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# Can The Complex Care and Intervention (CCI) Program be Culturally Adapted as a Model For Use With Aboriginal Families Affected by Complex (Intergenerational) Trauma?

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CAN THE COMPLEX CARE AND INTERVENTION (CCI) PROGRAM BE CULTURALLY  
ADAPTED AS A MODEL FOR USE WITH ABORIGINAL FAMILIES AFFECTED BY  
COMPLEX (INTERGENERATIONAL) TRAUMA?

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Chipo McNichols

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CAN THE COMPLEX CARE AND INTERVENTION (CCI) PROGRAM BE CULTURALLY  
ADAPTED AS A MODEL FOR USE WITH ABORIGINAL FAMILIES AFFECTED BY  
COMPLEX (INTERGENERATIONAL) TRAUMA?

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by the faculty of the Antioch University Seattle at Seattle, WA  
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

CAN THE COMPLEX CARE AND INTERVENTION (CCI) PROGRAM BE CULTURALLY ADAPTED AS A MODEL FOR USE WITH ABORIGINAL FAMILIES AFFECTED BY COMPLEX (INTERGENERATIONAL) TRAUMA?

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Despite living in a country with a world renowned healthcare system, Canadian Aboriginal children, youth and their families, consistently have poorer access to healthcare as well as higher mortality and morbidity rates, in comparison to non-Aboriginal Canadians (Tang & Browne, 2008). Among factors including their history of residential school and intergenerational trauma, the lack of a culturally specific treatment intervention for complex trauma, is identified as a key factor in maintaining this health disparity. This study used participatory action research within an identified Aboriginal community, to develop a culturally adapted complex trauma intervention model. This was based on an existing model that has been used with primarily non-Aboriginal children living in the foster care system. The result was an adapted model an intervention model that kept culture at the core of the treatment program. The model was adapted using both a Western neurodevelopmental theory and an indigenous framework based on local traditional knowledge. The adapted model will be applied in the community with the potential for further adaptations, and may be generalised for use with other Aboriginal communities. The electronic version of this dissertation is at AURA Antioch University Repository and Archive, <http://aura.antioch.edu/> and OhioLink ETD Center, <https://etd.ohiolink.edu/etd>

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In memory of my mom Eleanor Hlupekile Nyirenda who always believed in me. Thank you for teaching me by example that "I can do all things through Christ who strengthens me" (Phil. 4:13).

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## **Introduction**

### **Background/History**

According to a National Household Survey conducted by Statistics Canada in 2011, Aboriginal peoples (the indigenous Canadian population comprised of First Nations, Métis and Inuit peoples) represent 4.3% of the total Canadian population (Marshall et al., 2015, p. 3). In comparison to the total Canadian population, Aboriginal peoples make up a relatively small proportion of the population yet continue to have rates of mortality and morbidity that far exceed those of non-Aboriginal Canadians (Tang & Browne, 2008). Researchers have proposed several different theories to explain this disparity and overrepresentation of Aboriginal people in poor health indicators. This includes the proposal that factors such as cultural dislocation, intergenerational trauma and the impact of residential schools are strong contributors to this overrepresentation (Marshall et al., 2015). Additionally, policy makers recognize that many Aboriginal communities in British Columbia (B.C.) continue to struggle with high unemployment rates, problematic substance use, school absenteeism and high suicide rates. This makes it unsurprising that Aboriginal children and youth are at higher risk of mental health problems (Marshall et al., 2015). It is widely recognised that Aboriginal peoples in Canada have been impacted by the legacy of historical trauma based on the experiences of survivors of the Canadian residential school system (Health Canada, 2003, 2011).

It is therefore disconcerting that despite the recognition of the sequelae of this legacy, the Canadian mental health system has failed to provide culturally meaningful mental health services to Aboriginal Canadians, thus contravening the idea of providing equitable health care to all Canadians. There is a plethora of research and discourse, yet a dearth of results showing action towards the quest for understanding and treating the ongoing impact of the traumatic era in the

life story of Aboriginal peoples. While many trauma-focused interventions exist and are increasingly used in B.C., there is no evidence of a culturally specific intervention that addresses trauma based mental health concerns, not only at the individual level, but at the communal level as well. Such an intervention would account for the effects of intergenerational trauma and the associated problems that are unique in the experiences of Aboriginal peoples as a culture.

Due to the serious lack of literature on specific intervention programs for Canadian Aboriginal peoples, and to extend the scope of exploration in the study, I include some reference to literature that encompasses Australian Aborigine and Native American peoples, whose histories, I identified as most closely linked to that of Canadian First Nations people. I will use the terms 'Aboriginal' or 'indigenous' to refer to peoples whose ancestry is identified with the original inhabitants of Canada, Australia and the United States.

In this dissertation, I provide the reader with a history of the problem by discussing mental health concerns as they pertain to Aboriginal peoples in Canada. I then discuss complex trauma and both the general and culturally specific effects in relation to Aboriginal peoples. Finally, I discuss treatment and present the Complex Care and Intervention (CCI) program, as a community based treatment model that will be the focus of cultural adaption in collaboration with, the identified Aboriginal community. I also discuss existing challenges relating to research within indigenous communities and how the design of this study was chosen to pay heed to the concerns identified. On the premise of hypothesizing that Aboriginal peoples have been so impacted by intergenerational trauma that it has become embedded in their identity, I discuss the concept of critical race theory. This is the framework through which the exploration of cultural adaptations to the CCI model is made. The project goal is to develop an intervention model that

will address the gap in the availability of a culturally specific treatment intervention for exposure to complex trauma.

According to Linda Tukwila Smith (1999), for many indigenous peoples, colonial education was the main agency for Western authorities to impose superiority over knowledge, language, and culture. Smith cites numerous accounts of individuals who attest to the critical role of residential schools “in assimilating colonized people and in the systematic frequently brutal denial of indigenous knowledges, languages and cultures” (Smith, 1999, p. 67). The trauma associated with the systematic removal of Aboriginal children from their homes and the displacement from their culture is still active today. This continues to contribute to the malignant interconnected set of health and social problems afflicting most Aboriginal communities. Research shows that while the era of residential school placements is behind us, the effects of the experience, which include mental health and substance abuse issues, continue to manifest. These effects are rampantly evident in the lives of residential school survivors, as well as their children, and give face to the concept of intergenerational trauma which is discussed in more depth later in the document.

The cost of ignoring mental health and substance use affects all British Columbians. According to a report on B.C.’s 2010 ten-year plan ‘Healthy Minds, Health People’ to address mental health and substance use in B.C., the province spent over \$1.3 billion in the 2008/09 fiscal year on services that directly addressed mental health and substance use (a figure which only takes into account spending across three of the six main ministries involved in the delivery of mental health and substance use services). The report also shows the significant indirect cost of mental illness and a recent Canadian study shows that mental illness costs the Canadian economy \$51 billion annually in lost productivity -B.C.’s proportional share of this burden

would be more than \$6.6 billion each year. The mental health plan places strong emphasis on children and families in recognition of the fact that for most individuals, mental health problems originate in childhood strongly supporting the need for early intervention to reduce the risk of future suffering by delaying onset or reducing impact.

The mental health care system in Canada is one that is esteemed internationally as providing quality and accessible care to its residents, however Aboriginal peoples continue to evidence poor mental health outcomes. This is of particular concern with children and youth as research shows that Aboriginal children are at increased risk of developing multiple physical and mental health disorders. In 2003, B.C. led the way in Canada to address children's mental health by implementing the five-year Child and Youth Mental Health Plan for British Columbia. The plan broadened the continuum of services to include mental health promotion, prevention and reduction of risk for mental health problems, and the introduction of earlier evidence-based interventions to support children and youth with mental disorders.

Additionally, the plan included a specific focus on services for Aboriginal children. Using the framework of 'Healthy Minds, Healthy People', the Tripartite First Nations Health Plan (2007) recognized that the mental health and substance-related needs of B. C.'s Aboriginal peoples require culturally-specific approaches, a commitment was made to developing a complementary and culturally distinct plan for B.C.'s Aboriginal populations (Ministry of Children and Family Development, 2010). Unfortunately, despite recognition of this need and goals to meet the identified cultural specific need, the demand for children's mental health services far outweighs the capacity of public service providers. There are insufficient services to meet the need for the approximately 140,000 Aboriginal and non-Aboriginal children and youth suffering from seriously distressing mental health disorders (Ministry of Children and Family

Development, 2010). Of particular interest to this study is the fact that without a strategic and effective plan, this severe deficiency in mainstream services for children and youth, makes it even more challenging and further reduces the capacity of an overburdened system to provide interventions that are specialised by cultural need. The importance of recognising that interventions need to be culturally specific cannot be over emphasized and is supported by researchers who propose that culture and the self are inextricably bound (Christopher, Wendt, Marecek, & Goodman, 2014). They endorse the hermeneutic perspective that describes culture as the constellation of meanings that make up one's way of life and propose that culture is central, rather than marginal to human experience. In order to identify ways to fill this gap in critical, culturally meaningful interventions for Aboriginal peoples, it is therefore important to understand how culture has and is affected by the experience of exposure to complex trauma in ways that are unique to this population.

**Culture.** Particular consideration must be given to the culturally specific effects of complex trauma for Aboriginal children and their families. The experiences of injustices and colonialism are not only based in history; injustices continue to be found and may be entrenched in the current social conditions of inequality that many of Canada's First Nations people live in. This means that many aspects of the lives of Aboriginal peoples are continuously traumatic and this is a critical concept that must be emphasized. Haskell and Randall (2009) describe these ongoing traumatic events as relating to issues that include losses of language, land, culture and identity, disruption of traditional governance, high levels of child sexual abuse, sexual assault and domestic violence in many Aboriginal communities; and the epidemics of alcohol and substance abuse that are common to so many Aboriginal communities. While recognising that complex trauma typically results from chronic child abuse and neglect, researchers such as



Haskell and Randall propose that exposure to ongoing threats also comes from events such as witnessing domestic violence, war or genocide. These are collective rather than individual forms of traumatic experience. For Aboriginal children and their families, this happened because of the traumatic experience of being subjected to residential school. This was an education system that denigrated their indigenous languages, culture, and spirituality, while disrupting family ties and community involvement in traditional child rearing practices (Kirmayer, Gone, & Moses, 2014). This is the basis of the hypothesis that Aboriginal peoples can be described to have a collective cultural experience of trauma that presents unique challenges that complex trauma treatment models need to view as a central component of treatment. This view is supported by researchers such as Haskell and Randall, who suggest that it is necessary to have a more complete trauma framework that attends to the relevance of the social contexts which shape an individual's experience of trauma. They propose that this is a requisite for the development of a more holistic and sophisticated understanding of the effects of trauma on Canadian Aboriginal children and their families (Haskell & Randall, 2009).

Many Aboriginal children continue to live in conditions of poverty and deal with problems related to having parents with mental health and addictions issues. These difficulties are compounded by the fact that many Aboriginal people are not comfortable accessing much needed physical and mental health care due to negative experiences with the healthcare system. These experiences are based on discrimination, racial profiling and a lack of cultural sensitivity and safety. In their article, "Visible Minority, Aboriginal, and Caucasian Children Investigated by Canadian Protective Services," Lavergne, Dufour, Trocmé, and Larrivéé, (2008) cite Mitchell (2005) who proposes that families must overcome many systemic hurdles to meet the needs of their families and ensure their wellbeing. These hurdles include labor market entry problems,

discrimination (Lavergne et al., 2008), high rates of poverty, single parents (Lavergne et al., 2008), physical and mental health problems, lack of access to adequate housing (Mitchell, 2005), living in disadvantaged neighborhoods, and social isolation (Lavergne et al., 2008). Although some individuals have developed resiliency and transcendence from their parents, they are not likely to approach mental health professionals for help. This is unfortunate as these are the individuals from whom professionals might be more likely to learn from, and understand what is effective in helping to begin to heal the effects of intergenerational trauma.

**Trauma.** The disparities in health care between Aboriginal and non-Aboriginal Canadians continues to be the subject of much research and several theories have been proposed to explain this disparity. Some theories suggest that a significant barrier for Aboriginal peoples seeking treatment is the lack of culturally sensitive health care despite the thousands of dollars spent on cultural competency training. An alternative view of identified barriers to mental health accessibility for Aboriginal peoples may be to explore the impact of trauma itself on how services are perceived from a trauma-based worldview. There is strong evidence in the literature showing the impact of interpersonal trauma, specifically in childhood, on the structure and functioning of the brain and of the strong association between childhood maltreatment and social, emotional, behavioral, and cognitive adaptational failure as well as frank psychopathology both in later childhood and adulthood (Cicchetti & Toth, 1995; Post, Weiss, & Leverich, 1994). These effects can be seen in the interruption of typical developmental paths where expected attainment of growth or maturity in different areas is either delayed or actually hindered (Geddes, 2012). Traumatized children are often seen to have developmental lags in comparison to same aged peers and researchers have proposed that this is caused by a redirecting of the resources required for growth, to managing their persistently activated stress response

system (Geddes, 2012). Dr. Geddes cites Bruce Perry (1995), who proposes that victims of trauma develop persistent states of hypervigilance and hyperarousal that cause them to become focused on looking out for themselves and avoiding distress instead of connecting and bonding with others. The regulatory systems of trauma victims become wired to remain on high alert at all times which negatively impacts essential emotional, social, and intellectual development. This in turn leads to brain abnormalities in areas that depend on social experiences in order to develop. However, this writer posits that opportunities for socializing are likely to be reduced for children who have experienced trauma as their maladapted emotional and behavioral regulatory systems would predispose them to engaging in non-social and antisocial rather than prosocial behaviors towards others.

The experiences of trauma for Aboriginal children extend beyond the personal level and into the communal level due to the cultural history of intergenerational trauma. This may be a key factor in understanding the healthcare disparity as the collective cultural experience of trauma is likely to have a significant impact on whether families or caregivers are able to develop trust and feel safe enough to access the health care system. A social context complex trauma framework takes into consideration how historical trauma continues to adversely impact the opportunities for loving and attuned caregiving for Aboriginal children whose families and communities continue to experience the cumulative adversities that worsen the impact of complex trauma (Vogt, King, & King, 2007). The original injury of traumatic events is compounded by a lack of response and victim blaming, as well as inadequate protection and resources. The ongoing experiences of denigration, deprivation, neglect and loss interrupt the fundamental processes of psycho-biological development. The effects of intergenerational trauma have also been harmful to Aboriginal peoples' experiences of trusting others, learning

how to create healthy emotional boundaries and forming secure attachments which is a foundation for building healthy and reciprocal relationships (Haskell & Randall, 2009). The writer posits that the understandable lack of trust in others is a key outcome of traumatic experiences that clearly affects access to healthcare for Aboriginal Canadians. Intergenerational trauma effects can also be seen when caregivers act out the impacts of this generational grief at a personal and cultural level, which re-creates trauma as a way of life, making it part of the cultural expression and expectations for future generations (Wesley-Esquimaux & Smolewski, 2004). This means that the experience of many Aboriginal children is one of ongoing trauma.

This writer posits that this intergenerational history and ongoing experience of trauma may be a central factor to the barriers that maintain the disparities in access to mental health care for Aboriginal peoples. This would strongly support the need for a service that is not only ‘culturally competent’ but trauma specific from the perspective of a collective traumatic history. The disruption in normal brain development as it pertains to learning through social experiences creates a serious barrier to the formation of relationships with professional helpers who may be viewed as threatening by the traumatized individual. This concept may inadvertently be reinforced by well-meaning yet ill-informed professionals and serve to re-traumatize the victim when their maladaptive attempts at relating are met with labels such as ‘resistance’, ‘unreliability’, ‘inconsistency’, ‘noncompliance’ etc.

### **Identifying the Gap/History on the Problem**

There has been no shortage of discourse on efforts made towards healing and ameliorating the long standing and ongoing effects of the traumatic residential school legacy in Canada. A 2008 publication by the Aboriginal Healing Foundation ‘From Truth to Reconciliation: Transforming the Legacy of Residential Schools’ provides a meaningful

collection of personal accounts from residential school survivors of their experiences and exemplifies only one of several publications by the foundation that shines the light on a previously invisible era in history. However, it has been challenging to find literature on studies that have been done on providing treatment interventions that are culturally specific and take into account the intergenerational transmission of trauma. Despite extensive research on diagnosis and treatment based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR) (American Psychiatric Association, 2013) system of classification, trauma related disorders remain a prevalent presentation in Aboriginal populations with little indication of successful treatment outcomes using contemporary interventions alone. Mental health practitioners are becoming increasingly aware of the need to practice through a trauma-informed lens, which has helped to expand the scope of problem conceptualization. This approach has led to the development of different policies and procedures among mental health organisations in B.C. that incorporate a trauma informed way of practice, however, the element of culture as a central concept continues to be missing.

For Aboriginal scholars and practitioners, Aboriginal mental health must include the following principles: a holistic understanding of mental health, client focused and client designed services, community-family centred practice, self-determination and empowerment, and cultural relevance to each community (Marshall et al., 2015). They have long advocated for a move from medical pathologizing models, to models that use a holistic perspective that is consistent with an Aboriginal worldview. Marshall et al. contend that this means incorporating community, cultural identity, holistic healing and interdependence, proposing that this approach will better meet the mental health needs of Aboriginal peoples in Canada (Stewart, 2008). Mainstream mental health treatment approaches have shown limited success when compared to programs guided by a

cultural philosophy that includes traditional values and spirituality (McCormick, 2000). A paradigm shift towards this holistic approach would highlight the need to understand problem behaviors through the context of culturally bound, communal traumatic experiences and the detrimental impact on a child's developmental trajectory. There is evidence of the growing shift towards more trauma informed services following recognition that many children present with disorders that are trauma and stress related. This is seen in the changes in many mental health agencies in B.C. that are now actively endorsing and incorporating trauma informed models of practice in their treatment plans (Poole, 2013).

Despite this recognition, there is still a gap in providing a treatment program that keeps Aboriginal cultural history at the core while addressing mental health concerns arising as a direct result of exposure to complex trauma. Current interventions for trauma-related difficulties may consider culture as a periphery not central factor, thus failing to be informed by the unique issues that pertain to the history of intergenerational trauma that is the legacy of Aboriginal peoples. It is essential that mental wellness in the Aboriginal population is understood in the context of historical trauma and that neglecting to do so is what results in the frequent racially biased misdiagnosis of psychological disorders (Brave Heart & DeBruyn, 1998; Overmars, 2010). The Diagnostic and Statistical Manual Fifth edition (DSM-5) is widely accepted as the classification and diagnostic tool for mental health disorders. Although it now includes cultural factors for consideration, it still does not adequately explain the Aboriginal worldview of understanding the whole individual. Researchers suggest that the DSM-V is a classification system based on a Western worldview. They distinguish between Western paradigms which are described as dominant attitudes and beliefs, that are based on Western philosophies and practices and indigenous paradigms, which are defined as comprising of the shared cultural attitudes and

beliefs of indigenous people (Overmars, 2010). The DSM-V classification system shows little recognition of the fact that it is the balance of mental, physical, emotional, and spiritual wellness that is affected by the negative experiences, such as those associated with complex trauma. The heavy reliance on the Western-based DSM classification system for not only diagnosis but treatment planning, may be a key factor in creating and maintaining the disparity in healthcare access and outcomes for Aboriginal peoples. The cultural inadequacy highlights the long overdue need to develop models of treatment that will keep culture at the core while being experienced as culturally safe, sensitive, and effective for Aboriginal children and families.

