

Aboriginal and Torres Strait Islander Social and Emotional Wellbeing

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OVERVIEW

This chapter examines understandings of social and emotional wellbeing (SEWB) with the aim of clarifying the relationship between SEWB, mental health and mental health disorders from an Aboriginal and Torres Strait Islanders' perspective. The chapter begins with a brief historical overview of how the term 'social and emotional wellbeing' emerged as a signifier of Aboriginal and Torres Strait Islander concepts of health. We define SEWB as a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family, and community.¹ The domains and guiding principles that typically characterise SEWB are outlined and situated within a framework that places Aboriginal and Torres Strait Islander world views and culture as central. The importance of recognising social, cultural, historical and political determinants in shaping Aboriginal and Torres Strait Islander SEWB is also discussed. We suggest that working within a SEWB framework involves developing an understanding of how these principles, domains and determinants manifest and operate at a local level, and explore how to apply these in a practical setting.

INTRODUCTION

Health and wellbeing are complex concepts and there is no clear consensus across or within cultures as to how these constructs should be defined.^{2,3} Policy makers, researchers and practitioners working to improve the SEWB and mental health of Aboriginal and Torres Strait Islander peoples in Australia have to grapple with the task of defining these health concepts in terms that are relevant and consistent with Aboriginal and Torres Strait Islander understandings and experiences. The linguistic and cultural diversity that exists within Aboriginal and Torres Strait Islander cultures needs to be acknowledged from the outset, as there are significant differences in the way SEWB, mental health and mental health disorders are understood within different Aboriginal and Torres Strait Islander communities across Australia. Similarly, the variation in other Australian understandings of what constitutes mental health and mental health disorder also needs to be recognised.

SEWB WITHIN ABORIGINAL AND TORRES STRAIT ISLANDER CONTEXTS

The World Health Organisation's (WHO's) Alma Ata Declaration on Primary Health Care (1978)⁴ signalled a shift in thinking about health that mobilised a movement to tackle 'politically, socially and economically unacceptable' health inequalities through the delivery of comprehensive primary health care.⁴ At the time, these global shifts in approach to health care were seen to be consistent with the views of Aboriginal people and the establishment of

Aboriginal Community Controlled Health Organisations (ACCHOs) that began in the 1970s. The uptake of the term 'SEWB' to reflect holistic Aboriginal and Torres Strait Islander concepts of health can be traced to the early efforts of these organisations to define health from an Aboriginal perspective. In 1979, the National Aboriginal and Islander Health Organisation (now the National Aboriginal Community Controlled Health Organisation) adopted the following definition of health:

Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and must bring about the total wellbeing of their communities.

This definition was used in the first National Aboriginal Health Strategy (NAHS).⁵ In the section devoted to mental health, the NAHS Working Party held a strong line, arguing that 'mental health services are designed and controlled by the dominant society for the dominant society' and that the health system had failed 'to recognise or adapt programs to Aboriginal beliefs or law, causing a huge gap between service provider and user'.⁵ One of the strategy's key recommendations was for a health framework to be developed by Aboriginal and Torres Strait Islander peoples that recognised the importance of culture and history, and which defined health and illness from an Aboriginal and Torres Strait Islander perspective. The Royal Commission Into Aboriginal Deaths In Custody (RCIADIC)⁶ closely followed the release of the NAHS (1989),⁵ and implementation of the strategy was one of the commission's recommendations, as was the need for a national consultancy on Aboriginal and Torres Strait Islander mental health. The latter culminated in the landmark *Ways Forward* National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health.⁷ As detailed by Zubrick and colleagues in Chapter 5, the subsequent national efforts for policy reform led to the development of successive national action plans and frameworks, including the most recent National Strategic Framework for Aboriginal and Torres Straits Islander People's Mental Health and Social and Emotional Well Being 2004-09 (hereafter referred to as the 2004 SEWB framework).¹ Though now defunct, and with current efforts underway to renew this framework, it remains the guiding national document for defining Aboriginal and Torres Straits Islander-specific understandings of SEWB. Despite the limited implementation of past action plans and frameworks, the development of the SEWB concept at a nationwide level has been important to the process of reclaiming and renewing Aboriginal and Torres Strait Islander understandings of health and wellbeing, and legitimising and disseminating these understandings within the current health policy landscape.^{8,9}

DEFINING SEWB AND MENTAL HEALTH

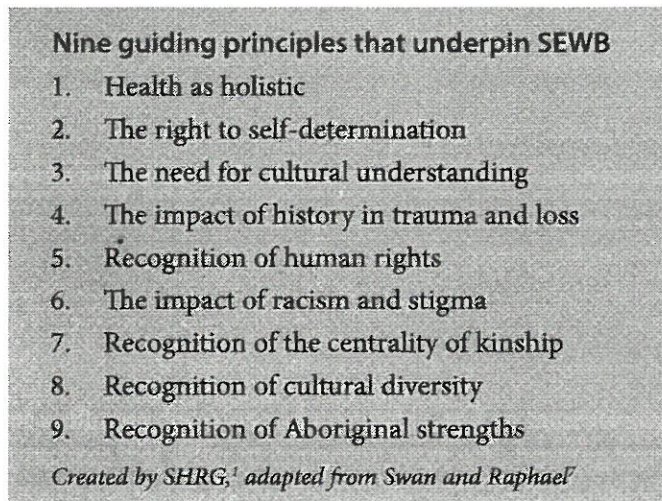
The synergies with Aboriginal and Torres Strait Islander mental health reform and the development and advocacy of SEWB as a guiding health concept have not necessarily translated into a clear and concise conceptualisation of the differences in understandings of SEWB and mental health, nor widespread agreement about how these concepts ought to coexist or intersect at the level of theory and practice.^{10,11}

Most of the Aboriginal and Torres Strait Islander SEWB and mental health literature draws upon the NAHS (1989)⁵ or the *Ways Forward* report (1995)⁷ to adopt a broad, holistic definition of health and wellbeing.^{12,13} Beyond that, as supported in the literature there is some divergence in understanding of the terms 'social and emotional wellbeing' and 'mental health' and what they mean. In some of the literature the terms have been used interchangeably, either as an attempt to subvert the stigma associated with mental illness or to try and move away from biomedical perspectives of mental health and mental illness.^{14,15} Kelly and colleagues¹⁶ suggest that the term SEWB signifies an Aboriginal and Torres Strait Islander concept of wellbeing that differs in important ways to Western concepts of mental health. We suggest that, within the Aboriginal and Torres Strait Islander SEWB and mental health landscape, SEWB signifies a relatively distinct set

of wellbeing domains and principles, and an increasingly documented set of culturally informed practices that differ in important ways with how the term is understood and used within Western health discourse, discussed in Chapter 6 (Zubrick and colleagues) and Westerman.¹⁷

Guiding Principles of Social and Emotional Wellbeing

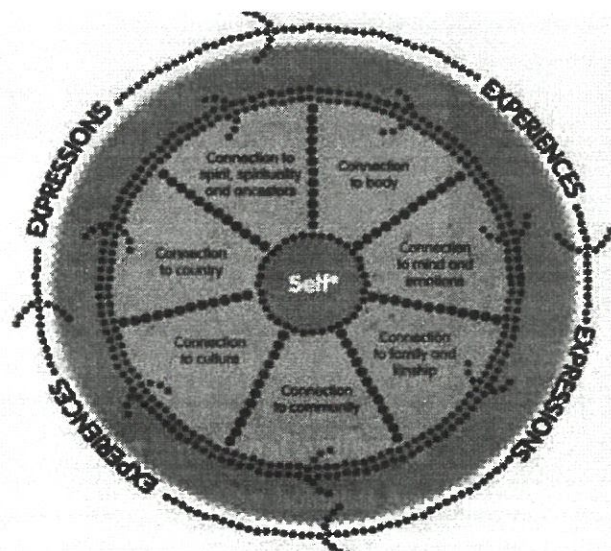
The 2004 SEWB framework¹ sets out nine guiding principles that were developed during the *Ways Forward* national consultancy⁷. These guiding principles shape the SEWB concept and describe a number of core Aboriginal and Torres Strait Islander cultural values that are detailed on page xxiv.



