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Healing Complex Trauma 1: A unity of minds, hearts, and culture

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Abstract

This article presents discussion suggesting that healing from complex trauma, including the intergenerational transmission of trauma, not only requires holistic treatment, but also training and educational resources for healthcare professionals to better facilitate healing. The training program is based on the mentoring process held in many Indigenous traditions throughout British Columbia, where one learns methods and theories through life experience. Tracing the contributing factors of trauma as it relates to colonisation and Indigenous wellbeing, this paper offers discussions for the necessity of reconceptualising the concept of trauma and its relationship with expressions of cyclical violence and compensatory behaviours to avoid reality, including sexual violence and substance use, respectively. This reconceptualisation of trauma, founded on ancestral teachings of a unity of heart, mind, and culture; draws on strengths of Western science while grounding itself in common Indigenous ancestral wisdom, informed an experimental curriculum entitled Healing Complex Trauma 1: Finding the Internal Language that served as both treatment and training module for 16 Indigenous (and two non-Indigenous) health and wellness service providers for Indigenous populations. The curriculum was developed by Dr Vickers in consultation with the Somatic Experiencing Trauma Institute and Dr Bessel van der Kolk, and was delivered in Tk'emlups territory British Columbia, Canada from May 28th—June 29th, 2018. The program found success through three distinctly hybrid treatment and educational streams, including a) the neurobiology of trauma, Beginner levels I, II, and III from the Somatic Experiencing (SE) Training Institute; b) group therapy for personal processing and experiential learning of SE methodologies; c) integration through art therapy and qi gong movement. The program was grounded on common cultural values and principles of respect and unity. One participant, an Indian Residential School Survivor, fluent in his Indigenous language and on faculty at an Indigenous training Institute remarked: "this program will always work." It is recommended that locations throughout the world experiencing high rates of trauma-related violence and compensatory behaviours, including sexual violence and substance use, integrate and promote curriculums that underline this aforementioned connection, including its deep colonial roots and intergenerational nature.

Keywords: Complex PTSD, Indigenous healing

practices, complex trauma training, humanising trauma

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> "as this week went by, I feel blessed that the greater power made me attend. The teaching and being able to connect with culture was quite different and made the learning easier and looking at the teaching from different aspects. I really enjoyed all the artwork we did continuously. Really helpful in opening ourselves to what we are doing. Great job ladies. Sechanalyah." (Healing Complex Trauma 1 Participant*)*

Introduction

Due in large part to the present collective inability for society to accept the facts of atrocities through domination/colonisation, resulting in health inequalities, and the limitations of the current and past health paradigm, First Nations people in British Colombia (B.C.) have taken control over their own health system governance to ensure that traditional holistic wellness perspectives are honoured (O'Neil et al., 2016). This transformation has included taking a holistic approach to what has typically been referred to as "mental health and substance use." This perspective on mental health and wellness involves moving away from an authoritative disease-based approach toward a perspective that proactively nurtures health through wellness founded on cultural values and principles associated with spiritual balance. This approach recognises the need for balance in mental, emotional, physical, and spiritual health while knowing that historical trauma is the ground that all behaviours emerge from. Thus, we recognise the importance of combining traditional knowledge of what spiritual balance means and how it relates to compulsive habitual behaviours that cause suffering to self and others.

While emergent research in the fields of developmental psychopathology, neurobiology, and neuroscience have provided explanatory frameworks for the field of trauma theory, the project of humanising trauma studies and its related social applications remains fledgeling (Visser, 2015). Humanising trauma is often conceptualised as a process of supporting the "cultural renaissance of the Red Man" through the promotion of Indigenous culture as a means to assist in remedying "post-colonial" anomie, and a lived rejection of the assimilatory practice of institutional colonialism (Gone, 2009, p. 690). For example, the Aboriginal Healing Foundation's *Framework for Understanding Trauma and Healing Related to Residential School Abuse* includes three pillars of healing that were deemed important, including cultural interventions, therapeutic healing, and reclaiming history (Archibald, 2006; Castellano, 2006). While these initiatives are recognised and certainly necessary, the process of humanising trauma in and of itself, including the behaviours that manifest through its "reliving", remains a prerequisite for healing. Just as active engagement for economic prosperity, social space, and Indigenous land title are essential components of reclamation; so too is engagement in the space of theory and its emergent, fluid, and capillarising discourses. Breaking with prior structures of power and meaning making that have calcified a domination-based model of mental health requires that the process of theoretical disenfranchisement be addressed as well, as colonisation remains an insidious two-fold möbius process featuring both the dehumanisation of consciousness as well as the consciousness of dehumanisation and domination. Comaroff and Comaroff (2008) maintain that through these processes Indigenous persons:

> are ushered…into the revelation of their own misery, are promised salvation through self-discovery and civilization, and are drawn into a

> conversation with the culture of modern capitalism—only to find themselves enmeshed, willingly or not, in its order of signs and values, interests and passions, wants and needs (p. xii).