### **How Will This Research Fill the Gap?**

One such model is the Complex Care and Intervention (CCI) program developed by Dr. Chuck Geddes of British Columbia. The CCI program was developed following a review of the literature, in which Dr. Geddes found a 2012 study by Greeson et al., showing that over 70% of children in the foster care system had suffered from multiple complex traumas. The word ‘trauma’ has multiple meanings and an all-purpose, consensus definition of ‘complex trauma’ is yet to be agreed upon. For this project, complex trauma was described by the National Child Traumatic Stress Network (NCTSN) as a child’s exposure to multiple, severe, and pervasive traumatic events that are often invasive, interpersonal in nature, as well as the wide-ranging, long-term effects of this exposure (NCTSN, 2014; Greeson et al., 2011). These events are severe and pervasive; such as physical or sexual abuse or profound neglect. They usually begin early in life and can disrupt many aspects of the child’s development and the very formation of a self. Since they often occur in the context of the child’s relationship with a caregiver, they interfere with the child’s ability to form a secure attachment bond.

The literature showed that in 2007, of the 9,271 children receiving out-of-home care in

British Columbia due to severe maltreatment, many suffered profound difficulties that were so severe that specialised resources were required to support them (Mulcahey M., Trocmé, N., 2010). It was with this knowledge and these children in mind that the CCI program was developed. The goal was to provide treatment to the children who required support that was outside the scope of typical outpatient care.

**Overview of the CCI process.** The CCI process has three general stages (Geddes, 2012). In the first, the ‘Preparation Stage’, a brief screening is conducted to determine the child or youths’ suitability for the program. The CCI coach discusses the existing case plan with the referral source and a care team is formed that is comprised of critical adults/members of the community who have a role in a child or youth’s life. The child’s main caregivers are asked to provide baseline data by completing an Achenbach System of Empirically Based Assessment ASEBA Child Behavior Checklist (C.B.C. L) as well as a CCI checklist in collaboration with the care team. The care team members sign an agreement committing to work collaboratively while bringing their unique perspectives to create a ‘therapeutic blanket’ to wraparound the child or youth in question. The second stage, which is the ‘Working Stage,’ has four steps. During step 1, ‘Theoretical overview of trauma and development’, care team members are oriented to the impact of complex trauma on child development with the goal of creating a trauma-informed platform on which to build the therapeutic model. This provides a framework for understanding the child’s behavior as impacted by trauma rather than pathological. It is through a trauma-informed lens that the care team commits to collaborating in making case decisions within the context of the team. During step 2, the ‘Functional Developmental Assessment’ (FDA), the team discusses the child’s typical behaviors and the associated causal neurological and developmental concerns. It is within the same context that a



functional developmental assessment is conducted to provide a visual representation of the child's developmental functioning along seven trauma domains as follows:

- Neurological & Biological Immaturity
- Over-reactive Stress Response Systems
- Emotional Regulation and Mood
- Attachment Style and Relationships
- Identity Development
- Behavioral Regulation
- Cognitive & Language Challenges

This 'picture' of the child serves to guide specific interventions targeting specific areas of need and prioritizing them as identified by the FDA (Geddes, 2012). In step 3, 'Intervention Planning', the team develops strategies and interventions. While recognizing that certain interventions are appropriate for different levels of developmental maturity, there is an awareness that most interventions are suitable and effective across multiple domains. Once interventions are agreed upon, the caregivers, guided by the CCI coach will implement the interventions with the child or youth. School staff are also supported in implementing interventions as appropriate for the child's learning environment. During the fourth step, 'Support and Monitoring,' priority intervention goals are identified and tracked over time using the Planning & Tracking Guide. As caregivers, and school staff implement the interventions, the process and outcomes are reviewed regularly through weekly support (or as needed) from the CCI coach. This also provides a template for the minutes of the monthly meetings with regular ongoing support being provided to the main caregiver leading up to the third and final stage, the 'Exit Stage.' This typically occurs at the 12 to 18-month mark and CCI facilitators gradually

withdraw their direct support to the care team and caregivers as driven by the developmental progress made by the youth and the stabilization of their problematic behaviors (Geddes, 2012).

In an unpublished review of the literature, Dr. Geddes found that the Public Health Agency of Canada (2010) classifies physical, sexual, emotional abuse, neglect, and exposure to violence as the five major categories of child and youth maltreatment that form its maltreatment typology framework. According to Cook, Blaustein, Spinazolla, and van der Kolk (2003), severe maltreatment, irrespective of its type, creates serious personal and developmental effects for children and influences seven general areas. Based on this research, Dr. Geddes developed the functional developmental assessment to examine the child's functioning and needs across the seven domains as listed above where development may have been disrupted due to exposure to complex trauma. To date, the CCI program has been implemented in approximately 27 communities with over 135 children and youth as well as 10 who were in the initial pilot group and results have shown success that has led to significant positive changes in the lives of the children served (Geddes & Austin, 2015). The CCI program has thus far only been used with children in foster care under the Ministry for Children and Family Development (MCFD), where interventions have been implemented by foster parents. Both the children and the caregivers have predominantly been of non-Aboriginal heritage.

### **Statement of the Problem**

The innovative work of Dr. Geddes in treating children and youth impacted by complex trauma is now well renowned in B.C. and has been paramount in filling a clearly identified gap by providing an effective trauma specific treatment model for children and youth. However, a serious deficiency remains in the availability of a treatment program for Aboriginal children and youth exposed to complex trauma that is not only trauma informed but both trauma focused and

culturally specific. Given that research has shown that severe trauma disproportionately affects Aboriginal Canadians when compared to non-Aboriginal Canadians (Karmali et al., 2005), the lack of a culturally specific trauma focused intervention not only presents a serious gap in service but illuminates the larger issue of social injustice. The failure of our mental health system to specifically address an empirically identified health problem in a specific population contravenes the notion of providing appropriate mental health services for all Canadians.

### **Research Question**

Dr. Geddes' work came to the attention of members of the Lytton First Nations community in B.C. who had just participated in a community education process based on Dr. Bruce Perry's Neurosequential Model of Therapeutics (NMT), which provides an in-depth understanding of the impact of chronic stress on the developing brain (Perry, 2006) A representative of the community consulted with Dr. Geddes and sought to find out whether the CCI program could be successfully implemented in their community in a culturally relevant way. In this research study, the Lytton research participants wanted to find out if the CCI program could be culturally adapted to develop an intervention program that could be used to treat Aboriginal children and youth exposed to complex trauma. Based on an understanding of the socio-cultural history of Aboriginal peoples and the impact of residential school experiences, the study included an exploration of the impact of intergenerational trauma on the (neuro) development of Aboriginal children and youth.

### **Specific Area of Research Focus**

The current CCI model has only been used with children in the welfare system where non-Aboriginal foster parents implemented the interventions. The application of the program in an indigenous community with children living with their biological families therefore

necessitates careful, and specific considerations and these will form the basis for three specific areas of focus. Firstly, the understanding of the impact of intergenerational trauma means considering the fact that the caregivers in these families will likely have a history of trauma making it important to ensure that they are screened appropriately for participation and supported accordingly to minimize risks of re-traumatisation. Secondly, consideration needs to be given to the readiness of participant caregivers to learn about the impact of trauma on a child's development and preparation for the impact of acquiring this knowledge in relation to their own parenting history. This includes consideration of the capacity of any caregivers who may be dealing with their own unresolved traumatic experiences to apply the interventions with their children. Thirdly, and perhaps most pivotal, is the exploration and understanding of what is expected of the healing process based on localised knowledge, beliefs and values as they pertain to this specific community. This will be a key part of the process, as the shared knowledge will be included in the parallel process of analysing the data received while using it to continuously adapt the current model resulting in the culturally adapted CCI model.

### **Goals of an Indigenous Healing Process**

In a 2004 publication prepared for the Aboriginal Healing Foundation by Cynthia Wesley-Esquimaux, and Magdalena Smolewski, the goals of any healing process for Aboriginal peoples are described as “a recovery of awareness, a reawakening to the senses, a re-owning of one's life experience and a recovery of people's enhanced abilities to trust this experience” (p. 78). They propose that a successful healing process includes the recovery of a social ability to create a new cultural paradigm thus bringing order to previous chaos and recovering and reintegrating the past into the present. This is an example of an Aboriginal specific framework for healing, and while this writer will continue to incorporate literature that captures the larger

Aboriginal population, it will be important to clarify when teachings and knowledge are localised in focus. This is an important distinction to make, as like other cultures, Aboriginal cultures are not all the same and will have features that are specific to their geographic locations and social networks (Isajiw, 1999).

This researcher also examined the theory of the intergenerational transmission of psychological trauma or Historic Trauma Transmission (HTT). Researchers suggest that as a cultural group, most Aboriginal peoples in Canada share the all too common experience of abuse, violence, neglect, and deprivation (Haskell & Randall, 2009). This will be the basis for the exploration of 'cultural trauma' as a phenomenon that manifests due to the experience of living with repeated traumatic stressors. According to Wesley-Esquimaux and Smolewski (2004), Aboriginal peoples not only continue to suffer from the impacts of generational grief, they act it out at personal and cultural levels, thus recreating trauma as a way of life. This has significant implications for Aboriginal children if these trauma laden experiences have become normalized and become part of the cultural expression and expectations of future generations.

### **Purpose of the Study**

The purpose of the study was to support the identified Aboriginal community in applying the CCI model of intervention within their community. The objective was to find out whether this model could be culturally adapted as an intervention for children and youth who have been exposed to complex trauma and present with the associated serious behavioral problems. The model was reviewed using a sample case study of a child living with his immediate and extended biological families. By considering the application of the model with family members in their natural environment, the study sought to uncover and address any potential barriers to the successful integration of the model for treatment within an indigenous community. A group of

identified community members, which included elders, were to be an integral part of implementing the program, identifying and facilitating cultural adaptations to the existing model as deemed necessary by the participants during the process. The adaptation process was also a forum for addressing issues of risk and possible harm, cultural sensitivity, and relevance. The outcome of this study was to achieve the development of a culturally adapted model of the CCI program that had the potential to be generalised for use by other indigenous communities.

The adaptations to the intervention were to be applied under the hypothesis that the intergenerational experience and effects of complex trauma have become embedded into the cultural identity of First Nations people. Under this premise, a culturally adapted CCI model would serve to provide an intervention that would extend beyond the targeting of specific developmental domains. Using a culturally adapted CCI model may also provide an avenue for participants to understand their individual and cultural identity from a trauma perspective in a way that serves to reduce existing group shame and humiliation (Weingarten, 2003) particularly regarding maladaptive parenting practices. The culturally adapted model will provide a culturally specific trauma intervention program that is co-created by an indigenous community, making this study one that not only benefits the larger field of psychology, but most importantly benefits the local community and possibly the larger indigenous population. This will add new knowledge to existing local knowledge, which will be used to bring positive change to the community, while generating a specific theoretical perspective through which to understand the experiences of Aboriginal peoples. In his book *Research is Ceremony* Shawn Wilson (2008) posits, “If one uses race or culture as a defining perspective, then theory and knowledge may be generated that reflect this perspective” (p. 38). Similarly, this writer hopes that using Aboriginal culture and race as defining perspectives will lead to the development of a theory that truly

reflects the history of Aboriginal peoples, and illuminates the pathway to intergenerational healing in their communities.

### **Theoretical Frameworks**

This study focused on a particular population as defined by culture and race. These two factors were used to explore the research question through a critical race theory lens. Critical theorists posit that our reality is shaped by our cultural, gender, social and other values. One of the central principles of Critical Race Theory (CRT) is that of ‘expanding the notions of expert knowledges’ (Torre, 2008). CRT has shown how important it is to find alternative narratives to subvert dominant rationalizations and ideologies through the use of methods such as storytelling, the sharing of oral history, biographies, parables or testimonies (Anzaldú, 1999; Bell, 1987; Guinier & Torres, 2002; Olivas, 1990; Torre, 2008). This idea fits well with the study, which is centered on the idea of using local knowledge. The use of local knowledge positions the participants in the study as experts, thus expanding the idea of who holds expert knowledge. This also supports the goal of using literature and principles that are defined under indigenous research at the center of the study. Wilson (2008), proposes that the dominant research paradigms are based on the fundamental belief of knowledge as an individual entity; this is contrary to the indigenous research belief of knowledge being understood in a relational context, that extends beyond interpersonal relationships, and is inclusive of all of creation.

Another key principle of CRT is that of ‘complicating identity categories’. Although the centrality of race and racism is a basic premise of CRT, scholars encourage us to expand our thinking beyond the understanding of race based on visible skin color, but to explore the ideas of political race and the way that power constructs relationships (Guinier & Torres, 2002). This is an important factor in the study. Power in relationships is embedded in the concept of

intergenerational trauma transmission, which will be explored in the study using the indigenous research paradigm of all things being related and therefore relevant. This challenges the hierarchical structure of power in relationships, and will be reviewed in relation to the principle researcher's role and identity, and how this influences the process and outcome of the study. From an indigenous research perspective, relationships are egalitarian, as symbolised by the traditional circle, once again challenging the hierarchical structure of relationships.

Despite having a good framework to begin with using CRT, the researcher deemed it inadequate as a stand-alone theory to capture the core concept of the study which places the traumatic experiences of this cultural racial group at the centre. CRT scholars propose that identities are shaped by multiple values including race, gender, and culture. However, the experience of trauma can permeate a community with such depth that it moves beyond the individual experience into the communal experience. Based on both personal and professional experience, this is much more likely to happen in a collectivist culture and appears to be common in many indigenous cultures. This creates the basis for the idea that the nexus of race, culture, and trauma generates a unique identity that is distinct from each concept as a standalone factor. This writer therefore proposes to use a 'cultural trauma critical race theory' in which each of the three concepts are germane. This idea may serve as a framework for identity reintegration work, as proponents of contemporary literary trauma theory assert that trauma creates "a speechless fright that divides or destroys identity", that creates the foundation for the larger claim that suggests identity is formed by the intergenerational transmission of trauma (Balaev, 2008).



## Literature Review

### Intergenerational Trauma in Aboriginal Communities

This section provides the reader with an overview of the research on what intergenerational trauma is and highlights the distinction between different terminology that is sometimes used interchangeably such as Historical Trauma Transmission (HTT) and psychological transmission of trauma. Intergenerational trauma is experienced by many cultural groups, and has been seen following traumatic events such as the Holocaust or cultural genocides such as occurred in Rwanda and Cambodia. Some indigenous scholars have used explicit analogies to the Holocaust and its' effect on the health of Jewish people as a way to better understand the transgenerational effects of historical trauma and the processes of recovery (Kirmayer et al., 2014). This analogy has been supported by some scholars such as Fassin and Rechtman in the fields of both psychiatry and psychology, where a universal trauma response has been presumed (Kirmayer et al., 2014). However, other scholars such as Vizenor have disagreed, and contend that there are striking differences in the social, cultural, and psychological contexts of the Holocaust and of post-colonial Indigenous "survivance" (Kirmayer et al., 2014). They propose that the comparison suggests that the persistent suffering of the Native peoples in North America is a reflection of ongoing structural violence rather than of past trauma. They agree that it may be helpful to use comparative studies of genocide and other forms of massive, organized violence to identify common mechanisms as well as distinctive features, and show the looping effects from political processes to individual experiences and back. However, they draw attention to the idea that each human catastrophe carries its own history, social dynamics, and associated patterns of individual and collective response that are rooted in the culture and the context. It is on this premise that this study focuses specifically on the unique

experiences of the historical trauma effects, and ongoing traumatic experiences of Aboriginal peoples in Canada.

Different terms have been used to discuss the idea of traumatic experiences that happen at not only the individual level, but at a communal level as well. These experiences continue as a legacy among a group of people within a culture. In a 2005 report published by the Aboriginal Healing Foundation, Chansonneuve (2005) describes 'intergenerational trauma' as a phenomenon that occurs when an older member of a community, such as a parent, grandparent, elder, chief, or community member transfers the effects of traumatic experiences and their ability or inability to cope with stressors (including poverty, addiction, discrimination, and abuse), to a younger member of the community. This transfer to children, grandchildren, nieces or nephews affects their ability to lead lives that are mentally, physically, emotionally and spiritually healthy. In the document Chansonneuve describes intergenerational trauma as being a process in which the lack of ability to cope with stressors is transferred from one generation to the next as a continuous, unresolved emotional and psychological disruption due to exposure to traumatic events.

In their report prepared for the Aboriginal Healing Foundation, Wesley-Esquimaux, and Smolewski (2004) use the interchangeable term 'Historical Trauma Transmission,' and describe their model of trauma transmission as a process in which "The trauma memories are passed to next generations through different channels, including biological (in hereditary predispositions to PTSD), cultural (through story-telling, culturally sanctioned behaviours), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory processes) channels" (p. 76). A review of the literature discussing some of the different definitions and conceptualizations of trauma transmission across generations, shows that the

different terms may be used interchangeably. There is however, a commonality and acceptance of the idea that the impact of trauma extends beyond the individual experience into the collective experience within a cultural group.

Although there are conflicting perspectives on whether trauma can actually be transmitted between generations, in a community presentation given in 2009, Allyson Cushing suggested that it is not the trauma itself that is transmitted but the effects of it. She proposes that this occurs at the biological level (low cortisol levels leading to biological stress response), the psychological level (projective identification), the familial level (learned behavior such as parenting as modeled using harsh discipline, negative communication, rejection, neglect) and at the societal level that often manifests as group shame and humiliation (Cushing, 2009). This transmission occurs at the interpersonal (parent to child) level and at the intergenerational (generation of parents to generation of children) level whence enough individuals are affected that the entire group or culture is impacted. Morgan (2009) describes child abuse and neglect as common avenues for the inter-generational transmission of trauma that leave many Aboriginal children vulnerable to social disadvantage, substance abuse and mental health problems in later life. The transmission of trauma can happen directly when parents subject their children to the same maltreatment with which they were treated. Trauma transmission can also happen indirectly when children of parents who were subjected to abuse learn the maladaptive coping behaviors that their parents used leading them to behave as though they have suffered the same trauma that their parents did (Morgan, 2009). When interpersonal trauma occurs and the source of distress is the caregiver, this creates confusion for the child who wants to reach out to the caregiver for comfort and support, but also wants to push him or her away for causing distress. This approach-avoid paradigm creates even further stress for the child but if this is the coping

style that the child has been exposed to by parents, this is what the child will adopt. If parents see the world as fearful and dangerous, this is the worldview that their children incorporate thus behaving as if they had been traumatized in the same way (Cozolino, 2006).