Cultural Domains of Social and Emotional Wellbeing

Members of the Australian Indigenous Psychologists Association (AIPA) have endeavoured to link some of these areas of SEWB in a way that has utility for mental health practitioners (AIPA cultural competence SEWB workshop module).^{16, 18} Figure 4.1 shows some of the domains of wellbeing that typically characterise Aboriginal and Torres Strait Islander definitions of SEWB.^{1, 14, 16, 19-21}

Figure 4.1: Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders' Perspective



*This conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.

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We note the somewhat artificial separation of these areas of SEWB, and recognise that the cultural diversity that exists amongst Aboriginal and Torres Strait Islander peoples means that no single grouping is necessarily applicable or relevant for every individual, family or community. Whilst cognisant of the dangers in essentialising Aboriginal and Torres Strait Islander SEWB, it is evident that there is considerable uncertainty amongst many practitioners about how to approach working in this area. Consequently, it is useful to make clear some of the guiding principles¹ and broad areas of wellbeing that need to be considered when working in this field.

The diagram shows that the SEWB of individuals, families and communities are shaped by connections to body, mind and emotions, family and kinship, community, culture, land and spirituality (the important role of broader level determinants is also addressed below). The term 'connection' refers to the diverse ways in which people experience and express these various domains of SEWB throughout their lives. People may experience healthy connections and a sense of resilience in some domains, while experiencing difficulty and/or the need for healing in others. In addition, the nature of these connections will vary across the lifespan according to the different needs of childhood, youth, adulthood and old age.

If these connections are disrupted, and for many Aboriginal and Torres Strait Islander peoples and families some of these connections have been significantly disrupted in multiple ways as a result of past government policies associated with colonisation, then they are likely to experience poorer SEWB. Conversely, restoring or strengthening connections to these domains will be associated with increased SEWB. We briefly describe each of these domains below and discuss how to apply some of the guiding SEWB principles in a practical setting.

Encouragingly, the arrangement of domains in Figure 4.1 has been presented and collectively discussed with, and supported by, over 300 SEWB members during National and State SEWB conferences held in 2012 and 2013.^{22, 23} An early version of the diagram was also used in the national consultation phase of the development of the renewed Framework for Aboriginal and Torres Strait Islander Social and Emotional Wellbeing (Social Policy Research Centre, 2013). The current diagrammatic representation incorporates feedback from the extensive community consultations that were held in 2013.

Connection to Body, Mind and Emotions

The wellbeing domains we have termed connection to body, and mind and emotions, refer to those aspects of health and wellbeing that are rooted in bodily, individual or intrapersonal experience.²⁴

Connection to Body

Connection to body is about physical wellbeing and includes all of the normal biological markers and indices that reflect the physical health of a person (i.e. age, weight, nutrition, illness and disability, mortality).

Connection to Mind and Emotions

Connection to mind and emotions refers not only to an individual's experience of mental wellbeing (or mental ill-health) but also the whole spectrum of basic cognitive, emotional and psychological human experience, including fundamental human needs such as: the experience of safety and security, a sense of belonging, control or mastery, self-esteem, meaning making, values and motivation, and the need for secure relationships. The 2008 National Aboriginal and Torres Strait Islander Social Survey²⁵ found that the majority of adults reported feeling happy, calm and peaceful, and full of life, all or most of the time. However, nearly one-third of adults reported experiencing high to very high levels of psychological distress (more than twice the rate for other Australians) and Aboriginal and Torres Strait Islander women are 31 times—and men 25 times—more likely than other Australians to be admitted to hospital as a result of family violence-related assaults.²⁶ Given these alarming statistics, we stress the primacy of personal safety and freedom from abuse as a most fundamental human right and determinant of SEWB. For further discussion see Chapter 17 (Atkinson and colleagues), Chapter 23 (Cripps and Adams) and McGlade.²⁷

In relation to working with mental health and SEWB, general recommendations in the literature include the need to:

- collaborate and build relationships within community
- have prior knowledge of appropriate referral pathways
- coordinate work with other service agencies
- have access to a cultural mentor or consultant
- carefully consider the meaning of the signs and symptoms of distress experienced by clients.^{28, 29}

Recognising Cultural Differences in Mental Health Diagnoses

From a practitioner perspective, it is important not to rely solely on Western psychiatric classification systems when trying to identify, understand, and work with symptom patterns of distress in Aboriginal and Torres Strait Islander populations. Westerman¹⁷ has written about some of the implications of cultural differences within an Aboriginal and Torres Strait Islander mental health context, identifying the need to recognise culture-bound disorders (for example, longing for country) that 'often mimic mental health disorders, however, the triggers and maintaining factors lie with the cultural beliefs of the client, and therefore resolution often needs to occur at the cultural level'.^{17(p4)} Brown's³⁰ work on depression and Aboriginal men in central Australia documents the unique determinants and ways in which the expression of depression differs from mainstream populations (for example, the presence of weakened spirit, anger and worry). Atkinson's³¹ research into post-traumatic stress identifies a wider range of associated cultural and interpersonal trauma symptoms that require assessment and attention, including fragmented identity construction, community disconnection and difficulties in maintaining close relationships.

The common denominator amongst their findings is that, while there are specific symptom patterns congruent with Western mental health diagnoses that can be detected in Aboriginal and Torres Strait Islander clients (making it all too easy for practitioners to simply tick the box), there are additional symptom patterns of distress that need to be recognised. The meanings, determinants and causal theories attributed to these distress patterns can often differ dramatically. Therefore, practitioners also need to consider the pathways of healing and recovery that are most congruent with the client's needs and world views. For example, traditional healing methods may be a preferred option for a client, or they may wish to use such practices in conjunction with the services offered by the practitioner. It is important not to assume that self-disclosure or emotional expression is necessarily valued by the client as a healing mechanism, as is often the case in Western therapies.

Connection to Family, Kinships and Community

The SEWB domains of connection to family and kinship, and community, refer to aspects of wellbeing that are rooted in interpersonal interaction.

Family and Kinship

Family and kinship systems have always been central to the functioning of traditional and contemporary Aboriginal and Torres Strait Islander societies. These systems are complex and diverse, and serve to maintain interconnectedness through cultural ties and reciprocal relationships.^{32, 33} Milroy states:

These systems locate individuals in the community and neighbouring clans within relationships of caring, sharing, obligation and reciprocity. Essentially, the kinship system provided a very secure attachment system that established caring relationships, so that everyone grew up with multiple carers and attachment figures and, in turn, provided care for others.^{12(p126-127)}

She also notes that in contemporary society, kinship and cultural obligations can place significant burdens on members of the family. Grandmothers, for example, may not have the adequate levels of support and resources necessary to care for large numbers of family. It is important that practitioners develop an understanding of the different language and family groups of the communities they work in.¹⁷ In traditional regions, this usually includes moiety or skin group systems that can entail complex avoidance relationships that determine the nature and extent of interaction between different family and kin members.

