect these difficulties in the lives of Aboriginal children and adolescents to the parents’ difficulties in these areas, thereby offering some data on the ways in which traumatic impacts can be transmitted through the generations, which we elaborate upon below of this paper in terms of disruptions to attachment.

This research provides empirical documentation of the intergenerational transmission of trauma responses. As Whitbek and colleagues explain:

Multivariate analyses suggest intergenerational continuity of mental and substance use disorders. Having a biological mother who met lifetime criteria for SUD [Substance abuse disorder] or an internalizing disorder about doubles the odds of her child meeting criteria for a psychiatric disorder. If the mother was comorbid for SUD and an internalizing disorder at wave 1, then the odds that her child met criteria for an externalizing disorder at wave 4 increased to more than three times. Families in which the mother has a history

of psychiatric disorder will likely to be those that will have the most difficulty coping with a child with a psychiatric disorder (Whitbeck et al., 2008, p. 898).

Whitbek and colleagues also point to the broader and compounding effects of these findings, including the effects on Aboriginal communities. They underscore the need for treatment and interventions to assist these young Aboriginal people at an early point in their lives. In their words:

The effects of social location are cumulative. Reservations lack resources to respond to the high numbers of emotional and behavioral problems among the adolescents, and the families in which they reside may well be those that are the least able to cope without support. (Whitbeck et al., 2008, p. 898)

These researchers further argue that their findings have highly significant policy implications, demonstrating the urgent necessity of adequate service delivery and resources to Aboriginal communities at risk and in crisis. As Whitbek and colleagues explain:

These results call attention to the critical need for mental health services on indigenous reservations and reserves. These numbers would overwhelm any pediatric health system, but these communities are among the least prepared in the nation to respond effectively. Indeed, these findings are one more blow to communities that are struggling to overcome the psychological effects of 300 years of systematic ethnic cleansing [emphasis added] (Whitbeck et al., 2008, p. 899).

Through this research, Whitbeck and colleagues explicitly connect the mental health problems, including substance and alcohol abuse facing Aboriginal peoples, with historical and contemporary trauma-producing conditions. In their words:

Empirical evidence is beginning to emerge linking historical losses to mental health and substance use symptoms of indigenous people. Such high rates of mental and substance abuse are indicative of this historical legacy (Whitbeck et al., 2008, p. 899).

In a different study, aimed at expanding these conceptualizations by measuring historical trauma and grief and its prevalence in Aboriginal people's lives, Whitbeck and colleagues collaborated with Aboriginal Elders to

devise what they call the "Historical Loss Scale" and the "Historical Loss Associated Symptoms Scale" (Whitbeck et al., 2004, p. 125). The scale included twelve items associated with emotional distress directly related to historical losses suffered by Aboriginal communities. Using these measures, they found that they were able to document that "historical losses were much on the minds" of Aboriginal peoples they studied, sometimes on a daily basis (Whitbeck et al., 2004, p. 124). Furthermore, they found that associated with cognitions about and awareness of historical losses were symptom constructs such as anxiety, depression, anger, and avoidance (Whitbeck et al., 2004).

In this way, these researchers have been able to document thoughts about and psychological reactions to historical losses were very present in the lives of Aboriginal peoples, and that these thoughts were associated with emotional distress (Whitbeck et al., 2004). This is an important way of assessing the ways in which collective historical traumas shape the everyday lives of those affected. This finding also moves us beyond assuming a correlation between historical trauma and psychological distress, towards actually demonstrating a causal connection empirically.

These studies make an invaluable and new contribution to knowledge about the ways in which trauma attributed to historical losses and mental health problems can affect Aboriginal communities. The innovative study devising scales to measure historical trauma illustrate the ways in which traumatic events can be represented in conscious mental life.

Important as these research efforts are in documenting some of the crucial dimensions of historical trauma, however, they are also necessarily limited. This is not a shortcoming of the study, but simply a comment that the complexity of the phenomenon of historical trauma exceeds what any single study can address. Most significantly, this study captures only impacts of historical trauma at the level of thoughts and cognitions. Important as this finding is in people's everyday lives, the realm of explicit and identified mental thoughts is only one level of human experience, and perhaps not even the most important level on which traumatic impacts and traumatic memories are stored, experienced and even sometimes re-enacted.

As is elucidated in the preceding sections of this paper, multiple traumatic events and complex trauma responses are not reducible only to the level of cognitions and their associated emotions, important as these are. Instead, complex trauma responses and dysregulate affect (emotional states) can create significant difficulties with concentration,

focus and memory, and can impair a person's levels of functioning in ways she or he might not even associate with prior traumatic experiences.

The ways in which personal experiences and individual lives are shaped by historical events, including traumatic collective events, then, are complex and not necessarily always readily identified, quantified or empirically "measured." This caution aside, it is nevertheless possible and important to develop and refine additional and more complex ways to assess traumatic impacts associated with collective harms. More research in this area is necessary to build on the excellent work already begun, and in order to better understand the ways in which collective complex trauma, as it is more expansively described, is lived within communities and within the individual lives of the Aboriginal peoples of Canada.

Some Limitations of the Concept Historical and Intergenerational Trauma in Relation to Aboriginal Communities

[T]he trauma, like a wave, continues to roll forward over generations leaving an array of effects in its wake [emphasis added] (Evans-Campbell, 2008, p. 329).

However useful comparisons of historical traumas across communities might be, these comparisons are also necessarily limited, and can fail to do justice to the specificity of the experiences of particular groups. For example, some researchers and writers have pointed out the ways in which the transposition of the idea of "historical trauma" suffered by the Jewish peoples as a result of the Holocaust is different from the nature of the events suffered by the Aboriginal peoples of North America over the four hundred years since the continent's colonization by Europeans.

More fundamentally, however, the idea of a "historical trauma" relation to Aboriginal peoples of Canada is arguably too static a concept for the context. This concept of "historical trauma" in relation to Aboriginal peoples makes the trauma in the lives of the peoples of Canada's First Nations appear to be only "historical," when in reality the trauma in their lives remains contemporary and current. In fact, many Aboriginal communities are in contemporary crisis, and are currently traumatized as a result of their current, and not only historical, social conditions.

This critical factor is central to explaining the high degree of difficulties faced in Aboriginal communities in comparison with other groups who have suffered historical

traumas (Whitbeck et al., 2004). In fact, a significant difficulty with engaging the term "historical trauma" in relation to the Aboriginal peoples of Canada lies precisely with the descriptor "historical." This term suggests that the traumatic event is something which is finished, over with, a relic of the past. For the Aboriginal peoples of Canada, however, it is clearly the case that the traumatic events continue on in the present, even if in different forms from some of the specific traumatic events imposed longer ago.

For these reasons, and because the experience of many Aboriginal peoples today is one of living with entire communities which have been and still are traumatized, we would argue for a term and a conceptual framework which more dynamically captures the levels and complexities of the trauma, past and present. A social context complex collective trauma framework precisely moves towards this goal.

Towards a Theory of Social Context Complex Trauma: A Dynamic and Multilayered View of Historical and Contemporary Trauma Responses

What have been described in the literature as historical trauma responses can perhaps more usefully be conceptualized as constituting part of or expressing a complex trauma response. Expressly situated within an analysis of social relationships, including structured relations of inequality, what we describe as a social context complex trauma framework, incorporates recognition of historical and contemporary traumas.

The social context complex trauma framework, therefore, appears to be a better, more dynamic and expansive approach for describing the circumstances of Aboriginal peoples of Canada as it captures both the community level aspect of the impact, and the idea that the trauma itself is multi-factorial and not reducible or traceable to a single event. Recognition of historical trauma must be understood to be one of the constitutive elements contributing to the complex trauma response in the lives of Aboriginal peoples and communities, yet in a way which grasps the ongoing presence of the historical in the present. Most significantly, it is important to recognize the impact on the everyday lives of many Aboriginal people, of *living in traumatized communities*. These communities are not traumatized as a result of previous experiences of historical wrongs which are now in the past, though this plays a significant role. Instead, they are currently traumatized as a result of contemporary social, economic and political conditions of their lives, and the ways in which individual lives are affected by ongoing complex trauma responses.

The way in which a complex trauma framework helps to explain the effects of trauma on Aboriginal peoples in Canada is articulated in greater detail in the next section of the paper, which ties together the general conceptualization of complex trauma, and integrates it with a social context analysis of the conditions of the lives of many Aboriginal people today.

PART VI – COMPLEX TRAUMA AND THE LIVES OF ABORIGINAL PEOPLES: A SOCIAL CONTEXT COMPLEX TRAUMA FRAMEWORK TO UNDERSTANDING TRAUMA RESPONSES IN ABORIGINAL COMMUNITIES

Theoretical Gaps in Explanations of the Intergenerational Transmission of Historical Trauma: Moving Towards a Social Context Complex Trauma Framework

A gradually increasing number of researchers, clinicians and scholars have been more specifically documenting and analyzing the ways in which historical abuses and the historical and contemporary forms of colonialism generate trauma in the peoples of the First Nations of North American (and also Australia) (Halloran, 2004). While there have been useful and eloquent attempts to describe how historical trauma is “transmitted,” the models advanced so far do not appear to adequately theorize, in a dynamic way, exactly how it is that trauma responses are lived and reproduced through the generations, a point we elaborate further below and throughout this section of the paper.

Marie-Anik Gagné (1998), for example, proposes conceptualizing the layers of persistently experienced trauma in terms of a series of overlapping tiers, which can be diagrammatically represented by a series of concentric circles. Tier 1, at the centre, is colonialism, which she sees as the “seed of trauma,” as it leads to “dependency, then to cultural genocide, racism and alcoholism.” Tier 2 is the socioeconomic and political dependency flowing from colonialism. Tier 3 is the experience of residential schools and the alcohol and substance abuse associated with coping with trauma. Finally, Tier 4 is cultural bereavement and the problems of domestic violence, child sexual abuse, child abuse, and accidental deaths also associated with coping with trauma (Gagné, 1998, p. 358).

