# Healing the Generations:

## *Post-Traumatic Stress and the Health Status of Aboriginal Populations in Canada*

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Abstract

The enduring impact of colonization and loss of culture are identified as critical health issues for Aboriginal populations. The authors discuss the concepts of historical and intergenerational trauma identifying steps to address the past as Aboriginal Peoples move forward to a healthy future. The authors analyze the enduring and unacceptable health inequalities between Aboriginal and non-Aboriginal people in Canada. This paper emphasizes the importance of addressing the substantial historical reasons for this inequality. The authors suggest that current popular explanations for such gross differences in health are limited and lack substantive historical perspective. Post-traumatic stress disorder is discussed critically as an important concept for understanding Aboriginal health inequalities. Post-traumatic stress response, versus disorder, is presented as a less stigmatizing and potentially culturally-appropriate framework to view the inequalities in a historical and political light. A historically and politically-based stress response is proposed as a framework for understanding the health inequities between Aboriginal and non-Aboriginal people to advance healing for indigenous people worldwide.

Key Words

Aboriginal, post-traumatic stress disorder/response, culture, residential schools, health, colonialism, historical trauma, intergenerational impact

## INTRODUCTION

> We have already paid the price. It's time to accept the many blessings that the creator has in store for us. We must honour our people who sacrificed everything through honouring ourselves and healing ourselves. By healing ourselves, we will also heal the wounds of our ancestors and the unborn generations.[1]

Canada is well-known for enjoying a high standard of living–among the best in the world–and for being an international leader in the theory and practice of health promotion. Canada has also been criticized because the health of Aboriginal Peoples in this country resembles that of people living in economically disadvantaged and underdeveloped countries. Aboriginal people die earlier than non-Aboriginal people and have a greater burden of physical and mental disease.[2] However, the reasons for this health inequality are not well understood. In this paper, the authors discuss the importance of acknowledging and addressing historical and intergenerational trauma in Aboriginal communities. Systemic racism, policies of assimilation, and cultural genocide are rarely identified as critical to contemporary health crises. Post-traumatic stress as a result of loss of culture and historical as well as intergenerational trauma is presented as an explanatory factor for the largely unexamined question of why gross health inequalities exist.

## HEALTH STATUS OF ABORIGINAL PEOPLES

> Issues of equity in health and well being for Canada's Aboriginal peoples are important to any vision of a just society.[3]

Despite tremendous progress, the health of the Aboriginal population in Canada continues to be significantly poorer than that of the national population.[4] A recent report on the Health of Off-Reserve Aboriginal Populations[5] found that Aboriginal people are 1.5 times more likely to have chronic health conditions and long-term restrictions on their activities than non-Aboriginal people. About 60 per cent were reported to have at least one chronic condition. High levels of diabetes and end-stage renal disease, cardiovascular disease, and some forms of cancer as well as injury and pneumonia[6] have been identified as more common in Aboriginal populations than the general Canadian population. Mental health issues or issues of imbalance are reflected in high levels of depression, addiction, and suicide rates.[7]

## Health Inequalities

There are enduring and unacceptable inequalities in the health of Aboriginal Peoples. The authors propose that there is a real, yet largely unaddressed, historical reason for these health inequalities. Mental health and social problems in Aboriginal communities have been linked to social and cultural disruption and historical trauma. However, the physical health of the population has not been adequately nor consistently linked to the historical and social-political context of the lives of Aboriginal people. This failure to remember and hold significant the history and long-term impact of domination and cultural genocide has led to limitations in current explanatory frameworks and to inadequate health interventions.