Community

The concept of community has been described as fundamental to identity and concepts of self within Aboriginal cultures (see Dudgeon and colleagues, Chapter 1), a collective space where building a sense of identity and participating in family and kinship networks occurs, and where personal connections and sociocultural norms are maintained.^{34, 35} The establishment of ACCHOs has been found to play an important role in strengthening cultural identity and fostering a sense of ownership, cultural pride and belonging for some communities.^{36, 37}

Connection to Spirituality, Land and Culture

Spirituality

Many Aboriginal and Torres Strait Islander peoples' cultural worldviews include beliefs and experiences that are grounded in a connection to spirituality.²⁰ Within traditional contexts, the essence of spirituality has been most popularly translated and depicted as '*The Dreaming*' or '*The Dreamtime*', which has become an iconic referent for Aboriginal metaphysical world views, though in reality Aboriginal and Torres Strait Islander nations and language groups have different terms, practices and epistemologies that reflect these world views. These understandings of spirituality broadly refer to a cultural group's traditional systems of knowledge left by the ancestral beings that typically include all of the stories, rituals, ceremonies and cultural praxis that connect person, land and place. In ceremony, the critical transitions from childhood to adulthood, and other life stages, are marked through specific rights of passage. It is through ceremony and everyday cultural praxis that children, women and men of the community learn about their culture's systems of moral and ethical practices that guide behaviour, and determine their personal, familial and cultural rights, obligations, and responsibilities.^{21, 38}

Perhaps here, in the connection to spirit and spirituality, the consequences of colonisation for many Aboriginal and Torres Strait Islander peoples are most keenly felt, because for many this has involved a permanent severance of the links to their traditional customs, leaving a cultural void and an unfulfilled longing and need for recreating and redefining the spiritual. It is not surprising then, that Poroch and colleagues²¹ in their review of spirituality and Aboriginal SEWB have found that spirituality is an evolving expression of Indigeneity that in contemporary Aboriginal cultures is experienced in a multitude of ways. They note that spirituality for many Aboriginal and Torres Strait Islander peoples today has been transformed by engagement with other cultures, and is now experienced in multiple contexts, including in combination with and alongside other religions; in contemporary Aboriginal healing practice settings; and as an ethos related to a holistic philosophy of care that underpins community-controlled health centres and other types of Aboriginal organisations.²¹

Land or 'Country'

For many Aboriginal and Torres Strait Islander peoples, spirituality is closely tied to their connection to land or 'country'. Country or land has been described as an area to which people have a traditional or spiritual association,³⁹ and the sense of connection as a deep experience, belief or feeling of belonging to country—see Chapter 1 (Dudgeon and colleagues).

Connection to country and land extends beyond traditional cultural contexts, however, and the SEWB literature documents the importance of country across the whole spectrum of diverse Aboriginal and Torres Strait Islander cultural groups around Australia.³⁹⁻⁴¹

Culture

Connection to culture, as we use the term here, refers to Aboriginal and Torres Strait Islander peoples' capacity and opportunity to sustain and (re) create a healthy, strong relationship to their Aboriginal or Torres Strait Islander heritage. This includes all of the associated systems of knowledge, law and practices that comprise this heritage. Culture is, of course, a complex concept to try and define or articulate. We ascribe to Hovane and colleagues (2013) articulation of Aboriginal culture as constituting a body of collectively shared values, principals, practices and customs and traditions—Chapter 30 (Hovane, Dalton and Smith). Within this context, maintaining or restoring SEWB is about supporting Aboriginal and Torres Strait Islander peoples to maintain a secure sense of cultural identity and cultural values, and to participate in cultural practices that allow them to exercise their cultural rights and responsibilities.

This can be deeply rooted in areas of wellbeing such as connection to spirituality and land, but also might not be due to the large variation and increasing complexity of Aboriginal identity.⁴² We suggest that important roles for practitioners include, for example, supporting people to develop and strengthen a sense of continuity and security in their Indigenous identity, supporting people to re-affirm and strengthen their cultural values, and assisting them to develop effective strategies to respond to racial discrimination, which has been shown to be associated with depression, anxiety and other mental health difficulties.⁴³

The wellbeing domains of spirituality, land and culture can be sensitive and complex areas to work with. For some Aboriginal and Torres Strait Islander families and communities, the extent of cultural loss associated with colonisation has been profound. Many members of the Stolen Generations and their descendants continue to experience a deep grief and a longing to reconnect with their cultural heritage and ancestry. With appropriate cultural supervision, and in the right circumstances, it is important for practitioners to be able to provide clients with an opportunity to discuss whether issues such as cultural loss, identity and belonging are in any way linked to their current difficulties, and whether personal work in this area is important for their healing process. Practitioners need to make sure they have a sound knowledge of the appropriate cultural services available in the community—for example, the availability of traditional healers, the nearest *Link Up* and *Bringing Them Home* services, and the availability of any local healing programs. Across the country, community-driven healing programs that have a focus on cultural healing and cultural renewal have gained greater prominence.⁴⁴ The Aboriginal and Torres Strait Islander Healing Foundation, for example, with a focus on the Stolen Generations and the intergenerational trauma impacting many families and communities, now funds over 97 community designed programs across Australia. These include healing programs, education and training programs centred on healing and trauma recovery, and research and evaluation programs that include measures of cultural wellbeing developed by communities themselves.

SOCIAL, CULTURAL, POLITICAL AND HISTORICAL DETERMINANTS

It is also important to consider SEWB connections within broader social, cultural, political and historical contexts. Zubrick and colleagues in Chapter 6 show that the social determinants of mental health and SEWB for Aboriginal and Torres Islander people include such things as socioeconomic status and the impact of poverty, unemployment, housing, educational attainment, racial discrimination, exposure to violence, trauma and stressful life events, and access to community resources. Importantly, they note these social determinants do not occur in isolation, but rather impact SEWB concurrently and cumulatively. For practitioners, this often translates into complex client and family presentations that involve multiple stressors and issues. Solutions to these types of issues often lie outside the health sector, and require accessing services related to housing and community infrastructure, education, employment, welfare services, family and children's services, and building community capacity. Swan and Raphael⁷ and the Social Health Reference Group (SHRG)¹ highlight the need to incorporate two additional dimensions in relationship to Aboriginal and Torres Strait Islander SEWB. The first is the historical context of colonisation and its legacy, which we have termed 'historical determinants' in the diagram. Historical determinants refers to the impact of past government policies and the extent of historical oppression and cultural displacement experienced by individuals, families and communities or, conversely, the extent to which communities have managed to accommodate cultural displacement (i.e. communities consisting of many language groups), and build capacity for self-governance that helps to maintain or renew cultural continuity and control. The second, which we term 'political determinants' refers to:

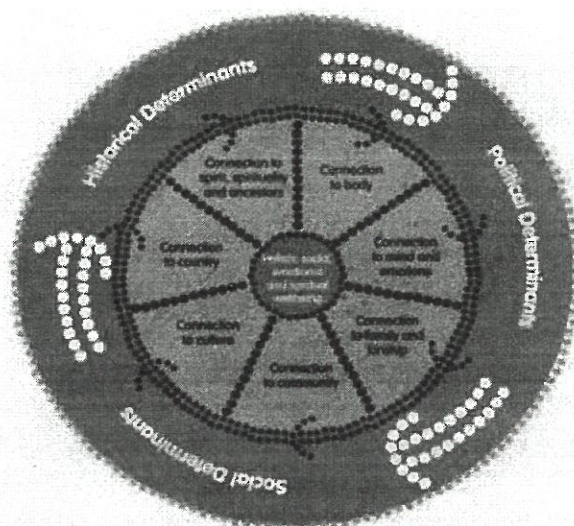
the unresolved issues of land, control of resources, cultural security, and the rights of self-determination and sovereignty, which are recognised as contributing to health and wellbeing and reducing health inequities for Aboriginal and Torres Strait Islander peoples.^{1(p7), 45, 46}

These individual and collective rights of Indigenous people are provided under the United Nations Declaration on the Rights of Indigenous People.

Historical and political determinants are an important part of the broader level of cultural determinants that help shape the environment and circumstances in which Aboriginal and Torres Strait Islander peoples are born into. These critical factors—such as a community's local history of colonisation and the extent to which a cultural group is able to resist assimilation, maintain cultural continuity, and retain the right of self-determination and sovereignty—will all significantly influence a community's capacity to retain their cultural values, principals, practices, and traditions. This, in turn, will differentially empower or impinge upon individual and family SEWB.

To develop awareness and engage practically with historical, political and cultural determinants involves practitioners developing a basic knowledge of the history of the traditional owner groups in the community they work in, and thinking about the ways in which colonisation has impacted the community. This includes being able to identify who the traditional owner families and clans are, as well as other Aboriginal and Torres Strait Islander families who are an integral part of the community but who may not have traditional links. Practitioners also need to be able to develop an awareness of the extent of self-governance and community control of resources that exists in this community (or lack of), and this often includes locating and making links with community-controlled organisations and other key stakeholders in the community.

