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Healing Historic Trauma: A Report From The Aboriginal Healing Foundation

Marlene Brant Castellano and Linda Archibald

Editor's Note:

The following chapter differs from others in this volume. Rather than being an individual research presentation, it is an overview of the findings from six presentations given at the Aboriginal Policy Research Conference (2006).

—Jerry White

Introduction

The Aboriginal Healing Foundation (AHF) hosted two sessions at the Aboriginal Policy Research Conference in 2006 to profile its final report and the research underpinning its findings. This paper brings together selected content from six presentations[1] at those sessions that, together, provide insight both into the traumatic legacy of the residential school system, and into interventions directed towards interrupting the transmission of that hurt through successive generations. Over the seven years of its first mandate, the AHF has taken direction from its board of directors, many of them residential school Survivors,[2] and those affected directly and indirectly by the residential school experience. This paper proposes that a new paradigm of healing is emerging, one that takes into account successive waves of trauma that were experienced by Aboriginal communities in the past, which continue to reverberate and may be repeated in diverse forms in the present. The paradigm draws on cultural resources, as well as the therapies of Western culture, to mobilize the inherent resilience of community members.

The Aboriginal Healing Foundation was established in March 1998 as a self-governing agency to manage the distribution of a $350 million, one-time grant from the Government of Canada for community-based healing of the legacy of physical and sexual abuse at residential schools. The healing fund was a concrete governmental response to volume 1 of the *Report of the Royal Commission on Aboriginal Peoples* (1996), which documented the damaging effects the schools had on Aboriginal culture and people. The fundamental aims of the residential school system had been to separate Aboriginal children from their families and communities, to erase their languages and identities as Aboriginal people, and to absorb them into Euro-Canadian society (337–44). Survivors who launched law suits seeking reparations emphasized that the emotional, cultural, and spiritual

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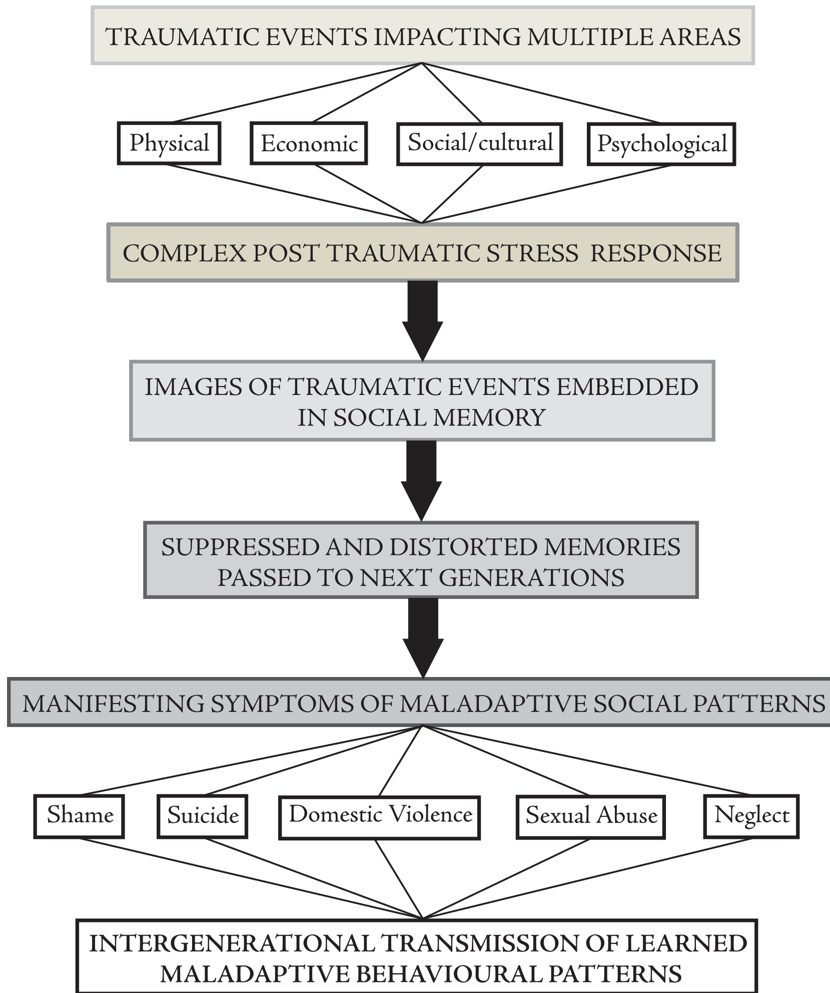
Figure 5.1: Historic Past



Source: Aboriginal Healing Foundation

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damage they suffered as a result was common to all and which made the physical and sexual abuse suffered by some of their numbers even more devastating.

Prior to the establishment of the Aboriginal Healing Foundation, residential school Survivor groups had formed to support one another, particularly during the painful process of taking criminal and civil court actions relating to physical and sexual abuse through the justice system. Clinicians had begun to associate symptoms displayed by former students with post-traumatic stress disorder (PTSD). Still, little was known about the complexities and extent of trauma resulting from the residential school experience. Even less was known about interventions that would promote healing in Survivors and in their families, who also were affected by those experiences.

The Aboriginal Healing Foundation launched a two-pronged research program to create a knowledge base for its initiatives in community healing. The first prong was an effort to engage scholars and practitioners in searching out relevant practice experience and literature that would shed light on trauma and recovery in Aboriginal contexts. The second prong was a plan to involve personnel in projects funded by the foundation to provide systematic data, both quantitative and qualitative, and to document what was being done to deal with trauma and recovery issues in communities, and with what effects.

Research reports, evaluations, and a survey of promising practices formed the evidence base for the three-volume final report, released in January 2006 (*Report of the Aboriginal Healing Foundation*).[3] At the APRC, authors presented highlights of three research reports and each of the volumes of the final report. Synopses of the presentations make up the bulk of this paper, with sections on historic trauma, resilience, strategies for healing men, measuring progress, promising healing practices, and the healing journey. References for the original papers and reports are provided, and copies can be obtained from the Aboriginal Healing Foundation.

Historic Trauma[4]

In her presentation, Cynthia Wesley-Esquimaux utilized work from her jointly authored study, "Historic Trauma and Aboriginal Healing," to propose a theory of "historic trauma transmission," to explain the origins of social malaise in Aboriginal communities and the dynamics of interventions particular to Aboriginal contexts. The research drew on historical, social science, and therapeutic sources to develop core concepts.

