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Addressing Individual and Community Transgenerational Trauma

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OVERVIEW

This chapter provides a focus on trauma as cause and effect which, when untreated, can compound within and across generations. The result is physical, mental, emotional, spiritual, and social distress for individuals and broader social groups. While the experiences and transfer of trauma are not limited to members of specific racial or cultural groups, religions, or socio-economic levels, there is substantial evidence that trauma-related behaviours and attitudes are most prevalent in Australia's disadvantaged and disengaged communities. The chapter acknowledges that the combined effects of colonisation (and the actions it legitimised), and more recent government policies and practices (e.g. child removal), have contributed substantially to the dire circumstances of many Aboriginal and Torres Strait Islanders' lives today. We argue that the provision of adequately resourced and credentialed trauma-specific services is vital if the current levels of mental health and social and emotional wellbeing are to be sustainably improved.

INTRODUCTION

The first section discusses conceptions of trauma; theories of its transgenerational transfer; its impact on the lives of Aboriginal families and communities, particularly the links between unresolved childhood trauma and participation in violence, sexually inappropriate behaviour, harmful substance use, and incarceration, as adolescents and adults. The second section explores the challenges associated with working in Aboriginal communities and highlights some community programs that are achieving positive results. These programs provide education and empowerment, and embed trauma-recovery in all facets of their curriculum and engagement.

IDENTIFYING TRAUMA

Identifying trauma in a given population must start with behavioural observations. Through observation we can begin to consider the likelihood of trauma in an individual, family, community, or other grouping. Our capacity to listen to, and witness the human story without judgment is vital, linking what we hear and see to empirical evidence.[1] However, we *must* act in a manner that does not re-traumatise those with whom we are working. The following case study highlights the need for further investigation, but not to label without understanding the full story.

A young man just entering early adolescence: 'expresses suicidal ideation, stating he wants to hang himself; has periods of antisocial behaviour, throwing stones at the house and climbing on the roof at home or school. During a recent episode at school he substantially damaged the school buildings. There is now court pending regarding this damage'.

A psychological assessment provided a diagnosis:

> 'Emerging psychosis with mood congruent depressive content, suicidal ideation with paranoid tendencies [a belief that the world is unsafe] and chronic unresolved grief, with chronic complex post-traumatic stress disorder'.

The label 'paranoid tendencies' may in fact be based in evidence. He may have good reason to believe the world is unsafe. At three years of age, he saw his mother killed. At 11 years-old he was present when his aunt was killed. To our knowledge he has received no loss and grief counselling support.

Clearly, the observable behaviour of this young man would be regarded as offensive to many and would likely attract a period of incarceration or community supervision. His behaviour also suggests the likelihood that he has experienced prior distress and that the affect is trauma-related affliction. In this instance, court action without consideration of the trauma-specific services he needs is not appropriate and arguably a contravention of his human rights.

The increasing incarceration of Aboriginal juveniles, while a reflection on the capacity and appropriateness of the justice system, is a product of young people, described in part in the above case study, transitioning from childhood trauma experiences as victims, to perpetrators of behaviours labelled as 'bad' or 'mad'. This behaviour usually results in engagement with the juvenile justice and/or the mental health system.

This case study highlights the need for practitioners working in the mental health sector and in the justice system (a place where many young people with inappropriate or offensive behaviours inevitably end up) to be able to identify when someone may have significant unresolved and undiagnosed behavioural issues.

Symptom as History

Richard Mollica, author of *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World* suggests that our response in such situations is far more likely to be authentic and appropriate if we are able to understand 'symptom as history' (personal communication: Richard Mollica, 17th January, 2013).[1]

The incarceration rate of Aboriginal women continues to rise.[2] An Aboriginal prison worker writes:

> ❝ *I would like to share the situation here in (my state). I work with Aboriginal women in prison. Some women are in there as they have killed their husbands/partners. This happened after years of domestic violence and abuse. Sometimes they are so damaged from years of violence, they are never the same. They have been beaten, broken, raped. They know no other life.*
>
> *And now they lose their husband (who they loved), children, community and homelands. They are put into a massive western system (prison) in another Aboriginal group's land. They are isolated, and often very alone. By the time I see them they are completely shattered and in shock. They never receive visits, as all their family are a long way away.[3]* ❞

The above passage illustrates 'symptom as history' and lists the co-contributing factors as:

- being removed as children;
- having their own children removed;
- experiencing violence on themselves and within their family and community surrounds;
- having alcohol and other drug issues;
- being homeless;
- having diagnoses of depression and other mental ill-health;
- *All* of the women have trauma histories.

For further discussion of these issues surrounding men, women and young people in incarceration, see Chapter 10 (Heffernan and colleagues), and for rehabilitation and preventative programs see Chapter 27 (Powell and colleagues) and Chapter 30 (Hovane and colleagues).

