Compensating Residential School Survivors & the Nosological Category of Post-Traumatic Stress Disorder: Critical Perspectives

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Introduction

On September 19, 2007, the largest class action settlement in Canada, the Indian Residential School Settlement Agreement (Settlement Agreement) began to be implemented with high expectations. In the words of Deputy Prime Minister Anne McLlenan, the Settlement Agreement promises to deliver a “fair and lasting resolution to the legacy of the Indian Residential Schools”\textsuperscript{1}. Her enthusiasm was shared by other federal cabinet ministers and Indian Residential School (IRS) survivors, notably Grand Chief Phil Fontaine of the Assembly of First Nations\textsuperscript{2}. “I know that every moment has been worthwhile. Justice has prevailed”, Fontaine proclaimed on the day the federal government offered a $1.9 billion compensation package.\textsuperscript{3} Today, whether the Settlement Agreement has delivered justice to the IRS survivors is a point of contention, which is too broad for our paper to address.

Instead, our paper will focus solely on the Independent Assessment Process (IAP), which is one of the five elements of the Settlement Agreement. The IAP is a non-adversarial process through which former IRS students who were victims of abuse can claim compensation for the abuses and other wrongful acts, as well as the harms suffered as a result. The compensable consequential harms are mainly of mental health pathologies, such as post-traumatic stress disorder (PTSD), psychotic disorganization, loss of ego boundaries, personality disorders, self-injury, suicidal tendencies… etc.

\textsuperscript{1} CBC News, “Residential School Victims Offered $1.9B” (23 Nov 2005), online: CBC News, <
\textsuperscript{2} Ibid.
\textsuperscript{3} Ibid.
According to mental health literature, PTSD is by large the most common mental condition diagnosed in Indian Residential School (IRS) survivors. In 2003, the Aboriginal Healing Foundation (AHF) did a study based on an analysis of 127 forensic reports of Aboriginal adults who were litigants against the federal government of Canada, the United Church of Canada, the Anglican and Roman Catholic Church for abuses they suffered in connection to IRS. Out of this sample, three-quarters of the case files provided information regarding the mental state of the subject, and 64.2% of survivors were diagnosed with PTSD, 26.3% with substance abuse disorder, 21.1% with major depression, and 20% with dysthymic disorder. The list includes several other disorders that do not, however, represent more than 10% of the population. Since PTSD is by large the most common mental disorder among IRS survivors, our analysis of the IAP will focus exclusively on this mental condition.

Outline

Our paper will reflect on the implications and the meanings of the use of the nosological category of PTSD in the IAP may have as a means for IRS survivors to obtain compensation.

The first part of our paper will examine some of the advantages and disadvantages of using the nosological category of PTSD. We will argue that, on the one hand, using

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5 While is true that the sample group does not represent the average Indigenous population in Canada, since they were litigants, the broader literature still finds that PTSD is by far the most common mental condition present in IRS survivors.
7 See Table 20 in the Appendix below.
this category to award damages has the advantage of presenting trauma as a ‘normal reaction to an abnormal event’. This understanding normalizes the development of trauma in the face of extraordinary events, and thereby avoids the re-victimization of survivors during hearings. On the other hand, relying on a PTSD diagnosis in the IAP fails to account for intergenerational trauma, since PTSD necessitates that one directly experiences the traumatic event. Moreover, the use of the PTSD category encourages the systemic and self-identification of survivors as victims, denying those who proved resilience compensation for their suffering and struggles in dealing with the traumatic events. As a result, this reinforces the image of the IRS survivor as a vulnerable and mentally fragile individual.

In the second part of our paper, we will argue that this analysis of the pros and cons of using the nosological category PTSD to allocate compensation has to be resituated within, and mitigated by, a critical understanding. Upon closer consideration, the category of PTSD, which is thought of as objective, is in fact highly subjective. It is a historically contingent product, born out of Western twenty first century clinical practices and technologies. The intercultural validity of its diagnosis is thus limited. The political power of a PTSD diagnosis rests precisely in the masking of a subjective decision behind a façade of objectivity. While evaluating compensation for consequential harm, we forget that psychiatry is itself political, normative, and a large source of power. As the judge bases the quantum of compensation on a psychiatrist’s expertise, she justifies her decision on the illusion of a scientific, objective fact. This recourse to a priori objective assessment allows for a subtle form of re-colonization. It forces IRS survivors to adopt the hegemonic Western way of knowing, thought, reasoning and language to obtain
compensation. The IAP excludes and suppresses Indigenous ways of knowing the world, and Indigenous voices of what constitutes justice, healing and restoration. Thus, re-colonization in the IAP occurs on two distinct levels. Firstly, it happens as IRS survivors’ claims are heard in the Canadian courts, and secondly it takes place as the judge uses a psychiatrist’s expertise to determine the quantum of compensation.

**Making a Claim Through the Independent Assessment Process (AIP)**

Before we can analyze the advantages and disadvantages of using the nosological category of PTSD to compensate IRS survivors, we have to better understand the IAP. From the outset, we would like to note that this paper will not examine the adjudicators’ decisions, since they are not publically available.

The IAP provides compensation to former IRS students who were victims of sexual abuse, serious physical abuse, and certain other wrongful acts which caused severe psychological consequences. It also provides compensation to individuals who are not former IRS students, but who were abused after being permitted on the premises of an IRS and were under 21 years of age at the time of the abuse.

The first step in the claims process is the completion of a lengthy application form. Based on the information on the form, the administration will decide under which of the three tracks the claim will be assessed.\(^8\) Most claims default to what is called the standard track, which comprises a hearing conducted by an independent adjudicator.\(^9\) The second option is called the complex issues track, and is used if a claim is being made for actual

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\(^9\) Ibid.
income loss, or for certain types of wrongful acts (other than sexual abuse and serious physical abuse) that caused the claimant serious psychological consequences. In this track, hearings, or at least interviews are necessary for all claims, and certain claims will require more detailed proof than in the standard one. Moreover, expert evidence will almost always be necessary, and deserved more than the maximum compensation that the IAP allows. The third and last option is the court track, reserved for claims that are exceptionally serious or complicated, and/or where appropriate compensation exceeds that granted by the IAP.