As a whole, Aboriginal populations still suffer from gross social and economic inequalities compared to non-Aboriginal Canadians. Many Aboriginal communities suffer incomes well below the poverty line, high levels of unemployment, low rates of high school completion, and inadequate housing (20 per cent of Aboriginal communities in Canada still have limited or no access to clean water).[8] Social and structural injustices compounded by unequal access to health information and services all contribute to the striking differential in health status between Aboriginal and non-Aboriginal populations. However, recent evidence from Statistics Canada based on data from the Canadian 2001 Community Health Survey has identified that the severe health inequities endured by Aboriginal populations cannot be accounted for simply in terms of low socio-economic status,[9] as is often suggested when discussing the health of Aboriginal Peoples. They also cannot be accounted for in health risk behaviours that frame health status within an individual's control. This is an important finding, one that challenges an individualistic approach to health inequities. That is, the health status of Aboriginal Peoples cannot be attributed solely or even largely to poverty or to individual choices and lifestyles, a common and limiting one-dimensional way of looking at issues of Aboriginal health.

This brings the key question of this paper into focus. What contributes to the enormous difference in health status between Aboriginal and non-Aboriginal populations? Despite extensive documentation of the health and social problems within Aboriginal communities, inadequate weight and attention outside of Aboriginal communities themselves has been given to the root source of these problems. By raising the question of historical stressors[10] and post-traumatic stress responses (PTSR) as critical to an understanding of current health status, the authors do not attempt to provide a simple solution to a complex and enduring challenge for Aboriginal communities. Rather, the authors wish to challenge the policies, programs, and health-funding strategies that fail to ask why this differential in health status exists and how it can be addressed in a timely manner. The question is no longer, What are the problems? The more appropriate questions are: Why do these differentials exist? What will be done to address these health inequities? What are successful models? and How can we implement them more widely?

## Loss of Culture, Historical Trauma, and Unresolved Grief

Articles on the health of Aboriginal people discuss the experience of collective and intergenerational trauma that has been referred to as the Native holocaust[11] and/or soul wound. The chronic trauma of both post-traumatic stress and intergenerational effects has been identified as historical trauma.[12] Historical trauma is referred to as collective emotional and psychological injury over the lifespan and across generations. It is viewed as resulting from a history of genocide with the effects being psychological, behavioural, and medical.[13]

Historical trauma response has been identified as a group of reactions to multigenerational, collective, historical wounding of the mind, emotions, and spirit. Historical trauma for Aboriginal populations is understood to be linked directly to the banning of cultural practices, policies and institutions of assimilation, and loss of culture. This is described as a process in which previously strong cultural identities,

rooted in traditional practices and world views, were devalued and replaced by cultures of dependence and imbalance.

> … under the relentless influence of forced assimilation, economic dependence and isolation, Aboriginal cultures have undergone a process of deculturation. Evidence for this process of cultural degeneration is found in such phenomena as alcoholism, substance abuse, suicide, family violence, sexual abuse, child neglect, vandalism and theft, all of which are epidemic in many Aboriginal communities. It is paramount to notice that none of these indicators of cultural and identity degeneration characterized pre-colonized Aboriginal culture.[14]

Deculturation, or cultural degeneration and loss, and related historical trauma are identified as leaving a "legacy of chronic trauma and unresolved grief across generations."[15] This devaluing and loss of culture has had long-term and intergenerational effects. It raises critical health challenges including new epidemics of injuries and social problems for Aboriginal communities. These have been identified as more difficult to address than the infectious diseases that historically killed many Aboriginal people and dramatically reduced the population of Aboriginal communities.[16] The compounding trauma of cultural devaluation and loss and social ills is therefore important to assess in attempting to understand the current health crises within Aboriginal populations.