This conceptualization is helpful not only for identifying distinct but inter-related levels on which trauma has been persistently experienced by Aboriginal peoples, but also for increasing understanding of the cumulative and compounding effect of these layers of trauma as they affect Aboriginal communities. It is an effective mapping of the layers, or overlapping tiers, of the social conditions and problems which structure the lives of so many Aboriginal peoples. However, this conceptualization is not a dynamic explanatory model; instead, it is a highly useful representation of multiple levels of factors shaping the lives of many Aboriginal communities.

These theories of historical “transmission” have been loosely grouped into four major models that explain the phenomenon of transmission across generations:

1. Psychodynamic: transmission to children through unconscious absorption of repressed and unintegrated trauma experiences of their parents.
2. Sociocultural and socialization: children learn vicariously through the impact of their parents and social environment.
3. Family systems: transmission through the communication between generations and the degree of enmeshment that takes place.
4. Biological: pre-disposing genetic or biological risk factors (Denham, 2008, p. 297, citing Kellerman, 2001).

The ways in which these models actually explain the “transmission” of historical trauma, however, is unclear. For example, the idea that children “absorb” unconscious, repressed trauma experiences of their parents is obscure and not consistent with the psychological literature. Similarly, it is not clear what “degree of enmeshment” means, and the idea that there are “biological” or “genetic” risk factors seems undeveloped and veering towards a static and inherited disease model of trauma. There is some sophisticated work on cortisol levels and trauma by Yehuda, Halligan and Grossman (2001), but this is quite different from suggesting that Aboriginal people are somehow biologically “pre-disposed” to reproduce historical trauma.

There have been several other conceptualizations developed to theorize how historical trauma is “transmitted” intergenerationally. However, even the idea of “transmission” of trauma is difficult, for it evokes an idea of the transmission of a disease, or a genetic flaw of some sort, in a way that might seem more static than is required.

While these levels may be significant to some degree, we take the view that a social context complex trauma framework more adequately explains some of the key ways in which trauma responses affect multiple generations of Aboriginal peoples.

Very few works expressly speak of complex trauma in relation to Aboriginal peoples, though not in an elaborated way, or expressly or fully expanded to situate it within a social context framework in the way we are advocating. Nevertheless, all writers do, of course, acknowledge the social conditions of colonization. In an interesting, although brief, paper, researchers in British Columbia suggest that there is support for the complex trauma conceptualization in relation to their work with a group of Aboriginal people who survived residential schools and their abuses. As Söchting and colleagues (2007) observe, the effects of historical trauma are very similar to the effects seen in people who suffer from complex post-traumatic stress disorder. As these mental health professionals note, complex trauma responses result from a series of traumatic events occurring in the life of a developing child or adolescent that are of a psychological, physical and/or sexual abuse nature in the context of inadequate emotional and social support. They further point out that, in their research sample of Aboriginal people, those seeking help display features of complex trauma, such as impairment in regulating impulses, self-destructive behaviour (such as substance abuse), alterations in self perception (such as chronic sense of guilt or shame), alterations in relationships with others, and alterations in systems of meaning (such as lost faith in existing belief systems) (Söchting et al., 2007).

Since their focus is on residential school survivors, the researchers argue, that the case for complex PTSD might be the overarching clinical conceptualization guiding any assessment and treatment planning of an Aboriginal person. The researchers further argue that a case may also be made for the view that the residential school syndrome is a culture-specific subtype of complex PTSD. This latter syndrome is, in their view, limited to residential school abuse (Söchting et al., 2007).

In a paper by Raphael, Delaney and Bonner (2007), they discuss culturally competent assessment of trauma for Aboriginal peoples in Australia. These researchers refer to the idea of complex trauma, though they rely more heavily on the idea of a trauma “archetype” throughout their discussion. They point to the need to recognize historical loss, the trauma complex and diverse impacts in developing culturally appropriate ways of assessing trauma in Aboriginal populations.

Further, in an interesting and insightful unpublished paper on the topic, Ross (2008) makes the case for the relevance of a complex trauma understanding in relation to some of the Aboriginal adults and children he worked with on reserves and in the context of the criminal justice system. Having heard a presentation on complex trauma in relation to assaulted women and domestic violence, Ross was intrigued to explore its applicability to Aboriginal peoples given the colonization and its effects on entire communities, a project he begins to analyze in the paper, from the point of view of his own professional collaborations with Aboriginal peoples.

Finally, in a paper on historical trauma prepared for the Aboriginal Healing Foundation, Wesley-Esquimaux and Smolewski (2004) make many eloquent observations about the nature and impact of historical trauma on Aboriginal peoples of Canada. The authors describe their model of trauma transmission as follows:

[T]he trauma memories are passed to next generations through different channels, including biological (in hereditary predispositions to PTSD), cultural (through story-telling, culturally sanctioned behaviours), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory processes) channels (p. 76).

Wesley-Esquimaux and Smolewski present many useful insights in their paper. Their new model for Historic Trauma Transmission (HTT) however, has some problems and explanatory gaps. While it would not seem to be their intention, the authors seem nevertheless to lapse in a disease model for explaining the transmission of historical trauma, and resort to the language of disease, which has pathologizing effects.

To illustrate, they refer to collective memories of powerlessness “passed on to successive generations as a collective contagion” (Wesley-Esquimaux & Smolewski, 2004, p. 5). Additionally, they speak of children catching a “trauma virus,” and falling “ill” with social disorders, such as family violence and sexual abuse (Wesley-Esquimaux & Smolewski, 2004, p. 65). The gender dimensions of these phenomena, which the authors gloss over, this language of contagion, of trauma as a virus, or as “genetically coded” (Wesley-Esquimaux & Smolewski, 2004, p. 74) and its description as a disease, is not only medicalizing and pathologizing, but is overly simplistic and fails to explain precisely what it sets out to. Elsewhere in the paper Wesley-Esquimaux and Smolewski (2004) argue that “symptoms

that parents exhibit . . . act as a trauma” (p. 65), which is circular insofar as this is tantamount to saying that trauma symptoms are a trauma. What is necessary, then, is a more detailed and nuanced explication of just how it is that through parenting, for example, trauma responses are replicated or induced.

It is the expanded approach offered by a social context complex trauma framework which helps to fill in these gaps, and to which we turn in the sections below. First, however, it is important to emphasize a very nascent recognition of the utility and applicability of the concept of complex trauma in relation to the lives and experiences of Aboriginal peoples. Although it is not defined, explained or well elaborated in their paper, Wesley-Esquimaux and Smolewski make reference to Judith Herman’s development of this idea of complex trauma; however, it is not juxtaposed against simple post-traumatic stress, and is in other places conflated with (simple) PTSD.

Why is a Social Context Complex Trauma Framework Important for a More Comprehensive and Dynamic Understanding of Trauma Responses in the Lives of Aboriginal Peoples?

What makes a social context complex trauma framework so useful and necessary for a better understanding of the current conditions of many Aboriginal communities at risk and in crisis?

The social context complex framework allows us to understand the multiple harms Aboriginal people face in terms of how these can shape the individual, how it shapes the person’s relationships to self and others, and how it shapes their connection to the community and even the world at large. This is a comprehensive and expanded socio-psychological framework which simultaneously grasps all of these critical dimensions of human life and development, along with the structural conditions in which they are situated.

Complex trauma and developmental trauma disorder provide a lifespan framework for conceptualizing accumulative harms and how they affect people’s capacities. Aboriginal communities have too often been faced with cumulative adversities that worsen the impact of complex trauma (Vogt, King & King, 2007). A second injury compounding the original injury of the traumatic events is the lack of response or adequate protection and resources, exacerbated further by victim blaming. All of these factors have been part of Aboriginal people’s experiences in Canada.

Ongoing experiences of abuse, denigration, deprivation, neglect, and loss interrupt the most fundamental aspects of psycho-biological development. These aspects are: the integrity of the body; the development of a healthy identity and coherent personality; and the ability to form secure attachment, which, in turn, leads to the ability to have healthy and reciprocal relationships. These experiences and their negative effects are especially formative when they begin early in life, when self-definition and self-regulation are formed and consolidated during childhood.

The nature of the harms that result in complex trauma include experiences that move beyond obvious instances of threat or violations of bodily integrity. Neglect and deprivation tend to be misunderstood and minimized in general understandings of trauma. For instance, emotional neglect may not be immediately life threatening, but lead to long-standing severe problems with self-regulation that are associated with psychobiological stress dysregulation and reactivity.

In fact, many of the harms that Aboriginal communities continue to experience and have suffered in the past are more expansive than instances of immediate harm or violation of bodily integrity (specified under criterion A of PTSD). As a result, the reactions of fear and anxiety that are associated with more immediate dangers in people’s lives do not adequately capture the more nuanced psychological responses Aboriginal people might express as a result of ongoing experiences of abuse, neglect and loss. These reactions might include a sense of resignation, defeat, betrayal, and shame.

Complex trauma in childhood leaves the child unable to self-regulate (control feelings, cognitions, beliefs, intentions, and actions), to achieve a sense of self-integrity, or to experience relationships as nurturing and reliable resources that support self regulation and self integrity. We have discussed the development of hyperarousal and hypervigilance in relation to external danger, but in complex trauma, the internal threat of being unable to self-regulate, self-organize or draw upon relationships to regain self-integrity are some of the worst outcomes of abuse and neglect.

Socially contextualized information about traumatic stress shifts the focus away from perceived flaws in the “personality” or “character” of survivors of abuse, and instead situates traumatized people’s coping within the range of normal and typical human responses to trauma imposed from external sources.

This is one of the more significant and important aspects of the kind of social context complex trauma framework we are advocating in this paper. This reframing

of individual “pathologies” is a crucial contribution of the post-traumatic stress framework, as is the connection of individual and community as well as forms of coping with the social contexts and material conditions in which people live. When integrated with a social context analysis, a complex trauma approach allows for an expanded and deepened appreciation of the ways in which trauma responses are fundamental aspects of human experience in the all too common face of abuse, violence, neglect, and deprivation in Aboriginal peoples lives in Canada.

