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Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization?

A framework that accounts for the possibility of "layers of trauma" may help survivors of the Indian residential school system.

ABSTRACT: A relevant and helpful framework for assessing Aboriginal people with a traumatic past may include complex posttraumatic stress disorder or disorder of extreme stress not otherwise specified. In a study for the Aboriginal Healing Foundation, 127 case files were obtained from former students of Indian residential schools in British Columbia. A coding system was developed to systematically analyze a number of psychosocial and mental health problems. The Aboriginal people studied were found to have several risk factors for complex posttraumatic stress disorder and many mental health problems associated with complex trauma. These findings suggest that it may be useful to adapt a complex posttraumatic stress disorder framework when assessing mental health problems in Canadian Aboriginal people. The findings also suggest that further research is needed to offer more definite conclusions about the associations between residential school experiences and mental health problems.

Numerous clinical observations by mental health professionals indicate that Aboriginal people have a much higher rate of mental health problems than non-Aboriginals.[1,2] Some argue that the higher rate of mental illness is a direct result of contact with European settlers and subsequent changes in Aboriginal lifestyle.[3] Others contend that some cultural practices among Aboriginal people, such as bereavement-induced hallucinations, are misidentified as evidence of mental illness.[3,4] Still, the incidence of a traumatic past, especially in the form of sexual abuse and assault, is much higher among Aboriginal people than any other racial group,[5,6] and while a number of studies have shown a link between a childhood abuse history and subsequent psychiatric problems for non-Aboriginal people,[7] there is a paucity of studies that address this link in an Aboriginal population. One such study on American Aboriginal people found that a childhood sexual abuse history was associated with three or more psychiatric diagnoses in adulthood.[8]

Clinical experience suggests that the symptom picture among Aboriginal people seeking mental health services is often quite extreme in terms of impairment in interpersonal relations, poor self-image, inability to regulate and control intense negative emotions, and serious substance abuse. A new diagnosis being considered for future revisions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*),[9] complex posttraumatic stress disorder (complex PTSD) or disorder of extreme stress not otherwise specified (DESNOS),[10] may be a relevant and helpful framework when assessing Aboriginal people with a traumatic past. The possibility

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that this conceptualization may lead to more meaningful and appropriate mental health care is supported by a qualitative study of former Indian residential school (IRS) students.[11]

Indian residential schools

For much of the 20th century, attendance at an Indian residential school was mandatory for Canadian Aboriginal children and youth. Indian residential schools were part of an explicit policy of assimilation designed to sever the ties between Aboriginal people and their ancestral culture and lifestyles. To this end, the residential schools focused on the supremacy of the English language and on Christianity as the only acceptable spiritual belief system. In many cases, Aboriginal students received corporal punishment for speaking their own language rather than English.

The long-term effect of abuse suffered by many who attended IRS has been a major concern within the Aboriginal community.[12-22] The damage suffered ranges from psychological and cultural abuse in the form of disrupted attachments to families and communities to physical and sexual abuse perpetrated by both male and female staff.[19,23,24] Also, many parents, grandparents, extended family members, and entire communities suffered significant psychological and emotional losses with the removal of their children for several years.

While there has been considerable research documenting the psychological, physical, and sexual abuse suffered by Aboriginal children in residential schools as a result of lawsuits initiated by victims against the Canadian government and the various churches that operated the schools, there has been little research exploring the possible long-term suffering caused by mental health problems or subsequent abuse experiences. Given the inherent trauma associated with the types of extreme abuse that occurred in residential schools, it has been hypothesized by several clinicians, including all of the co-authors of this article, that complex posttraumatic stress disorder can by used to characterize many of the now adult Aboriginal victims of the residential school system.

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Complex posttraumatic stress disorder

Complex PTSD was initially conceptualized by Judith Herman.[25] Risk factors for developing complex PTSD include a series of "blows" (as opposed to a single traumatic event, such as a motor vehicle accident) to the developing child or adolescent's body and psyche in the form of psychological, physical, and/or sexual abuse in a context of inadequate emotional and social support.[26] Interpersonal trauma appears to be particularly harmful. If the perpetrator of the abuse is in a so-called position of trust (e.g., a teacher, a dorm supervisor) or is someone the child is attached to and dependent upon (e.g., a parent, an uncle), the long-term damage is greater.

