

THE RESIDENTIAL SCHOOL  
EXPERIENCE;  
SYNDROME OR HISTORIC  
TRAUMA

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## ABSTRACT

Abuses at Indian residential schools have resulted in numerous lawsuits by Aboriginal litigants against four Christian denominations and the Government of Canada. The suggestion has been made that many of these litigants may suffer from a unique form of post traumatic stress disorder called "residential school syndrome." A competing concept is that these Aboriginal people, and others who never attended a residential school, suffer from a generalized intergenerational condition dating back to the days of colonization, and this condition has been called "historic trauma." This paper examines the historical evidence supporting both conceptualizations and the implications for treatment associated with each. I conclude that the evidence currently supports the RSS approach, but that further research is needed.

## INTRODUCTION

The central question to be answered in our understanding of the experience of individuals who have suffered trauma in Indian residential schools is whether their experience is a type of post traumatic stress disorder (PTSD) specific to those schools, or a manifestation of a larger, more historic process of colonization. Treatment flows from whichever understanding we choose. This paper examines related literature. I also draw on my personal involvement with the residential school system, integrating my relevant experience as a therapist. I conclude with suggestions for future research.

### LOOKING IN FROM THE OUTSIDE: FRAMING MY INTEREST

Indian residential schools were a reality in my childhood. Friends attended those schools. I heard accounts of public whippings, endless chores, and long hours in kneeful prayer. I was thankful that I did not have a treaty number that would have forced my attendance at such schools. Years later, I was asked to research a report that would help keep open the residential school in Lebret, Saskatchewan (Robertson 1986). I was surprised that many Saskatchewan chiefs and councillors were of the opinion that these schools had contributed to their success. Their vision was to have control of residential schools transferred from churches to chiefs, thereby keeping what was educational while adding Aboriginal values. With their leadership, the residential school system was maintained in Saskatchewan at a time when these schools were closing in other provinces.

I worked as a psychologist for one such residential school in 1991 and 1992. It was my observation that much of the old church culture had been maintained including crucifixes on the walls, corporal punishment, and damaging discrimination against two-spirited (homosexual) people. In my capacity as a psychologist, I assessed youth at the Prince Albert Indian Residential School a year after it had officially been closed.<sup>1</sup> I discovered that many of the youth did, in fact, suffer from emotional problems, and I helped plan for their futures. My involvement with residential schools did not end here. I continued to work with adults who carried with them the scars of their residential experiences.

### FRAMING THE OBJECTIVES OF THIS RESEARCH

The collective memory of a people is encoded in their history. This paper attempts to create an awareness of how the history of Aboriginal people, including the history of the Indian residential school system led to a form of post traumatic stress disorder with distinctive features. I also present an alternative view: that an historic trauma is the basis for observed symptomatology, and that there is, therefore, no specific trauma associated with residential schools except that which is shared by Aboriginal peoples collectively. My objectives are to select the most efficacious treatment framework and to suggest future directions for research.

## HISTORICAL OVERVIEW

### THE QUESTION OF GENOCIDE

European colonization of the American continents has been described as “genocidal” (Brave Heart 2003, Duran and Duran 1995, Wesley-Esquimaux and Smolewski 2004). During the 19th century, the Aboriginal northern Plains Nations were divided by a “medicine line” at the 49th parallel. South of that medicine line the U.S. authorities engaged in massacres,<sup>2</sup> biological warfare,<sup>3</sup> and indiscriminate extermination<sup>4</sup> (Robertson 1972). After the defeat of

- 1 The school had officially been closed as a residential school and, instead, designated a child and youth care institution with the same staff and students.
- 2 For example, the “Wounded Knee” massacre involved the killing of several hundred Dakota, mainly women, children, and the elderly.
- 3 In the 1870s, the U.S. military gave smallpox infected blankets to the Blackfoot as a “peace offering.”
- 4 In 1874, the territory of Wyoming posted the following schedule of rewards: \$50.00 for the scalp of a “buck,” \$25.00 for the scalp of a “squaw,” and \$15.00 for the scalp of “anything in the shape of an Indian under the age of 12.”

the second Riel Rebellion in 1885, the British/Canadian authorities north of the medicine line implemented strict control of Amerindians on reserve. For example, band members had to obtain the permission of the Indian Agent to travel off reserve and to harvest their produce.<sup>5</sup> All children were to attend a school designated by the Indian Agent, and for the majority in the northern plains, this meant a residential school (Barman, Hebra, and McCaskill 1986). While not all scholars agree that the criteria for 'genocide' have been met by the history of Aboriginal people (WalDRAM 2004), there is a consensus that the cultural breakdown associated with colonization has led to stressors with negative social and psychological impacts (Berry 2002, Poonwassie and Charter 2001, Wesley-Esquimaux and Smolewski 2004). There is a difference between genocide, which involves the intention to exterminate an entire people, and military and economic oppression. The existence of the residential school system lends support to the thesis that the intention of the colonizer, at least north of the medicine line, was not genocidal.

## THE HISTORY OF RESIDENTIAL SCHOOLS IN CANADA

*"The concept of God ... corresponds best to man's dark longing to reach perfection" (Adler 1967: 33)*

### THE COLONIAL CONTEXT

Colonization followed a pattern across North America that included military occupation, economic exploitation, and missionary activity (Duran and Duran 1995). In Canada, missionaries commonly thought of Aboriginal people as "savages" and their initial attempts to "civilize" and "Christianize" the local populations met with only sporadic success (Herstein, Hughes, and Kirbyson 1970). In eastern Canada, Methodist, Presbyterian, Roman Catholic and Anglican Churches developed Indian residential schools before these schools were officially sanctioned and supported by the colonial government. In 1877, Mme. Capelle, Superintendent of an all-girls' residential school in Ontario, summarized the philosophy behind the creation of these schools:

They [Native people] are in general very lazy, even more so than the Negroes, who have a great heat as their excuse; but the Indians living in the most healthy climate in the world, in a bracing air, have only neglected their mental as well as their bodily powers, and a good discipline is wanted to change them in a lapse of time to really useful working people (as quoted in Barman et al. 1986: 78).

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5 For example, in 1896 the Cree youth, Almighty Voice was jailed and eventually killed after he slaughtered a reserve cow for his wedding feast (Robertson 1972).

Regulations under the *Indian Act of 1876*, provided federal support for residential schools, but it was not until the aftermath of the second Riel Rebellion that residential schools became the rule in fulfilling the federal government's commitment to education under the recently signed treaties (Robertson 1972). In western Canada, the government paid for the construction of the residential schools while the churches were responsible for the majority of operational costs and maintenance (Barman et al. 1986, Stout and Kipling 2003). The churches planned to pay for their share of the costs through the labour of their students on an "industrial school" model.