## POST-TRAUMATIC STRESS AS A POTENTIAL FRAMEWORK FOR EXAMINING HEALTH DIFFERENTIALS

> You don't come with guns anymore; you don't have to. You come with briefcases and we kill ourselves.[17]

### Post-Traumatic Stress Disorder Defined

Post-traumatic stress disorder (PTSD) was first introduced into the American Diagnostic and Statistical Manual (DSM) in 1989.[18] Post-traumatic stress arises from external trauma and terrifying experiences that break a person's sense of predictability, vulnerability, and control.[19] Aboriginal Peoples' experiences of contact and cultural domination may reasonably be viewed as a loss of predictability and control and increases in vulnerability. As a case in point, a report on the mental health needs of 127 survivors of residential schools in British Columbia[20] found that 64.2 per cent of these individuals met the diagnostic criteria for PTSD.[21] While these individuals may have been more affected than others, as they were motivated to endure the hardships of court proceedings, there is nevertheless an important validation of the potentially high rates of post-traumatic stress in Aboriginal communities that have suffered the abuses of residential schooling.

In the United States, considerable research has been done on the issues of PTSD and intergenerational trauma. Historical trauma and unresolved grief have been identified as key issues for Native Americans.[22]

While not all Aboriginal people experience post-traumatic stress, current health inequalities suggest that historical trauma should at least be considered during diagnosis and treatment. The diagnostic criteria for PTSD include exposure to an external trauma that results in intense fear, helplessness, or terror that endures for 30 days or more and results in significant social or occupational distress. PTSD affects individuals in a vicious cycle of denial, avoidance, and becoming overwhelmed with memories and related feelings. The impact of PTSD affects the mind, emotions, body, and behaviour. Mentally, people who are traumatized may develop negative beliefs about themselves and their world. Emotionally, they may experience cycles of denial and anxiety. Physically, they can experience sleep disturbance, heightened sensitivity and anxiety, nightmares, and flashbacks. Behaviourally, they may avoid certain situations, isolate themselves socially, drink, and become increasingly aggressive. The three main characteristics of a PTSD affect the mind, emotions, and the body. The mind is affected by re-experiencing through dreams, flashbacks, unwanted memories, and repetitive thoughts. The emotions are affected by avoidance and numbing such as avoiding social contact, avoiding memory triggers, using alcohol or drugs to numb, and dissociation. The body is affected by exaggerated startle responses, sleeplessness, and anxiety.

### Four Factors Regarding Conceptual Relevance of PTSD to Aboriginal Health

While there is little representation of Aboriginal people in large population health studies on post-traumatic stress to date, post-traumatic stress has been used as a culturally-appropriate marker for Aboriginal

distress.[23] Despite the generally negative association society has with psychiatric diagnoses, the authors cautiously suggest that the diagnostic criteria for PTSD provides a useful model for beginning to understand the reason for the gross health inequities between Aboriginal populations and the non-Aboriginal Canadian population. PTSD has been criticized as a psychiatric term that "individualizes social problems and pathologizes traumatized people."[24] The authors argue that the uniqueness of the PTSD diagnosis within the DSM contradicts this criticism. The authors propose that the diagnostic profile provides a useful tool in confirming the long-term impact of colonialization, which may increase access to appropriate healing resources.

While the PTSD criteria were defined in terms of individual trauma, the diagnosis and treatment resources have also been applied to groups or populations affected by natural and man-made disasters and terrorism. The work of Eduardo Duran et al.[25] has paved the way to understanding and responding to trauma at the community and nation level. The authors agree with Bonnie Burstow[26] that healing from trauma should take place outside of a psychiatric frame and that a program of radical adult education will focus on strengths and capacities rather than illness. This is an existing practice of leading PTSD healing programs that are grounded in respect and support rather than blaming or focussing on weaknesses and illness.[27]

While the authors disagree with the use of the term "disorder," they believe the PTSD framework is an important model to consider in assessing the reason for and potential responses to current health inequalities. Post-traumatic stress is unique as a mental health diagnosis because one cannot meet diagnostic criteria unless there has been exposure to a traumatic event. What is observed among people who have been traumatized, therefore, is not a disorder but rather a stress response to horrific, intolerable events. The source or cause of the stress response has been defined as a traumatic event or series of events that occur outside the individual rather than resulting from an inherent psychological weakness. While the authors are cautious about suggesting an association with a psychiatric term in relation to the health of Aboriginal populations and specifically with the use of the terminology of DSM disorders, they find the unique criteria of PTSD worthy of review as a framework.

