Trauma in the Aboriginal and Torres Strait Islander Population

Pat Dudgeon
School of Indigenous Studies, University of Western Australia

Marshall Watson
Child and Adolescent Mental Health Services, SA Health

and

Christopher Holland
Private Consultant

Abstract: The prevalence of trauma is beginning to be recognised as an Aboriginal and Torres Strait Islander population health issue. Trauma in this context needs to be understood in a way that accounts for the experience of Aboriginal and Torres Strait Islander peoples. Furthermore, the impact and contribution of trauma to many other problems in Aboriginal and Torres Strait Islander communities is only starting to be acknowledged. Relevant types of trauma are those related to historical events with intergenerational and transgenerational impacts; trauma resulting from repeated exposure to life stressors; trauma resulting from specific, intense life experiences; and trauma arising from adverse childhood experiences including complex and developmental trauma. In clinical settings, this layering of trauma can present unique challenges to health and mental health professionals and workers. Community-level healing responses are also important. Trauma should be addressed as a significant Aboriginal and Torres Strait Islander population health issue.

Keywords: trauma, Indigenous, intergenerational, stressors, population health

This paper examines untreated trauma among Aboriginal and Torres Strait Islander individuals, families and communities and some of the challenges faced by health and mental health professionals and workers in ensuring effective diagnosis and treatment.

The discussion is informed by the work of the national Aboriginal and Torres Strait Islander Healing Foundation that has leadership in ensuring the recognition of trauma as an Aboriginal and Torres Strait Islander population health issue. The Healing Foundation has developed innovative trauma healing programs in Aboriginal and Torres Strait Islander communities, as well as proposed national strategic responses to trauma in the Aboriginal and Torres Strait Islander population (Aboriginal and Torres Strait Islander Healing Foundation, 2016). These are discussed in detail below.

As a starting point, there is a need to recognise different forms of trauma when working with Aboriginal and Torres Strait Islander people. Trauma relevant to Aboriginal and Torres Strait Islander individuals, families and communities include those:

1. Related to historical events with intergenerational and transgenerational impacts.
2. Resulting from repeated exposure to life stressors.
3. Resulting from specific, intense life experiences.
4. Arising from adverse childhood experiences including complex and developmental trauma.

**Trauma Related to Historical Events with Intergenerational and Transgenerational Impacts**

Indigenous Australia is made up of two distinct cultural groups; mainland Aboriginal peoples and the Torres Strait Islander peoples. Aboriginal peoples were hunter-gatherers with a culture that stretches back 50,000 years. Torres Strait Islanders have a distinct culture and practiced agriculture in addition to hunting and gathering. Both groups were subjected to a process of colonisation that has been characterised as genocidal (Human Rights and Equal Opportunity Commission [HREOC], 1997) and has been collectively traumatic.

Australia’s colonisation is recent, occurring within only three to eight generations of Aboriginal and Torres Strait Islander people living today. The multitude of deaths by introduced diseases and first contact conflict profoundly disrupted traditional ways of life. Violence and massacres that occurred as British settlement encroached onto Aboriginal lands were not uncommon, and some are in living memory. The last officially sanctioned massacre is recorded at Coniston, Northern Territory in 1928 (Bain & Foster, 2003).

A second wave of colonisation (late 1800s to the 1950s) involved the dispossession of people onto reserves and missions, or their confinement to camps outside of towns. Aboriginal people were subject to legislation that controlled all aspects of their lives (Dudgeon, Wright, Paradies, Garvey, & Walker, 2014). Against this background, the forcible removal of thousands of Aboriginal children to be assimilated occurred (HREOC, 1997). In the Australian Bureau of Statistics’ (ABS) 2008 *National Aboriginal and Torres Strait Islander Social Survey*, 12% of respondents aged 45 years and over (i.e., born before 1933) had personally experienced separation from their family (ABS, 2010).

Tracing one family line across six generations, Atkinson (2002) has mapped an intergenerational progression of the transmission of trauma which links the historical events of colonisation to increases in family violence, child sexual abuse, and family breakdown. The study provides some evidence that unacknowledged or unresolved trauma in previous generations is linked to dysfunction within an extended family in later generations (Atkinson, 2002).

The mechanisms by which trauma is transmitted down generations are the subject of ongoing research. Milroy (2005) proposes a variety of mechanisms to understanding transgenerational trauma, including:

- the impact of attachment relationship with care givers,
- the impact on parenting and family functioning,
- the association with parental physical and mental illness, and
- disconnection and alienation from the extended family, culture and society.