Colonisation's two-fold ability to produce suffering through dehumanisation while concurrently constructing the paradigms through which that suffering, and, just as importantly, its Manichaean manifestations of "health" and liberation, are interpreted and "treated", is well illustrated within the field of trauma studies. For example, concepts of relational and intergenerational trauma stand diametrically opposed to how the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), first published in 1980, conceptualised trauma as a sudden, singular, and static disturbance that maintains a cozening presence in the subconscious as it awaits its "release" to come via therapy (American Psychological Association, 1980). To be "traumatised", according to this paradigm, is to take up residence in the colonial kingdom of strictly sharp and individualistic trauma as a personal event, with weakness, victimisation, fragility, and melancholia as the only outcomes. While the DSM has updated its conceptualisations of trauma, its initial framework remains foundational to the field of trauma theory (Visser, 2015), its colonial bias runs through newer versions of the DSM and the domain of mental health in general (Kirmayer & Minas, 2000).

The mental health and related socio-legal "justice" paradigms in Canada, which handle the offspring of deeply rooted complex trauma in the form of punishing "deviance", are born from and remain inextricably linked to conceptualisations of the "Indian Problem". It effectively closes eyes and ears to stories and visions of violence against Indigenous in Indian residential schools, federal day schools, Indian hospitals, foster care, the justice system, and land loss; evidenced by the gross lack of services that will assist with gaining spiritual balance through understanding individual and collective losses through generations of oppression. The subsequent and understandable percolation of anger, hatred, and resentment amongst Indigenous populations was, and in many ways, still is, rendered axiomatic by a violent suppression of ceremony, the honouring of emotions, and relationships with the supernatural, which further supports intergenerational transmission. This transmission is reinforced through experiences of racism and discrimination that Indigenous populations face when seeking healthcare (Browne & Fiske, 2001).

It has only been within the past decade that as First Nations clinicians, we are beginning to assert ancestral teachings of soul loss as it relates to traumatic experiences. Soul loss is the basic understanding taught by healers in past generations that when a traumatic event occurred, a part of the soul is broken away and is lost to the particular geographic location where the trauma occurred. Healing then, was a process of returning to the incident with the intention of understanding and retrieving the part of self held captive by the traumatic event (S. Mine-eskw, Nisga'a Nation, personal communication, 2000; B. McKay, Nisga'a Nation, personal communication, 2000; M. Brown, Gitxaala Nation, personal communication, 2006; D. Brown, Gitxaala Nation, personal communication, 2006; S. Collinson, Gitxaala Nation, personal communication, 2006).

As the truth of cultural oppression through domination (colonisation's connection) with present-day behaviours become increasingly recognised and realised, so too does the importance of interrupting the intergenerational transmission of trauma or collective soul loss. This interruption is happening through dedicated healing work that is rooted in reclamation, which is a remembering of the authentic self, ancestral protocol, which is the following of process of who does what, when, where, and how; and a knowledge of the psycho-physiology of trauma. The process of humanising the history and current-day reality of trauma necessitates that we blaze a clear path, recognising and understanding the thread of domination realities in models of mental health while addressing and (re)negotiating trauma in a manner that is culturally safe and specific while remaining mindful of the historical roots from which trauma originates. The clearing of a healing path must (re)negotiate and (re)conceptualise trauma outside of a definition that negates soul loss and spiritual imbalance as a result of dehumanisation. Additionally, it must find within the medical field the facts necessary to foster greater understandings of the behaviours that may

manifest as compensatory mechanisms or social behaviours used to evade a reality made intolerable through intergenerational dehumanisation. The weaving together of humanising principles with medicine, psychology, and ancestral law is the task at hand; a task that is especially pressing given the current prevalence of the compensatory behaviour of substance use within Vancouver and B.C. as a whole.