Figure 4.2: Social, Cultural, Political and Historical Contexts



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THE RELATIONSHIP BETWEEN SEWB AND MENTAL HEALTH

Our interpretation and description of the principles and domains of SEWB outlined in this chapter suggests that, within an Aboriginal and Torres Strait Islander health context, SEWB is a complex, multidimensional concept of health that includes but extends beyond conventional understandings of mental health and mental disorder. Mental health and wellbeing is an important component of SEWB, but needs to be viewed as only one component of health that is inextricably linked to the social, emotional, physical, cultural and spiritual dimensions of wellbeing. The 2004 SEWB framework¹ describes an interactive relationship between SEWB and mental health, where the two may influence each other and where a person can experience relatively good SEWB and yet still experience mental health problems, or vice-versa. SEWB problems include a wide range of issues, such as: 'grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, cultural dislocation, racism and social disadvantage ... while mental health problems may include crisis reactions, anxiety, states, depression, post-traumatic stress, self-harm, and psychosis.'^(p3) Many of the issues identified as SEWB problems, such as abuse, violence, racism and social disadvantage are also well-established risk factors for various mental health disorders. For further discussion, see Chapter 2 (Parker and Milroy), suggesting that in some cases mental health disorders are likely to be symptomatic of greater SEWB disturbance. The framework also emphasises that cultural and spiritual factors can have a significant impact on the ways mental health problems develop, by influencing the presentation of symptoms and psychological distress, the meaning attributed to this distress, and the appropriateness of different therapeutic approaches and expected outcomes.¹

Other Considerations

We see a number of advantages to viewing mental health and mental health disorders as being positioned *within* a larger SEWB framework, rather than equated *with* SEWB. The first is that placing mental health within a broader SEWB framework helps to make explicit that, for many Aboriginal and Torres Strait Islander peoples and communities, mental health issues are still entwined with the past injustices associated with colonisation. The guiding principles and domains that define a SEWB framework as outlined in this chapter highlight the need to be

attendant to both mental health and social justice issues when working to improve the SEWB of Aboriginal and Torres Strait Islander individuals, families and communities.

Practitioners working in Aboriginal and Torres Strait Islander communities are often confronted with extremely complicated client presentations. It is not unusual to work with help seeking community members who simultaneously experience mental health issues, historical loss and cultural disconnection issues, multiple stressors in the form of poverty, child removal, or housing and other issues, as well as social and emotional difficulties such as trauma, abuse and loss. This level of complexity requires new approaches, different models of engagement, and new ways of thinking about working with Aboriginal and Torres Strait Islander mental health and SEWB. In circumstances where clients experience multiple SEWB and mental health issues and the negative impact of social determinants, it is often appropriate to begin with case management and problem solving approaches to address these issues, and support clients to establish safety, security and stability before focusing on other healing processes. It is also important to incorporate a trauma-informed approach to therapeutic practice, as often families and communities may have experienced multiple types of trauma (e.g. historical and intergenerational trauma associated with cultural dislocation and loss of identity and practices, direct interpersonal trauma such as physical or sexual assault/abuse, and within-community lateral violence). Strategies for addressing the associated trauma, grief and loss associated with the legacy of colonisation are discussed in several chapters of this book—see Chapter 17 (Atkinson and colleagues); Chapter 28 (Wanganeen); and Chapter 29 (Peeters and colleagues).

KEY ISSUES AROUND EFFECTIVE CLINICAL PRACTICE

There is a small but important literature base that documents some of the key issues around effective clinical practice, including knowledge related to: cultural disparities and gender differences between client and practitioner;¹⁷ the use of cultural mentors and supervisors⁴⁷; issues in mental health and psychiatric assessment—see Chapter 16 (Adams and colleagues); culturally appropriate counselling techniques;¹⁷ culture-bound syndromes;³¹ and the importance of accessing traditional and contemporary Indigenous healing models, programs and trainings developed by Aboriginal and Torres Strait Islander peoples themselves (refer to Part 6 of this book).

Finally, despite contemporary definitions of ‘mental health’ incorporating the notion of being ‘not simply the absence of mental illness’ and existing along a spectrum that includes ‘positive mental health’,⁴⁸ currently the discipline is still predominantly focussed on psychopathology and mental health disorders, with the notion of positive mental wellbeing yet to be really well defined.

We believe that situating mental health within an Aboriginal and Torres Strait Islander SEWB framework is more consistent with the view that Aboriginal and Torres Strait Islander concepts of health and wellbeing prioritise and emphasise wellness, harmony and balance rather than illness and symptom reduction.¹² This does not obviate the importance of addressing mental illness in our communities as a critical component of SEWB. However, the reduction of symptoms associated with mental health disorders should not be equated with experiencing a sense of wholeness or connectedness to the totality of SEWB as described in this chapter. In both research and at the therapeutic level, more priority needs to be given to understanding and promoting the kinds of strengths and resources that have assisted Aboriginal and Torres Strait Islander peoples, families and communities to maintain resilience and survive multiple and widespread adverse life events over several generations.

In the 1994 Wentworth lecture, Professor Mick Dodson, did well to remind us all that:

'Our people have left us deep roots, which empowered us to endure the violence of oppression. They are the roots of survival, but not of constriction. They are the roots of which all growth is possible. They are the roots that protected our end from the beginning'.^{49(p11)}

CONCLUSION

The aim of this chapter has been to define SEWB from an Aboriginal and Torres Strait Islander perspective. We have provided an overview of the guiding principles and broad domains of health and wellbeing that typically characterise SEWB, and highlighted the importance of social, cultural, historical and political determinants in shaping SEWB and mental health outcomes. The chapter has provided only the broadest of brush strokes in terms of identifying principles and domains of SEWB that may be relevant to Aboriginal and Torres Strait Islander peoples and communities. This is as it should be, because the concept of SEWB as we have defined it, is a cultural construct that describes general level features or characteristics of SEWB that are proposed to be 'similar enough' across different Aboriginal and Torres Strait Islander peoples and communities as to hold conceptual value and meaning.

We recognise and accept this limitation, as it underscores the important point that for health professionals to gain an in-depth, genuine understanding of mental health and SEWB as it relates to their local Aboriginal or Torres Strait Islander community, they must engage with that community in a meaningful way. This involves developing relationships with Elders, families and leaders of the community over time. There are no alternatives or short cuts to bypassing this need. A broad and coherent understanding of the SEWB concept and its relation to mental health should help to orientate health professionals and practitioners in their work. If practitioners can use this general knowledge within the context of developing meaningful relationships at a local level, then they will be able to work more effectively with Aboriginal and Torres Strait Islander peoples, families and communities in the areas of SEWB and mental health.

REFLECTIVE EXERCISES

1. Thinking about the concept of social and emotional wellbeing outlined in this chapter, and the holistic definition of health and wellbeing offered by NAHS, how might these understandings change the way someone works within the discipline of mental health?
2. If an Aboriginal and/or Torres Strait Islander client came to you presenting with mental health, social justice, and social disadvantage issues, what do you think would be some of most difficult challenges and tensions involved in trying to balance their needs? How would you try to address these challenges and tensions?
3. Connection to spirituality, land, culture and identity/belonging, can all be sensitive, complex areas of social and emotional wellbeing to work with due to the historical impact of colonisation and the cultural disparity that can exist between the client and the practitioner. What are some strategies you could use and things you could do (both face to face and when not directly engaged with the client) in order to feel more confident that your work is of value to the client (and culturally safe)?