These effects are compounded by exposure to high levels of stress and trauma in the present (Milroy, 2005). Recent research also suggests the possibility of epigenetic transmission (Yehuda et al., 2016).

The relationship between historical events and present day trauma in the Aboriginal and Torres Strait Islander population requires practitioners to understand the history and experience of families...
and communities with whom they are working. This includes culturally sensitive enquiry into the specific family and community history of Aboriginal and Torres Strait Islander clients with an awareness of the potential impacts of historical events on family and community life, in addition to potential impacts on the individual. This may require mean parenting support, connecting to culture and/or traditional and contemporary healing, in addition to clinical approaches as part of a holistic response to the client’s needs.

To better support their Aboriginal and Torres Strait Islander clients, practitioners should not only be clinically, but culturally, competent. To that end, practitioners should consider localised Aboriginal and Torres Strait Islander cultural competence training as a starting point. Culturally safe service environments must also be established. These have been defined as “environments that are spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need” (Williams, 1999, p. 213). Walker, Schultz and Sonn (2014) provide a comprehensive discussion about cultural competence and a further definition of cultural safety:

Cultural safety is about practitioners and services working to enhance rather than diminish individual and collective cultural identities, and empower and promote individual, family and community wellbeing. Culturally safe service delivery is crucial in enhancing individual and collective empowerment and more effective and meaningful pathways to Aboriginal self-determination (p. 201).

Guidelines on the practical applications of the cultural safety concept are available (Australian Indigenous Doctors’ Association, 2015).

Employing a local Aboriginal and Torres Strait Islander mentor, and ensuring Aboriginal and Torres Strait Islander presence in clinical governing bodies and among clinical staff and practitioners are important ways of supporting the above.

**Trauma Resulting from Repeated Exposure to Life Stressors**

Trauma associated with repeatedly experienced life stressors, or the perception of such, including racism and the threat of violence is important when considering trauma in the Aboriginal and Torres Strait Islander population.

Until recently, most of the research that explored the association of racism and trauma has been on African-American populations in the United States. Despite the differences, some of the studies and their findings can be generalised in broad terms. In these studies, relevant racism-related experiences range from ‘micro-aggressions’ (vague insults, non-verbal exchanges and looks which may be dismissed by others), and the perception that these things are happening, to actual violence. It has been theorised that chronic fear of these experiences may lead to constant vigilance or even paranoia, which, over time, may result in traumatisation and contribute to the severity of posttraumatic stress disorder (PTSD) when exposure to traumatic incidents occurs (Carter, 2007; Chou, Asnaani & Hofmann, 2012). Racism experienced vicariously—through the media, or seeing or hearing others from your racial group being subjected to racism—can reinforce the same need for constant vigilance that can become traumatisation (Williams, 2015).
Australian surveys show racism to be a relatively common experience for Aboriginal and Torres Strait Islander peoples. For instance, in a survey in Victoria, 97% of Aboriginal peoples and the Torres Strait Islander respondents had experienced racism in the previous 12 months (Ferdinand, Paradies, & Kelaher, 2012). Most people had experienced racism multiple times, with more than 70% experiencing eight or more incidents a year. While incidents of racism had occurred across a broad range of settings, it was most commonly experienced in shops (67%) and public spaces (59%).

In the 2014 - 2015 ABS National Aboriginal and Torres Strait Islander Social Survey, about one-third of Aboriginal and Torres Strait Islander respondents aged 15 years and over felt that they had been treated unfairly at least once in the previous 12 months because they were of Aboriginal or Torres Strait Islander origin. The most commonly reported form of racism was being subject to derogatory racial comments or jokes. One in seven respondents reported that they had been verbally assaulted (ABS, 2016a).

The potential of Aboriginal and Torres Strait Islander client trauma resulting from repeated exposure to racism requires practitioners to ensure cultural safety in their service environments. Such clients might prefer treatment by an Aboriginal and Torres Strait Islander practitioner, or with the support of Aboriginal and Torres Strait Islander mental health workers and health professionals. Carefully managed group work with other Aboriginal and Torres Strait Islander people with similar experiences may also be of benefit in addition to individual therapy.

Trauma Resulting from Specific, Intense Life Experiences

The social exclusion and disadvantage experienced by Aboriginal and Torres Strait Islander peoples (McLachlan, Gilfillan, & Gordon, 2013) is significant and associated with both increased exposure to multiple stressful events, and lower access to health and mental health services than non-Indigenous people (National Mental Health Commission [NMHC], 2014).