Intergenerational Trauma and Substance Use

Currently, Vancouver's Downtown Eastside (DTES) is the nucleus of the worst opioid overdose crisis in Canadian history. Due to the historical and ongoing legacies of colonisation, B.C. Indigenous persons are five-times as likely to experience an overdose event compared to the general B.C. population (First Nations Health Authority [FNHA], 2017). Despite mounting evidence that trauma plays a pivotal role in substance use, it remains absent from normative conceptual apparatuses used to make sense of substance use, illustrated by the absence of trauma as a concept used to explain excessive drug overdose deaths in Vancouver. For example, a recent report published by the British Columbia Coroner's Service (2018) mentions that over half (52%) of people who died as a result of drug overdoses were clinically diagnosed or had anecdotal evidence of a mental health disorder without mentioning trauma. Addiction expert and physician, Dr Gabor Maté calls on his extensive experience in the DTES to point out that the large majority of substance-use disorders (SUD) are rooted in trauma, and stresses that institutions working with Indigenous persons specifically must become "deeply trauma-informed. [including] Judges, teachers, law-enforcement personnel, nurses, doctors, psychiatrists, social workers, public employees, policy-makers [who] all must understand what trauma is, its multiple impacts on human mentality and behaviour, and how to address it" (Maté, 2016, para. 5). Maté's (2016) statement is consistent with wider findings that underline the comorbidity of trauma-related disorders (TRD) and SUD among the general population (Breslau, Davis, & Shultz, 2003; Kessler, 2000) and Indigenous populations specifically (Anderson & Collins, 2014; Boyd-Ball, Manson, Noonan, & Beals, 2006; Heart, 2003). Currently, SUD treatment outcomes and recruitment and retention levels continue to be adversely affected by not acknowledging trauma in interventions (Brown, Read, & Kahler, 2003; Ouimette & Brown, 2003). Additionally, relapse levels for residential detox programs remain upwards of 90% in some estimations (Smyth, Barry, Keenan, & Ducray, 2010) and current "gold-standard" treatments for trauma disorders, such as post-traumatic stress disorder, suffer from low retention and high drop-out rates (Najavits, 2015). It is becoming increasingly clear that innovative treatment methodologies that directly intervene in the underlying neurological bases of SUD and TRDs comorbidity must be explored.

Comorbidity between TRD and SUD are pronounced due to trauma directly shaping both the neurobiology and psychology of addiction in the brain (Maté, 2010), as the neurobiological alterations that characterise TRDs like post-traumatic stress disorders are complementary to those of SUDs (Ford & Russo, 2006). As Bessel van der Kolk (2014) succinctly states

> We have also begun to understand how overwhelming experiences affect our innermost sensations and our relationship to our physical reality—the core of who we are. We have learned that trauma is not just an event that took place sometime in the past; it is also the imprint left by that experience on mind, brain, and body. This imprint has ongoing consequences for how the human organism manages to survive in the present (p. 21).

This shift in our understanding of trauma has led to calls for trauma-related disorders to be conceptualised primarily as forms of information-processing and neural impairment that can be changed or healed. Indeed, experts and scholars are beginning to call for interventions and therapies to first and foremost address and/or improve neurological information processing functioning (Crittenden & Heller, 2017; van Der Kolk, 2006), which is an essential component in navigating and healing from SUDs (Ford & Russo, 2006). This direction recognises that if information-processing systems are not addressed prior to therapy, patients are often unable "step outside" their trauma enough to reflect on it and move forward (Van Der Kolk,

2014). Similar blockages in healing faculties and reductionist biomedical approaches to healing and justice also maintain a sense of helplessness among persons who become sexually violent.

Sexual Violence

Currently, the sexual assault rate for Indigenous persons is almost three times that of the general population (Boyce, 2016), however, similarly to SUD, punitive responses for sexual violence fail to account for the complex, collective, cumulative, and intergenerational qualities of colonialism and colonisation and may exacerbate and amplify the phenomenon.

Disproportionately high rates of sexual offending amongst Indigenous persons relate to the alarming frequency of physical and sexual abuse experienced during colonisation (Truth and Reconciliation Commission of Canda [TRC], 2015), as some have called Indian residential schools as nothing more than "institutionalized pedophilia" (Monchalin, 2016, p. 134) which has resulted in the intergenerational transmission of trauma (TRC, 2015). Sexual abuse is one of the most severe forms of trauma that can occur during childhood (Fox, Perez, Cass, Baglivio, & Epps, 2015) and voluminous research points to childhood trauma being a critical distal factor in developing sexually violent behaviour (Levenson, Willis, & Prescott, 2015; Levenson, Willis, & Prescott, 2016; Malamuth, Sockloskie, Koss, & Tanaka, 1991; Marshall & Marshall, 2000; McMackin, Leisen, Cusack, LaFrataa, & Litwin, 2002). Trauma, in turn, often manifests in criminality, as studies suggest up to 85% of male juvenile offenders have offence triggers related to prior trauma (McMackin at al., 2002). Additionally, historical and ongoing colonisation triggers the loss of identity and social support, the fragmentation of family, isolation, loneliness, and psychological stress; which are triggered and amplified by normative punitive policy processes (Robbers, 2009) thus paralysing pathways to recovery (Gone, 2009).

More specifically, the experience of childhood sexual abuse can become cyclical and manifest in lateral sexual violence, as histories of childhood sexual abuse are more prevalent amongst sexual abuse perpetrators (Fromuth & Conn, 1997; Fromuth, Burkhart, & Jones, 1991; McCloskey & Bailey, 2000; Seto & Lalumière, 2004). Furthermore, persons who have molested children and raped others have experienced significantly greater levels of childhood sexual abuse (Dhawan & Marshall, 1996; Marshall & Mazzucco, 1995; Marshall, Serran, & Cortoni, 2000). One explanatory model for this phenomenon is that disassociation, shame, and self-blame can arise from the experience of trauma and childhood sexual abuse, leading victims to not perceive the event as malicious and thus increase the possibility of offending in the future (Marshall & Marshall, 2000). Not only is this about intergenerational cyclic deregulation, it is also about the erosion of the collective soul.