Firstly, PTSD allows for the naming of externally imposed trauma providing a social-historical context for what has too often been viewed as behaviours or conditions rooted in individual character flaws or cultural deficits.

Secondly, PTSD is useful in an Aboriginal health context because it defines an individual's behaviour as a human response to an external traumatic event rather than a personal weakness or pathology. The fundamental claim is that the person is not to blame for their traumatic experience nor their symptoms. Post-traumatic therapy assumes that the patient's current emotional problems are caused by the traumatic event rather than by an already existing mental illness. Stress reactions are identified as normal patterns of adaptation to extremely stressful life events. Post-traumatic therapy involves educating people about the nature and experience of stress responses, "which reduces a sense of isolation and fear of mental illness and restores a sense of personal control over symptom manifestation."[28] The individual or group and the therapist work together to create a safe and supportive relationship in which healing can occur and human dignity and peace with and within oneself can be restored.

Thirdly, PTSD is a reasonable explanatory model for Aboriginal health inequities due to the high degree of emotional distress related to PTSD and associated increases in alcohol use. A high degree of other emotional health issues, such as anxiety, depression, and substance abuse co-exists with PTSD.[29] Among individuals with PTSD who seek treatment, up to 80 per cent have at least one additional mental health diagnosis including affective disorders (26 to 65 per cent), alcohol and drug abuse (60 to 80 per cent), or anxiety disorders (30 to 60 per cent),[30] all of which have been cited as contemporary social and emotional problems in many Aboriginal communities. Self-medication is common among people who experience PTSD. People use alcohol or drugs to reduce symptoms, therefore, alcohol and drug dependency treatment is often a part of PTSD therapy.[31]

Fourthly, the PTSD explanatory model is associated with increased risks of physical health problems including heart disease, stomach problems, abnormalities in thyroid and other hormonal functions, increased infections and immunological disorders, chronic pain syndromes,[32] and other forms of illness.[33] In their recent book on PTSD, Edna Foa et al. state that "trauma survivors report more medical symptoms, use more medical services, [and] have more medical illnesses detected during a physical exam."[34] The correlation between Aboriginal health conditions and the health conditions associated with

post-traumatic stress provides considerable weight to the theory proposed in this paper that post-traumatic stress may be a major determinant of health within Aboriginal communities and a significant contributor to the current inequities between the health status of Aboriginal and non-Aboriginal populations.

## COPING RESPONSE VERSUS DISORDER

Having identified a strong rationale for investigating PTSD as a conceptual and clinical model for understanding current health inequities, the authors reject the term "disorder." Given the stigma attached to psychiatry and the negativity and implied weakness and or illness of the term "disorder," the authors propose an alternate term while drawing on the clinical evidence of the DSM. The authors suggest the term post-traumatic stress response (PTSR). PTSR more accurately reflects the diagnostic criteria of the diagnosis and is a more respectful term for use with both individuals and communities. PTSR moves beyond the negative association with blaming the person and provides a compassionate lens from which to better understand a realistic human response to trauma rooted in oppression and cultural domination. The PTSR model serves as a place to begin to discuss the factors contributing to the health inequalities endured by indigenous peoples worldwide.

The authors suggest that a PTSR model for understanding and addressing various forms of trauma including cultural degeneration and loss is a critical aspect of healing that will acknowledge historical trauma and promote healing within holistic programs culturally appropriate to the individuals and nations for which they are designed. The authors present five components of a PTSR model for addressing Aboriginal health inequities. They are:

1. an acknowledgment of a socio/historical context;
2. a reframing of stress responses;
3. a focus on holistic health and cultural renewal;
4. a proven psycho-educational and therapeutic approach; and
5. a communal and cultural model of grieving and healing.