While the experience of intergenerational trauma and its' detrimental effects remains subject to controversy with cynics questioning its validity and continued impact in current society, it is difficult to dispute the fact that the experience of a young child being forcibly removed from his or her caregivers is traumatic. For decades, scholars have provided evidence to show that one of the many ways in which damage to the attachment relationship can be severely disrupted or damaged is separation from a primary caregiver(s). The forced removal of Aboriginal children from their caregivers and the widespread often severe abuse and neglect experienced in the institutions is a clear representation of profound early trauma for those children (Human Rights and Equal Opportunity Commission [HREOC], 1997; Read, 1981). According to Bruce Perry (1995), this early experience of trauma would have led to a disruption in the development of brain structures which in turn would have had a profound and lifelong negative impact on the socio- emotional functioning of removed children. Other studies have shown that there is a direct relationship between early childhood exposure to chronic trauma and higher rates of mental illness, substance abuse problems, and lower levels of social, emotional and cognitive functioning in adulthood (Arnold, Rogers, & Cook, 1990; Swan & Raphael, 1995). Findings from one of the largest studies examining the relationship between childhood maltreatment and later life health and wellbeing the well-known Adverse Childhood Experiences (ACE) study also showed that ACEs are very common, are highly interrelated and that there is graded relationship between number of ACES and the number of social and health outcomes. This graded relationship gave a good indicator of the effects of cumulative stress on (neuro)

development (Newlin, 2011). Findings such as these make a strong case for early intervention in children and youth to circumvent a developmental trajectory that is at serious risk of going awry due to exposure to trauma. Early intervention is also important from the perspective of the community who are stakeholders in our provinces' economy. It presents an avenue for changing the typical financial pathway of mental health dollars spent on longer, less malleable, costlier, later life intervention in adulthood to earlier, more effective, more malleable, reduced duration childhood intervention and prevention.

In considering early intervention, Vogt et al. (2007) emphasize the importance of taking into consideration how historical or intergenerational trauma continues to have a harmful impact on the opportunities for loving and healthy caregiving for Aboriginal children.

Understanding the impact of intergenerational trauma means taking into account the fact that the child's caregivers will likely have a history of trauma that affects their current way of receiving and sharing information regarding trauma as well as their parenting abilities. As a result of the residential school legacy where children were removed from their families, the attachment ties that had already been established from infancy were forcibly disrupted. This left caregivers with a sense of grief and immense loss as opportunities for parenting and the passing on of traditions were taken away. Intergenerational trauma effects can be seen when caregivers act out the impacts of this generational grief at a personal and cultural level, which re-creates trauma as a way of life, making it part of the cultural expression and expectations for future generations (Wesley-Esquimaux & Smolewski, 2004).

### **Incorporating Indigenous Principles of Research**

There is no shortage of literature on studies conducted in the health and psychology fields exploring physical and mental health outcomes among vulnerable populations, which includes

indigenous populations. However most of the studies are conducted by non-indigenous researchers and this remains the subject of much controversy with some indigenous researchers contending that non-indigenous researchers cannot truly grasp the multifaceted culturally bound layers and complexities of research within indigenous populations. One such researcher is Linda Tukwila Smith who posits that indigenous people want to tell their own stories, in their ways, in their versions and for their purposes as a process that is not merely the giving of an oral account but a powerful need to give testimony and bring back into existence a fragmented world. Smith further proposes that writing has been viewed as the mark of a superior civilization that has created a judgement of others as incapable of critical thinking or having distance from ideas and emotions (Smith, 1999).

The challenge of having indigenous researchers conduct research within indigenous communities is heightened by their shortage, particularly in the field of psychology. This shortage is reflected in the visibly inadequate representation of indigenous students in psychology graduate programs, based on personal experience and conversations with other indigenous students. This lack of indigenous students results in a lack of indigenous instructors and researchers, therefore, until this changes, non-indigenous researchers will continue to conduct most of the research. As researchers learn more about the significance of keeping culture as central in the exploration of human behavior, the incorporation of indigenous principles in research is becoming less atypical. However, simply incorporating the principles does not mean the study will transcend other culturally embedded variables that are pertinent to the successful outcome of a study with indigenous populations.

This is evidenced in a study by Loppie (2007) who sought to explore the perceptions of midlife health experiences (spiritual, physical, psychological, emotional, and social) of elder

Aboriginal women in Nova Scotia, Canada. This research built on her master's thesis exploring the knowledge, attitudes, and experiences of menopause among African Canadian, Aboriginal, and Euro-Canadian women; the findings of which highlighted the distinct influence of cultural context on women's perceptions of menopause (Loppie, 2007). In her research, Loppie (2007) sought to incorporate indigenous principles into her work and qualitative methods with an indigenous worldview allowing her to gain knowledge and competence in Aboriginal health research. A partnership emerged between the researcher's team and the participating Mi'kmaq women that created opportunities for the researcher to incorporate the paradigmatic and methodological traditions of Western science and indigenous culture. Loppie also discussed learning through her interactions with the Mi'kmaq women about how the lack of culturally relevant information regarding midlife experience presented difficulty for them. She also articulates her developing awareness of the tension that arose out of conducting Western social science research among Aboriginal peoples and her own ignorance regarding how to create a more equitable process.

Given these experiences, the researchers' choice of research method seems to be appropriate for exploring a complex issue in a way that honors and transcends cultural distinctions. Loppie (2007) developed a research design that accommodated the multiple realities and unpredictable interactions between research partners. Her design was representative of an amalgamation of the principles of indigenous and Western methodological traditions such as ethnography, participatory action research and feminism. The soundness of Loppie's methodology is evidenced in several ways; for example, she positioned herself within an indigenous epistemology by acknowledging the wisdom of elder women and inviting their partnership in storytelling as a vehicle of teaching, learning, and sharing (Battiste, 2002;

Castellano, 2000). She also exemplified her incorporation of an ethnographic approach through contextualizing and emphasizing the social and cultural meaning of Aboriginal women's experiences.

This writer finds Loppies' use of qualitative research refreshingly flexible and truly reflective of an approach that is respectful of participant beliefs and traditions in the absence of a self-serving agenda. In honor of Western methodology, the researcher's initial analysis was based on an adapted form of the grounded theory approach and the use of open, axial, and selective coding to derive themes inductively and deductively (Loppie, 2007). The author reports yielding a very rich collection of stories that enabled her to delve into major themes to uncover the deeper meanings of the women's words. The study was successful in answering the research question and not only provided results that highlight how challenging the midlife experiences of Aboriginal women are, but also provided learning for future research with indigenous communities on the level of skill, commitment and willingness required to enter into prolonged and intimate engagement of one's consciousness in this process.

While this writer supports Loppies' claim that although creative expression is an essential component of indigenous knowledge (Battiste, 2002; Castellano, 2000), it is often constrained by notions of what is acceptable within scientific literature, it appears that the field of psychology has strong evidence for endorsing creative approaches. The recognition of the self as being constructed in a historical and cultural context has been increasingly supported. It is my strong belief that where creative expression is constrained in research, it may be the individuals' own fear of allowing the vulnerability that comes with deep engagement on an emotional, psychological and spiritual level that may be the deterrent rather than the disciplinary boundaries of research.



## **Treatment of Complex Trauma**

A literature review was conducted to find out what if any of the many programs and models for treating complex trauma in children had culture as a central consideration. This review did not result in the identification of a program that was not only culturally sensitive but had culture at its centrality and that was specifically designed from an Aboriginal worldview. While it is generally agreed that a child's response to trauma is mediated by his or her age and developmental level, this writer did not find any interventions that took into account a child's *developmental age* as a guide for providing treatment. Ongoing traumas starting in early life have potential to dramatically alter the developmental trajectory of young children more than chronic traumas that begin in later life and this has implications for treatment planning.

The literature shows an array of different models that have been and are currently used to treat complex trauma in children and adolescents. Arnold and Fisch (2011) propose an integrated model of psychotherapy based on a developmental psychoanalytic perspective. They suggest that a comprehensive and consistent framework is necessary for effective psychotherapy to occur and support author Lawrence Hedges' assertion that the best form of treatment is that which matches an individual's ego structure (Arnold & Fisch, 2011). According to Hedges, individuals who have experienced complex trauma over a long period of growth and development, the ego structure fluctuates making the most effective treatment one that is capable of fluctuating to match the client's current state or current experience. This idea supports the CCI framework as a treatment model that applies specific interventions to match the clients' existing developmental state across different domains. Arnold and Fisch propose that a psychotherapy framework based on developmental issues and relationships that also allows for the integration of specific techniques such as eye movement desensitisation and reprocessing (EMDR), tapping, cognitive

behavior therapy (CBT), dialectical behavior therapy (DBT) or hypnosis would be developmentally and therapeutically appropriate (Arnold & Fisch, 2011) as an intervention for complex trauma. These interventions are widely used to treat trauma related disorders however clients often present with a complex array of other comorbid concerns such as depression and anxiety making it challenging to distinguish whether the interventions are successful at ameliorating the trauma specific symptoms.

The identification of symptoms that are specific to trauma is not an easy task as many of them will present in other disorders too. This increases the likelihood of misdiagnosis and in turn inappropriate intervention. How then are trauma symptoms identified? Judith Cohen in her 2006 book *Treating Traumatic Grief in Children and Adolescents*, describes trauma symptoms as behavioral, cognitive, physical and/or emotional difficulties that are directly related to the traumatic experience and typically correspond with PTSD symptoms (Cohen, Mannarino, & Deblinger, 2006). Other symptoms include depressive, anxiety or behavioral symptoms and include self-injury, substance abuse, impaired interpersonal trust and affective instability. Children who exhibit trauma symptoms may experience profound changes in how they perceive themselves, the world and other people due to their exposure to trauma. Long standing research has shown that children's early attachment experiences are also adversely impacted by trauma. These are key to developing their template for relating to others into later life. Negative interactions such as those borne out of parental neglect or inconsistent availability, make children vulnerable to developing insecure attachment patterns. In contrast, high levels of positive emotion experienced in a playful, responsive, and joyful attachment relationship move children towards developing positive social, emotional and relational experiences throughout their lives (Schoore, 2003). Evidence now shows that psychobiological changes also occur that contribute to

the development and maintenance of these psychological symptoms (Cohen et al., 2006). She classifies trauma symptoms into different categories, which include affective, behavioral, and cognitive, and proposes that these symptoms overlap and interact continuously.

Cohen et al. (2006) posits that the most common affective symptoms include fear, depression, anger, and affective dysregulation, where children exhibit frequent mood changes and/or difficulty tolerating negative affective states. Fear is instinctive and learned as when children are in life threatening situations, the autonomic nervous system responds to perceived threat with the release of copious amounts of adrenergic neurotransmitters which can reinforce anxiety (Cohen et al., 2006). Cohen et al. also propose that fear memories of the trauma are encoded in the brain differently from non-trauma related memories. The fear response can become generalized to people, places, things that are inherently innocuous, but remind the child of trauma. General anxiety can develop and children may feel generally unsafe, act hyper-vigilant and 'on guard' to protect themselves. A sense of impending doom can interfere with children's ability to engage in developmentally appropriate tasks and contribute to them taking on responsibilities beyond what is typical for their maturity level. Parentification can occur and constant vigilance for possible future threats can occur and all interfere with healthy adjustment. Depressive symptoms may be experienced after trauma leading to loss of trust in people and the world since the child feels a loss of innocence, faith or hope for the future. Some may have concrete losses, for example a child who is sexually abuse having loss of virginity and painful genital injuries. Children's egocentric view of the world although developmentally appropriate may lead them to blame themselves for the trauma and in turn can lead to feelings of guilt, shame, low self-esteem, worthlessness and even suicidality. Negative self-image can contribute to children making poor choices regarding friends and romantic partners and lead to engaging in

self-destructive behaviors such as substance abuse, cutting, unsafe sexual practices, suicide attempts all of which are strongly related to a history of child abuse or other traumas (Cohen et al., 2006).

Other researchers such as Bancroft and Silverman (2002) have identified anger as a symptom that can manifest as child becomes aware that trauma was unfair and that child didn't do anything to deserve it, children who are physically abused or bullied can develop anger when they witness their caretakers coping inappropriately with difficulties or frustrations. Children who experience domestic violence may develop 'traumatic bonding' (Bancroft & Silverman, 2002) as they realise that their safety depends on aligning with the abuser. Anger can also manifest as non-compliant behavior, unpredictable rages or tantrums, physical aggression towards others or property, sexually abused children may engage in sexual aggression towards others.

According to Haskell and Randall (2009), a child exposed to complex trauma also suffers effects that disrupt the core developmental experience of learning to manage their emotions effectively. In optimal conditions a child develops the capacity to be calmed when their emotional arousal is too high and to be stimulated when their arousal is too low. Traumatized children often do not have the opportunity to learn these skills and are unable to regulate their emotional and behavioral states, i.e. to self soothe. This affect dysregulation may persist into adulthood and is at the core of a range of trauma responses, many of which can lead to further harm for the traumatized person, often manifesting as substance and alcohol abuse (Haskell & Randall, 2009).

Affect dysregulation and disrupted attachment are intricately tied consequences of traumatic experiences of abuse, neglect and deprivation. Haskell and Randall (2009) suggest that

abuse and neglect are intergenerational as parents pass on their learned way of parenting. If parents were abused and neglected themselves, leading to deficits in their ability to care for themselves, this makes it difficult for them to care for others, which includes their children. This inadequate childrearing is especially likely in homes where parents live a chaotic and disorganized life due to depression, substance abuse and dissociation. This neglectful parenting in turn often leads to impaired attachments between caregivers and their children, limiting much needed opportunities for a child to develop emotionally healthy relationships with others (Haskell & Randall, 2009).

For Aboriginal families, the responsibility for the child's physical and emotional wellness is not left to the mother (or father) alone. Instead, the "nuclear" family of mother, father and children is only a household that is part of a larger family (Neckoway et al., 2007). The family ranges from the extended family concept where bloodlines and lineage are important to the wider view in which clans, kin and totems can include elders, leaders, and communities. This means that all these family members share responsibility for caring and nurturing of the child (Neckoway et al., 2007). The attachment bond is therefore between the child, parent and other caregivers, making it a multi-layered rather than dyadic relationship. It is within these diverse overlapping bonds that a strong network of relationships is built, where mutual sharing and obligations of helping each other form the child's secure base of exploration. It is on this basis that the suggestion is made that Aboriginal parenting is often a shared parenting experience (Neckoway et al., 2007). This is therefore, the context within which a child develops their attachment style. In the case of a child growing up in a family and community that has been impacted by intergenerational experiences of trauma and associated disrupted attachments, this is the context in which the child's attachment template and identity develops. This writer

hypothesizes that this intergenerational transmission of the effects of trauma is an experience that has affected all Aboriginal peoples. As a collectivist culture that engages in shared parenting practices with values that embody a relational connectedness that extends across blood family, extended family and kin, as well as the larger community, it can be expected that traumatic effects are also shared.

### **Cultural Trauma Critical Race Theory**

This study is based on the hypothesis that as community and a culture, the identity of Aboriginal peoples has been shaped by a communal experience of trauma, proposing that this may be described as ‘cultural trauma critical race theory.’ This hypothesis is made through the perspective of a Critical Race Theory lens (CRT). CRT suggests that an individuals’ reality is constructed within a social historical context and that the facts cannot be viewed in isolation from the domain of values (Kincheloe & McLaren, 1994). They propose that some of the basic assumptions of CRT are that language is central to subjectivity, that certain groups in society are privileged over others and that oppression has many faces, therefore to focus on one at the expense of others, is to ignore the interconnectedness among them. Additionally, the assumption is made that mainstream research is generally implicated in the reproduction of class, race and gender oppression systems (Kincheloe & McLaren, 1994).

Critical Race Theory commits to theoretical, ethical, and methodological principles and practices that embody these assumptions. Three of these principles are as follows: (a) To expand the notions of expert knowledge; through the use of storytelling, oral histories, biographies, parables, or testimonies, CRT seeks to demonstrate the significance of finding alternative narratives that destabilize dominant explanations and ideologies (Anzaldú 1999; Bell, 1987; Guinier & Torres, 2002; Olivas, 1990; Williams, 2004 as cited in Torre, 2008). This supports the

recognition of the fact that those at the bottom of social hierarchies often have good insight into the social constructs that maintain those hierarchies (Matsuda, 2002). CRT therefore values and build research around local expertise. (b) CRT seeks to recognize that individuals have multiple, overlapping, potentially conflicting, identities, loyalties and allegiances. CRT researchers broaden our understanding of intersectionality scholars have furthered our understandings of the multiple identities within individuals, urging us to remember the immense variability within groups (Delgado & Stefancic, 2001; Crenshaw, 1995; Matsuda, 2002). This has led to different methods of data collection that have opened the door to many layers of participation and allows participants to access the different identities to better understand material and make connections in seemingly different theoretical positions. (c) To complicate identity categories. The most basic premise of CRT is the centrality of race and racism to US society, however, CRT scholars urge us to expand our understandings of race beyond skin color and to think about the idea of “political race” and relationships are socially constructed based on power. (Guinier & Torres, 2002). The use of Participatory Action Research (PAR) compliments this perspective as this is a research method that acknowledges the role of power and privilege in the multiple and varying relationships. PAR goes a step further than simple acknowledgement by encouraging research that engages rather than ignores these differences, thus fostering equal participation across groups that have historically been positioned against each other (Torre 2005; Torre and Ayala forthcoming).

The principles described, and their positioning within PAR as a method of research are reminiscent of the experiences of Aboriginal peoples. The use of stories, biographies and parables is one of the main ways that knowledge is shared for many indigenous people. The inclusion of these methods by CRT scholars as a way of expanding notions of expert knowledge,

not only honors an Aboriginal tradition, but pushes researchers to transcend the mainstream Eurocentric idea of who is identified as an expert with valuable knowledge to share. It is in the stories of Aboriginal peoples and their histories that researchers embrace the invaluable opportunity to learn about the identity of Aboriginal peoples as it has been affected by historical trauma. Using a CRT lens allows us as researchers, to move towards a paradigm shift that renders the carriers of local, traditional knowledge in Aboriginal communities, as the true experts in what affects their way of being.

The CRT principle of recognizing that individuals have multiple overlapping identities, is also an important perspective through which to consider how trauma has shaped the identities of Aboriginal peoples. In general, individuals understand their identity as being made up of many different values which include race, gender and culture. For Aboriginal peoples, these values and beliefs are impacted by racist stereotyping with negative attributes, and a bias towards trauma based behaviors being described as mental health problems, while the histories of abuse are overlooked (Haskell & Randall, 2009). According to Bessel van der Kolk (2005), many trauma survivors who seek mental health services end up being misdiagnosed with multiple psychiatric diagnoses because consideration is not given to the context in which the individual developed these responses. Van de Kolk proposes that many of the “symptoms” that these individuals exhibit are in fact attempts to cope with, and adapt to stress; he contends that research supports his claims, showing that many of those seeking treatment, are typically found to have histories of prolonged and/or multiple traumatic experiences (Haskell & Randall, 2009). This leads to a collective experience of trauma based shame and guilt. Instead of developing an identity of ownership and gratification in their culture and in who they are, many Aboriginal adults and children’s sense of self is characterized by sadness, self-hatred, guilt and shame. This leads to



self-destructive behaviors, loss of meaning and hope, and aggression often expressed against themselves (Haskell & Randall, 2009). This writer hypothesizes that ongoing traumatic experiences that are part of the everyday lives of Aboriginal peoples, due to the loss of protective factors such as language, cultural ties, traditions and ways of being in the world, have become embedded into the very fabric of Aboriginal communities. This in turn shapes the identity of Aboriginal peoples as values and beliefs are eroded by the reenactment of trauma resultant negative behaviors. This may be a key factor for children who then deny their cultural heritage and are too ashamed to embrace a positive cultural identity that allows for the development of their natural gifts and strengths. This hypothesis is supported by different researchers including Isaak et al. (2010), whose findings show that in Aboriginal communities where there are lowered incidences of mental health related concerns such as youth suicide, and maladaptive stress coping skills such as alcohol and substance use, traditional protective factors are present (Chandler & Lalonde, 1998). Isaak et al. propose that the effectiveness of protective factors that include: participation in community practices, ceremonies and restoration (Chandler & Lalonde, 1998), good school performance, regular attendance of church or spiritual based practices (Kirmayer, Brass, & Tait, 2000), keeping connections to cultural past and feeling a sense of ownership and control of one's community or environment (Chandler & Proulx, 2006), high community social networks, and enriched relationships and communication between adults and youth has been shown to protect individuals, families and communities from negative experiences that result from trauma, such as suicide and substance abuse (Isaak et al., 2010).