Aboriginal peoples have lived through an unremitting series of traumatic events: demographic collapse resulting from early influenza and smallpox epidemics and other infectious diseases, conquest, warfare, slavery, colonization, religious proselytizing, famine and starvation, the residential school period from the 1890s to the late 1960s, and continuing assimilative pressures. These experiences have left

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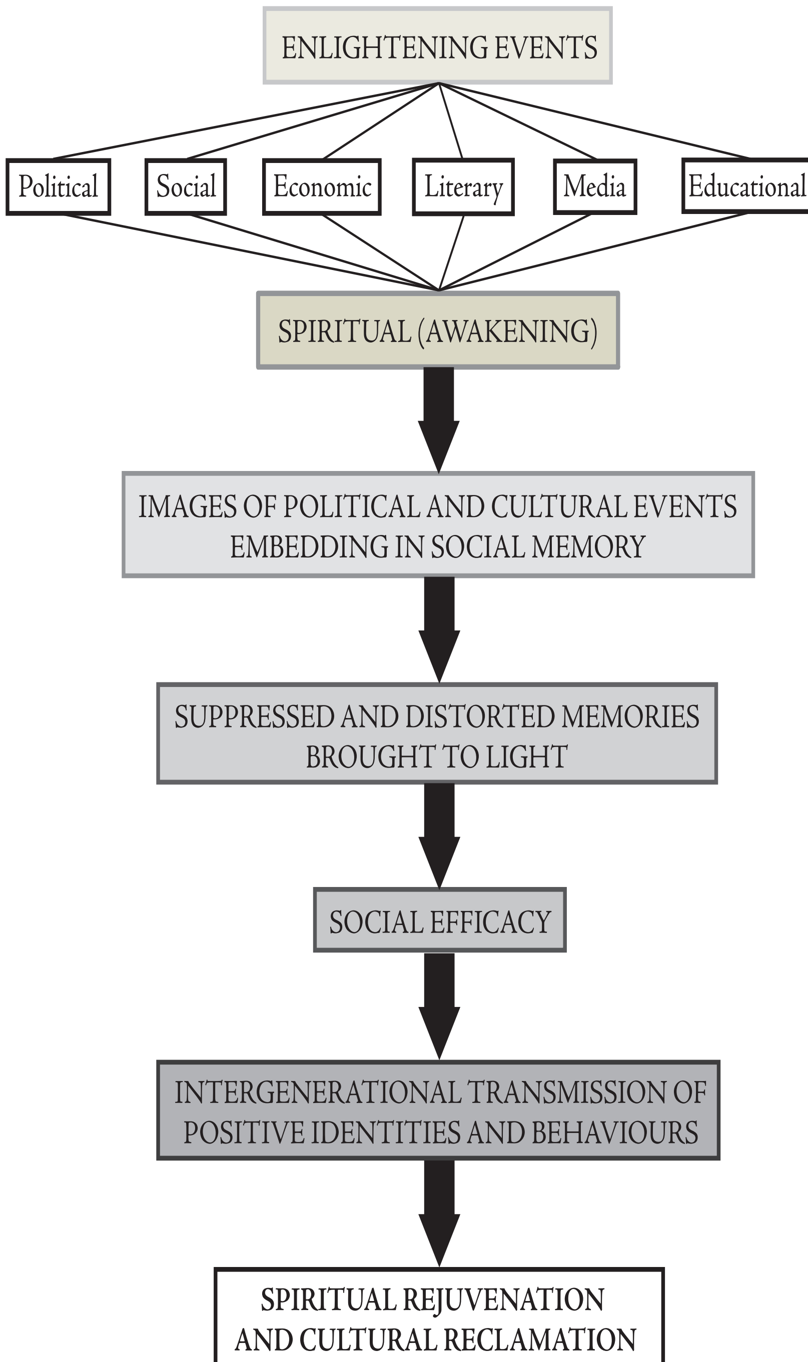
Figure 5.2: Historic Present



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Indigenous cultural identities reeling with what can be regarded as a pervasive and complex form of PTSD.

Figure 5.1 (page 70) depicts a model of historic trauma transmission whereby traumatic events in the past have implications and consequences for how Aboriginal peoples function in the present, both culturally and socially. In this model, symptoms of social disorders exhibited in the present are not only caused by immediate trauma; the memories and images of past traumatic events are being passed, from generation to generation, disrupting adaptive patterns of behaviour and diminishing social efficacy.

The traumatic events that accompanied the process of colonization and assimilation of Aboriginal peoples have been grouped into four categories, depending on their area of impact. These are physical impacts (introduction of infectious diseases and their consequences), economic impacts (such as forced removal of people from their familiar territories and changes in subsistence patterns), cultural/social impacts (such as changes brought by religious proselytizing, changes in social structures and cultural norms), and psychological impacts (including changes in perceived locus of social control). In the last case, individuals, families, and communities lost all sense of being able to control their lives, livelihoods, territories, and, in the case of residential schools, the care and education of their children. Multiple stressors over time elicit a response that is being named in the therapeutic literature as Complex Post-Traumatic Stress Syndrome (CPTSS).

Images and memories of traumatic events are passed on to following generations through cultural (storytelling, community discourse, myth), social (types of parenting), psychological (memory processes), and biological (e.g., hereditary predisposition to PTSD) modes of transmission. Over time, and with each generation, these images and memories of suffering become selectively distorted and not fully remembered but are still present, even if people may not be fully aware of the influence these stressors have on their own perceptions and ways of adapting. Recurrent recollections of trauma experienced by individual members of a society will, sooner or later, enter into a social narrative of the group and become transmitted to subsequent generations. Individual memories are recounted and enter into cultural collections of symbols and meanings, into rituals and ceremonies, and into the group's shared cultural memory and behavioural patterns.

Generations of people who have never experienced actual trauma may develop maladaptive patterns of behaviour and symptoms of social disorders by having memories of trauma passed on to them from their grandparents' or parents' generations. These patterns and symptoms are passed on again to their sons and daughters in the same way as the traumatic memories were to them. At this point, we can talk about an inheritance of socially learned, maladaptive behavioural patterns: addictions, helplessness, neglect.