In the IAP, the burden of proof is the civil standard of the balance of probabilities for matters of like seriousness. This means that the claimant has to prove that it is more likely than not that the event occurred. By contrast to school abuse class action lawsuits, where the plaintiff is obliged to prove essentially that Canada or the church breached a duty of care owed to the IRS students, liability is considered admitted in the IAP. The claimant only has to advance proof of personal damages, after which the independent adjudicator will question the claimant to assess the credibility of the testimony and the veracity of the evidence. There is no cross-examination by lawyers, as there is in class action litigation, and thus less chances of re-victimizing the claimant. Next, we will explain how this compensatory quantum is calculated.

**Calculating the Compensatory Quantum in the Independent Assessment Process**

The adjudicator calculates compensation for validated assaults based on compensation tables,\(^\text{10}\) ensuring that damages are assessed on an individual basis. The

\(^{10}\) See Appendix 2
adjudicator consults the table to identify how many points correspond to a given proven assault claim. For instance, the proven act of one or more incidents of anal or vaginal intercourse corresponds to 36 to 44 compensation points (the author will suppress, for the sake of brevity and clarity, her urge to make the obvious comment about the blood-chilling bureaucracy of this process). It is at the discretion of the adjudicator to decide how many points to award within this spectrum based on the details of a given claim. For example, more points are awarded for vaginal than oral intercourse. However, there could be factual situations in which maximum points are awarded for repeated instances of oral intercourse.

In addition, where applicable, the adjudicator allocates compensation points for consequential harm, loss of opportunity, and future care. Aggravating factors, such as verbal abuse and racist acts, are also accounted for in the calculation of the quantum. In this paper, we will focus solely on the consequential harms table, where the category of PTSD appears.

The adjudicator determines the appropriate level in the consequential harms table by matching the proven harms to the descriptions in the harm categories. While the determination of the severity of the assault is an objective assessment, that of the consequences is a subjective one. In the former the adjudicator asks whether the existence of the injury was proven; in the latter, she determines the extent to which the proven harm has affected the claimant. For example, alcohol addiction is regularly proved, and is one of the syndromes listed as evidence in the continued detrimental impact category under level H3. However, the proven addiction does not necessarily qualify the claimant

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11 See Annex 2.
for compensation points at level H3. To do so, the addiction has to constitute a “Continued Detrimental Impact” to the claimant. Besides, only a plausible link between the proven assault and consequential harms needs to be established, and the adjudicator does not need to determine whether there may be other causes, more significant causes, or contributing causes to the harm.\textsuperscript{12} After deciding how many compensation points to grant in function of the subjective assessment of the level of abuse, of consequential harms, and of loss of opportunity, the adjudicator converts those compensation points into compensation dollars.\textsuperscript{13}

In order to be granted damages for consequential harms at levels 3, 4, and 5, an expert psychological or psychiatric assessment of the claimant’s condition will be required, unless the parties agree otherwise.\textsuperscript{14} Only the adjudicator may order an expert assessment, and before doing so, she must hear the claimant’s evidence to make preliminary findings on credibility. Thus, the claimant must provide any treatment records relevant to the harms, such as clinical, hospital, medical or other treatment records. In the complex issues track of the IAP, the adjudicator will consider records from general practitioners, clinics, or community health centers. Thus, in order to be compensated for PTSD at level 3 and above, claimants must provide a treatment record evidencing that they suffer from PTSD. Records from Aboriginal healers will be accepted,


\textsuperscript{13} See Annex 2.

\textsuperscript{14} Supra note 12 at 10.
but only as preliminary evidence. If sufficiently credible, the adjudicator will order an expert to assess the claimant’s mental state.

**PTSD and the DSM**

In order to assess if a claimant has PTSD and its level, the expert uses the diagnostic outlined in the DSM. According to the DSM, post-traumatic stress arises from exposure to an event that “involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others”, and which results in “intense fear, helplessness or horror” in the victim. In children, the response may be expressed in agitated or disorganized behaviour. PTSD alters a person’s sense of predictability, vulnerability, and control.

To diagnose this disorder, the DSM outlines specific symptoms in four different categories, which have to last for more than a month. The first category of symptoms amounts to re-experiencing the traumatic event; that is, the patient must have both flashbacks and/or vivid recollections of the events while awake, and nightmares while asleep. These re-experiences compromise stimuli that symbolize the event, and trigger intense emotional upset. The second category of symptoms involves avoidance of any stimuli that are associated with the traumatic event. For example, victims avoid thinking about the traumatic event and stimuli that resemble or remind them of it. They might also

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15 *Ibid* at 25.
16 *Supra* note 14.
17 In the IAP’s consequential harms grid, Chronic PTSD is considered level H5, severe PTSD level H4, some PTSD level H3, and mild PTSD level H2.
19 *Ibid* at 1011-1021.
withdraw socially and feel emotionally numb. The third category of symptoms comprises increased rates of arousal. These include sleep disturbance, difficulties in concentration, hyper-vigilance and an exaggerated startle response. The final category involves distress or impairment in social and occupational (or other areas) of functioning.

**Advantages of Using PTSD as a Nosological Category for Awarding Compensation**

The etiological description of trauma by the DSM undeniably presents some advantages. The sanctification of PTSD by psychiatry, and especially by the DSM, has normalized trauma, which was previously thought of in Western society as an abnormal neurosis. It has normalized trauma by the mere fact that it is now a standardized diagnostic, and even more so by portraying PTSD as a normal reaction to an abnormal event, as opposed to an individual nervosa in which reality must be doubted and falls outside of the normal. These two different levels of normalization of trauma make it doubly easier for lawyers to prove consequential harms of assaults, and for their clients to obtain compensation as a result thereof.

The nosological category of PTSD was invented and included in the DSM III in the context and as a result of numerous studies conducted on Vietnam war veterans. However, traumatic disorders are not an American invention of the late XX century. Although the diagnostic was not as refined at the end of the XIX century, European psychologists and psychiatrists were already attuned to trauma psychiatry. It was Jean-Martin Charcot who first depicted a clinical syndrome, which the German psychiatrist Oppenheim later named “traumatic neuroses” in *Die traumatischen Neurosen*, published
in 1889.\textsuperscript{20} At this point in time, traumatic neurosis did not presuppose a psychological etiology; it is with the interventions of Freud and Janet that this paradigm shift occurred.\textsuperscript{21}

Janet relates the etiology of hysteria to the organism’s psychological reaction in front of an external trauma.\textsuperscript{22} He advanced that it is the concordance of an external trauma and someone’s psychological predisposition that leads to either hysteria if the trauma arises during childhood, or to traumatic neurosis if it arises during adulthood. Freud’s theory of hysteria differs from that of Janet in that he limits trauma to sexual abuses.\textsuperscript{23} For Freud, sex is already traumatic in the unconscious. As for Janet, the traumatic event is an occasion of revelation, and not the exclusive etiological agent. However, Freud goes further, and tries for the first time to give a new content to the psychological notion of trauma.\textsuperscript{24} For him, it is not just a reaction of the organism to an external event; it is the essential characteristic of psychic functioning. In this notion of trauma, the trauma is already there, the external event simply allows it to reveal itself. Trauma is an internal force, which in connection with certain events or phantasms, creates pathological manifestations.