Shame and self-blame mediate victims' abilities to recover from early traumatic experiences (Andrews, Brewin, Rose, & Kirk, 2000; Talbot, Talbot, & Tu, 2004), and these emotional states are exacerbated and amplified by normative punitive sex offender policy (Matravers, 2013). Indeed, victimisation is compounded, and traumatic symptoms are exacerbated by criminal justice proceedings (Campbell & Raja, 1999). As shame is associated with suicidality (Dutra, Callahan, Forman, Mendelsohn, and Herman, 2008), Herman (2012) explain that states of shame induced by trauma are indeed life-threatening. Locating a response to sex offence solely within the criminal justice system is not only "unlikely to offer an adequate or holistic approach to sexual offenders" (Brayford, Cowe, & Deering, 2013, p. 329) when employed with populations already experiencing high-rates of trauma, it can be potentially life-threatening. Maté (2016) states, "Alternative forms of justice must be developed, aligned with native traditions and in consultation with First Nations" (para. 6).

The Ojibway community of Hollow Water, encompassing four neighbouring communities of Manigotagan, Ahbaming, Seymourville, and Hollow Water in the province of Manitoba in Central Canada, has become an exemplar for community-based restorative justice movements (Sawatsky, 2009). The community was suffering from cyclical violence and compensatory behaviours to avoid reality, including sexual violence and substance use, and the justice system in Manitoba was ineffective in lessening the cycle.

Hollow Water had an alcohol abuse rate of almo-

st 100 per cent and an unemployment rate of over 70 per cent. Only as the community began to work at healing destructive patterns did they begin to understand how pervasive sexual violence was within the community. It dated back at least three generations, and estimates suggested that 66-80 per cent of the community were victims of sexual violence and 35-50 per cent of the community had initiated sexually violent acts themselves (Sawatsky, 2009). They had been conditioned through cultural oppression to accept abusive sexual relationships as normal. In developing a new relationship with the punitive justice system, Hollow Water waived incarceration as the primary mode of reconciling these injustices and instead looked to their ancestral values and principles along with knowledge of sexual compulsivity and offending to be their guidance toward establishing a healing pathway. Through encouraging and supporting traditional teachings and ceremonies, as well as developing a 13-step program for the disclosure of sexual abuse, and focusing on holistic healing involving the person who has committed sexual violence, the victim, the victim's families and the entire community, Hollow Water began to heal. Not only is it largely judged as a success within community it is also deemed a success by organisations such as the Aboriginal Corrections Policy Unit (1997) and a cost-effective one as well (Couture, 2001). Standardised punitive responses and interventions for sexual violence are failing Indigenous populations—but there is hope. The largest meta-analysis of restorative justice practices found that offenders in Restorative Justice (RJ) programs were three times less likely to re-offend than those processed through punitive systems (Latimer, Dowden & Muise, 2005) and RJ practices that incorporate local culturally-based protocol has been proven to be both cost-effective and successful (Couture, Parker, Couture, & Laboucane, 2001). Unfortunately, there is currently "no government willing to invest adequate resources in designing and developing the infrastructure and training necessary to reap the full potential of community justice" (Cayley, 1998, as cited in Couture et al., 2001, p. 91). The FNHA is strategically situated to utilise its relationships, partnerships, and knowledge to reverse these trends by way of collaborating with communities to envision and enact culturally safe and holistic programs to address, calm, and mitigate sexual violence.

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> Institutions and individuals interacting with First Nations people must become deeply trauma-informed . . .without such information, as I have witnessed repeatedly, the best-meaning people can unwittingly retraumatize those who can least bear further pain and loss (Maté, 2016, para. 5).

In recognition of the need for services that assist with gaining spiritual balance to move towards healing from intergenerational dehumanisation and community disruption, and drawing on inspiring success like that in Hollow Water, a program was created for healthcare professionals in B.C. This program, Healing Complex Trauma 1 (HCT1), sought a unity of heart, mind, and culture in servicing the people. It grounded itself in common Indigenous ancestral wisdom while also actively incorporating strengths of neurobiology and psychology, and was brought together for the primary purpose of fostering healing, both through providing opportunities for participants to understand the dynamics of intergenerational trauma and also allowing for healing techniques to be tested by the participants themselves through group therapy, so they understand, at a deeply personal level, that healing is possible.