People who seek help with various problems in their lives, including, but not limited to, use and abuse of substances, depression, self-harming behaviours, and chronic difficulties in intimate relationships, may not even connect the difficulties they are experiencing in their current lives with their own prior experiences of abuse and neglect. They most likely do not grasp the ways in which many of these issues are possible complex trauma responses. If mental health professionals and other social service providers are not trauma informed, these people seeking help may not receive the kind and extent of care they require to assist them with their distress and with their healing and recovery.

These problems and gaps in care can be particularly acute for traumatized Aboriginal persons and communities. As one set of writers observes:

Maladjusted [sic] Aboriginal patients, much like borderline personality disorder patients, tend to be viewed pejoratively by mental health professionals, to the point where they are dismissed as too complicated, unreliable, and treatment-resistant. As a result, such “difficult” patients are often denied appropriate and responsible care and treatment (Söchting et al., 2007, p. 325).

A social context complex trauma framework, therefore, offers a comprehensive and non-pathologizing way of understanding layers of responses to traumatic events when applied to the lives of Aboriginal people. This formulation takes into account the cumulative traumas that many Aboriginal people have faced. For example, in a complex trauma framework, chronic self-destructive behaviours, such as substance abuse and self-harm such as cutting, are understood to be forms of coping with overwhelming traumatic memories and underdeveloped capacities to regulate disturbing emotions. Most importantly, however, complex trauma does not merely explain the more severe traumatic responses people may experience, but also helps explicate the difficulties that many people have with everyday life as a result of the harmful effects of traumatic events.

Adaptations and Trauma Responses: Understanding People’s Ways of Coping in a Social Context Complex Trauma Framework

In responding to the effects of abuse-related trauma and chronic neglect and deprivation, people devise a range of diverse coping methods throughout their lives. While these coping methods may sometimes interfere with functioning, they are also in some fundamental ways useful to the survivor. This means that people’s ways of coping with trauma are complex, and therefore must be understood in an expansive and nuanced way.

As mentioned earlier, many traumatized people will rely on emotional numbness (distancing from their feelings), or will use dissociation and appear to have “checked out.” One of the central harms of complex trauma response is the absence of the development of secure attachment.

When abuse is prolonged and repeated, these coping behaviours result in psychological and physiological changes or adaptations. Eventually, the adaptations that were developed to survive become no longer functional. For example, some of these responses keep the body on high alert for danger (arousal and hyper vigilance) or disconnected and numb in order not to feel pain (Haskell, 2003, p. 2).

Central to the trauma model we are outlining in this paper is the shift from a deficit model to an adaptation, resiliency model. This paradigm shift allows for a focus on a survivor’s best attempts at coping with overwhelming abuse, neglect or maltreatment in intolerable circumstances.

This positive appraisal and reframing of “problems” and “symptoms” as “adaptations” assists survivors in recognizing their strengths and inner resources, instead of defining themselves by weakness and failure. For example, dissociation protects them from overwhelming pain in childhood. In adulthood, dissociation protects them from remembering painful events or experiencing unacceptable feelings. Trauma survivors learn that many of their symptoms are the result of adaptations that helped them survive in the past, and, to some degree, in the present.

From this perspective, people dealing with post-traumatic stress are not collections of symptoms. Instead, they are viewed as traumatized people who are attempting to cope as best as they are capable — even if this coping is not always successful. A central goal of trauma treatment is to help people to develop more effective ways of coping (Briere & Scott, 2006).

The adaptations people make in the face of trauma, including substance abuse, self-harm and dissociation, can themselves be problematic or can create their own additional problems. Nevertheless, there is something extremely important about validating and recognizing that traumatized people are making their best efforts to cope in overwhelming situations or environments. This recognition, however, does not preclude a compassionate recognition of the harms associated with these attempts to cope. This is a crucial shift from a deficit model to a validating model that recognizes people's courageous attempts to survive. This is exactly the approach which must be taken when understanding the experiences of Aboriginal peoples and communities in Canada, as is elaborated in the sections below.

The Overlapping and Inter-Connected Elements of Complex Trauma in a Social Context Framework

Each of the six major elements comprising the diagnostic criteria for complex trauma response is discussed below, integrated with research findings on specific aspects of the lives of Aboriginal peoples in Canada. While we have framed our discussion within this six-part organization, it is important to recognize that these six elements are inextricably related; their separation, while assisting with analytic clarity on one level, is somewhat misrepresentative on another level, as they cannot so easily be separated.

There is no need, then, for slavish adherence to this six-part construct. However, for the sake of continuity, we have followed it for purposes of our discussion of a social context complex trauma framework and the lives of Aboriginal peoples.

Below we reiterate and apply an expanded version of a complex trauma framework, one which centrally addresses social context, to some of the key aspects in the lives of Aboriginal peoples in Canada today. Each of the dimensions is discussed in turn.

1. Affect Dysregulation, Abuse, Neglect, Deprivation, and Complex Trauma

Affect dysregulation, as outlined in previous sections of this paper, describes difficulties regulating emotional states. Affect dysregulation, then, translates to a disruption of a core self capacity. It is at the core of a wide range of other secondary problems, such as, for example, alcoholism and substance abuse. In the absence of more functional and effective coping, traumatized people often use drugs or alcohol to avoid feeling intolerable levels of emotional

arousal (pain, grief, despair, loneliness, fear, and shame). Unlike a more traditional and limited "disease" model of alcoholism and substance abuse, understanding that a trauma response, specifically expressed as affect dysregulation, is at the heart of much substance abuse offers a more expansive and less static understanding of this problem in people's lives, and indicates a very different approach to treatment and intervention.

Substance abuse, including drug and alcohol abuse, is in fact a common problem within Aboriginal communities. This problem must be considered in the socio-economic context of Aboriginal living conditions in Canada, including such factors as poverty, under- or unemployment, isolation on reserves, and poor living and health conditions (MacMillan et al., 1996). A number of studies on the mental health problems currently found within the Aboriginal community, including high incidences of physical and sexual abuse, suicide, psychiatric problems, and alcoholism, have been linked to the experience of former residential school students or to the mass adoption of Aboriginal children in the mid-twentieth century (Fournier & Crey, 1997; Kirmayer et al., 2007; Colmant, 2000; Grant, 1996; Knockwood & Thomas, 1992; Haig-Brown, 1988).

Children who have been subjected to ongoing abuse or neglect are very likely to experience significant problems relating to their emotional regulation capacities, their self-concept, their social skills and their academic motivation. Research has shown that severe depression, substance abuse, impulsiveness, hyperactivity, and aggression are long-term outcomes of abuse in childhood. Chronic physical and/or sexual abuse has been shown to play complex roles in the development of mental health symptoms, substance abuse and a wide range of physical health problems.

The long-term outcomes of chronic abuse are clearly manifested in the lives of many Aboriginal children and parents in Canada. As one study by the Ontario Federation of Indian Friendship Centres on Aboriginal families living in Ontario states, "Words such as low self-esteem, depression, anger, self-doubt, intimidation, frustration, shame and hopelessness were used to describe some of the crushing feelings of Aboriginal children and parents living in poverty" (Ontario Federation of Indian Friendship Centres (OFIFC), 2000, p. 7). In fact, mental conditions, such as depression, anxiety and PTSD, are the most common mental disorders found in Aboriginal communities, and in some communities are endemic (Kirmayer, Brass & Tait, 2000). A review of case files for 127 Aboriginal survivors of residential schools who had undergone clinical assessments in British Columbia revealed that 82 per cent

reported that their substance abuse behaviours began after attending residential schools (Corrado & Cohen, 2003). Another study on Aboriginal substance abuse treatment centres across Canada revealed that 80 to 95 per cent of their clients had been victims of child abuse. Employees of these programs reported that they now saw “alcohol and drug addition[s] merely as symptoms with sexual abuse as the underlying cause” (Fournier & Crey, 1997, p. 116).

Abused children often re-enact behavioural aspects of their abuse through aggressive, self-harming or sexualized acting out. These responses can be conditioned triggers to trauma reminders or attempts to gain some control over their experiences. Affect dysregulation is an element of this phenomenon as well.

In one study on sexual abuse among a group of young Aboriginal people between the ages of 14 and 30 years in British Columbia, the researchers found that nearly half of the participants reported that they had experienced sexual abuse as a child. These survivors of childhood sexual abuse were also found to be at a significantly higher risk of serious negative outcomes in other areas of their lives, including their health. Sexual abuse survivors, in fact, were twice as likely to be HIV-positive compared to those who did not report any sexual abuse (Pearce et al., 2008), a finding elaborated in the section on alterations in relationships with others, below.

2. Dissociation and Complex Trauma

The complex trauma model identifies dissociation as a key feature of chronic traumatization. Dissociation can be thought of as a form of disconnection to the self, as well as to the outside world.

Memories previously dissociated often cause problems in current behaviour, when the immediate need to defend oneself has expired. For many Aboriginal people, fundamental capacities are affected by chronic trauma coupled by a broader social environment of disempowerment.

Dissociation describes an inability to integrate information and experiences. Dissociation is believed to be one of the outcomes of disrupted attachment. Young infants who have a parent who is frightened (a traumatized, or dissociative parent) or frightening (a parent who is intoxicated, high on drugs or violent), learn to deal with these overwhelming experiences by dissociating. It is considered fright without solution.

Dissociation begins as a protective mechanism in the face of overwhelming trauma, but often develops into problematic chronic coping. Put differently, it can be used

adaptively to survive trauma, or maladaptively to avoid feelings. People also experience dissociation from others, their communities, and from their own bodies, feelings and thoughts. Thought of in this way, dissociation is a specific form of disrupted attachment.

Many traumatized people respond to daily stressors, anxieties and irritations with dissociative defenses. In this way dissociation goes hand in hand with affect dysregulation. People do not learn to regulate their emotional states because they learned to dissociate as part of a trauma response at a very young age. Dissociation becomes an automatic physiological response, an adaptation gone awry. As a result, people who dissociate do so without conscious choice or awareness.

Due to this over reliance on dissociation as a form of coping, dissociation potentially blocks effective coping with danger and dealing with everyday stressors. This can result in experiences of revictimization and attempts to cope by using means such as substances or self-harm. These are all forms of coping which have been well documented in Aboriginal communities.