Historic trauma is understood as both a cluster of traumatic events and a disorder in itself. Suppression of memories of painful events is a common defensive

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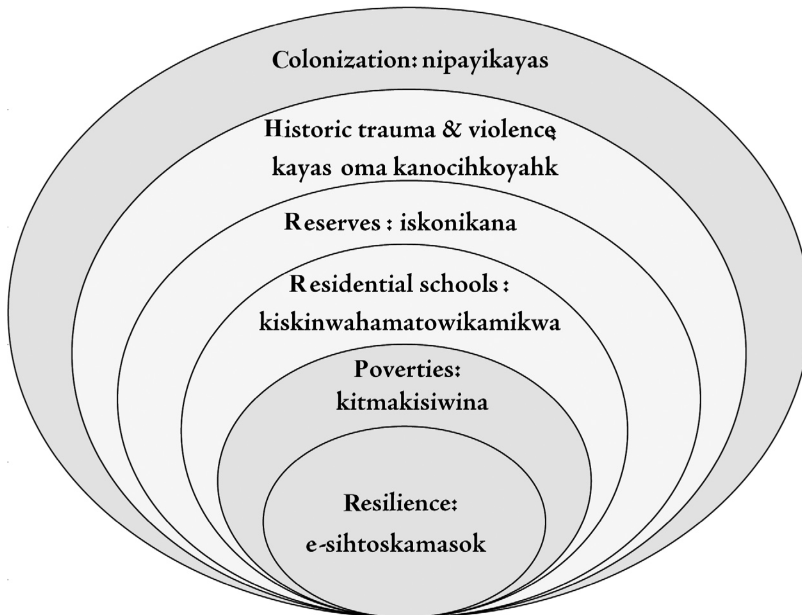
Figure 5.3: Risk Pile Up



Source: Aboriginal Healing Foundation

response. Hidden collective memories of trauma, or a collective non-remembering, are passed from generation to generation, as are associated maladaptive social and behavioural patterns. There is no "single" historic trauma response; rather, there are different social disorders with respective clusters of symptoms. Historic trauma transmission disrupts adaptive social and cultural patterns and transforms them into maladaptive ones, manifesting in symptoms of social disorder. In short, historic trauma causes deep breakdowns in social functioning that may last for many years, decades, and even generations.

At the present time, many Aboriginal communities are re-engaging in positive social and cultural activities, which can be viewed as "enlightening events" (see **Figure 5.2** – page 72). Aboriginal people are revisiting their past, and making connections between the traumatic events from the past and disruptive social behaviours in the present. They are becoming aware of their memories of suffering and understanding the meaning behind the images of loss and grief. They are revitalizing their political, social, and economic spheres, and their participation in a collective enterprise of bringing wellness to their communities is creating positive changes. Good things are happening to people and communities more and more often and, one by one, these good experiences serve as competent guides for how to deal with the future.

When these experiences accumulate, people feel more competent, empowered, rejuvenated, and ready to participate in life. These very images of "enlightening

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events" and successful attempts to regain control become embedded in social memory and they are passed to successive generations, enabling members of the community to participate in self-healing, reclaim their spirituality and culture, and break through the interconnected bonds of loss, grief, and sadness. Using their reclaimed culture as a "healing tool," clusters of healthy, revitalized people are fostering community renewal, reforging their identities, and asserting their place within the wider Canadian society.

Resilience

The research in the present paper on Native People's historic trauma was undertaken in a broad historical and societal framework. The work that Madeleine Dion Stout reported on turned a more specific focus on human resilience in the context of residential school experience. The conference presentation elaborated on a study she authored jointly for the Aboriginal Healing Foundation (Dion Stout and Kipling 2003).

The original study on which Dion Stout's presentation was based contained no Cree words, but she included some Cree in order to locate the concept of resilience in the context of her personal knowledge. For Aboriginal people who have undergone and survived residential schooling, the memories of that experience are visceral. Dion Stout, herself a Survivor, used the Cree language (in which she is fluent) to help dislodge popular views of residential school students as passive victims and to elaborate on a culture-specific interpretation of adaptive responses. The stories told in Cree contain messages of warriorhood and survival as well as hardship, with words full of strength in adversity. By telling these stories and knowing these words, resilience and healing are tied to one's sense of identity, and retaining or recovering fluency in an Indigenous language is an assertion of agency contesting attempts to erase identity with harsh resocialization and routine corporal punishment.

Expressing concepts in Cree in a presentation on the residential school legacy, as Dion Stout has done, recognizes the intergenerational trauma and losses this legacy has inflicted on Survivors, their families, and their communities. Most importantly, words spoken in Cree or any other Indigenous language strengthen a sense of self, family, and community, while at the same time affirming all other relationships.

The presentation provided an overview of the literature, which defines resilience as the capacity to spring back from adversity and have a good life outcome despite emotional, mental, or physical distress. The definition was adapted to describe the innate capacity of Survivors to get along, get through, and get out of the risk position created by residential school experiences. The interplay between risk and protective factors is complex and fluid, and crosses lifespans and generations. Undue emphasis on risks reinforces deficits and reveals little about the human agency of residential school Survivors.

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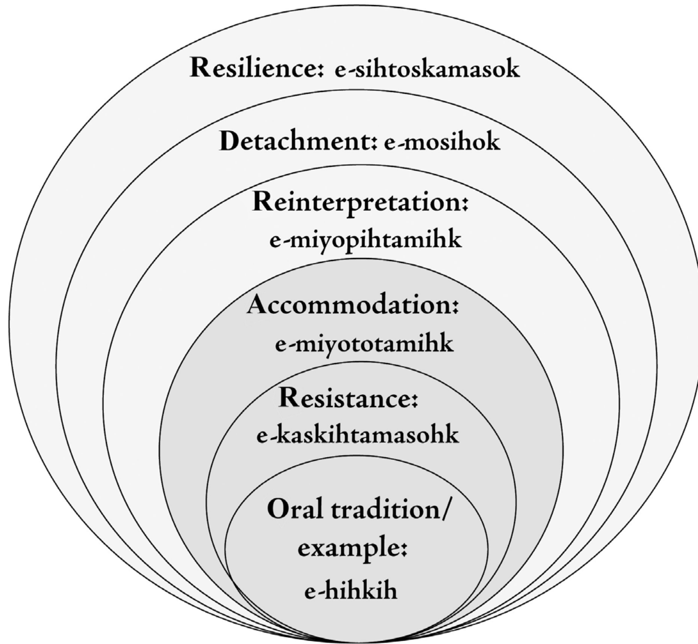
Figure 5.4: Protective Defences



Source: Aboriginal Healing Foundation

Reframing the issue to examine risks and protective factors as understood by Aboriginal people in terms of their language and culture creates a narrative that is healing as well as explanatory. The analytical task remains the same: to consider the factors that increase the probability of a negative outcome and those that help to counteract risk and decrease individual vulnerability to adverse conditions. **Figure 5.3** (page 74) illustrates the reality that risk increases exponentially with each additional stressor. Starting from a core of resilience, the Cree expression for each layer of risk expands our understanding of the corresponding English term reaching the extreme condition of colonization of body, mind, and spirit.