#### THE LIVED EXPERIENCE

A Shuswap Elder described the ritual of children entering residential schools:

At the mission, the truck backed-up and off we went. Right away, boys were separated from girls. We were lined up, sat on chairs, and had our long, beautiful braided hair chopped off. We were thrown into the shower, then had DDT sprinkled hair and all over. It stunk. They gave me a number 79. My name was gone. I was only a number now. We all had the same little bundle of clothing, pinafores, black clothes, socks. You couldn't tell one kid from the other; they transformed individuals into a group. I don't understand how my Shuswap language was turned into English in just one day (Snow 1999: 58).

Residential school survivors often report feelings of loneliness while in these schools (Robertson 1986). Not only were they separated from their families for long periods of time (for example, it was after 1948 before children were allowed to spend Christmas with their parents), but brothers and sisters in the same institution were not allowed to communicate with each other (Barman et al. 1986). Corporal punishment was the norm and punishment could be combined with humiliation (Stout and Kipling 2003).

The churches had expected that the residential schools would be self-sufficient with respect to operating costs. When the schools were not able to generate sufficient income based on farming or animal husbandry, student diets were restricted accordingly. Malnutrition coupled with disease, and half the children who entered residential schools did not survive to adulthood according to the 1941 census (Barman et al. 1986). Sexuality was repressed. Barman et al. (1986: 152) report, "As girls approached puberty nuns would bind the girls' breasts to keep them from showing." Nuns would supervise the washing of genitals, male and female, with brushes. While sexual abuse was not condoned by the churches, it was, nonetheless, widespread (Brasfield

2001; Stout and Kipling 2003). It may not be possible to determine the exact numbers. In a 1991 study based in the community of Williams Lake, British Columbia, of 187 adults who attended residential school, 89 admitted to being sexually abused as children, 38 said they had not been abused and 60 refused to answer the question (Millar 1996, cited in Waldram 2004).

### CHURCH MIND CONTROL: EXAMINING PURPOSE AND FUNCTION

Colonization involved conquest, economic exploitation, and the attempted assimilation of the colonized peoples into the new economic order. The missionary activity in early colonial society may be seen as part of this process. For example, missionaries commonly taught that smallpox was visited on Aboriginal people as a sign from the Christian God that they must change their pagan ways (Wesley-Esquimaux and Smolewski 2004). Figure 1 illustrates how colonizers attempt to instil units of “macro-society” cultural belief, values, and behaviours in a colonized population.

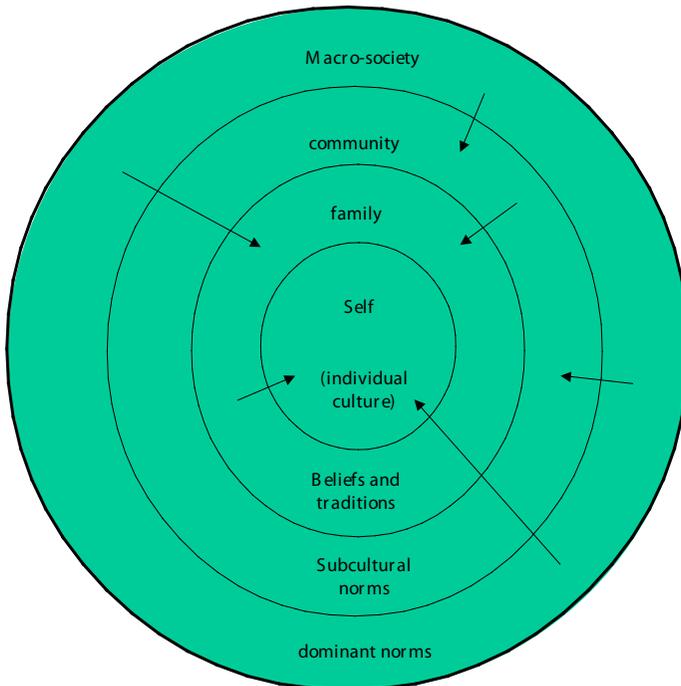
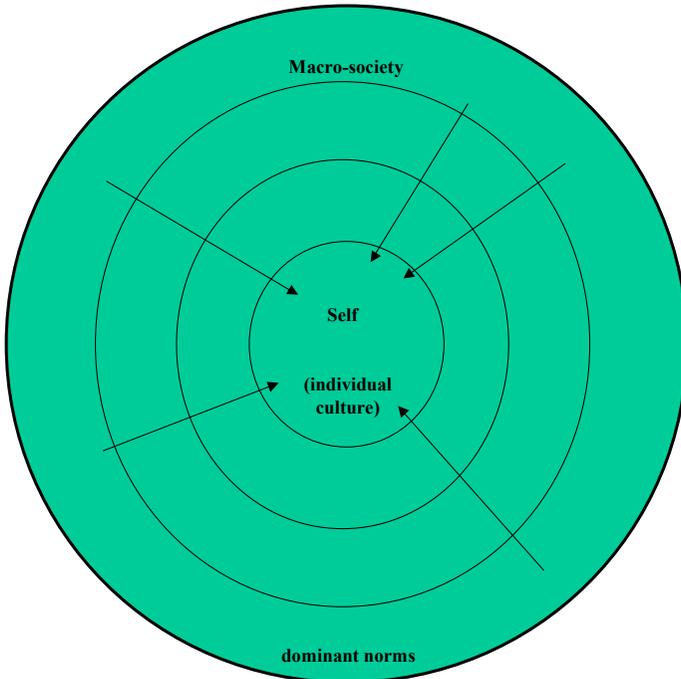


Figure 1. *An illustration of how a dominant society attempts to change the values and beliefs of individuals with a unidirectional flow of cultural units to the communities and families within the colonized society.*

Residential school students were separated from their families and their communication with each other was tightly controlled. Severe punishments were meted out for minor infractions. Students were taught that their sexuality was evil and sinful. Their diets were high in carbohydrates but low in fruit, vegetables, and proteins. The students often worked long hours with insufficient opportunities to sleep. The similarity between these conditions and those faced by youth involved in cult activity has not gone unnoticed (Robertson 1998). In essence, the churches were attempting to eliminate the influence of Aboriginal families and communities on the minds of their children. This is illustrated in Figure 2.

