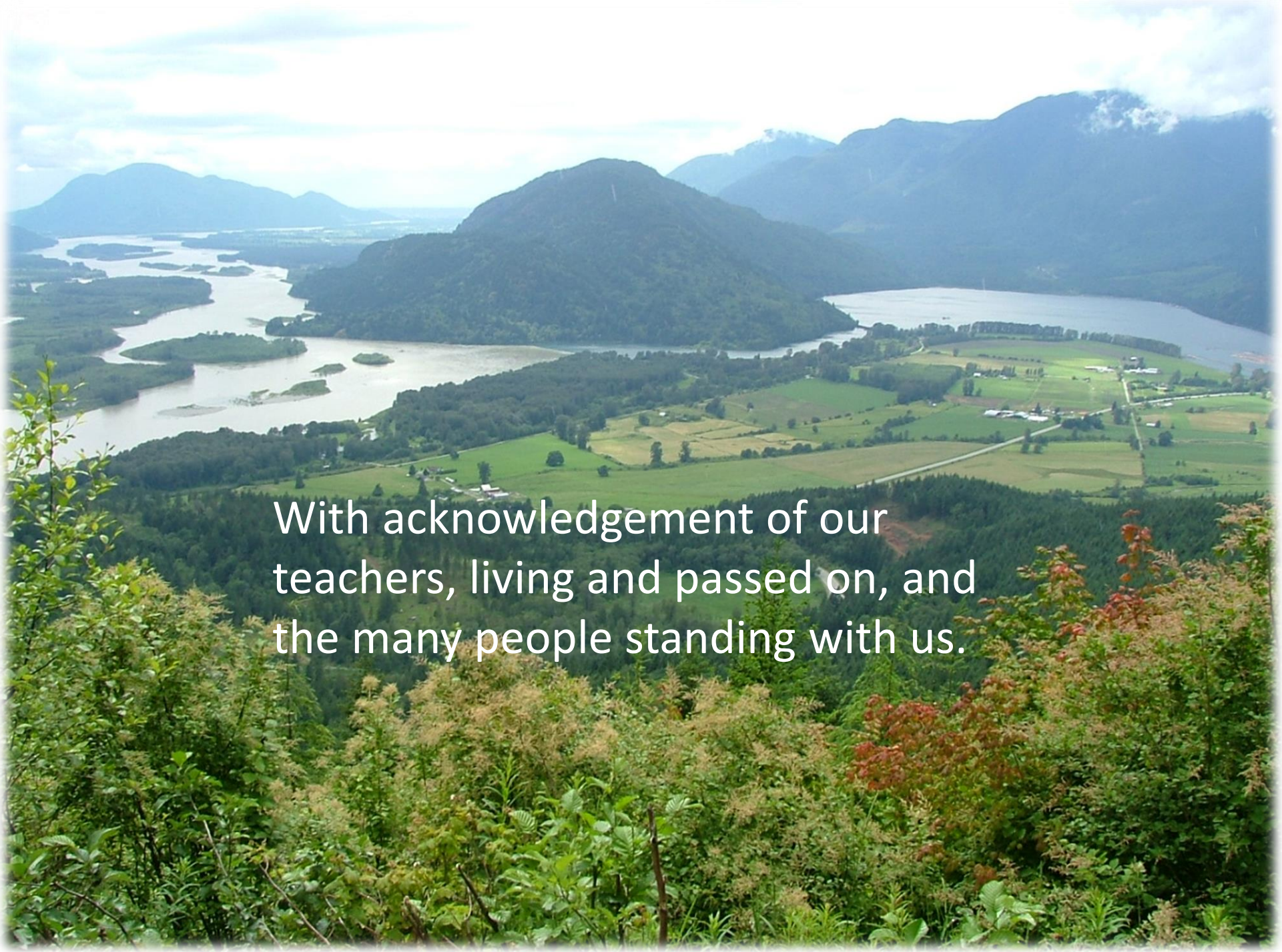
Intergenerational Trauma and the Impacts of ~~Colonial History~~ Historical and Ongoing Colonialism and Racism on the Health and Wellbeing of Indigenous People

DR. ELDER ROBERTA PRICE

DR. COLLEEN VARCOE

Who we are: “raced”, “classed”, “gendered”, “abled”… humans with responsibility for our actions



Goals

At the end of this session, participants will be able to:

- Gain an understanding of the impacts of colonial history and intergenerational trauma on the health and wellness of Indigenous communities and people,
- Consider the intersections among historical and contemporary forms of violence and the pathways of harm including stigma, discrimination and epigenetics,
- Describe the historical and contemporary impacts of the residential school system, Indian Day School, foster care and other forms of state incursion on the health and wellness of Indigenous communities,
- **Explore how health care providers can go beyond self-reflection to create culturally and emotionally safe organizations and practices, and contribute to meaningful change in health care cultures**.