- **resilience—**capacity to spring back from adversity and have a good life outcome despite emotional, mental or physical distress
- **e-sihtoskamasok**—the will and ability to stand up for one's survival
- **poverties—**multiple unmet basic human needs, leading to pathology
- **kitmakisiwina—**any action or inaction that causes deprivation of the body, mind, and spirit
- **residential schools**—the residential school system in Canada attended by Aboriginal students, including industrial schools, boarding schools, homes for students, hostels, billets, residential schools with a majority of day students, or a combination of any of the above

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- **kiskinwahamatowikamikwa**—the structure where schooling takes place; the setting for an opportunity
- **reserves—**land measured out for "Indians"
- **iskonikana**—leftover land
- **historic trauma and violence**—the cumulative wounds inflicted on Aboriginal people over their lifetime and the lifetime of their ancestors, resulting in chronic symptoms that range from depression and psychic numbing to hyperglycemia and substance abuse
- **kayas oma kanocihkoyahk**—a long, visceral threat and assault
- **colonization**—the process by which local populations are displaced and subjugated
- **nipayikayas**—the deadly or extreme past

Some individuals are able to achieve a good life, despite the pile-up of adversity, by adopting protective defences. **Figure 5.4** represents layers of adaptation that build on the core of oral tradition. Resilience is the encompassing response, which includes the capacity to let go of defences when a place of safety is reached. Healing initiatives in the present need to take into account that people who have been severely traumatized in the past may be locked into rigid defences that undermine their capacity to respond flexibly to present opportunities for relationships and a good life.

- **oral tradition and example**—time-tested means of knowledge transfer and exchange that build and transform character
- **e-hihkih**—being and becoming
- **resistance**—provides opportunities to register opposition to an oppressive system. Direct resistance is overt—for example, stealing from pantries, defending younger children from mistreatment, and running away. Indirect resistance is covert—for example, wearing a "mask" to hide one's true feelings.
- **e-kaskihtamasohk—**one's self-deliverance
- **accommodation**—involves currying favour with those in power by working harder; co-operating with school personnel and feeling that giving in to the advances of staff members will provide protection
- **e-miyototamihk**—restoring peace and goodwill
- **reinterpretation**—recasting negative situations in positive ways—for example, maintaining strict composure during beatings, living out fantasies about present and future circumstances, idolizing those who ran away from school
- **e-miyopihtamihk**—aligning with order and balance
- **detachment**—distancing oneself from the source of hurt by "shutting down," not speaking or hearing, or laughing about the source of pain

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- **e-mosihok**—an intuitive response to a sense of foreboding
- **resilience—**capacity to spring back from adversity and have a good life outcome despite emotional, mental or physical distress
- **e-sihtoskamasok**—the will and ability to stand up for one's survival

This framework for understanding resilience in residential school survivors can provide a basis for policy responses. Planning and research should include identifying risk and protective factors that operate in individuals and communities, conducting longitudinal and ethnographic research to map the healing of deep-rooted distress as it manifests and is relieved in particular persons and environments, and developing a resilience enhancement strategy.

Interventions should be targeted to identifying risk and protective factors at each life stage and to carrying out culture-based initiatives that acknowledge a historic trauma framework. Particular attention should be directed to Survivor populations who have been most directly affected by the residential school experience and youth who are most vulnerable to risk pile-up.

Quantitative and qualitative evaluations of progress in coping skills and adjustment levels will help to gauge success, and such evaluations should directly involve the perspectives and judgment of those who have a stake in increased personal and community resilience.

Healing of First Nations Men

The APRC presentation by Bill Mussell, a social worker, educator and mental health advocate, drew on a paper he prepared for the AHF (Mussell 2005). The paper incorporated a review of the limited literature, key informant interviews with social service and community workers, including one Elder, and Mussell's own extensive cultural and professional experience.

Fewer men than women become engaged in healing activities. This knowledge provided the impetus behind the exploration of challenges associated with healing men. A review of the sources suggests that men in general, and First Nations men and boys in particular, face a number of significant challenges.

Reports focusing on men and boys with problematic life adjustment indicate that boys, more than girls, are less likely to graduate from high school or to pursue higher education. Boys are expected to be tough and to look after themselves. They are not expected to be good students and, at home, little is done to facilitate success in the school system. In fact, they tend to learn more from their peers than from parents and caregivers. At the same time, boys are not expected to learn life skills associated with caring for and maintaining the home, and few boys are taught to make a living and provide for a family.

As adults, men are less connected in supportive ways to family and community than women. Men have difficulty expressing and addressing emotions and are less likely than women to seek professional help or to ask for assistance, especially

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in personal matters. They pay less attention to their physical health and are prone to deny violence and abuse in their lives. When things go wrong, both men and boys tend to blame others or they blame conditions, such as fetal alcohol spectrum disorder (FASD), addictions, the effects of residential school, and abuse.

Historically, colonization diminished the role of men as providers and protectors, and racism often prevented men from getting jobs or developing businesses that would allow them to be self-supporting. Today, too many men are no longer important role models or teachers of traditions and values for their sons and daughters. In light of the scarcity of positive models for First Nations males in many communities, the concept of the Warrior-Caregiver, introduced by Bill Mussell in healing and educational venues, is striking a responsive chord.

The concept of Warrior-Caregiver synthesizes the multiple roles and responsibilities filled by effective males at all stages of development within healthy family and community life. It represents an ideal, rather than a picture of one individual; it draws upon traditions, but speaks to the contemporary world in which First Nations men live their lives.

A Warrior-Caregiver is defined as a family and community member who cares about his environment and all things within it. He enjoys inner peace and relates well to the life forces in his world. As an adult, he takes pride in being responsible and accountable. He values safety and security, knows the importance of acceptance, understanding, and love, and enjoys relationships with people of all ages and in all stages of life. In family and community, he provides well, enjoys his work, volunteers to assist others, and is pleased to discuss needs and challenges when occasions present themselves. He has clear beliefs, stands on principle, and is alert and prepared to resolve conflict when in the presence of injustice, unfairness, and violence. He knows humility and genuine pride and believes in the ability of people to modify their outlook and behaviour. A “good” upbringing is not a necessary background to become a Warrior-Caregiver.

Warrior-Caregivers help enrich the identity of persons they interact with and the community itself. They know and facilitate awareness of connections between the past and the present and contribute to building optimism for the future. This vision of the Warrior-Caregiver as a healthy, responsible, connected First Nations’ man has guided the development of practical strategies for healing historical damage. Before detailing these strategies, however, it is necessary to have a short discussion of teaching/learning models.

Prior to the introduction and imposition of formal Western education, knowledge and culture were transmitted in less formal ways among Indigenous peoples. While there were no physical institutions, learning was purposeful and took place in formal and informal settings and experiential modes. Strategies for catching game, constructing dwellings, making snowshoes, and building canoes, for example, were learned in non-formal ways. Informal learning happens when a

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parent, Elder, or other caregiver takes advantage of a “teachable moment” to help someone discover on their own what they need to know.