What is important to emphasize for our purposes is that in these two early conceptions of trauma, it is not the event that is the key of the traumatic neurosis. The event only triggers a pre-existing neurosis, or predisposition to neurosis. Thus, in the notion of traumatic neurosis, the event is not determining; rather, the psychological


\textsuperscript{21} \textit{Ibid} at 53.

\textsuperscript{22} \textit{Ibid}.

\textsuperscript{23} \textit{Ibid} at 55.

\textsuperscript{24} \textit{Ibid} at 57.
profile of the individual is. People who have traumatic neurosis suffer from a pre-existing psychological fragility. Traumatism is understood as an individual and subjective experience, making the question of compensation very complex. Consequently, the subjective character of trauma introduces a regime of doubt.²⁵ Are these people really sick, do they really have traumatic neuroses, or are they merely pretending in order to obtain compensation? Thus, a few years before the advent of the first World War, the expert practice of traumatic neurosis was permeated with the discourse of doubt, suspecting the authenticity of the victims’ suffering, accusing them of making claims in bad faith, and invested in suspect financial interests.²⁶ Moreover, it was accepted by society at large that if the traumatic event is not the cause of the trauma, but merely the catalyzer, the person responsible for the traumatic event should not be held liable and owe compensation to the person suffering from traumatic neurosis, since her trauma amounts to the manifestation of her own psychological fragility.²⁷

The introduction of the etiological category of PTSD in the DSM III demonstrates a shift from “a regime of doubt to a regime of authenticity”.²⁸ The new scholarly and scientific definition of PTSD and a moral change in mentalities completely silenced the language of suspicion that haunted the figure of the victim. As early as in 1942, Marcel Moreau contributes to major innovations regarding the authenticity of traumatic neuroses, and the status of their victims in legal medicine as well as military psychiatry. Legal psychiatry, after twenty years of civil expertise in injured workers, has recognized the

²⁵ Ibid at 29-31.
²⁶ Ibid at 39-65.
²⁷ Ibid at 63.
²⁸ Ibid at 41.
clinical autonomy of traumatic neurosis, and distinguished it from simulation.\textsuperscript{29} It was acknowledged as a true disease following an accident, but of which is the accident is not the cause. For the most radical like Moreau, the etiology amounts to the compensation; for the more moderated, the traumatic neurosis is a form of quasi-delirious conviction, constructed around the prejudice of the accident. As to the status of victim, the notion of “traumatic prejudice” begins to be used to qualify the psychological condition of victims of certain types of accidents.\textsuperscript{30}

The clinical diagnosis of PTSD, as described in the DSM, normalizes trauma, and nullifies previous doubts posited about the sincerity of the traumatized person, signaling a change in thinking from previous methods of defining trauma. Specific events, rather than disposition, are from then on considered the cause of trauma. The development of PTSD is thus considered as a normal reaction to abnormal or extraordinary external events.\textsuperscript{31} The person traumatized is now considered \textit{a priori} credible. Moral evaluations are put aside, leaving room for an ethical truth beyond individual singularities: traumas are themselves ‘the proof of the intolerable’.\textsuperscript{32} The shift in the conceptualization of trauma is not solely stemming from clinical advances and refinements, it is also a result of a change in collective sensibilities themselves generated by social activists. Fassin & Rechtman mention the struggles of 1960’s American feminists and Vietnam War veterans, who fought for the recognition that the suffering of victims of trauma is authentic, and that the abuses are real.\textsuperscript{33}

\textsuperscript{29} \textit{Ibid} at 102-104.
\textsuperscript{30} \textit{Ibid}.
\textsuperscript{31} \textit{Ibid} at 134.
\textsuperscript{32} \textit{Ibid} at 146.
\textsuperscript{33} \textit{Ibid} at 120-130.
Consequentially, the use of the category of PTSD in the IAP simplifies the process of obtaining compensation for former IRS students who are victims of trauma. The normalization of trauma through its categorization as PTSD means that experts and adjudicators will not a priori doubt the students’ traumatic experiences avoiding thereby the re-victimization of claimants. Experts judging whether or not a claimant has PTSD will not take into account her psychological singularities. Experts will simply have to make sure that the claimant meets the criteria set out in the DSM’s diagnostic of PTSD.

**Practical Disadvantages of Using PTSD as an Etiological Category for Claims for Consequential Harms of Abuses and Other Wrongful Harms**

On a practical level, the use of PTSD as a nosological category in the table of “consequential harms” has some negative consequences: the denial of intergenerational trauma, and the portraying and self-identification of former IRS students as victims.

*PTSD, Intergenerational Trauma and Residential School Syndrome*

In awarding compensation on the basis of a PTSD diagnosis, the IAP focuses solely on the individual. Although addressing individual trauma is very relevant in the IRS context – victims of sexual and physical abuse or other wrongful acts need and deserve to receive individual legal recognition/compensation and medical treatment – the PTSD diagnosis nonetheless fails to account for the suffering caused by intergenerational trauma. Following the structure of the American Psychological Association criteria for PTSD, Charles Brasfield\(^{34}\) has developed diagnostic criteria for what he called “Residential School Syndrome” (RSS), which takes into account intergenerational trauma,

and while it is recognized by the AHF, RSS is not used to compensate IRS survivors. The RSS particularizes the definition of PTSD to the IRS experience. For example, Brasfield’s description – namely, that people suffering from RSS may experience recurrent distressing dreams of the IRS, intense distress when exposed to stimuli that symbolize residential schools, etc – follows precisely the DSM’s listing of PTSD symptoms.