Our Assumptions

- All attending today are committed to truth, reconciliation and action on the impacts of racism and colonialism
- Each of us are at different places in enacting that commitment
- We can each tailor enactment of our commitment to our specific roles

Before we start: Triggering and vicarious trauma

Because 1 in 2 women over the age of 16 have experienced physical or sexual assault, and the incidence and prevalence for people of other genders is underreported, it is reasonable to assume that many, if not most, people have (or currently are having) such experiences, or know some one close who has.

Many of you also have had experiences of other forms of violence and trauma: racism, torture, war, incarceration, apprehension by the state.

Just talking about violence and trauma will cause you to reflect on your own experiences, which may be retraumatizing.

We will be as 'trauma-informed' as possible, but feel free to tune out, get a glass of water, or whatever you need (but please come back when you are ready)

"Turning toward the abyss" [of suffering] (Mitchell & Bunkers, 2003), can be healing and is rewarding in health care practice

EQUIP Health Care

Preventing, Recognizing & Addressing Vicarious Trauma

A Tool for Primary Health Care Organizations and Providers Working With Individuals

Anyone in a health or social service role will encounter suffering, and we know that hearing traumatic stories every day can be taxing.

Providers often feel helpless in the face of this suffering, and how complex people's lives can be - there are rarely "easy fixes."

Understanding the nature and effects of vicarious trauma can be a first step in preventing, recognizing and dealing with it.

What is Vicarious Trauma?

Also known as secondary traumatic stress (STS) or compassion fatigue (CF), vicarious trauma is a negative reaction to trauma exposure and includes a range of symptoms that are similar to experiencing trauma directly. Vicarious trauma is common but there are ways to prevent it and limit it's impacts.

"When I get home, I can't stop thinking about what happened at work."

"Sometimes it's hard to hear what my patients have to say."

The first step is prevention. All health care and social service providers are exposed to suffering, but some settings have better supports than others.

Preventing, Recognizing & Addressing Vicarious Trauma

This tool offers actions you can take to implement equity oriented harm reduction in your primary health care practice. Harm reduction, cultural safety, and trauma & violence informed care (TVIC) are interrelated concepts that can help promote equity.

For other tools in the toolkit, see: https://equiphealthcare.ca/toolkit

Steps to Preventing, Recognizing & Addressing Vicarious Trauma

To move your practice toward equity-oriented harm reduction

1. **TAKE STOCK** of your work environment. Do the conditions of your work increase or decrease the likelihood of vicarious trauma having a negative impact? Consider:

- Does your workload allow you to provide good care, with adequate breaks?
- How is human suffering acknowledged and dealt with?
- How are providers expected to act in the face of suffering? Tough? Distant? Compassionate?
- Is reflective supervision from a manager or team leader formally available?
- Are staff encouraged to debrief informally amongst themselves, perhaps using a "buddy system"?
- How are providers who are struggling supported? Are people seen as "burned out" (an individual's weakness and problem) or "used up" by the organizational practices?
- How is workplace violence - including between staff or client or staff-client/client-staff - acknowledged and dealt with?

2. **BE AWARE** of the signs and symptoms of vicarious trauma and how to recognize them in both yourself and your co-workers:

- Social withdrawal
- Extreme or rapid changes in emotions (e.g., involuntary crying)
- Aggression
- Increased sensitivity to violence
- Physical symptoms (e.g., aches, pains)
- Sleep difficulties
- Intrusive imagery
- Cynicism
- Difficulty managing boundaries with clients
- Relationship difficulties

3. **IF YOU'RE CONCERNED** take an online self-test, such as the one here: http://www.compassionfatigue.org/pages/selftest.html

https://equiphealthcare.ca/toolkit/

Research in Violence and Inequity

Studies about Violence

- ER Nursing practice in relation to violence
- Women's experiences of system responses
- Violence/HIV risks for rural and Indigenous women
- Rural Aboriginal Maternity Care
- What are the health effects of intimate partner violence (BC, ON, NB)?
- Indigenous women's experiences of 'leaving'

Can interventions with individual women who have experienced partner violence improve health?

iHEAL Intervention for Health Enhancement and Living

- Pilot ON
- Pilot NB
- Reclaiming our Spirits (BC)
- RCT

Studies about Equity

- What shapes access to care for diverse people (e.g. single mothers, women in rural settings, Indigenous people)?
- What is equity oriented health care?