The units of culture that are transmitted by societies, communities, families and individuals have been given the name “memes” (Dawkins 1976, Dennett 1995, Wilson 1999). Susan Blackmore (1999) has shown how the self, defined by Harre (1989: 404) as the “theory about who we are,” may be a



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Figure 2. An illustration of the residential school model: The transmission of units of culture from a dominant society unfiltered by community and family.

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complex of these memes. Since some memes attract others, a relatively stable self is possible even though it consists of socially constructed units.

When viewed through this lens, the churches were attempting to re-engineer the selves of Aboriginal children, and they did so incompetently. They did not have the knowledge to take into account the Aboriginal memes already within the selves of the children, nor did they understand how their new Euro-centric memes would interact those already in place. Further, they offered a caricature of a Euro-Canadian self from which these children could model. Coupled with practices of mind-control, damage was inevitable. Ishu Ishiama (1995: 264) has demonstrated how cross-cultural dislocation, under much milder circumstances than were found in residential schools, may result in damage to the self:

The experience of self-validation is characterized by any or all of the following thematic components: (a) security, comfort, and support as opposed to insecurity, discomfort, and abandonment; (b) self-worth and self-acceptance as opposed to self-depreciation and self-rejection; (c) competence and autonomy vs. incompetence and helplessness; (d) identity and belonging vs. identity loss and alienation; and, (e) love, fulfillment, and meaning in life vs. lovelessness, emptiness and meaninglessness.... Cultural dislocation may therefore manifest as undervaluation or invalidation of self.

The federal government has acknowledged its culpability where victims of physical or sexual abuse in residential schools have symptoms of post-traumatic stress disorder. Some Aboriginal mental health professionals (Brave Heart 2003, Duran and Duran 1995, Wesley-Esquimaux and Smolewski 2004), have suggested that this ignores a historic trauma that can affect those who did not experience such events. The memetic conceptualization presented in this paper allows for a third possibility: that the residential school experience traumatized a generation of children without the necessary pre-condition that each one experienced physical or sexual abuse.

## AT ISSUE: RESIDENTIAL SCHOOL SYNDROME VERSUS HISTORIC TRAUMA

### THE CASE FOR RESIDENTIAL SCHOOL SYNDROME (RSS)

Although the issue of sexual and physical abuse in residential schools had become public knowledge earlier (Lane, 1986), litigation against the various churches and the federal government did not begin until the mid-1990s. Corrado and Cohen (2003) reviewed a sample of 127 British Columbia liti-

gants. All of the litigants had suffered sexual abuse and 90 percent experienced physical abuse while at residential school. Seventy percent were male. More than three-quarters of the respondents reported that they had abused alcohol after residential school. Half of the subjects reported that they had a criminal record, the majority for assault and sexual assault. Thirty-one percent reported that they had assaulted police officers. All but two had been diagnosed with at least one mental disorder. The diagnoses included: PTSD (64.2 percent), substance abuse disorder (26.3 percent), major depression (21.1 percent), dysthymic disorder (20 percent), anxiety disorder (7.4 percent), borderline personality disorder (7.4 percent), and RSS (6.3 percent). The researchers concluded that "Residential School Syndrome is a subtype of PTSD which focuses on intense feelings of fear and anger and the tendency to abuse alcohol and drugs" (Corrado and Cohen, 2003: iii). They explained the low rate of RSS as a diagnosis: it is not widely known nor is it approved by the American Psychological Association. Following the structure of the APA criteria for PTSD, Charles Brasfield (2001) offered a diagnostic criteria for RSS (see Appendix A).

The Brasfield definition largely particularizes the American Psychological Association (1994) definition of post traumatic stress syndrome. For example, Brasfield's suggestion that people suffering from RSS may experience recurrent distressing dreams of the Indian residential schools, act or feel as though the events in the residences are re-occurring, and experience intense distress at exposure to stimuli that symbolize residential schools, follows precisely the DSM-IV listing of the ways in which traumatic events may be re-experienced in survivors of PTSD.

The Brasfield criteria for RSS differ qualitatively from the APA approved criteria for PTSD in at least three ways. First, Brasfield recognizes a diminished interest in significant cultural activities. Second, Brasfield recognizes a persistent tendency to abuse alcohol or other drugs "often at a very young age" (2001: 79) with accompanying outbursts of anger. Third, Brasfield allows for a diagnosis of RSS in the absence of a specific traumatizing incident:

- A. The person has attended an Indian residential school or is closely related to or involved with a person who has attended such a school.
  1. The school attendance was experienced as intrusive, alien and frightening.
  2. The person's response to the school attendance involved fear, helplessness, passivity, and expressed or unexpressed rage. (Brasfield 2001: 80)

Under the Brasfield criteria it is not necessary that the traumatized individual experience sexual or physical abuse or a fear of death or injury. The experience of going to a residential school with attempts of enforced assimilation and attendant methods of mind control is sufficient exposure to a traumatizing event. Further, it is not even necessary to have personally attended a residential school to experience this trauma. It is possible to pass on this trauma to someone who is "closely related or involved." This allows for the possibility of second and third generational victims of RSS.

### HISTORIC TRAUMA: THE COLLECTIVE SOUL WOUND

Historic trauma has been promoted as a more encompassing explanation of Aboriginal trauma than the concept of RSS (Wesley-Esquimaux and Smolewski 2004). Under this concept, the military, economic, and cultural conquest of people aboriginal to the American continents was a form of genocide. The descendents of those conquered people continue to face the traumatic effects of that genocide similar to the inter-generational trauma faced by descendents of holocaust victims (Brave Heart 2003). The symptoms proposed for this trauma include depression, suicide ideation, and unresolved grief, in addition to many of the symptoms Brasfield notes for residential school survivors.

Historic trauma (HT) is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences; the historical trauma response (HTR) is the constellation of features in reaction to this trauma. The HTR often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. It may include substance abuse, often an attempt to avoid painful feelings through self-medication. Historical unresolved grief is the associated affect that accompanies HTR; this grief may be considered fixated, impaired, delayed, and/or disenfranchised (Brave Heart 2003: 7).

Wesley-Esquimaux and Smolewski (2004: 3) suggest a mechanism by which this historic trauma is passed on inter-generationally: "The experience of historic trauma and intra-generational grief can best be described as psychological baggage.... It is continuously being acted out and recreated in contemporary Aboriginal culture." This is a behavioural explanation; the trauma is recreated in the actions of each succeeding generation. Duran and Duran (1995: 46) offer a more Jungian mechanism: "The dream religion of the Iroquois speaks of a 'soul wound' that occurs at the level of myth and

dream.” The suggestion here is that the historic trauma becomes embedded in the cultural memory of a people and is passed on by the same mechanisms by which culture, generally, is transmitted.