DSM-IV field trials indicate that childhood interpersonal trauma is a strong predictor for developing complex PTSD. The following diagnostic criteria have been proposed:

- Impairment in regulating affective impulses, in particular anger directed at both self and others.
- Chronic self-destructive behaviors, such as self-mutilation, eating disorders, or drug abuse.
- Alterations in attention and consciousness leading to dissociative episodes, amnesia, or depersonalization.
- Alterations in self-perception manifested by a chronic sense of guilt, shame, or inflated sense of responsibility.
- Alterations in relationships with others, primarily evident by the inability to trust and enjoy emotional intimacy.
- Complaints of diffuse somatic pain and dysfunction for which there is no medical explanation.
- Alterations in systems of meaning, such as lost faith in existing belief systems or the value and meaning of one's unique life.[27,10]

Furthermore, with reference to the tendency to engage in self-destructive behaviors, the experience of repeated harm at the hands of others, that is,

revictimization, has also been identified as a characteristic feature of complex PTSD.[27] For example, victims of sexual abuse are at significantly greater risk for subsequent abuse and assaults.[28] Finally, a diffuse and complex mental health diagnostic picture is often present in complex PTSD.[27]

Perpetrators of abuse were most often dormitory staff, followed by other student residents, school staff, teachers, principals, priests, and nuns.

The complex PTSD syndrome is known to overlap with the diagnosis and conception of borderline personality disorder (BPD).[9] This is not unexpected given the high rate of childhood sexual abuse (45% to 86%) reported by persons diagnosed with BPD.[29,30] It is also the case that the complex PTSD syndrome overlaps with the formal diagnosis of posttraumatic stress disorder,[9] but expands this by addressing critical issues such as interpersonal impairment and self-destructive behaviors. A significant proportion of abused and neglected children do no meet the diagnostic criteria for PTSD, yet are not without serious clinical problems linked to their trauma.[10,31] Several studies have also found that the recommended empirically supported treatments for PTSD do not lead to positive outcomes for persons whose trauma was not a single unexpected blow, and that those treatment approaches may be counter-therapeutic in cases where the trauma was a series of abusive events.[32,33]

Recognizing the limitations of the PTSD diagnosis when applied to former residential school students, Brasfield proposed the concept of a "residential school syndrome," modelled after the diagnostic criteria of the *DSM-IV* PTSD diagnosis.[34] This proposal expands the PTSD diagnosis to include substance abuse, anger, deficient parenting skills, and a markedly deficient knowledge of the patient's own Aboriginal culture. Symptoms such as harm to self or others and negative self-perceptions are, however, not specifically included in the residential school syndrome.

Study of IRS survivors

In a study for the Aboriginal Healing Foundation, mental health and health profiles of former Indian residential school students in British Columbia were reviewed.[11] In total, 127 case files from Aboriginal people who had sued the federal government of Canada and various churches were used in the study. Selection was based on an individual having attended an IRS and felt harmed by this experience. All files contained a comprehensive clinical psychological or psychiatric assessment that included a detailed psychosocial history and a diagnostic formulation based on *DSM-IV* nomenclature.[9] The assessments were conducted by either a senior clinical psychologist or a senior psychiatrist. The present article discusses only a small proportion of the data collected for the Aboriginal Healing Foundation study. These data refer to some of the long-term mental health consequences associated with complex PTSD.

There are several limitations to the data. Most importantly, the data derived from assessments of plaintiffs involved in litigation and may not, therefore, be representative of all former residential school students. It might be the case that severely abused individuals are more likely to launch lawsuits. However, there are currently more than 12 000 such lawsuits in Canada, suggesting that this present sample might be fairly representative. In addition, while the clinical assessment reports and files were scored using a standard template, the information was not collected in a standardized, structured interview format. This resulted in inconsistency in available information across all the files. Lastly, as is always the case with retrospective studies, human memory is vulnerable to decay and distortion over time. However, all of the subjects indicated they clearly remembered their childhood abuse.

Of the 127 residential school survivors, 70% were male. The mean age of the subjects at the time of their assessment was 48.5 years with a range of 17 to 81 years. The mean age at which the subjects left the residential school system was 14.6 years. The 127 files represent 24 different Aboriginal bands in BC.