### 1. Social/Historical Context

PTSR within Aboriginal communities may arise from a multitude of individual and community trauma, within and across generations. This compound trauma is referred to as historical trauma that is rooted in cultural loss. The Royal Commission on Aboriginal Peoples provides important documentation of the experiences of Aboriginal Peoples' in Canada. It makes a direct link between trauma and physical health. In the last 10 years, there have also been positive developments that have broken the silence surrounding residential schools.

Partnering and sharing information about the social/historical impacts on the health of indigenous people and conducting research between similar populations such as Aborigines in Australia, Maori in New Zealand, and First Nations and Native Americans in North America can serve to further enable society to understand some of the complex issues involved in providing more effective heath care. Solid partnerships with clear and concise goals in common can help further identify the relationship between historical trauma, health inequities, and strategies to improve health outcomes within and across indigenous communities in Canada and abroad.

### 2. Reframing Stress Responses

The PTSR model reframes PTSD symptoms as human responses to extreme circumstances. The disorder is clearly identified as a response to an external trauma that is outside the range of tolerable human experiences. The PTSR model promotes compassion for individuals and communities who have endured external trauma that is so profound that it affects their ability to cope. A process of naming historical and systemic sources of personal and social ills (imbalances) provides a critical, compassionate, and political lens from which to view current health inequities. As health care providers become more aware of the social/historical origins of distress, the more compassionate and therefore the more effective they can be in the delivery of health services to Aboriginal communities. As communities name historical stressors, stress responses can also be renamed and increasingly managed and transformed to health promoting behaviours and positive health outcomes.

### 3. Focus on Holistic Health and Culture Renewal

Most health initiatives, research, and services are designed to deal with specific aspects of health. There are mental health centres and health clinics. The mind and body dualism of the western medical model continues to be maintained within the mainstream health care system. For example, independent research and services are funded for heart health, diabetes, and cancer care despite the existence of com-

mon risk factors. A PTSR model views mental health and physical health as inseparable. The PTSR model looks at life experiences and environmental stressors as preconditions for health and illness. It promotes a holistic perspective on health that is consistent with cultural concepts of the Medicine Wheel with its focus on the interaction and balancing of the mind, emotions, spirit, and body. Post-traumatic stress is characterized by intense and constant effects on the mind, body, emotions, and spirit. Mainstream therapy for PTSD has responded to the need for respectful approaches to healing that incorporate a lifespan approach to healing, focus on capacity building, and address all aspects of the person's response. This includes behavioural responses that need addictions counselling as part of, or in addition to, PTSD counselling programs. A PTSR model would acknowledge historical stressors and the importance of culture, Elders, community processes, and traditional healing.

### 4. Proven Psycho-Educational and Therapeutic Approaches

People can and do recover from post-traumatic stress and heal the mental, physical, emotional, and spiritual wounds. Great attention has been given to the clinical and therapeutic aspects of responding to post-traumatic stress, in particular since the Vietnam and Gulf wars and since the 1980s when society began to break the silence on child sexual abuse. There are effective psycho-educational and therapeutic approaches to addressing trauma that can be adapted to Aboriginal settings and approaches to historical trauma that have been proven effective among the Lakota First Nation. In particular, there are four main aspects to healing from trauma. These include attending to:

i. the mind by remembering, speaking, and coming to terms with the horrifying, overwhelming experience(s) that led to the trauma response;
ii. the body by learning to acknowledge and master the physical stress responses like anxiety and sleeplessness;
iii. the emotions by re-establishing relationships and secure social connections; and
iv. the spirit by recognizing that the spiritual and the cultural have often been critical aspects of the original wound or trauma for Aboriginal people.

