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

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

Prepared for

The Aboriginal Healing Foundation

by

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Executive Summary

The purpose of this research project is to examine the abuse, mental health and health profiles in a sample of 127 Aboriginal Survivors of the residential school system who have undergone a clinical assessment. Through an analysis of their case files, the report discusses: the demographic and problem profiles of residential school Survivors and their families prior to, during and after residential school; the residential school experiences of the sample; the prevalence and co-morbidity of post-traumatic stress disorder (PTSD) and other mental disorders; and the treatment needs of residential school Survivors.

Three clinical psychologists with extensive experience assessing residential school Survivors provided their clinical reports to be coded and analyzed for this research project. In light of the sensitive issues and the use of confidential information used for this report, oral consent was obtained by the 127 individuals that make up this sample. Concerning the oral consent, the three clinicians stated that, in dealing with residential school cases, they felt that it is imperative that oral consent was the most sensitive approach since their patients were more reassured not having to write their names on any document, particularly at the initial stage of their assessments and/or treatment.

As university affiliated researchers, each clinician explained to their patients, in detail, that material from their cases may be used for teaching and research purposes only and that no identifying information would ever be conveyed. For example, actual characteristics of the cases were altered in order to protect such information. In addition, the three clinicians reviewed the final report to reassure themselves that no individual case could be identified based on the aggregated data presented.

In fact, each clinician reported to us that they could not identify even one case characteristic, let alone an individual, from the report. They felt that this report strictly maintained confidentiality and that the information contained in the report was vitally important for clinicians in this country and other countries dealing with residential school syndrome. There is specific information that could assist clinicians to better understand the complex aspects of mental health issues associated with residential schools. The clinicians also stated that the report's information may be extremely helpful in both assessment and treatment strategies. Finally, to further augment confidentiality, the three clinicians' names are not named in this report.

Executive Summary

A detailed research instrument was created in order to code all of the information from the 127 case files. All of the subjects were Aboriginal adults who are litigants against the federal government of Canada, the United Church of Canada, the Anglican Church, and/or the Roman Catholic Church for abuses they suffered while students at residential schools.

The majority of the sample are males and the mean age of the sample is 48.5 years old. The mean age that subjects arrived at residential school was 8.5 years old and they typically came from intact families. Upon leaving the residential school system at 15 years of age, only a small minority returned to intact families. The majority of the subjects did not continue with their education after leaving the residential school. Nonetheless, one-quarter of the case files indicated that post secondary institutions had been attended. Employment history was equally divided between jobs that required no formal training or education and those requiring more extensive training and education.

While data limitations generally prevented any valid or direct comparisons across the time periods of pre-residential school, during residential school and post-residential school, there appeared to be a dramatic increase in alcohol consumption by the subjects between the pre-residential school period and the subsequent time periods, which cannot be completely accounted for solely by differences in age. More than three-quarters of the subjects report having abused alcohol in the post-residential school period. As expected, the number of case files that provide information about sexual, physical and emotional abuse increased overwhelmingly for the time period when subjects were attending residential schools and then declined for the post-residential school period. One hundred per cent of the case files reporting abuse during attendance at residential school indicate that the subjects had been sexually abused and nearly 90 per cent of the case files report physical abuse.

Nearly half of the case files that provide information about the subject's criminal history report convictions mainly for assault and sexual assault. While there were multiple victims mentioned for many of these criminal incidents, most involve intimate partners and family members, although 31 per cent also involve police officers and 20 per cent involve strangers.

Mental health information was present in three-quarters of the case files. In only two cases did the subjects not suffer from a mental disorder. The most common mental disorders were post-traumatic stress disorder (64.2 per cent), substance abuse disorder (26.3 per cent) and major depression (21.1 per

cent). As expected, half of those diagnosed with PTSD were co-morbid with other mental disorders, including substance abuse disorder (34.8 per cent), major depression (30.4 per cent) and dysthymic disorder (26.1 per cent). Only 4.3 per cent of the case files mentioned the new, but unofficial, clinical category: residential school syndrome. The residential school syndrome is a sub-type of PTSD which focuses on intense feeling of fear and anger and the tendency to abuse alcohol and drugs.

The development of the exhaustive code book used in this research project was a necessary initial step in developing a systematic quantitative database regarding the mental health, health and social problems of residential school Survivors in Canada. This code book will also facilitate cross-national comparisons with residential school Survivors in other countries. This could provide clinicians with a more complete understanding of residential school Survivors and may assist them in the development of more specific treatment interventions.

Please contact the Aboriginal Healing Foundation's Director of Research if you would like to obtain a copy of the code book.

Chapter 1

Project Background

In June 2001, Corrado Research and Evaluation Associates Inc. proceeded with a research project to examine the mental health outcomes of a sample of 127 Aboriginal people who had litigated the federal government of Canada, the United Church of Canada, the Anglican Church and the Roman Catholic Church for the abuse they suffered as residents of the residential school system. The Aboriginal Healing Foundation (AHF) provided the funding and policy direction for the research, which is intended to assist in understanding the extent, types and effects of physical, sexual and psychological/emotional abuse on the mental health of a sample of Aboriginal Survivors of the residential school system. Three clinicians who have extensive experience working with Aboriginal Survivors collaborated in the development of the research project and provided the case files that constitute the data base for this report.

In light of the sensitive issues and the use of confidential information used for this report, oral consent was obtained from the 127 individuals that make up this sample. Concerning the oral consent, the three clinicians stated that, in dealing with residential school cases, they felt that it is imperative that oral consent was the most sensitive approach since their patients were more reassured not having to write their names on any document, particularly at the initial stage of their assessments and/or treatment. As university affiliated researchers, each clinician explained to their patients, in detail, that material from their cases may be used for teaching and research purposes only and that no identifying information would ever be conveyed.

For example, actual characteristics of the cases were altered in order to protect such information. In addition, the three clinicians reviewed the final report to reassure themselves that no individual case could be identified based on the aggregated data presented. In fact, each clinician reported to us that they could not identify even one case characteristic, let alone an individual, from the report. They felt that this report strictly maintained confidentiality and that the information contained in the report was vitally important for clinicians in this country and other countries dealing with residential school syndrome. There is specific information that could assist clinicians to better understand the complex aspects of mental health issues associated with residential schools. The clinicians also stated that the report's information may be extremely helpful in both assessment and treatment strategies. Finally, to further augment confidentiality, the three clinicians are not named in this report.

Chapter 1

Research Objectives

The purpose of this research project is to examine the abuse, mental health and health profiles in a sample of 127 Aboriginal Survivors of the residential school system. The sample was drawn from Aboriginal plaintiffs in British Columbia, most of whom have sued the federal government of Canada, the United Church of Canada, the Anglican Church and the Roman Catholic Church for the abuse that they suffered as students of the residential school system.

A review of the research literature on the prevalence of mental health problems indicates that Aboriginal people experience mental illnesses and disorders at a significantly higher rate than non-Aboriginal people[1] (Duclos et. al., 1998; Kirmayer, Brass and Tait, 2000). However, there has been no systematic research that assesses the psychiatric profiles of the sub-set of Aboriginal people who experienced abuse in the residential school system. Most importantly, it has been hypothesized by clinicians that many residential school victims present symptomatology identified as Post-traumatic Stress Disorder (PTSD). Little is known about the variation in this mental disorder among residential school victims and its co-morbidity with associated disorders such as depression, anxiety and substance abuse. This report has seven main objectives:

- to create a research instrument that can be used to code and analyze clinical assessments of residential school Survivors throughout Canada;

- to identify the demographic profiles of residential school Survivors and their families;

- to identify the problem profiles of residential school Survivors and their families prior to, during and after residential school;

- to identify the residential school experiences of the sample;

- to identify the prevalence of PTSD and the different impacts of PTSD in a sample of residential school victims;

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[1] Research indicates that Aboriginal people also experience higher rates of suicide, poverty, substance abuse, interpersonal violence, certain diseases, imprisonment, lower education attainment, greater unemployment and shorter life expectancies (Rowe, 2001).

- to provide information on the clinical diagnoses of residential school Survivors and to examine co-morbidity issues; and

- to assess the variety of treatment needs recommended for residential school victims.

Chapter 2

Canadian Literature and Research on the Residential School System

While there is a growing body of literature on Aboriginal people and the residential school system, there is very little published research on the individual mental health life profiles for Aboriginal Survivors of the residential school system. Typically, research on the effects of the residential school system on Aboriginal people takes the form of government reports and testimonials of the physical, sexual, emotional, psychological and spiritual abuse suffered by Aboriginal children at residential schools. The literature is primarily focused on: providing accounts of individuals experiences at residential schools; analyzing the government's objectives and policies with respect to residential schools; examining the relationship between the residential school system and the myriad of contemporary problems facing Aboriginal people and their communities; and the most effective strategies for government and the churches to compensate and restore Aboriginal victims, families and their communities.

However, there is a small selection of research that examines the clinical assessments of residential school Survivors in terms of their current mental health functioning and the effects that their mental health and psychological development has had on a number of other related personal and familial issues, such as alcohol and drug abuse, employment, physical health, offending history, criminal victimization, family dysfunction and general life outcomes.

Residential schools in British Columbia operated from 1863 to 1984 with approximately 10,000 Aboriginal children in Canada attending these schools in the 1960s. In British Columbia alone, there were 16 Indian residential schools and, by 1920, attendance was mandatory for all Aboriginal children between the ages of 7 and 15 (Brasfield, 2001). There is the widespread belief among many Aboriginal and non-Aboriginal people in Canada that the policies and practices within Indian residential schools both disrupted many Aboriginal children's lives and communities[1] and, for some victims, effectively resulted in a lifetime of pain and tragedy not only to them, but to their immediate families and subsequent families through marriage and partnerships (Law Commission of Canada, 2000; Haig-Brown, 1988: Kirmayer, Brass and Tait, 2000).

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[1] For the purposes of this report, residential schools refers to Indian residential schools.

Chapter 2

These residential schools were part of a policy of assimilation that was sustained for over one hundred years and, ultimately, severed the connection between many Aboriginal people and their ancestral culture. Moreover, the harm was not only done to individual Survivors of the residential school experience, but also to the cohesiveness of Aboriginal communities.

Residential institutions for children have been described as "total institutions," which housed large numbers of Aboriginal children who lived and worked together while being separated from both Aboriginal societies and the broader Canadian community (Law Commission of Canada, 2000). In effect, one critical distinguishing feature of this residential school experience from other boarding school experiences was that the assimilation of Aboriginal children was intended to undermine their culture. The objective of the schools was to "elevate Aboriginal people from a 'savage' behavior state to a state of self-reliant 'civilization'" (Law Commission of Canada, 2000).

In 1920, Duncan Campbell Scott, Deputy Superintendent-General of the Department of Indian Affairs, explicitly stated that the national residential school system's policy depended on forced assimilation to meet his ultimate objective:

> I want to get rid of the Indian problem. I do not think, as a matter of fact, that this country ought to continuously protect a class of people who are able to stand alone … Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department (Chrisjohn and Young, 1997:42).

This forced assimilation involved Aboriginal children being instructed in the tenets and practice of Christianity, basic mathematics, farming and ranching that strictly utilized the English language (Brasfield, 2001). By forcing the English language on Aboriginal children, their cultures would, through subsequent generations, eventually disappear.

Given the central role that Christian religions had long played in local education in Canada, many residential schools were operated by Christian churches. Its officials, who were in charge of the residential schools, recognized that they had a larger assimilation role to play beyond the formal education of children. For example, Reverend Alexander, in the late 19th century, ascertained that the only way in

which the 'Indians' could be permanently elevated and civilized was by removing them from their home life and keeping them separated long enough to form "those habits of order, industry, and systematic effort" (Law Commission of Canada, 2000).