REFERENCES

1. Social Health Reference Group. In: National Strategic Framework for Aboriginal and Torres Straits Islander People's Mental Health and Social and Emotional Well Being 2004-09. National Aboriginal and Torres Straits Islander Health Council and National Mental Health Working Group. 2004. Canberra: Department of Health and Ageing.
2. Huber M, Knottnerus JA, Green L, Horst H, Jadad AR, Kromhout D, et al. How should we define health? *BMJ*. 2011; 343.
3. Jada AR, O'Grady L. How should health be defined? *BMJ*. 2008; 337.
4. World Health Organisation. [Internet]. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, Geneva. 1978 [cited 10 January 2013]. Available from: www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
5. National Aboriginal Health Strategic Working Party (NAHSWP). In: A National Aboriginal Health Strategy. 1989.
6. Royal Commission into Aboriginal Deaths in Custody. [Internet]. Fact sheet 112. Available from: <http://www.naa.gov.au/collection/fact-sheets/fs112.aspx>.
7. Swan P, Raphael B. Ways forward, vol. 1 & 2. National consultancy report on Aboriginal and Torres Strait Islander mental health. 1995.
8. Urbis, Keys C, Young JG. In: Evaluation of the Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan. 2007. Canberra: Commonwealth Department of Health and Ageing.
9. Wilczynski A, Reed-Gilbert K, Milward K, Tayler B, Fear J, Schwartzkoof J. Evaluation of Bringing Them Home and Indigenous mental health programs. Report prepared by Urbis Key Young for the Office for Aboriginal and Torres Strait Islander Health. Canberra; 2007.
10. Atkinson G, Kerr S. The Purro Birik Social & Emotional Wellbeing Strategy 1999-2000 (Indigenous Mental Health Services) Evaluation Report. 2003.
11. Hunter E. Commonality, difference and confusion: Changing constructions of Indigenous mental health. *Australian eJournal for the Advancement of Mental Health AeJAMH* Vol. 2004; 3(3).
12. Milroy H. Children are our future – Understanding the needs of Aboriginal children and their families. In: Williams S, Cowling V, editors. *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives*: Australian Academic Press; 2008.
13. McEwan A, Tsey K, & Empowerment Research Team. The role of spirituality in social and emotional wellbeing initiatives: The family wellbeing program at Yarrabah, Discussion Paper No. 7. Darwin, Cooperative Research Centre for Aboriginal Health; 2009.
14. Henderson G, Robson C, Cox L, Dukes C, Tsey K, Haswell-Elkins M. Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People within the Broader Context of the Social Determinants of Health. In: Anderson I, Baum F, Bentley M, editors. *Beyond Band Aids: Exploring the Underlying Social Determinants of Aboriginal Health*. Canberra: Cooperative Research Centre for Aboriginal Health (CRAH); 2007. p. 165-180.
15. West R, Usher K, Thompson G, Spurgeon D, L. K. Chapter 20 Indigenous (Australia and New Zealand) and Remote Mental Health. In: *Mental Health Nursing Dimensions of Praxis I* Munro A Robins A Welch Eds Oxford University Press Australia and New Zealand; 2011.
16. Kelly K, Dudgeon P, Gee G, Glaskin B. In: *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People*; Discussion Paper No.10. 2009. Darwin: Cooperative Research Centre For Aboriginal Health.

17. Westerman T. Engagement of Indigenous clients in mental health services: What role do cultural differences play. *Australian e-Journal for the advancement of Mental Health*. 2004; (3):3.
18. Jones T, Gee G, Schultz C, Hart A, Dudgeon P, Kelly K. *Working Together: Journey Towards Cultural Competence with Aboriginal and Torres Strait Islander Peoples – Participant Workbook* 2012.
19. Garvey D. A review of social and emotional wellbeing of Indigenous Australian peoples - considerations, challenges and opportunities. *Australian Indigenous Health Bulletin*. 2008; 8.
20. Grieves V. *Aboriginal Spirituality: Aboriginal philosophy, The basis of Aboriginal Social and Emotional Wellbeing*. Discussion Paper No. 9. Cooperative Research Centre for Aboriginal Health Darwin; 2009.
21. Porocho N, Arabena K, Tongs J, Larkin S, Henderson G. *Spirituality and Aboriginal People's Social and Emotional Wellbeing: Discussion Paper No. 11*. Cooperative Research Centres for Aboriginal Health Darwin; 2009.
22. Dudgeon P, Kelly K. Keynote Presentation and Workshop, Aboriginal and Torres Strait Islander Social and Emotional Wellbeing November QAIHCC Cairns & Unite 2012 Working Together Social and Emotional Wellbeing June 4-7, Adelaide.
23. Dudgeon P, Schultz C. Keynote Presentation and Workshop Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, NSW SEWB Workforce Support Unit Forum, 20-21 March, 2013, Charles Stuart University Wagga Wagga.
24. Anderson I. Aboriginal Well-being. In: Grbich C, editor. *Health in Australia: Sociological Concepts and Issues*. Sydney: Longman; 1999. p. 53-73.
25. Statistics ABS. *National Aboriginal and Torres Strait Islander Social Survey Key Findings*. No 47140 ABS Canberra; 2009.
26. Steering Committee for the Review of Government Services Provision (SCRGSP). *Report on Government Services* 2011. Canberra; 2011.
27. McGlade H. *Our Greatest Challenge: Aboriginal children and human rights*. ACT: Aboriginal Studies Press; 2012.
28. McKendrick J. *Patterns of psychological distress and implications for mental health service delivery in an urban Aboriginal general practice population*. Unpublished thesis: Doctor of Medicine. [dissertation]: University of Melbourne; 1993.
29. Vicary D, Westerman T. That's Just the Way He Is: Some implications of Aboriginal mental health beliefs, [Internet]. *Australian e-Journal for the Advancement of Mental Health*, vol.3, issue 3. 2004 [cited February 2013]. Available from: <http://auseinet.flinders.edu.au/journal/vol3iss3/index.php>.
30. Brown A, Scales U, Beever W, Rickards B, Rowley K, O'Dea K. Exploring the expression of depression and distress in aboriginal men in central Australia: a qualitative study. *BMC Psychiatry*. 2012; 12:97.
31. Atkinson C. *The violence continuum: Australian Aboriginal male violence and generational post-traumatic stress* (Unpublished PhD thesis). Charles Darwin University, Darwin [dissertation]; 2008.
32. Walker R, Shepherd C. *Aboriginal Family Functioning - What works and why* [Internet]. [cited February 2013]. Available from: <http://www.aifs.gov.au/afrc/index.html>.
33. Austin-Broos D. Places, practices, and things: the articulation of Arrernte kinship with welfare and work. *American Ethnologist*. 2003; 30(1):118-135.

34. Dudgeon P, Mallard J, Oxenham D, Fielder JI. Contemporary Aboriginal perceptions of community. In: T. Fisher CSBBE, editor. *Psychological sense of community*. New York: Plenum Press; 2002. p. 247-267.
35. Taylor J, Edwards J, Champion S, Cheers S, Chong, A., Cummins R, et al. Towards a conceptual understanding of Aboriginal and Torres Strait Islander community and community functioning. *Community Development Journal*. 2011.
36. Reilly RE, Doyle J, Bretherton D, Rowley KG, Harvey JL, Briggs P, et al. Identifying psychosocial mediators of health amongst Indigenous Australians for the Heart Health Project. *Ethn. Health*. 2008; 13(4):351-73.
37. Sonn C, Fischer A. Sense of community: Community resilient responses to oppression and change. *Journal of Community Psychology* p. 1998; 26:457-472.
38. Edwards B. Mutuka Nyakunyitja - seeing a motor car. *Aboriginal History*. 1994; 18(2):145-58.
39. Ganesharajah C. Indigenous health and wellbeing: the importance of country. Canberra Australian Institute for Aboriginal and Torres Strait Islander Studies. 2009.
40. Garnett ST, Sithole B, Whitehead PJ, Burgess CP, Johnstone FH, Lea T. Healthy country, healthy people: policy implications of links between Indigenous human health and environmental condition in tropical Australia. *Australian Journal of Public Administration* 2009; 68(1):53-66.
41. Kingsley JY, Townsend M, Phillips R, Aldous D. If the land is healthy...it makes the people healthy: The relationship between caring for country and health for the Yorta Yorta Nation, Boonwurrung and Bangerang Tribes. *Health Place*. 2008; 15:291-299.
42. Paradies YC. Beyond Black and White: Essentialism, Hybridity and Indigeneity. *Journal of Sociology, The Australian Sociological Association*. 2006; 42:355-367.
43. Paradies YC, Cunningham J. The DRUID study: Exploring mediating pathways between racism and depressive symptoms among Indigenous Australians. *Social Psychiatry and Psychiatric Epidemiology*. 2012; 1:165-173.
44. Human Rights & Equal Opportunity Commission. Aboriginal and Torres Strait Islander Social Justice Commissioner, Social Justice Report. Sydney; 2008.
45. Chandler M, Lalonde C. Cultural Continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*. 1998; 35(2):191-219.
46. Ring IT, Firman D. Reducing indigenous mortality in Australia: lessons from other countries. *The Medical Journal of Australia*. 1998; 169(10):528-9, 532.
47. Garvey DC. *Indigenous Identity in Contemporary Psychology: Dilemmas, Developments, Directions*. Victoria: Thomson Learning; 2008.
48. Australian Health Ministers. In: *National Mental Health Plan 2003-2008*. 2003. Canberra: Commonwealth Department of Health and Ageing.
49. Dodson M. The Wentworth Lecture. In: *The End in the Beginning: Re (De) Finding Aboriginality*. 1994 The Australian Institute of Aboriginal and Torres Strait Islander Studies.