While the difference between trauma and psychological distress is acknowledged, data about the latter can shed light on experiences in Aboriginal and Torres Strait families and communities. In the ABS 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, 73% of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life events in the previous year. That rate is 1.4 times that reported by non-Indigenous people (ABS, 2013).

The most frequently reported stressful life event reported by Aboriginal and Torres Strait Islander peoples was the death of a family member or friend (reported by 37% of respondents in the previous year) followed by serious illness and inability to get a job (ABS, 2013). Researchers have noted the traumatising impact of repeated deaths among family, kin and community in Aboriginal and Torres Strait Islander peoples (Dudgeon et al., 2014).

Aboriginal and Torres Strait Islander people also experience high rates of actual and threatened violence. In 2014-15:

- more than one in five Aboriginal and Torres Strait Islander people reported experiencing physical or threatened violence, which is two and half times the rate for non-Indigenous people,
- Aboriginal and Torres Strait Islander women experienced physical assault at almost five times the rate for non-Indigenous women according to police records, and
hospitalisation rates for family violence-related assaults were 32 times the rate for non-Indigenous females, and 23 times the rate for non-Indigenous males (Steering Committee for the Review of Government Service Provision, 2016).

Every effort should be made to support Aboriginal and Torres Strait Islander communities to reduce these elevated rates of violence. In the immediate situation, a person presenting at health services with injuries provides an opportunity for identifying and treating trauma, including, but not limited to, that resulting from the cause of injury itself. This might also involve working with family members and even whole communities as appropriate.

Aboriginal and Torres Strait Islander people make up over one quarter of all adult Australian prisoners (ABS, 2016b) with even higher rates of Aboriginal and Torres Strait Islander young people in detention (Australian Institute of Health and Welfare, 2016). Incarceration is sometimes associated with traumatic and stressful life events as well as being a stressful life event in itself. A 2008 Queensland study reported 12.1% of Aboriginal and Torres Strait Islander male prisoners and 32.3% of female prisoners had been diagnosed with PTSD (Heffernen, Andersen, Dev, & Kinner, 2012). The potential for prison health and mental health services to identify and effectively treat trauma with Aboriginal and Torres Strait Islander prisoners is seldom addressed and remains a challenge. Programs in prisons could significantly contribute to reducing Indigenous incarceration and recidivism rates.

Trauma is often masked by other presentations, whether they are either internalising or externalising behaviours, and diagnosis might be made with reference to these alone if a clinician does not understand their client’s life context. For practitioners, and as referred to previously in the context of historical trauma, in addition to other clinical approaches the process of diagnosis should involve culturally sensitive enquiry into client’s individual, family and community circumstance and experience, supported by working with their families, trusted Elders and community members as appropriate.

**Adverse Childhood Experiences and Complex and Developmental Trauma**

Adverse childhood experiences (ACEs) refer to stressful and traumatic life events for children. They can include a death in the family, injury, household alcohol or drug problems, parental violence, child neglect and abuse, living in out-of-home care and being bullied at school. Aboriginal and Torres Strait Islander families have a much higher recorded prevalence of childhood adversities compared to non-Indigenous families (Jacobs, Agho, & Raphael, 2012).

Nationally in 2014-15, the most common reason for substantiation of child protection orders for Aboriginal and Torres Strait Islander children aged 0–17 years was neglect (38.3%) followed by emotional abuse (37.7%) (SCRGSP, 2016). Whilst the actual prevalence of child sexual assault by Aboriginal and Torres Strait Islander children status is not known, data from incidents that come to the attention of police are available and indicate rates are significantly higher than that in the non-Indigenous population (SCRGSP, 2016).

Emerging dialogues hold promise in understanding trauma in the above context. Complex trauma is a term used to refer to multiple associated traumatic events and is associated with child maltreatment that can involve sexual abuse, physical abuse, neglect and exposure to family violence. Further, a child in out-of-home care as a result of these experiences may also experience compounding attachment-based traumas (Kisiel et al., 2014). These young people often present with issues centred on the fear and mistrust of others, and these are likely to be brought to the clinical relationship. This can
be a barrier to engagement that requires patience on the part of practitioners in the process of establishing trust as a foundation for effective treatment. It may require the involvement of trusted Elders and/or mentors in the treatment process as appropriate.

Also important here is the concept of developmental trauma, whereby the cognitive, neurological and psychological development of a child is disrupted by exposure to traumatic incidents resulting in wide-ranging impairments in arousal, cognitive, emotional and social functioning (Atkinson, 2013). Those young people with developmental trauma often come to the attention of child protection and family services, mental health services, and the police and the juvenile justice system at the same time. Furthermore, each agency may attempt to ‘manage’ or treat such children without coordination, and with different goals and priorities.