3. Altered Self Perceptions, Changes to How People View Themselves and the World, Or The Disrupted Self

Disruptions in relationships with self and with others (as elaborated below) is one of the core impacts of complex traumatic stress. Harm to a sense of self underpins the alterations, or difficulties, with relationships to others, and it is the harm to self-perception which we address here. However, alterations to sense of self is inextricably connected to alterations in relationships with others, so there is a somewhat artificial disconnection between elements three and four, altered relationships to self and with others, for the purposes of our discussion here. Most of our discussion of these interrelated aspects of complex trauma, then, takes place in the next section, Alterations to Relationships with Others, which follows below.

The altered sense of self associated with the complex trauma response revolves around the significant and sometimes overwhelming feelings of guilt, shame and inadequacy which are extremely typical trauma responses for abuse survivors, and well documented in the literature. In a society saturated with negative and racist images of Aboriginal peoples, it is not difficult to see the ways in which the damaged self-perception associated with complex trauma is layered and compounded by the harmful social (mis)representations of the peoples of the First Nations.

In a clinical case study of the Inuit of Northern Québec, mental health professionals reported that “of 100

consecutive cases referred for psychiatric consultation, the single most common [DSM] diagnosis was major depression with melancholia” (Kirmayer et al., 1994, p. 12). Other studies with Aboriginal peoples have documented emotional states such as “low self-esteem, depression, anger, self-doubt, intimidation, frustration, shame and hopelessness” reported by Aboriginal parents and their children (OFIFC, 2000, p. 7). Interestingly, this study focused on the impact of living in poverty, which effectively demonstrates the interplay between social conditions of deprivation and internal emotional worlds of those affected by that very deprivation.

There is also a documented link between histories of child sexual abuse and harms to a person’s experience of their own sexuality, their vulnerability to revictimization and the increased likelihood of future negative physical health effects. This link is especially pronounced in some Aboriginal populations. As a result of their distorted and damaging experiences of sexuality, adults who were sexually abused as children may later in life engage in inappropriately sexualized behaviours in an attempt to gain some acceptance or believing this is the only way they can have intimacy (Durst, 1991; Robin, Chester & Rasmussen, 1998; Barnett & Fagan, 2003; Chansonneuve, 2007). This kind of disruption to one’s sense of sexuality and sexual relationships with others has, in turn, a series of compounding and negative health consequences.

One study, named the Cedar Project, sought to determine the factors associated with sexual abuse among a group of young Aboriginal people in British Columbia between the ages of 14 and 30 years who used injection and non-injection drugs. In this study, over half of the sexually abused participants reported having a sexually transmitted infection, as well as were twice as likely to have more than twenty lifetime sexual partners (Pearce et al., 2008). Young people with a history of sexual abuse are therefore more likely to have greater sexual vulnerability in adulthood.

The long-term yet still under appreciated consequences of abuse and trauma, particularly sexual abuse in childhood, can, as a result of sexual disconnection and a larger number of sexual partners, include greater susceptibility to other very significant deleterious health problems, such as HIV infection. This point can be illustrated through the alarmingly high rates of HIV infection within the Aboriginal community in the last decade. Although Aboriginal people comprise only 3.3 per cent of the Canadian population, as of 2005, an estimated 3600–5100 Aboriginal people were living with HIV in Canada (Public Health Agency of Canada, 2006).

This high rate of HIV infection cannot, then, be viewed in isolation, but the long-term trauma which Aboriginal people face throughout their lives must also be acknowledged. The Cedar Project, for example, found a significant association between having at least one parent who attended residential school or was involved in the child welfare system, and sexual abuse experiences among the project’s participants. Nearly half of the participants reported that they had experienced sexual abuse, many as children. Survivors of childhood sexual abuse in this group were found to be at a significantly higher risk of serious negative health outcomes, including HIV infection (Pearce et al., 2008).

These findings demonstrate the complex and multi-layered interconnections between child sexual abuse, a damaged sense of self (alterations to sense of self), feelings of shame, and affect dysregulation and harmed sexuality, along with the consequences of forcing Aboriginal children into residential schools aimed at destroying their culture. All of these layers are tied to later mental and physical health consequences, revealing the necessarily intertwined dimensions of the complex trauma response and the necessity of situating it within a social context framework in order to make comprehensible the conditions of the lives of many Aboriginal people in Canada today.

4. Alterations to Relationships with Others and Complex Trauma, Or Disrupted Attachment to Others

Another way of speaking about this category of complex trauma speaks to disruptions in attachments to others, and to relationships with other individuals. We would argue that this category can and should be broadened, however, particularly in the case of Aboriginal peoples, to describe the ways in which the traumatic dislocations of Aboriginal communities and ways of life have profoundly severed attachments to not only relationships with other individuals, but also to community and to a sense of cultural identity.

This component of complex trauma, described as “alteration to relationship with others,” is not merely a state of being wary of other people, though it may include that as well. More fundamentally, complex trauma disrupts people’s abilities to experience safety and comfort in relationships. Yet, relationships and closeness to others is what sustains us through our lifetimes. We heal in relation.

In fact, this sense of connection and the significance of relationships are already deeply acknowledged in Aboriginal culture; indeed it is an ethos which suffuses many of the Aboriginal worldviews about the relationship between individuals, communities and nature.

Research has demonstrated that people with close relationships live longer lives. Safety in relationships is one of the biggest resilience factors against mental health problems, and is one of the most important factors in general health and well-being. Suicide, particularly among young people, has been a profound problem in some Aboriginal communities, and research has shown that strengthened attachments serve as a protective function against suicidal ideation.

Pharris, Resnick and Blum (1997) in fact found that perceived attention and caring from family and other adults were associated with the absence of suicidal ideation and attempts among American Indian and Alaska Native youth with a history of sexual abuse.

Attachment is another way of speaking about relationships. Disruptions to attachment, then, are a fundamental effect of complex trauma. A rich and important literature on attachment has been developed in the psychological field. Drawing on the insights of this literature, we have identified some of the ways in which complex trauma as experienced by Aboriginal peoples has disrupted attachments, a core source of human nurturance and well-being. Some of the ways in which attachments are disrupted through traumatic events are elucidated in relation to disrupted attachment and parenting capacities, and in relation attachment to communities.

Trauma, Parenting and Disruptions of Attachment: Intergenerational Impacts

The early parenting relationship is the primary way children learn about themselves, their emotions, their relationship to themselves, the world, and their relationships with others. Therefore, a secure attachment relationship is essential for a child's development of core self-capacities. This attachment provides the context which facilitates developing the capacity for regulating emotional states, a sense of agency and a sense of how to exert an influence on the world (to assert one's will), as well as the capacity for expression and communication.

Parental responses to traumatic events, including reactions to the traumas of their own personal histories, can play a significant role in the mental health of their children. A child whose parents are traumatized, depressed or suffering with chronic stress in their own lives will often be neglected. Traumatized parents might typically not be able to consistently comfort their children or demonstrate emotional attunement because of their own depleted or unacknowledged emotional states. A parent with unresolved trauma related to earlier losses or abuse in their childhoods

may become overwhelmed by his or her child's fears or need for comfort and reassurance. This can trigger a parent's own feelings of loss, despair or fear, or result in diminished ability to respond with emotional sensitivity.

Aboriginal children who attended residential schools often brought back to their communities and their families the learned control and abuse from the teachers, and inflicted this abuse upon their own children (Pearce et al., 2008). As former residential school students raise their children and grandchildren, the intergenerational effects of abuse and fragmentation of family are evident among Aboriginal families and communities, especially where abuse and alcohol and substance misuse is widespread (Fournier & Crey, 1997; RCAP, 1996a; Wesley-Esquimaux & Smolewski, 2004; Frank, 1992; Hylton, 2002; Walters & Simoni, 2002). In fact, the 1998 British Columbia Children's Commission Annual Report found a relation between the rates of child maltreatment within Aboriginal families and intergenerational trauma, stating that this is a result of "Aboriginal parents and grandparents ... coping with the effects of residential schools, loss of family, isolation, poverty, and a sense of hopelessness" (British Columbia, 1999, p. 7).

For women, and especially Aboriginal women who are shown to have experienced higher levels of violence in their intimate relationships, depression, which is very often associated with abuse, affects their parenting skills. Three recent studies demonstrated this relationship between women's depression, a lack of financial resources and the subsequently more limited capacities women had available for the work of mothering (Roy-Byrne, 2009). While these studies did not inquire into the sources of women's depression, they nevertheless documented a link between women's depression and the adverse effects of this depression on the women's children, along with the children's resulting poorer adaptive skills.

At moments of threat, children with secure attachment seek proximity to a parent figure for safety. However, for abused children, a parent can often be the source of danger. These children face the dilemma of requiring the protection from the very person who is also the source of danger. This dilemma lays the groundwork for disorganized attachment, an attachment style found in children, as young as twelve months of age, whose parents are characterized by researcher observation as either frightened or frightening (Aber, Allen, Carlson, & Cicchetti, 1989; Liotti, 1999).

When the source of trauma is from a child's own parents or primary caregivers, the attachment relationship is severely compromised. Parenting that is abusive or neglectful leaves a child feeling helpless and abandoned. Children

exposed to unpredictable violence or repeated experiences of neglect and abandonment may attempt to cope by emotionally shutting down.

Neglect and abuse impinge on a child's sense of self-agency and promote a defensive withdrawal from the mental world. This self-protective retreat from the mental world impairs the child's reflective capacities, resulting in the absence of language referring to internal states and diminished interpretive ability. Put differently, one of the traumatic effects of neglect and abuse is a child's difficulty in identifying, naming and understanding her or his own internal and emotional states, and how these states are related to the world around the child and the child's reactions. As a result, the child may be unable to process what is occurring in the external world.

Complex traumatic responses develop because the harm done in childhood is twofold:

1. The early childhood abuse results in both extreme distress.
2. It undermines the development of the capacities to deal with that distress.

Furthermore, and perhaps most importantly, the inability to be safely and securely attached to others undermines the traumatized person's capacity to use relationships as a source of safety and comfort.