Those favoring the historic trauma approach suggest that there is no need for a syndrome specific to the residential school experience (Brave Heart 2003, Wesley-Esquimaux and Smolewski 2004). There may be specific incidents of sexual or physical abuse that induce PTSD, but beyond those specific incidents the experience of students in residences is similar to those of all Aboriginal people. Thus the experience of historic trauma transcends context.

## RESOLVING THE ISSUE

The RSS view is, essentially, an extension of traditional diagnostic categories. Corrado and Cohen’s (2003) review of British Columbia litigants suggested that those who had been diagnosed with PTSD could have been diagnosed with RSS had the latter term been more widely known. Brasfield, in his definition of RSS, paralleled the DSM-IV criteria for PTSD with extensions to take into account unique features of Aboriginal history and culture. These extensions allow for greater latitude in diagnosing the trauma, and for the possibility of an inter-generational trauma suffered by people who did not, themselves, go to a residential school.

The historic trauma view minimizes the importance of the residential school experience by placing that experience within a pan-Aboriginal frame. All Aboriginal peoples share the same genocidal history, and that historic shared experience is paramount in understanding Aboriginal social and mental health issues. From this perspective, specific conditions such as depression, alcoholism, anxiety, suicide ideation, and anger management problems are merely symptoms of a larger malaise.

### THE TWO CONSTRUCTS: IMPLICATIONS FOR PRACTICES

#### RESIDENTIAL SCHOOL SYNDROME

Corrado and Cohen (2003: 52) found that traditional psychological therapies had been recommended for the sample of residential school litigants they studied who had been diagnosed with PTSD. Specifically, 47.6 percent had been referred for cognitive therapy, 28.6 percent for cognitive-behavioural therapy, 28.6 percent for residential counselling, and 14.3 percent for “treatment to deal with negative self-image.” Brasfield (2001) explained that Residential Counselling refers to a treatment centre approach often used for alcohol and

drug issues, incorporating cultural practices such as healing circles, sweatlodges, and traditional feasts. He explained that, with respect to outpatient services, "The approach I use is cognitive processing therapy for rape trauma" (2001: 79).

### HISTORIC TRAUMA

Duran and Duran (1995: 179) define illness as spiritual imbalance and suggest that for Aboriginal people, "The balance can only be accomplished through living life as prescribed in traditional lifestyle, thus allowing for a relationship of sacred and profane levels of existence." By combining cultures as diverse as Apache, Hopi, and Iroquois they attempt to create a "pan-Indianism" that can be considered traditional in the modern context.

Brave Heart's (2003) "pan-Indianism" includes Lakota (Siouxian) prayer and purification ceremonies. She conducts psycho-educational group experiences within a "traditional retreat-like setting" (p. 11). Her most controversial technique is to "awaken" within clients "historically traumatic memories" by using audiovisual materials recounting genocidal massacres. Wesley-Esquimaux and Smolewski (2004: 81) agree that "Aboriginal people ... must be given enough information about their history to recognize the often illogical nature of the convictions some people hold on Indigenous people and an opportunity to revise their beliefs." They recommend "Aboriginal spirituality" be emphasized along with traditional psychotherapies including "insight-giving psychotherapy, behavioural therapy, group therapy, relationship and family therapy" (p. 80).

### THE PRAXIS<sup>6</sup> OF EACH POSITION

At first glance, the positions of those who see the traumatic problems faced by Aboriginal people who attended residential school as a function of those schools, and those who see it as more closely related to colonialism, do not appear mutually exclusive. This apparent similarity increased with the Brasfield addition that trauma may be faced by individuals who only experienced the general school atmosphere and that the traumatic effects may be passed on to people who had not attended such schools. This masks a fundamental difference in conceptualization.

The logic of the RSS concept leads to a focus on individual treatments with some group and cultural components added. The logic of the historic trauma position leads to a search for an essentialist "pan-Indianism" or

6. Praxis is defined as "the integration of theory and action, science and practice" (Morrow and Smith, 2000: 226).

“Native spirituality” as the cornerstone of wellness although, as we have seen, two theorists (Wesley-Esquimaux and Smolewski 2004) would also make adjunctive use of a variety of psychotherapies. As Waldram (2004: 212) noted, “The existence of two differing understandings of trauma is evident. One focuses on the individual and is diagnosable as a disorder; the other is within the popular realm and conceives of whole communities and even cultures as being affected.”

### RELATING THE RESEARCH TO THE THEORETICAL MODELS OF TRAUMA IN ABORIGINAL POPULATIONS

Do Aboriginal people who have gone to residential schools suffer more trauma than other Aboriginal people? If the answer to this question is “yes,” then it is possible that the difference in trauma rates could be explained by the presence of a specific syndrome as postulated by Brasfield. If the answer is “no” and if rates of PTSD are generally higher in Aboriginal populations than in non-Aboriginal populations then there is support for the concept of historic trauma. Unfortunately there is little research comparing these groups of Aboriginal populations.

In a study conducted jointly by the Caribou Tribal Council in British Columbia and the University of Guelph, participants whose fathers had gone to residential school were more likely to report physical violence perpetrated by their father against their mother (Claes and Clifton 1998, cited in Stout and Kipling 2003). While this study was not about trauma, it does lend support to the suggestion that the two Aboriginal populations differ in some ways.

A U.S. study of 65 high school students (Manson et al. 2002) found that only one had been diagnosed with PTSD despite a prevalence of conduct disorder (18 percent), major depression (15 percent), and alcohol dependence (13 percent). A quarter of the students had attempted suicide. The researchers concluded that PTSD was under-diagnosed, possibly because Aboriginals are “stoic” or possibly because, for Aboriginals, “events may have different meanings” due to cultural differences such as “a belief in witchcraft” (p. 255).