DEFINING TRAUMA: EVENT, ENVIRONMENT OR REACTION?

It remains contentious among mental health professionals as to whether 'trauma' relates to a single event or series of events, an environment, to the process of experiencing the event or environment, or to the psychological, emotional, and somatic effects of that experience. Briere and Scott[4] argued that trauma only refers to 'major events that are psychologically overwhelming for an individual'[4(p3)] and refer readers to the DSM-IV-TR definition of 'extreme traumatic stressor'[5(p463)] for clarification. A stressor, in this definition, must be assessed as extreme to qualify an individual for a diagnosis of Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD), but can be of lesser severity for a diagnosis of Adjustment Disorder (AD). The DSM-IV-TR's reliance on the extreme/not-extreme dichotomy assumes homogeneity in how people process events and the perceived severity of the experience across individuals. The criteria do not take into account individual differences, the effects of previous histories, or current living conditions.

The DSM-5

The recently released DSM-5 does place a far higher importance on trauma and its effects. As well as providing a more clearly defined diagnostic procedure, it lists pre-traumatic, peri-traumatic and post-traumatic factors (temperamental, environmental and genetic/physiological) that must be taken into account when considering a diagnosis. It also clarifies what constitutes trauma, what qualifies as a trauma-related effect, the minimum duration of effect and the breadth of its effects.[6(p265-290)]

Figley[7] breaks his definition of trauma into two clear but related areas— psychological and behavioural. He defines *psychological trauma* as 'an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm'.[7(pxviii)] He also defines *behavioural trauma* as 'a set of conscious and unconscious actions and behaviours associated with dealing with the stresses of catastrophe and the period immediately afterwards'.[7(pxix)] Figley's requirement that events be necessarily catastrophic, extraordinary and memorable to trigger a traumatic stress reaction is consistent with the DSM- IV-TR's references to substantial severity.

Scaer[8] and Van der Kolk[9] concur with Figley by arguing that the inability to cope with highly traumatic events results in psychological and physiological effects that limit the ability to act or respond appropriately at the time of the event. It is more important to understand that overcoming the effects of trauma-related distress requires addressing not only the suffering (of the individual) but also the prevalence of events (within the community) that lead to re-experiencing and poor mental health.

DIAGNOSING TRAUMA IN ABORIGINAL CONTEXTS

A sociological and historical perspective is needed to understand trauma within colonised populations, which requires new policies and programs that move from individual treatment to whole-of-community healing. Distressing experiences result from a complex interaction between biological, social and psychological factors.

Several writers have argued that mental illness diagnoses such as PTSD do not conceptually capture the levels of chronic, ongoing stress that Aboriginal peoples experience in their everyday lives.[10,11] The sources of this stress are multiple, repeated and of great severity. The levels of this stress are argued to be unacceptably high and compounded by:

- the inability to identify and overcome a single source of stress;

- the presence of cumulative stressors; and

- the realisation that many of these stressors are inflicted by people in authority over, or well known to the victims.

Atkinson[10] developed the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) as a more culturally competent measure of specific traumatic stressors and trauma symptoms (DSM-III-R criteria for PTSD). This questionnaire included specific cultural idioms of distress reactions that are relevant to Aboriginal people.

As well as the problem of inadequacy at diagnosis, there are more substantial problems regarding treatment and control. Trauma-related illnesses, such as PTSD, ASD and AD, are conventionally managed by psychiatrists and psychologists, usually through medication, individual or group therapy and behaviour modification techniques.

IMPACTS OF TRANSGENERATIONAL TRAUMA

Atkinson's research[10] has identified a substantial lack of services that could effectively support victims of abuse and interrupt its intergenerational progression.

Her research also demonstrated a link between government policies and interventions, including the removal of Aboriginal children and behaviours associated with trauma experiences in Aboriginal people. These policies and interventions did so much damage, although they were often presented as bureaucratic generosity to people who were frequently living in clear distress. Atkinson's work exposes the role of intentional racism in the lives of Aboriginal Australians, including traumatic interventions which compounded the trauma of already distressed lives.[12] These findings highlight the need to invest in a skilled, culturally competent workforce who can respond in a healing way to the needs of children and their families.

Individual and Community Costs of Unresolved Childhood Trauma

Van der Kolk argues that childhood trauma is probably today's single most important public health challenge which could be overcome by appropriate prevention and intervention.[9] His work with trauma in childhood shows links with ongoing physical health problems, with intra and intergenerational transference of negative attitudes and troubled behaviour, and with the transmission of historical trauma across family and communal systems. He argues that childhood trauma violates a child's sense of safety and trust in the world in which they live, reducing their sense of worth. It establishes and/or increases their levels of emotional distress, shame and grief, and increases the proportion of destructive behaviours in the child's normal repertoire.