For young people with developmental trauma, such multiple processes can be overwhelming to the point of causing distress and disengagement. For practitioners working in this context, understanding what is happening to their client across many settings, and working with other agencies in a coordinated and sensitive way is important for effective treatment.

Complex childhood and developmental trauma can present in many ways. However, the underlying issue is a client perspective of others and life based on fear, confusion and mistrust. Problems in diagnosis can arise if resulting behaviours are taken at face value and the client’s underlying emotional state is not understood, including what they have contextually experienced. When trauma is missed, clients are misdiagnosed and mistreated. This perpetuates not only morbidity for those affected, but can give rise to their mistrust in practitioners and in the system.

Addressing trauma, whether it be with psychological or pharmacological treatment, needs to be tailored to clients. Practitioners should avoid a ‘one size fits all’ approach. Service providers need to adopt trauma-informed care practices. Those involved in the support and care of those affected by trauma also need to be educated and supported to avoid the effects of vicarious trauma.

Stigma is a very real issue in mental health, as is institutional racism for Aboriginal and Torres Strait Islander people in health care settings. Practitioners need to be mindful not only of what problems and challenges clients bring to them, but also of their own biases and prejudices that may interfere with the therapeutic relationship.

**Practical Implications**

**Individual therapy and healing.**

Along with ensuring the cultural safety of service environments and their own cultural competence, practitioners need to consider that the way trauma presents in an Aboriginal and Torres Strait Islander client may be professionally challenging.

The client’s presentation is unlikely to fit neatly into diagnostic categories. It may be compounded by a personality trait or disorder, or a mental health or alcohol and drug problem. The trauma response may be complicated by evidence of symptoms of exposure to a traumatic event(s), alongside factors that are more relevant to the causal factors associated with the event(s). The overall trauma presentation may be inseparable from repeated exposure to stressful life events, unresolved childhood trauma, with or without developmental impacts, and the intergenerational and transgenerational transmission of historical trauma.
Further, contact with social and health/mental health services may be traumatising or re-traumatising for Aboriginal and Torres Strait Islander clients, thus further complicating treatment. All practitioners should also be aware that staff from government social and health services were historically among the agents who carried out forced child removals and that even today the removal of Indigenous children by child protection services occurs at significantly higher rates than in the general population (HREOC, 2007). Again, this experience could have an impact on the professional and therapeutic relationship.

There are also challenges regarding treatment and control as trauma-related illnesses are conventionally managed by psychiatrists and psychologists. This usually involves trauma focused individual therapies, with or without medication. The suitability of such treatment for Aboriginal and Torres Strait Islander peoples requires consideration and cultural adjustment. Further, treatment is likely to require time and patience, and practitioners should be aware of its potentially overwhelming impact on clients. Either consciously or not, people with exposure to traumatic experiences and multiple sources of trauma can have a sense of “safety in chaos”. It can therefore be challenging, even threatening, for people to move from this to a more orderly way of life because of effective treatment.

Community healing.

As noted, the work of the Healing Foundation has been central to the development of trauma healing programs developed by and for Aboriginal and Torres Strait Islander communities and can occur alongside clinical and other approaches focused on individuals. The Healing Foundation (2016) suggest that the following principles should be used to guide community-levels responses to healing trauma:

- Trauma should be understood in the broader context of historical and continuing colonisation and the forced separation of children from their families.
- Aboriginal and Torres Strait Islander peoples have the knowledge and skills to resource healing from trauma.
- Healing involves reconnection to culture and traditions, including ceremony.
- Healing provides a safe place for people to share their stories, gain and sustain hope, develop their sense of identity and belonging, be empowered and seek renewal.
- Healing attends to the needs of both survivors and perpetrators.
- Healing is an ongoing journey to restore and sustain physical, social, emotional and spiritual wellbeing.
- Healing is most effective when designed, developed and delivered by Aboriginal and Torres Strait Islander people with and for their own communities.
- Aboriginal and Torres Strait Islander peoples have shown great resilience over the generations, building on these strengths is critical.

A range of community level (and individual) healing models have been published by the Healing Foundation, in addition to those presented in the second edition of the Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Dudgeon, Milroy & Walker, 2014).
Responding to Trauma in Aboriginal and Torres Strait Islander People

While addressing trauma presents challenges to practitioners and Aboriginal and Torres Strait Islander communities, there are also implications at the population level. To that end, the Healing Foundation has advocated for a national strategic response to address trauma in the Aboriginal and Torres Strait Islander population (Aboriginal and Torres Strait Islander Healing Foundation, 2016). More broadly, the idea of addressing trauma as a population-level health issue that might be significantly contributing to other problems in Aboriginal and Torres Strait Islander communities (including mental health, alcohol and drug use problems, and suicide among other issues) is only beginning to be explored.