Upon arriving at residential schools, Aboriginal children were stripped of all their belongings, including any artifacts of their culture, their hair was cut and their clothes were replaced with institutional uniforms. The Aboriginal children were forbidden to speak their native languages or practice their cultural traditions. Many Aboriginal children were severely disciplined by utilizing various forms of corporal punishment for school violations such as whippings for speaking their Aboriginal language. The prohibition against Aboriginal children speaking their mother tongue has been asserted to be destructive to their self and community identity (Law Commission of Canada, 2000).

Again, it is evident that the overall policy of the residential school system was to reinforce a sense of cultural and spiritual alienation among Aboriginal children in order to accelerate their assimilation into Canadian society. The Law Commission of Canada stated that such a denial of language and the subsequent loss of traditional culture led to psychological disorientation and spiritual crisis among Aboriginal children. After their return to their families and communities, Aboriginal residential school Survivors were less able than children who had not attended these schools to eventually assume positions as mothers, fathers and community members. While there is considerable evidence attesting to these negative consequences of residential schools, there are few quantitative studies that describe the specific pattern of mental health disorders of residential school Survivors.

Four major categories of abuse are identified in the literature involving residential schools. The research literature on the abuse suffered by those who attended residential schools can be organized into **physical**, **sexual** and **psychological** abuse. In addition to these forms of abuse, Kirmayer, Brass and Tait (2000) contend that Aboriginal children suffered **spiritual** abuse by not being able to practice their traditions or retain their cultural identity.

Chapter 2

Physical Abuse

The strict behavioural requirements imposed on Aboriginal children frequently led to the use of corporal punishment to enforce school rules. The most common punishment was strapping. The strap was used on all parts of the body, most commonly on the hands and buttocks. Other reported punishments include choking, shaving heads and being forced to eat regurgitated food (Bailey, 1991). Children were punished for behaviours over which they had no control, such as bed-wetting (Grant, 1996). Since the rules of residential schools were completely alien from their traditional upbringing, many children, especially the younger ones, found the unfamiliar institutional rules difficult to understand and conform to.

In effect, Grant (1996) asserts that various rules had no justifiable basis from the perspective of many of the children. The greatest amount of confusion for the children resulted from the capricious administration of corporal punishment as too often they had no idea what behaviours might be punished. A common response in children to unpredictable punishment or an inability to avoid punishment is internalized feelings of anxiety and fear (Briere, 1997).

Yet, in one study that examined the effects of the residential school system on members of the Nuu-chah-nulth Nation, 30 per cent to 83 per cent reported that they were the victim of some form of abuse. In some instances, physical abuse preceded or accompanied sexual abuse (Cariboo Tribal Council, 1991a).

Sexual Abuse

Sexual abuse appears to have been common in residential schools; however, little systematic empirical research exists that identifies the extent of this form of abuse. Nonetheless, numerous references are made to sexual abuse in various reports and testimonies. It has been asserted that sexual abuse in some residential schools affected every student (Rogers, 1990). Haig-Brown (1988) disclosed the wide range of sexual molestation ranging from fondling to rape and sodomy that occurred in residential schools. The prevalence of abusive homosexual activity in residential schools was also asserted to have been extremely high (Haig-Brown, 1988).

Chapter 2

In 1995, several court cases illustrated what was likely the pattern of homosexual abuse. A former supervisor at the Port Alberni school was sentenced to eleven years in prison for sexually assaulting fifteen boys between 1948-1968. The sentencing judge called the supervisor a "sexual terrorist" and described the residential school system as "nothing but a form of institutionalized pedophilia" (Grant, 1996: 229).

A personal account of how sexual abuse occurred was described by the eminent political and business advisor, Billy Diamond, a Cree from the Waskaganish community in Northern Quebec. Mr. Diamond described incidents of sexual abuse at the Kamloops residential school in British Columbia where certain male supervisors showed a persistent interest in young Cree boys. These supervisors would entice these boys to their rooms with sugar cubes even while the older Aboriginal boys tried to explain awkwardly why these youths should not accept any of the supervisors' invitations (MacGregor, 1989).

Other reports describe how nuns molested children. Various sexual incidents occurred at the Shubenacadie Residential School when boys between the ages of nine and eleven were bathed. These Aboriginal children would suffer physical assaults if they attempted to resist the sexual overtures of the nuns (Knockwood and Thomas, 1992). Another form of sexual abuse by nuns occurred when Aboriginal girls were disciplined into thinking negatively of their bodies.

Women who lived at the residential school recall the experience of being taught to abhor their bodies and having to scrub their genitals thoroughly in the presence of the nuns. One psychological outcome of this form of abuse is that it can instill in young girls a belief that their bodies are evil and dirty (Grant, 1996). Hodgson (1992) discusses how many of the Aboriginal children who did not realize that the sexual abuse they suffered was happening to other children. Common results of this isolation were feelings of shame and guilt because the children frequently blamed themselves for the abuse they endured.

Spiritual Abuse

Aboriginal spirituality is premised on the themes of trust, sharing, respect, honor and acceptance. This spirituality has sustained Aboriginal people throughout their existence, including the period prior to the introduction of residential schools (Grant, 1996; Brasfield, 2001). Once children were placed into the residential school system, they were no longer permitted to practice their spiritual values and they

were forced to adopt an entirely new set of values, attitudes and beliefs. For many Aboriginal children, the cultural schools of Christian indoctrination became another form of abuse since Aboriginal belief systems were ridiculed, demeaned and replaced by Catholic and Protestant rituals.

Students were taught to consider themselves sinners and to believe that no amount of penance could absolve them of their sinful nature (Grant, 1996). The effects of socialization into the dominant culture and the subsequent cultural loss experienced by Aboriginal victims of the residential school system also impacted the families and communities of the children when they returned to their homes. Kirmayer, Brass and Tait (2000) argue that Aboriginal people have suffered significant interference and change to their traditional ways of life through this type of destructive cultural contact. Most critically, prolonged separation from family and community, especially at a young age, has contributed to spiritual abuse and the loss of culture because of the residential school system.

Psychological Abuse

Psychological abuse has been described in various reports and testimonials as being an integral part of every child's daily experience in the residential school system simply because of the trauma of being wrenched from the only physical, cultural and emotional environment a child had experienced. Isolation from family and community, the suppression of one's native language, imposition of an alien religion and style of communication, experiencing ridicule and harsh punishment, neglecting healthy nutrition and clothing, treating the sick callously and inconsistently applying unjustified school rules amounted to fundamental psychological abuse (Haig-Brown, 1988; Brasfield, 2001; Cariboo Tribal Council, 1991a; Deiter, 1999; Duclos et al., 1998; Fournier and Crey, 1997; Law Commission of Canada, 2000).

The residential school system incorporated other forms of psychological abuse. Loneliness has been identified as a central aspect of life at a residential school by many Aboriginal children. Many residential school Survivors recall the degree of loneliness as emotionally devastating. Some adult Survivors mention being originally excited about the prospect of attending a residential school and then quickly become acutely lonely and afraid after a brief time (Grant, 1996).

In other words, many adults reported that they were completely emotionally and psychologically ill-prepared to reside at a residential school. Others mention that they were not prepared to be totally

separated and isolated from their siblings, families and communities for such extended periods of time. In addition, there are various accounts of being exposed to the cruelty of other Aboriginal children, the systemic racism of the residential school system and the perpetuation of the cycle of abuse. Ultimately, it is argued that these discriminating and punitive experiences were devastatingly traumatic to many Aboriginal children (Grant, 1996).

According to Knockwood and Thomas (1992), another prominent aspect of psychological abuse was the use of direct threats. In residential schools, fear could take many forms. However, one form that was particularly distressful to Aboriginal children was the fear of telling their families and/or Elders about their traumatic experiences at residential schools during holidays, visits or returns to their communities.

Knockwood and Thomas state how many of the children received direct warnings against speaking to others about their residential school experiences:

> I remember Sister Superior coming into the classroom to lecture us about loyalty to the school and how it was our responsibility to keep its reputation good and not bring disgrace to it and Father MacKey. "You give the school and your teachers the same loyalty you give your parents…Don't repeat what you've seen and heard about the fights or punishments in the school especially when you go on vacation because we have ways of finding out if you do" (1992:142).

As a result, parents and the community were frequently not aware of the abuse that was going on in the residential schools, although they were often faced with children that displayed a range of troubling behaviours, such as alcohol and drug use and being emotionally withdrawn.

Another form of psychological abuse that residential school children experienced occurred after they returned to their communities as most abused children did not receive the emotional and/or psychological support needed to assist them in coping with their traumatic experiences. In some cases, the community simply could not or did not understand the nature of the childrens' problems.

However, in other cases, parents who had previously attended residential schools themselves did not relate their experiences to anyone. These parents often felt isolated in their grief and assumed that the experiences of others, including their own children, were not as bad (Grant, 1996).

The Effects of the Residential School System

There are many Aboriginal and non-Aboriginal people who attribute the disproportionate number of health and substance abuse issues, mortality/suicide rates, criminal activity and the overall disintegration of families and communities primarily to the above-mentioned residential school abuses. According to the Law Commission of Canada (2000), the devastating effects of the residential school system on Aboriginal families and communities has been so pervasive that some believe that this school system could have only been part of a larger campaign of cultural genocide.

Consequently, the federal government and the churches that ran residential schools have been accused of having violated Article II(c) of the Convention of Genocide. It defines genocide as acts committed with the intent to destroy a national, ethnical, racial or religious group by such means as "deliberately inflicting upon the group conditions of life calculated to bring about its physical destruction in whole or in part" (Law Commission of Canada, 2000:66).

In addition to the cultural damage to Aboriginal societies effected by the residential school system, it is estimated that 85 per cent of the Aboriginal clientele in drug and alcohol abuse treatment programs today have been in residential schools. Moreover, it is argued that the high levels of various psychological problems facing Aboriginal people, including depression, family violence and breakdown, mental health problems and specific self-destructive behaviours such as suicide are the direct result of the abuse suffered by Aboriginal people in the residential school system (Grant, 1996).

Other significant negative effects of the residential school system have been identified. According to Miller (1996), one of the more general consequences of the residential school experience was that it instilled an institutional dependency mentality in the students so completely that many of them found it difficult to leave behind as adults. In addition, this dependency mindset perpetuates a discomfort with the responsibilities of everyday life and a lack of self-confidence and initiative when dealing with non-Aboriginal people.

Another institutional impact involved the sub-standard living conditions common in many residential schools because of grossly insufficient government funding. Severe malnutrition and poor health resulted with many Aboriginal children becoming ill. Death from tuberculosis and other diseases was not unusual. The long-term impact of these childhood illnesses has to be considered in any attempt to understand post-residential school negative outcomes.

Recent court cases have begun to acknowledge that the degree of abuse suffered by Aboriginal residential school Survivors has contributed to their behavioural and social dysfunctions. Such outcomes, however, remain controversial because it is very difficult to establish direct causal links between such problems as alcoholism, family violence, crime, sexual abuse and other community problems to the negative residential school experiences.

While these causal links are very difficult to establish, the research literature clearly indicates that serious abuse and trauma was experienced by many of the Aboriginal children who attended residential schools. This conclusion is supported by the numerous victims who experienced extremely difficult short-term and long-term psychological adjustments once they left the residential schools. Clinically diagnosed symptoms, such as anger, low self-esteem and fear, have been identified among residential school Survivors (Brasfield, 2001).

It has also been argued that residential school experiences had a direct impact on the lives of Survivors in their adulthood (Brasfield, 2001; Kirmayer, Brass and Tait, 2000; Bull, 1991; Rosalyn-Ing, 1991). Specifically, many of those Aboriginal children abused in residential schools have grown to became abusers themselves (Brasfield, 2001; Kirmayer, Brass and Tait, 2000). In many cases, the cycle of violence for the abused and the abusers is seen to be caused by the shame and guilt that was inflicted on them during their time in the residential schools.

The dynamics between the abuse that some Aboriginal children experienced and becoming an abuser is not completely understood. Nonetheless, it has been suggested that this relationship is based on the notion that suffering various forms of abuse at such a young age and being forced not to tell anyone can result in people expressing their anger, shame and frustration on members of their own family (Briere, 1997; Cariboo Tribal Council, 1991a).