This aspect of trauma work can be seen in the Qul Aun Healing Initiative that promotes well-being and pride in Aboriginal identity through the use of traditional cultural approaches to treatment.[35]

### 5. Communal and Cultural Models of Grieving and Healing

The therapeutic approaches to PTSD are consistent with Aboriginal values of respect, care, and collective models of healing. PTSD healing programs are often conducted in communities reflecting the recognition of a common human response to stress. Most PTSD therapy is done with both individual and group programming. There is great benefit in bringing people together who share a history of trauma. They can identify with one another and further accept their stress responses and support a path to wellness.

There are rich traditions of healing and purification practices in Aboriginal cultures that can be used to help people grieve, to share their experiences of common trauma reactions, and to reduce trauma through increased understanding and cultural renewal.[36] Cultural ceremonies provide individuals, families, and communities structures within which to acknowledge and mourn common wounds. Group healing, within ceremonies, reduces isolation; alleviates guilt, shame, and anger; and enhances feelings of self worth.

The Condolence Ceremony of the Haudenosaunee (Iroquois) is a perfect example of a cultural process wherein part of the group (the non-mourners) act as caretakers to those who are mourning—wiping their eyes so they can see more clearly; cleaning their ears so they may again be able to hear the truth; and clearing their throat so they may once again breathe, speak, and eat in a healthy manner.

## MOVING FORWARD: HEALING THE GENERATIONS

Mainstream health interventions directed towards Aboriginal populations are often developed outside of a historical, cultural framework. Health programs are most often disease-specific, focussing primarily on the physical aspect of an individual rather than the emotional, cultural, mental, and spiritual (holistic) aspects of health. Little or no attention is given to personal and collective histories and related trauma. However, prior experiences in attempting to eliminate health inequities have indicated the importance of combining traditional Aboriginal healing methods within a critical historical perspective, along with available western medical resources.[37] The report of the Royal Commission on Aboriginal Peoples[38] emphasized the importance of Aboriginal perspectives on health. It includes a belief in, and understanding of, the complex relationships between body, mind, emo-

tions, and spirit and the importance of knowing and naming Aboriginal histories and experience.

Various programs have been designed specifically to address historical trauma such as the Aboriginal Healing Foundation (AHF)–an important Canadian initiative that addresses the impact of residential schools. The AHF vision statement focuses on well-being achieved by addressing personal and intergenerational trauma, ending cycles of abuse, and building strength and resiliency in survivors of residential schooling. The AHF programming has identified four phases to community healing: The Journey Begins, Gathering Momentum, Hitting the Wall, and From Healing to Transformation.[39] (See Table 1.) These four phase describe a developmental process characterized by moving from crisis to transformation.

These developmental phases are applicable to a wider range of historical and contemporary health and social concerns. The four main elements of community healing that are identified are: leadership, psycho-educational programming, capacity building, and systemic healing. These active phases can shift communities from supporting problem-focussed programming to sustainable health promoting programs and communities grounded in awareness of history and culture.

The Takini Network in the United States has developed expertise relevant to phases two and three of community healing. They conduct research and provide community education and healing to address historical trauma among American Indians.[40] The Takini Network's psycho-educational model for addressing historical trauma is organized around three major themes: trauma testimony, trauma response issues, and moving beyond trauma. The Takini Network's programs focus on education about the historical trauma and its impact, discussing the past in a supportive group context, providing emotional release through collective mourning/healing on both individual and community levels, and reconnecting with traditional cultural values. The Takini Network found tremendous success and benefit in their programming. All of the participants found the intervention helped them with their grief resolution and felt better about themselves after the intervention. Nearly all (97 per cent) felt they could make a constructive commitment to the memory of their ancestors. In a related study,[41] the participants also experienced improvement in their parenting. Participants in the group interventions of the Takini Network report beginning to understand why they have been feeling so bad and why they have been experiencing so many health and social problems. With this understanding, their pain is transformed into a powerful, life-giving force. These findings illustrate the benefits of including psycho-educational and critical adult education components in healing programs where individuals and groups give meaning to their experience and are empowered to heal and move beyond their pain though knowledge, support, and culture.