Can an organizational intervention improve care?

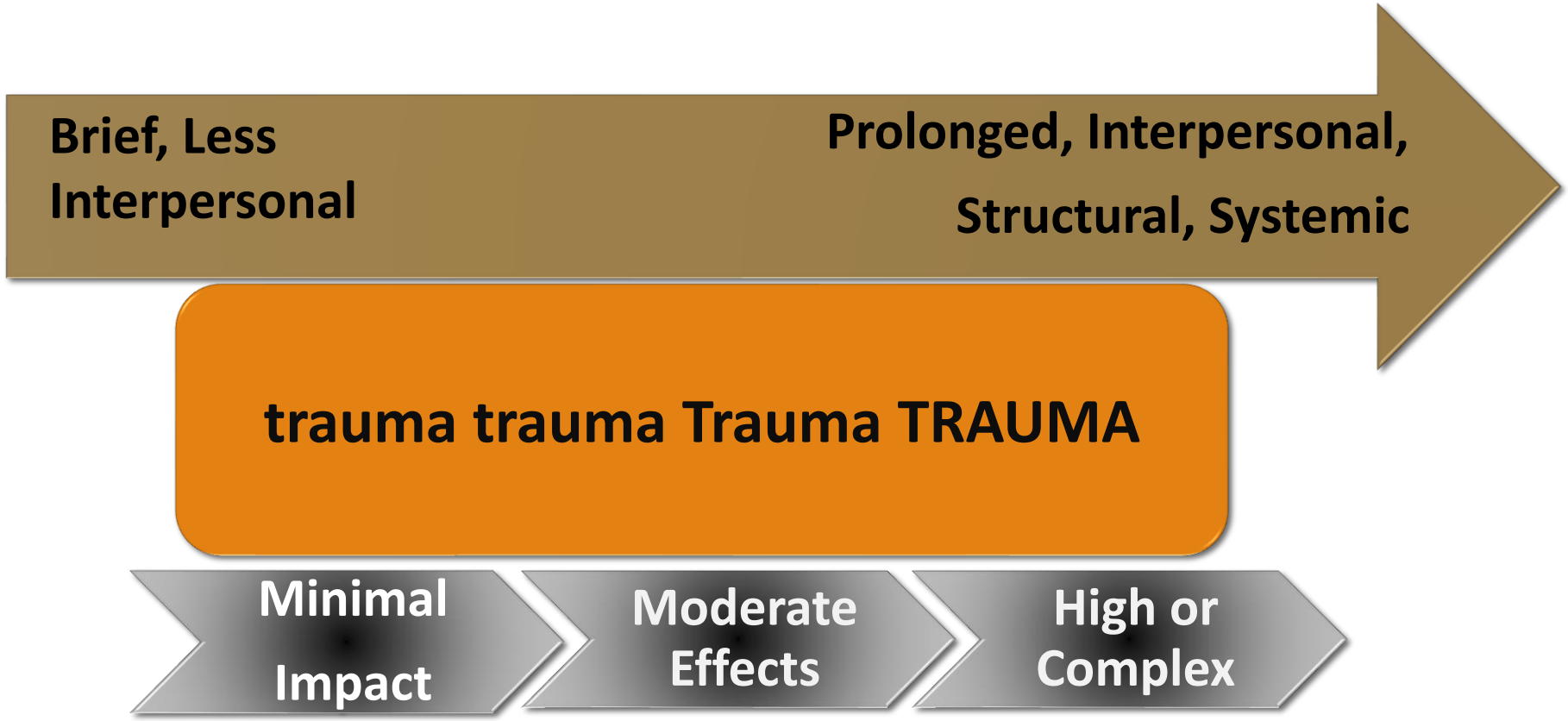
EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

EQUIP Emergency
Research to Equip Health Care for Equity

What we know:

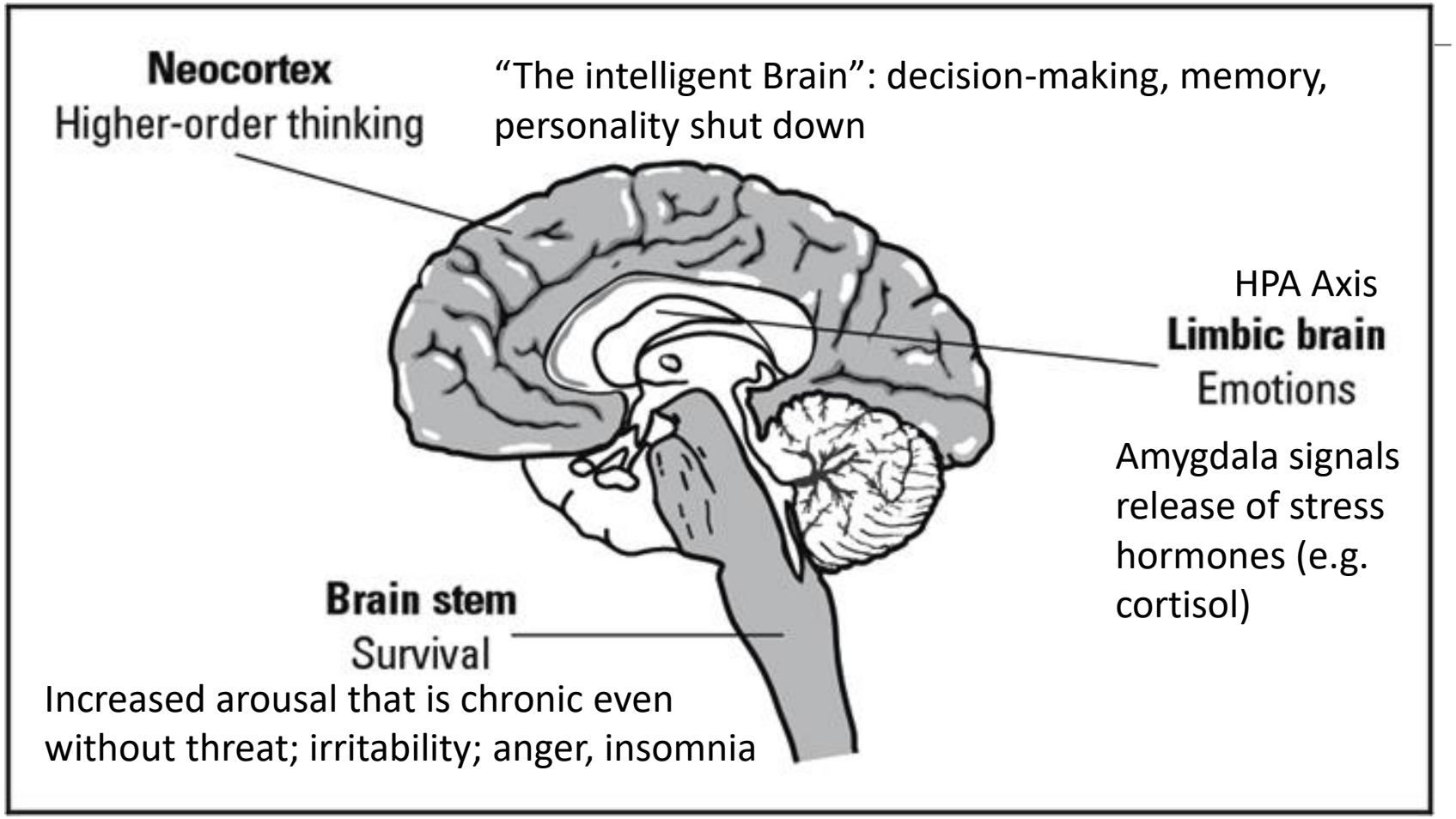
- Trauma and violence are pervasive
- The effects over the life span are cumulative
- The effects are **physiological**
- The effects are transmitted epigenetically (that is physically, not just through intergenerational social experiences)
- Healing, structural change and better practice are within reach.

Traumatic Stress Varies: Simple to Complex



Used with Permission of Susan McPhail

Traumatic Stress Reorganizes the Brain



Decreased activity in Neocortex,
Chronic hyper-arousal ("Brain Stem Driven")

Complex Post-Traumatic Stress Impacts:

- Ability to regulate emotions (e.g. persistent sadness, suicidality, anger)
- Consciousness (e.g. forgetting or reliving, detachment)
- Self Perceptions (e.g. shame, guilt, stigma, helplessness)
- Perceptions of “perpetrators” (e.g. all powerful)
- Relationships disrupted (e.g. mistrust, isolation)
- Meaning and beliefs (e.g. hopelessness, despair)

(Based on the National Center for PTSD (US)’s definition by Dr. Judith Herman)

What we can do:

- Acknowledge land and First People WITH COMMITMENT TO MEANINGFUL CHANGE
- Position ourselves FOR MEANINGFUL ACTION (beyond rote self-identification)
- Lead with analysis of the consequences of our **privileges**
- Engage in true partnership and true ally-ship (beyond tokenism, appropriation)
- Bring a **structural analysis** to all policy and practices
- Act to counter culturalism, racism, individualism, all intersecting forms of stigma and discrimination
- Understand that people come to health care bearing all past experiences
- Replace ALL labels (e.g. “drug seeking”, “frequent flier”) with trauma- and violence-informed explanations
- Seek to challenge and change the status quo in health care
- Learn about racism, historical and ONGOING colonial harms

Housing policy

Indian Act

Interim Federal Health Program

Structural violence encompasses the forms of violence that are **embedded in social, political and economic policies and organizations** (Farmer, 2003).