### **Trauma Theory**

Trauma theory has its history rooted in several different areas of work. In their book *The Future of Trauma Theory: Contemporary, Literary and Cultural Criticism*, Buelens, Durrant,

and Eaglestone (2014) situate the origin of trauma theory in post deconstructive work. They contend that the trauma theory developed from the Yale school of deconstruction, was part of the ‘ethical turn’ in literary theory and European philosophy and grew largely through the work of Cathy Caruth and Shosana Felman to become a critical-theoretical way of addressing and representing personal and communal human suffering and wounding at both the literal and metaphorical levels (Buelens et al., 2014). This perspective of a post deconstructive origin to trauma theory is interwoven with other schools of work and include memory studies and critical historiography as well as the works of Judith Herman and Roger Luckhurst (Buelens et al., 2014). However, Buelens and colleagues consider the post deconstructive perspective as central to trauma theory and postulate that it gives answer to the question of the ethics of deconstruction. They also cite other scholars such as Michael Rothberg, Jane Kilby and Susannah Radstone, who have found flaws and omissions in trauma theory, and suggest that there are certain areas in the theory that require further development. A contention of Steph Craps is that trauma theory has largely focused on the holocaust as a representation of individual and communal trauma thus marginalizing other atrocities (Buelens et al., 2014). Craps criticizes trauma theory as being too Eurocentric in its development creating the risk of appropriating other, non-Western events into a Western model of traumatic suffering (Buelens et al., 2014). Other scholars such as Wulf Kansteiner have given a parallel but harsher critique to the theory. In a series of articles Kansteiner describes trauma theory as an “interdisciplinary research trajectory that has gone astray,” one that obliterates ‘historical precision and moral specificity’ (Buelens, 2014, p. 13). Kansteiner argues that trauma theory conflates the traumatic and the non-traumatic providing instead an “aestheticized, morally and politically imprecise concept of cultural trauma, which

provides little insight into the social and cultural repercussions of historical traumata” (Buelens et al., 2014. p. 13).

Kansteiner’s arguments find shortcomings with trauma theory that are largely embedded in the idea that the post deconstructive approach fails to capture the concept of cultural trauma from a moral and political standpoint. He contends that Caruth and others show more interest in trauma as a way of demonstrating their view of language and references than in the particular history of the trauma itself, yet he does not offer an alternative perspective himself. This writer contends that the context for understanding trauma theory needs to extend far beyond language and its references, social and political contexts and reach into the realm of the individuals’ identity at both the personal and communal level. This forms the basis for the assertion of a theory that embeds the experience of mass trauma within the identity of a cultural group.

## **Method**

### **Introduction**

This chapter will provide the reader with an understanding of Participatory Action Research (PAR) as the chosen research method and the underpinnings of this advocacy/participatory worldview. The purpose is to show the reader the historical issues that led to the development of this research method, and how these very issues make this approach the most suitable for the project. This chapter also serves to introduce the reader to the indigenous research paradigm that will be kept at the core of the study, showing why this is a critical component of the methodology. This section will also orient the reader to the characteristics of a qualitative approach. It will also provide some background to the use of a case study, which is the chosen strategy of inquiry. The participant screening and selection, data collection, and analysis processes will be discussed in the context of following suggested principles of indigenous research.

### **History of Participatory Action Research (PAR)**

Research in Aboriginal communities remains an issue of contention due to the inequities and injustices that continue to permeate indigenous health. The issue of how research is prioritised, carried out, disseminated and translated so that Aboriginal peoples are the main beneficiaries of the research in every sense is still not satisfied. Scholars acknowledge that historically, research on Indigenous groups by non-Indigenous researchers has benefited the careers and reputations of researchers, often with little benefit and considerably more harm for Indigenous peoples in Australia and internationally (Wesley-Esquimaux & Smolewski, 2004). They propose that the use of research methodologies, such as community participatory action research is paramount to ensure that Aboriginal peoples

have control of or give significant input into the dialogue on indigenous health at different levels. With an understanding of the challenges that have been identified as commonplace when research is conducted with indigenous populations, this writer sought to find the least harmful way to conduct the study that would also be the most beneficial to the community. The researcher also considered what would be the most culturally relevant way to conduct the study and answer the question asked by the community. This led to the decision to use Participatory Action Research (PAR) in order to invite the community's engagement in the process as well as to give them control over the project. In both practice and meaning, participatory action research is what the name implies: 'participation'— "to have a part or share in something"—and 'action'— "the bringing about of an alteration"— using research as a tool (Participation, n.d.). In PAR stakeholders participate in one or more processes of the project, that is, problem definition, problem assessment, intervention planning, implementation and evaluation (Dworski-Riggs & Langhout, 2010).

According to Kidd and Kral (2005), PAR developed from the unique needs, challenges and learning experiences of a group of people. The need for PAR came out of a perceived need for action on an area where people felt existing knowledge or ways of addressing an issue are not effective (Kidd & Kral, 2005). PAR was developed in the 1960's when researchers started to question positivism and recognised the need for participants in research to become more involved in the process with the goal of the research having practical benefit for the participants (Kidd & Kral, 2005). Kidd and Kral (2005) note the term *action research* was first introduced by Kurt Lewin (German-American Psychologist) around 1944, and discussed in his 1946 article "Action Research and Minority Problems" that describes action research as a type of research where the conditions and effects of various forms of social action and research led to social

action through steps that included a circle of planning, action and fact finding about the result of the action. PAR was not only used in the field of psychology and as it grew in popularity scholars from different fields became proponents of this worldview. Kidd & Kral (2005) describe Saul Alinsky as a professional who started a participatory community organization with disadvantaged members of his community in the 1970s. They noted his book *Rules for Radicals* and role in the political arena where he was criticised by some and hailed by others as someone who impacted American democracy. He used his organisational skills to advocate for improvements in the living conditions of poor communities in North America, later focusing on improving conditions in African American ghettos.

Kidd and Kral (2005) contrast Alinsky's use of participatory community action with the ideologies of authors Franz (1963) and Friere (1970), who spoke about an ideology that advocated for equal rights for the disempowered, which led to the development of social psychiatry and public health. The liberationist movement is most evident in community psychology which was born out of the idea that most causes of and solutions to problems that people experience are more community based than individual based therefore empowering the community became a major goal (Kidd & Kral, 2005). More recent movement focused on human agency and global human rights and in present day the emphasis on subjectivity in human and social sciences as qualitative research continues to grow. There is also movement from a uniform theory that was applied to all people and contexts towards a practical philosophy that affects social science e.g. feminist, linguistic, interpretive, reflexive, historical, cultural, critical (Kidd & Kral, 2005). This continued into the 1980s and 1990s with ongoing dissatisfaction from individuals who felt that the post positivist assumptions did not reflect the experiences of marginalized populations in society. They claimed that the structural laws and theories did not

address the issues of social justice faced by marginalized individuals and that research enquiry needed to address important social issues such as empowerment, inequality, oppression, domination, suppression and alienation (Creswell, 2013). This further strengthened the position of PAR as a method of research enquiry that would allow democratic relationships to form among participants while encouraging flexibility and uncertainty with regards to the process and outcomes. PAR is a research method that draws on political perspectives and the cultural histories of communities thus enhancing participants' critical awareness of power relations and resources such as knowledge, social networks, sense of community (Dworski-Riggs & Langhout, 2010).

However, while this is an undeniably good fit as a methodology for this study, PAR does not come without challenges that it would be an act of folly to ignore. Although the approach is popular, Dworski-Riggs and Langhout (2010) contend that few researchers actually disclose the degree of participation that is achieved, making it appear as though the process is simply used rather than acknowledging that it develops over time with varying degrees of implementation (Greenwood, Whyte, & Harkavay, 1993). Another challenge is that participants may become frustrated with the demand on their time and resources especially if they don't see the significance of their participation and if the benefits are not immediately evident. It is also important to note that PAR is based on an egalitarian power structure, yet some communities have asymmetrical power structures. This makes it imperative for the researcher to understand the community members' consciousness of power relations, in order to promote second order change and create PAR (Greenwood et al., 1993). For PAR to emerge, researchers must promote increasing consciousness of power asymmetries and create structures that enable community members to challenge those asymmetries, to create a structure that is locally meaningful.

In order to increase the scope of awareness of power relations, that may inadvertently further marginalize participants, examples from existing literature will be examined. The experiences of other researchers using PAR in indigenous communities will serve as learning tools to give awareness of what has been deemed helpful or unhelpful by indigenous participants in earlier research. There are several examples in the literature that illuminate some of the challenges that have arisen for well-intentioned PAR researchers, that resulted in much unexpected outcomes. One such example is based on a 2009 Canadian study of a community partnership to explore mental health services in First Nations communities in Nova Scotia (Vukic, Rudderham, & Misener, 2009). The study sought to identify the gaps, barriers and successes in mental health services in a rural Aboriginal community in Nova Scotia, Canada. The researchers chose to use community based participatory action research method to conduct this research. This was a befitting choice particularly given that the method is consistent with the Aboriginal research principles of ownership, control, access and possession. However, on closer analysis of how the community was invited to participate in the research, one questions whether the researchers' attempts may in fact have inadvertently served to recreate a mechanism of oppression instead of a sharing of power. This writer contends that the roles that community members were given in the research process could be deemed hierarchical in nature. The researchers chose to have only the health directors from the 13 communities represented to participate in generating the research question, design and write up of the qualitative descriptive study thus only accommodating a managerial perspective on what would be significant to explore and how to do so. The community's consumers, family members and health care providers were only asked to participate as responders in structured open ended interviews.

According to the power theory (Greenwood et al., 1993) an important part of making a



research process align with true PAR ideology would have been not only to address this asymmetrical power structure but to identify ways to raise the researchers' consciousness of the community members understanding of power relations in their community. By using only the directors' voices in the design and write up process, this writer posits that the researchers may have imposed a power structure that was not wholly egalitarian unless this issue was in fact addressed but not alluded to in the article. The interview transcripts were transcribed and a thematic analysis was used to analyze the data. Despite the limitations regarding an asymmetrical power structure, the use of participatory action research was still beneficial as the researchers recognized that past efforts to study the issues of mental illness in Aboriginal communities have been largely proposal or crisis driven. Data from the study was effective in not only identifying gaps in service that are unique to rural communities and that are not necessarily present in urban communities, but also in the identification of existing successes in the community.

The results of the study showed that there is a need for community-based, culturally appropriate, coordinated and sustainable mental health services and also highlighted programs that were protective factors, providing further evidence for continued support of them. Although the final report was submitted to the community and to relevant health agencies with the goal of having the results used to provide evidence to support changes in policy and practice, the outcome of this dissemination of information remains unknown. This writer wonders where the responsibility of the researcher ends in a participatory action model; in providing information to the hands of others as most other research does or in going a step further and remaining involved and being part of a change process thereby demonstrating the 'action' part of the PAR process not only during but after the study is complete?

## **Rationale for the Particular Approach Used**

Community psychology uses PAR to promote social justice and create conditions that empower the community. Research from an indigenous paradigm is described as acceptable when the methodologies used benefit the community and accurately reflect and build upon the relationships between the ideas and the participants (Wilson, 2008). The choice of PAR as a methodology is therefore deemed non-negotiable for this study, due to the ongoing controversy surrounding research in Aboriginal communities that is based on the continued inequities and injustices in indigenous health. According to Dudgeon, Kelly and Walker, (2010), research on indigenous people by non-indigenous researchers has historically benefitted the careers and reputations of researchers often with little benefit and in some cases causing harm to the indigenous people researched. They argue that key contemporary research issues remain, regarding how the research is prioritized, carried out and disseminated, so that indigenous people are the main beneficiaries of the research. Other research supports this view and Isaak et al. (2010) highlight the fact that today, PAR is one of many ethical requirements for researchers conducting Aboriginal health research in Canada. Guidelines for health research have been developed by the Canada Institutes of Health Research (CIHR) and include a clause that states: “communities should be given the option of a participatory-research approach” (Isaak et al., 2010). This will be kept in consideration, with the goal of keeping the study as a collaborative process from beginning to end. Participants will be considered from the context of the definitions given by Dworski-Riggs and Langhout (2010) where the distinction is made between participation as ‘having a say’ and collaboration as ‘working together’.

Although PAR and CRT developed out of different traditions, the two paradigms share some of key principles that make the intersection between them a good fit for the proposed

study. Fine et al. (2004) claim that when PAR is used one of the goals is to build the research around local expertise and to develop methodologies to “surface counter stories” (Fine & Torre, 2004; Harris, Carney, & Fine, 2001; Payne, 2001; Torre & Fine, 2003; Torre et al., 2001). This is based on a positioning of the co-researchers as the holders of unique knowledge and history that is invaluable to the framing of the research questions, design, data analysis and interpretation leading to the creation of change and/or production of something that is meaningful to the community. This supports the CRT principle of ‘expanding the notions of expert knowledge’. PAR also recognizes the ways that members of the research team are socially located within multiple and varying relationships to power and privilege and encourages research that engages these differences (both within and across individuals) rather than ignores them (Torre 2005; Torre and Ayala forthcoming). This fosters more equal participation across groups that have historically been positioned against each other and supports the CRT principle of ‘complicating identity categories’.

### **Research Approach**

The study was conducted using a qualitative approach that incorporated an advocacy/participatory worldview with an indigenous lens. The decision to use a qualitative approach was based on the emphasis on social justice as one of the primary features of this worldview. According to Creswell (2013), Denzin and Lincoln (2011) define qualitative research inquiry in a way that shows its evolution from social construction, to interpretivism, to social justice. They define qualitative research as a situated activity that locates the observer in the world and state that “qualitative research consists of a set of interpretive, material practices that make the world visible and transform the world into a series of representations including field notes, interviews, conversations, photographs, recordings and memos to the self” (Creswell,

2013, p. 44). Qualitative researchers use an emerging qualitative approach to enquiry, and collect data in a natural setting that is sensitive to the people, and places in the study. According to Creswell, data analysis is both inductive, and deductive, allowing patterns or themes to emerge. Interpretation of the phenomena being studied, is done in the context of the meanings that people give them. The final written report provides a complex description and interpretation of the problem, and includes the voices of the participants and a reflection of the researcher as a participant observer. This also includes a call for change or a demonstration of how the study contributes to the literature (Creswell, 2013). Qualitative research has some key characteristics which distinguish it from quantitative research. One is the natural setting in which the study is conducted. Researchers gather information up close not from a distance, and talk directly to people, while observing them behaving within their contexts, and interacting with them face to face over time. In qualitative research, the researcher is the key instrument and collects data him or herself through methods like observation or interviews. If instruments are used, these are often designed by the researcher using open-ended questions. Qualitative researchers typically use multiple data collection methods such as interviews, observations, review of documents etc. and do not rely on one data source. Qualitative researchers use complex reasoning through inductive and deductive logic to organize their data, building categories and themes in a bottom up manner into increasingly more abstract components of information. During the inductive process, researchers work back and forth between the emerging themes until they have a comprehensive set of themes. This is often done in collaboration with the participants allowing them to make meaning of and shape the themes that emerge from the process.

The meaning making from the participants is another key characteristic of qualitative research that the researcher keeps as a focus and that should be reflected in the report as a

representation of the multiple perspectives of the participants. In qualitative research, the process is emergent therefore the initial plan should be flexible not tightly prescribed. The qualitative researcher remains open to the notion that all phases of the process may change once the work in the field begins. This supports the goal of learning about the problem from the participants and following best practices to gather this information. In qualitative research, the researcher positions him or herself within the study and describes how their background such as work or cultural experiences or history informs their interpretation of the information in the study and what they will gain from it. The researcher can position him or herself in the introduction or method or other sections of the study. Qualitative researchers strive to develop a complex picture of the problem being studied that is shown in the reporting of multiple perspectives, identification of multiple factors that impact a situation and the complex interaction of these multiple factors (Creswell, 2013).

Data from the study was gathered, analyzed and interpreted through a cultural trauma, critical race theory lens. The purpose of this study was to investigate whether the CCI model can be culturally adapted to create an effective intervention for Aboriginal children and youth impacted by exposure to complex trauma. Although qualitative research has been challenged by proponents of quantitative research as not being scientifically sound, there is surmounting evidence to support not only the validity and rigor of qualitative methods, but its value in enabling researchers to examine phenomena with depth and quality. Methods of data collection in this type of research include observation, interviews, focus groups, and the increasingly popular creation or collection of images like photos and video. There is no doubt that qualitative interviewing is a flexible and powerful tool to capture the voices and the ways people make meaning of their experience (Creswell, 2013). This made it an appealing way to conduct this

study, where the meaning of the data collected was provided by the participants. Qualitative data management methods include recording, transcription, and transcript checking, which are methods that were used for this study. Creswell contends that qualitative data analysis methods include constant comparison, memo writing, and theory building, narrative analysis techniques, and micro linguistic analysis techniques (Creswell, 2013). For this study, the principle researchers' thoughts on the process, as well as the participants' interpretation of the data gathered, were part of a parallel process of data analysis. Information was continually gathered and analyzed for meaning throughout the intervention process, and cultural adaptations were made as they were identified. Qualitative research reporting can include articles for the peer-reviewed literature, advocacy or conference presentations and an important goal of this study is to provide a report on the findings for the benefit of advocacy for the community.

### **Research Method**

According to Creswell (2013), one of the strategies of enquiry that is used with a qualitative approach that also uses the philosophical assumptions of participatory action research and associated knowledge, claims is a case study. A case study allows for an in-depth understanding of a single problem using the case as a specific illustration. This involves the study of a case within a real life context. Creswell (2013) distinguishes between researchers such as Stake (2005), who suggest that a case study research is not a methodology but is a case within a bounded system bound by time and place, and others such as Denzin & Lincoln, 2005, Merriam, 1998, and Yin (2009), who argue that it is a strategy of inquiry. This researcher chose to use a case study as a methodology or type of design within a qualitative research. For this purpose, a case study is qualitative approach in which a real life contemporary case (or cases) over time is explored. However, for this study, due to the nature of the intervention process and

to avoid potential harm to the participant (who would need to be a child or youth impacted by complex trauma), a simulated case study using role plays was used. In adherence with typical case study exploration methods, data was obtained through the use of multiple information sources including observations, interviews, which included traditional storytelling, video reviews, and the reporting of a case description or themes. While the unit of analysis in a case study may involve multiple cases, for the purposes of this study a single case or (within-site study) was used.