Table 1: Four Phases to Community Healing

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|---|
| ***Phase 1: The Journey Begins*** |
| Gathering of a core group of people begin to address their own healing needs |
| ***Phase 2: Gathering Momentum*** |
| Increasing in healing activity with recognition of root causes of addiction and abuse though community-wide awareness workshops |
| ***Phase 3: Hitting the Wall*** |
| Building healing capacity by providing training and employment with a focus on community development |
| ***Phase 4: From Healing to Transformation*** |
| Shifting from fixing problems to transforming systems |

The work of the AHF and the Takini Network illustrate critical elements of community development and healing programs that can inform Aboriginal health programming to deal with historical stressors as a shared legacy and which draw upon culture as a common key to wellness and the elimination of health inequities.

## OPPORTUNITIES AND KEY SECTORS

Within Canada, Aboriginal structures have been developed that could provide and support leadership for partnership development, research, healing, and knowledge sharing in response to PTSR. The creation of the National Aboriginal Health Organization (NAHO) and the *Journal of Aboriginal Health*; the Institute of Aboriginal Peoples Health; the AHF; and the agreement between Canada, New Zealand, and Australia are important developments in Aboriginal health. Each promotes access to information, capacity building, and self-determination in health with attention to traditional knowledge, success stories, health determinants, and Aboriginal cultures. These are important vehicles for examining the intersection of the past and the present, for addressing the impact of cul-

tural loss and intergenerational trauma, and improving the health status of indigenous peoples in Canada and elsewhere.

Holistic, collaborative health support systems have been identified as important as well as governments that are prepared to address "the racism that remains a barrier to progress in (the) health of indigenous people(s)."[42] Post-traumatic stress is a compassionate and useful lens to consider the gross health inequities endured by indigenous peoples within Canada and around the world. The AHF examples are important to the health of Aboriginal individuals, families, communities, and nations. The authors believe the mandate and funding frame of the AHF, or a parallel organization, should be broadened to expand beyond residential schooling to larger issues of cultural loss and historical and intergenerational trauma. Further Aboriginal research and programming in the area of historical trauma that attends to the specific links between trauma and physical health is required to address health inequalities.

More education for all levels of health care providers, researchers, policy-makers, and practitioners is required for the impact of cultural loss and historical trauma to be understood, recognized, and responded to appropriately. Those who work in any of these fields should understand the principles of PTSR assessment and treatment, be informed about traditional and cultural approaches to trauma, and be aware of the potential links between trauma and health status. The authors support emerging health discussions in which historical and intergenerational trauma are viewed as contributing factors to existing health inequalities and not only as contributors to mental health and social problems. These would be addressed across all sectors: research, health, education, and community.

- Further research, policy development, communications, and programming needs to be done by a consortium of Aboriginal organizations to understand and attend to both the historical and contemporary reasons for health inequalities with attention to links between cultural loss and historical trauma.
- Culturally-sensitive delivery of health models that shift the health discussions from a dualistic (mind and body) to a holistic framework are needed. Post-traumatic stress should be a routine clinical question in diagnosis and assessment supported by appropriate clinical training in all of the health professions. Health services should support psycho-educational programming and offer culturally-appropriate and effective trauma recovery programming.
- Educators, on-reserve and off-reserve, at all levels from primary to post-secondary schools, should ensure that Aboriginal and non-Aboriginal students understand the impact of history and current social-political-economic relations on Aboriginal people and their health.
- Communities can engage in community development initiatives that reflect the four phases of the AHF model to promote wellness and adapt the Takini Network's proven psycho-educational programming in historical trauma to their individual community and culture.