Risk factors for complex PTSD in subjects

Nearly all of the files (n = 113, 89%) provided some information about the physical, sexual, or emotional abuse suffered or perpetrated by the residential school students in at least one of three time periods—before, during, or after attendance at a residential school—as demonstrated in **Table 1**. The overwhelming majority of subjects suffered abuse or neglect, or witnessed the abuse of others. For those few individuals who were abused before attending a residential school, perpetrators were usually members of their own family. Accordingly, sexual abuse before IRS attendance was most often committed by an aunt (27.3%), a cousin (27.3%), or an uncle (9%), but also by a father (9%), an acquaintance (18.2%), or a stranger (9%). It is important to bear in mind that these percentages were derived from only 11 files that had information about sexual abuse before residential school attendance. While there were slightly more files (n = 25) that included information about sexual abuse after the student's residential school attendance, the proportion of subjects who reported being sexually abused after IRS was 100% compared with 92.9% of subjects who reported being sexually abused before residential school attendance. Most strikingly, all of the files that assessed whether the subject suffered sexual abuse during residential school contained a report of at least one occurrence of such abuse. Several files indicated more than 10 or an unknown number of times.

There were also high rates of reported physical abuse. However, the proportion of files that included information about physical abuse before and after residential school attendance was quite low (21 subjects before and 15 subjects after). The most common perpetrators of physical abuse before residential school attendance were mothers (37.5%), followed by fathers (31.2%), employers (12.5%), stepmothers (6.3%), foster parents (6.3%), and uncles (6.3%).

The reported incidence of all forms of abuse substantially increased during a subject's residential school attendance. Perpetrators of abuse were most often dormitory staff (27.9%), followed by other student residents (15.4%), school staff (14.7%), teachers (5.9%), principals (2.9%), priests (3.7%), and nuns (2.9%). As subjects were residing at the school, very few family members were reported to have perpetrated sexual abuse during the subject's attendance at a residential school.

Table 1. Kinds of abuse experienced by 113 subjects before, during, and after residential school attendance.

	Before n (%)	During n (%)	After n (%)
Physical abuse	21 (71.4)	77 (89.6)	15 (53.3)
Sexual abuse	11 (92.9)	101 (100)	25 (100)
Emotional abuse	7 (100)	50 (100)	3 (100)
Neglect	4 (100)	18 (61.1)	2 (100)
Witnessing abuse	8 (100)	18 (88.9)	1 (100)

Table 2. Alcohol use by subject and parents before, during, and after residential school attendance.

	Before (n = 28)	During (n = 24)	After (n = 110)
Subject	17.9%	87.5%	90.9%
Mother	85.7%	70.8%	10.0%
Father	100%	16.7%	11.8%

Revictimization

As mentioned above, all files for which there was information (n = 25) indicated that the subject had been sexually abused after residential school. The perpetrators were mostly strangers (33.3%) followed by peers (11.1%), partners (7.4%), federal inmates (7.4%), and various family members. All files for which there was information also reported that the subjects had been emotionally abused, neglected, and witnessed the physical, sexual, and/or emotional abuse of others. Slightly more than half of the files for which there was information (n = 15) indicated that the subject had been physically abused after their residential school experiences.

Self-destructive behaviors

Table 2 presents data on alcohol use by the subject and their biological parents. The vast majority of subjects said their parents had problems with alcohol and the subjects themselves began to drink while attending a residential school. Moreover, an extremely high proportion of subjects continued drinking following their residential school stay. Interestingly, while the subject attended a residential

Table 3. Victims of abuse perpetrated by subjects (n = 23).

Intimate partner	82.6%
Offspring	13.0%
Stepchild	26.1%
Unrelated child	47.8%
Cousin	4.3%
Acquaintance	4.3%
Priest	4.3%

Table 4. Mental health diagnoses received by subjects (n = 93).

Posttraumatic stress disorder (PTSD)	64.2%
Substance abuse disorder	26.3%
Major depression	21.1%
Dysthymia	20.0%
Anxiety disorders (other than PTSD)	12.6%
Borderline personality disorder	7.4%
Antisocial personality disorder	3.2%
Obsessive-compulsive personality disorder	7.4%
Schizoid personality disorder	6.3%
Avoidant personality disorder	3.2%

school, parental drinking decreased dramatically according to the subjects' reports, especially for fathers, and fewer parents were reported to have consumed alcohol after the subject returned home from residential school.

With respect to official offending, slightly less than two-thirds (62%) of the files indicated that the subject was ever convicted of a criminal offence. For those with a conviction, the most common offences were major driving offences (64.5%), physical assaults (54.8%), sex offences (51.6%), theft (24.2%), drug offences (11.3%), robbery (8.1%), and murder (4.8%).