Mental Illness in Aboriginal and Torres Strait Islander Peoples

Robert Parker and Helen Milroy

OVERVIEW

This chapter specifically deals with mental illness, a concept associated with a 'clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and is associated with significant distress and disability'.^{1(pxxi)} The common types of mental disorders that affect people are anxiety disorders, mood disorders, psychosis and personality disorders and these are discussed in this chapter in terms of what Aboriginal and Torres Strait Islander peoples may have experienced in both traditional and current contexts.

It is important to view the information in this chapter in the context of other material in this book, particularly the chapters on psychology, social determinants, and harmful substance use (see Chapter 3, Dudgeon and colleagues; Chapter 6, Zubrick and colleagues; and Chapter 8, Wilkes and colleagues). We also caution that any diagnosis of mental illness affecting an Aboriginal and Torres Strait Islander person should be conducted by expert clinicians, such as psychiatrists and psychologists within a culturally safe context, wherever possible. This allows for a more accurate assessment of the person being reviewed, with recognition of culturally relevant issues, in addition to the recognised availability of adjunctive therapeutic supports, such as social and emotional wellbeing counsellors, to assist the person, if appropriate. The chapter does not recommend any specific treatments for the conditions discussed per se, but mentions a number of standard resources that may be used by the Aboriginal and Torres Strait Islander person suffering from mental illness and their family membersto discuss available treatments with their clinician.

WHAT IS MENTAL ILLNESS?

An appropriate introduction to this chapter should focus on the question of 'What is mental illness?' in respect of Aboriginal and Torres Strait Islander peoples in Australia. Since it was first published in the early fifties the DSM has been recognised as a key diagnostic manual. It has been updated on a regular basis to reflect new understandings about mental illness. The newly released DSM-5 (replacing the DSM-IV) is the standard text for classification of psychiatric disorders and mental illness in a Western cultural context. It emphasises the need for explicit definitions as a way of promoting reliable clinical diagnoses.^{1(pxxii)} However, there has been an increasing recognition of other factors that may affect the validity of such diagnoses in cultural groups, such as the Aboriginal and Torres Strait Islander population. These include, the standards of what constitutes scientific evidence, the meaning and uses of ethnic and racial categories, interpretations of differences of prevalence for mental disorders, and the tension between universal and group-specific approaches to mental health research and policy.²

An inherent concept in the reliability of the definition of such data is an atmosphere of, and commitment to, cultural safety as an essential component of any mental health intervention with Aboriginal and Torres Strait Islander peoples. See Chapter 12 (Walker and colleagues) for a detailed discussion of cultural safety.

Unsafe cultural practice is defined as:

any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual, whereas culturally safe practice is simply defined as 'effective clinical practice for a person from another culture'.^{3(p2)}

The emphasis on culturally safe practice with Aboriginal and Torres Strait Islander peoples is particularly important in the context of perceived deficiencies in medical practice in Aboriginal communities in remote Australia, where 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions'.^{4(p203)} This can also be true in the cities, as miscommunication can occur on a variety of levels and there can also be significant misinterpretation of symptoms and behaviour within the mental health context.⁵ Chapter 15 (Dudgeon and Ugle) further explores the issues and strategies for communicating and engaging effectively with Aboriginal and Torres Strait Islander peoples in diverse contexts.

English may not be the first language of remote community-based Aboriginal people and might be the fifth or sixth language. Other compounding influences in the remote setting include differing belief systems regarding illness, a potential perceived inefficiency of health systems and the disempowerment of Aboriginal patients, compliance issues and an overwhelming high burden of disease.^{4(p204)} In addition, mental illness issues are often compounded by issues of stigma where the term:

mentally ill ... causes a variety of reactions when used with Aboriginal people, depending on their level of education, knowledge and the way that they use language ... [P]eople gave warnings about how the term could be reinterpreted in ways that would reflect other meanings than [w]hat was intended. These meanings cluster around both what people have heard about their relatives' experiences with mental health services and what they would have heard or seen of peoples' behaviour when experiencing a mental illness.^{6(p95)}

Hunter also comments on the increasing complexity of defining mental illness in Aboriginal and Torres Strait Islander peoples.⁷ He notes an increasing coincidence of mental disorders associated with harmful substance use and the problem that this leads to in diagnostic systems where the two entities are often separate. In addition, Hunter notes that:

Indigenous societies have undergone rapid social change and it should be no surprise that there have been changing patterns of mental health problems including mental health disorders.^{7(p129)}

He adds that:

a constant across most of the above considerations ... is a change, both in the patterns of disorders for social and emotional wellbeing and in the social context in which these disorders arise.^{7(p130)}

A number of factors therefore contribute to the accuracy of diagnosis or definition of any mental illness in Aboriginal and Torres Strait Islander peoples. Sheldon notes the particular importance of an appropriate review of contextual data and the familiarity of an interview setting in engaging Aboriginal and Torres Strait Islander peoples in any therapeutic process for mental health issues.⁸ The involvement of family, along with Aboriginal and Torres Strait Islander Mental Health Workers (AMHWs) in assessments of Aboriginal and Torres Strait Islander clients, is also an important component of culturally safe practice and the reliability

of information thus obtained.⁹ Additional factors involve the use of translation services where appropriate, along with Social and Emotional Wellbeing (SEWB) workers, where the affected person may have specific needs in respect of grief or loss and the Stolen Generations. See Chapter 17 (Atkinson and colleagues) for further discussion of these factors.

Given the above cautionary factors, the remainder of this chapter attempts to review the past and current burden of mental illness as it affects the Aboriginal and Torres Strait Islander population.

Depression

Mood disorders are currently defined by the ICD-10 classification system with a graded transition from mild mood disturbance (commonly described as adjustment disorders) to the more severe types of depression such as major depression with melancholia, and major depression with psychosis. The category also covers bipolar disorder (previously known as manic depression). The new DSM-5 has removed the 'mood disorder' category and made changes to the major depression (also known as clinical depression) and depressive disorders area. There is a new condition known as 'persistent depressive disorder' which includes both chronic major depressive disorder (MDD) and the previous dysthymic disorder.

Major depression, as defined by DSM-5,¹ usually involves the affected person developing a low mood along with feelings of worthlessness and loss of interest in normal activities, which is out of character with their normal persona. The person may experience suicidal ideation. They often have altered vegetative features such as poor sleep, reduced appetite with weight loss and impaired concentration. The person may also have developed emotional restriction and anxiety in the context of the mood disturbance. The DSM-5 made no changes to any of the core criteria symptoms of major depression.

There is also a new condition introduced in the DSM-5 called 'Disruptive Mood Dysregulation' disorder. This new disorder can be diagnosed in children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme, out of control behaviour.