The curriculum fosters greater understanding of the neurobiological mechanisms of trauma's operation while remaining grounded in traditional Indigenous culture and protocol in the programs and interventions it informs. A unity of teachings offers the distinctly different cultural sources of knowledge and understandings that inform the creation of this program; developed by Dr Patricia Vickers, an Indigenous psychotherapist from the Eagle clan in the village of Gitxaala, British Columbia; in consultation with Bessel van der Kolk, M.D., a former Harvard Medical School professor of psychiatry; and in cooperation with the Somatic Training Institute. This union of mind, heart, culture, and techniques is necessary given that trauma, whether accrued via intergenerational transmission or current conditions, manifests in phenomenon on a global scale. With non-

Indigenous facilitators and therapists, coordinated by Dr Vickers, the HCT1 training recognises that settlers seeking better relationships with their Indigenous neighbours must first learn to love and heal themselves, and that trust can shift the shape of fear and shame to truth and peace through teaching, understanding, compassion, and action.

The three-week training program was delivered in Tk'emlups territory British Columbia, Canada from May 28–June 29, 2018. The 16 participants were Indigenous service providers (with the exception of two non-Indigenous working with/in Indigenous programs) with an age variance of approximately 20 years, four are confirmed survivors of Indian residential school, six were fluent speakers of their Indigenous language with an even gender balance of participants. The final group consisted of 16 participants from the following Nations and treatment centres in B.C.: Lhoosk'uz Dené, Esk'etemc, Nenqayni Wellness Centre, Tsow-Tun Le Lum Society, Indian Residential School Survivors Society, Nazko First Nation, Yunesit'in Government, Wilp Si'Satxw, Carrier Chilcotin Tribal Council, Ashcroft Indian Band, and Round Lake Treatment Centre. The program found success through three distinctly hybrid treatment and educational streams, including a) the neurobiology of trauma, Beginner levels I, II, and III from the Somatic Experiencing (SE) Training Institute; b) group therapy for personal processing and experiential learning of SE methodologies, and; c) integration through art therapy and movement. Additionally, ceremonial brushing was offered twice a week by local practitioners, and a Sweat Lodge Ceremony was hosted each Friday by a local Pipe Carrier and Sweat Lodge Keeper. This program is founded on the sayings, "physician, heal thyself" and "you can only take a person as far as you've been yourself".

This 3-week project is both a brief treatment model and a training model. The program schedule was determined by the community and was facilitated every other week for a total of 15 training days. Those who completed the program are now co-facilitators for the second delivery of the program. This project-training model is grounded in international, research-based training models including Eye Movement Desensitizing and Reprocessing (EMDR), Low Energy Neurofeedback System (LENS), Somatic Experiencing (SE), and Neurosequential Model Treatment (NMT). The sequence for participants began with lectures and personal practice for integration, followed by assisting with service delivery before facilitating the program in the community.

The primary goal of this three-week program was to assist the participants with accessing a language and framework within which they can begin to understand and articulate their internal reality and see individual level trauma as it relates to the collective reality. Activities and services were designed to assist with

- understanding the neurobiology of trauma;
- understanding the connection between threat, emotion, and reason (creating meaning);
- understanding and describing to others personal experience in the collective reality;
- physical activities that assist with clearing energy and grounding (e.g., Qi Gong, yoga, and meditation) for daily practise; and
- communicating internal reality in a small group.

The primary purpose of the personal integration model is to reduce the shame core—the primary beliefs of worthlessness—that has developed largely through conditioning from cultural oppression over the past two hundred years and to assist the service providers to understand the process for restoring balance within themselves. The shame core inhibits spontaneous response to threat; and along with changes in the brain from repeated violence, shame either induces the nervous system in a highly activated state (stuck on "on"), the nervous system is shut down (stuck on "off"), or an extreme oscillation between these two. By addressing complex trauma and the shame core, the individual has a greater opportunity to discover their coherence and true nature with the resulting reality of self-awareness; self-inquiry skills; and a connection with self, others, and the collective with the resulting change in neuropathways in the brain. Once the individual has undertaken their own healing journey, their ability to identify and support others on their journey will expand.

Preliminary Evaluation Measures for HCT1

This evaluation moved forward with a deep understanding of the historical legacy of research and evaluation's failure to genuinely serve Indigenous persons and communities, and often insidiously harm them (LaFrance & Nichols, 2008; Smith, 2013), as well as the collective stress of being over-burdened and over analysed by evaluators (Smith, 2013). Due to this understanding, the preliminary evaluation measures used to assess HCT1 were delicate, compassionate, and limited in scope, comparatively speaking. A standardised post-evaluation design was used, including a brief survey and semi-structured interview methods, to assess participants views about the program, including its material and conduct; views of the efficacy of the facilitator, as well as their own feelings during the program. Additionally, in the spirit of participatory action research, qualitative semi-structured interviews solicited and assessed participants' ideas of program improvements at both the level of logistics and specifics, as well as larger systems-level recommendations for stage two of the program. Ultimately, it was a process of gathering information described by the generation of grandparents as relational inquiry. In the spirit of formative evaluation, during week one, opinions were collected, de-identified, aggregated, and disseminated to program facilitators to immediately improve the following week's curriculum and program conduct.