In addition to an increased risk for becoming abusers themselves, the experiences of Aboriginal children in residential schools is asserted to be linked to poor and inconsistent employment histories, criminal offending, substance use, poor parenting skills and higher rates of suicide in adulthood (Brasfield, 2001; Cariboo Tribal Council, 1991a; Deiter, 1999; Hodgson, 1992; Kirmayer, Brass and Tait, 2000; Rosalyn-Ing, 1991). All these crucial assertions require a better understanding of the mental health profiles of residential school Survivors.

Chapter 3

Mental Health Problems and Aboriginal People

There are a few Canadian clinical studies on the specific mental health problems and needs of Aboriginal people (Clarkson, Lavallee, Legare and Jetté, 1992; Gouvernement du Québec, 1994). While this research only provides very basic estimates of the level of mental illness in two samples, there is little dispute in the general literature that Aboriginal people experience mental illnesses, such as depression, post-traumatic stress disorder (PTSD) and anxiety at significantly higher rates than members of the dominant Canadian culture (Duclos et al., 1998; Kirmayer, Brass and Tait, 2000).

Some researchers and historians contend that the high rate of mental illness among Aboriginal people is the result of settlement, i.e., fundamental changes in rural lifestyles that occurred with the advent of an urban and industrial Canada (Barlow and Walkup, 1998). Others contend that high rates of suicide and other signs of distress among Aboriginal people are more specifically related to problems in the development of individual identity and low self-esteem stemming from experiences such as attending residential schools (Brasfield, 2001; Kirmayer, Brass and Tait, 2000).

In order to begin to understand this fundamental relationship, it is necessary, first, to recognize cultural differences between Aboriginal culture and the dominant culture with respect to mental health. In certain situations, what is considered mentally unhealthy in the Western cultural context is not considered unhealthy in an Aboriginal context. Aboriginal people who practice the use of hallucination as a form of bereavement, in part, because it allows for open expressions of emotion, such as grieving, are frequently discouraged from doing so (Matchett, 1972).

In Canadian culture, the practice of hallucination can be identified as a form of psychosis associated with schizophrenia (Matchett, 1972). In recognition of the differences in cultural definitions of mental disorder, the 1994 Diagnostic and Statistical Manual (DSM-IV) has included an outline for cultural formulation (OCF) and 25 culture bound syndromes (Novins, Beals, Shore and Mason, 1997).

The OCF aims to assist clinicians in assessing the impact of a cultural context on the diagnosis and treatment of mental disorders and illnesses. More specifically, the OCF is a section of the DSM-IV that describes cultural issues that should be considered when assessing disorders. The OCF has been criticized by some for failing to demonstrate how cultural awareness is acquired and integrated into every day

clinical practice. Also, the OCF has not been validated to ensure that it operates adequately to bring cultural sensitivity, diagnosis and treatment together in a way that reflects its underlying principles (Novins, Beals, Shore and Mason, 1997).

Culture bound syndromes are defined as "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may not be linked to a particular DSM-IV diagnosis" (DSM-IV, 1994:128). Some examples of DSM-IV culture-bound illnesses that are considered to be specific to Aboriginal people include Ghost Sickness and Pibloktoq. Ghost sickness involves:

> [a] preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian Tribes. Various symptoms can be attributed to ghost sickness, including bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation (DSM-IV, 1994:130).

Pibloktoq is defined as an "abrupt dissociative episode accompanied by extreme excitement of up to 30 minutes in duration, and frequently followed by convulsive seizures and coma lasting up to 12 hours" (DSM-IV, 1994:130). An individual inflicted with Pibloktoq may also tear off their clothing, break furniture, shout obscenities, eat feces, flee from protective shelters or perform other irrational or dangerous acts (DSM-IV, 1994). Prior to the onset of Pibloktoq, an individual may be withdrawn or mildly irritable for some time, such as hours or days.

After an episode, the individual may not remember the events and actions that occurred during Pibloktoq. It should be noted that the term Pibloktoq is specific to Arctic and sub-Arctic Inuit communities. One reason why the attempts of the DSM-IV to address cultural diversity may be inadequate is due to great diversity within cultural groups. The term "Aboriginal" refers to numerous diverse groups of people that may maintain unique cultural identities (Barlow and Walkup, 1998). Regarding the bereavement example, Aboriginal groups differ concerning the appropriate duration and quality of bereavement (Shen, 1986).

Moreover, different Aboriginal groups view the entire concept of mental illness in ways that do not necessarily conform to Western values. Some Aboriginal groups believe that mental illness is caused

when the individual sufferer is possessed by supernatural beings or lost souls, while other Aboriginal groups contend that mental illness is the result of breaking a code of cultural conduct. Still, other groups maintain that mental illness is caused through an imbalance with the natural world or that the presence of a mental illness is a special gift (Barlow and Walkup, 1998).

In addition to fundamental differences between Aboriginal and non-Aboriginal concepts of mental illness and between Aboriginal groups, there are substantial variations within an Aboriginal group regarding such definitions. The extent that an Aboriginal person identifies with their culture's traditions and values can affect their view of mental illness (Barlow and Walkup, 1998). Cultural identity is dynamic and fluid over time. This shift in identity and commitment to an Aboriginal versus a non-Aboriginal cultural orientation does have a direct impact on how mental illnesses are viewed, diagnosed and treated (Novins, Beals, Shore and Manson, 1997).

In one of the few research studies conducted on a sample of Aboriginal psychiatric patients, a study conducted in 1981 with First Nation, Inuit and Métis psychiatric patients demonstrated this notion of individual diversity within specific Aboriginal groups (Pelz et al., 1981). Using a sample of 41 participants, this study found that 59 per cent of respondents had been raised on a reserve. At the time the study was conducted, 59 per cent of the respondents were living on a reserve, 63 per cent of the respondents had relatives who lived on a reserve and 66 per cent had friends who lived on a reserve.

Regarding Aboriginal culture, 66 per cent stated that they felt positively about their Aboriginal identity, 17 per cent claimed to be indifferent and 5 per cent felt negatively about being Aboriginal. Knowledge of Aboriginal culture, defined as participating in traditional Aboriginal activities, also varied significantly. Fully, 27 per cent of the respondents did not participate in any traditional Aboriginal activities, only 34 per cent of the participants could identify one or two Aboriginal ceremonies or legends and 54 per cent had no basic knowledge of any traditional Aboriginal ceremonies or legends (Pelz et al., 1981). Despite the considerable differences between and within Aboriginal groups, there are common Aboriginal cultural values of sharing, cooperation, non-interference and harmony with nature. Moreover, most Aboriginal people share the challenge of adapting to larger social norms of the dominant society (McShane, 1987).

Chapter 3

Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) has been classified as a valid psychological condition only within the last twenty years (Briere, 1997). PTSD is a psychiatric disorder that can occur when an individual experiences or witnesses one or more severe traumatic events. There are many events that can trigger PTSD, including natural disasters and violent personal offences. This disorder is characterized by both psychological and physiological changes within the individual after a traumatic event. Anxiety and emotional numbness are characteristics of PTSD patients. Such individuals experience intensive and intrusive recollections of the event(s) when awake and asleep. In addition, they may find it difficult to concentrate and can feel an intense sense of detachment from their surroundings (Davison and Neale, 2001).

PTSD often occurs in conjunction with other psychiatric disorders. Most common are major depression, substance use, memory and cognitive dysfunctions, and a variety of other physical and mental health problems (National Center for Post-Traumatic Stress Disorder, 2003). Typically, symptoms of PTSD manifest in the days and weeks following a traumatic event; however, PTSD can occur months or even years after the traumatic event(s). Current research on PTSD indicates that about 8 per cent of men and 20 per cent of women who experience or witness an intensely traumatic event eventually develop PTSD and approximately 30 per cent of these people will experience symptoms of PTSD throughout their lifetimes (National Center for Post-Traumatic Stress Disorder, 2003).

Post-traumatic stress disorder is distinct from other psychiatric disorders because it requires an evaluation of etiology, or on-set history, as well as phenomenology or presenting symptoms, in order to diagnose the disorder (Davison and Neale, 2001). Traditionally, PTSD is associated with the reaction that some soldiers have as a result of military combat. However, more common types of events can trigger PTSD, such as being the victim or witnessing a sexual and/or physical assault, a robbery, being kidnapped, being taken hostage, a terrorist attack, being subjected to or witnessing torture and natural disasters (Briere, 1997).

These kind of events are defined as stressors that trigger trauma in an individual following the event. The DSM-IV defines trauma as the:

> [D]irect or personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror, (or in children, the response must involve disorganized or agitated behavior) (DSM-IV, 1994:424).

Although it does not adhere strictly to the criterion outlined in the DSM-IV definition, childhood sexual abuse is also considered a form of trauma. Adults who were abused as children tend to exhibit a wide range of psychological and inter-personal problems, including symptoms of PTSD, dissociative problems such as emotional avoidance, and inter-personal problems such as affect regulation and identity problems (Briere, 1997).

Rape and sexual assault are also considered victimizations that can lead to the development of PTSD. Rape can be defined as "nonconsensual sexual penetration of an adolescent or adult obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent" (Briere, 1997:8). Sexual assault is defined as including rape and any other form of forced sexual contact that does not meet the definitional criteria of rape. While this inclusive definition of sexual assault is used throughout this report, it must be kept in mind that the definition of rape and sexual assault commonly varies between legal, clinical and research contexts.

Regardless of the definitions used, some of the psychological effects of rape include extreme emotional reactions, such as fear, anxiety, anger, low self esteem, depression, sexual difficulties, substance abuse, dissociative symptoms and PTSD. In the cases of sexual assault, symptoms of PTSD are most prevalent soon after the incident indicating the presence of an acute stress disorder. Typically, the symptoms of PTSD decrease with time.

Chapter 3

As this research project is interested in the long term mental health effects of residential school experiences, it is important to note that clinical research demonstrates that approximately 13 per cent of rape victims have symptoms of PTSD up to 15 years after the incident occurred (Briere, 1997). A significant problem associated with assessing trauma and, subsequently, PTSD is that stressors evoke different responses at different levels of intensity for different people (Briere, 1997). In other words, the effect of a traumatic event is subjective; therefore, psychological and physiological responses to events and stressors are varied. In effect, the same event can traumatize one person but not another and, also, the extent of trauma varies widely when it occurs.

For example, an individual may exhibit emotional avoidance in response to a trauma but not exhibit fear or helplessness. Moreover, individuals may engage in self-medication as a coping mechanism resulting in other potential indicators of PTSD or psychological trauma being muted and less likely to be recognized. In other words, PTSD is a complex diagnostic assessment that requires considerable information about the individual to avoid "false negatives" and not identify PTSD because the complete range of symptoms are being masked and are not obvious.

Still, the research literature on PTSD suggests that the degree of post-traumatic stress that an individual will experience is a function of four broad determinants: (1) the characteristics of the stressor; (2) victim-specific variables; (3) the individual's subjective response to the stressor; and (4) the response of others to the victim. The characteristics of the stressor are those that are directly related to the manifestation of PTSD. These characteristics are the magnitude and severity of the stressor. For example, the degree of violence experienced during a sexual or physical assault would increase the magnitude of the stressor and the severity of the PTSD. Other characteristics of the stressor that influence the severity of PTSD symptoms are a subjective sense of unpredictability, uncontrollability and the fear of sexual victimizations (Briere, 1997).