This leaves children very vulnerable when faced with challenging situations. They do not feel safe turning to others for help, and they have great difficulty formulating meaningful self-protective actions and managing the stresses and challenges in their everyday lives. *The complex traumatic experiences, therefore, result in long-term effects that alter core psychological capacities and create a host of ongoing problems.*

A number of socio-economic factors, including being raised in the context of family violence, poverty, lack of education, substance and/or alcohol abuse, and poor living conditions contribute to the traumatic social context in which Aboriginal children in Canada are raised. Many Aboriginal living conditions remain below the national average, with little heat, water, inferior bathroom facilities, and long distances from adequate medical facilities. Another factor contributing to the traumatic upbringing of some Aboriginal children is the lack of parenting skills of a number of Aboriginal parents. This can be linked to the legacy of residential schools and the mass placement of Aboriginal children in the 1960s and 1970s into foster

or institutional care, where these parents, as children, were not raised in an environment that enabled them to observe parenting skills and behaviours first hand (Tait, 2003).

Complex Traumatic Effects: Disruption to Relationships (Disrupted Attachments) in Aboriginal Communities and the Intergenerational Transmission of Trauma

One of the most significant, powerful and profound effects of trauma is the disruption to relationships, including, perhaps most importantly, the disruption the traumatized person experiences in relation to their self and one's own capacities. Clearly, relationships with others are limited and disrupted to the extent that the individual's relationship to self is damaged and in need of repair. This captures one profound and central element of the ways in which traumatic effects harm individuals. It can most usefully be described as traumatic disruption to attachments. This harm necessarily interferes with the traumatized person's ability to form, experience and engage fully and safely in relationships with others.

One of the ways in which abuse-related traumatic effects reverberate across generations relates to the ability to parent, which, in turn, limits the abilities of the child of the traumatized parent to develop his or her capacities fully. If a family of origin is not a place of safety and comfort, and does not offer relationships in which the child can securely attach and develop, a range of difficulties inevitably face that child. Furthermore, if the child's parents or caregivers are themselves traumatized (and not healed), and if that child is also abused, abandoned or neglected, then that child will invariably deal with complex post-traumatic stress, continuing the trauma legacy through the generations.

To fully capture this harmful traumatic effect, not only on the individual but also on entire communities, we need a broadened conceptualization of trauma that takes into account disruptions of relationships and systems of relationships, writ large. As Gagné (1998) explains in relation to her work on historical trauma and First Nations peoples, "the role of sociologists and anthropologists is to consider trauma as dramatically changing the system of human relationships, which will, as a consequence, directly affect future generations" (p. 357).

For the Aboriginal communities of Canada, in distinct yet shared ways, disruptions to relationships have been, and continue to be, one of the most deep and pervasive harms of collective complex trauma. This disruption has taken place simultaneously on the macro- and micro-levels. Beginning with colonial contact and enduring up into present day society, the disruption to relationships imposed

upon Aboriginal peoples, often achieved through violence, includes severing of Aboriginal peoples' ties to their lands, disruption of traditional forms of governance, disruption to families, and disruption to community relationships organized around cultural rituals and practices. Perhaps the most deeply troubling and violent experience is the systematic state sponsored sweep of Aboriginal children out of their families of origin, into the abusive residential school system, or into other kinds of care. The term "disruption," in fact, is too mild to capture the extent of these harms and the forceful and violent means through which these relationships have been damaged.

To illustrate the impact of this disruption in their community and familial relations, Carol Anne Heart Looking Horse discusses "the historical grief we bear [as a people] and its relation to not only the attempted eradication of our cultures, but also the trauma our parents experienced as they were forced through this (residential school) [experience]" (as cited in Morrison, 1997, p. 65). In fact, the residential school teachers expressly taught students to be ashamed of their languages, cultures and Aboriginal identity (Hylton, 2002). This disruption to Aboriginal families and communities, however, did not end with the eventual phasing out of the residential school system. Rather, throughout the middle to late twentieth century, provincial and territorial governments began to place an increased number of Aboriginal children in foster homes and state institutions. One study found that the number of Aboriginal children in state care in British Columbia rose from 29 children in 1955 to 1,446 in 1965 (Johnston, 1983; Stanbury, 1975).

This disruption to Aboriginal families and communities continues today. The Canadian government recently estimated that Aboriginal children are currently four to six times more likely than non-Indigenous children to be removed from their families and placed in the care of the state (Standing Committee on Human Resources Development and the Status of Persons with Disabilities, 2003). The painful loss of ties to family, community and culture is a common element of many of the stories of these children. For these children, this loss of a sense of identity, belonging and self-worth must be understood and addressed as a critical factor potentially contributing to their eventual self-destructive behaviour, including substance abuse and to their vulnerability to exploitation by others (National Aboriginal Consultation Project, 2000).

To the extent that healthy, balanced and respectful relationships are central to the health and well-being of individuals and communities, the harm to relationships

associated with collective complex trauma is a fundamental and enduring form of damage. This harm of collective complex trauma for Aboriginal peoples is one that urgently requires additional remedies at both the micro and macro levels.

5. Somatization and Complex Trauma

Somatization speaks to the ways in which the body holds and expresses trauma responses. It refers to the physical ailments, physical health problems and unwellness, which, for trauma survivors, often express what people are not able to articulate or express in other ways.

This is, most emphatically, not the same as saying that the physically unwell person is simply suffering from "something in their head," and is not actually physically unwell. Or, put differently, to identify physical illness as part of the trauma response is not the same as the common (and victim-blaming) (mis)perception that people's physical health problems are "all in their head." To the contrary, it is a more sophisticated set of arguments, well documented empirically in the medical and trauma literature. Put differently, the idea here is that *there are specific physical outcomes of living with ongoing emotional distress*.

For example, with chronically high cortisol levels running throughout the body, which are shown to be associated with high arousal, a consequence of abuse, there is an eventual strain on and erosion of people's internal organs. This can lead to gastro-intestinal problems, cardiac problems and chronic headaches, among other things. There is actually an erosion of people's internal organs as a result of high hormonal and systemic stress on the body. This is not surprising once one moves past the rigid binary of mind/body and grasps the physical dimensions of extreme psychic distress, especially over the long term.

In a qualitative study of a sample of residential school abuse survivors, researchers found that all of the Aboriginal peoples included in the sample suffered from a range of negative affects on their physical health, or "somatic complaints." These researchers report that "virtually all subjects specifically mentioned suffering from chronic headaches. Other frequent physical health problems included heart problems, high blood pressure, and arthritis" (Söchting et al., 2007, p. 324).

The authors of this study observe that much more research is necessary to delineate the possible connections between traumatic stress responses and somatic difficulties in Aboriginal populations. As they explain,

Considering that medical problems such as heart disease, diabetes, and rheumatoid arthritis are much

more common among Canadian Aboriginals than non-Aboriginals, it would be important to further investigate the relationship between complex PTSD and somatic complaints (Söchting et al., 2007, p. 324).

6. Alterations in systems of Meaning, Loss of Meaning and Complex Trauma

The sixth diagnostic component of complex trauma describes a sense of loss of meaning, which refers to a loss of purpose, or feelings of hopelessness, that can often be a fundamental part of the complex trauma response. This can entail an individual's loss of their belief systems or loss of belief that their own individual life has any meaning or purpose. Hopelessness and despair are different ways of describing aspects of this dimension of complex trauma.

In a society which, in general, profoundly devalues, marginalizes and disempowers Aboriginal peoples through colonial state policies; simultaneously perpetuates through dominant ideologies, a victim-blaming view of the current situation of many Aboriginal communities, it is not a stretch to understand the interconnections between this social devaluing and internalized loss of meaning at the individual levels. Even without reference to recent tragedies such as the residential school system and its multiple abuses, the kind of systematic state neglect so many Aboriginal communities experience today in terms of lack of safe drinking water, substandard schools and inadequate health care services, all of which are most acute on remote and isolated reserves, can only serve to send a message that these communities are unworthy of basic services and proper care which other Canadians take for granted. Canada has, in fact, recently been excoriated by Amnesty International for its failure to deal with violence against Aboriginal women, as documented in the *Stolen Sisters* report (Amnesty International Canada, 2004), and also for its violations of the human rights of Aboriginal peoples in Canada (Amnesty International Canada, 2009).

In an article published in 1999, Derrick Silove advanced a conceptualization of the effects of extreme trauma that specified the kinds of impacts this trauma has on undermining five "adaptive systems" which are necessary for the health of individuals and of communities. This analysis has obvious relevance for the situation of Aboriginal populations, especially in light of the kinds of neglect and human rights violations outlined above. According to Silove (1999):

The working hypothesis underpinning the model proposed hereunder is that the various types of extreme trauma represent fundamental challenges to one or

more of the major adaptive systems that support a state of psychosocial equilibrium in individuals and their communities. The five salient adaptive systems hypothesized as being threatened by war and mass HRVs are those subsuming the functions of "personal safety," "attachment and bond maintenance," "identity and role functioning," "justice," and "existential meaning." Such systems, it is assumed, have evolved in an orchestrated manner to ensure that, under normal circumstances, the interaction of the individual and his/her society occurs in a way that promotes personal and social homeostasis (p. 203).

Silove's analysis applies to human rights violations, and he largely focuses on the examples of populations subjected to torture. While it is arguable that the treatment of Aboriginal populations in Canada is not exactly parallel to that situation, we would argue that some of the experiences to which Aboriginal peoples and communities have been subject, such as institutionalizing children in residential schools where they were captive and subjected to ongoing physical and sexual abuse, is more similar than different. Clearly the human rights violations are evident in this situation, and Silove advances:

Exposure to inexplicable evil and cruelty can shake the foundations of the survivor's faith in the beneficence of life and humankind. The extreme violation of torture often leaves survivors with existential preoccupations in which they strive, often unsuccessfully, to find a coherent reason for the abuses they have suffered. They thus face a crisis of trust, faith, and meaning that may intensify feelings of alienation and emotional isolation (Gorst-Unsworth et al., 1993). The existential domain often is central to psychotherapy with survivors (Kinzie and Boehnlein, 1993). Characterizing and operationalizing more clearly the impact on systems of values and faith brought about by exposure to HRVs remains an important task for researchers in the field (Silove, 1999, p. 205).