## CONCLUSION

Knowledge about the health status of Aboriginal Peoples has largely been individualized and has been taken out of its historical and political context. In resistance and opposition to this stance, the authors have argued that the gross health inequalities between Aboriginal and non-Aboriginal people must be made a political issue. The current health status of the world's indigenous population is undoubtedly to some degree a result of injuries of colonialism and cultural loss characterized by systemic attempts at domination and cultural genocide. Future health policy and programs must address current structural inadequacies (including inequalities in environmental risk, inadequate housing, and lack of access to appropriate health services and information, etc.) in trying to address the inequalities between the health status of the Aboriginal and non-Aboriginal populations. However, as recent statistical data indicate, health inequities cannot be simply explained by socio-economic status or health behaviours. PTSR is a useful model for understanding and addressing health inequities as it:

1. provides a social/historical context for what has been incorrectly viewed as individual/cultural weaknesses, or illness;
2. confirms a holistic understanding of well-being and cultural renewal;
3. compassionately validates stress responses as appropriate human reaction to trauma;
4. offers access to proven psycho-educational and therapeutic approaches for addressing trauma; and
5. points to the use of group/community models for collective mourning, support, and healing.

PTSR is presented as a critical and compassionate lens from which to assess and respond to the health needs of Aboriginal people, families, and communi-

ties within an historical, contemporary, and holistic perspective that extends beyond mental health to implicate a broad range of health disparities worldwide.

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# Further Reading

## ETHNOCULTURAL ASPECTS OF POSTTRAUMATIC STRESS DISORDER

### Issues, Research and Clinical Applications

Edited by Anthony J. Marsella, Matthew J. Friedman, Ellen T. Gerrity, and Raymond Scurfield
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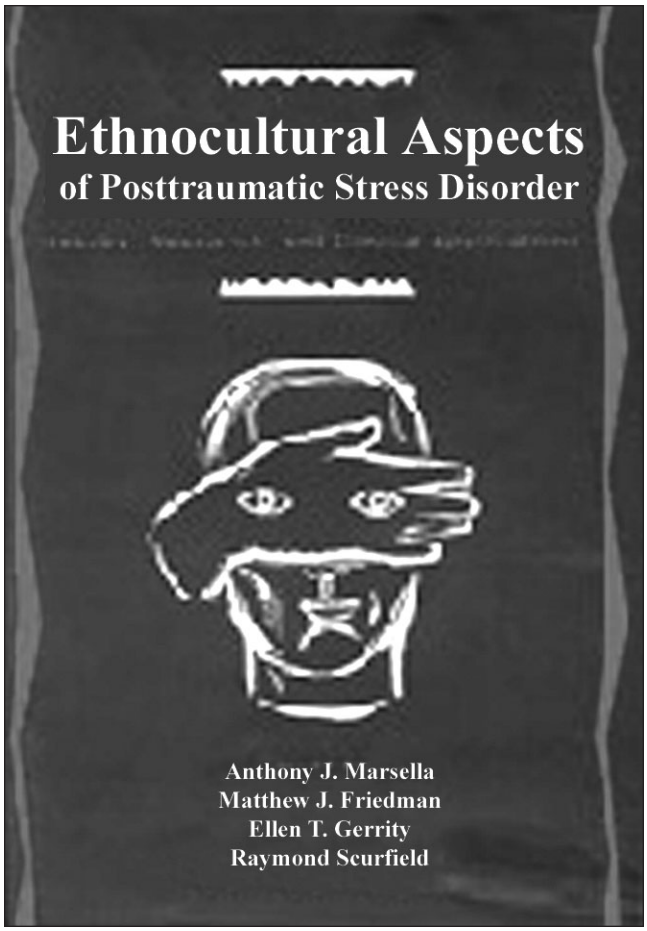


In recent years, the concept of post-traumatic stress disorder (PTSD) has captured the attention and concern of clinicians and scientists. Reactions to traumatic stress have been extensively studied. But are such reactions universal? Although the PTSD diagnosis is now used internationally, it is by no means clear whether it is meaningful across cultures and ethnic groups. Most of the research and clinical experience validating the diagnosis has been carried out in western industrialized nations. Some clinicians have raised the question of ethnocentric bias in its formulation.

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