First, participants were asked to complete evaluations of the training program and facilitators at the end of weeks one and two. At the end of week one, 14/15 participants (94%) felt the material was well organised and presented in an easily understandable way, and 15/15 participants (100%) felt that integration activities contributed to learning; affirmed in participation; ceremonies and clinical support enhanced personal processing and wellness; content was relevant to the challenges of family, community, and clients; novel strategies and methods for addressing personal trauma were learned; and strategies and methods for addressing trauma that can be applied to help family, community, and clients were learned. Week two produced identical evaluation results.

In evaluating program facilitators, participants were overwhelmingly clear that throughout the program they felt heard and understood, respected, safe, clearly instructed, provided ample time for clarification, and were able to contribute. Evaluations were done on a binary scale of "yes" or "no". Understanding that participants felt comfortable and respected was essential to enable and increase the validity of the later evaluations, which asked participants to provide honest and raw feedback regarding the program.

At the closing of the third and final week of training, participants had an opportunity to share their overall opinions of the training through a group discussion. They provided recommendations for the structure, content, and approach for future curricula, as well as requests for future phases of the HCT1 program. The improvement suggestions as they related to programming logistics and specifics were

- some of the content was too technical – simplify medical language and concepts,
- provide handouts of all materials/slides,
- improve organisation (e.g., better audio, preparation of resources, etc.),
- inclusion of more self-care options (e.g., energy healer, reiki, massage),
- visuals for physiology/neurobiology,
- more use of role-play and other experiential modalities,
- explanation of therapy techniques from the beginning onward,
- more time dedicated to each topic/concept,
- modify information to spiritual curriculum.

Participants shared overwhelming support for the current structure and content of the training: from the group size, diversity to the schedule, and flow of content. Each component currently included in the training was validated as being critical to its success, as well as the approach and methods of the facilitators.

For example, one participant who works with cedar and spruce stated that:

> "The flow of each day, information, group therapy, art integration… enabled me to connect more to myself to do some more personal healing. As a class, we all moved forward together

> in a good way" (Healing Complex Trauma 1 Participant)

While another participant stated that:

> "The mixture of different tribal communities was a blessing. We webbed together and supported each other. I would be glad to get in as an observer on future training. We are coming together as First Nation's people. We need more trainings for other community department workers" (Healing Complex Trauma 1 Participant)

Additionally, there was consensus within the group to advocate for an opportunity to come back together in 2-3 months to allow for the continuation of the network of support and assessment of how the experiences of HCT1 have impacted graduates' work. The group also expressed a desire to support future HCT1 training as mentors and facilitators, bringing the strengths of each team member to other communities and treatment centres. There was also interest to continue as a committed group to stage two of HCT1 once it has been developed. Participants also brainstormed ways in which the HCT1 model could be built upon, including

- pursue accreditation for HCT1 through an academic institution;
- develop specialised streams related to Indian residential schools and sexual trauma;
- adapt training for communities: helpers, grandparents, teachers;
- support participants in staying connected to clients while in training (e.g., opportunities to share what is being learnt etc.);
- Integrate EMDR and neurofield therapy into the training;
- Incorporate more cultural healing (e.g., spirit and soul retrieval work, medicines, and teachings of Elders).

There were two additional discussions related to opportunities to contribute to emerging research with a First Nations perspective; including an opportunity to lead the way in neurotherapy research and implications for mental health and substance use; and adapting Adverse Childhood Experiences (ACEs) research to a First Nations context.

Conclusion

The misunderstanding and disease-based conceptualisation of trauma today is illustrated by the lack of services that can assist in gaining spiritual balance through understanding individual and collective losses through generations of oppression. The necessity for continuing to reconceptualise and integrate the concept of intergenerational trauma within the wider public health milieu is necessary in order to begin to heal cyclical violence and compensatory behaviours in B.C. and throughout the world.

Since the first draft of this paper, four of the sixteen participants of HCT1 have assisted with five brief training sessions; their understanding and healing continue. This article is not conclusive for it is the people themselves who will validate the effectiveness of the training through lived experience. Terminologies such as one heart, one mind, and spiritual balance are common between Indigenous nations in B.C. There is a reluctance to conclude as a writer or one who has developed the program, that HCT1 is the training program for all Indigenous peoples. To date, the fledgeling approach to trauma whether brief training or HCT1, the approach has been affirmed by Indigenous participants.

Peoples of different cultures and understandings of meaning and time have united in agreement regarding the necessities needed for healing, and strengthen the process through a diversity of techniques and concepts that unite hearts and minds. HCT1 shows great promise in assisting in healing from dehumanisation and supporting the change from compensatory behaviours to understanding, compassion, unity, and change—healing.

References

Aboriginal Corrections Policy Unit. (1997). *The four circles of Hollow Water*. Ottawa, Canada: Solicitor General of Canada.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

Anderson, J. T., & Collins, D. (2014). Prevalence and causes of urban homelessness among

Indigenous peoples: A three-country scoping review. *Housing Studies*, *29*(7), 959-976.