The second determinant includes variables specific to the victim. Certain variables are more highly correlated with the likelihood of experiencing PTSD. Gender, age, race, socio-economic status, previous psychological dysfunctions or disorders, less functional coping styles, family dysfunction, history of psychopathology and genetic predispositions have all been associated with the likelihood of developing PTSD (Briere, 1997; Cohen and Roth, 1987; Davison, Hughes, Blazer and George, 1991; Foy et al., 1984; McCahill, Meyer and Fishman, 1979; McFarlane, 1989; Penk et al., 1988; Ruch and Chandler,

1983; Ursano and McCarroll, 1994; Wilkenson, 1983). For example, females are at greater risk of being physically or sexually assaulted than males. Younger children are less capable of defending themselves against sexual predators and, as a group, at a higher risk for physical and sexual victimization. Insufficient coping strategies or having experienced a trauma in the past can also increase the likelihood of developing symptoms of PTSD. People of lower socio-economic status are often situated in areas of urban centres characterized by elevated crime rates that increase the potential to be victimized. In other words, there are certain variables that are specific to the victim that can increase the chances of being exposed to a stressor, which may lead to the development of PTSD.

The subjective response of the individual to the stressor will also affect the likelihood and magnitude of the PTSD. Related directly to the characteristics of the stressor is whether or not the victim actually perceives an event as a threat. As a result, regardless of the actual level of danger to the individual or the nature of the threat, the degree to which the subject defines the event as a threat or a danger directly effects the magnitude of the PTSD. The fourth variable that influences the degree of PTSD an individual will experience includes the degree of social support that the victim receives, other social responses to their trauma, and the resources, services and programs that the victim accesses.

Social support and resources are extremely important for recovery (Briere, 1997). While strong social support networks can moderate the effects of PTSD, it must be kept in mind that the social responses to trauma tends to vary depending on the nature of the trauma. For example, the stigma attached to certain types of traumatic events, such as sexual assault, is generally negative. Compared to traumatic events, such as natural disasters, the victim may be seen as contributing in some way to their own victimization with respect to certain types of trauma, such as a physical or sexual assault. Accordingly, depending on the nature of the trauma, social responses may function to counteract social support.

For a diagnosis of PTSD, specific symptoms must be evident in three different categories for more than one month. The first category of symptoms involves re-experiencing the traumatic event. In other words, the subject must experience both nightmares of the event and flashbacks and/or vivid recollections while awake. Typically, these re-experiences have triggers or stimuli that symbolize the event and trigger intense emotional upset. The second category of symptoms includes avoidance of any stimuli that are associated with the traumatic event. This includes an avoidance to think about the traumatic event and an avoidance to any stimuli that resembles the event or might trigger recollections of it.

Social withdrawal and emotional numbing are common characteristics of avoidance symptoms. The final category of symptoms involves increased rates of arousal. For example, the victim may experience difficulties falling or staying asleep, concentrating, hyper-vigilance and an exaggerated startle response (Davison and Neale, 2001). Other documented symptoms of PTSD include anger, depression, substance abuse and marital and occupational dysfunctions. Dissociative symptoms such as depersonalization, amnesia and out-of-body experiences can also increase the probability of developing PTSD because these states prevent the victims from confronting the trauma.

Post-traumatic states are often co-morbid with other psychological symptoms and disorders. In addition to low self-esteem, hopelessness and an overwhelming sense of distress and loss, suicidal thoughts and behaviours are relatively common among individuals diagnosed with PTSD. Clinical research also indicates that victims of childhood physical and/or sexual abuse who experience trauma also appear to have elevated rates of substance abuse. Medical or neurological disorders are also correlated with PTSD:

> a number of physical disorders can mimic or exacerbate posttraumatic pathology. These include reactions to drugs (prescribed or abused), endocrine disorder (including hypothalamic, pituitary, thyroid, adrenal, and diabetic dysfunction), neurological disorders (including acute or organic brain injury endured in the trauma), cardiac, hepatic, and respiratory problems (Kudler and Davison, 1995:76).

Other presentations that are associated with PTSD include: central nervous system pathology, such as seizure disorders; dementia caused by head trauma or systemic disease; delirium; substance-induced mental disorders; and organic amnesic disorders caused by brain injury (Davison and Neale, 2001). Regardless of co-morbid conditions, PTSD significantly impacts psychosocial functioning, such as problems developing and maintaining interpersonal relationships, problems with employment and involvement with the criminal justice system. In addition, there are physical problems that are associated with PTSD, such as chronic headaches, gastrointestinal problems, immune system problems and chest pain.

Chapter 3

Residential School Syndrome

The individual trauma of the residential school era has been so severe that clinicians have begun to identify a distinct cluster of problems and behaviours termed "residential school syndrome" to explain the mental health outcomes of some Survivors of the residential school system. While related to post-traumatic stress disorder, residential school syndrome is characterized by an "intense silence and a great fear of feeling" (Muller, 1991:4). Specifically, residential school syndrome involves:

> … recurrent intrusive memories, nightmares, occasional flashbacks, and quite striking avoidance of anything that might be reminiscent of the Indian residential school experience. At the same time, there is often a significant detachment from others, and relationship difficulties are common. There is often diminished interest and participation in [A]boriginal cultural activities and markedly deficient knowledge of traditional culture and skills. Often there is markedly increased arousal including sleep difficulties, anger management difficulties, and impaired concentration. As might be the case for anyone attending a boarding school with inadequate parenting, parenting skills are often deficient. Strikingly, there is a persistent tendency to abuse alcohol or sedative medication drugs, often starting at a very young age (Brasfield, 2001:79).

As detailed by Dr. Brasfield, there are some common criteria between residential school syndrome and post-traumatic stress disorder, such as having experienced or witnessed some trauma that resulted in feelings of helplessness or fear. However, a significant difference between residential school syndrome and post-traumatic stress disorder is that "there is a significant cultural impact and a persistent tendency to abuse alcohol or other drugs that is particularly associated with violent outbursts of anger" (Brasfield, 2001: 79). Another unique feature of residential school syndrome is deficient parenting skills (Brasfield, 2001).

Chapter 4

Research Methodology

This current study is based on an analysis of 127 forensic reports of Aboriginal adults who are litigants against the federal government of Canada, the United Church of Canada, the Anglican Church and/or the Roman Catholic Church for abuses they suffered while students at residential schools. The primary sources of data are psychological assessments prepared by three clinicians who have extensive experience working with Aboriginal Survivors of the residential school system in British Columbia. In terms of the relationship between the respondent and the clinicians in the overall majority of cases, the respondents were assessed by the clinician on the request of their lawyers. In a small minority of cases, assessments were completed on the joint request of both the plaintiff's lawyer and the defence counsel. Another small minority of cases (less than 15% of all cases), derived from the private practice of one of the clinicians.

The first clinician has considerable experience in forensic psychology for both criminal and civil cases. He has assessed many victims/plaintiffs and defendants/respondents in so-called "historical abuse" cases, which usually include individuals who are accused of abuse or who allege experiencing abuse and trauma. Additionally, this clinician evaluates and treats people who are victims of childhood sexual, physical and/or psychological abuse and other trauma. He also provides consultation and treatment services to a victim witness service program.

The second clinician is a clinical psychologist registered with the College of Psychologists of British Columbia since 1997. Since 1994, this doctor has specialized in the assessment and treatment of anxiety disorders including post-traumatic stress disorder. This doctor has designed and implemented treatment programs at two British Columbia hospitals for a number of anxiety disorders including post-sexual assault treatment programs and, in addition, has developed and implemented post-sexual trauma treatment plans for First Nations people throughout British Columbia and has implemented treatment programs in both the Lower Mainland and in Northwestern British Columbia.

The third source of psychological assessments comes from a licensed physician in the province of British Columbia who holds specialty certification in psychiatry. This physician is also a registered psychologist in the province of British Columbia, has a Doctor of Philosophy degree in that field from the University of British Columbia and holds the academic rank of clinical associate professor in the Department of

Psychiatry at the University of British Columbia. This physician is currently on active or courtesy staff at several hospitals in British Columbia. All three clinicians provided their psychological assessments, interview notes and any other material that they had about their clients. Before any information was included in the research, all of the documents were vetted by either a trained researcher or the clinician's staff and given a code number in order to ensure that the subject's anonymity and confidentiality were protected.

As stated earlier regarding participant consent, at the onset of all of the psychological assessments, all subjects were informed that the information they disclosed might be used for research or teaching purposes. All subjects were made aware that strict protocols would be used to ensure their confidentiality and anonymity and asked for their consent to have their assessments used in any future research conducted by the clinician. After this was explained, the subject was asked to give their oral consent. The three clinicians indicated to the principal researchers that, in dealing with residential school cases, they felt that having respondents provide oral consent was the most sensitive approach since their patients were more reassured not having to write their names on any document, particularly at the initial stage of their assessments and/or treatment.

As university affiliated researchers, each clinician explained to their patients, in detail, that material from their cases may be used for teaching and research purposes only and that no identifying information would ever be conveyed. For example, actual characteristics of the cases were altered in order to protect such information. In addition, the three clinicians reviewed the final report to reassure themselves that no individual case could be identified based on the aggregated data presented.

In fact, each clinician reported to us that they could not identify even one case characteristic, let alone an individual, from the report. In addition, as mentioned above, a large number of subjects have engaged in litigation against the federal government of Canada and a number of church institutions. The psychological assessments used in this study were part of the trial documents used in the litigation process and, therefore, are part of the public record. All names or otherwise identifying information were not coded from the case files.

Chapter 4

In general, all of the psychological assessments and supporting documents provided considerable information about each subject. The psychological reports provide sufficient time-based information that facilitated coding information on a number of issues in the subject's life before, during and after their residential school experiences. Most of the psychological assessments were organized into common categories, such as previous psychiatric history, presenting complaint, previous medical history, personal and social history, alcohol and drug history, legal history, mental health status, diagnostic impressions and recommendations.

In addition to basic demographic information, the psychological assessments provided information on the subjects that included: family profile; family issues, such as abuse and violence; descriptions of family relationships; history of physical, sexual and/or psychological abuse pre-residential school; the impact of the abuse on the subject; childhood problems; education profile; specific experiences at residential schools; post-residential school family profile; post-residential school history of being a victim of physical, sexual and/or emotional/psychological abuse; family adjustment to the return of the subject to the family; vocational history; physical and mental health history; criminal behaviour; substance use; intimate relationships; sexual problems and deviations; relationship with their children; clinical impressions; psychological test scores; clinical diagnoses; clinical prognoses; and treatment recommendations.

In order to analyze all of the information presented in the psychological assessments, a detailed code book and coding form were created. Once the code book and the coding form were completed, it was thoroughly reviewed by all of the research principals, including the three clinicians, in order to determine its completeness in terms of clinical categories and related historical information. After the code book was approved by the research team, it was pre-tested by three researchers who all coded the same psychological assessment report.

Once it was determined that the code book and coding form were appropriate to the project's research objectives and that the psychological assessments could be coded reliably, a team of eight graduate and undergraduate students from Simon Fraser University were trained in using the code book and the coding form. After the research team was trained, they were all given a "test case" to code in order to ensure inter-rater reliability and to address any problems or concerns.

The coding forms were periodically reviewed by the principal investigators to ensure reliability and regular meetings were held with the entire research team in order to address any problems or concerns. Once all 127 psychological assessments were coded onto the coding forms, all coding forms were entered into a computer using the Statistical Package for the Social Sciences software for statistical analysis.

Interpreting the Data

Since all of the data collected for this report is derived from psychological assessments conducted by three clinicians with subjects from a wide variety of differing personal, social and legal contexts, and not through standardized questionnaire interviews with residential school Survivors, there is considerable variation in the information obtained from the 127 case files. In other words, not all of the case files provided information on the same issues. For example, while all of the files have some information about the current mental health of the subjects, not all of the files provide information about physical or sexual abuse within the subject's family prior to attending a residential school or while the subject was at a residential school.

While many of the case files provide information about the subject's current physical health and drug use, not all of the files provide information on these issues for the subject's family. It is important to recognize that having no indication in the file of physical abuse within the family, for example, does not mean that no one in the subject's family was physically abused. Instead, one can only infer that the file does not "indicate" family physical abuse. Given this major limitation in the data, the results reported below refer to instances where an issue or event is explicitly mentioned as either having occurred or not having occurred. Unless otherwise specified, the results from the data always refer to the number of subjects for which information was clearly stated either present or absent.