Minimum Wage and welfare rates

Barbaric Practices Act

Individualism, corporatism, “efficiency”, biomedical dominance

What is the status quo in health care?

Daily, unrelenting, insidious, pervasive racism against Indigenous people, supported by structures infused with racism and colonialism

Racism that drives people away from care, leads to mismanagement, misdiagnoses of failed diagnoses, poor quality care, errors and harm, poor or tragic health outcomes

Holding individuals accountable for their health and well being without consideration of their historical and life circumstances

Some dynamics that keep it all in place

Understanding *violence* as spectacular eruptions of “violence performed by a clearly identifiable agent”

(Žižek, 2008, p.1)

(instead of a pervasive feature of society designed to protect privilege)

The constant default to the ‘bad apple’ analysis of racism, interpersonal violence

More dynamics that keep it all in place

The constant pull toward “culturalism”

“Individualism” dominating health care (seeing individuals as responsible for their health, ignoring the historical and contemporary circumstances of their lives)

Many strategies further “othering”, offer only the appearance of something being done, and ignore the missing ingredient – white privilege

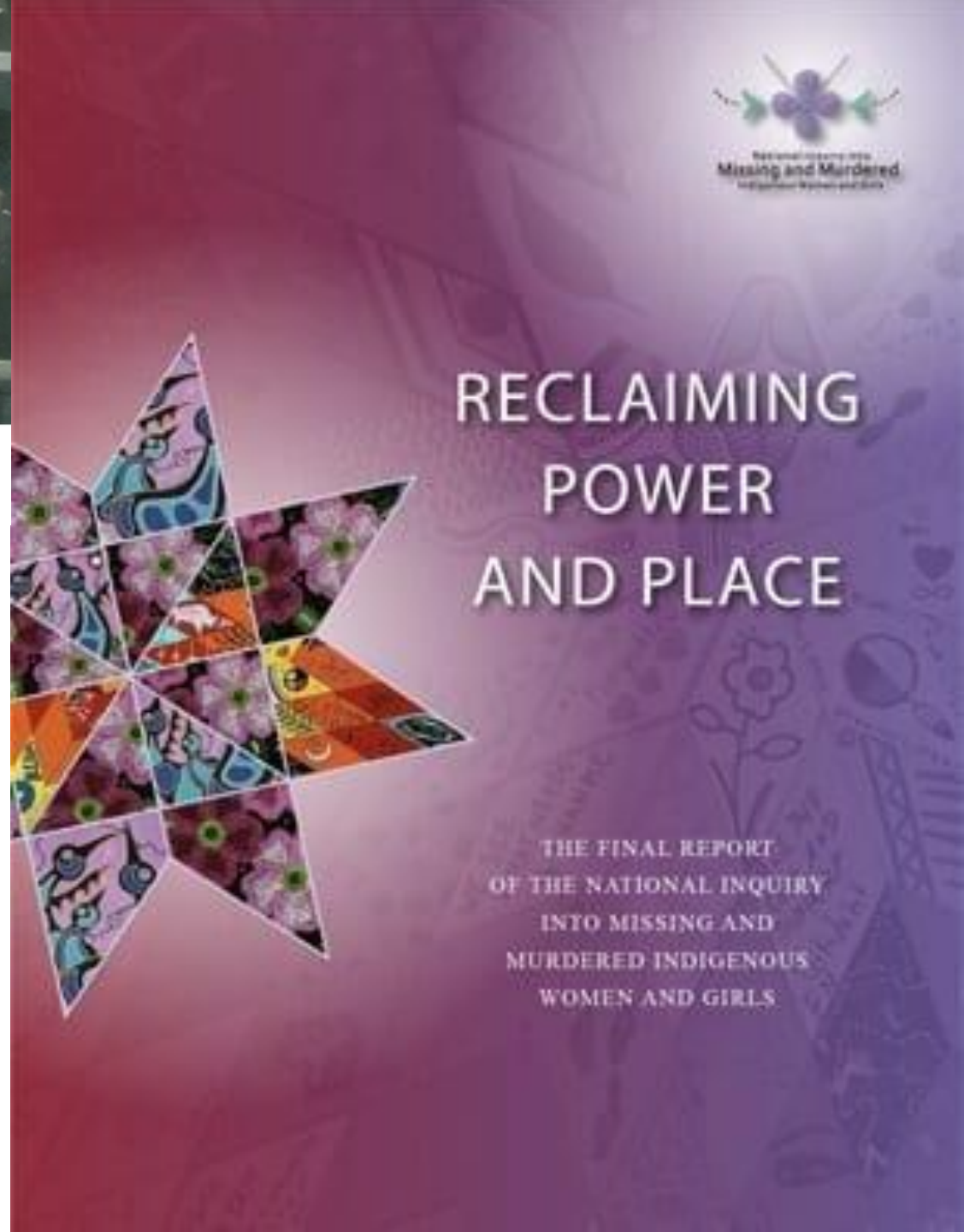
Photo by Maurice Bruneau used with permission of Mr. Brian Sinclair's family