In residential schools, children did not learn anything about their family, community history, or culture, nor did they learn how to learn. Methods employed in the classrooms were designed to implant what the teacher taught as facts into the students. When these young people returned to their communities, common language and nurturing relationships to facilitate the sharing of knowledge were mostly absent. Extended families and community networks were stressed by grief at the loss of their children and by the poverty and powerlessness of their lives. Conditions for the transmission of knowledge, history, and culture from family and community to their children were impossible to create in these circumstances. These constraints on knowledge transmission between family and young people persisted when the residential school system ended.

Mediated learning is a process whereby a mediator (teacher, parent, grandparent, counsellor, healer, etc.) creates conditions that promote the integration of received information and lived experience. Connecting new information with life experience transforms it into personal knowledge, mitigating the malaise associated with formal learning, especially for boys. This learning/teaching model is designed to increase feelings of self-worth and self-esteem in learners. Whether the learning takes place in a structured environment, such as a healing program or a school, or informally within the family and community, it is especially important for men and boys who are not well prepared by prior socialization to take on the roles of caregivers and warriors.

The integration of culture and family and community history is essential to the learning process. Building upon the strengths of the family and extended family and incorporating culture, history, and traditional teachings creates an environment where boys can be nurtured and taught in a way that motivates them to become healthy, responsible, nurturing adults. Evidence is accumulating that shows how this type of learning can take place through storytelling and dialogue or during talking circles, informal and formal get-togethers, and ceremonies.

Practical strategies for healing men can be embedded in strategies for supporting healthy families and communities. One of the findings from key informant interviews is that a great many young families live with male violence. Men have major roles to fill in healing the effects of such experience and developing safe, secure, nurturing, and inspirational environments so that infants, young children, and youth can grow into healthy, strong, intelligent, and wise adults who value family and community life.

There are numerous practical strategies that can support and guide work with men. These include:

- Building upon values that reflect an Aboriginal world view and relate to the life experience of the learner

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- Paying attention to family and community history, including institutionalization and posing issues in ways that connect to the learner's experience
- Offering cultural activities that speak to the learner
- Appealing to the person's intelligence
- Focusing on hands-on activities or "learning by doing"
- Focusing on the learner/client, not the practitioner; tailoring the nature and timing of interventions to fit the needs of participants
- Valuing the richness of lived-life experience.

The AHF Final Report

The final report of the AHF is published in three volumes and builds on insights derived from more than three dozen commissioned studies, including 13 case studies of community healing projects. *A Healing Journey: Reclaiming Wellness* (volume 1) presents a narrative covering the formation, activities, and accomplishments of the AHF over seven years; major findings are documented more fully in volumes 2 and 3, along with implications for future healing initiatives. *Measuring Progress: Program Evaluation* (volume 2) presents quantitative data from successive evaluations and interprets project impacts. *Promising Healing Practices* (volume 3) reports on in-depth survey responses from community projects.

Volume 2: Measuring Progress: Program Evaluation

Kim Scott, evaluator and author of volume 2, highlights evidence of the impact that the program has been having. The most significant question asked in the evaluation of AHF program activity during the period 2000 to 2005 is "What difference does it make?" Methods of inquiry included a review of project files, three national mail-out surveys in 2001, 2002, and 2004, respectively, telephone interviews with AHF board members and personnel, five national focus groups, 13 in-depth case studies, and 1,479 individual participant questionnaires (IPQs) that captured information about individuals' experiences in the therapeutic heal-ing process.

An estimated 111,170 individuals have participated in healing and, of these, almost two-thirds had never previously participated in a similar program. AHF-funded organizations hired and trained large numbers of Aboriginal people: 4,833 employees (91% of full-time and 85% of part-time workers are Aboriginal people), and 28,133 participants in training programs. Over time, projects demonstrated an increased capacity to meet the need for healing and they facilitated, through training, an increased connection between those in need and

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those able to help. At the same time, project teams identified increasing numbers of people with special needs who required access to longer-term individual treatment or specialist services, such as addiction treatment. Participants rated the following healing services as most effective: Elders, ceremonies, individual counselling, healing/talking circles, and traditional medicine. Western therapies were rated least effective.

Overall, people who participated in healing projects felt that they were better prepared to handle difficult issues (72%), to move beyond past traumas (76%), to handle future trauma (79%), and to find ways to get support once the project was over (69%). Project teams, however, noted a wide variability in "success" between individuals. This was attributed primarily the individual's "readiness to heal" and the fit between participants' needs and the intervention offered.

Readiness to heal or "fit" was sometimes assessed through a vigorous intake process, but most projects worked with a variety of priority-setting strategies. Some placed Survivors and their descendants at the top of the list and accepted them without assessment. Other projects identified those at greatest risk as a top priority, or specific target groups (gender, Aboriginal identity, sexual orientation, age), or those who self-initiated enrolment. However, there was recognition among some of the projects, expressed in the case studies or by focus group participants, that an individual's readiness to heal had an impact on their success in the program.

In assessing readiness, projects are determining who is likely to benefit most from the program being offered. For example, readiness to participate in therapeutic intervention is indicated in individuals who are self-motivated, interested, and willing to participate, as well as in those with a track record of regular, ongoing, or previous participation in healing. Other indicators include having a reasonably stable lifestyle and being alcohol- and drug-free. Individuals should be prepared to be accountable for their past and their present behaviour and have a source of outside support before, during, and after the program.

Recognizing that there are gradations of readiness, great flexibility and a variety of strategies were outlined to engage those who were not yet ready. For example, communities used public awareness campaigns, including education on the legacy of residential schools, and program promotion; they engaged in outreach to individuals and specific target groups; and they organized feasts and other social events and invited the community to participate.

Communities also exhibited varying degrees of readiness to engage in and support healing. High local demand for services, as opposed to high need, is a prime index of community readiness. Communities are generally ready when they exhibit an ongoing commitment to wellness, when whole groups are interested in or attending addictions programs, and community leaders support these efforts.

One significant piece of learning that emerged in the evaluation is that the nature and extent of Survivor involvement in projects are indicators of community

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readiness for healing. For example, in the early stages, the fact that Survivors want healing services is an important indicator. This demand for services is very different from situations where a high need for healing programs is evident but there is little desire on the part of community members and leaders to act.

Community progress along a continuum can be tracked in four stages. A demand for healing services often emerges along with a growing awareness of residential school history and its impacts on individuals, their families and previous generations. In the early stages of healing, progress is indicated by the creation of opportunities for Survivors to meet, connect, support each other, and encourage one another to heal. Survivors groups may meet informally or formally, with the support of a local, regional, or national organization.