Pink and Allbon, using the ICD-10 criteria, note that the admission to hospital of Aboriginal and Torres Strait Islander men with severe mood and neurotic disorders is 1.2 times the rate of the non-Aboriginal population, with the rate for Aboriginal and Torres Strait Islander women being the same as the non-Aboriginal population.¹¹ However, individual Aboriginal community surveys have found differing rates of mood disorder, with these being variously reported at 2.5 per cent for Mornington Island, 6 per cent at Bourke, but 1 per cent for a community in the Kimberley.⁷ McKendrick conducted a survey of Aboriginal people attending a community-controlled health service in Victoria, reporting that 54 per cent of the people tested with standard psychiatric rating scales were suffering from psychiatric illness and that depression was the most common among this group.¹² Jorm reports that recent community surveys have shown similar high levels of psychological distress (anxiety and depression) amongst Aboriginal and Torres Strait Islander peoples, with a rate of 50 per cent of respondents to the survey being three times higher (overall rates 20.2%–26.6%) compared with other Australians.¹³

In terms of atypical features of mood disturbance that may be present in the Aboriginal and Torres Strait Islander population, Jones and de la Horne, in a survey of a Central Australian Aboriginal group, noted that people affected by mood disturbance in the group suffered vegetative disturbance and restriction of emotional response.¹⁴ They also noted that the affected population often projected feelings of unworthiness and guilt onto others, were more aggressive and had more physical or somatic symptoms. Cawte also describes a number of features of atypical depression experienced by Aboriginal people.¹⁵ He notes a 'suicide fit' in the context of alcohol withdrawal, where a person develops a significant degree of anxiety following an intense encounter with a relative. The affected person will often run away to seek a private

place and may then attempt to harm themselves. Cawte describes depression precipitated by a person being shamed or being fearful that they were subject to sorcery or payback.¹⁵ Morice has reported that the Pintubi have a range of words to express a range of feelings of sadness and depression from mild to severe.¹⁶ Brown, in a survey of Aboriginal men from Central Australia, found that symptom profiles for depression were comparable to other Australians.¹⁷ However, what the Aboriginal men understood and related to depression was as a weakness or injury of the spirit. In addition, the Aboriginal participants felt that depression related to a loss of connection to social and cultural features of Aboriginal life, cumulative stress and marginalisation.¹⁶ The participants identified a reluctance to talk about their emotional issues and described anger and impulsivity as prominent features of depression, particularly in the context of trying to suppress the anger they felt in respect to what had occurred in their lives.¹⁶ The importance of strong spirit and strong mind is explored in Chapter 26 (Casey).

Ketchell, following a description of normal funeral rituals required by members of the Torres Strait Islander population, notes that people may become emotionally distressed if they are unable to fulfil these duties for some reason related to their present circumstances.¹⁸

Given the high rates of social disadvantage affecting Aboriginal and Torres Strait Islander mothers, along with additional factors such as being a member of the Stolen Generation and having much higher numbers of children in out-of-home care,¹⁹ it would be considered that the potential for postpartum depression in Aboriginal and Torres Strait Islander women would be greater. A recent survey of 25,455 women in South Western Sydney did not reveal a greater prevalence of postpartum depression in the very small component number (481) of Aboriginal and Torres Strait Islander women sampled.²⁰ However, the survey did point to some significant health and social issues leading to an increased prevalence of postnatal depression (PND) that also commonly affect Aboriginal and Torres Strait Islander peoples. These included placement in public housing, difficult financial situation, single status, poor rating of own health and poor rating of their child's health.²⁰ A study of 210 Aboriginal and Torres Strait Islander mothers in Queensland using an adapted, more culturally appropriate form of the Edinburgh Postnatal Depression Rating Scale (EPDS) found higher rates of participants with 'at risk' issues (27.7 per cent) on the culturally adapted scale compared with 16.7 per cent identified with the normal scale. This disparity suggests that miscommunication and cultural safety issues may be leading to a poor recognition of postpartum depression within the Aboriginal and Torres Strait Islander population.²¹ The issues and strategies around perinatal maternal and infant mental health are discussed in detail in Chapter 19 (Marriott and Ferguson-Hill).

Anxiety

Anxiety disorders encompass a range of mental illness conditions, where there is elevated psychological arousal accompanied by physical sensations of fear.¹ The psychological and physical features, along with avoidance behaviour to reduce these issues, are core features of anxiety disorders. There are seven categories of disorders listed in the 'anxiety disorder' section of the new DSM-5 criteria. Some of these disorders may be a fear of a particular object or situation (phobia); fear in response to certain social or performance situations (social anxiety disorder); chronic persistent fear with physical overactivity (generalised anxiety disorder); sudden unexpected episodes of fear (panic attack) and the fear of experiencing anxiety or having a panic attack (agoraphobia). The symptoms of anxiety disorders may sometimes be the consequence of medical conditions such as thyroid disease, and are frequently associated with substance misuse, both intoxication and withdrawal. It is therefore important to have these matters examined before a diagnosis of anxiety disorder can be definitively made.

Listed under a new heading in the DSM-5 called 'obsessive-compulsive and related disorders', is the intrusive thoughts and associated ritualistic avoidant behaviour known as obsessive compulsive disorder. Acute Stress Disorder (ASD) which is emotional numbing and recurrent

traumatic memories and dreams following exposure to a severe traumatic incident and post traumatic stress disorder (PTSD) are now listed under the new DSM-5 heading known as 'trauma and stressor-related disorders'.

Anxiety conditions rarely reach the severity required for admission to hospital. However, community surveys of mental illness point to varying prevalence rates of anxiety, from 1.5 per cent of community members in Mornington Island and 1.4 per cent of community members in the Kimberley, to 5 per cent of community members in Bourke.⁷ More focused surveys, such as the Western Australian Aboriginal Child Health Survey, showed that up to one-quarter of surveyed children aged 4–17 years may have been at risk of developing emotional and behavioural disorders that may be associated with anxiety conditions.²² This finding is not surprising against a background where Aboriginal and Torres Strait Islander peoples are exposed to high levels of multiple life stressors. Forty-four per cent of Aboriginal and Torres Strait Islander respondents surveyed by the Australian Bureau of Statistics reported at least three life stressors in the previous 12 months, and 12 per cent of respondents reported experiencing at least seven life stressors that included the death of a family member or close friend, serious illness or disability, inability to get work, overcrowding at home, and alcohol and drug-related problems. Multiple stresses were more prevalent for Aboriginal and Torres Strait Islander peoples living in remote and rural locations.²³ Walker and colleagues discuss the issues associated with anxiety, depression and behavioural issues for young Aboriginal and Torres Strait people in Chapter 22.

The high level of exposure to stress can be contrasted with Aboriginal and Torres Strait Islander cultural factors that appeared to reduce stress and anxiety in traditional cultures. Hunter and Eastwell have commented on the ability of Aboriginal and Torres Strait Islander peoples to express strong feelings within a defined cultural context such as a funeral.^{24,25} Eastwell also comments that the Yolgnu tribe of Eastern Arnhem Land relieved stress by ascribing significant adverse personal events, such as the unexpected death of an individual, to sorcery, which was satisfying to individuals and the community and carried great local conviction.²⁵ However, there are also occasional reports of significant anxiety disorder in the traditional Aboriginal and Torres Strait Islander context. During his time with the Walpiri in the 1960s, Meggitt described what is most likely a case of dissociative fugue, secondary to intense anxiety resulting from a woman accidentally viewing sacred items.²⁶ Morice reports that Pintubi language describes extreme fear, in addition to other grades of anxiety, that could also account for such a phenomenon.¹⁶

Psychosis

Psychotic disorder usually refers to a complex of symptoms of mental illness. These include hallucinations (abnormal sensory perceptions), delusions (false beliefs), disorganised speech and behaviour, and cognitive issues such as emotional blunting, limited intellectual function and ability to motivate oneself.¹ The experience of psychosis is often very frightening for the individual concerned and is related to a range of conditions, such as schizophrenia (a long-term condition where the affected person has disability related to persistent psychosis), mania (elevated mood related to bipolar disorder or manic depression), severe depression and substance misuse. Occasionally, psychosis may be precipitated by a severe emotional stress.