The Brasfield criteria for RSS, however, differ qualitatively from that of PTSD in three major ways. Firstly, Brasfield describes a diminished interest in significant cultural activities. Secondly, he recognizes persistent alcohol or other drug abuse “often from a very young age”, accompanied by bursts of anger. Thirdly, according Brasfield, a diagnosis of RSS does not necessitate a specific traumatizing event:

A. The person has attended an IRS or is closely related to or involved with a person who has attended such a school.
   a. The school attendance was experienced as intrusive, alien, and frightening.
   b. The person’s response to the school attendance involved fear, helplessness, passivity, and expressed or unexpressed rage.

Thus, to be diagnosed with RSS, it is not necessary that the traumatized individual experienced sexual or physical abuse or a fear of death or injury. Having gone to residential school and experienced attempts of enforced assimilation and attendant methods of mind control qualifies as exposure to a traumatizing event. Furthermore, one does not need to have personally attended a residential school to experience this trauma. The Brasfield criteria recognize that it is possible to pass on this trauma to

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35 Supra note 5 at 23; see appendix 3 for Brasfield’s diagnosis.
37 Supra note 32 at 79.
38 Ibid at 80.
39 Supra note 34 at 10.
someone who is “closely related or involved”.  

This is a very important difference with the DSM’s diagnostic of PTSD, as it accounts for the reality of intergenerational trauma that exists prominently among Aboriginal communities as a result of the legacy of IRS, and more generally, as a result of colonization.

In the residential school system, Aboriginal children were forbidden to speak their own language, practice their cultural and spiritual traditions. Oral transmission of child-rearing practices were also lost as a result of lost of language, making it difficult for former IRS students to parent their children as it used to be traditionally done. Moreover, the trauma generated by the residential school experience, and more generally by colonization, stripped indigenous people of their knowledge, spirituality, physical and emotional well-being, and led to the loss of community. In these different ways, traumatic experience has had a ripple effect across generations of Aboriginal people. It is thus crucial that compensatory regimes include a more encompassing notion of trauma than the narrow one recognized in PTSD.

Victimization & Lack of Legal Recognition and Compensation for Resilient Sufferers of Trauma

While it is true that using the nosological category of PTSD in the IAP allows traumatized victims to obtain compensation without subjecting their stories and suffering to doubt and cross-examination, and thus usually without being re-victimized, it is

40 Ibid.
equally true that this nosological category portrays survivors as victims and encourages them to label themselves as such in order to obtain compensation. This systemic problem in turn reinforces an image of IRS survivors as weak, mental ill, and reliant on social assistance. Importantly the IAP, through its use of the nosological category of PTSD, fails to recognize and to compensate those who proved resilience to traumatic events. Former IRS students who were able to resist the traumatic consequences of an abuse cannot be compensated for the suffering and healing efforts that it took them to carry on, and resist developing PTSD in the aftermath of a traumatic event. It is not because one does not develop PTSD that one does not suffer from exposure to traumatic events.

The report of the Aboriginal Healing Foundation on “Aboriginal People, Resilience and the Residential School Legacy” defines resilience as “the capacity to spring back from adversity and have a good life outcome despite emotional, mental or physical distress”.42 While the popular media often depict resilience purely in terms of individual character traits, it results rather from an interplay between risk factors on the one hand, and various protective factors on the other.43 Richman & Fraser define “risk factors” as “the presence of one or more factors or influences that increase the probability of a negative outcome”, and “protective factors” as individual characteristics or environmental conditions that help people “resist or otherwise counteract the risks to which they are exposed”.44

A person may be called resilient if she uses her protective factors effectively, such as self-esteem and community involvement, in order to counter the ill effects of risk factors, such as abuse.\textsuperscript{45} While risk and protective factors play a critical role in shaping individual responses to a traumatic event, they do not determine these responses. Rather, they enable or limit certain courses of action, and tint one’s worldview.\textsuperscript{46} How people interpret life events is pivotal in how they respond to them,\textsuperscript{47} and thus these factors influence individuals’ responses to traumatic events. Moreover, the AHF report emphasizes that culture is linked to resilience in two ways. First, cultures condition parent-child interactions in ways that can either promote or limit the development of protective factors. Secondly, cultural expressions, such as traditions, ceremonies and language, often constitute sources of pride and self-esteem, serving to support individuals in their struggles against adversity.

Although IRS students were often separated from their parents at a young age and IRS implemented discipline to “take the Indian out of the child”, some Indigenous children possessed protective factors that insulated them from the impact of traumatic events. This can be explained by the fact that traditional Aboriginal societies have always placed great emphasis on fostering child resilience, so that children can participate in their own health and healing processes.\textsuperscript{48} Aboriginal parents often protect their children by acting in ways that validate and reinforce their survival capabilities, and by fostering a health and healing ethos in their children.\textsuperscript{49} By way of illustration, there exists a ritual

\textsuperscript{45} Supra note 40 at 6.
\textsuperscript{46} Ibid at 15.
\textsuperscript{47} Ibid at 13.
\textsuperscript{48} Ibid at 23.
\textsuperscript{49} Ibid.
whereby parents preserve the umbilical cords in amulets as a constant reminder for children to behave, or will share traditional sayings to their children to promote health-seeking behaviours. This health and healing ethos embraces the sacredness of all living things, the importance of self-reliance, community obligations, and cultural continuity.\textsuperscript{50} Child resilience is especially important, since traditionally children are considered to be gifts, loans or souls sent by the Creator; parents, extended family members, and the community at large must take shared responsibility for nurturing, protecting, and guiding them.\textsuperscript{51} Thus, traditional Indigenous societies cultivate a spiritual understanding between adult and child, whereby children’s sacredness ordains that they be treated with respect.\textsuperscript{52}

Moreover, the importance that Indigenous people attach to the four directions of the Medicine Wheel gives them a natural disposition to resilience promotion.\textsuperscript{53} As they believe that a balance must be maintained between the physical, mental, emotional, and spiritual dimensions of life, indigenous communities ensure that each of these is engrained in children so they can become well-rounded, productive adults. Some resilient IRS survivors recall turning to prayer and their religious beliefs as a way to transcend the mistreatment and abuses to which they were subjected.\textsuperscript{54} Parents who share this