Waldram (2004) reviewed the Manson (2002) study, and eight other U.S. studies all of which showed lower rates of diagnosed PTSD in the Aboriginal population as compared to the non-Aboriginal population. He concluded, “It is crucial to consider that Aboriginal peoples may exhibit low rates of diagnosed PTSD because they have low rates of PTSD” (p. 221). As we have seen, there are substantial rates of PTSD diagnosed for survivors of residential

schools in Canada (Corrado and Cohen 2003). While these studies are not directly comparable, they do support the suggestion that there is a difference between the residential school population and the non-residential school population within the Aboriginal community. It is interesting to speculate that some Aboriginal cultures may have supports built into them that protect individuals from traumatic stress, and that these protective mechanisms were unavailable to children who were placed in residential schools. Addressing this theme Stout and Kipling (2003: iv) said:

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

These interventions include the development of informal support networks and healing circles; teaching respect for cultural values such as cooperation, wisdom, and the role of the extended family; psycho-education group sessions to enhance the ability of participants to overcome trauma and to increase their understanding of colonialism; community development with the aim of building empowerment; and building parenting skills. It is instructive to note that I was involved in a community development effort that independently incorporated these principles in a northern Saskatchewan community from 1992 to 1995 (Robertson 2004). That community, which had previously been dubbed “the suicide capital of Canada,” did not have a completed suicide for a subsequent six-year period.

John Berry (1999, 2002) has developed the concept of acculturative stress as an underlying factor contributing to social and psychological problems. This would tend to support the historic trauma model. On the other hand, he also notes, “There is widespread evidence that most people who have experienced acculturation actually do survive! They are not destroyed or substantially diminished by it; rather, they find opportunities and achieve their goals ...” (2002: 33). Berry’s comments suggest that the notion that Aboriginal people are perpetual and universal victims of a colonial genocide may be simplistic. A qualitative study in Vancouver’s downtown eastside (van Uchelen et al. 1997) recorded that urban Aboriginal participants felt that recognizing their existing strengths did more to promote wellness than did needs-based

approaches. The study concluded that supporting existing strengths promotes wellness in holistic, culturally appropriate, and empowering ways.

### CASE VIGNETTES OF THREE RESIDENTIAL SCHOOL SURVIVORS

Case studies can be a valuable form of research especially when triangulated with other methods (Creswell 1998). These case studies were selected to supplement and enrich the scant direct research that has been completed with respect to residential school survivors. The first of these vignettes is about an elder with whom I have had a long association. The other two vignettes are drawn from my client file; confidentiality has been protected through the use of pseudonyms.

#### ELDER DANIEL NIPPI

While attending the residential school in Prince Albert, Saskatchewan, Daniel was abused sexually by two nuns, a priest, and an older youth. He also suffered physical beatings. On leaving school he displayed many of the symptoms of RSS outlined by Brasfield (2001). He spent the majority of his time from age 16 to 40 in prison for alcohol-related offences, assault, and sexual assault. The only emotion he remembers feeling during this period was anger. He had recurrent dreams and flashbacks about his residential experiences.

Daniel reports that he received cognitive behavioural therapy but that this was only partially effective. He eventually turned to Native (Saulteaux) spirituality, and he credits this with saving his life.

#### “GEORGE”

George’s history of physical and sexual abuse while in residential school, and his subsequent story of alcohol abuse, domestic violence, and jail time parallels that of Daniel. He reports that he did not experience recurrent dreams or flashbacks until he initiated legal action against the Roman Catholic Church and the federal government. His lawyer encouraged him to remember details of the abuse. As he attempted to remember those details his anxiety levels and his aversion to religious symbols increased.

Rational emotive behavioural therapy proved effective in dealing with George’s alcohol abuse, but he became a compulsive gambler. Eye movement reprocessing and desensitization gave him a “bad headache.” He attempted “Native spirituality,” but reported that no matter how hard he tried it did not feel true. He terminated therapy following an assault on his wife.

## “DIERDRIE”

As a child this woman was physically and sexually abused by her mother, her mother’s boyfriend, and by a number of staff at residential school. She presented with symptoms of depression, anxiety, anorexia, compulsive gambling, anger control, and marital discord. I initially saw her with her husband, but then treated her individually over a two-year period.

Dierdrie responded well to eye movement reprocessing and desensitization used to gain emotional control over specific instances of childhood trauma. She subsequently was able to establish a respectful relationship with her mother. Dierdrie responded well to Adlerian psychotherapy aimed at understanding and revising her worldview, and credits this with helping to save her marriage. She responded well to a cognitive behavioural approach to gambling, but she continues to eat minimal amounts and to exhibit irregular sleep patterns.

## OBSERVATIONS

All three individuals discussed in this section exhibited a cluster of symptoms consistent with Brasfield’s typology. No therapy was consistently successful. It strikes me that Dierdrie, despite a host of problems, was ready to change, and open to allow almost any therapy to be effective in that quest. George, on the other hand, was in a Prochaska “pre-contemplative” stage. He believed his excuses for bad behaviour should be accepted. Daniel was ready to change, at mid-life, but only in a manner that had meaning for himself.

## SELECTING A THEORY TO GUIDE PRACTICE

*“Nothing in science — nothing in life for that matter — makes sense without a theory...”* (Wilson 1999: 56)

The historic trauma model has great appeal as an anti-colonial ideology. The events, to which the proponents of this theoretical model refer, occurred, and Aboriginal people suffered greatly. Even if the historical events were not genocidal the acculturative stress that resulted would have impacted negatively on the mental health of the people (Berry 2002). The historic trauma model supports building community and developing resilience within community. This historical, anti-colonial approach may also aid in externalization, a therapeutic approach which has met with some success (O’Hanlon 1994; White 1993).

The weaknesses of the historic trauma approach include the assumption that all Native people are the same regardless of their culture of origin and whether the colonization happened to their particular cultural group 150 or

450 years ago. In its “pan-Indianism” the historic trauma can be just as assimilationist as oppressive European cultures. The approach carries with it the assumption that culture is a “thing” that either you have or you don’t have, and that Aboriginal people who do not share this “pan-Indian” culture are not well. The method of Brave Heart in using audiovisual material to instill historic anger in clients follows from the “pan-Indian” approach and has potential dangers to the individual. In the words of Waldram (2004: 227) Brave Heart is “educating individuals to develop grief reactions to events that occurred outside their lifetime or which were otherwise of little concern to them...”

The concept of RSS fits with the research that suggests there is a difference in trauma rates between Aboriginal people who attended residences and those who did not. Further, a diagnosis of RSS allows for a variety of individualized treatments including those with demonstrated efficacy for trauma such as eye movement reprocessing and desensitization (Feske and Goldstein 1997; Wilson, Becker, and Tinker 1995) and cognitive behavioural therapy (Devilley and Spence 1999, Liashko and Manassis 2003) and promising new treatments related to cultural strengths and practices that are part of the client without the totalizing tendency of the historic trauma approach. RSS allows for a more flexible diagnosis than does the more standard diagnosis of PTSD including the effect of accumulative environmental impacts. Further, RSS allows for the possibility of an inter-generational transfer of the effects of the trauma, thereby allowing counsellors the opportunity to treat those effects. As with the concept of historic trauma, RSS allows for an externalizing of mental health issues with reference to anti-colonial understandings.