'Destructive' behaviours include unchecked 'aggression, adolescent suicide, alcohol and other substance misuse, sexual promiscuity, physical inactivity, smoking and obesity.'[9(p226-227)]

Survivors of childhood trauma are more likely to have difficulty developing and maintaining relationships with caregivers, peers and marital partners. Adults with a childhood history of unresolved trauma are more likely to develop lifestyle diseases (heart disease, cancer, stroke, diabetes, skeletal fractures and liver disease) and be likely to enter and remain in the criminal justice system. Van der Kolk's findings highlight the need for the early identification of children who are being offended against, to support these children and to help heal the behaviours that are compounding their already distressed conduct.[9]

Atkinson[10] recently investigated the link between being a victim of childhood trauma (direct or indirect) and being a perpetrator of higher-level violence in adulthood. Her study showed that a statistically significant proportion of Aboriginal men incarcerated for violent offending reported frequently experiencing traumatic and violent events in their childhood and youth. There was also a strong link between trauma and transgenerational transfer, the number of traumatic stressors or cumulative degree of traumatic exposure, and the likelihood of displaying PTSD symptomology.

The normalisation of family violence and the high prevalence of grief, loss and substance misuse were as much symptoms as causes of traumatic stress. One of the most alarming aspects of this study was this abuse, which often began in early childhood (victim) and continued until maturity, triggered the later acting out (perpetrator) on members of extended family and others. Atkinson concluded that the link between childhood suffering and adult offending was mediated by the presence of unresolved trauma and undiagnosed PTSD.

Such research findings have implications in our understanding of the serious situation of Aboriginal children who display distressed behaviour. In the case study above, Mitch, the 13 year-old, was unable to get assessment until he threatened suicide. Once a report was made by the school, Child and Adolescent Mental Health (CAMH) had him assessed. It would be hard to distinguish between his mental health diagnosis and co-contributing factors related to his childhood trauma. Developmental trauma[9] has now metamorphosed into complex trauma.[13] The more pressing issue is, however, the lack of trauma-informed therapeutic services delivered by a skilled workforce to meet the needs of our most vulnerable and disadvantaged children. This would go a long way toward interrupting the passage from childhood trauma into incarceration (juvenile detention and adult prison), involuntary detention in mental health wards, or serious self-harm and/or suicide. The potentially harmful impacts across the life course related to child mental health and social and emotional wellbeing (SEWB) are further illustrated in Chapter 21 (Milroy)and Chapter 22 (Walker and colleagues).

Child Sexual Abuse

While between 40 per cent to 73 per cent of all psychiatric inpatients have histories of sexual abuse in childhood,[14,15] there are generally other stressors and trauma present. As many as one-third of child victims of physical (including sexual) and psychological abuse grow up to demonstrate parental difficulties or become abusive of their own children; one-third of previously abused parents do not have this experience; but the remaining one-third remain vulnerable and, under stress, have an increased likelihood of becoming abusive.[16] According to Green:

> There is considerable evidence that the abused child is at risk for re-enacting the original violent interaction with his parents in subsequent relationships with peers and offspring, supporting a theory of intergenerational transmission of violence.[17(p582)]

The NSW Aboriginal Child Sexual Assault Taskforce[18] argued that the normalisation of violence that comes with generations of abuse was a determining factor in current rates of physical and sexual violence. One participant in the inquiry stated:

> The trauma of child sexual assault makes it very difficult for people to develop healthy relationships...because you've got, you know, children being raised like three generations in a row where sexual and family violence has been part of their life.[18(p61)]

According to Atkinson and Atkinson,[19] the endemic nature of family violence over a number of generations has resulted in a situation where:

> *violent behaviours become the norm in families where there have been cumulative intergenerational impacts of trauma on trauma on trauma, expressing themselves in present generations as violence on self and others.*[19(p7)]

The full implications of family violence and strategies that address these issues are discussed in Chapter 23 (Cripps and Adams).

The Intergenerational Transmission of Trauma

Atkinson[12] has mapped a progression of the transmission of trauma in a 6th-generation traumagram which links the historical events of colonisation to increases in family violence, child sexual abuse, and family breakdown in Aboriginal Australian societies. Tracing one family line across six generations, Atkinson listed the known memories of being victims of physical and/or sexual violence, being perpetrators of violence, suffering from mental health illness, attempting suicide and having substance misuse problems. The study provides evidence that unacknowledged or unresolved trauma in previous generations was linked to dysfunction within an extended family in later generations.