Discourses in Healthcare to protect white privilege:

"……We treat all patients equally…. We treat everyone the same"

"….We are completely color blind"

"….We have no assumptions, and if we do, it doesn't shape the services we provide"



Point 1: We have to understand racism as *violence* and as *structural*

Point 2: We have to understand every instance, every micro-aggression, every problematic policy as but the tip of the iceberg

Point 3: We have to recognize that **one off** responses to racist incidents are not effective

Used with the permission of the family of Mr. Brian Sinclair

Point 4: We have to bring the protection of privilege and wealth into the analysis of the function of racism in health care

Point 5: We have to recognize that Antiracism and Cultural Safety Training are necessary but not sufficient

Point 6: multi-tiered actions must be designed and initiated to address the routine, everyday ways in which Indigenous people experience health inequities

Key Dimensions of Equity-Oriented Health Care

Tailored to context and responsive to inequities

From: Browne, A. J., Varcoe, C., Ford-Gilboe, M., Nadine Wathen, et al. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. *International Journal for Equity in Health, 17(1), 154. doi: 10.1186/s12939-018-0820-2;* Browne, A. J., Varcoe, C., Ford-Gilboe, M., & Wathen, N., on behalf of the EQUIP Research Team,. (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *International Journal for Equity in Health, 14*(152). doi:10.1186/s12939-015-0271-y

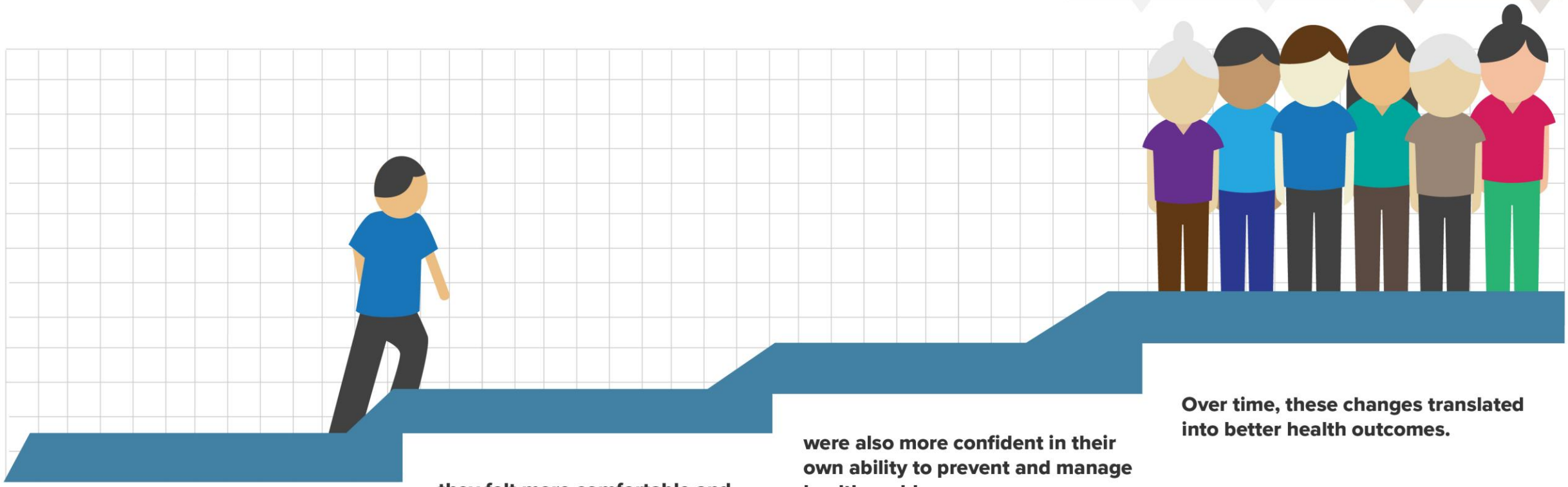
10 Strategies to Guide Organizations in Enhancing Capacity For Equity-Oriented Services