The case study approach is commonly used in psychology and was made popular by Sigmund Freud and his study of human behavior using case studies such as the renowned ‘Rat man’ (Creswell, 2013). Case studies have distinct features which include the identification of a specific case. This may be a concrete entity such as an individual or group or an abstract concept such as a relationship or decision process. Although case studies can be described within certain parameters like time or place, it is more typical to study current real life cases that are in progress so that information gathered is accurate, current and not lost in time (Creswell, 2013). In a case study, the intent of the study is important. Some case studies are conducted to examine a unique case of unusual interest in which case there needs to be described and detailed; this is an ‘intrinsic case’ (Creswell, 2013). In other case studies, the goal is to understand a specific issue or concern and one case or case are selected to best understand the problem; this is an ‘instrumental case’ (Creswell, 2013). Case studies are also distinct in their presentation of in-depth information and this requires the collection of data through multiple sources. The data collection process in case studies is varied and can involve the analysis of multiple units within the case such as within a school or can be based on the analysis of one entire case such as a school district. In a good case study, a description of the case is important in both intrinsic and instrumental case studies. The

researcher can identify themes, issues or specific situations to study in each case and report in the findings both the case description as well as the themes uncovered by studying the case. The themes can be organized chronologically, analyzed across cases or presented as a theoretical model and the findings presented with assertions that the researcher includes regarding what he or she has learned from studying the case (Creswell, 2013).

This project used a single instrumental case study to examine the perceptions of CCI care team members (also known as research participants), regarding their experiences during and after participation in the CCI process. The simulated case study was used to examine the team's perceptions on specific components of the current CCI model that require cultural adaptation to make them more meaningful within the context of local knowledge. The researcher also sought out the care team members' knowledge on the specific cultural adaptations that needed to be made. Additionally, the participants gave guidance on how to implement the adaptations in ways that would be culturally meaningful for Aboriginal children and youth accessing the program. The case study was conducted in the community of Lytton using a sample story of a child and family. The setting, characteristics and social story were endorsed by the research team as being representative of a typical child living in their community, who had been impacted by complex trauma. This strategy of enquiry was deemed to be a good fit for the study not only because of the design of the CCI model, which is to work with one family at a time, but because this also fit well within the indigenous research framework.

The literature shows clear evidence for the usefulness of qualitative research studies in examining phenomena where depth of information is key, and where multiple issues converge as was the case in this study; culture, trauma, and race are all considered pivotal issues. One such study was conducted by Padula and Miller (1999). The study was conducted to explore the



experiences of married mothers re-entering psychology doctoral programs at a Mid-western university. The researchers also wanted to demonstrate the benefits of using a qualitative case study approach to examine these experiences, noting that although numerous quantitative studies have been done in on the subject, they have yielded information lacking in depth. The research focus was identified using 'grand tour' questions, an approach drawn from ethnography to describe the process of taking someone around a business or residence to show them the facility's highlights. The author cites Creswell (1994) who explained the applicability of grand tour questioning to research as being a statement of the question being examined in the study in a very general form to avoid limiting the enquiry. Three grand tour questions guided the study; how women in psychology doctoral programs describe their decision to return to school, the re-entry experience and how the return to school changed their lives.

Purposeful sampling was used to select participants. The researchers identified that women re-entering graduate studies were negotiating the demands of multiples roles such spouse, mother, employee and community member, therefore participants were purposefully selected to enable exploration of these complex roles. The four participants who were all married mothers at varying stages in their doctoral programs ranged in age from 32 to 48 and included one African American woman and three European American women. The use of an exploratory descriptive case study method for this project was suitable for asking the 'how' and 'why' questions that are central to the enquiry. According to Padula and Miller (1999), case studies are also the preferred research method when the researcher has little or no control over events, or when the focus is on a contemporary phenomenon with real life context. Although observations over a two-and-a-half-year period were also conducted, the primary mode of data collection for the study was semi-structured interviews. The interviews were conducted and

audiotaped in a university office. The researcher espouses the idea of studies being conducted in the field as an important distinguishing characteristic of qualitative study that is lacking in quantitative research. This writer contends that by conducting all the interviews in an office rather than in the participants' homes or communities where the multiple complex roles being explored are embodied, the researchers contravene their own position. The participants' environments were only part of the study for classroom observations and some informal observations of the participants engaging in activities. Data obtained through transcripts and field notes was reviewed and coded continuously in order to identify themes; the participants and a peer reviewer then reviewed these themes.

The researcher acknowledges the potential for bias as a researcher not only because of her inherent values and beliefs but also due to her own role as re-entry doctoral student herself. With the understanding that an awareness of this bias is in itself not sufficient to minimize the effect, the researcher created transparency by implementing verification strategies into the research design to address researcher subjectivity. The results showed family variables was a common and important reason for re-entry and all the women reported having thought about returning to school for at least one year prior to re-entry. Another common finding was that faculty were not an important part of the re-entry process and that there was a general sense of disappointment regarding lack of faculty support, particularly from younger professors and poor understanding of the non-traditional learning needs of students with families. The participants all identified frustrations related to lack of time to meet all their commitments and poor understanding from both community members/family and school staff regarding how difficult the experience of juggling their multiple complex roles was.

The depth of information obtained from this study is clear evidence of the usefulness of a qualitative case study approach to explore such a multifaceted topic. The richness of the information described in the results is much appreciated. The authors' penmanship draws the reader into the experience of the study with language that is unambiguous and brings the voice of the participants into the room. The study design and method are described in a clear and easy to follow manner that makes case study methodology appealing. The study generated a deep sense of connection that likely arises due to identifying with both the researcher and the participants, as a married, employed mother, also experiencing the phenomenon of re-entry into a doctoral program.

The use of a case study allowed for an in-depth exploration of the CCI program being used within a specific indigenous community, in the context of a child or youth living with biological (and/or) extended family. This provided a specific context as caregivers will have been directly or indirectly impacted by historical trauma themselves. The study being situated in a natural environment allowed for the gathering of detailed information, using different data collection strategies that included narrative story-telling and video reviews. This was done over a sustained period of time in various formats such as focus groups, during telephone conversations, in one to one sittings and in education groups. It is important to outline key aspects of the methodology that were central to conducting this study using indigenous research principles.

- Indigenous research is to be seen as ceremony; the indigenous value of relational accountability will be a central ethic; i.e., the researcher will fulfill a role and obligations in the research relationship - being accountable to your relations by being a part of your research (Wilson, 2008). This relationship will continue beyond the end of the study.

- The researcher has a vested interest in the integrity of the methodology and the usefulness of the results for the community.
- The researcher will attempt to understand and interpret the knowledge received in a respectful way in order to continue to build relationships through the process of gathering and sharing information (reciprocity).

## Procedures

### Procedures

A research team was created that included this researcher as the primary researcher, Chuck Geddes, PhD, as research consultant and eight identified community members as co-researchers. Lytton First Nations (LFN) has an existing committee that was formed to strategize and develop a community mental health plan. This is the circle of caring or Shch Ema meetkt committee. Involvement in the research was therefore at two levels: primary involvement at the planning level with the committee members only. At this level the committee's goals were to create a trauma-informed children's mental health practice in partnership with a culturally adapted Complex Care and Intervention (CCI) program, while providing training to community members at different levels to develop a trauma informed community. A sub group of co-researchers were identified from this group who helped to generate the research questions, design the study (which included informing the write up of a sample case study that was used in the study for simulation of a CCI family during training), interpret data and review the draft report before it is finalized.

At the second level, participation was as a member of the simulated care team which was made up of adults who have experience of working with a child or youth who has experienced complex trauma. This group was comprised of school based and community based mental health clinicians, social workers, child protective services agency directors and child development program supervisors. This group gathered for four separate days of 5-hour focus groups that incorporated training sessions based on what is implemented for training new CCI coaches. The sessions were facilitated by this researcher and a secondary CCI coach assigned by the research consultant. These sessions covered the CCI overview and care team agreement, an overview of complex trauma theory and discussion on the CCI process

steps, including choosing and applying interventions. During the sessions, aspects of a critical race theory were discussed in order to situate the training into a cultural framework. The process also involved role plays using a case study sample provided by the researcher, during which the CCI process was simulated. During the course of the four separate days, ongoing feedback was obtained regarding cultural adaptations. The suggested changes were made in draft form and then reviewed with the group in a reflective process throughout the course of the research. Additional participation at this secondary level was from 7 existing CCI coaches from communities outside Lytton who have experience of applying the CCI model with Aboriginal children and youth. Information was gathered from these coaches using telephone interviews. While the Lytton participants received their orientation in the CCI process, trauma and development overview, from this researcher and a co-facilitator, participants from other regions who were existing CCI coaches had already received the orientation as part of their initial training.

### **Participants**

For the case study in this project, a written case study based on the description of one family with an 11-year old Aboriginal boy who would be identified as meeting eligibility for involvement in the CCI program, was the focus of the study. Eight community service providers formed the research team and participated in the experiential component of the orientation. Each participant was assigned a role as a member of a care team and enacted that role in the simulation of a CCI care team for an 11-year-old Aboriginal boy. Five of the participants were Aboriginal women, two were Caucasian males and one was a Caucasian female. The participants were aged between 28 and 60 years old. The case study was endorsed by the community research team members who agreed that the sample case was

representative of a typical child and family in their community, where a history of intergenerational trauma was a key component of the families' experiences. The written case study was used instead of an actual case study to protect a vulnerable participant who would have been a child or youth presenting with the effects of trauma exposure.

Eligibility for participation in the CCI program is based on the child or youth presenting with severe behavior challenges that are problematic in both the home and community settings. Additionally, the child or youth must be in a stable placement with main caregiver(s) who are willing to participate in the program and do not have a recent (within two years) history of traumatic exposure themselves. Preference is given to youth aged between 5 and 16 years old based on the recognition of the "window of opportunity" that presents the most optimal timeframe within which to intervene and produce significant developmental gains. The age consideration is also based on the premise that the increasing age of the youth is very likely to correlate to a lengthier trauma history which further reduces the capacity of the youth to be positively impacted by interventions in the program.

**Exclusion criteria.** There are limited exclusion criteria for entry in to the CCI program however some diagnostic classifications such as intellectual disabilities, pervasive developmental disorders or severe Alcohol Related Neurodevelopmental Disorders (ARND) where sufficient supports are in place for the child or youth may be reasons for eligibility exclusion. While the original CCI model does not screen for caregiver eligibility as determined by traumatic experiences, this study included the process of assessing for recent histories of trauma for caregivers. Case by case consideration of caregivers with a history of traumatic experience that is within the last two years would be included in the process, to examine readiness for participation and explore potential for re-traumatization.

## **Data Collection**

During the training and orientation, participants in the Lytton research team generated questions regarding the CCI program, creating a feedback loop that led to direction on areas to be culturally adapted. These questions formed an important pivotal point in the reflective process; dialogue started based on the questions, but often led to broader narratives that then ended up bringing the group back to responding to the question. Participants who were existing coaches from other regions, provided information through telephone interviews during which the principle researcher used open-ended questions to elicit information about their experiences of using the CCI program with Aboriginal children. Data was also gathered through the sharing of ideas and/or teachings. This included personal narratives and stories about the history, particularly related to intergenerational trauma, and the day to day experiences of members of the community. This local information provided a rich context for the research and informs the themes of the culturally adapted localized model of CCI. Data collection was an ongoing reflective process throughout the research. As information was shared, the researcher reviewed it, returned to the group for clarification to establish the intended meanings, and then went back through the data. Further data was gathered through participation in the initial planning committee. This was part of a process for developing and implementing plans to provide trauma training to different groups within the community, with the goal of building a trauma-informed community.

The use of focus groups or circles in the data collection process is of specific cultural significance in research that applies an indigenous research paradigm. Shawn Wilson (2008) describes the underlying rules of using circles as non-judgmental and non-interference listening. Wilson (2008) shares some of the perspectives of fellow indigenous researchers in



explaining relational accountability in research. In an interview with dialogue with some of his research associates, Wilson cites an associate Cora (n.d.), who describes research done within the traditions of the circle as inclusive, participatory, and proactive which he says teaches the individuals in that circle to become participatory, inclusive and so forth (Wilson, 2008). Cora outlines how critical it is to focus on hearing shared stories instead being focused on asking questions. She describes a process of getting the history of the land in these dialogues, and that while this may be data that is not going to be used in the research, it is critical to establishing and maintaining relationships and to contextualize the interview information. She describes the importance of knowing what to say, and what not to say, and what is, or isn't, of value to the people in the circle or community. The study endeavored to keep these principles at the center of the process of enquiry throughout the data collection process, and used these guidelines as a way to align with the ceremonial parts of research in maintaining relational accountability. One researcher described the traditional circle as a foundational platform that is like an individual's canvas to place on it what he or she wishes; "it's egalitarian, it's relational, it's a structure that supports an inclusion, a wholeness" (Wilson, 2008, p. 92).

### **Data Analysis**

Based on indigenous research paradigms the analysis of data gathered must be true to the voices of all the participants and reflect and understanding of the topic that is shared by the researchers and participants alike (Wilson, 2008). Data from this study was transcribed and analyzed in relationship with the participants. This was done with the goal of developing analyses of topics that emerged based on the localized experience of the CCI program. Weber-Pillwax identifies one of the principles of an indigenous methodology as that of

permitting and enabling indigenous researchers to be who they are while they are actively engaged as participants in the research processes (as cited in Smith, 2008). This was a goal in this research during with the principle researcher acknowledged and was transparent about being positioned in multiple roles. The role of CCI coach trainer was clearly articulated and embedded into the research process as the researcher not only co-facilitated the orientation, but participated in a data collection process that was continuous, relational and reflective. Additionally, the principle researcher self-identified as an indigenous researcher due to being a native of Zambia, an identity that carries some shared experiences such as a history of colonialism, and associated experiences of racism and marginalization. With this identity, the researcher participated in the process as an individual with similar experiences of historical trauma, albeit at a very different level than that of Aboriginal history. The researcher therefore acknowledges that these different aspects of her identity influence the process of data collection, as information and stories shared were filtered through the additional lens of these identities. The researcher was cognizant of the potential to affect the outcome of the study as data interpretation was also filtered through her own experiences as an indigenous person. This was managed using a continuous process of self-reflection, maintaining an awareness of biases, and a reliance on the expertise of the holders of local knowledge for interpreting and making meaning of the data.

The goal of the data analysis was to identify any emerging themes across any aspect of the CCI process. Preliminary analysis was conducted by this researcher in consultation with the research consultant. At this stage, information was transcribed and placed into different broadly classified categories such as cultural (localized) context themes, and CCI process or content themes. Once these initial broad themes were identified, they were categorized into

secondary, narrower themes. The secondary thematic analysis was conducted as a reflective process with members of the whole research team. The goal of this process was to derive meaning and context from the data, and to ensure that culture was kept at the center of the entire process, instead of as an 'add-on'. This was a collaborative process of data interpretation. The data was then classified into narrower themes that emerged categories as they pertained to areas of the CCI that were modified in the process to align with cultural meaning. These themes were further classified into the three main areas that the proposed adaptations fit into. Additionally, individual quotes were kept as a separate category to be used as direct representation of the community's voice.

Once the information had been transcribed, the data analyzed and the results summarized, the research team as an ad hoc working group, had the opportunity to view the summary and draft document which was created using the information, providing reflective feedback regarding situating specific ideas and information in the document.

### **Role of the Researcher**

The researcher identifies having a particular motivation for conducting this research specifically within the Aboriginal community. While acknowledging that there are many other cultural groups that have experienced collective traumas such as the holocaust and other cultural genocides, the researcher feels more closely connected to the Aboriginal culture and experiences. This stems from the close similarities between African culture, values, beliefs, and practices with those of Aboriginal peoples. Additionally, this researcher identifies with persistent issues of racism, that are part of the experience of members of visible minority groups such as black people and Aboriginal peoples. Further similarities are found in the historical experiences of colonialism, as an individual born and raised in a country that was once a British colony.

As the primary researcher, although positioned as a participant researcher, it is important to acknowledge the influence of culture, race, and time in history, on the participants and the process of the study. As a black African woman, born and raised in Zambia under the influence of British colonization, this area of research is of both professional and personal interest. I also have a keen interest in the impact of complex trauma on the developing brain and the adverse, potentially long lasting effects on a child's developmental trajectory. This has created an even greater interest in me as a mental health professional in finding ways to help those impacted by complex trauma. I have a specific interest in research within the Aboriginal population as an indigenous community on both a personal and professional level. Personal interest stems from being raised in a culture that upholds the matrilineal influence of mothers and grandmothers as primary caregivers in a shared parenting model. Also similar is the idea of relational accountability that has been outlined as key in indigenous research. This is a guiding principle in African traditions that extends the responsibility for one's way of being beyond the individual child to the tribe and larger community. Researchers such as Neckoway, Brownlee, and Castellan (2007) have found that the shared parenting approach is common in many Aboriginal communities and this has been my own professional experience. This leads me to question what the impact of unresolved trauma is on the parenting capacity of women in these populations where issues of substance abuse make it likely that interpersonal violence is a common experience. Wasserman (2005) cites researcher Williams (2002) who contends that there is a dearth of information on the incidence of domestic violence committed against Native American women in particular, a small study of pregnant Native American women showed that 33% report experiencing battering during their current pregnancy, with 55% reporting battering during their

previous pregnancy. This increases the likelihood of children being exposed to complex trauma even before they are born (Wasserman, 2005).

Professionally, I have worked for the last seven years as a mental health therapist with Aboriginal children and youth; the majority of whom have been exposed to complex trauma. Unfortunately, most of these children and their families continue to live in environments that are contaminated by the effects of intergenerational trauma and I am witness to the multi-layered, cross-generational detrimental effects that this continues to have on their own development.

In addition to positioning myself as a participant researcher, in order to align myself with the principles of an indigenous research worldview in which relational accountability is critical, I am positioning myself as being part of, and inseparable from the subject of my research (Wilson, 2008). Wilson (2008) cites Weber-Pillwax (2001) who proposes that adherence to the principles of relational accountability dictates that the three 'R's of indigenous methodology respect, reciprocity and responsibility must be key features of a healthy research relationship and must be included in an indigenous methodology.

## Findings and Discussion

### Findings

The outcome of the study was a compendium of information in the form of questions, stories, personal narratives including quotes, proverbs, and traditional teachings from an Aboriginal perspective. The community generated questions regarding the existing CCI process that deepened their understanding of the process and enabled them to provide feedback that became the basis for making cultural adaptations. The following is a list of the questions that the community research team asked:

- Can we have more knowledge of CCI to understand how it might work?
- Does the CCI provide a way to incorporate traditional knowledge into the theory?
- Can the model incorporate a holistic approach that looks at the aspect of working with children?
- Can the model be inclusive of the needs of caregivers and not use only a child focus but a family focus?
- CCI is currently used with children in foster care; can it be adapted as a traditional model for child and family living in their own community with foster families but maintaining connection to families of origin?
- Can it be adapted to be used if child is in the care of blood family or kin who likely have their own histories of trauma?
- Can the model take into account the persistent stress that our children and families experience due to exposure to domestic violence, poverty, abuse and parental substance abuse in the community?
- Can the CCI program get the community ‘on the same page’ regarding dealing with trauma within our community?

- How will information on trauma be shared?
- How will information on trauma be adapted to fit our community so that we can own it?
- Is the knowledge transferrable and can it be developed and adapted during the process?
- Current and past interventions have been disjointed and lacked continuity of care as professionals come and go; how will the CCI program ensure follow up care after the child is stabilised?
- What is the eligibility criteria for individuals in the community to be trained as CCI coaches?
- Will individuals without formal education be considered?