Historical Trauma and the Breakdown of Family and Community

Historical trauma is defined as the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as 'collective emotional and psychological injury ... over the life span and across generations'.[20(p36)] Helen Milroy in Zubrick et al.,[21] gave a comprehensive explanation of how trauma is transmitted across generations and the role of community networks in this transmission:

> *The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effect of the original trauma, which a parent or other family member has experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality.*[21(pxxi)]

A study by the Aboriginal and Torres Strait Islander Healing Foundation,[22] analysing the stories of 90 people who had contributed to the Stolen Generation Australian National Library Oral History Project, identifies the long term impacts on the SEWB of children removed from family, listing the risk and resilience factors.[22] Figure 17.1 reports on the analysis of 89 Stolen Generations oral histories. It shows that 53 per cent, 28 per cent and 29 per cent of people screened positive for loss and grief, PTSD and depression respectively, while 35 per cent of people did not experience any of the outcomes. It is considered that these are likely to be underestimates as the oral histories were not aimed at identifying mental health outcomes. The four PTSD items are from a standard screening tool, where the criteria is the avoidance item or two of the others; the nine items for depression scale were validated in Alice Springs, the criteria used was suicidal ideation or two of the other eight items. For loss and grief, the criteria was experiencing two of five items from a scale of traumatic grief adapted to the cultural context.

Figure 17.1: Factors that Contribute to Mental Health or Lack of Social and Emotional Wellbeing.[22(p3)] Percentage of Respondents with Identified Factors.
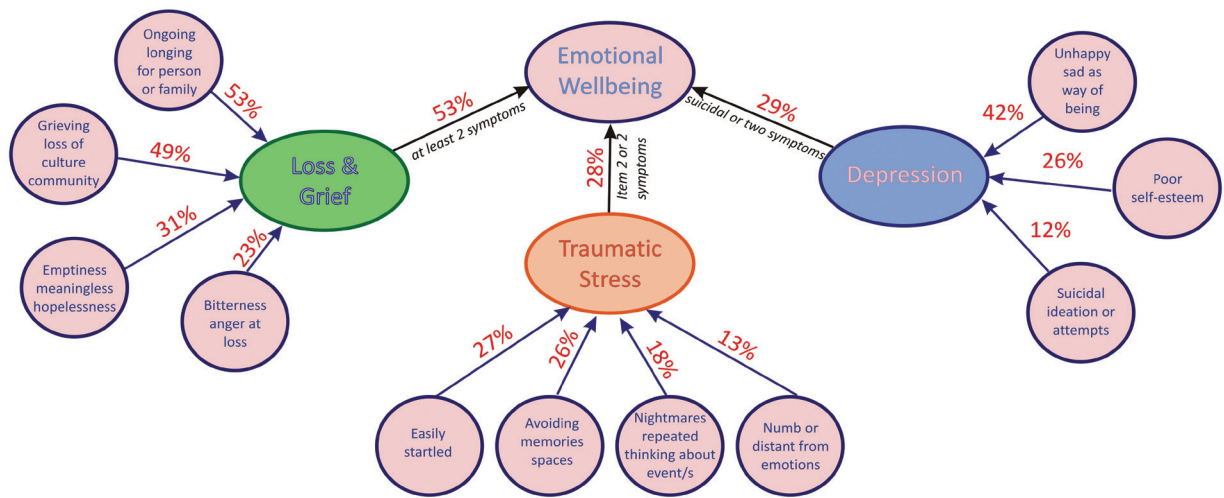
Source: Aboriginal and Torres Strait Islander Healing Foundation[22]

It is clear that these rates of depression, PTSD and loss and grief are substantially higher than the Australian population, where PTSD and depression are a few per cent. Thus the Stolen Generations members are likely to be experiencing significant disability associated with mental health issues resulting from their traumatic histories.

The risk and resilience factors are described in Table 17.1.

Table 17.1: Risk and Resilience Factors

Risk Factors	Resilience Factors
• victimisation because of Aboriginality	• a sense of control – autonomy
• traumatic removal	• positive memories before removal
• incomplete education and missed opportunities to learn	• family tried to stay together
• fractured identity	• siblings stayed together
• sense of powerlessness	• family visits with positive memories
• multiple care experiences	• developing a new loving family
• lack of attachment	• having a mentor
• domestic violence	• having peer support
• significant losses	• western education
• hidden punishments and/or victimisation in institutions	• learning to adopt responsibility
• multiple generation removal.[22(p3)]	• access to bush food, bush-land
	• cultural education
	• transferring cultural knowledge and identity maintained.[22(p2)]

Links Between Trauma and Suicide Ideation

Suicide is a traumatic and highly distressing event in the lives of family, friends and communities. It is also an indicator of problems occurring within communities and families. There is evidence to suggest that the more suicide experienced, the greater the levels of distress and dysfunction. In Chapter 9, Silburn and colleagues examine the individual and community level factors that contribute to a sense of cultural identity for Aboriginal young people.