During the second stage of community healing, as Survivors continue to meet, momentum gathers, and groups are more formally established. Indicators of success include the extent to which Survivors are involved in decision making in a formal healing project, the level of support of local leadership, Survivor involvement in the design of programs and services to meet their needs, and their involvement in hiring decisions for members of healing teams.

These indicators continue to be tracked in the third and fourth stages of community healing, with increased levels of Survivor action and involvement being expected as more and more community members, other Survivors, and leaders become involved. By the fourth stage, many Survivors have moved from wanting help to giving help.

It is interesting to note the dual role Survivors play in the healing process; evidence from project surveys, case studies, and IPQs reveals that those who are seeking healing and those who can facilitate healing are often the same people at different stages of their journey. It is clear that the qualities and attributes of healers/helpers[5] can have a profound impact on success. Identifying the range of skills and qualities possessed by effective healers/helpers was one of the tasks presented to focus groups.

In general, formal training and post-secondary education are valued, as are traditional training and experience, and knowledge of the local culture, language, and the community itself. A good healer/helper has a solid track record of ethical conduct and is recognized and respected by the community. People are advised to be wary of self-proclaimed healers.

Other qualities include evidence of stable recovery; that is, Survivors have worked through their own issues, including grief and anger, and are willing and able to share their experiences with others. Well-established personal boundaries protect them from burnout and harm. They are fearless and unflappable leaders who are comfortable with and knowledgeable about the residential school Legacy. They have an open mind, are free from the need to control people and situations, and have a clear understanding of their own limitations. When necessary, they make knowledgeable and appropriate referrals. Spiritually grounded, they have a

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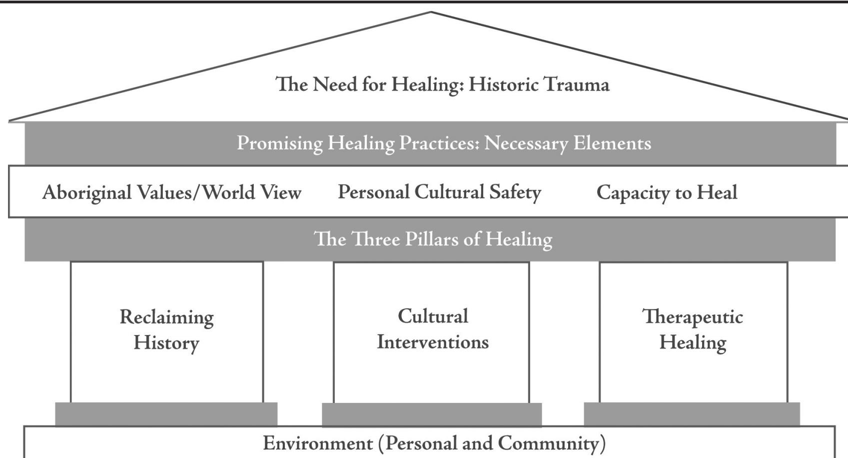
Figure 5.5: Promising Healing Practices



Source: Aboriginal Healing Foundation

respectful relationship with the land and are comfortable leading or participating in traditional ceremonies.

Skills of effective healer/helpers include the ability to listen attentively, process intense emotion, diffuse negativity, and differentiate between the need for crisis intervention and long-term therapy. In a crisis, they respond quickly and effectively and they have the skills to intervene in and prevent suicide. They understand the connection between the physical, mental, emotional, and spiritual aspects of self and know where trauma is stored in the body.

Skilled healers/helpers understand and dissipate lateral violence, counsel sexual abuse victims and/or perpetrators, and are comfortable discussing healthy sexuality openly. They have access to a variety of techniques and interventions, either as part of their own skill set or as a member of a multi-skilled healing team. They use traditional medicine themselves or partner with a traditional healer, and their commitment to ongoing learning includes working with clinical supervision.

In summary, three significant contributions to our collective learning about healing from the residential school Legacy have been highlighted: the link between readiness/fit and outcomes of interventions; the participation and leadership of Survivors as an indicator of success; and the qualities and characteristics of the good healers/helpers. Other learning, not addressed here, relates to the extent and complexity of the healing journey and the need to devote sufficient time and resources to sustain progress over the long term.

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Volume 3: Promising Healing Practices in Aboriginal Communities

Linda Archibald, researcher and author of volume 3, reported on healing programs designed by and with Aboriginal people that make innovative use of both traditional and contemporary therapies. Research into promising healing practices[6] has led to the development of a framework for understanding trauma and healing, a framework which is based on the experiences of AHF-funded projects and which can be used to guide the development of new programs and services.

This study was based on responses by 103 AHF-funded projects to a questionnaire about healing programs and practices that are working well, supplemented by information gathered through five focus groups held throughout 2003–2004 (two in Ottawa and one each in Montreal, Winnipeg, and Iqaluit), internal file review, and workshops held at a national gathering in Edmonton.

Diversity is the word that best describes the healing methods and approaches found to be working well in Aboriginal communities. Promising healing practices share a number of key characteristics that are interrelated and mutually reinforcing, as portrayed in **Figure 5.5**.

In this figure, Aboriginal values, personal and cultural safety, and capacity to heal are viewed as necessary in the development of successful healing programs. The programs themselves are built around three intervention strategies: reclaiming history, cultural interventions, and therapeutic healing. The first three characteristics can be viewed as necessary elements of effective healing programs. The last three—referred to as the three pillars of healing—represent components of a holistic healing strategy.

In the figure, historic trauma theory is positioned across the top, providing a context for understanding that the residential school system represents only one of many historical assaults on Aboriginal people. At the socio-political level, the accumulated effects of oppression and dispossession are viewed as a root cause of the compromised social, economic, and health status of Aboriginal populations. At a personal level, they underlie the need for healing. However, we also recognize that individual and community experiences vary greatly and, therefore, the nature and extent of their losses will vary accordingly.

Situated below "Historic Trauma" are the program elements that support the healing process:

Aboriginal Values/World View. Successful healing programs reflect the values, underlying philosophy and world view of the people who design them. For healing programs designed by and with Aboriginal people, this includes values of wholeness, balance, harmony, relationship, connection to the land and the natural environment, and a view of healing as process and a lifelong journey.

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Personal and Cultural Safety. Establishing safety is a prerequisite to healing from trauma. Promising healing practices ensure the physical and emotional security of participants. Moreover, for Aboriginal people whose cultures and beliefs have been under attack, creating safety extends beyond establishing physical and emotional security to building a culturally welcoming healing environment. Cultural safety includes providing services consistent with and responsive to Aboriginal values, beliefs, and practices, as well as creating a physical setting that reflects and reinforces the culture and values of participants.