A clear expression of a sense of hopelessness and despair, and loss of meaning, is evident in the tragedy of suicides in some remote Aboriginal communities. More broadly still, the suicide rate for Aboriginal peoples is 2.1 times the rate for other Canadians. When factoring in gender differences, statistics show that the suicide rate for Aboriginal women is three times higher than the national suicide rate (Chenier, 1995).

It is in this area where enculturation is an extremely relevant component to a complex trauma treatment approach, because a sense of meaning and purpose is very often intimately associated with a sense of meaningfully belonging to a larger social group, a culture, a community. Enculturation is, in fact, a resilience factor, and is extremely important in assessing how best to intervene in the dimension of complex trauma concerning loss of meaning.

PART VII – MOVING PAST TRAUMA: INDIVIDUAL AND COMMUNITY HEALING

In the 21st century, health is a shared responsibility, involving equitable access to essential care (WHO, 2008).

Trauma, Resilience, Enculturation and Cultural Continuity: Strengthening Aboriginal Peoples and Communities

The negative effects of the vicious cycle of traumatic events witnessed by First Nations citizens cannot be resolved without substantially diminishing their economic, social and political dependence (Gagné, 1998, p. 367).

It is critically important to note that despite centuries of genocidal state policies and practices enacted upon Aboriginal peoples, many Aboriginal communities and individuals have continued to demonstrate great resilience and strength. A key question warranting further analysis and research, then, is how it is that people can and have achieved health and well-being in the face of the profound effects of trauma and in the face of repeated assaults on their well-being. Put differently, as important as it is to study and understand the effects of trauma, it is equally imperative to study and understand the conditions of wellness and resilience, and how these are achieved.

Resilience describes a person's capacity to resist the violent and destabilizing effects of a traumatic experience. It is a means used to survive, resist and cope with the destructive effects of violence on one's personal and cultural well-being (Noël & Tassé, 2001). In a qualitative study involving twelve female former residential school students, Noël and Tassé (2001) found common themes of resilience in the women's accounts of their experiences. Despite the fact that the "residential school was the monster who deprived them of affection, who wounded them, crushed them and punished them for being who they were," these

women "reclaim[ed] those elements that had been banned, forgotten or erased from Aboriginal culture and history with conviction. Spiritually for one, legends for another, the language and creation stories" (Noël & Tassé, 2001, p. 6).

Through empirical studies, researchers have concluded that enculturation is a resilience factor in the development of Native American children. Enculturation speaks to the degree to which a person is integrated within their culture. It is a socialization process as well as an integration process. Obviously for Aboriginal communities whose culture and family forms have been subjected to centuries of disruption and threat, the process of enculturation is of critical importance, and is, indeed, a factor associated with protection and resilience.

Zimmerman and colleagues (1998, [1994]) reported the first use of enculturation in their research. They did not find, however, any primary, direct effects of enculturation, but they did find that "the influence of enculturation on alcohol and substance use interact with self-esteem ... youth with the highest levels of self-esteem and cultural identity reported the lowest levels of alcohol and substance use" (Zimmerman, Ramirez-Valles, Washienko, Walter, & Dyer, 1998, [1994], p. 215). However, the researchers also found that youth with low levels of self-esteem and high levels of cultural identity reported the most alcohol and substance use.

Whitbeck and colleagues (2001) furthered this research on enculturation in the Aboriginal community, finding a positive association between enculturation and academic success. They concluded that enculturation is a resilience factor in the development of Native American children. Whitbeck et al. (2002) again reported on traditional activities, perceived social support, perceived discrimination, and depressive symptoms, and found a significant interaction between discrimination and traditional practices. For those whose participation in traditional practices was above the mean, discrimination had almost no effect on depressive symptoms. In this study, the traditional practices appear to have acted as a buffer. Finally, Whitbeck and colleagues (2004) reported on enculturation, discrimination, historical loss, and alcohol abuse, finding a limited protective effect of traditional culture in relation to the problem of alcohol abuse. They also found that those who are highly enculturated also report higher levels of historical loss. According to Whitbeck and colleagues, this research suggests that traditional culture both sensitizes one to loss and serves as a protection from reminders of loss.

More recently, Torres Stone et al. (2006), La Fromboise et al. (2006) and Yoder et al. (2006), have found enculturation protective against alcohol and other substance

abuse and suicidal ideation. Torres Stone et al. (2006) found that traditional activities and spirituality are associated with alcohol cessation, but that cultural identity was not. LaFromboise et al. (2006) found that age is associated with decreasing resilience, stating that “[w]ith each year of increase in age (from 10 to 15 years), there was an associated lowering of resilience by a multiplicative factor of 0.626. This represents an approximate 10% decline in resilience with each year of age” (p. 202). Finally, Yoder et al. (2006) found enculturation did not appear to be significant when analyzed in a simple relationship with suicidal thoughts, but when the researchers took all other variables into account in a multivariate model. It did become significant and proved to be the second strongest predictor variable (after drug use) of suicidal ideation. More research, however, is needed to evaluate the potential buffering effect of enculturation on the effects of trauma.

An important area of research which has demonstrated the important correlation between cultural continuity as a moderator of suicide risk in some Aboriginal communities has been undertaken by Chandler and colleagues, over a period of decades. Contrary to the mistaken view that suicide is a particularly “Aboriginal” problem, Chandler and colleagues demonstrate the dramatic differences between suicide rates in First Nation communities. Some had no suicides at all and the problem of high rates of suicide being confined to a few communities, which had up to five to ten times the national average (Chandler & Lalonde, 2009).

In epidemiological studies first published in 1998, Chandler and Lalonde demonstrate that “cultural continuity,” measured in terms of six factors which marked the degree to which individual Aboriginal communities had successfully taken steps to secure their cultural past in light of an imagined future, “proved to be strongly related to the presence or absence of youth suicide” (Chandler & Lalonde, 2009, p. 221). As the researchers explain:

Every community characterized by all six . . . protective factors [of cultural continuity] experienced no youth suicides during the 6 year reporting period [of the study], whereas those bands in which none of these factors were present suffered suicide rates more than 10 times the national average (Chandler & Lalonde, 2009, p. 221).

What is particularly interesting about Chandler and Lalonde’s work, aside from its great significance methodologically and substantively for what it has demonstrated, is the extent to which these researchers

have delineated a link between enculturation or cultural continuity, and an Aboriginal community’s degree of autonomy and self-governance. In this way they have shown the interplay at the community level, between greater material resources, strength of cultural identity, ability to exercise meaningful self-governance, and the absence of traumatic mental health indicators such as the extreme distress and despair expressed in higher than average rates of youth suicide. Put differently the interconnection between the social and the individual, the material and mental health are elucidated in their important studies.

The most effective healing from responses to trauma centrally incorporate attention to a person’s and/or a community’s strengths, and build the capacities of the individual and the community. The idea of cultural continuity as described by Chandler and Lalonde, itself expresses a strengths based approach to measuring a community’s sense of cultural identity and capacities in relation to factors such as self-government, success in land claims, control over education, health and child services, and promotion of women. The body of research which exists, powerfully suggests that enculturation and cultural continuity facilitate better overall wellness, well-being and mental health, and act as important buffers and protective factors against signs of mental health distress such as substance abuse and suicide. These insights support the idea that effective trauma treatment necessarily builds from a strengths based centre, and indicate that enculturation is an important aspect for work within Aboriginal communities.

Validation, Empathy and Responsibility:

Finding the Balance

A challenging but important aspect of approaching the work of healing from trauma is the need to acknowledge victimization and agency, that is, the limits as well as the possibilities in any individual life. Put differently, while traumatized people did not choose the conditions of their traumatic experiences, there are nonetheless possibilities for some choices, even if constrained, to be exercised towards moving away from the damaging effects of trauma and towards a process of healing. Another way of thinking about this, in the context of the specific situation of any person or community who has been harmed, is to focus on the possibilities for repair and empowerment.

The layers of harms that have been inflicted on the Aboriginal peoples of Canada can hardly be overstated. While keeping an acknowledgment of these external harms always firmly and centrally in view, we must also pay attention to individual and community capacities for

healing, and for enhancing the possibilities of restoring relationships and expanding spheres of choice.

Even in the face of Canada's still neglected responsibility for addressing and remedying a multitude of wrongs perpetrated against the Aboriginal peoples of Canada, Aboriginal peoples have no choice but to draw on their resources and strengthen their capacities as part of their journey of healing and community strengthening.

This simultaneous grasping of the external and internal, the social and the individual, is central to a complex and nuanced account of the possibilities for healing from and transcendence over traumatic impacts.

The responsibility for healing, at the individual and community levels, must also include a responsibility to self as well as to others. Fulfilling a responsibility to self, however, cannot be undertaken without adequate self-capacities. Given that trauma interferes with the development of self-capacities, individual healing must take place in order for men and women to be able to express self-care and responsibility to self and others.

Further Analysis and Suggested Directions: What A Social Context Complex Trauma Framework Suggests for Policy, Treatment and Community Interventions

Assimilation policies failed because Aboriginal people have the secret of cultural survival. They have an enduring sense of themselves as peoples with a unique heritage and the right to cultural continuity (RCAP, 1996b).

After years of extensive research and consultation, the groundbreaking report of the Royal Commission on Aboriginal Peoples outlined an ambitious and important agenda for change to improve the lives of Aboriginal peoples of Canada. Put simply, the Commissioners wrote that the purpose of the agenda for change was:

to ensure that Aboriginal children grow up knowing that they matter - that they are precious human beings deserving love and respect, and that they hold the keys to a future bright with possibilities in a society of equals (RCAP, 1996a).