A weakness of RSS is that it may become “too clinical” with a sole focus on treating the individual. In a situation where a majority of some generations of Aboriginal people have been forced into residential schools, treatment should also focus on family and community levels. While family therapy has become recognized in our field (Chang and Phillips 1993, Fergus and Reid 2002), psycho-social work at a community level is still in its infancy (Poonwassie and Charter 2001, Robertson 2000).

## FUTURE DIRECTIONS

### IMPLICATIONS FOR PRACTICE

As was demonstrated in the case vignettes, many residential school survivors view their experiences to be unique both with respect to other kinds

of trauma and from the experiences of Aboriginal people who did not go to these schools. The use of the diagnosis of RSS may allow these individuals to feel they have been understood. Therapies may then be selected based on the personal understandings and expertise of the client.<sup>7</sup> Some therapists may feel comfortable offering a menu of possible treatments with the client actively collaborating in the development of the treatment plan (Bohart 2001, Warwar and Greenberg 2000).

An effect of the residential schools was to damage the identity of Aboriginal students within the system. Counselling may focus on what Lent (2004) called eudemonic issues such as autonomy, self growth, meaning, and purpose in life. The diagnostic protocol developed by Brasfield (2001) recognizes the loss of eudemonic purpose inherent in the residential school experience as a cultural or identity loss. Counsellors using the RSS diagnosis in their practice must be aware that some of their clients may benefit from incorporating some cultural elements (such as smudging, sweatlodges, sun dances, herbal treatments) into their treatment. In many cases, the individuals will be able to pursue this aspect of their self-growth independently of the counsellor (although the counsellor should be aware of these efforts and their meaning to the client), but in other cases it may be advisable to have the counsellor work collaboratively with a traditional healer or shaman.<sup>8</sup> Similarly, the counsellor will also need to be prepared to work eudemonically with the client where the client has chosen to work from different traditions, for example, within a Christian framework<sup>9</sup> or from a framework involving no religious belief.

Therapists may find that a narrative approach (Strong 2002, White 1993) resonates with many Aboriginal clients who find it compatible with the “story telling” found in most oral traditions. The stories related to residential schools may be retold in ways that give the client new meanings. The process

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7 A variety of schools of psychology identified as “humanistic” have viewed the client to be expert on him or her self (Bohart 2001, Compas and Gotlib 2002, Mosak 1979). This perspective may have particular application for counsellors who do not have personal experience with residential schools.

8 Respecting the rules of confidentiality, this can only be done with the client’s expressed agreement and cooperation.

9 Although the residential schools were run by Christian denominations for the purpose of proselytizing, it is possible to decry the practices imposed on the Aboriginal population while maintaining a Christian perspective by re-interpreting the Christianity imposed by the residential school system.

of externalizing the experience as part of re-framing may lead to greater control of emotional outcomes from the remembrances.

As has been clear from both the vignettes and the Brasfield (2001) criteria, families may suffer a trauma related to that of the person who actually experienced the direct effects of residential schooling. Both the client and counsellor need to be aware that the dynamic of the family includes roles and expectations that operate interdependently (Coguen 1985, Fergus and Reid 2002). Counsellors should be prepared to discuss with clients how change may impact on that dynamic, and how change may even be resisted by the system. It may be necessary to consider both family strengths and areas where the family may benefit from skill development, for example, in parenting or communication (Wesley-Esquimaux and Smolewski 2004). It may be necessary for the counsellor and client to consider the question of family counselling, either as an adjunct to the present client/counsellor relationship or with another counsellor working collaboratively. Given the complexities of this dynamic including possible cross-cultural considerations, the counsellor may well be advised to consider working with a team of therapists in a process Adler called "multiple therapy" (Mosak 1979: 69).

The epidemiology of RSS leads to the recommendation that treatment include an element of community development (Poonwassie and Charter 2001, Stout and Kipling 2003), but this is not an area with which counselling psychologists are ordinarily familiar. Community development is a process of self-empowerment whereby groups of people, who have defined themselves to be part of a common community, take on the responsibility of defining their problems, assessing their needs in coping with those problems, and developing an action plan to meet those needs (Robertson 2000). Since culture is not static but is dynamic and evolving (Hutcheon 1999, Johnson 2003), and since residential schools were part of a process that destroyed Aboriginal cultures, community development, in this context, involves people planning developmental transitions to change their community culture. This approach differs from that offered by advocates of the historic trauma model in that the process is not prescribed but is evolutionary and individualized to each community.

The community developer acts as a facilitator who encourages public participation, acts as a consultant to the community development process, conducts needs assessments and surveys as directed by community members, and suggests resources the community may choose to access. Unless the counselling psychologist has expertise in this area, it is recommended that

s/he not attempt this work. The counsellor can still be part of the community development process as a resource accessible to community members. The counsellor may also act as a consultant to the community and advocate on behalf of clients. More generally, the counsellor may be able to offer opinions on actions that could be taken to improve communication, self-esteem, self-efficacy, inter-generational transmission of values, and mental health awareness.

### IMPLICATIONS FOR FUTURE RESEARCH

North American Aboriginals are among the most studied peoples on Earth (Waldram 2004). The largest number of these academic studies have been anthropological and have varied between the “noble savage” and “superstitious savage” themes with the former gaining the ascendancy in this era of political correctness. As a result of all of this activity there is considerable resistance to academic research of any kind in Aboriginal communities. Recognizing this, the Canadian Institute of Health Research, through its newly created “Institute for Aboriginal Peoples’ Health” has recently issued a request for applications setting up regional research initiatives with the following stipulations: 1) academics must be partnered with Aboriginal organizations, 2) only “culturally appropriate” research will be allowed and, 3) no quantitative research will be permitted (Nowgesic 2004).

Research does not occur in a contextual vacuum, and given the present “chill” toward such research in Aboriginal communities, academics will have to tread carefully. Partnering with Aboriginal leadership is becoming a political necessity. If this leads to more research as part of a process of community development, both the researcher and the community benefit. Qualitative research has the potential to become part of a process of community enrichment (Kral and Burkhardt 2002). With this in mind, the following is offered as a partial list of research areas that may utilize a qualitative approach:

1. An examination of different strategies employed at a community level to build resiliency and to ameliorate the social effects of residential schools;
2. An examination of the felt experience of empowerment of those who participate in community development and community healing projects;
3. An examination of the experience of Aboriginal school survivors who have used community healing circles to deal with their trauma issues;

4. An examination of the experience of people with RSS in therapy not yet mentioned in the literature, but with demonstrated efficacy in non-Native populations (e.g., narrative, eye movement reprocessing and desensitization, emotion focussed therapy);
5. Studies of the symptomatology and etiology of descendants of residential schools.