Ralph et al.,[23] investigating proposed links between depression and the high youth suicide rates of the Kimberley region of Western Australia, concluded:

> *Aboriginal youth in the Kimberley region may experience several layers of trauma, through their own direct and secondary exposure as set against a backdrop of historical unresolved trauma and grief. These layers of trauma are thought to be cumulative in the manner in which they inform the adolescents' experience, and continue to adversely reinforce the basic assumptions that are violated by chronic trauma exposure; that the world is meaningful and safe, that the self is worthy, and that others can be trusted. It was thought that the current rate of suicide amongst Aboriginal adolescents in the Kimberley region may be the youths' contemporary expression of distress in response to chronic trauma exposure, as underpinned by the legacy of historical unresolved trauma and grief.[23(p123)]*

Importantly, Ralph et al.[23] demonstrated a clear link between being exposed to trauma and developing PTSD symptoms with suicidal ideation, particularly in Aboriginal children, both girls and boys, who identified as being victims of childhood abuse. Understanding this link between chronic and unresolved trauma throughout childhood and suicide ideation, and developing strategies early to provide young people with pathways to healing and recovery, is a critical step in suicide prevention.

The next section explores the challenges of working in communities to support positive change using community resources to their greatest potential, supported by a trauma-informed policy and educational service delivery.

COMMUNITY AND INDIVIDUAL HEALING MODELS

Healing from the social, emotional and psychological outcomes of traumatic experiences that has impacted whole communities requires interventions at both individual and the community levels. This section outlines recent examples of interventions for communities recovering from conflict, disaster and colonisation. They are the **Ad**aption **A**fter **P**ersecution and **T**rauma (ADAPT) model;[24] the Five Essential Elements of immediate and mid-term mass trauma intervention as outlined by Hobfall;[25] and evidence from the research work of Chandler and Lalonde supporting Cultural Continuity as a Moderator of Suicide Risk with First Nations from British Columbia.[26]

Silove[24] and Hobfoll[25] emphasise the link between community and individual healing. Silove stresses that healing the community contributes substantially to healing the individual, consequently requiring less 'clinicians' to heal individuals. The Chandler and Lalonde[26] study results show that communities with a strong sense of cultural continuity have significantly lower rates of youth suicide. Their work reinforces the connection between community wellbeing and individual wellbeing, with stronger communities having stronger individuals.

Silove[24] argues that there are five pillars of both the society and the individual which trauma and mass violence undermines:

- **Safety and Felt Security**—when threatened results in traumatic stress and depression

- **Attachment and Bonds**—when threatened results in loss and grief and damaged relationships

- **Justice**—when threatened results in anger and violence, often turned in on family and community
- **Identity and Roles**—when threatened results in isolation
- **Meaning and Coherence**—when threatened results in alienation.

Table 17.2 highlights the threats to each of the five pillars, the adaptive responses to each of the threats, and the consequence of not adapting.

Table 17.2: The ADAPT Model and the Impact of Threats to each Pillar

Pillar	Threat: Past Present and Future	Normative Psychological Response	Normative Adaptive Response	Negative Outcomes (if Adaptive Responses Fail)
Security	Ongoing violence, poverty, lack of food, absence of medical care	Fear, anxiety, hyper-vigilance, insecurity	Security seeking, protectiveness, vigilance	Anxiety, post-traumatic stress
Attachment and Bonds	Forced separation, losses, disappearances	Grief, separation anxiety	Parental protectiveness, attention to restoring families and networks	Complicated grief, pathological separation anxiety, depression
Justice and Human Rights	Discrimination, racism, humiliation, degradation, rejection, incarceration, dehumanization	Suspicion, lack of trust in authorities, anger	Sensitisation to justice, universalism, human rights promotion and demanding of justice	Pathological anger and violence, loss of trust
Roles and Identity	Dispossession and deprivation, genocide, denial/inadequate rights to: work, residency, and self-support	Aimlessness, reduced awareness, loss of sense of belonging, reduced efficacy	Role confusion, recreation of new or hybrid roles and identities	Loss of direction, giving up, persisting aimlessness or persistent inactivity
Meaning and Coherence	Destruction of places of worship, banning of religious/spiritual activities, suppression of spiritual, political and cultural aspirations and practices	Loss of coherence, a feeling of disorientation and alienation from society. Cultural disintegration	Rediscovery or regeneration of cultural, and religion/spirit, pursuit of social and political causes	Isolation, discontinuity, fragmentation, loss of coherence

Adapted from Silove[29]