In keeping with an indigenous research paradigm, information gathering is community driven, conversational and relational because research is ceremony (Wilson, 2008). This was evident in this process as the questions were asked as part of conversation and not in a linear way, once again embodying the indigenous symbolism of a circular, relational approach. The discussions that emerged from the questions led to a feedback loop of ongoing rich discussions and reflections that included the historical context of how the community seeks out information to address problems that arise. Shawn Wilson (2008) discusses the importance of gaining knowledge and being accountable to the relationship you build with the knowledge, cautioning that to use this knowledge out of context is tantamount to cultural appropriation. With this in mind, the researcher built groupings for the main themes that emerged, based on how often they came up in the conversations.

**Coding for adaptations.** Typical qualitative data analysis strategies involve the examination, detection and interpretation of data collected that is mostly done by the researcher. In this study which is community led research, participants, as co-researchers, were more involved in the analysis and interpretation of the data. Data analysis was conducted through a cultural and critical race theoretical lens, to ensure that culture was kept as the center of enquiry. This also ensured that the voices of the community that were usually silenced as a racial minority, would be heard. Topic coding was used to place data into different categories based on subject matter that was similar, or represented the same themes. This was the first step, as the initial data was a lot of information obtained through conversation and narratives that were not single phrase responses, but rather short passages of dialogue. Some themes were brought up in conversation multiple times, while others were only talked about once or twice. After coding the data into categories by topic, these categories were reviewed and then shared with the co-researchers for interpretive analysis. The result of this secondary analytic process was a broader topic categorisation, that was based on collapsing some of the earlier categories into one larger category. The co-researchers' interpretation of the data clarified meanings, and provided feedback on what areas would provide the most cultural meaning to the model. This was followed by a final analysis conducted by this researcher, during which consideration was given to which of the data was directly applicable as adaptations to the model. This formed the third category of analysis resulting in a three tiered table which is visually represented as Figure 1 below. The table shows how the data was placed in the different areas identified for cultural adaptations and these are described in more depth under the heading 'cultural adaptations'.



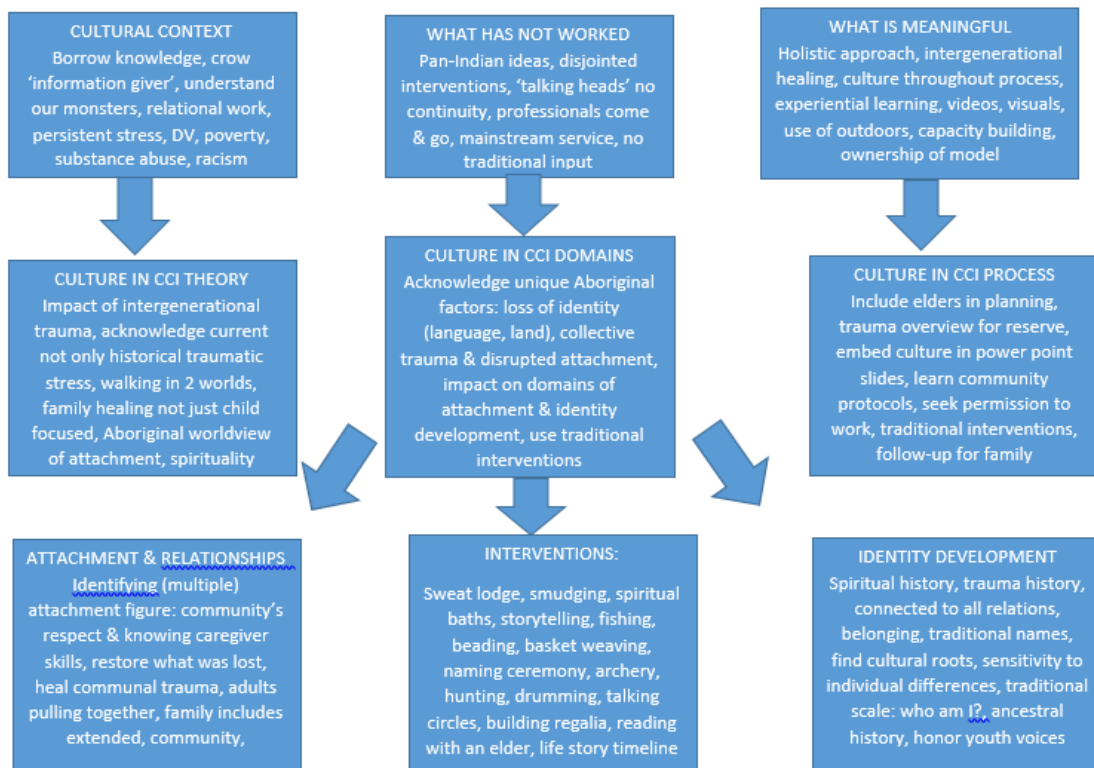


Figure 1. Cultural adaptations to CCI model results.

Original quotes were maintained for inclusion in the analysis to represent ‘direct voices’ from the community and served to provide context for the research. Participants shared their voices regarding why they had chosen to use the CCI process.

“Our community is known for borrowing from other tribes or bands; its’ a good thing to borrow from the CCI program to build our own model”

“The crow is our ‘information giver’, it tells us where we need to go to get help, and how or what needs to be done to address the problem”

“If we see something good, we say: we can use that and we borrow it, so it’s good to borrow from CCI”

**Cultural adaptations.** Based on the data analysis, four dominant topics were identified as the main focus for the cultural adaptations to be made. Adaptations were made throughout the various aspects of the process, as well as to the theoretical content of CCI. The major adaptations were made (a) in the introductory section which provides the theoretical overview of trauma, (b) in the attachment style and relationships domain, (c) in the identity development domain, and (d) in the interventions section of the manual.

**Theoretical overview of trauma.** Adaptations were made to the theoretical overview of trauma that sets the stage for the CCI model by providing the premise behind the concepts used to develop the program. The goal of the adaptations in this area, was to include an Aboriginal worldview into the framework. This was in response to the community’s desire to provide direction regarding what they felt would be important to include in the model that they wanted developed. A few quotes from the dialogue are included:

“we need to build the community’s’ capacity”

“we need a process that helps caregivers to recreate . . . to heal”

“we need to ‘understand our monsters’ and challenges as a community, for example domestic violence”

“issues are kept under the table; we need courage to put them on the table and address them”

“Aboriginal perspective means culture should be evident throughout the process”

“CCI program goals should be to build relationships”

Adaptations made in this area included a broadening of the trauma theory background, to include the history of Aboriginal peoples in Canada. This section provides information on the ‘Sixties scoop’ and how this systematic removal of Aboriginal children from their families led to the experience of intergenerational trauma. The adaptations provide an in-depth description of the

concept of intergenerational trauma transmission as it pertains to Aboriginal history. The adaptations show why it is necessary to understand how this impacts the CCI work to be done with Aboriginal children, youth, and their families. The theoretical background also includes information on the experience of collective trauma, grief and loss. The impact of both historical and current ongoing traumatic experiences on parenting ability, are also discussed.

The concept of relationship building is a core component of working in partnership with the local community of Lytton. As one community member stated “programmes do not heal our children, it’s in the relationship, that our children heal”. This is particularly significant given the loss of trust born out of the long-standing history of systemic oppression and is addressed in this section. The community expressed a desire to engage in a working partnership with the CCI program and this goal was reflected in one participants quote: “We want to work in collaboration with CCI using the ‘Nlakapamux’ approach, which represents working in partnership”. In honor of this traditional way of working, the cultural adaptations include a process for ongoing partnership that is discussed in more detail under the process steps.

**Attachment style and relationships domain.** This domain covers the idea of how trauma affects a child’s desire and ability to connect to others. This is discussed as the process of developing their attachment pattern and way of relating to others, through learning from experiences in the parent-child relationship (often as a dyad). The different attachment styles that may be formed are also impacted by caregiver availability and attachment style. Distinctions are made between the different types of insecure attachment patterns that are typically seen in children exposed to complex trauma. Examples are given of traits showing behaviors seen on the continuum between avoidant/dismissive attachment styles and preoccupied/angry attachment styles. Under this domain, adaptations were made that explained the difference between a

Western view of attachment and an Aboriginal view of attachment. The adaptations provide information on a widened view of attachment that includes more than one primary caregiver. This is based on the shared parenting model that is common in many Aboriginal communities, and practitioners are invited to work with an openness to expanding their own worldview on parenting practices. The adaptations address the inclusion of family and community in the attachment relationship, and why this is a key component of changing current CCI practice. The adaptations require practitioners to work towards a shift in practice paradigms and in the understanding of what ‘family’ means from an Aboriginal perspective. While the current CCI model based the framework of attachment work on the child, and typically one primary caregiver, the cultural adaptations extend the framework to focus on the child and his/her family. The concept of family is also extended based on an Aboriginal worldview, as this is likely to include in addition to biological parents, extended family, kin and community members.

With the cultural adaptations, the inclusion of an Aboriginal Elder, representative or traditional knowledge keeper at the CCI table has been made a requirement to meet practice standards of practice. This will ensure that the indigenous voice of the child or youth is represented and that the CCI process keeps the relational aspects of Aboriginal culture at the centre. The adaptations also include information on the collective experiences of disrupted attachments that resulted from the residential school legacy. The loss of culture, including language, connections to land, kin and traditional practices, is identified as a primary factor that has reduced opportunities for healthy parenting practices today. The forced separation of caregivers and children created a major disruption to family ties and connections to community involvement in traditional child rearing practices. These are described in this section as losses,

but also identified as protective factors to strive towards rebuilding, as part of the CCI intervention goals.

Like many other Aboriginal communities, the community of Lytton has also experienced significant disruptions to family ties due to multiple losses during and following the residential school era. Epidemics of measles, flu and pneumonia were responsible for the deaths of many young students at what was then called St Georges Indian Residential School. Participants reported that these losses and communal grief continued after the residential school closed in 1979, with death by suicide accounting for many of the losses. There are reports of approximately 18 deaths from various causes in one year in particular, that devastated the community. The bands in the area had experienced an epidemic of suicides over many years, particularly as reports of sexual abuse at the residential school began to surface and go to trial. An understanding of this tragic history is necessary for practitioners to gain an understanding of the attachment injuries, and related difficulties with forming healthy, trusting relationships. It is important to recognize that suicides, problems with addictions, domestic violence and sexual abuse are aspects of ongoing traumatization that have decimated the community's wellness. Many of Lytton First Nations bands have also endured years of continued traumatic stress associated with participation in or exposure to criminal abuse cases against clergy. This has often meant having to relive the horrific experiences of abuse, and further traumatization. The adaptations take this history into account and provide a context for understanding how to heal the community through the rebuilding attachments. This also helps to foster healthy parenting styles that recapture and restore traditional parenting practices.

**Identity development domain.** This domain covers the child's sense of who they are in the world, and how their experiences shape this view. The child's feeling of belonging and

having a connection to others is impacted by their experiences and are core pieces of how identity is formed. The cohesiveness of a child's life story, or the lack thereof, is an important concept that helps to ascertain whether a child develops a strong and positive sense of self or not. The community of Lytton's history of intergenerational trauma has also impacted community members' identity development. Losses endured during the 'Sixties scoop' included loss of connection to traditional values and beliefs which included spirituality, and were a core part of having a strong and positive cultural identity. One community member explained why they felt spirituality needed to be included in discussions regarding identity development:

In my opinion, the word 'spirituality' is a broad term that often leads to a debate on religion versus spirituality. It could easily derail the care team. Also, it is subject to interpretation because it is personal to an individual and cannot be defined objectively. On the other hand, if someone were to bring it to the table we could engage in discussion to respect the individual's spiritual practice and being mindful of the child that is being supported by the care team.

The concept of spirituality in identity development was a consistent theme that emerged and was also voiced by one of the CCI coaches working outside of Lytton as follows:

"spirituality is a domain that encompasses all areas of a child's life"

Other aspects of the dialogues gave voice to what had been tried before to restore the community's wellness and identity, but was not meaningful or a good fit for the community:

"we don't want to use 'pan-Indian' ideas"

"use local knowledge, we don't use the medicine wheel in this community"

Adaptations made to this domain were to prioritize cultural identity development as a core part of an Aboriginal child or youths' identity. The community's direction on using localized knowledge was facilitated by them providing links to videos that had been created by Lytton youth, describing what made them who they were. This was a point of pride for the community as the voices of the youth rose up to take their place as the generation that would

rebuild their cultural identity. The links to these videos on ‘YouTube’ are referenced in the adaptations as resources for CCI coaches to use as part of their learning on integrating cultural practice.

Additionally, the model now includes the step of ‘gathering the child/youth’s cultural story’ to support his or her identity development. Participants described the disruptions to healthy identity development that resulted from the forced removal of very young children from their families, during what were their early years of identity formation. This not only included the loss of connection to traditional practices and ceremonies that were part of shaping identity, but the loss of a history that tells an individual who they are. This also had the impact of leading to a sense of shame in ones’ identity as the process of colonization served to denigrate their native identity with all associated spiritual practices being forbidden. As guided by the dialogue with the community who identified spirituality as an integral part of cultural identity, gathering the child’s story is a process that includes the exploration of the child’s spiritual identity. The process of finding out about the child’s history, community, traditions and practices is presented as an ongoing process that continues even after the CCI stages have ended. This supports the child’s ongoing journey of cultural identity development. The community also wanted to use local knowledge to shape the model and in keeping with this direction, the adaptations include the idea of ‘connectedness’ as a key aspect of identity development. The community identified that a child’s identity is based on connectedness to others and that this connection is to all his relations which includes the land, creatures of the earth, water and sky. It also includes having knowledge of where he or she comes from, which is difficult for youth who have been disconnected from their culture. To address this, the adaptations include the development of a cultural plan with goals for reconnecting the youth to their cultural practices and values as an important part of

identity development. The adaptations also discuss the impact of intergenerational trauma on a child or youth developing a shame based identity. Coaches are encouraged to explore whether this is compounded by living with caregivers who have the same sense of identity and associated guilt. Further exploration is required regarding the effect of communal guilt and shame and how this may present. Recommendation was made for consideration of using an identity scale that integrates a Western and an indigenous approach to explore how a youth perceives their cultural identity.

**Intervention planning stage of the program.** Many of the interventions already being used in the CCI process are compatible with an Aboriginal worldview because they are holistic and strengths focused. However, there was still an identified need for cultural adaptations in this area. The goal was to more fully embody culture in the intervention planning process, as well as in the interventions applied. In the current CCI model, interventions are developed in collaboration with the care team, and are based on a rough assessment of the child's maturity and level of development across different domains. The child's level of development is determined using the Functional Developmental Assessment (FDA), which is a structured group interview. This serves to provide the care team with a rough picture of the child's functioning. With the cultural adaptations made, the importance of including an elder or designated traditional knowledge keeper at the table had been recognised and made into standard practice. This is viewed as a way to keep balance, bring wisdom and guidance into the process. This means that the FDA and subsequent intervention planning, will now be done with guidance from care team members who hold traditional knowledge. This will help the care team to include FDA questions and intervention options that are culturally meaningful based on the child and family's cultural beliefs or connectedness. Some examples of traditional interventions that may be applied across



different developmental domains are provided in the adaptations and shown in table 1 which is shown below.

Table 1

*Examples of Cultural Interventions Across Domains*

Neurological and biological immaturity	Beading, berry picking: these might be used to support development of fine motor skills Song: The use of song with an adult, that is accompanied by rhythmic clapping movements or participation in a drumming group may be used to calm the brain and body
Over reactive Stress Response system	Taking the child to sit by the river to listen to calming flow of water and connect to the land, healing circles, smudging, spiritual baths, may be used to help reduce stress and calm the child in response to stress
Emotional Regulation	Sweat lodge, healing circle, talking circles, drumming circles can help a child to regulate emotions
Attachment Style and Relationships	Belonging and Cultural connection (as appropriate for local Aboriginal culture and the child's home community) storytelling, sharing songs, preparing food with an adult, serving food to Elders, talking circles, land based activities like berry or asparagus picking, basket weaving, beading with an adult, playing traditional games
Identity Development	Learning meaning & strengths associated to own name, names of home, names of clan, identifying belonging through traditional stories, building opportunities for child to practice generosity
Behavioral Regulation	No adaptations made as interventions are not given in this domain due to behavior regulation occurring as outcome of other domains developing
Cognitive and Language Development	Re-telling of traditional stories; artwork to support learning

In the adaptations, examples are also given of some FDA questions that seek to elicit responses that capture aspects of a child's functioning from a relational, cultural and communal based perspective. The adaptations encourage CCI coaches to be creative about using the FDA questions in ways that help the team to think about the child's strengths and challenges through both the Western and the indigenous lens.

Another major adaptation in the interventions domain is the new concept of 'gathering the cultural story'. This is a core part of intervention planning for all youth, but particularly when working with Aboriginal youth. Gathering the cultural story is now a standard part of planning holistic interventions. It supports the child's overall development as many of the children exposed to complex trauma who are seen in the program, have fragmented lives and histories of disrupted attachments that leave them with no cohesive life story. Gathering the youths' life story is the responsibility of a designated adult or adults on the care team. Their role is to aggressively seek out and find information about the child's home community, their traditions, belonging, cultural activities etc., and then offer this story to the child at the appropriate time. This is an important step towards helping to build a healthy cultural identity. Coaches are reminded that this process is likely to be challenging due to different barriers including mistrust and a reluctance to share information. However, persistence in achieving this goal is an expectation. This honors and recognizes culture as a child or youth's way of being in the world and not simply an 'add-on' to their life.

Although the four areas outlined above were the focus of the major adaptations, other themes emerged that are worth mentioning. Although not major themes, they also led to some meaningful adaptations that ensured that the Aboriginal worldview was embedded through the whole CCI process. These themes are (a) Respectful Engagement: This theme pertained to the

importance of practitioners being aware of respectful protocols for seeking permission and building relationships in order to work in partnership with Aboriginal communities. This was viewed as a necessary step towards learning how to incorporate specific Aboriginal concepts into CCI practice. Adaptations were made to give coaches guidelines on how to do this, and included seemingly basic suggestions such as encouraging CCI coaches to exercise patience and take the time needed to learn and respect the community's protocols. Information is given on finding out who the family spokesperson is, in order to approach the right individual. This is identified as a precursor to seeking permission to begin working with the child or youth and their family. This process is now incorporated into the model, and an example letter is provided as a guide for CCI coaches learning how to do so respectfully (sample letter is included as Appendix C) and (b) Culturally Sensitive Format and Delivery: The need to have culture embedded not only into the content, but also in the format and delivery of the theoretical overview of the CCI program was another theme that emerged. Participants discussed the importance of having a more 'community friendly', culturally representative, power point presentation. The suggestion was to adapt it so that it was not overly clinical, but retained the important scientific concepts of neurodevelopment to maintain fidelity to the programs framework. The recommendation was made that the presentation be adapted according to the audience, with a specific request for one that could be delivered to community members living on the reservation. This would include caregivers, grandparents, community Elders and band members. The request was also made for another presentation adapted for community professionals and para-professionals to include school staff, youth workers, and support workers. These adaptations were made and included a change in the images used from those of Caucasian children only, to include images of indigenous children as

well. The mode of delivery was also adapted to include more story telling and experiential learning as requested and reflected in this quote from a participant:

Sharing of knowledge should use multiple formats: the visual side is important, role plays and videos are meaningful, we are an experiential culture so it works to use experiential activity. 'Talking heads' are not a good way to teach.