Chapter 5

Data Analysis

General Demographics

For this research project, 127 psychological assessment files of Aboriginal people were analyzed. In terms of the gender of these subjects, 70 per cent are male and 30 per cent are female. Because of the different procedures required by the three clinicians to ensure their client's anonymity, the age of the sample at the time that the psychological assessment occurred could only be determined for 76 per cent of the sample. For those subjects where age could be determined, the mean age was 48.5 years old. The oldest subject was 81 years old and the youngest was 17 years old. In the 81 files where birth order is mentioned, 21 per cent of the sample are the first born in their families and 15 per cent are the last born.

In order to ensure the anonymity and confidentiality of both the subject and their communities, the community and/or nation of origin of the subjects is not reported. However, the subjects came from 24 different bands and 14 different First Nations. There was information about the ability to speak or not speak an Aboriginal language in 52 files; 12 different Aboriginal languages were identified. In 64 per cent of the files, information was provided about the legal guardianship of the subjects pre and post residential school. As indicated in Table 1, 55 per cent of the files included information about guardianship and both parents were identified as the legal guardians prior to the children being sent to residential school. However, after returning from residential schools, only 9.9 per cent of the subjects had both their parents as legal guardians. Given the mean age of leaving residential schools was 14.6 years old, most subjects did return to their families. This change in family status is further evident in the increase of subjects with foster parents, which increased to 21 per cent post-residential school from 7.4 per cent pre-residential school.

Chapter 5

Table 1- Legal Guardianship of Subject		
n=81	**Pre-Residential School**	**Post-Residential School**
Mother	12.3%	9.9%
Father	8.6%	6.1%
Both mother and father	55.6%	9.9%
Foster parents	7.4%	21%
Grandmother	4.9%	3.7%
Grandfather	6.1%	7.4%
Grandparents	6.1%	4.9%
Sibling	-	3.7%
Aunt	4.9%	7.4%
Uncle	2.5%	7.4%
Aunt and uncle	1.2%	-
In-law	1.2%	-
Unspecified family member	2.5%	-
Family friend	-	4.9%
Ward of the state	-	2.5%

While all 127 subjects attended at least one residential school, most (55.3 per cent) did not continue with their education post-residential school. In 114 of the 127 files, there is information about post-residential school academic experiences: 9.2 per cent attended a private junior, secondary, or high school; and 27.4 per cent attended a post secondary school (see Table 2).

Table 2 - Highest Level of School Attended	
Type of School	**% of Subjects (n=114)**
Public elementary school	7.4%
Private elementary school	0.4%
Indian residential school	4.6%
Indian day school	42.9%
Public junior, secondary, or high school	7.8%
Private junior, secondary, or high school	9.2%
Post secondary school	27.3%
Home schooling	0.4%

In terms of academic resilience, 40 per cent of the files report the reasons why subjects left school. At the time that the psychological assessment took place, 25.5 per cent of the sample report graduating from school and 7.8 per cent being enrolled. For those who were not in school or had not graduated, the reasons for leaving school are reported as: 19.6 per cent being expelled; 43.1 per cent quitting; 7.8 per cent poor health; and 2 per cent financial reasons. In only three files are learning disorders mentioned as the basis for the subject not graduating or being enrolled in school. Auditory perceptual problems are indicated in two of the cases and a learning disability is noted in one file.

In terms of employment, all the jobs that the subjects held after attending residential school were re-coded into three categories: (1) employment requiring advanced education or training, such as a medicine, finance or law; (2) employment requiring moderate education or training, such as carpentry, auto mechanics or management; and (3) employment requiring minimal or no education or training, such as physical labour. Reports of specific periods of employment were found in 92 files totaling 232 distinct instances of employment.

Of these 232 jobs that the subjects held, 12.9 per cent of the files indicate the subject held at least one job that required advanced education or training, 37.5 per cent of the subjects held at least one job that required moderate training and education and 49.6 per cent of the subjects held at least one job that required minimal or no education or training. Very few files provide any information about whether the subject had any inter-personal problems when interacting with others at work, their attitudes toward employment or their performance at work. For example, only three cases state that the subject had any difficulty interacting with others, only two files report that the subject had a negative attitude towards employment and only one file suggests that the subject's performance at work was below average when compared to the performance of an "average" worker.

Family Alcohol Patterns

In 110 files, information was obtained concerning the alcohol use of at least one member of the subject's family before, during or after attending residential school. Table 3 demonstrates the alcohol use of family members identified in the files. Only one file indicates that a subject's mother used alcohol while pregnant and only three files report that the mother abused alcohol while pregnant with the subject. Only four files report a family member using or abusing drugs. Regarding the subject's use of

alcohol, 17.9 per cent indicate alcohol use prior to attending residential school, 87.5 per cent used alcohol while attending residential school and 90.9 per cent report using alcohol post-residential school. The subjects' use of alcohol will be described in greater detail below.

Table 3 - Alcohol Use

	Pre-Residential School (n=28)	During Residential School (n=24)	Post-Residential School (n=110)
Subject	17.9%	87.5%	90.9%
Mother	85.7%	70.8%	10%
Father	100%	16.7%	11.8%
Step-parent	-	4.2%	-
Foster parent	-	4.2%	-
Grandmother	10.7%	4.2%	1%
Grandfather	14.3%	4.2%	1%
Brother/step-brother	3.6%	25%	38.2%
Sister/step-sister	7.1%	16.75%	30.9%
Aunt	7.1%	-	-
Uncle	3.6%	-	-
Child of subject	-	-	11.8%

There are indications that parental alcohol consumption patterns may have changed in an unexpected direction. Again, given the substantial differences in the reporting of alcohol consumption in the case files between "pre" and "during" residential school periods, and then the "post" residential school period, considerable caution is required in interpreting the substantial decline in the percentage of case files where fathers and mothers are reported as either not using or abusing alcohol. In the 28 case files where alcohol is mentioned prior to residential schools, 85.7 per cent of mothers and 100 per cent of fathers were identified by the subjects as problem drinkers.

During the residential school stage, 24 case files mention alcohol consumption and, while 70.8 per cent of mothers are reported as having problems, only 16.7 per cent of fathers are similarly identified. The decrease is even more substantial in the post-residential school stage where in 110 cases reporting alcohol consumption within families, only approximately 10 per cent of mothers and fathers were seen by subjects as having alcohol consumption problems. These declines are unexpected because all the research

and theorizing about the impact of residential school on parents definitely asserts that parental consumption increased substantially and even catastrophically. As stated numerous times in this report, there are substantial variations in the completeness of each file; therefore, it cannot be assumed that the absence of parental alcohol problems in the "pre" and "during" residential school stages supports the inference that such problems did not exist.

In contrast to the decline in parental alcohol problems, sibling patterns appear to increase from the pre-residential and during residential stages to the post-residential stage. During the first stage, only 3.6 per cent of male siblings and 7.1 per cent of female siblings of the 28 cases reporting alcohol use were identified as having alcohol-related problems. However, for the during residential school stage, one-quarter of the male siblings and 16.7 per cent of the female siblings in the 24 case files were reported as having problems. The increase continued in the "post-residential school" stage as 38.2 per cent of the male siblings and 30.9 per cent of the females were reported as having alcohol problems.

A limitation in interpreting this trend is that the data analysis could not introduce the age of the sibling as a control variable. In other words, older siblings are more likely to be seen by the subjects differently than younger siblings, since alcohol consumption patterns are likely to change with distinctive age stages, i.e., access to alcohol of very young siblings versus teenage and adult siblings access to alcohol. Another caution in interpreting both parental and sibling alcohol problems is the memory recall limitations of the subjects. Remembering what occurred with parents and siblings is likely related to not only the subject's age when they attended residential school, but also to their exposure to their family's alcohol problems during visits.

Family Deaths

Nearly half of the files (48 per cent) provided information about a family member's death. Again, age is a major factor in the differences between the categories of pre-residential school attendance and post-residential school since most family deaths are expected to occur in the post-residential school period when the subjects are at various stages of adulthood (see Table 4). Nonetheless, in 61 files, subjects reported 15 family member deaths while they were in residential schools. Even though far more deaths occur in the pre-residential school period (n=44)[1] and the post-residential period (n=62), the emotional

[1] (n=x) refers to the total number of files.

impact of such losses experienced while isolated from the support of the nuclear and extended family within an Aboriginal community context may be linked to a traumatic event for a child or young adolescent. Also, the deaths during the residential school period nearly all involved immediate family members.

Table 4 - Death of a Family Member			
	Pre-Residential School (n=44)	**During Residential School (n=15)**	**Post-Residential School (n=62)**
Mother	11.4%	6.6%	46.8%
Step-mother	2.2%	-	-
Father	20.5%	20%	51.6%
Step-father	2.2%	-	-
Grandmother	4.5%	6.6%	14.5%
Grandfather	2.2%	20%	14.5%
Brother/step-brother	36.4%	20%	54.8%
Sister/step-sister	20.5%	20%	14.5%
Aunt	-	6.6%	32.8%
Uncle	-	20%	9.7%
Child of subject	-	-	43.2%

Family Interactions

One-quarter of the files (n=32) provide an assessment of the subject with family interactions pre and post-residential school. Two-thirds state that the family relationships were positive, while 30 per cent report a mixed positive and negative family relationship, and only 3 per cent recall completely negative family relationships prior to attending residential school. Only 10 files provide a family environment assessment after a subject returned from a residential school; only two case files report positive relationships, while four case files report negative family environments. Unfortunately, with only 10 case files reporting about family interactions, few inferences can be made concerning this critical variable. An important concern is the impact of the residential school not only on youth, but also on their family during and after their return. One issue is whether the removal of the child initiated or exacerbated negative family interactions beyond key related problems, such as alcohol abuse.

Chapter 5

Subject's Marital, Intimate, and Family Relationships

The majority of files provide information about the subject's marital status, the nature of the subject's relationship with intimates, whether the subject was a parent and the nature of the parent-child relationship. Approximately three-quarters (73 per cent) of the case files contain information about marital status. Nearly all (92.5 per cent) of the case files indicate that the subject had been married at least once, while 42.6 per cent had more than one marriage. Including marital relationships, 202 intimate relationships were reported by the 93 subjects. Only one of the 93 files for which there was any marital status information available indicated that the subject had never been married, never lived in a common-law relationship or never dated anyone for a significant period of time. No information was available on marital status for 34 subjects.

Close to three-quarters of the case files (72 per cent) do not mention any actual, attempted, or threatened non-sexual harm between the subject and their partners. Of the remaining 36 case files, one-quarter report no physical violence between intimates, while one half involved physical violence by the subject, 11.7 per cent indicate physical violence by partners against subjects and 13.3 per cent report physical violence committed by both. In four case files, there is information concerning attempted, actual or threatened sexual violence between intimates. Only one file indicated sexual violence by the partner against the subject. There are few cases (14 per cent) mentioning verbal or non-verbal behaviour that caused emotional or psychological damage or distress. In seven cases, the subjects identified themselves as using emotional violence against their partners.

Only one-quarter (26 per cent) of the case files do not mention whether or not the subject has any children. Collectively, the 91 subjects identified 153 children with approximately one-third (35.9 per cent) with a single child. One subject reported having 14 children. Of the 153 children, subject-parent relationship information is available for 143 children: 77.6 per cent are the biological child of the subject; 10.5 per cent are step-children; 3.5 per cent are adopted; and 1.4 per cent are foster children. Regarding living arrangements, information is available for nearly one-quarter (24 per cent) of the subjects at the time that the psychological assessments occurred: 12.9 per cent were living with the subject alone; 32.3 per cent were living with the other parent exclusively; 48.4 per cent were living with both the subject and their partner; and 29 per cent of the subjects' children are either adults or live on their own (see Table 5).