\textsuperscript{50} Ibid.
\textsuperscript{51} Ibid at 24 (The Inuit emphasized the importance of the communal raising of children by engaging in a specific form of adoption. From a very young age, the child is told that she will be adopted and who the birth parents are. Both sets of parents engaged in forms of teasing and play to reinforce attachment to the foster family, while sustaining a sense of closeness to the biological family. This form of adoption reinforces resilience by teaching children to adapt to fluid, ever-changing environments).
\textsuperscript{52} Ibid.
\textsuperscript{53} Ibid at 24-25.
\textsuperscript{54} Secwepemc Cultural Education Society, \textit{Behind Closed Doors: Stories from the Kamloops Residential School} (Kamloops: Secwepemc Cultural Education Society, 2000) at 27 [Secwepemc].
worldview foster physical prowess, critical thinking, a strong sense of ethics, and a capacity to empathize with others.\(^{55}\)

In the IRS, the general coping strategies of students capable of resilience were detachment, reinterpretation, accommodation and resistance.\(^{56}\) Firstly, detachment involved suppressing any feeling and emotion, or recourse to humour and laughter, as ways of dealing with pain and fear in the face of traumatic experiences.\(^{57}\) Some former students recount that they simply ceased to hear or speak.\(^{58}\) Secondly, through re-interpretation, students were able to view negative situations in ways that stressed positive or hopeful elements. Instead of viewing themselves as victims, they decided they were survivors whose strength of spirit would allow them to get passed the IRS experience.\(^{59}\) For example, a number of survivors explained that they refused to cry out or show pain when abused in order to maintain a sense of dignity in the face of oppression. They would also imagine a better future life outside of the IRS.\(^{60}\) Thirdly, some students thought that their best chance to survive was to reach an accommodation with those in positions of power. A former student of Port Alberni’s IRS reported: “I learned to use sexuality to my advantage, as did many other students. Sexual favours brought me protections, sweets, and even money to buy booze”.\(^{61}\) Some students instrumentalized the abuses to their advantages. Lastly, many students engaged in acts of individual and collective resistance. It went from stealing bread to escaping schools. There were also more subtle forms of resistance, including those that took place inside of

\(^{55}\) Supra note 40 at 25.
\(^{56}\) Ibid at V.
\(^{57}\) Ibid at 43.
\(^{58}\) Ibid at 43.
\(^{59}\) Supra note 52.
\(^{60}\) Supra note 40 at 43.
\(^{61}\) Ibid.

\(^{61}\) Ibid at 44.
the survivors’ minds. A survivor of Kamloops IRS recalls thinking before being physically abused: “It’s not going to hurt. Just so I can make you [the nun] angry, I’m not going to let you know it hurts”\textsuperscript{62}. This mental attitude challenged the nun’s authority, and proved to the student herself that she had the capacity to resist abuses.\textsuperscript{63}

In conclusion, the children attending residential schools were not only victims, but also agents who employed strategies and strength to cope with the abuses and other traumatic experiences they faced. By using a clinical category such as PTSD to compensate the suffering of former students caused by an exposure to a traumatic situation, the IAP encourages and reinforces the identification of IRS survivors as victims, and fails to recognize those who demonstrated resilience. Compensation other than that based on the abuse itself should also be awarded to resilient students who employed coping mechanism to deal with traumatic events.

**Re-Situating and Mitigating our Analysis of the Positives and Negatives by a Critical Reflection**

Our analysis of the advantages and disadvantages of using the nosological category of PTSD to allocate compensation to IRS survivors has to be resituated within, and mitigated by, critical reflection. While offering certain expediencies, at a more fundamental level, it is questionable that we can apply the diagnostic of PTSD to former IRS students, as the existence of PTSD is not objective, but depends on social, historical and technological factors. Allan Young and Derek Summer, among other scholars,\textsuperscript{62,63}

\textsuperscript{62} Ibid at 46.
\textsuperscript{63} Ibid.
debunk the objective existence of PTSD, and thereby put into question the universal application of its diagnostic. In his seminal book, *Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, Young argues that PTSD is an historical product, whose existence depends on the gaze and practices of psychologists and psychiatrists. Grief, trauma, fear and the like are common problems that have been present throughout history, and which have been understood in many different ways by different cultures and time periods. However, trauma becomes a “disorder” only with the development and refining of clinical diagnosis, institutional exigencies, and advanced medical experimentation. Young writes that

> The disorder [PTSD] is not timeless, nor does it possess an intrinsic unity. Rather it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented by the various interests, institutions, and moral arguments that mobilized these efforts and resources.  

The scientist’s phenomena are products of his technologies, practices, and pre-conditioned ways of seeing: “Every scientific phenomenon is simultaneously a techno-phenomenon”. Young insists, however, that affirming that PTSD is a historical product does not entail that PTSD is not real. On the contrary, he believes that people suffer terribly from this disorder: “The reality of PTSD is confirmed empirically by its place in people’s lives, by their experiences and convictions, and by the personal and collective investments that have been made in it”.

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65 Young, supra note 62 at 5.

66 Ibid at 6.

67 Ibid at 5.
The fact that PTSD does not have an objective existence only entails that its truth and reality cannot be divorced from the social, cognitive, and technological conditions through which clinicians and researchers acquire knowledge of their facts and the meaning of facticity. The co-dependence of the reality of PTSD and of certain socio-historical and technological conditions implies that PTSD, as defined in the DSM, is not a universal reality, and thus limits the intercultural validity of its diagnosis.

For example, the DSM dictates that the traumatic event must be “outside the range of usual human experience” and experienced as distressful in order to qualify as an event that could cause PTSD. While it would be possible to come up with a list of events that are universally outside the range of usual human experience and universally experienced as distressful, the list would be very short, and dismiss many events that are considered to be causes of PTSD. What constitutes an abnormal and distressful event is contingent on cultures and sometimes sub-cultures. The corporal punishments and harsh discipline that IRS students endured, as part of the civilizing agenda, constituted in their eyes an abnormal event, since Aboriginal child-rearing did not condone the use of physical violence against children. Instead, families would make use of such methods as “teasing, modeling good behavior and ignoring naughty behavior, putting older siblings in charge of younger ones, and using storytelling to instruct”. Having psychiatric (and in most case non indigenous) experts diagnose PTSD is a problem in that they may not consider abnormal events that were the source of trauma for indigenous children. While it is true that the compensatory models do accept as evidence of consequential harms proof

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68 Ibid at 10.
69 Ibid at 127.
70 Supra note 40.
71 Ibid at 37.
that the claimants consulted traditional healers who are better equipped to understand indigenous sensibilities, expertise from psychiatrists are still necessary to obtain damages for consequential harms at level H3 and above.