The adapted presentation also included a visualization exercise using a story to explain the concept of the stress response system. This was adapted to use the community's geographic location and the use of a bear as an animal that had symbolic meaning and was a normal part of community members' experiences in that territory. The adaptations to the format and delivery of the CCI program embody the idea of keeping culture evident throughout the model

c. Culturally Meaningful Language. There was also discussion regarding some of the terms used to distinguish CCI principles from other programs with similar terminology. This was also discussed in terms of replacing some terms that conveyed judgement rather than equality in what was seen as a circular process of equal voices. The participants provided direction on adaptations in several areas of the curriculum to ensure the use of language that was respectful, and honoring of the experiences of the residential school legacy and the associated impact of intergenerational trauma. The importance of practitioners recognizing that this has created unique challenges for Aboriginal peoples was emphasized. This was a key theme that resurfaced across several conversations and gave a strong framework for the inclusion of CCI interventions that were based on Aboriginal culture and traditions. Great emphasis was made on how to keep culture at the centre of the process and not to have it inserted simply as an 'add-on' to the program, which the team felt was a common tendency for many mainstream researchers. Participants also discussed ideas regarding some of the language describing the different domains. One example that was the subject of rich discourse was the name of the Identity Development domain. Participants highlighted the fact that 'identity' was a Western construct which served as a

reminder of the colonial mechanism of oppression, which bestowed a forced identity on Aboriginal peoples. Suggestions were made to consider more culturally meaningful terms such as “connectedness” as this conveyed a holistic sense of ones being and was based on the Aboriginal worldview of understanding who you are by your connectedness to all your relations. It was agreed that this would be part of ongoing discourse as further revisions are anticipated following implementation of the adapted model.

Following the working groups approval, the cultural adaptations described above were made to different sections of the CCI Resource Manual, starting from the theoretical overview section, through to the sections on ‘how to do CCI’ which is comprised of the preparation, working, and exit stages. The integration of the data into a draft of the existing CCI manual has resulted in the successful development of a culturally adapted form of the intervention. The adapted CCI model now includes educational information on Aboriginal history which includes the 60’s scoop and residential schools, the historical and ongoing resultant community trauma, intergenerational trauma transmission and disrupted attachments, loss of land, knowledge and culture and the impact on parenting, trust and attachment injuries. The adaptations also provide a framework for working with Aboriginal children and families and includes specific, practical steps on applying the CCI process through an Aboriginal worldview. Although the adaptations made are very likely to have meaning and applicability across many different Aboriginal communities in B.C., users of the adapted manual are reminded in specific instances to allow for regional and territorial variations. It is noted that like many other cultures, Aboriginal cultures are not homogenous and that even with work within the community of Lytton, practitioners need to be guided by the child, youth, family and traditional knowledge keepers to determine whether particular concepts will have applicability.

Additionally, findings will be used to inform future application of the new model in the community. Final approval of research content and dissertation use, including publication will be given by the research team. As the primary researcher and research consultant have an established relationship with the community, there will be an ongoing reflective process to support the application of the adapted model. A feedback loop has been created to allow for a reflective process that will allow the community research team to continue to provide feedback on how the model is being applied and any challenges or benefits being seen. The CCI model has a built-in process for assessing progress and this will continue to be used in conjunction with the regular feedback from the community research team. It is anticipated that this feedback will also guide decisions on whether additional adaptations need to be made.

Upon approval and finalizing of the draft document, a report will be presented to the Shch Ema meetkt committee and may also include a presentation to chief and council or others at the request of the committee. At this time approval will also be sought regarding the sharing of knowledge with other Aboriginal communities and other community agencies such as MCFD. The data will be owned by the research team and may not be used by the researcher for purposes not related to the application of CCI without the CCI consultant's consent. The outcome is not only the development of a draft of a culturally adapted CCI model but the process also led to the building of relationships with the community that will continue beyond the scope of this study as this researcher has been invited to provide training on the impact of trauma on child development to various groups in the community, including chief and council, families, educational staff and community service providers.

## Discussion

For this study, members of the community of Lytton identified that children and youth in their community were struggling with emotional and behavioral dysregulation, that was the direct result of exposure to complex trauma. The community's history of intergenerational trauma was identified as a key factor that continued to erode the community's wellness. They chose to use the CCI model as a community based model which was holistic and used a wraparound approach, that paralleled the Aboriginal concept of building a circle of care around a child. However, the community also expressed concern the centrality of culture was missing from the model and that this was needed in order to make the model applicable and meaningful for use with Aboriginal children and families. Out of this was born a three-year process of relationship building leading to collaboration on this community action project. Thus began the quest to find a way to develop a culturally effective way to successfully treat Aboriginal children, youth and their families who were suffering the impacts of exposure to complex trauma. The community placed emphasis on the need to heal not only the children but the caregivers and community as a whole as a way to move from intergenerational trauma to intergenerational healing. The sense of a communal, relational, connectedness perspective became the framework for the cultural adaptations to the CCI model.

**Potential ethical issues.** As a marginalized group, Aboriginal peoples are considered a vulnerable population. This researcher therefore took into account some potential ethical issues which include, the re-colonizing of participants due to a lack of conscious acknowledgement of the power differentials introduced by the researchers' position. This was addressed by having an open dialogue with the participants regarding the role of the researcher as a doctoral student and as a CCI coach trainer. The inclusion of a co-facilitator in delivering the CCI theoretical

overviews brought some balance to the process and allowed for periods of time when the researcher stepped out of the primary teaching role and was merely an observer of the process. The consideration of dual relationships was also key as the study was conducted in a small community where members have multiple roles. To address this, an introductory discussion was held which allowed for disclosure of existing relationships and while some participants self-identified as co-workers, no conflicts of interest were declared. Furthermore, participants' expressed that the adaptation process was one in which they wanted their participation and voices to be evident. While original quotes were maintained to accomplish this, anonymity is still maintained in the document in accordance with the consent and research agreement signed. As no actual children or youth or their family participated in the study, there was no potential risk of a disclosure regarding harm to child, that would mandate reporting procedures to be discussed. In the event that a child or youth was participating, protocols regarding reporting to child protection services would have been established. This would have been important in order to preserve the critical component of conducting indigenous research with relational accountability. This would also have been done in order to maintain adherence to APA standards of practice as pertaining to research, as well as mandatory reporting standards for professionals.

### **Discussion of Themes**

**Intergenerational trauma and its impact on identity development.** This writer's hypothesis for the study was that Aboriginal people's collective experiences of trauma have become embedded into their cultural identity. Findings from the project revealed how this is indeed the experience of participants who revealed that, for many of the families they have worked with, trauma is a part of their way of being in the world. One participant described a recent encounter with a family as follows:



I have had a grandparent in tears (not joy - but fear) when I suggested the program and stated the full title—of Complex Care Intervention—the word complex was a trigger for the grandparent - as she has witnessed the emotional abuse her grandson has repeatedly endured . . . by birth mom. Grandparent was not ready to hear that this intervention - with the big name - would be helpful for her grandson. A learning lesson for me - about bringing/suggesting this approach in a softer fashion.

This encounter was a reminder for this researcher of the complexity and multi-layered impact of trauma that is not always visible to others, but is important for us as practitioners to bear in mind. The findings also showed how validating it was for caregivers to understand how trauma at the individual and collective level influences not only brain development for their children, but how it has impacted their own identities. A recurring topic that came up in conversations was the need for their children to know who they are, by knowing where they came from; “this is where they are going to find their identity, it’s knowing what happened in their community, and what our traditional ways were before residential school”. This is an important step towards helping youth to reclaim an identity that is not shaped by a collective trauma, but one that is shaped by the strengths found in traditional ways of being and relating. This inspired one of the participants to develop an ‘identity rating scale’ that is an amalgamation of traditional and mainstream ways of rating where youth and their families feel that they fall in terms of culturally centered identity development.

The cultural adaptations made in the identity development trauma domain of CCI, have captured an Aboriginal worldview. As a model that is strengths focused, the CCI program creates room for growth and healing that supports the building of a positive cultural identity. As caregivers apply the CCI interventions with their children or grandchildren, opportunities for their own healing continue to be created. In this way, the culturally adapted CCI model is an intervention that embodies one of the key goals of indigenous research; that of honoring the

impact of intergenerational trauma by creating a vehicle for intergenerational healing (Wilson, 2008).

**Attachment style and relationships.** The impact of disrupted relationships due to the legacy of the residential school era was a topic that was discussed with high frequency. It emerged as one of the dominant themes in multiple ways, and was interconnected to several other areas of discussion. The running theme from the discourse, was the impact of intergenerational trauma on attachment for Aboriginal families. There was recognition that this had, and continued to impact all areas of a youth and family's way of being. Disrupted attachments were closely associated to grief and loss in relation to loss of land, language, traditions, rites of passage, traditional ceremonies and names. The far reaching implications of these losses included loss of trust in others, which made it difficult to build healthy relationships, one of the fundamental pillars of a healthy community. This was particularly the case with healthcare providers who represented a system of oppression. The need to repair and build new attachments was a strong message. This is a critical piece of the required work with children who receive intervention through the CCI program. This writer posits that healthy relationships are one of the main pillars of a community and that this is a much needed precursor to the restoration of healthy families that will be able to support and maintain their own and their children's journey of wellness.

The community was very aware that many of the losses they had suffered were the losses of things that served as protective factors: e.g. language, ceremony, cultural knowledge, healthy relationships and role models, connection to the land. Exacerbating these losses were losses resulting from the lack of these protective and healing factors, which led to a lost generation of residential school survivors who coped through addictions, were lost to Vancouver's downtown

east side area, suicide, and children being taken into government care. It was therefore critical that these traditional pieces were embedded into the interventions. Understanding just how deep the wounds of disrupted attachments went for the community and culture as a whole, was very poignant for this researcher. There was a very real awareness of just how privileged I had been, to be invited into the community when trust was fragile and based on relational accountability.

The researcher hypothesizes that using a critical theory lens had a significant influence on how participants perceived her role in the research. Critical race theorists contend that mainstream research is generally implicated in the reproduction of class, race, gender oppression systems. The researchers' discussion with the participants about using a CRT lens and its assumption that reality is constructed within social historical context (Kincheloe & McLaren, 1994), was well received by the participants. The findings showed just how significant attachment and relationship building is to the entire research ceremony process. This clearly illuminates the role of respectful relationships as a key component of successful research with indigenous communities.

**Adaptations to CCI interventions.** This was the third dominant theme that emerged from the findings and where cultural adaptations that are more readily visible have been made. The findings showed that there was dissatisfaction with previously used interventions that 'paid lip service' to the idea of including culture in treatment. The findings showed that there was a general sense that culture was often seen as being periphery and not central to an individual's way of being and was not seen as a core aspect of interventions. Additionally, concerns were raised regarding the sense that practitioners saw the inclusion of culture as optional not mandatory. There was general agreement that this should be the case not only for Aboriginal families but for every client irrespective of their identified culture.

Participants provided rich discourse regarding traditional ways of healing and how balance in an individuals' wellness was achieved through connection to the land. This was an area that once again raised the issue of losses that were endured during and after the cultural genocide of the residential school era. The traditional ways of being that were in place pre-contact, were evidence of the protective factors that were part of living in harmony with one's relations, which included land.

The CCI program provides suggestions of interventions to use that support maturity in the different Developmental domains. Many of these interventions such as drumming and massage, have cross-cultural meaning and can be used across more than one domain. This was the framework used to add traditional interventions into the various domains, acknowledging that most intervention plans would include a combination of traditional and mainstream ideas. There was recognition that these would be individualized based on the youth and family's self-identification with their cultural values and beliefs. This included exercising sensitivity to an individuals' sense of who they were. Additionally, it was important to recognize heterogeneity within Aboriginal groups and to account for geographic and territorial specificities in selecting and using traditional interventions.

The process of identifying which traditional interventions were applicable into certain domains was an enriching process for this researcher. It highlighted more similarities than differences between a Western and an Aboriginal worldview in the principles applied towards healing. As the therapeutic bookends of the CCI program are to 'decrease stress' and to 'deepen attachments', a review of the cultural interventions demonstrated that they are based on the same goals. The traditional interventions often include adult and child interaction in teachings, guidance and applying of interventions, all of which have the ultimate goal of restoring a child or

youth's balance back to a place of calm. Examples of these are: smudging, spiritual baths, sweat lodge, storytelling and healing circles.

### **Developing Community Capacity**

In addition to developing a new model for healing, a successful outcome for this study is the community's acquisition of knowledge that increases understanding of the impact of trauma on child development. This first stage of this ongoing knowledge acquisition, has been partially achieved by members of the research team who received training on the impact of complex on child neurodevelopment. This was primarily education provided at the level of community professionals and helpers. The training will continue with the larger community at the extended family and kin level after this initial project. This will be an important avenue for beginning to address the concept of collective shame, and its impact on the identity of Aboriginal children, youth and families. Additionally, the community's concerns about lack of follow up care in prior work with other professionals, are addressed as this is built into the CCI process. Additional follow up will be available through a feedback loop has been created, to allow for ongoing review and feedback as the adapted model is implemented. In the exit stage of the CCI process, although the coaches gradually withdraw their support, the relationships that have been established with the community, will continue to evolve. The researcher will join alongside the community for an undefined period of time as ongoing adaptations are anticipated and will be part of an ongoing journey of wellness.

### **Community Empowerment**

This community action research study met the two primary objectives participatory action research; acquiring knowledge and implementing action that is directly useful to a community, and empowerment through 'consciousness-raising' (Reason, 1994). Following a

PAR method of inquiry, the research was conducted in, with, and for the community. PAR principles are based on advocating for change and positive action for the community. These changes are to remain in the community after the research ends. This was achieved in this study and has led to community ownership of an indigenous, locally informed culturally adapted intervention. Additionally, participation in the project has served to increase community capacity as participating service providers' are now able to use knowledge acquired to support children affected by complex trauma and their families. As one participant stated: "I am honored to be part of building community capacity and being an agent of change in our community". With the community's consent, the model may be generalised for use by other Aboriginal communities leading to increased community capacity across multiple communities. In true PAR ideology, the development of a trauma focused culturally specific treatment intervention also serves to increase the community's sense of empowerment in having co-ownership of a localised intervention that is both culturally meaningful and effective.

### **Limitations, Implications for Future Research and Conclusion**

**Limitations.** The study was conducted using a sample case study instead of using an actual child or youth and their family which was a factor that limited the opportunity for the research participants to engage in true experiential learning. The original plan for the study was to use an actual child or youth and their family as participants in the CCI program. The intent was for data to be collected while the intervention was provided to the youth with cultural adaptations being made simultaneously, based on feedback from the coaches who would be supporting the family and care team. However, given how vulnerable a child or youth in the program is, and with the additional layer of working with the child's family and community where historical trauma effects continue to manifest, the safety of the child and family far

outweighs the need for experiential learning. Consideration was also given to the high likelihood of experiencing challenges with obtaining Institutional Review Board (IRB) approval for the study to proceed with an actual complex trauma exposed client. This led to a change in the original plan, resulting in the decision to use a sample case study with simulation of the CCI process. This change limited the availability of data from a family actually experiencing the intervention, which would have provided a richer quality of data to guide the adaptations. Potential weaknesses and strengths of the model, as well as data on the efficacy of the model within an intergenerational context, might have been more readily seen with an actual family. Therefore, the use of a simulated case study placed great limits on these opportunities for learning. The use of the model with a specific community may also be seen as limiting opportunities for generalizability of the model. However, this writer contends that this is a significant step towards generalizing to other Aboriginal communities since the enormity of the work lay in the development of this model that can now represent a template for other communities to localize for their own territory.

A further limitation of this study is that fact that although I am a black African indigenous woman who can relate to many of the issues regarding oppression that Aboriginal peoples have experienced, I am nonetheless an outsider as a non-Aboriginal woman. This may have limited the degree of openness and access to data that I was given, in comparison to a researcher who is of Aboriginal identity. Additionally, my desire to be perceived as an 'indigenous ally' may have obscured my ability to filter some of the information as 'new' because they were concepts that I had personal experiences of. This could potentially have led to my missing important aspects of the data as it was seen and interpreted through the eyes of another.

## **Implications for Future Research**

The next phase of this process will be to apply the culturally adapted model with families in the community. This researcher has been invited to go back to the community to provide further training to community members, and to apply the culturally adapted model with two identified families. This is an important step for future directions as the outcome of implementing the model will direct next steps for researchers not only regarding complex trauma intervention, but also regarding protocols and procedures for establishing respectful working partnerships with indigenous groups. It is this writer's hope that this first step of collaboration between a western theoretical orientation and an indigenous worldview based around the CCI program, will be the platform for bridging the gap in health care access for Aboriginal peoples, and provide guidance for practitioners in working effectively with Aboriginal children, youth and their families.

Further, the development of this model provides an opportunity for practitioners to engage in a new way of providing intervention to Aboriginal children and their families. This use of a culturally adapted intervention that has been co-created by members of an indigenous community has the potential to revolutionize the mental health system in B.C.

## **Conclusion**

In reminding us that research for indigenous people is ceremony, Shawn Wilson (2008) describes an integral part of any ceremony as 'the setting of the stage'. In his description, he makes a critical point which practitioners would do well to pay heed to and says that "everyone who participates needs to be ready to step beyond the everyday and to accept a raised state of consciousness", (Wilson, 2008, p 69). The development of a culturally adapted model is but the first step. In order for change to be effected, clinicians need to be willing to learn about, immerse



themselves in, and actually apply the new model which as Wilson (2008) so eloquently reminds us, requires a readiness to step beyond the everyday in a raised state of consciousness.

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## APPENDIX A

IRB Application for Approval to Use Human Participants

## Antioch University Seattle

### IRB Application for Approval to Use Human Participants

This application should be submitted electronically to the IRB Chairperson, at [IRB\\_AUS@antioch.edu](mailto:IRB_AUS@antioch.edu) after pre-scientific review and approval by student Faculty Research Advisors or Dissertation Chair. Please include the Informed Consent Document and a copy of any fliers, questionnaires, or assessment instruments you plan to use. When the application is approved you will be requested to provide a hard copy with all the signatures to the Academic Dean's office.

Name of Researcher: Chipo McNichols

Phone Number: xxxx\_\_\_\_\_ Email Address: xxxx@antioch.edu

Research Advisor or Chair of the Dissertation Committee (if researcher is a student): Jude Bergkamp

Date Proposal Submitted: Nov 14, 2014

**Title of Research Project:**

Can the Complex Care & Intervention (CCI) program be culturally adapted as a model for use with Aboriginal families affected by complex (intergenerational) trauma?

**Funding Agency (if applicable):**

N/A

**Project Purpose(s):**

The purpose of the study is to facilitate the request from the Aboriginal community of Lytton First Nation (LFN) to apply the Complex Care and Intervention (CCI) model within their community. The CCI model is based on the recognition that exposure to complex developmental trauma can lead to social-emotional-behavioural problems in children along with other comprehensive developmental lags. A care team comprised of adults in the child's life which includes main caregivers is created. Under the guidance of a CCI coach, the team conducts a Functional Developmental Assessment (FDA) to determine the child's developmental level across 7 trauma domains and applies specific interventions based on the results of the FDA. CCI has established a good track record of positive outcomes for youth within British Columbia's child welfare system (Geddes, 2014)

The objective of the study will be to gain the perspective of the professional members of the care team on aspects of the existing model that are not culturally relevant, sensitive or meaningful, and how these identified areas may be adapted to make the model more effective for use with Aboriginal children, youth and their families.