Table 5 - Where Subject's Children are Living	
	(n=31)
Subject alone	12.9%
Other parent alone	32.3%
Subject and partner	48.4%
Subject's relatives	12.9%
Foster care	3.2%
Adoptive parents	3.2%
Child is an adult or lives on their own	29%

For the vast majority of case files, there is little mention of the type of relationships between subjects and their children. For approximately one-third (36 per cent) of the subjects, 62.5 per cent identified themselves as the primary caregiver, while at the other extreme, 29.2 per cent report no contact with their children. One of the key hypothesized impacts of the abuse suffered by these subjects at residential schools and a fundamental distinguishing characteristic of residential school syndrome, is the difficulty Survivors have in parenting their children. Only one-fifth (21 per cent) of the files report on the subject's parenting ability (see Table 6).

Table 6 - Subjects' Parenting Ability	
	(n=27)
Positive Parenting Ability	
Support of child	7.4%
Involvement in extra curricular activities	3.7%
Appropriate punishment of child	3.7%
Loving	7.4%
Good parenting	14.8%
Negative Parenting Ability	
Unaffectionate	11.1%
Physically abusive	22.2%
Emotionally abusive	7.4%
Neglectful	3.7%
Avoidance due to fear of abusing child	14.8%
Inappropriate disciplining of child	33.3%
Overly strict	18.5%
Overly protective	11.1%
Displaying anger towards child	7.4%

While the parenting sample size is extremely small, 33.3 per cent of the case files report that the subject used inappropriate forms of discipline or inappropriately punished at least one of their children, 22.2 per cent were physically abusive to at least one of their children and 18.5 per cent were overly strict. In contrast, only 10 subjects mentioned positive parenting abilities, including being supportive of their child, being loving and being a good parent.

Residential School Entry, Family Contact, and Exit Profile

Given the need to maintain confidentiality and anonymity, residential schools are not identified. The mean age that subjects first attended residential school was 8.5 years old; however, this mean was derived from 68 per cent of the files. Slightly more than half of the case files (59 per cent) report the age of the subject when they left the residential school system as a mean age of 14.6 years old. In 27 per cent of the files, there are reports of the reasons given to the subject for why they were being sent to a residential school (see Table 7). While 34 per cent of the subjects report that they were not provided with any reason, 22.9 per cent were told that it was simply necessary for them to attend. One subject reported that they were told they were going on a bus ride.

Table 7 - Reasons for Attending Residential School

	(n=34)
No reason given	34.3%
Necessary	22.9%
Economic or financial decision	5.7%
Misbehaviour by subject	5.7%
To learn English	11.4%
Apprehended by social services	11.4%
Subject being sent to a reform school	2.9%
Location of residential school	2.9%

Many subjects attended a residential school with members of their family as nearly 40 per cent of the files (n=50) provide information indicating that the subject had at least one family member simultaneously attending the same residential school. Only three files specifically mention no additional members of the subject's family attending the same residential school. Most of the 50 case files (88.8 per cent)

report at least one sibling attending the same school. Approximately one half of the 50 case files (52 per cent) make reference to whether or not the subject had any contact with siblings who were attending the same residential school at the same time. A minority (36.5 per cent) of these subjects had some contact with their sibling students.

There is information about whether the subject had any contact with their families while at a residential school in less than one-third of the case files (31 per cent). The most common contact (42.6 per cent) occurred during the summer vacation or during major holidays that was mentioned in 14.8 per cent of the case files. Weekend visits were infrequent (11.1 per cent) while 14.8 per cent of the case files report that the subject had no visits with family while attending a residential school. Except for those who had no visits, the other categories are not mutually exclusive in that a subject could have received visits from family, for example, at both the major holidays and the summer holidays.

Discipline at Residential Schools

In approximately one-fifth (21 per cent) of the case files (n=27), there are 41 reports of disciplinary actions taken against the subject while at residential school. Nearly half of all disciplinary actions (46 per cent) had involved physical punishment. Being expelled or suspended from the school accounted for 14.6 per cent of the disciplinary actions, while 12 per cent involved physical isolation and 14.6 per cent involved the loss of privileges. Of the 27 case files that mention disciplinary actions, only three files state that the subject never received any disciplinary action. Again, it must be kept in mind that there is no information about the presence or absence of any disciplinary action taken against the subject in 79 per cent of the files.

Physical, Sexual and Emotional Abuse Against Subjects

Most of the files (89 per cent) have extensive information about the physical, sexual and emotional abuse suffered by the subject and members of the subject's family before, during and after the subject attended residential school. All of the instances of abuse were coded into one of five categories: (1) physical abuse – actual, attempted or threatened non-sexual harm; (2) sexual abuse – actual, attempted or threatened sexual physical harm; (3) emotional abuse – any verbal or non-verbal behaviour that causes emotional/psychological distress or damage or inappropriate/unusual sexual activities or games;

(4) neglect – failure to provide the necessities of life, such as food, shelter, clothing, health care or hygiene; and (5) witnessing – exposure to physical, sexual or emotional abuse or neglect. Also, all instances where the files explicitly state that the subject or a family member did not experience any abuse were coded. Table 8 demonstrates the type and the victim of abuse pre-residential school.

Table 8 - Abuse Before Attending Residential School

	Physical Abuse (n=21)	Sexual Abuse (n=14)	Emotional Abuse (n=7)	Neglect (n=4)	Witnessing (n=8)
Subject	71.4%	92.9%	100%	100%	100%
Mother	42.9%	-	-	-	-
Father	4.8%	-	-	-	-
Brother	9.5%	7.1%	-	50%	-
Sister	4.8%	14.3%	-	50%	-

Nearly one-fifth (18.5 per cent) of the files indicate no abuse against the subject before attending residential school. This finding, however, is difficult to interpret because, of the total sample, 33 per cent of the files do not discuss the issue of abuse inflicted before attending residential school. It is, therefore, simply not known if these subjects did or did not experience any form of abuse before attending residential school. Again, while 71.4 per cent of the case files report that the subject was physically abused, this only refers to the 21 files that mention pre-residential school abuse.

Table 9 contains the perpetrators of the abuse against the subject in the pre-residential school period. As it is possible for the subject to be abused by more than one person, the number of abusers exceeds the number of subjects. While the number of subjects that were abused before attending residential school is low, in those instances where it occurred, the most common perpetrator was the subject's parent.

Table 9 - Perpetrators of Abuse against the Subject Prior to Attending Residential School					
	Physical Abuse (n=16)	**Sexual Abuse (n=11)**	**Emotional Abuse (n=8)**	**Neglect (n=8)**	**Witnessing (n=7)**
Mother	37.5%	-	-	25%	-
Step-mother	6.3%	-	-	-	-
Father	31.2%	9%	50%	87.5%	71.4%
Step-father	-	-	25%	12.5%	-
Foster parent	6.3%	-	-	-	-
Brother	-	-	-	-	-
Sister	-	-	-	-	-
Grandfather	-	-	-	-	14.3%
Grandmother	-	-	-	-	-
Uncle	6.3%	9%	-	-	-
Aunt	-	27.3%	-	-	-
Cousin	-	27.3%	-	-	-
Partner	-	-	-	-	14.3%
Acquaintance	-	18.2%	25%	-	-
Employer	12.5%	-	-	-	-
Stranger	-	9%	-	-	-

Very few files provide any information about the frequency of the abuse suffered by subjects. However, six files report that the abuse only occurred once, five files report that the abuse occurred 11 or more times, and five files report that the abuse occurred an unknown number of times. In addition, only six files indicate that the subject disclosed being abused to anyone prior to attending a residential school. Of those six subjects who did disclose their abuse, four disclosed to a family member, one to a psychologist and one to a health care professional prior to attending residential school.

The rates for all of the forms of abuse for the subject substantially increased during residential school (see Table 10). Only two case files report that the subject was not abused while at a residential school. Of those case files with abuse information, all of the subjects were sexually abused, 89.6 per cent were physically abused and 100 per cent were emotionally or psychologically abused. Since the sample for this study consisted of litigants who experienced serious abuses in residential schools; nonetheless, these astonishing figures are not completely unexpected.

Table 10 - Subject Abuse While Attending Residential School and External Abuse Within the Family					
	Physical Abuse (n=77)	**Sexual Abuse (n=101)**	**Emotional Abuse (n=50)**	**Neglect (n=18)**	**Witnessing (n=18)**
Subject	89.6%	100%	100%	61.1%	88.9%
Mother	1.3%	1%	-	-	-
Father	-	-	-	-	-
Brother	1.3%	4.9%	-	-	-
Sister	-	1%	-	-	-

While the subject was at a residential school, the main perpetrators of abuse were the administration, teachers and staff of the residential school (see Table 11). In total, 49 per cent of the files that reported the subject had been sexually abused identified a member of the dorm room staff as an abuser and 25.6 per cent identified an unspecified staff member at the residential school. In addition, 26.9 per cent of the files indicate that the subject was sexually abused by a fellow resident or classmate. Again, it must be kept in mind that subjects could be abused by more than one abuser and the abuse could fall into one or more categories of abuse. In terms of physical abuse, the main perpetrators were identified as follows: 25.6 per cent as dorm room staff, 19.2 per cent as residential school staff members and 10.2 per cent as fellow residents or classmates.

Table 11 - Perpetrators of Abuse Against the Subject While Attending Residential School					
	Physical Abuse (n=83)	**Sexual Abuse (n=136)**	**Emotional Abuse (n=45)**	**Neglect (n=5)**	**Witnessing (n=16)**
Dorm staff	24.1%	27.9%	26.7%	40%	18.8%
Principal	8.4%	2.9%	4.4%	-	-
Resident/classmate	9.6%	15.4%	13.3%	-	-
Priest	1.2%	3.7%	2.2%	-	-
Nun	3.6%	2.9%	-	-	-
Residential school staff	18%	14.7%	28.9%	60%	43.8%
Residential school teacher	8.4%	5.9%	13.3%	-	-
Defendant in litigation	8.4%	3.7%	-	-	6.3%
Mother	-	1.5%	-	-	-
Father	-	1%	-	-	-
Step-father	-	-	2.2%	-	-
Grandparent	2.4%	2.9%	2.2%	-	6.3%
Cousin	-	1.5%	-	-	-
Other family member	8.4%	8%	4.4%	-	-
Partner	1.2%	1.5%	2.2%	-	-
Acquaintance	-	2.2%	-	-	-
Stranger	-	2.2%	-	-	25%

In total, 120 files report the frequency of the abuse experienced by subjects during their attendance at a residential school. Approximately one-fifth (17.5 per cent) of these files indicate that the abuse occurred an unknown number of times, 56.7 per cent report 11 or more times, 15.8 per cent indicate only one occurrence and 10 per cent report two to seven times.

Nearly half of the files (46 per cent) provide information about the subject's disclosure of the abuse they suffered while attending residential schools. Fully, 32 per cent state that the subject never disclosed their abuse to anyone prior to undergoing the current psychological assessment. For those who did disclose their abuse: 52.5 per cent disclosed to a family member; 72.5 per cent to a psychologist or psychiatrist; 57.5 per cent to the police; and 30 per cent to a lawyer (see Table 12).

Table 12 - Disclosure of Abuse Suffered at a Residential School	
	(n=40)
Family member	52.5%
Psychologist/psychiatrist	72.5%
Principal	5%
Staff member at the residential school	15%
Friend	15%
Health care worker	27.5%
Police	57.5%
Partner or intimate	25%
Elder	7.5%
Church official	12.5%
Government official	7.5%
Lawyer	3%

Nearly one-third (31 per cent) of the case files provide information about how the subject responded to being abused at a residential school. The most common responses were: fear (66.7 per cent); physical resistance to the abuser (23.1 per cent); attempting to run away from the residential school (30.8 per cent); running away from the residential school (41 per cent); complaining to residential school staff (46.2 per cent); and disassociation (10.3 per cent).