- Explicitly commit to equity
- Develop supportive organizational structures, policies, and processes
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local contexts
- Actively counter racism and discrimination
- Promote meaningful community & patient engagement
- Tailor care to address inter-related forms of violence
- Enhance access to the social determinants of health
- Optimize use of place and space

EQUIP Health Care
Research to Equip Health Care for Equity

Equity Oriented Care is Part of the Path to Better Health

Using longitudinal data from 395 patients, EQUIP is one of the first studies to show **a path between equity-oriented care and better patient health outcomes over time.**



EQUIP Health Care
Research to Equip Health Care for Equity

For more information please visit: www.equiphealthcare.ca

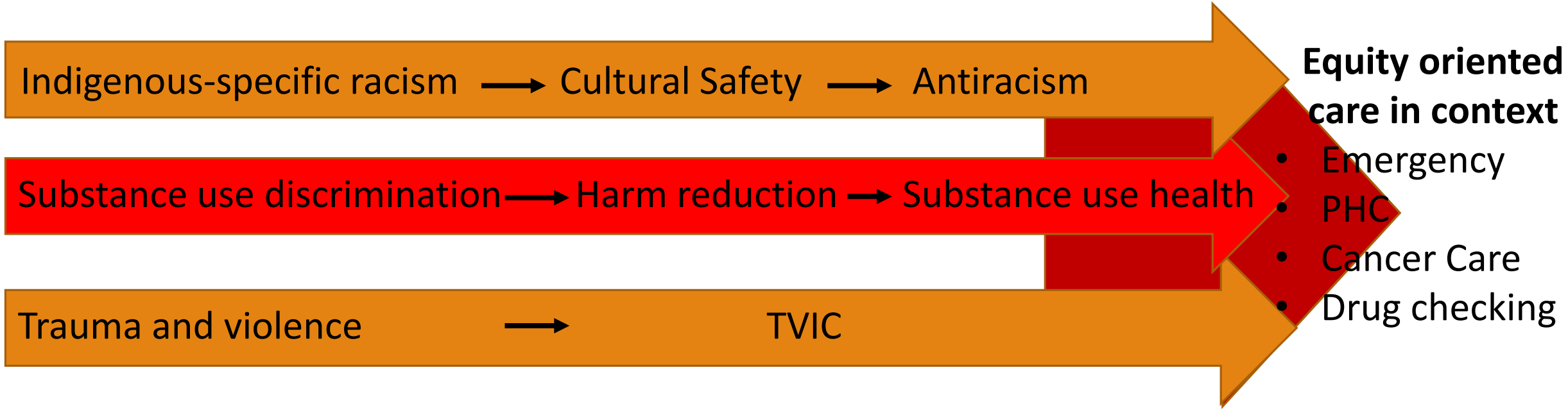
Ford-Gilboe, M., Wathen, C. N., Varcoe, C., Herbert, C., Jackson, B. E., Lavoie, J. G., . . . Browne, A. J. (2018). How equity-oriented health care affects health: Key mechanisms and implications for primary health care practice and policy. Milbank Quarterly, 96(4), 635-671. doi: 10.1111/1468-0009.12349

EQUIP Emergency

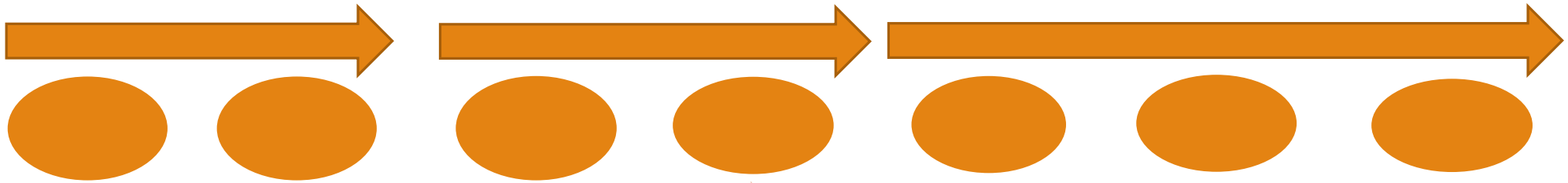
Research to Equip Health Care for Equity