Alterations in relationships

The files were coded for information on fairly extreme forms of dysfunctional relationships, such as physical abuse, whereas issues pertaining to psychological problems, including communication difficulties and lack of emotional and sexual intimacy, were not coded. Of the subject files that included information on abuse perpetrated by the subject (n = 23), nearly three-quarters (74.2%) reported engaging in physical abuse, more than half (54.8%) in sexual abuse, approximately one-quarter (25.8%) in emotional and psychological abuse, and one subject reported neglect of others. **Table 3** indicates that the vast majority of victims were intimate partners or children, regardless of the form of abuse.

Mental health diagnoses

Mental health diagnoses were available for 93 subjects (73.2%) and are presented in **Table 4**. The most commonly diagnosed disorder was posttraumatic stress disorder, followed by substance abuse, major depression, dysthymia, anxiety disorders, and personality disorders, including borderline personality disorder. Of those diagnosed with PTSD, nearly half (49.5%) were also diagnosed with at least one other mental disorder, most commonly major depression (30.4%), substance abuse disorder (34.8%), avoidant personality disorder (26.1%), and borderline personality disorder (13.0%).

Somatic complaints

Information was available on 43 subjects about their physical health. Virtually all subjects specifically mentioned suffering from chronic headaches. Other frequent physical health problems included heart problems, high blood pressure, and arthritis. Considering that medical problems such as heart disease, diabetes, and rheumatoid arthritis are much more common among Canadian Aboriginals than non-Aboriginals, it would be important to further investigate the relationship between complex PTSD and somatic complaints.

Consequences of abuse

Given that the subjects in the Aboriginal Healing Foundation study were residential school litigants, it was expected that the sample would be characterized by high levels of abuse during the residential school years. In a small percentage of cases, there were similar forms of abuse before residential school attendance.

These data highlight the problem of vulnerability to revictimization and pose the question of whether findings elsewhere affirming the phenomenon of revictimization also hold true for this sample of Aboriginal people. The data also indicate that many psychosocial problems and multiple mental health diagnoses were prevalent among this sample. A surprisingly high proportion of serious problems such as criminal behavior, including murder and family violence, were evident and raises the possibility of childhood interpersonal abuse being a risk factor for serious impairment in adult interpersonal relations.

The results associated with alcohol abuse are also of note as they indicate serious substance abuse by the parents of subjects during the subjects' childhood years, followed by a substantial decline as the subjects returned from IRS and became adolescents and adults. This raises interesting questions about the long-term effects of parental drinking on young offspring, but also suggests that posi-

tive role modelling may not be sufficient for some individuals with substance abuse problems. In the subjects studied, there appears to be no relationship between parents decreasing their alcohol consumption and their children's subsequent alcohol abuse problems. Perhaps the parents were not perceived as role models given the subjects' prolonged absence from them, or perhaps the urge to consume alcohol as a way of coping with abuse overrode the effects of positive parental modelling.

Implications of complex PTSD conceptualization

In the Aboriginal Healing Foundation study, a complex PTSD diagnosis was not coded because this diagnosis lacks formal clinical recognition at present. Neither were the dimensions of complex PTSD specifically assessed. However, the available data indicate that many issues and mental health problems associated with complex PTSD were evident in the subjects studied. In effect, a complex PTSD conceptualization may have important implications when applied to Aboriginal people. Maladjusted Aboriginal patients, much like borderline personality disorder patients, tend to be viewed pejoratively by mental health professionals, to the point where they are dismissed as too complicated, unreliable, and treatment-resistant. As a result, such "difficult" patients are often denied appropriate and responsible care and treatment. In contrast, a complex PTSD formulation takes into account the possibility of layers of trauma and the many potential long-term consequences of such trauma. Using this diagnosis in future may have positive implications for treatment recommendations and identification of gaps in health care resources for Aboriginal people. For example, chronic self-destructive behaviors such as serious substance abuse may be a form of coping with unresolved traumatic memories, and a comprehensive assessment and treatment plan would therefore inquire about and address both problems as well as their connection. Our experiences with these cases indicate that family physicians and other health care providers do not routinely ask about a history of sexual abuse or assault.

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While a case may be made for complex PTSD as the overarching clinical conceptualization guiding any assessment and treatment planning of an Aboriginal person, a case may also be made for seeing the residential school syndrome as a culture-specific subtype of complex PTSD. This latter syndrome is limited to residential school abuse, whereas the data in this study indicate that abuse may occur in different contexts and be perpetrated by a range of people, including family members.

Finally, more detailed research is needed in order to offer definite conclusions about possible associations between residential school experiences and various forms of dysfunction. Research involving a non-abused comparison group would also be helpful in examining associations between childhood abuse and adult mental health problems.

Competing interests

None declared.

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