A little more than a quarter (27 per cent) of the case files report on post-residential school abuse suffered by the subject or members of their families. Again, these files provide information that the subject was sexually abused (100 per cent) and physically abused (53.3 per cent) after leaving residential school (see Table 13). A disturbing finding is that 52 per cent of these case files indicate that at least one of the subject's children has been sexually abused. One-third of the files state that a subject's child has been physically abused and only four of the files specifically mention that the subject's children did not experience any form of abuse. However, most of the case files (73 per cent) in this sample do not contain any information about post-residential school abuse regarding either the subject or their families.

Table 13 - Abuse After Attending Residential School					
	Physical Abuse (n=15)	**Sexual Abuse (n=25)**	**Emotional Abuse (n=3)**	**Neglect (n=2)**	**Witnessing (n=1)**
Subject	53.3%	100%	100%	100%	100%
Mother	6.7%	4%	-	-	-
Sister	20%	4%	-	-	-
Subject's child	33.3%	52%	-	-	-
Nephew	-	4%	-	-	-

In terms of the abuse that the subjects suffered after attending residential school, only 14 per cent of the files provide any information about the abuser. The most frequent perpetrator of physical abuse (45.5 per cent) and sexual abuse (33.3 per cent) was a stranger (see Table 14).

Table 14 - Perpetrators of Abuse Against the Subject Post-Residential School				
	Physical Abuse (n=11)	**Sexual Abuse (n=27)**	**Emotional Abuse (n=2)**	**Neglect (n=3)**
Dorm staff	-	7.4%	-	-
Resident/classmate	-	11.1%	-	-
Residential school staff	9%	-	-	-
Teacher at residential school	-	3.7%	-	-
Mother	18.2%	-	50%	66.7%
Step-father	9%	-	-	-
Foster parent	-	3.7%	-	-
Brother/step-brother	-	3.7%	-	33.3%
Aunt	-	3.7%	-	-
Cousin	-	3.7%	-	-
Other family member	-	3.7%	-	-
Partner	9%	7.4%	50%	-
Acquaintance	-	3.7%	-	-
Friend	-	3.7%	-	-
Federal inmate	9%	7.4%	-	-
Employer	-	3.7%	-	-
Stranger	45.5%	33.3%	-	-

Only 12 per cent of the files provide information about the frequency of abuse suffered by the subject after attending residential school. Five of these case files indicate that the subject was abused only once and three files report that the abuse occurred 11 or more times. In addition, other than during this current psychological assessment, only 12 per cent of the files (n=15) indicate that the subject ever disclosed their post-residential school abuse to anyone. Regarding the person disclosed to: eight were to the police, two were to a family member, two were to a health care professional, one was to an Elder and one was to a partner or intimate.

Physical, Sexual and Emotional Abuse by Subjects

In total, 21 files (16.5 per cent) report that the subject abused others. In all of these instances, the subject abused others after attending residential school. There are only two files that report that the subject sexually abused a fellow classmate while attending residential school. All of the cases of abuse were re-coded in the categories of: (1) physical abuse; (2) sexual abuse; (3) emotional or psychological abuse; and (4) neglect. Nearly three-quarters of the subjects (74.2 per cent) report engaging in physical abuse, 54.8 per cent in sexual abuse, 25.8 per cent in emotional or psychological abuse, and 3.2 per cent in neglect. Table 15 indicates the victims of the subject's abuse. While information was only available for 23 files (18 per cent), overwhelmingly, the victims of abuse were an intimate partner or a child.

Table 15 - Victims of Subjects' Abuse

	(n=23)
Intimate partner	82.6%
Offspring	13%
Step-child	26.1%
Unrelated child	47.8%
Cousin	4.3%
Acquaintance	4.3%
Priest	4.3%

In terms of the subjects understanding that their abusive behaviour is inappropriate, 13 per cent of the files provide relevant information. In all cases, the subject demonstrated an understanding that their behaviour was inappropriate. However, 58.8 per cent also indicate that while they know it is

inappropriate, they are unable to stop their abusive behaviour. There were no data available for 87 per cent of the files.

Drugs and Alcohol Use/Abuse

The great majority of files (81.9 per cent) provided information about the subject's alcohol use and abuse. However, very few files mention drug use and only 14 files provide any information about cocaine use, and then only its use after attending residential school. Nine subjects used cocaine and three subjects abused cocaine. Only four files indicate heroin use after attending residential school and, in addition, one file indicates that heroin use had a negative impact on the subject's health. Two files indicate sniffing gas or glue both during and after attending residential school.

With respect to marijuana use, no files report that the subject used marijuana prior to attending a residential school and only one file reports marijuana use during residential school. However, for the 27 files that report marijuana use, 63 per cent report that the subject abused marijuana following their residential school experience and 14.8 per cent used marijuana. As demonstrated in Table 3, there were few subjects who used alcohol prior to attending a residential school. Moreover, there are few files that provide information about the subject's alcohol use during residential school. However, 82 per cent of the case files reveal that the subjects' alcohol use or abuse occurred after attending residential school with 78.8 per cent having abused alcohol, while 15.4 per cent report alcohol use. In 46 case files, problems that the subjects experienced as a result of their alcohol use or abuse are evident. Alcohol-related health problems are indicated in 17.4 per cent of the cases, while alcohol-related problems at work or in finding employment occurred in 39.9 per cent of the cases. Problems maintaining positive relationships with family members or intimates because of alcohol use or abuse are evident in 28.3 per cent of the cases. Only two files indicate criminal justice problems and one file includes at least one suicide attempt related to alcohol use or abuse.

Offending – Criminal History

Nearly half (49 per cent) of all the files provide information about the charges for which the subjects have been convicted (see Table 16). In total, 62 subjects have been convicted of 150 charges. This is not unexpected given the extensive abuse history of this sample, which is slightly more than half (51.6

per cent) of the subjects for which there is information that the subjects were convicted of at least one sexual offence and 55 per cent have been convicted of assault. Similarly, with the sample's alcohol use/abuse history, it is not surprising that 64.5 per cent of the subjects have major driving convictions. Nearly a quarter of the sample have been convicted of theft. As it is possible for the subject to be convicted of more than one crime, the rates presented below exceed 100 per cent.

Table 16 - Criminal History	
	(n=62)
Murder	4.8%
Sex offences	51.6%
Possession of a weapon	4.8%
Assault	54.8%
Robbery	8.1%
Theft	24.2%
Drug offences	11.3%
Major driving offence	64.5%
Fraud	1.6%
Escape from custody	1.6%
Arson	4.8%
Public drunkenness	3.2%

Only 23 per cent of the case files report the victim of the criminal activities. As indicated in Table 17, with over half of the criminal convictions, the victim was a family member and in 34.5 per cent of the crimes, the victim was an intimate partner of the offender. In only 20 per cent of the crimes a stranger was the victim and in nearly one-third (31 per cent) of the incidents, police officers were victimized. Given the pervasiveness of abuse perpetrated by residential school authorities, it is not unexpected that police officers are such frequent victims of residential school Survivors. It is possible that the residual resentment of these subjects toward all authority figures is directed at the police as well. Alcohol and mental health problems also likely explain why so many confrontations with the police occur. Finally, the police are not uncommonly brought into contact with the offender in the context of domestic disputes or public places where disorderly conduct is more likely to occur.

Table 17 - Victims of Subjects' Criminal Offending	
	(n=29)
Stranger	20.7%
Acquaintance	3.4%
Friend	3.4%
Unspecified child	6.9%
Intimate partner	34.5%
Family member	51.7%
Police officer	31%

The sentence outcomes are provided in 34 per cent of the case files. All of the reported sentences involved a period of incarceration (see Table 18). While none of the case files provide any indication for why a subject was sentenced to custody, several possible explanations include the serious nature of most of the offences, the victim profile, the offending history of the subject, the subject's psychological problems and the subject's substance abuse history. Only three files report that the subject participated in any traditional Aboriginal-based interventions as a result of their criminal dispositions.

Table 18 - Sentences That Subjects Received for Criminal Activity	
	(n=34)
Fine	20.9%
Probation	39.5%
Prison sentence	100%
Loss of driver's license	14%
Mandated treatment	11.6%
Shame feast	9.3%

Sexual Problems and Deviations

As indicated in Table 19, only six case files provide any information about the subject's sexual problems and deviations before attending residential school. In these cases, three subjects report sexual anxiety and three report homosexual anxiety. Eleven case files include information on the sexual problems and deviations of subjects during residential school. There are too few case files in the pre-residential school and during residential school periods to detect any patterns, however, sexual anxiety is evident in both

time periods. In contrast to the "pre" and "during" residential school periods, several sexual problems are extensive in the post-residential school period. It is not evident why the number of case files reporting sexual problems and deviations is not higher for this time period given the widespread anecdotal history of institutional sexual abuse. It may be that the residential school Survivors are more likely to have identified their sexual problems in the post-residential school period because of the trauma and shame they felt during childhood and early adolescence. Support for this trauma-based explanation is provided in the following section on mental health profiles.

Table 19 - Sexual Problems and Deviations

	Pre-Residential School (n=6)	During Residential School (n=11)	Post-Residential School (n=53)
Sexual anxiety	50%	18.2%	60.4%
Homosexual anxiety	50%	-	30.2%
Erectile dysfunction	-	-	26.4%
Confusion regarding sexual orientation	-	18.2%	22.6%
Unable to have intercourse	-	-	11.3%
Negative feelings about self during sex	-	18.2%	26.4%
Premature ejaculation	-	18.2%	30.2%
Easily over stimulated	-	18.2%	11.3%
Discomfort ejaculating	-	-	18.9%
Negative body image	-	-	11.3%
Difficulties ejaculating	-	-	11.3%
Unable to masturbate	-	-	7.5%
Sexual relations with age inappropriate people	-	36.7%	11.3%
Aggressive sexual behaviour	-	-	11.3%
Afraid of sexual contact	-	-	3.8%
Arousal to non-consenting people	-	-	3.8%
Incest	-	-	7.5%
No sexual problems or deviations	-	18.2%	52.3%

Chapter 5

Physical Health Profiles

Physical health information was available in 43 case files. Virtually every file mentioned the presence of chronic headaches. This ailment is one of the characteristics of PTSD and this result is not surprising since, as will be discussed below, it is the most frequently diagnosed mental disorder among residential school Survivors. Heart problems are the next most frequently diagnosed category (41.9 per cent) and includes a wide range of ailments including high blood pressure, arteriosclerosis, angina and hypertension. Slightly more than a quarter of the sample (27.9 per cent) suffer from some form of arthritis. Finally, cancer was evident in 18.6 per cent of the case files. Stomach and liver-related diseases were not frequent as liver disease was only mentioned in two case files and ulcers were reported in only five case files. Diabetes was unexpectedly low, with only three cases mentioned, as Aboriginal people have disproportionately high rates of this disease. A wide range of other health problems were infrequently mentioned in the case files, such as human immunodeficiency virus (HIV), fetal alcohol syndrome, meningitis and lupus erythematosus.

Mental Health Profiles

Three-quarters of the case files (74.8 per cent) provide information about the current mental health of the subjects. Of these case files, only two indicate that the subject did not suffer a mental disorder. As expected, based on the mental health literature on residential school Survivors, the most commonly diagnosed disorder is post-traumatic stress disorder (64.2 per cent), followed by substance abuse disorder (26.3 per cent), major depression (21.1 per cent) and dysthymic disorder (20 per cent) (see Table 20).