Clearly this laudable goal must also underpin efforts to deal more effectively with the impact of trauma in Aboriginal communities in Canada. As some of the research discussed above shows, the connections between

trauma, discrimination and mental health difficulties in Aboriginal communities, and the high rates of substance abuse even in Aboriginal youth and children, should be cause for alarm and, more importantly, effective action on behalf of Canadian decision makers responsible for health and government policy. Dealing with trauma in Aboriginal communities at risk and in crisis in Canada, is not a luxury but an urgent imperative.

Some general recommendations which emerge from the social context complex trauma framework we have developed in this paper follow below. These recommendations are intended to contribute to the conversation about how most effectively to approach healing work from trauma within Aboriginal communities.

1. Information, Training and Psycho-Education is Necessary in Aboriginal Communities About Trauma Responses and Complex Traumatic Stress

Although trauma and, in particular, the phenomenon of Post-traumatic Stress Disorder (PTSD) has been more visible in public consciousness in recent years, there remains a vast lack of information and understanding about the nature of traumatic responses and how these affect human development and capacities. Additionally, in spite of the growing awareness of PTSD, there is still, outside highly professionalized mental health circles, insufficient awareness of the phenomenon of complex trauma responses and the developmental impact of *complex* trauma.

Even within mental health circles, the awareness of complex trauma responses is not as extensive as it could be, and many of those trained years ago do not have the time or resources to keep abreast of all of the new insights, research and debates in a dynamic and rapidly developing field. For this reason, more research and awareness on complex post-traumatic stress is necessary for mental health professionals and others working in the healing fields.

Education and information about trauma, and most especially about complex trauma (captured under DESNOS in the DSM-IV) and the new category of "Developmental Trauma Disorder" [sic], must be a central component of any effective approach when beginning efforts to help Aboriginal peoples and communities heal from trauma. This education and information must, of course, be contextualized, not only through an ongoing acknowledgment of the social conditions producing trauma responses, but also through a recognition of the specificities of the lived experiences of Aboriginal communities in Canada and the historical and contemporary situations producing trauma responses. The most comprehensive

approach to understanding these complexities is through a social context, developmental complex trauma framework.

Survivors of child abuse, and those who have endured other traumatic events, often cannot explain or even recognize their own psychological responses and methods of coping as being trauma-related. Furthermore, they often do not relate their difficulties in their adult lives to traumatic experiences they had as children or at earlier points in their life histories. Put differently, they may not recognize the role of abuse-related trauma in the development of some of their own ways of coping and managing in their everyday lives. This points to the critical importance of psycho-education, at both the individual and community levels, concerning the nature of trauma and its effects.

As is explained in preceding sections of this paper, trauma survivors may cycle in and out of mental health and substance abuse systems for years, using a tremendous number of services without experiencing any improvement in their health and well-being, or the kind of relief they require. Given this situation, it is not surprising that many people dealing with complex traumatic stress feel mistrustful of the mental health system's ability to offer help, which in turn, keeps them further isolated and without necessary support and treatment.

For Aboriginal peoples who have been and continue to be subject to multiple traumatic events, education about what trauma is, the causes of traumatic responses, and how they manifest in people's lives within the social context is extremely important. It provides a framework for understanding people's coping and adaptation strategies with traumatic stress at the micro- and macro-levels. Moreover, by normalizing and explaining these trauma responses as ways of coping, this education may assist in challenging stigmatization and the sense of shame which can compound the damage in so many traumatized people's lives.

Not only is this information important for Aboriginal individuals and communities in order to recognize trauma and trauma responses, it is also important in order to be able to develop culturally appropriate methods of treating traumatized individuals and peoples. This information about complex trauma also helps reduce the stigma and shame which can prevent traumatized people from understanding some of the aspects of their own lives, and can prevent them from getting the kind of help and support they need.

The connection between the social context, recognition and respectful understanding of a problem and how those who suffer it are treated, seems obvious. As one writer in the field observes, "Intergenerational traumatologists speculate that public reactions significantly affect individual

and communal posttraumatic adaptation and healing" (Evans-Campbell, 2008, p. 330). Attitudes of social denial and victim blaming, then, are obviously not only counter productive, but compound the harms suffered by traumatized people.

Speaking within a U.S. context, Evans Campbell also notes the minimal recognition of colonialism and the denial of the traumatic histories associated with colonial injustices against the North American First Nations. As she explains, "acknowledgments of traumatic events perpetrated on . . . [American Indian and Alaskan Native] communities are limited, and, not surprisingly, . . . [American Indians and Alaskan Natives] routinely encounter social relations such indifference, disbelief, and avoidance" (Evans-Campbell, 2008; Evans-Campbell & Walters, 2006). There are clear parallels to the Canadian context. While there is some general acknowledgment that Aboriginal communities were subject to genocidal and racist policies "in the past," this problem isn't always viewed that seriously in mainstream society, and, more problematically, it is often understood to be a relic of the past which Aboriginal people's should now "get over." This kind of misapprehension misses the fact that many Aboriginal people currently live in traumatized and depleted communities, communities which have had inflicted upon them layers and layers of harms which continue today.

In order to understand the present socio-economic and health conditions of Aboriginal people, one must also examine the ways in which Aboriginal people's lives were affected and transformed during the process of colonization. As one author writes, "[t]he Government and Church were largely successful at separating First Nations people from their culture, language, religion, families, communities, and land. First Nations people have recognized the overwhelming need to be reconnected and to reclaim that which was taken, and now are acting to reconnect and strengthen these bonds" (McCormick, 1997, p. 178). Any approach to address trauma must restructure this past with the present, to empower, acknowledging the role that this past has in the present lives of Aboriginal people.

Education and increased awareness about trauma and its effects, therefore, are critically needed, especially to disrupt the simplistic yet widely held idea that abuse is "in the past" and the expectation that people can and should be able to "forget" and "get on with things." It is imperative to recognize the seriousness of the problem of untreated trauma in people's lives, and this is particularly urgent in relation to the Aboriginal peoples of Canada. This recognition is long overdue.

In summary, this recommendation calls for:

- An expanded understanding of the nature of trauma and the range of ways in which complex trauma affects people's lives in Aboriginal communities.
- An understanding of the concept of complex trauma, and of the new and more comprehensive category "developmental trauma disorder," (which is relevant for abused children) in relation to the harms perpetrated against and suffered by Aboriginal peoples.
- At the level of communities, recognition of and communication about complex trauma, incorporating recognition of historical trauma as a vital part of a healing approach.
- The provision of adequate resources to undertake this work in a meaningful and sustainable way.

2. Trauma Informed Programs to Treat Alcohol and Substance Abuse Are Needed

Trauma drives a range of ways in which people cope with overwhelming experiences. This coping includes the use and abuse of alcohol and other substances. Programs to treat these difficulties, therefore, must be deeply shaped by knowledge of complex trauma and responses to traumatic stress.

This recommendation is especially critical because so many mainstream approaches tend to minimize or miss entirely the trauma driven nature of many of people's ways of coping and adapting to overwhelming experiences. Programs which treat "symptoms" such as alcohol and substance abuse -- as if these problems exist as distinct and separate "diseases" severed from people's life histories and experiences problems -- are bound to fail or have minimal efficacy.

Substance and alcohol abuse programs *must be trauma informed*. This approach to substance and alcohol abuse programs means that an understanding of trauma responses, including the nature of complex trauma and developmental trauma must underpin and inform the delivery of services to Aboriginal peoples struggling with substance and alcohol use problems. It also requires an approach which acknowledges the role of intergenerational trauma among Aboriginal people (Mitchel & Maracle, 2005). Additionally, Aboriginal people must be meaningfully involved and

provide leadership in design of all programming that address the relationship between trauma, mental health, and substance and alcohol abuse (Pearce et al., 2008).

3. Restoring Attachments: Understand Healing as a Process, A Process of Transformation

A more expansive, nuanced and dynamic view of healing from trauma is necessary. This view recognizes that healing is not a static state which is achieved, but instead is better understood as a dynamic and sometimes lifelong process. *This view recognizes that given that the most profound harms of trauma are relational, and revolve around attachments, the nature of healing from trauma must also be relational.*

Healing from trauma takes place through connection, through developing and experiencing healthy attachments. These attachments can be individual but must also be fostered at the level of the community. To the extent that disrupted attachments are a core harm of complex trauma, restored and healthy attachments, to self, to others and to community, are fundamental parts of healing from trauma.

This insight is already profoundly compatible with many of the core and defining approaches of Aboriginal cultural understandings.

4. Support is Necessary for the Expanded Development of Culturally Appropriate Approaches to Healing Trauma in Aboriginal Communities

Important initiatives have already been undertaken in Aboriginal communities in Canada to deal with the effects of trauma, but the need still outstrips the availability of these programs and the resources allocated to them. More trauma treatment for Aboriginal communities in Canada is an urgent priority.

Work within traumatized Aboriginal communities must be informed by, and either led by or in collaboration with Aboriginal community insiders. Put differently, programs of support and intervention to address trauma in Aboriginal communities must be culturally appropriate and specific.

An important resource addressing a variety of innovative healing approaches developed within diverse Aboriginal communities in Canada is found in the report, *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*, a publication of the Aboriginal Healing Foundation (Waldram, 2008). Contributors to this report document and analyze case studies, models of healing and youth projects from a variety of Aboriginal contexts in Canada, and importantly, centrally examine the question of effectiveness and how it can be measured and improved. As Waldram (2008) points out, a key finding which emerged

from this research is “the importance of flexibility and eclecticism in the development of treatment models.” He continues to explain that “there is no singular Aboriginal client, as there is no singular Aboriginal individual” (p. 4).

The National Aboriginal Health Organization and the Aboriginal Healing Foundation have produced a number of important resources and publications of relevance. The importance of understanding and respectfully engaging with Aboriginal worldviews, is an obvious point and one which is emphasized by those working within the field of Aboriginal mental health (McCormick, 2009).

5. A Collaborative and Integrative Approach to Specialized Knowledge Within the Trauma Disciplines in Connection with Aboriginal Knowledges and Worldviews

Integration between new and important advances in the field of trauma research and treatment, and Aboriginal approaches to healing and mental health, promise to yield the most rich and effective ways to assist traumatized individuals and communities of Canada’s First Nations.