A recent report examining the protective capacity of resilience in children shows clearly that once there is substantial trauma, resilience is not protective[27] and that substantial sustained threats will damage individuals and communities as their capacity to adapt is diminished. The establishment of security, maintenance and repair of family and social bonds, creation of effective systems of justice, re-establishment of social roles and identities and the building of institutions that create communal coherence and meaning (religious, spiritual, existential, political or cultural) may be necessary components of healing a community and consequently the individuals and families within it. 'Repairing these damaged systems and the institutions that support them forms the basis for building a framework of recovery for both individual survivors and their collectives.'[28]

The ADAPT model developed from clinical practice with torture and trauma survivors, and the Essential Elements model developed through a systematic literature review of post-

conflict and post-disaster communities shows that community level interventions may be an essential precursor to the provision of individual care, and at least reduce the size of the population requiring individual care following significant traumatic experience.[24,25,28] The cultural continuity work with First Nations people of British Columbia provides evidence that strong communities are very protective in the wellbeing of their members.[26,30] In fact this model supports community control of community services. Thus, the importance of the work by Chandler and others is less about the specific factors and more that strong communities, however they are defined, are protective of the wellbeing of their members. Thus, there is a need to identify Aboriginal and Torres Strait Islander specific factors. The work of Silburn et al.,[31] *Strengthening the Capacity of Aboriginal Children, Families and Communities* offers some important insights in this regard.

PROGRAMS TO SUPPORT COMMUNITY RECOVERY IN ACTION

Achieving sustained positive in-community change requires a substantial investment of resources, personnel and time which is beyond the reach of many organisations. It is partly because of this demand that successful programs such as the Family Wellbeing Program;[32-35] the *Yarning up on Trauma* of the Bouverie Centre, Latrobe University;[36] and the We Al-li Program[37-41] use the 'train the trainer' model to achieve and support community change over the longer term. The *Yarning up on Trauma* training had three layers in terms of understanding trauma and its impact, namely: within the community; with the work with children and families; and with the impact on self.[36(p71)]

These programs focus as much on the development of worker and community strength, confidence and skills as they do on overcoming the behaviours and attitudes that lead to dysfunctional communities. By establishing and equipping a core group of community members with the skills necessary to direct vulnerable individuals away from disruptive and damaging behaviour, substance and alcohol misuse and family violence and neglect, these programs are contributing to the development of safe, structured and stable Aboriginal communities.

The 'theory to practice' approaches outlined by Silove[24] and Hobfall[25] supports the work of Atkinson's whole of community model of education as healing (educaring), developed in the mid-1990s, and outlined as a response to the Northern Territory intervention, designed to provide trauma-informed health, mental health, and community therapeutic worker training.

We Al-li Program (Educaring Model)

The Ways Forward report names the We Al-li Program as a model for healing from trauma.[43] Developed at an Aboriginal community level over the period 1993 to 1997 by Aboriginal people, this program was documented in an applied research project into violence, relational trauma and healing in Aboriginal families and communities in Central Queensland.[12]

In the beginning, people wanted personal healing. In later years they wanted to enhance professional skills. In 1997 the principles and practice of We Al-li as a trauma-informed educational healing program was accredited at the tertiary level, with a balance of both personal and professional development. The teaching-learning approach was called an *Indigenous critical pedagogy*[42] at the university level, and *educaring* for all other purposes.

> In Indigenous education, the process of identifying 'who am I' and 'how I relate to the world' is of paramount importance and is considered the starting point for learning. The emphasis in the first instance is on what is happening for me 'in here' rather than an objective analysis of what is happening in the world 'out there'.[44(p5)]

Educaring is a trauma-specific blend of Aboriginal traditional healing activities and western therapeutic processes. It uses experiential learning to enable participants to explore their

understanding of the long-term consequences of trauma across generations and cultural tools for healing. It promotes and ensures relationships of mutual respect within the learning environment. Learning is through dialogue. Trauma-informed practice works to build cultural safety and spiritual integrity through individuals working together in the group. This requires the worker-educator to be culturally competent. It focuses on enhancing deep listening skills, self and other awareness, self and group reflective discussion and practice. Educaring is designed to heal the person while building on professional skills by focusing on transformational learning and social justice as fundamental to healing practice. It enhances levels of empowerment and self-confidence to support leadership potential.[12]

Educaring provides skills for working with individuals and groups using the healing power of story, cultural and personal narratives, emotional release and emotional regulation, in family history reconstruction, story maps, loss history graphs, trauma healing grams, using art, music, dance, theatre, in ceremonial processes, with children, young people, adults and Elders.