Table 20 - Subject's Mental Health Diagnoses	
	(n=93)
Major depression	21.1%
Anxiety disorder	7.4%
Anti-social personality disorder	3.2%
Substance abuse disorder	26.3%
Conduct disorder	3.2%
Adjustment disorder	3.2%
Paranoia	1.1%
Obsessive-compulsive personality disorder	7.4%
Panic disorder	4.2%
Post-traumatic stress disorder	64.2%
Sexual dysfunction	6.3%
Borderline personality disorder	7.4%
Schizoid personality disorder	6.3%
Stuttering	8.4%
Dysthymic disorder	20%
Avoidant personality disorder	3.2%
Impulse control disorder	7.4%
Acute stress disorder	4.2%
Adjustment disorder with depressed mood	4.2%
Depressive disorder not otherwise specified	3.2%
Residential school syndrome	6.3%

Of those diagnosed with PTSD, nearly half (49.5 per cent) are co-morbid with at least one other mental disorder. Again, consistent with the literature, the most common co-morbid disorders with PTSD in the sample are: major depression (30.4 per cent); substance abuse disorder (34.8 per cent); avoidance personality disorder (26.1 per cent); anxiety disorder; obsessive-compulsive personality disorder; dependent personality disorder; and borderline personality disorder (13 per cent) (see Table 21).

Table 21 - Co-Morbidity With Post-Traumatic Stress Disorder	
	(n=46)
Major depression	30.4%
Anxiety disorder	15.2%
Anti-social personality disorder	2.2%
Substance abuse disorder	34.8%
Conduct disorder	4.3%
Obsessive-compulsive personality disorder	13%
Panic disorder	6.5%
Sexual dysfunction	10.9%
Borderline personality disorder	5.7%
Schizoid personality disorder	6.5%
Stuttering	10.9%
Dysthymic disorder	26.1%
Impulse control disorder	8.7%
Acute Stress disorder	4.3%
Adjustment disorder with depressed mood	2.2%
Depressive disorder not otherwise specified	2.2%
Residential school syndrome	4.3%

The majority of case files for those subjects with PTSD (59.3 per cent) include an overall prognosis for the subject. Using a 4-point scale anchored by very poor and good, 40 per cent of the subjects have a positive overall prognosis. However, very few case files contain more specific prognoses. Only 11 case files contain detailed information about the mental health prognosis of the subjects and only two subjects have a detailed or specified positive prognosis. Five case files report on physical health with two subjects having a positive prognosis. Eight case files provide an education prognosis with four subjects having a positive prognosis. Three case files have a behavioural prognosis with all three being poor and 11 case files provide a vocational prognosis with six subjects having a positive prognosis.

Approximately one-fifth of all the case files (22 per cent) provide recommendations for mental health treatment. The most common treatment recommendation is cognitive therapy (46.4 per cent) followed by residential counselling (28.4 per cent), cognitive-behavioural treatment (25 per cent) and treatment to deal with a negative self-image (10.7 per cent). For the subjects who are diagnosed with PTSD, 22.5 per cent have treatment recommendations. Similar to the larger sample, 47.6 per cent have recommendations for cognitive therapy, 28.6 per cent for cognitive-behavioural treatment, 28.6 per cent for residential counselling and 14.3 per cent have recommendations for treatment to address a negative self-image.

Chapter 6

Conclusions

The residential school Survivor sample utilized in this study involves mainly males; however, approximately one-third are females. The mean age of the total sample is 48.5 years old. The 127 subjects are from a wide range of communities and First Nations. Since the sample subjects were not randomly selected from the population of all residential school Survivors in Canada but rather from only those litigants in British Columbia who had been assessed by the three clinicians involved in this research project, it is not evident whether this sample is representative of the population of residential school Survivors in Canada.

It might be argued that this sample represents the most extreme cases because of the project's selection process, i.e., the underlying assumption is that the decision of a residential school Survivor to undergo the stressful experience of litigation in the public legal system and at least one clinical assessment is more likely to involve those Aboriginal victims who were the most severely abused. While the results of this research project have limited generalizations, nonetheless, they represent an extremely important initial step in providing a more systematic and quantitative understanding of the major policy issues involving residential school Survivors in Canada.

Where possible, the code book was structured to obtain information about the sample subjects in three successive time periods in their lives: prior to entering the residential school system; during residential school; and post-residential school experience. As expected, the most detailed data was available for the last period, while the least amount of information was reported for the pre-residential school period. Since the average age marking the end of the pre-residential school period is 8.5 years old, it is not surprising that memory or recollection of events from early childhood are less complete than in the subsequent periods.

In addition, the data in the clinical assessments vary considerably, in part, because of both the different clinical interview approaches of the three assessing clinicians and their focus on events from the residential school period and the post-residential school period. Also, the recollection of events concerning the residential school Survivor's family is limited by the absence of regular contact during the residential school period.

Chapter 6

The family profile did change for many residential school Survivors in the post-residential school period. In a majority of case files, both parents were identified as legal guardians in the pre-residential school period, while only a small minority returned to two-parent families that were intact. Given the mean age of leaving the residential school system was 14.6 years old, many adolescents had to cope not only with what occurred to them in the "total institution" of residential schools, but also the disorientation of broken families.

Regarding post-residential school education, most subjects (55.3 per cent) did not continue. Nearly one-fifth were expelled from schools and nearly half simply quit. While no direct link can be made to a subject's negative residential school experience and the high educational drop-out rate, this inference is not untenable. Equally important, slightly more than one-quarter (27.3 per cent) did attend post secondary institutions even though there was no information concerning graduation rates. Available information about the job profiles of subjects indicates that there was an equal division between subjects who had jobs requiring no formal training or education and those requiring either some moderate and/or extensive training or education.

Alcohol use appears to be associated, in part, to residential school experiences since consumption rates vary from a minority (17.9 per cent) of users in the pre-residential school period to nearly all subjects (87.5 per cent) consuming alcohol during residential school and the same approximate figure (90.9 per cent) in the post-residential school period. While age is an important determinant of alcohol use, it does not solely account for such a pervasive consumption rate. The surprising result from the data was the enormous decline in parental alcohol use from the pre-residential school and during residential school periods to the post-residential school period.

This unexpected result is most likely an artifact of the vast differences in the number of case files (24 and 28) for the first two time periods versus the final time period (110 case files) that contain references to alcohol use. Again, there is the concern that recall of such events is not as reliable among subjects regarding the family situations in early childhood and adolescent periods. As well, the subject rates of alcohol use stand in sharp contrast to parental rates in the post-residential school period; more than three-quarters (78.9 per cent) of subjects report having abused alcohol. In the same period, marijuana abuse is evident in nearly two-thirds (63 per cent) of the case files.

In contrast, there are a few references regarding the use of hard drugs, such as heroin, cocaine and inhalants. More than one-quarter (28.3 per cent) of the case files mention that alcohol problems caused difficulties with family and/or other intimate partners.

Nearly all (92.5 per cent) of the subjects were married at least once, and slightly less than half (42.6 per cent) more than once. Importantly, given the anger identified in the research literature as resulting from the harsh discipline and abuse in residential schools, nearly three-quarters of the case files do not mention actual, attempted or threatened harm that subjects have directed toward their partners and intimates. In the remaining case files, violence between one or the other partner was limited to a few relationships (11.7 per cent and 13.3 per cent).

These results are in stark contrast to the abuse and physical violence experienced by all of the subjects during the residential school period. Most files (89 per cent) contain some information that allowed for a very limited comparison among the three historical periods. Approximately one-fifth (18.5 per cent) of the case files indicate no abuse of the subjects as a child during the pre-residential school period. The few cases mentioning physical abuse usually involved parents as the abuser. However, the abuse profile, as expected for this sample, changed drastically during the residential school period. Only four per cent of the case files report no abuse.

For the case files in which some form of abuse was indicated, all of the subjects were sexually assaulted and emotionally and/or psychologically abused. Most subjects (89.6 per cent) were also physically abused. The most frequent abusers were dorm staff (25.6 per cent) and residential school staff (19.2 per cent). One-tenth of the abusers were classmates. Again, it is evident that both the structure of staff authority and vulnerability to other residential school students combined to facilitate the pervasive and multiple abuses against this sample of residential school Survivors.

What is not available in this sample is data that could help identify and explain the particular vulnerabilities of these residential school students compared to those who escaped abuse. While there are too few case files (19.7 per cent) to infer a broad trend, those subjects whose children were abused all suffered sexual assaults. The issue here is whether the residential school abuse instigated intergenerational vulnerability for perpetuating abuse. Again, there is some limited support that suggests some of the subjects' children were vulnerable, at least, to sexual abuse.

As mentioned above, only in a minor number of case files (18.1 per cent) is there any evidence that the abused became an abuser. Most of this abuse (82.6 per cent) is directed towards partners; however, children are also less frequent victims.

A related issue is whether there is any association between the residential school experience and subsequent criminality. Again, an explanation found in the literature on residential school Survivors is that unresolved anger issues, especially those that involve deep resentment towards authority figures, such as the police, can be related to violent behaviour. More specifically, anger management difficulties are hypothesized as one reason why those suffering from residential school syndrome have disproportionate problems with the criminal justice system. There is some support for this relationship since approximately half of the case files (49 per cent) indicate criminal charges where the subject was then convicted.

Equally important, in terms of the anger theme, is the high rate of conviction for sexual assault (51.6 percent) and the slightly higher rate for assault convictions (55 per cent). Nearly two-thirds (64.5 per cent) of case files where information was available report convictions for major driving offences. It is not evident if alcohol abuse was involved in these charges. However, it is possible that, at least in some of these incidents, alcohol was a contributing factor given the extremely high rate of alcohol abuse in this sample during the post-residential period when all of these charges occurred.

In slightly more than half (51 per cent) of these criminal incidents, the victims were either police officers (31 per cent) or strangers (20 per cent). Since there could have been multiple victims involved in a single incident, it might be possible that the police were victimized as a result of their involvement in violent domestic disputes and other confrontational contexts, such as bars. This multiple victim scenario is likely, given intimate partners and family members together constituted 87.2 per cent of the victims. The seriousness of many of these charges generally is evident in the astonishing finding that all convicted offenders in this sample, at some point, received a prison sentence.

The file data did not allow for an assessment of whether the prison experience aggravated the problems of this sample of residential school Survivors, although one case file reported that the subject had been physically abused by a federal inmate and two case files indicate sexual abuse by a federal inmate. Moreover, with a few possible exceptions, it is difficult to avoid the inference that, in some respects, the "total institution" structure of prisons is not unlike the structure of residential schools. Given the high

prevalence of PTSD among the sample's subjects, it is also likely that prison may serve to aggravate this mental health disorder. A related health problem likely compounds the negative impact of prison. Where health information is available in the case files (33 per cent), every file mentioned the presence of chronic headaches. This ailment, along with other physical problems, is associated with PTSD and the related residential school syndrome.

Mental health information is evident in approximately three-quarters (73.2 per cent) of the case files. Only two of these case files stated that the subjects did not suffer a mental disorder. As expected, PTSD was diagnosed in nearly two-thirds (64.2 per cent) of these files. In turn, half of the PTSD cases were co-morbid with related mental illnesses, such as substance abuse disorder (34.8 per cent), major depression (30.4 per cent) and dysthymic disorder (26.1 per cent).

Since residential school syndrome is not an official DSM-IV clinical category, it is not surprising that only 4.3 per cent of the case files include this new disorder. It is important to remember that one of the clinicians originated the residential school syndrome category based on his extensive clinical experience with residential school Survivors. Despite the infrequency of this diagnosis in this sample, there is substantial support, particularly among many of those subjects with PTSD and co-morbid disorders, for the utility of residential school syndrome both for the better understanding of the specific impact of residential school abuse on Survivors and for the potential development of detailed treatment plans that, in turn, could increase the likelihood of more positive outcome prognoses.

All three clinicians involved in this research project did so, in part, to enhance their understanding of the complex mental health and health issues they consistently encounter in their extensive case involvement with Survivors of the residential school system. The development of the code book based on a sample of their cases is the first step in providing a research instrument that can be utilized in gathering systematic information from the thousands of other residential school Survivors' case files across Canada and even in other countries, such as Australia, New Zealand and the United States. The primary objective is to use the code book to gather information systematically from enough residential school Survivors to eventually allow for a more valid evaluation of the distinctive patterns of mental health disorders associated with residential school Survivors and the validation of such newly recognized syndromes as the residential school syndrome.

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