Capacity to Heal. Skilled healers, therapists, Elders, and volunteers guide promising healing practices. Respondents expressed high regard for the skills, dedication, and capabilities of their healing teams. This is consistent with the best practices literature, which consistently identifies committed, skilled staff, and volunteers as characteristic of successful projects. Healing teams that include Aboriginal people and Survivors, especially people from the home community, were recognized as contributing to success.

The next level of the framework addresses intervention strategies. Healing is posited as a three-pronged process, and referred to in the framework as the *three pillars of healing*: reclaiming history, cultural interventions, and therapeutic healing. Participants can move back and forth among these interventions, concentrate their efforts in one area, or participate in two or all three at the same time.

Reclaiming History. This first pillar includes learning about the residential school system, its policy goals and objectives, and its impacts on individuals, families, and communities. It also includes delving into family and community histories as well as Canadian history from an Aboriginal perspective. This is a form of psycho-education, an intervention with recognized benefits with respect to preparing participants for the healing journey. Moreover, work in the fields of post-traumatic stress, historic trauma, and decolonization all recognize the need to acknowledge and mourn individual and collective losses, including losses that occurred in previous generations. The process allows personal trauma to be understood within a social context and serves to reduce self-blame, denial, guilt, and isolation. Understanding history can be a catalyst for healing and pave the way for mourning what was lost, a recognized stage in the trauma recovery process.

Cultural Interventions. The second pillar includes activities that engage people in a process of recovering and reconnecting with their culture, language, history, spirituality, traditions, and ceremonies. Such activities reinforce self-esteem and the development of a positive cultural identity. These are powerful, empowering experiences that provide a secure base from which to launch personal healing. They also contribute to individual and community healing. The evidence suggests that culture is good medicine. It also promotes a sense of belonging that can support individuals in their healing journey.

Therapeutic Healing. The third pillar encompasses the wide variety of therapies and healing interventions used by communities to facilitate recovery from trauma.

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Practitioners use a broad range of traditional therapies, often in combination with Western or alternative therapies. In fact, more than half (56.3%) used traditional therapies coupled with Western and/or alternative methods The approaches chosen are holistic and culturally relevant and they recognize that healing from severe trauma, especially sexual abuse, can be a long-term undertaking.

Multiple interventions were standard among the projects participating in this study: 86.4% identified promising healing practices that include interventions in more than one area. The most popular approach involved a combination of therapeutic healing and cultural interventions (42.7%). This was followed closely by approaches falling into all three areas—reclaiming history, cultural interventions, and therapeutic healing (33%). The use of multiple intervention strategies is consistent with Aboriginal values, and it suggests that projects are implementing a holistic approach to healing.

Situated below the three pillars of healing in **Figure 5.5**—and in many ways determining a particular individual's need for healing—are factors related to their personal, family, and community history. These include an individual's particular experiences, strengths, motivations, resources, and relationships within the family, as well as the social, political, and economic conditions in which they live. Other factors also have an influence, such as the community culture, language, history, and resources, and the community's capacity to support healing. These individual and community characteristics represent a series of variables that impact upon both the need for healing and the success or failure of the healing process.

Healing programs and strategies for specific target populations, such as women, men, and youth, are built around the realities and experiences relevant to each group. Similarly, programs for Inuit and Métis, like that of First Nations, are rooted in distinct cultures and take account of differences in the experience of colonization. Still, the framework for understanding trauma and healing applies to each of these groups.

Among Inuit, for example, the experience of colonization and the introduction of residential schools are relatively recent phenomena. Traditional approaches to healing placed a strong emphasis on talking through one's problems. Land-based activities, talking therapies, drumming, singing, and prayer are incorporated into promising healing programs.

Métis' experiences with the residential school system and its intergenerational impact are only beginning to be documented. Breaking the silence and recovering Métis identity and pride are recurring themes. Oral history gathering, Survivor support groups, parenting classes, gatherings, and traditional and Western therapies are all techniques that support healing.

In urban centres, the mixture of cultures, languages, people, and backgrounds leads to an approach inclusive of First Nations, Metis, Inuit, and diverse Aboriginal people. A number of projects attempt to utilize resource people and Elders from a variety of Aboriginal cultural groups so that the clients' backgrounds are

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represented. Medicine wheel teachings, healing circles, smudging, and sweat lodge ceremonies are available in cities across Canada, often in combination with Western and alternative therapies. It is especially noteworthy that more than 80% of urban programs place an emphasis on spirituality.

Women have been at the forefront of the healing movement and have participated in AHF-funded projects to a greater degree than men. For many women, safety is a major concern and this is often best addressed in women-only groups. Engaging men in healing has been challenging for many projects but success has been enhanced by adopting a male-centred approach, which reframes healing as an act of courage and provides both hands-on and land-based activities and access to male healers, counsellors, team members, facilitators, and role models. Psycho-education that includes exploring ideas about masculinity, gender roles (traditional and Western), and the impact of colonization on traditional male roles work well, as do experiential therapies, such as psychodrama, and providing a variety of support services.

Among youth, a strategy that focuses on strengths rather than problems is preferred. Promising approaches include healthy peer modeling, peer support, cultural activities, teachings, learning aboriginal history, connecting with Elders, active non-verbal activities such as sports and crafts, and working in partnership with schools.

Volume 1: A Healing Journey: Reclaiming Wellness

A Healing Journey (volume 1) takes a narrative approach to the work, impact, and future of the AHF. The volume provides a brief organizational history describing its origins and early initiatives, and the structures and processes established to fulfill the AHF mandate as detailed in the funding agreement that set parameters for distributing the grant of $350 million. Results of evaluations and promising practices research reported more fully in volumes 2 and 3 are profiled. The volume concludes with lessons for the ongoing work of healing in communities and argues for renewal of the AHF mandate and funding.

The APRC presentation by Marlene Brant Castellano, author of volume 1, focused on evidence from research and evaluations that the AHF has mapped new territory in community healing, setting down guideposts for future Aboriginal-specific healing initiatives.

The healing needs uncovered in the course of the AHF's work make it clear that one-on-one therapies delivered by mental health professionals are by themselves inadequate to respond to the pervasiveness and depth of trauma that continue to reverberate in Aboriginal communities The distress that requires healing intervention is not limited to the span of an individual's life. Aboriginal communities have suffered repeated shocks from epidemics, displacement, and loss of control over their lives. The loss of children to residential schools laid down another layer of trauma and its distorting effects. When children returned from residential school

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lacking language and relationships and practical skills that would enable them to reintegrate into the community, the capacity of extended families to support recovery from abusive and demeaning experiences was compromised by their own grief over multiple losses.