There are some important research questions that cannot be answered without the use of quantitative methods. One such question is whether survivors of residential school are more likely to suffer trauma than other Aboriginal people (thereby substantiating the use of an RSS concept). A second area where quantitative methods are needed involves the question of whether Aboriginal people who have adopted traditional spiritual practices are healthier than those who have maintained a Christian faith (as suggested by those in the historic trauma camp). Third, there is the question of efficacy. Are the methods that have proven efficacious in dealing with trauma in non-Native populations, such as cognitive behavioural therapy and eye movement reprocessing and desensitization equally efficacious with Aboriginal populations who have faced residential school trauma?

## CONCLUSIONS

There appears to be a near consensus that Aboriginal populations exhibit some unique characteristics with respect to some forms of trauma. This has led to two conceptualizations: a specific form of PTSD called residential school syndrome and a generalized condition that has been called historic trauma. On the basis of the available research I have concluded that there is more support for the RSS concept. I have also concluded that RSS offers a better framework from which to offer individual and family therapies. Concomitantly, community development work needs to be done to mitigate the disastrous effects of the residential school experiment. Psychologists should be prepared to act within this framework, in keeping with their areas of expertise. Perhaps psychologists will then have established sufficient credibility within Aboriginal communities to encourage those communities to support further crucial research. It may become the basis of a collaborative partnership involving academics, practitioners, and communities.

## APPENDIX A

### SUGGESTED DIAGNOSTIC CRITERIA FOR RESIDENTIAL SCHOOL SYNDROME (BRASFIELD, 2001: 80-81)

- A. The person has attended an Indian residential school or is closely related to or involved with a person who has attended such a school.
  - 1. The school attendance was experienced as intrusive, alien and frightening.
  - 2. The person's response to the school attendance involved fear, helplessness, passivity, and expressed or unexpressed rage.
- B. The effects of attendance at the Indian residential school persist following cessation of school attendance in one (or more) of the following ways:
  - 1. Recurrent and distressing recollections, including images, thoughts, or perceptions;
  - 2. Recurrent distressing dreams of the Indian residential schools;
  - 3. Acting or feeling as if the events of Indian residential school attendance were recurring (includes a sense of reliving the experience, hallucinations, dissociative flashback episodes, including those that occur on awakening or those that occur when intoxicated);
  - 4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of Indian residential school attendance;
  - 5. Physiological reactivity on exposure to internal or external clues that symbolize or resemble an aspect of the Indian residential school attendance.
- C. Persistent avoidance of stimuli associated with the Indian residential school and numbing of general responsiveness (not present before Indian residential school attendance) as indicated by three (or more) of the following:
  - 1. Efforts to avoid thoughts, feelings, or conversations associated with Indian residential schools;
  - 2. Efforts to avoid activities, places, or people that arouse recollections of Indian residential school attendance;
  - 3. Inability to recall one or more important aspects of Indian residential school attendance;

4. Markedly diminished interest or participation in significant cultural activities;
  5. Feelings of detachment or estrangement from others;
  6. Restricted range of affect (e.g. apparently high levels of interpersonal passivity).
- D. Persistent symptoms of increased arousal (not present before Indian residential school attendance), as indicated by two (or more) of the following:
1. Difficulty falling or staying asleep;
  2. Irritability or outbursts of anger, particularly when intoxicated with alcohol;
  3. Difficulty concentrating, particularly in a school setting;
  4. Hypervigilance, particularly with regard to non-First Nations social environments;
  5. Exaggerated startle response.

Symptoms may also include:

- E. Markedly deficient knowledge of one's own First Nations culture and traditional skills;
- F. Markedly deficient parenting skills, despite genuine fondness for offspring;
- G. A persistent tendency to abuse alcohol or sedative medication/drugs, often starting at a very young age.

## REFERENCES

Adler, A.

1967 *Superiority and Social Interest: A Collection of Later Writings*. London: Routledge and Kegan Paul Ltd.

American Psychological Association

1994 *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychological Association.

Barman, J., Y. Hebra, and D. McCaskill

1986 *Indian Education in Canada: The Legacy*. Vol. 1. Vancouver, BC: University of British Columbia Press.

Berry, J.W.

1999 "Aboriginal cultural identity." *Canadian Journal of Native Studies* 19(1): 1-36.

2002 "Conceptual approaches to acculturation." Pp. 17-38 in K.M. Chun, P.B. Organista and G. Marin, eds., *Acculturation: Advances in Theory, Measurement, and Applied Research*. Washington, DC: American Psychological Association.

Blackmore, S.

1999 *The Meme Machine*. Oxford: Oxford University Press.

Bohart, A.C.

2001 "The evolution of an integrative experiential psychologist." Pp. 221-245 in M.R. Goldfried, ed., *How Therapists Change: Personal and Professional Reflections*. Washington, DC: American Psychological Association.

Brasfield, C.R.

2001 "Residential school syndrome." *B.C. Medical Journal* 43(2): 78-81.

Brave Heart, M.Y.

2003 "The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration." *Journal of Psychoactive Drugs* 35(1): 7-13.

Chang, J. and M. Phillips

1993 "Michael White and Steve de Shazer: New directions in family therapy." Pp. 95-111 in S.G. Gilligan and R. Price, eds., *Therapeutic Conversations*. New York: Norton.

Coguen, T.

1985 "Diagnose the system, treat the individual: Hypnosis for secondary impotence." *Family Systems Medicine* 3(3): 308-312.

Compas, B.E., and I.H. Gotlib

2002 *Introduction to Clinical Psychology: Science and Practice*. Boston: McGraw Hill.

Corrado, R.R. and I.M. Cohen

2003 *Mental Health Profiles for a Sample of British Columbia's Survivors of the Canadian Residential School System*. Ottawa: Aboriginal Healing Foundation.

Creswell, J.W.

1998 *Qualitative Inquiry and Research Design: Choosing among Five Traditions*. Thousand Oaks, CA: Sage Publications.

Dawkins, R.

1976 *The Selfish Gene*. Oxford: Oxford University Press.

Dennett, D.

1995 *Darwin's Dangerous Idea: Evolution and the Meanings of Life*. New York: Simon and Schuster.