If PTSD is often thought to have an objective existence, it is because science, technology, and medicine naturalize this disorder. In Young’s words, science provides ideology by giving PTSD an existence independent of clinical practices, and in turn, ideology supports science “with the institutional surfaces on which its invisible object is inscribed”.72 Thus, the problem with emphasizing psychological harm is not only, as Carole Blackburn argues, that it “medicalize[s] issues that are political, like the struggle for self-determination, or structural, like aboriginal poverty”,73 but more radically that in the way we do so, we forget that clinical medicine is itself political, normative, and a great source of power. Psychiatry is what Foucault would call a “regime of truth”; in other words, psychiatry welcomes certain forms of discourse and makes them operate as truth. He writes in The Birth of Biopolitics, that analyzing a “regime of truth” does not amount to

montrer comment [la folie, la maladie, la délinquance, la sexualité] ne sont que de vaines illusions ou des produits idéologiques à dissiper à la lumière de la raison enfin montée à son zénith. Il s’agit de montrer par quelles interférences cette série de pratiques a pu faire que ce qui n’existe pas (la folie, la maladie, la délinquance, la sexualité etc) devienne cependant quelque chose, quelque chose qui pourtant continue à ne pas exister. […] comment c’est un certain régime de vérité et donc, par conséquent, pas une erreur qui a fait que quelque chose qui n’existe pas a pu devenir quelque chose. Ce n’est pas une illusion puisque c’est précisément un ensemble de pratiques et de pratiques réelles qui l’a établi et le marque ainsi impérieusement dans le réel.74

72 Young, supra note at 199.
74 Michel Foucault, La Naissance de la Biopolitique, (Lonrai: Gallimard, 2004) at 21-22.
Thus, all real phenomena exist through categories from which and that allow us to think the phenomena. PTSD becomes real through the technical language (“avoidance behaviour”, “symptomatic anger”, etc) used by the medical body. As a result,

loin d’irréaliser la réalité pour agir sur l’esprit du malade, le médecin devient le maître du réel […]. La psychiatrie donne ainsi un sur-pouvoir réel, dans ce qui ne peut que produire un affrontement inéluctable et brutal avec la maladie mentale. Détenir la vérité, pour le médecin, c’est redonner tout son pouvoir à la réalité.75

Through clinical practices and discourse, the psychiatrist creates a reality that is highly normative. It dictates what constitutes a normal versus a pathological subject, and thereby entails a constant regulation of irregularities. As knowledge of the norm, medicine has a political and social agenda: the fight against disorder and indiscipline in the name of the science of abnormality.76 Both law and medicine have the same end; that is, defining what is normal and what is abnormal in our society.77 They both are regimes of truth and techniques of normalization. As Vandewalle explains, “l’expertise médico-légale confond dans l’unité d’une même pratique le pouvoir du juge et celui des médecins unis dans une même traque de l’anormalité”.78

The danger with the medicalization of law -- characterized by the rise of medico-legal expertise -- is therefore that legal decisions are based on and legitimized by medical ‘truths’ that are believed to have objective existence. When deciding whether or not to grant compensation to a former IRS student on the basis of whether or not they have been diagnosed with PTSD by a medical expert, judges justify their decisions on the illusion of a scientific, objective fact. It is precisely in this masking of subjective decisions behind a

76 *Ibid* at 107-110.
77 *Ibid*.
façade of objectivity that the diagnostic of PTSD and the judges’ decisions gain political power and force.

While it is rather clear that using the Canadian legal framework in order to settle claims between former IRS students and Canada constitutes a form of re-colonization, it is important to understand that a more subtle form of re-colonization also occurs as judges legitimize their decisions through psychiatrists’ expert reports. Understandably, re-colonization takes place from the mere fact that IAP compensation claims are heard by Canadian judges in the Canadian courts, since this means that Indigenous claimants have to adopt the legal language, concepts and reasoning of the colonizer for ‘justice to be rendered’. The IRS survivor has to leave aside her own understanding of justice, healing and restoration. Moreover, there is no third party, the IRS survivor is subject to the judgment of the perpetrator itself; namely, Canada. Furthermore, a more latent form of colonization occurs. As judges justify their decisions upon psychiatrists’ expert reports, Indigenous voices and understandings of mental health are excluded and suppressed. In order to be compensated, IRS survivors are forced to employ the powerful and hegemonic Western discourse of psychiatry, undermining as a result Indigenous ways of knowing, thought, reasoning, language, and understanding of mental health.

Conclusion

This paper examined the advantages and disadvantages of the ADR process and IAP’s use of the nosological category of PTSD as a recourse for IRS survivors to obtain compensation, and re-situated and mitigated this analysis within a critical perspective. The IAP allows damages for consequential harms resulting from abuses they suffered on
the basis of various categories of mental conditions, such as borderline personality disorder, depression, substance abuse disorder to name a few. This paper focused on PTSD in particular, since it is by far the most common mental disorder among IRS survivors.

On the one hand, we argued through a genealogical analysis that using the DSM’s category of PTSD for awarding damages presents the advantage of conceptualizing trauma as a “normal reaction to an abnormal event”. This understanding normalizes the development of trauma in the face of extraordinary events, and thereby avoids the re-victimization of survivors at hearings. Before the birth of the nosological category of PTSD, trauma had a subjective character; only people who had a pre-existing psychological fragility would be diagnosed with traumatic neurosis. Thus, the introduction of PTSD into the DSM operates, in the words of Didier Fassin and Richard Rechtman, “a shift from a regime of doubt to a regime of authenticity”.79

On the other hand, the use of the category of PTSD in the IAP presents several disadvantages. Firstly, PTSD as defined in the DSM fails to recognize intergenerational trauma, as its diagnosis necessitates that one directly experiences the traumatic event. Consequentially, it fails to address a reality characteristic to the Canadian Aboriginal populations in Canada; that is, one where trauma has been passed on from IRS survivors to close community members and relatives. Lastly, the use of the PTSD category encourages the systemic and self-identification of survivors as victims. Resilient children who nonetheless experienced traumatic events are denied compensation for consequential harm, even if they suffer and struggled in dealing with the traumatic events.