First Nations, Inuit, and Metis communities and urban Aboriginal communities of interest seized the opportunity provided by AHF funding to submit 4,612 proposals and sign 1,346 contribution agreements for self-directed healing projects over the seven years covered by the final report. They made it clear that everyone who attended residential school was impacted, not only those who were subjected to physical or sexual assault while there. The need for healing extends to families who suffered alienation from their children, communities who saw the removal of large proportions of their children over decades, and subsequent generations who inherited distorted memories and battered self-esteem. Although healing the legacy of residential schools was necessarily the focus of community projects, those experiences were only one dimension of the risks that overwhelmed the resilience of individuals and communities.

Project reports consistently demonstrated that healing takes time. The work of healing starts with outreach and the breaking of self-imposed silences. The motives for keeping silence are diverse. Some Survivors believe they can protect their children by withholding knowledge of what they had endured. Others adopt a common response to trauma by suppressing memories and avoiding triggers that bring the past to consciousness. Still others hide shame at complicity with their tormentors or Survivor guilt that they live while their relations and peers have died. When the silence is broken, a tide of remembrance and pain is unleashed requiring skilled, persistent, and supportive responses over time.

Along with the depth and extent of need, deep currents of resilience were also discovered. Survivors of residential schools are themselves a key resource in healing. As they embark on their healing journey and uncover their innate resilience, they want to help others. In fact, some of the most prominent leaders and role models in contemporary Aboriginal life are Survivors of residential schools. Survivors who take on the role of healer/helper continue to carry vulnerabilities that need to be balanced with team support to protect them from overtaxing their emergent strength.

Professional therapies have a role in community healing and are almost always supplemented and modified by cultural approaches. Creating cultural safety in concert with personal safety for trauma survivors requires particular competencies on the part of healer/helpers. These competencies include familiarity with the history and protocols of the local community and the strengths and vulnerabilities of family networks, along with experience that can call into play the words, gestures, and symbols that heal rather than hurt. Because the impacts of trauma reverberate through extended family networks and across generations, healing initiatives must rebuild community support networks as well as reinforce individual resilience.

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Reports from communities have advanced understanding of the many ways that spiritual healing is mediated as an essential dimension of holistic healing. Spiritual healing involves the discovery or recovery of meaning in existence. Spiritual healing facilitates connection with a life force that is greater than personal strengths, flaws, and circumstances. It puts individuals on the path of right living, where they have something to give and freely share it. It is often mediated through prayer and ceremony, healing circles, and a relationship with an Elder or mentor, and may include Christian practice or traditional teachings. Living on the land, feasting, and sharing traditional foods and stories that awaken awareness all play a part in spiritual healing, depending on the cultural context. Skilled practitioners who themselves have undergone rigorous apprenticeship guide individuals through stages of healing and awareness at a pace that allows integration of learning in daily life. The insights revealed in community reports confirm that spiritual healing is congruent with the most ambitious goals of psychotherapy.

Overall, the story of the Aboriginal Healing Foundation is one of hope and resilience set, nevertheless, against a background of massive risks to wellness that have accumulated over generations. The final report presents evidence of the effectiveness of AHF-funded interventions, estimates the extent of unmet needs, and argues that time is required to peel back the layers of risk that still tax the capacity of individuals and communities to achieve good life outcomes.

Conclusion

Media coverage of the tsunami in Southeast Asia and of Hurricane Katrina in the southern United States has created public awareness of how whole communities are affected by massive shocks. Aboriginal communities across Canada are engaged in recovery from a succession of disasters comparable in magnitude to a flu epidemic, followed by a hurricane, followed by occupation of their homelands, and the removal of thousands of their children.

Political agency and economic vitality in Aboriginal communities are necessary complements to interventions that support healing from historic trauma. As recovery proceeds on all fronts, documentation from community-directed healing initiatives funded by the AHF presents compelling evidence of how community healing can be pursued most effectively.

The healing paradigm that is emerging places healing interventions in the context of historical experience and cultural diversity. Interventions engage the energy and capacity of local personnel who bring cultural competence and growing expertise as they partner with western-trained professionals, local agencies, and community leaders. Vulnerable individuals who have started the journey to wellness are recognized as offering inspiration and support to those further back, with responsibilities appropriate to their strengths and team support in areas and periods of fragility. Community-led healing gives substance to the

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ideal of holistic healing involving body, mind, emotions, and spirit. Training of healer/helpers draws on both traditional wisdom and scientific knowledge.

As the first mandate of the AHF was winding down, communities made urgent pleas that the work of healing must continue to bring a degree of closure for those who had come forward for help, and to reach out to those who were just becoming aware of the possibility of healing.[7] Project personnel also underlined the need for specialized training to address the complex needs being presented.

Personnel in community projects made an extraordinary commitment to participating in research to report on participation and outcomes and to map promising healing practices. The healing approaches presented at the APRC are derived from analysis of self-reports from projects and participants, and are detailed more fully in research papers and the final report available from the AHF. These approaches require further testing and refinement to articulate a paradigm of community healing that can be incorporated into educational materials and training programs.

Advancing knowledge of healing modalities for Aboriginal people and others living with the intergenerational impacts of trauma will be a research challenge for the next mandate of the Aboriginal Healing Foundation.

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Endnotes

1 The speakers in the APRC sessions, in addition to the two authors, were Cynthia Wesley-Esquimaux, Madeleine Dion Stout, Bill Mussell, and Kim Scott, all of whom gave access to their speaking notes for this paper. The authors also acknowledge the contribution of Gail Valaskakis, Director of Research for the Aboriginal Healing Foundation, in conceiving and directing the research on which this paper is based.

2 The term "Survivor" was adopted by the Aboriginal Healing Foundation to refer to former students of residential schools and in some contexts those who were intergenerationally impacted.

3 Report of the Aboriginal Healing Foundation (2006a,b,c). An interim extension of the AHF mandate with an additional grant of $40 million was announced in the federal budget in 2005.

4 This section draws on Wesley-Esquimaux and Smolewski (2004).

5 The term "healer/helper" encompasses members of project teams directly engaged in therapeutic healing work, including counsellors, therapists, traditional healers, circle keepers, Elders, etc.

6 The term "promising healing practices" is used because it suggests movement along the healing path, and acknowledges the likelihood of success without implying that only a particular practice or approach will succeed. Yet, like best practices, promising practices encourage learning, information sharing, innovation and adaptations in other settings.

7 In May 2006 the Minister of Indian and Northern Affairs announced an agreement providing compensation to former residential school students and a further grant of $125 million to support community healing initiatives for an additional five years.

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