While the current CCI model has only been applied with children in foster care, for this study, the model will also be applied with children /or youth who are living with immediate or extended family. By using the model with family members in their natural environment the proposed study will uncover and address any potential systemic barriers to the successful integration of the model for treatment within an indigenous community.

A group of identified community members, which will include elders and a local research committee, will be an integral part of implementing the program, identifying and facilitating cultural adaptations to the existing model as deemed necessary. The adaptations will address issues of risk and possible harm, cultural sensitivity and relevance.

The outcome of this study will be the development of a culturally adapted model of the CCI program that may be generalized for use by other indigenous communities. This researcher hypothesizes that the intergenerational experience and effects of complex trauma have become embedded into the cultural identity of First Nations people, forming the basis for a cultural trauma race theory. The culturally determined adapted model would be an intergenerational intervention as both children and caregivers alike would benefit from its use as treatment for trauma related disorders.

**Describe the proposed participants: (age, sex, race, or other special characteristics, such as students in a specific class, etc.)**

Lytton First Nations (LFN) has an existing committee that was formed to strategize and develop a community mental health plan. This is the circle of caring or Shch Ema meetkt committee. At this level the committee is seeking to create a trauma-informed children's mental health practice in partnership with the CCI program. This group will be oriented to the CCI model which includes psychoeducation on the impacts of complex trauma on child development. It was from this committee that the request for the implementation of the CCI model was initiated. For the proposed study, participants will fall into three separate categories:

1. Three to five participants will be selected from the Shch Ema meetkt committee to form the first participant category: 'the Lytton research team'. Members of this sub group will participate as co-researchers with the primary researcher by helping to generate research questions, identifying a family for participation in the CCI process, engaging in data interpretation and reviewing of the draft report before it is finalized. This team will include one elder.
2. The second participant category will be the care team members. These will be adults who have worked with the child/youth in a professional capacity and will include the primary caregiver (s). These participants will be asked for their regarding the CCI *process*, providing the main data source. The caregivers' perceptions will not be sought for the research component to avoid introducing research bias and protect the family by keeping their right to treatment free of any research influence.
3. The third participant category will be the child/youth and their family/caregiver who will only have direct participation in the treatment component of the study. This will be an Aboriginal child or youth from Lytton First Nation aged between 5 and 16 years old. The child/youth will present with severe behavior challenges that are problematic in both the home and community settings and meet eligibility criteria for involvement in the CCI program. Preference will be given to youth under the age of 16 based on the recognition of the "window of opportunity" that presents the most optimal timeframe within which to intervene and produce significant developmental gains. The age consideration is also based on the premise that the increasing age of the youth is very likely to correlate to a lengthier trauma history, which further reduces the capacity of the youth to be positively impacted by interventions in the program. The child/youth will need to be in a stable placement with biological or extended family members who are willing to participate in the program.

**Describe how the participants are to be selected:**

- The Lytton research team members will be selected from among the Shch Ema meetkt committee. They will receive additional orientation on the Participatory Action Research (PAR) process, on cultural trauma and critical race theory.

- Care team members will be community members selected for their knowledge of and involvement with the child or youth in a professional capacity, e.g. social worker, youth worker, teacher etc.
- Family participants will be selected by recommendation from the Shch Ema meetkt committee based on local knowledge of the child or youth's presenting concerns and the family capacity to engage in the CCI process.

There is limited exclusion criteria for entry in to the CCI program, however some diagnostic classifications such as moderate to severe intellectual disabilities, pervasive developmental disorders or severe Alcohol Related Neurodevelopmental Disorders (ARND) where sufficient supports are in place for the child or youth may be reasons for eligibility exclusion.

**Describe the proposed procedures in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described here. Copies of questionnaires, survey instruments, or tests should be attached (use additional pages if necessary).**

- The Lytton research team will collaborate with the primary researcher to generate questions to be asked during application of the CCI model with the family. Obtained using a semi structured format, the care team's responses will guide both application and cultural adaptation of the existing model.
- The principle researcher in collaboration with the Lytton research team and Dr. Chuck Geddes, founder of the CCI model and research consultant for this study will develop the care team.
- Dr. Geddes will assign an external CCI coach to facilitate the treatment component of the intervention. The care team under the facilitation of the external CCI coach will use the CCI model to provide treatment to the child/youth and their caregiver.

Based on the nature of the proposed study and in line with most qualitative studies, the principle researcher's role will be that of participant observer. The principle researcher will engage in ongoing data collection through observation and relational dialogue.

#### **Data collection**

Open ended questions will be used to elicit information from members of the care team who have been involved in the application of the CCI model. The questions that will guide this process will be generated in collaboration with the Lytton research team at the start of the process.

Data will also be gathered through the sharing of ideas and/or teachings including personal narratives to inform the application and adaptation of the localized, adapted model. This will be done in individual sessions with each care team member and will be a continuous and integral part of producing the final culturally adapted CCI model. To provide context for the findings, data will also be gathered from members of the Shch Ema meetkt committee through the sharing of stories and local practices as they relate to their community. Data will also be collected through observation and the review of any documents that the Lytton research team may deem helpful to the process.

Recording of information will be done using paper and pencil for note taking and audio recording (with direct consent of the participants).

#### **Data analysis**

Data will be transcribed and analyzed with the goal of identifying any emerging trauma-domain specific themes. Preliminary analysis will be conducted by this researcher in consultation with the research consultant and one co-researcher. Once themes are identified, secondary analysis will be conducted with the whole research team to derive meaning from the data and to engage in a collaborative process of data interpretation. The data will then be classified into specific categories as they pertain to areas of the CCI that were modified in the process to align with cultural meaning. Possible data categories include language, relational meaning, traditional teachings, localized knowledge, etc.

Once the information has been transcribed, data analyzed and the results summarized, the Lytton research team will have the opportunity to view the draft document which will be created using the information. Final approval of research content and dissertation use including publication will be given by the Lytton research team. Upon approval and finalizing of the draft document, a report will be presented to the Shch Ema meetkt committee and may also include a presentation to chief and council or others at the request of the committee.

### **Instruments**

#### **Will questionnaires, tests, or related research not explained above be used?**

Yes  No  *If yes, attach a copy to this application.*

The semi structured interview questions will be derived from a collaborative process with the members of the Lytton research team. A copy of the questions is therefore not available at this time but will be included as part of the research data.

#### **Will electrical or mechanical devices (biofeedback, electroencephalogram, etc.) be used?**

Yes  No  *If yes, attach a detailed description of the device(s) and their use(s).*

#### **Will audio-visual devices be used?**

Yes  No  *If yes, attach a detailed description of the device(s) and their use(s).*

An audio recording device will be used to record conversations with participants for later transcribing. This will be done using a TASCAM DR-05 Portable Digital Recorder. Separate consent will be received by any participant who is being recorded.

#### **Current Risk (Acknowledge and describe any psychological, social, legal, economic or physical discomfort, stress or harm that might occur to research participants. How will it be held to an absolute minimum?):**

The family participating in the proposed study are of Aboriginal origin, an ethnic minority group, and qualify as members of a vulnerable population. Particular attention will therefore be paid to any risks that may be magnified due to the cultural history of intergenerational trauma. This is one of the key reasons why this researcher chose not to interview the family to reduce the potential for harm. Some members of the research team may also self-identify as Aboriginal.

Possible risk to participants may include emotional and/ or psychological distress if care team members are triggered by hearing something from the child, youth or their family that vicariously traumatizes them. There is also the possibility of a child making a disclosure regarding their history of trauma that may be distressful for caregivers to hear. Thinking about the symptoms related to the traumatic event may also elicit painful emotions or memories for the caregiver.

Steps taken to minimize this risk will include preparing the family and care team members for the possibility of this occurring (also included in consent form) before conducting the selection interview. The researcher will also inform participants of their right

to withdraw from the study in the event that they experience emotional distress and feel unable to continue.

The principle researcher will also have a separate research agreement with LFN in addition to two consent forms that outline the agreed steps to be taken in the event of a child/youth making a disclosure regarding harm to self or others. One consent form will be for the Shch Ema meetkt committee which includes members of the Lytton research team; the other consent form will be for the family participants.

The researcher will also make available information regarding both traditional and contemporary counseling to the participant. It is particularly important to include traditional approaches as the family being Aboriginal identifies them as members of a vulnerable group. The family will also be informed that should they decide to withdraw from the research, this decision will not affect their treatment. The care team will continue to provide intervention and treatment will not be terminated.

**Future Risk (How are all research participants protected from potential harmful future use of the data collected in this project? Specify whether participation will be anonymous or confidential; and specify measures to ensure anonymity or confidentiality. If audio or video tapes are used, state specifically who will see them and the date they will be destroyed. All data must be maintained in a secured situation for at least one year after analysis and longer if the report is publicized):**

All reported information will be anonymous and kept confidential, apart from indicating that participants were from a specific (geographical location) community for the purpose of localizing the findings. Only the principle researcher and the research consultant will have access to the raw data before it is transcribed and analyzed. The Lytton research team will then have access to the transcribed analyzed data and in order to assist with the interpretation process.

Once audio recordings have been transcribed, these will be destroyed within 60 days of the process being completed. Paper copies of data will be kept by the principle researcher for the required duration i.e. one year after completion of the research or longer in the event of publication. The data will be owned by the research team and may not be used by the researcher for purposes not related to the application of CCI without the CCI consultant's consent.

**How do the benefits of the research outweigh the risks to human participants? This information should be outlined here.**

The findings will provide a basis for the creation of an effective and culturally adapted indigenous model of CCI program for use with Aboriginal clients/families that have experienced complex trauma. The ownership of an indigenous localized intervention and participation in the project will serve to increase community capacity for supporting children affected by complex trauma and their families. Additionally, given that the healing for the child or youth involves caregiver/family participation in applying intervention strategies, opportunities for intergenerational healing are created. As the adults in the child's life learn and apply the strategies there is a mutual benefit of building attachment and increasing opportunities for successful interaction.

**Are there any possible emergencies that might arise in utilization of human participants in this project?**

Yes  No  *Details of these emergencies and provisions for dealing with same should be provided here.*

### What provisions will you take for keeping research data private?

Response sheets and analyzed data will be kept in a locked metal filing cabinet in the primary researchers' office and will only be accessible to the principle researcher and the research consultant.

#### ATTACHED:

1. Consent letter for family participants. This researcher has chosen to use a letter in consideration of meeting cultural norms for new people coming into the community to introduce themselves in the traditional way. One of the key principles of indigenous research is the relationship. The principle researcher is seeking to align with this principle by using a letter which is more relational and inviting than a form.
2. Consent form for Shch Ema meetkt committee participants

**STATEMENT OF AGREEMENT:** I have acquainted myself with the policies and procedures regarding the use of human participants in research and related activities and will conduct this project in accordance with those requirements. Any changes in procedures will be cleared through the IRB.

Signature of Principal Investigator(s) Chipo McNichols \_\_\_\_\_ Date \_\_\_\_\_

For Research Conducted by Students: This research involving human participants, if approved, will be under my supervision. I have reviewed and approved this proposal.

Responsible Faculty or Dissertation Chair: Jude Bergkamp, PsyD

Faculty Signature \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE SUBMIT AN ELECTRONIC COPY OF THIS INFORMATION TO:

IRB\_AUS@antioch.edu. Please also submit one hard copy to the Academic Dean's office after the project has been approved. Approval must be reviewed on a yearly basis. Any change or amendments require IRB approval

By completing and submitting this form I certify that:

- The information provided in this application form is correct.
- I will notify my Advisor/Committee Chairperson and the Chairperson of the Review Committee in the event of any substantive modification in the proposal, including, but not limited to changes in cooperating investigators and agencies, as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to my Faculty Advisor/Committee Chairperson, the IRB Chairperson, and to the participants.
- The research may not and will not be initiated until final written approval is granted.
- This research, once approved, is subject to continuing review and approval by the Faculty Advisor/Committee Chair and IRB Chairperson. The Principal Investigator will maintain complete and accurate records of this research.

If these conditions are not met, approval of this research could be suspended.

Chipo McNichols

Name of Principal Investigator:

xxxxxx

Student ID #

xxxxx

December 2, 2014

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Email Address

Date

As Faculty Advisor/Dissertation Chair, I assume responsibility for ensuring that the student complies with University and federal regulations regarding the use of human participants in research. I acknowledge that this research is in keeping with the standards set by the University and assure that the Principal Investigator has met all the requirements for review and approval of this research.

Jude Bergkamp, Psyd

---

Name of Faculty Advisor/Dissertation Chair

Date

xxxx@antoch.edu

---

Email Address



## APPENDIX B

Antioch University Seattle Informed Consent Form (Committee Version)

## **Antioch University Seattle Informed Consent Form (committee version)**

The Antioch University psychology graduate program supports the practice of protection for individuals participating in research and related activities. The information on this form is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you choose to withdraw from the study, your information will not be used for the research.

*Procedures to be followed in the study, identification of any procedures that are experimental and approximate time it will take to participate:*

### Project Steps

A research team will be created that will include the principle researcher Chipo McNichols, Chuck Geddes, PhD, as research consultant and 5-8 identified community members.

As a participant you may be involved at one of three levels in the research:

First, at the planning level with the steering committee members who will provide the questions and information to guide the research and select research team members. The committee will also choose a child or youth (and family) to receive treatment using the CCI model.

Second, as one of the members of the planning committee selected as co-researchers (called 'the Lytton research team' for clarification). Research team members may also become members of the child's care team.

Thirdly, you may be involved as an existing CCI coach with experience working with First Nations children or youth. Your perspective on your experience of using the CCI process will be sought. Information will be gathered during a 20-30 minute phone call.

Your participation in the study as a researcher will take approximately three to six months.

During this time, you will provide information regarding your views on how the CCI model is being used and what you feel might be helpful to change about the model to make it more culturally relevant for the community. This will include information that provides context on how best to implement the use of this model into the local community.

### Confidentiality and Anonymity

Information will be recorded in writing or audio recording (with my direct consent). All reported information will be anonymous. If anyone in the study reports that there is a risk of harm to a minor child, to the individual reporting or to someone else, this information will be shared with the appropriate member (s) of the child protection agency as pre-determined by the committee.

### Sharing of information

All written and recorded information will be kept in a safe location which only members of the research team may access. The Lytton research team will be invited to read the summary and draft document which will be created using the information. Final approval of research content and dissertation use including publication will be given by the Lytton research team. This will be followed by a presentation of the report to the steering committee. This may also include a presentation to chief and council at the request of the committee. The sharing of knowledge with other Aboriginal communities and other community agencies such as MCFD may also be done with the committees' approval.

*Description of any attendant discomforts or other forms of risk involved for those taking part in the study:*

No risks have been identified as you will be asked about information regarding the CCI model and its application and are not required to share any personal information.

*Description of benefits to be expected from the study or research:*

The findings will be used to help with the development of a culturally adapted model of the Complex Care Intervention program for use with Aboriginal clients/families that have experienced complex trauma. The community will own a locally informed intervention model and the process will lead to more community members using trauma informed work in their various roles. The intervention will support healing for both children and caregivers in the community.

By signing this consent form, you agree that you have read the above statement and have been fully advised of the process of the study, you are aware of and understand the possible risks involved, you understand that you may withdraw from the study at any time or ask for information that you have provided to be removed. You may also ask for a summary of the results of this study. If you have questions you may contact the investigator, Chipo McNichols, at xxxx or Research Advisor, Dr. Chuck Geddes, at xxxxx, or Faculty Research Advisor, Jude Bergkamp, at [xxxx@antioch.edu](mailto:xxxx@antioch.edu).

Signature _____	Date _____
Primary Researcher (s)	
Signature _____	Date _____
Participant and/or Authorized Representative	
Signature _____	Date _____
Chuck Geddes, PhD, Research Consultant	

APPENDIX C

Antioch University Seattle Informed Consent Form (Traditional Format Family Version)

## **Antioch University Seattle Informed Consent (Traditional Format Family Version)**

Dear participants

I thank you for welcoming me into your community and want to acknowledge that I am on Lytton First Nations traditional territory.

My traditional name given to me by my father is Chipo Thokozile Nyirenda. My married name is McNichols. Chipo means ‘gift from God’ and Thokozile means ‘be happy’ in two of my native languages. I was born and grew up in Lusaka, Zambia and am the daughter of Wesley and Eleanor Nyirenda. I came to Canada in 2003 and live in Abbotsford with my husband Bob and our three children who are 13, 16 and 20.

I am a psychology graduate student at Antioch University in Seattle. The psychology program at Antioch University wants to make sure that people who agree to take part in our studies are not hurt while they are helping us but are kept safe.

For my research, I am doing a study to find out if I can use Dr. Chuck Geddes’ Complex Care and Intervention (CCI) program to help Aboriginal children who are not doing well at home or school. These are children whose teachers or other adults in their life are worried about their behavior. In the CCI model, we believe that these children are often not doing well because something happen to them that hurt their body, mind and spirit and want to find ways to help them to heal.

To help with this, I will invite some people in your community to help me to support your family as part of the treatment for your child. They will be called ‘the care team’. As part of my study, I will ask people in the care team to share their voice with me and tell me what is working and what is not working to help your child. They will be called ‘the Lytton research team’. I will also ask them to share their cultural knowledge to tell me what we need to change in the CCI way of healing. I will do this so that the help that we bring is respectful to your child, your family and to all our relations. I will not be asking you to tell me about your part in the treatment because I would like to keep your information private. Although I will not be speaking to you myself, please feel free to talk to the people in the care team about how the program is going.

I am asking for your permission to bring the CCI way of healing to your child and family.

If you give your permission for me to use the CCI program with your family, you will be taking part in the program for about 6 to 8 months. Your child and your family’s names will not be used anywhere in the study and I will do my best to make sure that anything that you tell the care team is kept private. Everything will be kept confidential unless I hear about something that makes me worry that someone might not be safe.

If you agree to take part in the study, you will receive help with changing your child’s behavior from the care team. The research team will share their voice with me about what they think is working and what is not working about the treatment. This is the research part of the study and you will not be directly involved in this. By doing this study, we will be helping your family and also hope to help other Aboriginal families whose children are also suffering. The research part of the study will help us to learn how to make the CCI model more helpful for Aboriginal families. By doing the study, we will also teach people in the care team how to continue to support families with children who are struggling with their behavior.

If you agree to take part in the treatment part of the study, you might feel emotional, mental, or spiritual pain after you hear or remember something about your child being hurt. This may cause you to remember some times in your own life when you might have been hurt as well.

If this happens and you feel that you need some help, please use any of the helpers that I have

listed here or talk to somebody that you choose to help you.

Traditional healing supports: Identified elders for support

Mental health counseling supports: Identified by committee

If you agree to give your permission for your child to take part in the study and understand that you might feel some difficult emotions as you take part in the study, please sign this form.

Please remember that you may choose to stop taking part in the research part of the study at any time but that your child will continue to get help with the treatment part of the CCI program until it ends. If you have any questions, you please feel free to contact me as the main researcher at: xxxx, Research Advisor, Dr. Chuck Geddes, at xxxx, or Faculty Research Advisor, Jude Bergkamp, at xxxxx.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Chipo McNichols, Principal Researcher

Signature \_\_\_\_\_ Date \_\_\_\_\_

Participant Caregiver/Guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_

Chuck Geddes, PhD, Research Consultant