79 Supra note 20 at 41.
In the second part of our paper, we argued that our analysis of the advantages and disadvantages of using the nosological category of PTSD in the IAP needs to be resituated within, and mitigated by, a critical understanding. A closer examination of the nosological category of PTSD reveals that, while thought of as objective, PTSD is in fact highly subjective. Ideology lies at the heart of PTSD; medicine has naturalized PTSD to the extent that we forget that it is a historical by-product of Western twenty first century clinical practices, discourses and technologies. The political power of a PTSD diagnosis lies precisely in the masking of a subjective interpretation behind a façade of objectivity. A PTSD diagnosis loses its relevance and meaning when applied to Aboriginal cultures. The desire of the colonizer was always to hear his own voice spoken out of the mouths of Indigenous people. This was the very enterprise of the residential school program. We see this process reproduced once again in the use of these medical categories, this process that desires to hear a white voice speaking through Indigenous bodies. It is a continued dismissal of Aboriginal modes of thought and belief, a continued demand that if he or she wants to be heard it must be in the colonizing power’s own words.
APPENDIX

1 – Aboriginal Healing Foundation Study of IRS Survivors’ Mental Health.

Table 20 - Subject's Mental Health Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>21.1%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>7.4%</td>
</tr>
<tr>
<td>Anti-social personality disorder</td>
<td>3.2%</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>26.3%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>3.2%</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>3.2%</td>
</tr>
<tr>
<td>Paranoia</td>
<td>1.1%</td>
</tr>
<tr>
<td>Obsessive-compulsive personality disorder</td>
<td>7.4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>4.2%</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>64.2%</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>6.3%</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>7.4%</td>
</tr>
<tr>
<td>Schizoid personality disorder</td>
<td>6.3%</td>
</tr>
<tr>
<td>Stuttering</td>
<td>8.4%</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>20%</td>
</tr>
<tr>
<td>Avoidant personality disorder</td>
<td>3.2%</td>
</tr>
<tr>
<td>Impulse control disorder</td>
<td>7.4%</td>
</tr>
<tr>
<td>Acute stress disorder</td>
<td>4.2%</td>
</tr>
<tr>
<td>Adjustment disorder with depressed mood</td>
<td>4.2%</td>
</tr>
<tr>
<td>Depressive disorder not otherwise specified</td>
<td>3.2%</td>
</tr>
<tr>
<td>Residential school syndrome</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
## Tables from the IAP Guide

<table>
<thead>
<tr>
<th>Acts Proven</th>
<th>Compensatio n Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>SL5  - Repeated, persistent incidents of anal or vaginal intercourse.</td>
<td>45-60</td>
</tr>
<tr>
<td>- Repeated, persistent incidents of anal/vaginal penetration with an object.</td>
<td></td>
</tr>
<tr>
<td>SL4  - One or more incidents of anal or vaginal intercourse.</td>
<td>36-44</td>
</tr>
<tr>
<td>- Repeated, persistent incidents of oral intercourse.</td>
<td></td>
</tr>
<tr>
<td>- One or more incidents of anal/vaginal penetration with an object.</td>
<td></td>
</tr>
<tr>
<td>SL3  - One or more incidents of oral intercourse.</td>
<td>26-35</td>
</tr>
<tr>
<td>- One or more incidents of digital anal/vaginal penetration.</td>
<td></td>
</tr>
<tr>
<td>- One or more incidents of attempted anal/vaginal penetration (excluding attempted digital penetration).</td>
<td></td>
</tr>
<tr>
<td>- Repeated, persistent incidents of masturbation.</td>
<td></td>
</tr>
<tr>
<td>PL   - One or more physical assaults causing a physical injury that led to or should have led to hospitalization or serious medical treatment by a physician; permanent or demonstrated long-term physical injury, impairment or disfigurement; loss of consciousness; broken bones; or a serious but temporary incapacitation such that bed rest or infirmary care of several days duration was required. Examples include severe beating, whipping and second-degree burning.</td>
<td>11-25</td>
</tr>
<tr>
<td>SL2  - One or more incidents of simulated intercourse.</td>
<td>11-25</td>
</tr>
<tr>
<td>- One or more incidents of masturbation.</td>
<td></td>
</tr>
<tr>
<td>- Repeated, persistent fondling under clothing.</td>
<td></td>
</tr>
<tr>
<td>SL1  - One or more incidents of fondling or kissing.</td>
<td>5-10</td>
</tr>
<tr>
<td>- Nude photographs taken of the Claimant.</td>
<td></td>
</tr>
<tr>
<td>- The act of an adult employee or other adult lawfully on the premises exposing themselves.</td>
<td></td>
</tr>
<tr>
<td>- Any touching of a student, including touching with an object, by an adult employee or other adult lawfully on the premises which exceeds recognized parental contact and violates the sexual integrity of the student.</td>
<td></td>
</tr>
<tr>
<td>OWA  - Being singled out for physical abuse by an adult employee or other adult lawfully on the premises which was grossly excessive in duration and frequency and which caused psychological consequential harms at the H3 level or higher.</td>
<td>5-25</td>
</tr>
<tr>
<td>- Any other wrongful act committed by an adult employee or other adult lawfully on the premises which is proven to have caused psychological consequential harms at the H4 or H5 level.</td>
<td></td>
</tr>
<tr>
<td>Level of Harm</td>
<td>Consequential Harm</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>H5</td>
<td>Continued harm resulting in serious dysfunction. <em>Evidenced by:</em> psychotic disorganization, loss of ego boundaries, personality disorders, pregnancy resulting from a defined sexual assault or the forced termination of such pregnancy or being required to place for adoption a child resulting therefrom, self-injury, suicidal tendencies, inability to form or maintain personal relationships, chronic post-traumatic state, sexual dysfunction, or eating disorders.</td>
</tr>
<tr>
<td>H4</td>
<td>Harm resulting in some dysfunction. <em>Evidenced by:</em> frequent difficulties with interpersonal relationships, development of obsessive-compulsive and panic states, severe anxiety, occasional suicidal tendencies, permanent significantly disabling physical injury, overwhelming guilt, self-blame, lack of trust in others, severe post-traumatic stress disorder, some sexual dysfunction, or eating disorders.</td>
</tr>
<tr>
<td>H3</td>
<td>Continued detrimental impact. <em>Evidenced by:</em> difficulties with interpersonal relationships, occasional obsessive-compulsive and panic states, some post-traumatic stress disorder, occasional sexual dysfunction, addiction to drugs, alcohol or substances, a long term significantly disabling physical injury resulting from a defined sexual assault, or lasting and significant anxiety, guilt, self-blame, lack of trust in others, nightmares, bed-wetting, aggression, hyper-vigilance, anger, retaliatory rage and possibly self-inflicted injury.</td>
</tr>
<tr>
<td>H2</td>
<td>Some detrimental impact. <em>Evidenced by:</em> occasional difficulty with personal relationships, some mild post-traumatic stress disorder, self-blame, lack of trust in others, and low self-esteem; and/or several occasions and several symptoms of: anxiety, guilt, nightmares, bed-wetting, aggression, panic states, hyper-vigilance, retaliatory rage, depression, humiliation, loss of self-esteem.</td>
</tr>
<tr>
<td>H1</td>
<td>Modest Detrimental Impact. <em>Evidenced by:</em> Occasional short-term, one of: anxiety, nightmares, bed-wetting, aggression, panic states, hyper-vigilance, retaliatory rage, depression, humiliation, loss of self-esteem.</td>
</tr>
</tbody>
</table>
### Aggravating Factors
Add 5-15% of points for Act and Harm combined
(rounded up to nearest whole number)