It is place-based. The stories of *place* can be both stories of trauma and stories of strength and resilience-healing. Place-based learning is community focused as it works to build sustainability while it skills local people to deliver local services. Aboriginal approaches to *education* place a strong emphasis on enhancing self and community learning. It is the *process* of becoming aware of self and others which underpins purposeful personal development and healing as a cornerstone to education, training and skill enhancement and professional practice:

> *At the basis of Indigenous philosophies and educational strategies are the underlying principles of relationships and balance…the individual is required to develop to the full those personal attributes that can enhance the life of the group. Learning is very much a process of experiencing, of watching patiently and quietly, and of absorbing. Learning is a life-long process, which takes place formally and informally. As people become increasingly knowledgeable, and assert their knowledge, they also become increasingly responsible for teaching the new generation who will take over from them. In an Indigenous educational environment this 'sharing of knowing' is made possible through the literature of Orality, Iconography and Ritual: of narrative, song, symbol, dance and drama.[44(p4)]*

A community of practice evolved, comprising a group of people who have completed the educaring model of personal and professional development, share a concern and passion for what they do, and how they do it at the community level. Graduates applied their theory and practice in diverse locations and situations across Australia and supported each other in the context of essential worker support for possible vicarious trauma—burnout.

The Educaring model is aimed at healing personal trauma while building a professional Aboriginal workforce skilled to address trauma issues in communities. The ADAPT model indicates the need for community-based interventions to reduce the amount of work required at the individual level and maximise the effectiveness of individual work.

Trauma-informed and trauma-specific programs and treatments are ones in which attention to traumatic experience is a key therapeutic strategy.[45] This is in contrast to therapeutic models which concentrate on psychosocial functioning and focus on a range of psychosocial stressors or issues (e.g. alcohol use). Hence, an educational approach that is trauma-informed encourages community conversations and has greater possibility of sustainable change and healing.

Ethical Community Engagement

The coverage of Aboriginal issues in the Australian print and digital media, in government reports and discussion papers, and in academic institutions is high. The number of other Australians who are now 'informed' and 'understand' Aboriginal issues has increased. There are positive and negative aspects of this.

Life in Aboriginal communities is fluid and has the same fluctuations as many other regions. People experience the full spectrum of emotions, children play in the streets and parks, but generally, life is restricted because of inadequate employment opportunities and widespread poverty. With inadequate employment and poverty come disengagement and resentment, increasing the probability of trauma-affected people not receiving the services they critically need. Being marginalised within an already marginalised population is a compound jeopardy.

In spite of history, there is considerable functionality, creativity and productivity in Aboriginal lives. There is, however, a small but significant group of people and families who, for many reasons, have fallen through the gap, and who have been made increasingly marginalised and disadvantaged within their own communities, as well as within broader service delivery functions. Often they have been misdiagnosed and, in many cases, maltreated by a system which is not trauma-informed and sometimes is trauma-inducing.

Being effective in these environments is stressful and requires specific trauma-recovery skills, skills that this chapter argues need to be more fully developed. Service providers need to acknowledge their ethical responsibility, to conduct trauma assessments as part of their service delivery before making assumptions about mental health/trauma problems. We therefore endorse a trauma-informed approach, which promotes ethical community engagement at all levels of policy development and service delivery. Table 17.3 has been adapted from the Australian Institute of Health and Welfare (AIHW) Resource Sheet: *Trauma-informed services and trauma-specific care for Indigenous Australian children.*[46]

Table 17.3: The Core Values for Trauma-informed Services

Understand trauma and its impact on individuals, families and communal groups.	People can be re-traumatised by inappropriate programs or service delivery, and hence may disengage from a service that could be critical to recovery. Two strategies that promote understanding of trauma and its impact, are trauma-informed policies, and trauma-specific training. Trauma-informed policies and service development and delivery formally acknowledge that some people have experienced trauma, demonstrate commitment to understanding trauma and its impacts, and detail trauma-sensitive practices. Training responds to the need for a skilled and qualified workforce at all levels of service provider responsibility. Ongoing trauma-related workforce training and support is therefore essential. For example, staff members need to learn about how trauma impacts across the lifespan.
Create environments in families and in social groups, where people feel physically, emotionally and spiritually safe.	Individuals and families who have experienced trauma require spaces in which they feel physically and emotionally safe. People themselves should be allowed to advise what measures make them feel safe. Creating safe physical and emotional environments involves allowing people to feel welcome and valued in the service, providing full information about service processes (in their preferred language), being responsive and respectful of all their needs and ensuring their physical safety in residential services is ensured. The identified measures must be consistently, predictably and respectfully provided. Workers report that creating a safe physical space for Aboriginal Australians in mental health/SEWB services, is both a basic human right, as well as critical for healing and recovery. *Continued . . . .*

Table 17.3: The Core Values for Trauma-informed Services (continued)