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of abnormal psychology, 109(*1), 69-73.

Archibald, L. (2006). *Final report of the Aboriginal Healing Foundation: Promising health practices in Aboriginal communities* (Vol. 3). Ottawa, Canada: Aboriginal Healing Foundation.

Boyce, J. (2016). Victimization of Aboriginal people in Canada, 2014. *Juristat, 36(1)*, 1-44.

Boyd-Ball, A. J., Manson, S. M., Noonan, C., & Beals, J. (2006). Traumatic events and alcohol use disorders among American Indian adolescents and young adults. *Journal of Traumatic Stress*, *19*(6), 937-947.

Brave Heart, M. Y. H. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, *35*(1), 7-13.

Brayford, J., Cowe, F., & Deering, J. (2013). Conclusion: Sex offenders: Punish, help, change or control? In J. Brayfor, F. Cowe, & J. Deering (Eds.), *Sex offenders: Punish, help, change or control? Theory, policy and practice explored.* New York, NY: Routledge.

Breslau, N., Davis, G. C., & Schultz, L. R. (2003). Posttraumatic stress disorder and the incidence of nicotine, alcohol, and other drug disorders in persons who have experienced trauma. *Archives of General Psychiatry*, *60*(3), 289-294.

British Columbia Coroners Service. (2018). *Illicit drug overdose deaths in BC: Findings of coroners' investigations.* Retrieved from https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicitdrugoverdosedeathsinbc-findingsofcoronersinvestigations-final.pdf

Brown, P. J., Read, J. P., & Kahler, C. W. (2003). Comorbid posttraumatic stress disorder and substance use disorders: Treatment outcomes and the role of coping. In P. Ouimette & P. J. Brown (Eds.), *Trauma and substance abuse cases, consequences, and treatment of comorbid disorders* (pp, 171-188). Washington, DC: American Psychological Association.

Browne, A. J., & Fiske, J. A. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, *23*(2), 126-147.

Campbell, R., & Raja, S. (1999). Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims, 14*(3), 261-275.

Castellano, M. B. (2006). Final report of the Aboriginal Healing Foundation: A healing journey: Reclaiming wellness (Vol. 1). Ottawa, Canada: Aboriginal Healing Foundation.

Comaroff, J., & Comaroff, J. L. (2008). *Of revelation and revolution: Christianity, colonialism, and consciousness in South Africa* (Vol. 1). Chicago, IL: University of Chicago Press.

Couture, J. E. (2001). Comments on Hollow Water community healing. In L. J. Kirmayer, M. E. Macdonald, & G. M. Brass (Eds.), *The mental health of Indigenous peoples*: *Proceedings of the Advanced Study Institute The Mental Health of Indigenous Peoples McGill Summer Program in Social and Cultural Psychiatry and the Aboriginal Mental Health Research Team* (pp.173-176). Montreal, Canada: Division of Social and Transcultural Psychiatry, McGill University.

Couture, J., Parker, T., Couture, R., & Laboucane, P. (2001). *A cost-benefit nalysis of Hollow Water's community holistic circle healing process.* Ottawa, Canada: Aboriginal Corrections Policy Unit, Solicitor General of Canada.

Crittenden, P. M., & Heller, M. B. (2017). The roots of chronic posttraumatic stress disorder: Childhood trauma, information processing, and self-protective strategies. *Chronic Stress*, *1*, 1-13.

Dhawan, S., & Marshall, W. L. (1996). Sexual abuse histories of sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *8*(1), 7-15.

Dutra, L., Callahan, K., Forman, E., Mendelsohn, M., & Herman, J. (2008). Core schemas and suicidality in a chronically traumatized

population. *The Journal of Nervous and Mental Disease, 196*(1), 71-74.

First Nations Health Authority (2017). Overdose data and First Nations In B.C.: Preliminary findings. Retrieved from: https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf

Ford, J. D., & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy (TARGET). *American Journal of psychotherapy*, *60*(4), 335-355.

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect, 46*, 163-173.

Fromuth, M. E., & Conn, V. E. (1997). Hidden perpetrators: Sexual molestation in a nonclinical sample of college women. *Journal of Interpersonal Violence, 12*(3), 456-465.

Fromuth, M. E., Burkhart, B. R., & Jones, C. W. (1991). Hidden child molestation: An investigation of adolescent perpetrators in a nonclinical sample. *Journal of Interpersonal Violence, 6*(3), 376-384.

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology, 77*(4) 751-762.

Herman, J. L. (2012). Shattered shame states and their repair. In J. Yellin & K. White (Eds.), *Shattered states: Disorganized attachment and its repair,* (pp. 157-170). London, England: Karnac Books.

Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry, 61*(Suppl. 5), 4-12.

Kirmayer, L. J., & Minas, H. (2000). The future of cultural psychiatry: An international perspective. *The Canadian Journal of Psychiatry*, *45*(5), 438-446.