<table>
<thead>
<tr>
<th>Aggravating Factors</th>
<th>Additional Compensation (Dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse</td>
<td></td>
</tr>
<tr>
<td>Racist acts</td>
<td></td>
</tr>
<tr>
<td>Threats</td>
<td></td>
</tr>
<tr>
<td>Intimidation/inability to complain; oppression</td>
<td></td>
</tr>
<tr>
<td>Humiliation; degradation</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse accompanied by violence</td>
<td></td>
</tr>
<tr>
<td>Age of the victim or abuse of a particularly vulnerable child</td>
<td></td>
</tr>
<tr>
<td>Failure to provide care or emotional support following abuse requiring such care</td>
<td></td>
</tr>
<tr>
<td>Witnessing another student being subjected to an act set out on page 3</td>
<td></td>
</tr>
<tr>
<td>Use of religious doctrine, paraphernalia or authority during, or in order to facilitate, the abuse.</td>
<td></td>
</tr>
<tr>
<td>Being abused by an adult who had built a particular relationship of trust and caring with the victim (betrayal)</td>
<td></td>
</tr>
</tbody>
</table>

### Future Care

<table>
<thead>
<tr>
<th>Additional Compensation (Dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General – medical treatment, counselling</td>
</tr>
<tr>
<td>If psychiatric treatment required, cumulative total</td>
</tr>
</tbody>
</table>

### Consequential Loss of Opportunity

<table>
<thead>
<tr>
<th>Consequential Loss of Opportunity</th>
<th>Additional Compensation (Points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OL5 Chronic inability to obtain employment</td>
<td>21-25</td>
</tr>
<tr>
<td>OL4 Chronic inability to retain employment</td>
<td>16-20</td>
</tr>
<tr>
<td>OL3 Periodic inability to obtain or retain employment</td>
<td>11-15</td>
</tr>
<tr>
<td>OL2 Inability to undertake/complete education or training resulting in underemployment, and/or unemployment</td>
<td>6-10</td>
</tr>
<tr>
<td>OL1 Diminished work capacity – physical strength, attention span</td>
<td>1-5</td>
</tr>
<tr>
<td>Compensation Points</td>
<td>Compensation ($) (Canadian dollars)</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>1-10</td>
<td>$5,000-$10,000</td>
</tr>
<tr>
<td>11-20</td>
<td>$11,000-$20,000</td>
</tr>
<tr>
<td>21-30</td>
<td>$21,000-$35,000</td>
</tr>
<tr>
<td>31-40</td>
<td>$36,000-$50,000</td>
</tr>
<tr>
<td>41-50</td>
<td>$51,000-$65,000</td>
</tr>
<tr>
<td>51-60</td>
<td>$66,000-$85,000</td>
</tr>
<tr>
<td>61-70</td>
<td>$86,000-$105,000</td>
</tr>
<tr>
<td>71-80</td>
<td>$106,000-$125,000</td>
</tr>
<tr>
<td>81-90</td>
<td>$126,000-$150,000</td>
</tr>
<tr>
<td>91-100</td>
<td>$151,000-$180,000</td>
</tr>
<tr>
<td>101-110</td>
<td>$181,000-$210,000</td>
</tr>
<tr>
<td>111-120</td>
<td>$211,000 to $245,000</td>
</tr>
<tr>
<td>121 or more</td>
<td>Up to $275,000</td>
</tr>
</tbody>
</table>
APPENDIX A

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

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

B. The effects of attendance at the Indian residential school persist following cessation of school attendance in one (or more) of the following ways:
   1. Recurrent and distressing recollections, including images, thoughts, or perceptions;
   2. Recurrent distressing dreams of the Indian residential schools;
   3. Acting or feeling as if the events of Indian residential school attendance were recurring (includes a sense of reliving the experience, hallucinations, dissociative flashback episodes, including those that occur on awakening or those that occur when intoxicated);
   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of Indian residential school attendance;
   5. Physiological reactivity on exposure to internal or external clues that symbolize or resemble an aspect of the Indian residential school attendance.

C. Persistent avoidance of stimuli associated with the Indian residential school and numbing of general responsiveness (not present before Indian residential school attendance) as indicated by three (or more) of the following:
   1. Efforts to avoid thoughts, feelings, or conversations associated with Indian residential schools;
   2. Efforts to avoid activities, places, or people that arouse recollections of Indian residential school attendance;
   3. Inability to recall one or more important aspects of Indian residential school attendance;
4. Markedly diminished interest or participation in significant cultural activities;
5. Feelings of detachment or estrangement from others;
6. Restricted range of affect (e.g. apparently high levels of interpersonal passivity).

D. Persistent symptoms of increased arousal (not present before Indian residential school attendance), as indicated by two (or more) of the following:
1. Difficulty falling or staying asleep;
2. Irritability or outbursts of anger, particularly when intoxicated with alcohol;
3. Difficulty concentrating, particularly in a school setting;
4. Hypervigilance, particularly with regard to non-First Nations social environments;
5. Exaggerated startle response.

Symptoms may also include:

E. Markedly deficient knowledge of one's own First Nations culture and traditional skills;

F. Markedly deficient parenting skills, despite genuine fondness for offspring;

G. A persistent tendency to abuse alcohol or sedative medication/drugs, often starting at a very young age.