Employ culturally competent staff and adopt practices that acknowledge and demonstrate respect for specific cultural backgrounds.	Culture plays an important role in how victim/survivors of trauma manage and express their traumatic life experience(s). Culturally competent services are respectful of, and specific to, cultural backgrounds. Such services may offer opportunities for clients to engage in cultural rituals, speak in their first language, offer specific foods and have access to traditional healers if appropriate. Culturally competent staff are aware of their own cultural attitudes and beliefs, as well as those of the individuals, families and communities they work to support. They are alert to the legitimacy of inter-cultural difference and able to interact effectively with different cultural groups. Their first responsibility is to refer back to the client. Do they feel safe in how they experience the delivery of the service? Not, 'I am now culturally competent, and therefore you will be safe in the service I provide'. See Chapter 12 (Walker, Schultz and Sonn) for further discussion of cultural competence.
Support people who have experienced trauma to regain a sense of control over their daily lives and to be actively involved in all aspects of their lives, including their mental health–social and emotional wellbeing care.	Trauma denies a person or group a sense of being in control. Regaining a sense of control consists of two important aspects. First, victims/survivors of trauma must be supported to regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy and capability to respond to their own needs. Second, service systems are set up to keep individuals (and their caregivers) well informed about all aspects of their treatment, with individuals and groups having ample opportunities to make daily decisions and actively participate in the healing–recovery process.
Share power and governance, including involving individuals, families and community members in the development, design, delivery and evaluation of programs.	Power and decision-making is shared across all levels of the organisation, whether related to day-to-day decisions or the review and creation of new policies and procedures. Hence sharing power and governance reflects the same principles in community engagement. Practical means of sharing power and governance include recruiting Aboriginal and Torres Strait Islander peoples to boards, ensuring they are involved in the development, design and delivery of services, and involving them in the design and evaluation of programs and practices. Sharing power and governance involves supporting people in designing and managing their lives including their social health care plans and services.
Integrate and coordinate care to holistically meet the needs of individuals, families and communities, wherever the broad range of mental health, social and emotional wellbeing support services are required.	Integrating care involves bringing together all the services and supports needed to assist individuals, families and communities to enhance their physical, emotional, social, cultural and spiritual wellbeing. Documented practice experience suggests that approaches informed by Aboriginal culture and western health and healing practice, including neuroscience, show promise for supporting healing and recovery. There is also evidence that support of an ecological approach, which considers and acts on all systems that are negatively affecting an individual and community situation, are more effective than a separation of services.
Support relationship building as a means of promoting healing and recovery from trauma, both for clients as individuals or in groups, and within workforce teams.	Safe, authentic and positive relationships assist healing and recovery. Trauma-informed services facilitate relationship building and relationship healing. Trauma-informed services empower individuals, families and communities to take control for their own healing and recovery. Such services adopt a strengths-based approach, focusing on the capabilities that individuals, families or communities bring to a problem or issue. Facilitating peer-to-peer support across families and social groups is important. Appropriate support activities for staff within organisations might include regular supervision, team meetings and opportunities for self-care.

Source: Australian Institute of Health and Welfare (AIHW)[46]

P A R T 4

CONCLUSION

This chapter has discussed definitions of trauma and how the different forms of trauma, particularly transgenerational trauma, impact on Aboriginal peoples. The consequences of colonisation expressed in trauma have been examined along with the links between unresolved childhood trauma and participation in violence, inappropriate sexual behaviours and incarceration. Importantly, the challenges of engaging with Aboriginal communities are discussed and examples of successful programs for community empowerment are outlined. While this chapter focused on a perspective of life in Aboriginal communities that is disadvantaged and fraught with dysfunction, it is mitigated by the fact that empowering solutions are available.

However, these solutions require full and long-term commitment by communities themselves, government agencies and service providers, whether community controlled or the non-government service sector. The impacts of trauma on individuals and communities can be changed if appropriate preventions and interventions are identified and implemented in culturally appropriate and safe ways. We promote trauma-informed policy development and service practice in response to particular and pressing mental health and SEWB needs for individuals, families and social groups.

REFLECTIVE EXERCISES

1. There are many factors that contribute to the traumatisation of individuals and communities. List what these factors are, how they are associated and how you would develop a service plan.

2. It is common to hear service providers arguing that improving the education and quality of life of children is the only way of overcoming chaos and dysfunction in Aboriginal communities. Discuss this statement focusing on the child–family and child–community relationships.

3. If the evidence that links being exposed to violence in childhood to perpetrating violence in adulthood is accepted, and we acknowledge the prevalence of violence, how do we intervene to break the cycle?

4. Discuss the trans-generational nature of trauma and outline a trauma informed service delivery to a community in crisis of multiple symptom factors.

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