Promoting Health Equity for Indigenous and non-Indigenous People in Emergency Departments in Canada

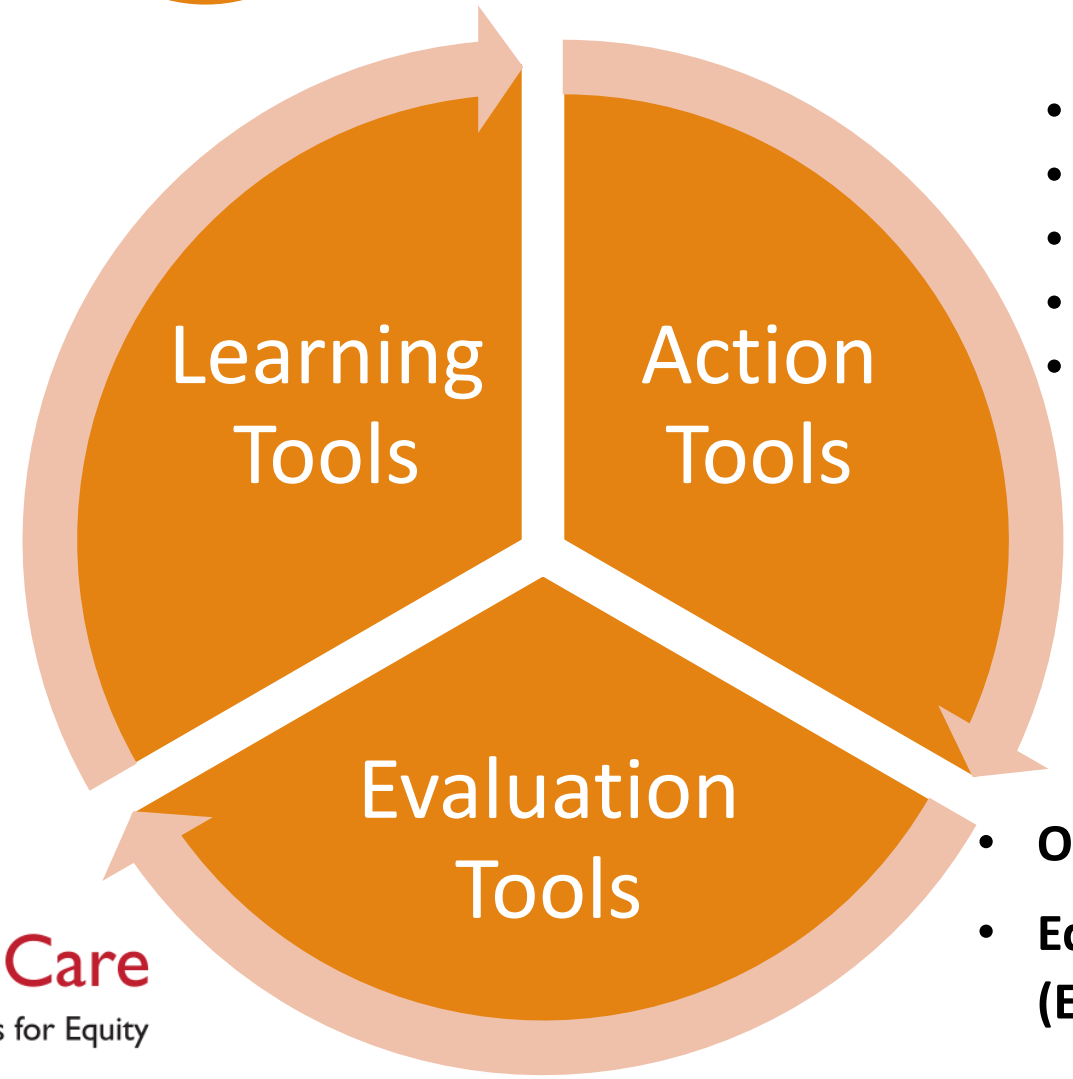
Pathways Project Action Kit for Equity Oriented Care



- Offers ‘steps’ on a journey to increase health and health care equity
- Starts wherever the setting is ‘at’
- Each step includes actions supported by resources, including information and tools for discussion, planning, information and evaluation with related instructions



- E-learning modules
- Animations
- Info-graphics
- “What is” tools



- Rate Your Organization tools
- Walkthrough/Review tools
- "Map Your Landscape" tool
- “10 things” tools
- etc.

- Organizational stigma tool
- Equity-Oriented Healthcare Scale (EHoCS)

EQUIP Health Care
Equipping Health & Social Services for Equity

https://equiphealthcare.ca/toolkit/

Dialogue