The following are proposed as programmatic elements of a national strategic response to trauma in Aboriginal and Torres Strait Islander people, families and communities that could be progressed by policy makers and mental health services working in partnership with Aboriginal and Torres Strait Islander peoples. They include proposals by the Healing Foundation (2016).

For the workforce and practitioners.

- Guidelines around ensuring the cultural safety of service environments.
- Mapping of local cultural competence training programs and inclusion of such in relevant education curricula and professional development pathways.
- Approaches based on principles for healing trauma developed by the Healing Foundation and including acknowledging and respecting the cultural knowledge and expertise of Aboriginal and Torres Strait Islander peoples.
- Review of existing specific literature to guide appropriate clinically and culturally based assessments and treatment responses.
- The agreement of a common language and understanding for discussing and addressing trauma in Aboriginal and Torres Strait Islander people, families and communities and at the population level. Ongoing education for all relevant health and mental health professionals and workers focused on identifying and treating trauma in Aboriginal and Torres Strait Islander peoples.
- Enhancing the assessment, treatment and healing options available to psychologists and mental health workers working with Aboriginal and Torres Strait Islander prisoners and detainees with trauma. More generally, promoting a trauma-aware judicial system and appropriate sentencing options that include healing pathways for people with trauma who are convicted of a criminal offence.
- A culturally appropriate monitoring and evaluation framework to support the effective implementation of a national strategic response and to ensure positive outcomes for Aboriginal and Torres Strait Islander peoples.

National approaches.

- A nationwide evaluation of the effectiveness of existing responses to trauma including building the evidence base for the effective healing and treatment of, and recovery from, trauma in Aboriginal and Torres Strait Islander settings.
- Continuing national efforts to reduce racism and promote reconciliation.
- Research to close knowledge gaps.
For Aboriginal and Torres Strait Islander peoples.

- Training and educating relevant Aboriginal and Torres Strait Islander practitioners including building and expanding upon existing Aboriginal and Torres Strait Islander workforce capacities across diverse settings (Aboriginal and Torres Strait Islander Healing Foundation, 2016).

- Community-level programs to help communities become safer, including reducing violence, alcohol and other drug use and suicide that can have traumatic impacts.

- Integrated responses to healing trauma that also acknowledge the need for broader social, economic and political processes to address collective trauma, socioeconomic disadvantage and promote reconciliation (Aboriginal and Torres Strait Islander Healing Foundation, 2016). If exposure to stressors in communities is to reduce, it is particularly critical to address the poverty that is all too evident in many Aboriginal and Torres Strait Islander communities using a community empowerment model.

- Healing programs to address the sense of powerlessness and loss of control still evident in many communities and resulting from historical trauma are needed. Programs to address the profound sense of loss, grief and disconnection experienced by these communities are also needed. These might involve the revitalisation of cultural, community and family life norms and help ensure the safe development of children and young people (Milroy, Dudgeon & Walker, 2014).

- Community level services that respond effectively to trauma and supporting Aboriginal and Torres Strait Islander organisations to provide healing programs in their communities (Aboriginal and Torres Strait Islander Healing Foundation, 2016).

- Supporting Aboriginal and Torres Strait Islander peoples’ access to traditional and contemporary healing practices in addition to clinical treatment.

- Support for Aboriginal and Torres Strait Islander families, children and young people to prevent and reduce the impact of trauma.

- Enhanced school-based responses to trauma including promoting or requiring trauma-awareness among teachers and school counsellors and psychologists.

- Principles and processes for collaboration between Aboriginal and Torres Strait Islander communities and their services and stakeholders, including government and NGO services, for both policy development, to improve service delivery and to support the development and implementation of a national strategic response (Aboriginal and Torres Strait Islander Healing Foundation, 2016).

Trauma is yet to be recognised as a priority population health issue among Aboriginal and Torres Strait Islander peoples. This is partly because trauma needs to be understood in a way that includes the experience of Aboriginal and Torres Strait Islander peoples. In addition, trauma is often unacknowledged as contributing to the high rates of mental health and alcohol and other drug problems, suicide and self-harm, incarceration, family and community violence and substantiated child protection orders in Aboriginal and Torres Strait Islander settings. It is time to address trauma as a critical Aboriginal and Torres Strait Islander population health issue; and practitioners can play a significant role in this.
References