Given the history and continued contemporary reality of colonization of the peoples of First Nations it is not surprising that mainstream or traditional psychological or psychiatric approaches to mental health might be viewed as either alien or entirely inappropriate to the lives and values of Aboriginal peoples. Joseph Gone, a self-described Native clinical psychologist, writes eloquently of the discomfort surrounding the “psy” professions within many First Nation communities, including his own. He also describes the “cultural perils” Aboriginal mental health professionals encounter in seeking advanced training in western graduate education because the categories, language and ways of knowing are so often discordant with those of Aboriginal cultures and traditions (Gone, 2009). Despite these challenges Gone’s work speaks to the urgent need for more Aboriginal people to become trained and skilled in the professions of the mental health fields. Speaking of the costs and benefits of engaging in such an endeavour Gone (2009) concludes that, “although the colonial pressures of formal education are indeed oppressive, the costs to our communities of allowing cultural outsiders to determine our collective fates are more oppressive still” (p 423).

There are good reasons for a deep skepticism or even antipathy towards the “psy” professions on the part of many Aboriginal peoples as Gone (2009) describes. And it is certainly the case that much of the mainstream, uncritical and uncontextualized knowledge and practices of traditional psychology and especially psychiatry are deeply problematic and pathologizing.

Nevertheless we would argue that from within these professions (and others) a small but critical mass of non-traditional clinicians, scholars, researchers, and practitioners are engaging in ways of understanding and approaching mental health and healing which are contextualized, expressly acknowledge social injustice, colonialism and the social relations of inequality, and which interpret and apply the insights of the psychological and neuro-sciences in a social context framework. Moreover, even in the face of deep cultural differences across humanity, there remain some common ways in which human experiences of fear, abuse and other traumatic events are registered neurologically and are embedded somatically and psychologically. Gone describes these approaches as “ethnopsychologies,” others working within this kind of approach might frame it as “transcultural” psychiatry or psychology.

Many of the experiences and effects of complex trauma are profound and complex and require highly skilled interventions. Recent advances in neuroscience and neurobiology and new models of understanding trauma assist in better recognizing, conceptualizing and articulating the ways in which this trauma shapes children’s and people’s psychological development, emotional selves, narratives, and lives.

The importance of affect dysregulation as a component of trauma responses, about which a great deal has recently been theorized and understood, is but one example of this. A significant advance in studying complex trauma is the greater understanding of people’s dysregulated affect as a result of traumatic experience, and how this dysregulated affect has neurobiological underpinnings.

Affect dysregulation can be effectively dealt with through a number of different methods, including through a close therapeutic relationship, through psycho-education, and through skill building to learn tools to comfort, soothe and modulate dysregulated affects, which, in turn, affect the physiology. These components of the healing work to address affect dysregulation can certainly be translated and incorporated into models that are contextually appropriate for Aboriginal communities and which engage with and honour Aboriginal cultural approaches and ways of knowing.

For these reasons, we would argue that there is no necessary incompatibility between contextualized, socially conscious and culturally sensitized psychology and other mental health professions, and Aboriginal ways of knowing and approaching mental health and wellness. Indeed, a respectful and deep engagement of the two would seem to be the most viable, politically possible and an enriched

way of facilitating the further development, expansion and creation of culturally appropriate and effective ways of undertaking meaningful trauma work. In more general terms, and as Gone (2009) expresses it,

instead of importing and embracing Western ethnotheoretical notions and their attendant practices mental health professionals serving Native North Americans ought to be struggling with how best to tailor a scientific epistemology to the grassroots efforts of Tribal communities that seek to more effectively combat distress and promote wellness among our peoples (p 429).

An approach which deeply engages both the knowledge and insights gleaned from the developments in the research on neurobiology, neuroscience, attachment theory, and developmental psychology, with the wisdom and traditional Aboriginal approaches to mental health, can only be a richer one. As George Erasmus has insightfully noted:

The terrain of mental health is broad, varied, and incompletely seen from any one vista (Erasmus, 2009).

6. Gender Issues and the Specific Problem of Violence Against Women Should be Foregrounded in Trauma Treatments in Aboriginal Communities

It is well documented that Aboriginal women suffer disproportionately high levels of sexual and physical abuse and violence in their lives, such as intimate violence in their relationships, including those with Aboriginal men. Furthermore, there is an under acknowledged national crisis with regard to the high numbers of murdered and missing Aboriginal women in Canada, a problem which has received insufficient attention and resources.

The Native Women's Association of Canada has long worked on this issue and Amnesty International has taken note of Canadian authorities' disregard of this significant problem (Amnesty International Canada, *Stolen Sisters: A Human rights Response to Discrimination and Violence Against Indigenous Women in Canada*, Amnesty International, 2003-04). So severe has the lack of attention and action been that Andre Picard in the *Globe and Mail* has recently asked why the more than 500 Aboriginal women missing in Canada is "not considered a national priority for police, justice and public-health officials" (Picard, 2009, September. 3).

Any serious and effective attempt to deal with traumatic stress within Aboriginal communities, then, must address the issue of violence against women as well as the ways in which gender might mediate trauma responses.

7. Healing from Trauma Requires Building on Strengths, Fostering Resilience and Facilitating Enculturation

The best and most comprehensive approaches to trauma treatment centrally focus on fostering strengths, building resilience and capacity building. This can and should happen at the individual, the family and the community levels. This is an essential and defining feature of an effective approach to trauma treatment.

This emphasis on strengths and resilience is consistent with the social context, complex trauma framework we have elaborated through this paper. Under this approach, a positive appraisal and reframing away from "problems" and "symptoms" and towards recognition of "adaptations" assists survivors in recognizing their strengths and inner resources, instead of defining themselves by weakness and failure. In this way, survivors learn that many of their "symptoms" are the result of adaptations that helped them survive in the past and, to some degree, survive in the present as well. This is but one example of a strengths based approach to trauma treatment.

The link between a community's greater strengths and resources and the lower levels or even absence of problems such as suicide, has been demonstrated in relation to Aboriginal communities. Social problems such as high suicide rates can be markers of community distress, expressed in individual lives. Research has documented that there is a positive correlation between Aboriginal communities with low or non-existent suicide rate. Chandler and Lalonde report in a recent study their results which confirm the findings of a decade before. In their words,

[a]t least in the case of British Columbia, it is . . . those communities that have achieved a measure of self-government, that were quick off the mark to litigate for Aboriginal title to traditional lands, that promote women in positions of leadership, that have supported the construction of facilities for the preservation of culture, and that have worked to gain control over their own civic lives (i.e. control over health, education, policing and child welfare services) that have no youth suicides and low to zero rates of adult suicide (Chandler & Lalonde, 2009, pp 244-245).

Put differently, Aboriginal communities which have more successfully decolonized appear to have freed themselves from the trauma expressed in high rates of youth suicide.

Documenting and foregrounding the examples of strength and resilience in particular Aboriginal communities, then, and providing the resources for building on these strengths, must necessarily be an essential component of an effective trauma healing approach, so that these strengths can be recognized, honoured, further enhanced, and expanded.

8. Long and Short Term Strategies and Approaches are Necessary for Trauma Work in Aboriginal Communities

Policies, Programs and Interventions to approach trauma treatments need to be aimed at both long term and short term solutions. Long term solutions require indigenous resources, including training and educating Aboriginal people from within various First Nations communities to meet the needs of trauma healing within those communities.

But in the absence of adequate resources from within communities, including sufficient numbers of members from within Aboriginal communities to carry out trauma work, creative collaborations and interdisciplinary and cross cultural teams can be formed to meet immediate needs, keeping always in view the need to build towards long term and sustainable strategies.

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END NOTES

1. We would like to thank Jennifer Del Vecchio for her excellent research assistance, and Caitlin Mary-Faith Turner and Kate Leslie for research assistance on earlier versions of this paper.
2. In this paper, we use the term Aboriginal people to speak of the Indigenous peoples of Canada, including First Nations, Native and Métis peoples and nations who have lived in Canada continuously for centuries. We use the term Aboriginal and First Nations interchangeably throughout this text, recognizing that there are separate and distinct origins and identities amongst Aboriginal peoples in this country.

3. See, for example, Razack (2002); Malloy (1999); Grant (1996); Fournier & Crey (1997); Berger (1999).
4. See, for example, Waldram, Herring & Kue Young (2006); Royal Commission on Aboriginal Peoples (RCAP) (1996a); Statistics Canada (2003).
5. See MacMillan, MacMillan, Offord, & Dingle (1996); Minich (2006); United Nations Permanent Forum on Indigenous Issues (UNPFII) (2006).
6. See, for example, Indian and Northern Affairs Canada (2005); Statistics Canada (2001); Statistics Canada (2003); RCAP (1996).
7. See, for example, the expert consensus of the Joint Task Force of the National Child Traumatic Stress Network (NCTSN), the International Society for Traumatic Stress Studies (ISTSS), and the International Society for the Study and Treatment of Trauma and Dissociation (ISSTD) led by Bessel van der Kolk, M.D, who have proposed a new diagnostic condition for inclusion in the DSM-V that addresses the complexity of adaptation to survive child maltreatment and neglect. See van der Kolk et al. (2009).
8. A recent study, for example, just demonstrated this point. As reported by Harding (2009), researchers found that the stigma is greater for those seen to have “gender typical” mental illnesses.
9. For examples of this increased violence in intimate relationships in Aboriginal women’s lives, see Bachman (1992); Rennison (2001); Trainor and Mihorean (2001); Harwell et al. (2003); Brownridge (2003); Brzozowski (2004); Brzozowski, Taylor-Butts, & Johnson. (2006). To give one recent example, in his study examining Aboriginal women’s elevated risk for violent victimization relative to non-Aboriginal women, Douglas A. Brownridge (2008) found that Aboriginal women had about four times the odds of experiencing violence compared to non-Aboriginal women.
10. A very current example of this can be seen in the very significantly disproportionate rates of swine flu in some Aboriginal communities. See Fitzpatrick (2009, June 23).
11. For examples of this scholarship, see Danieli (1982); Danieli (1985); Baranowsky et al. (1998); Felsen (1998); Yehuda et al. (2000).