Devilley, G.J. and S.H. Spence

1999 "The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of post-traumatic stress disorder." *Journal of Anxiety Disorders* 13(1). Retrieved March 1, 2005, from <http://80-www.sciencedirect.com.ezproxy.lib.ucalgary.ca:2048/science>

Duran, E. and B. Duran

1995 *Native American Postcolonial Psychology*. Albany, NY: State University of New York Press.

Fergus, K.D. and D.W. Reid

2002 "Integrating constructivist and systemic metatheory in family therapy." *Journal of Constructivist Psychology* 15: 41-63.

Feske, U. and A.J. Goldstein

1997 "Eye movement desensitization and reprocessing (EMDR) treatment for panic disorder: A controlled outcome and partial dismantling study." *Journal of Consulting and Clinical Psychology* 65: 1026-1035.

Harre, R.

1989 "The self as a theoretical concept." Pp. 389-411 in M. Krausz, ed., *Relativism: Interpretation and Confrontation*. Notre Dame, IN: University of Notre Dame Press.

Herstein, H.H., L.J. Hughes, and R.C. Kirbyson

1970 *Challenge and Survival: The History of Canada*. Scarborough, ON.: Prentice-Hall.

Hutcheon, P.D.

1999 *Building Character and Culture*. Westport, CT: Praeger.

Ishiyama, F.I.

1995 "Culturally dislocated clients: Self-validation issues and cultural conflict issues and counselling implications." *Canadian Journal of Counselling* 29(3): 262-275.

Johnson, D.M.

2003 *How History made Mind: The Cultural Origins of Objective Thinking*. Chicago: Open Court Books.

Kral, M.J. and K.J. Burkhardt

2002 "The new research agenda for a cultural psychology." *Canadian Psychology* 43(3): 154-162.

Lane, P. (Writer)

1986 "Circle of healing," *Man Alive*. Toronto: Canadian Broadcasting Corporation.

Lent, R.W.

2004 "Toward a unifying theoretical and practical perspective on well-being and psychosocial adjustment." *Journal of Counseling Psychology* 51(4): 482-509.

Liashko, V. and K. Manassis

2003 "Medicated anxious children: Characteristics and cognitive-behavioral response." *Canadian Journal of Psychiatry* 48(11): 741-749.

Manson, S., J. Beals, T. O'Neil, J. Piasecki, D. Bechtold, E. Keane, and M. Jones

2002 "Wounded spirits, ailing hearts: PTSD and related disorders among American Indians." Pp. 255-284 in A.J. Marsella, M.J. Friedman, E.T. Gerrity, and R.M. Scurfield, eds., *Ethnocultural Aspects of Post-traumatic Stress Disorder: Issues, Research, and Clinical Applications*. Washington, DC: American Psychological Association.

Morrow, S.L. and M.L. Smith

2000 "Qualitative research for counseling psychology." Pp. 199-230 in S.D. Brown and R.W. Lent, eds., *Handbook of Counselling Psychology*. 3rd ed. New York: John Wiley and Sons.

Mosak, H.

1979 "Adlerian psychotherapy." Pp. 44-94 in R. Corsini, ed., *Current Psychotherapies*. 2nd ed. Itasca, IL: Peacock Publishing.

Nowgesic, E.

2004 "Aboriginal Capacity and Developmental Research Environments." *Canadian Institutes of Health Research*. Retrieved January 18, 2005, from <http://www.cihr-irsc.gc.ca/e/25612.html>

O'Hanlon, W.H.

1994 "The third wave." *The Family Therapy Networker* Nov./Dec.: 19-29.

Poonwassie, A. and A. Charter

2001 "An Aboriginal worldview of helping: Empowering approaches." *Canadian Journal of Counselling* 35(1): 63-73.

Robertson, L.H.

1972 *Nations of the Northern Plains: The Political Economy of the Historic Cree, Saulteaux, Blackfoot and Sioux*. Unpublished manuscript, Saskatoon, SK.

1986 *A Plan for Transferring Control of the Lebret Indian Residential School to an Indian Administration*. Regina, SK: Lebret Indian Residential School Council.

1998 "Satanic culting in the North: Working with Aboriginal youth involved in cult activity." *Guidelines: Journal of the Saskatchewan Guidance and Counselling Association* 33(1): 4-6.

2000 "Community and its counterfeit: Community development issues in mental health." In W.J. Mussel, ed., *Eliminating Barriers in First Nations and Other Aboriginal Communities*. Naramata, BC: Native Mental Health Association of Canada.

2004 "Youth suicide: A community response." In W.J. Mussel, ed., *A Matter of Life: Suicide, Addictions and Mental Health*. Calgary, AB: Native Mental Health Association of Canada.

Snow, A.

1999 "Residential school trauma: A dynamic study of issues, their effects, and resolution." Pp. 58-63 in W.J. Mussel, ed., *Journey towards Wellness: From Trauma and Loss to Cultural Healing and Restoration*. Saskatoon, SK: Native Mental Health Association of Canada.

Stout, M.D. and G. Kipling

2003 *Aboriginal People, Resilience and the Residential School Legacy*. Ottawa: Aboriginal Healing Foundation.

Strong, T.

2002 "Collaborative 'expertise' after the discursive turn." *Journal of Psychotherapy Integration* 12(2): 218-232.

van Uchelen, C.P., S.F. Davidson, S. Quressette, C.R. Brasfield, and L.H. Demarais  
1997 "What makes us strong: Urban Aboriginal perspectives on wellness and strength." *Canadian Journal of Community Mental Health* 16(2): 37-50.

Waldram, J.B.

2004 *Revenge of the Windigo: The Construction of the Mind and Mental Health of North American Aboriginal Peoples*. Toronto: University of Toronto Press.

Warwar, S. and L.S. Greenberg

2000 "Advances in theories of change and counselling." Pp. 571-600 in S.D. Brown and R.W. Lent, eds., *Handbook of Counselling Psychology*. 3rd ed. New York: Wiley and Sons.

Wesley-Esquimaux, C.C. and M. Smolewski

2004 *Historic Trauma and Aboriginal Healing*. Ottawa: Aboriginal Healing Foundation.

White, M.

1993 "The histories of the present." Pp. 121-135 in S.G. Gilligan and R. Price, eds., *Therapeutic Conversations*. New York: Brunner/Mazel.

Wilson, E.O.

1999 *Consilience: The Unity of Knowledge*. New York: Vintage Books.

Wilson, S.A., L.A. Becker, and R.H. Tinker

1995 "Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals." *Journal of Consulting and Clinical Psychology* 63(6): 928-937.