LaFrance, J., & Nichols, R. (2008). Reframing evaluation: Defining an Indigenous evaluation framework. *The Canadian Journal of Program Evaluation*, *23*(2), 13-31.

Latimer, J., Dowden, C., & Muise, D. (2005). The effectiveness of restorative justice practices: A meta-analysis. *The Prison Journal*, *85*(2), 127-144.

Levenson, J. S., Willis, G. M., & Prescott, D. S. (2015). Adverse childhood experiences in the lives of female sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 27*(3), 258-283.

Levenson, J. S., Willis, G. M., & Prescott, D. S. (2016). Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. *Sexual Abuse: A Journal of Research and Treatment, 28*(4), 340-359.

Malamuth, N. M., Sockloskie, R. J., Koss, M. P., & Tanaka, J. S. (1991). Characteristics of aggressors against women: Testing a model using a national sample of college students. *Journal of Consulting and Clinical Psychology, 59*(5), 670-681.

Marshall, W. L., & Marshall, L. E. (2000). The origins of sexual offending. *Trauma, Violence, & Abuse, 1*(3), 250-263.

Marshall, W. L., & Mazzucco, A. (1995). Self-esteem and parental attachments in child molesters. *Sexual Abuse: A Journal of Research and Treatment 7*(4), 279-285.

Marshall, W. L., Serran, G. A., & Cortoni, F. A. (2000). Childhood attachments, sexual abuse, and their relationship to adult coping in child molesters. *Sexual Abuse: A Journal of Research and Treatment, 12*(1), 17-26.

Maté, G. (2010). *In the realm of hungry ghosts: Close encounters with addiction*. Berkeley, CA: North Atlantic Books.

Maté, G. (2016). Addiction, Trauma and Dispossession. Retrieved From http://www.fnha.ca/about/news-and-events/news/addiction-trauma-and-dispossession

Matravers, A. (2013). Setting some boundaries: Rethinking responses to sex offenders. In A.

Matravers, *Sex offenders in the community: Managing and reducing the risks* (pp. 1-28). https://doi.org/10.4324/9781315065618

McCloskey, L. A., & Bailey, J. A. (2000). The intergenerational transmission of risk for child sexual abuse. *Journal of Interpersonal Violence, 15*(10), 1019-1035.

McMackin, R. A., Leisen, M. B., Cusack, J. F., LaFratta, J., & Litwin, P. (2002). The relationship of trauma exposure to sex offending behavior among male juvenile offenders. *Journal of Child Sexual Abuse, 11*(2), 25-40.

Monchalin, L. (2016). *The colonial problem: An Indigenous perspective on crime and injustice in Canada*. Toronto, Canada: University of Toronto Press.

Najavits, L. M. (2015). The problem of dropout from "gold standard" PTSD therapies. *F1000Prime Reports, 7*(43).

O'Neil, J., Gallagher, J., Wylie, L., Bingham, B., Lavoie, J., Alcock, D., & Johnson, H. (2016). Transforming first nations' health governance in British Columbia. *International Journal of Health Governance*, *21*(4), 229-244

Ouimette, P., & Brown, P. J. (2003). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. Washington, DC: American Psychological Association.

Robbers, M. L. (2009). Lifers on the outside: Sex offenders and disintegrative shaming. *International Journal of Offender Therapy and Comparative Criminology, 53*(1), 5-28.

Sawatsky, J. (2009). *The ethic of traditional communities and the spirit of healing justice: Studies from Hollow Water, the Iona Community, and Plum Village*. London, England: Jessica Kingsley Publishers.

Seto, M. C., & Lalumière, M. L. (2004, October). *The uniqueness of juvenile sex offenders: A meta-analysis*. Paper presented at the 23rd annual meeting of the Association for the Treatment of Sexual Abusers, Albuquerque, NM.

Smith, L. T. (2012). *Decolonizing methodologies: Research and Indigenous peoples* (2nd ed.). London, England: Zed Books

Smyth, B. P., Barry, J., Keenan, E., & Ducray, K. (2010). Lapse and relapse following inpatient treatment of opiate dependence. *Irish Medical Journal*, *103*(6), 176-179.

Talbot, J. A., Talbot, N. L., & Tu, X. (2004). Shame-proneness as a diathesis for dissociation in women with histories of childhood sexual abuse. *Journal of Traumatic Stress, 17*(5), 445-448.

Truth and Reconciliation Commission of Canada. (2015). *Canada's residential schools: The history, part 1 origins to 1939. The final* report *of the ruth and Reconciliation Commission of Canada (Vol. 1)*. Montreal, Canada: McGill-Queen's University.

Van der Kolk, B. A. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences, 1071*(1), 277-293. https://doi.org/10.1196/annals.1364.022

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Viking.

Visser, I. (2015). Decolonizing trauma theory: Retrospect and prospects. *Humanities*, *4*(2), 250-265.

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