The experience of psychosis in traditional Aboriginal and Torres Strait Islander culture was likely to have been rare. As an example, Kidson and Jones estimated that the rate of schizophrenia among tribal Aboriginal people in Central Australia was about 0.46 per cent.²⁷ This estimate stands in significant contrast to the high rate of psychosis currently affecting the Aboriginal and Torres Strait Islander population. Pink and Allbon report that Aboriginal and Torres Strait Islander men were admitted to hospital with mental disorders due to psychoactive substance misuse, at 4.5 times the expected rate for their proportion of the Australian population, and the same population had hospital admission for schizophrenia and related

disorders at 2.7 times the expected rate. Aboriginal and Torres Strait Islander women have 3.3 times the expected rate of mental disorders due to psychoactive substance misuse and 2.5 times the expected rate of hospital admission for schizophrenia and related disorders.¹¹

It appears, therefore, that the experience of psychosis, particularly in the context of substance misuse, is a significant issue for the Aboriginal and Torres Strait Islander population at present. A recent study by McKetin and a review by Paparelli point to the contribution of substances such as cannabis and amphetamines in the current epidemic of psychosis, and how it is often difficult to differentiate psychosis related to substance misuse from psychosis associated with a more pervasive cause such as schizophrenia.^{28,29}

The recognition of cultural factors and use of AMHWs is an important component of care and diagnosis for any Aboriginal and Torres Strait Islander person presenting with psychosis. As an example, it is common for Aboriginal people to experience the voices of their relatives, and this may be misinterpreted as a hallucination by clinicians who do not have an appropriate understanding of relevant cultural issues.³⁰ Notwithstanding the above cultural factors, psychotic disorders have been reported in a number of cases of the traditional Aboriginal and Torres Strait Islander context. Aboriginal people apparently suffering from positive symptoms (hallucinations) and negative symptoms (emotional and cognitive blunting) of schizophrenia were observed by Jones and de la Horne in Central Australia in the 1970s.^{14,31} Morice notes that the Pintubi words to describe someone suffering from schizophrenia are having closed ears or living in a world of their own.¹⁶ Meggitt described the case of a woman suffering from psychosis, most likely related to emotional stress, as well as a person suffering from mania in the Walpiri.²⁶ Eastwell commented on transient delusional states in certain Yolgnu family groups in East Arnhem Land.^{32,33} Ketchell also reports on delusions that affect Torres Strait Islanders where they become abnormally jealous of their partner, incorrectly believing that they are having an affair, or believe that sorcery is being performed against them.¹⁸

Personality Disorder

Personality disorders are a class of social disorders characterised by enduring maladaptive patterns of behaviour, cognition and inner experience, exhibited across many contexts and deviating markedly from those accepted by the individual's culture. The DSM-5¹ now lists personality disorder in exactly the same way as other mental disorders, rather than on a separate 'axis' as previously. Personality, defined psychologically, is the set of enduring behavioural and mental traits that distinguish human traits. Hence, personality disorders are defined by experiences and behaviours that differ from societal norms and expectations.

Pink and Allbon note that Aboriginal and Torres Strait Islander men have a rate of admission to hospital for personality issues that is 1.8 times the rate expected for their proportion of the population.¹¹ The rate of admissions for Aboriginal and Torres Strait Islander women with similar issues is 0.8 times the rate. Community prevalence surveys have reported rates of personality disorder of 4 per cent in Mornington Island, 16 per cent in Bourke and 8.2 per cent in a Kimberley community.⁷ However, one has to be careful diagnosing personality disorder in situations where an atmosphere of cultural security was not maintained or supported during the assessment, as outlined at the beginning of the chapter. Morice notes a number of qualifying issues in the diagnosis of personality disorder when the assessor is from a different culture to the person being assessed. He cautions that:

there are many people who exhibit atypical (for themselves) behavioural responses to certain environmental stimuli. These behavioural reactions occur in direct response to the stimuli and usually disappear when the stimuli are removed ... A diagnostic dilemma occurs when adverse environmental stimuli are prolonged and behavioural responses may appear to be relatively fixed.^{34(p296)}

Given this caution, there is still a range of information about the vulnerability of Aboriginal and Torres Strait Islander peoples to personality issues. A number of authors³⁵⁻³⁷ have commented on tribal sanctions that were applied to continually disruptive individuals (usually young men) that may be indicative of antisocial personality, as currently defined by DSM-5.¹ The significant amount of stressors affecting young Aboriginal and Torres Strait Islander peoples currently, seen against the historical background of the negative impacts on their health, culture and society generally, may be considered vulnerability factors for further continuing personality dysfunction.²³ This may be an issue in the case of members of the Stolen Generations in Western Australia, where surveys have shown that people are more likely to live in households where there is problematic gambling and drinking, more likely to have been in contact with mental health services, and almost twice as likely to have been charged by police.²² The findings may also indicate that, although personality disorders are problematic categories of illness due to historical, cultural and political factors, they cannot be ignored due to the cumulative impact of trauma, grief and loss on a person's development and hence require strategies for management.

ISSUES FOR FAMILIES

The 2008 submission of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to the Australian Government House of Representatives Standing Committee on Family, Community, Housing and Youth Inquiry into Better Support for Carers, outlines a number of issues which affect the carers of people suffering from mental illness that are also quite applicable in the Aboriginal and Torres Strait Islander context. The College submission points out that those general attitudes to mental illness add to the existing social exclusion and pressures faced by carers. In addition, most people are largely uneducated in the effects of mental illness on the individual, let alone carers. The College submission adds:

The reality is that mental illness is difficult to understand and often generates fear and considerable stigmatisation for the consumer and their family. It is often seen as being in the 'too hard basket' by many in the service system and the greater community. Consequently, social support structures such as housing, rehabilitation, justice systems, income support arrangements, employment assistance etc., all face particular difficulties and are often less effective in providing well tailored services and outcomes to people with mental illness. For carers, these difficulties and complexities are at least as great, but the pressures they face in trying to deal with all of the issues and interactions can be extreme and unrelenting. As a result, carers' own health needs can suffer adversely and/or be overlooked.^{38(p3)}

These issues are further complicated for the families of Aboriginal and Torres Strait Islander peoples with mental illness in remote Australia. According to Dillon and Westbury, there may be a performance gap in terms of the provision of services, a legitimacy gap in that standards of governance are deficient, and a security gap in that levels of violence are high.³⁹ A similar situation may also face families of Aboriginal and Torres Strait Islander peoples with mental illness who reside in cities where they tend to be poorer and more marginalised than their non-Aboriginal counterparts, thus reducing their access to quality support services.³⁹

Thus, an appropriate clinical response to the large majority of Aboriginal and Torres Strait Islander peoples suffering from mental illness would involve a comprehensive appreciation of the community that they live in.^{8,40} Further, the essential interaction between the family of individuals suffering from mental illness and AMHWs within a primary health setting is considered an important component of the management of that individual.⁴¹ The authors go on to suggest a range of ways that mental health clinicians, including AMHWs, can work with families. These include clarifying mutual goals; not forcing families to fit specific models

to encompass the diversity of Aboriginal and Torres Strait Islander culture and social issues; acknowledging your own limitations as a therapist when working with Aboriginal and Torres Strait Islander families; working with the families as a team; pointing out family strengths; learning to respond to the family's intense feelings; encouraging family enrichment to fulfil their own needs in the context of care for the affected individual; providing information about the illness and therapies (including medications) required; providing practical advice (including information on community resources); encouraging family involvement in support and advocacy groups; acknowledging a diversity of beliefs; and making a personal commitment to the issues at hand.⁴¹

Forensic Issues

Aboriginal and Torres Strait Islander peoples continue to make up a disproportionate amount of prison populations in Australia. In 2004, they were 11 times more likely to be imprisoned than non-Aboriginal Australians.⁴² It is estimated that approximately 19 per cent of men and 30 per cent of women in full-time custody in Australia are Aboriginal and Torres Strait Islander. Butler⁴² suggests that the high rates of mental illness recorded for Aboriginal and Torres Strait Islander women indicate that they are one of the most psychologically vulnerable groups in the community.⁴² Forensic mental health issues are particularly pertinent for Aboriginal and Torres Strait adolescents. Over one-third of young people under juvenile justice supervision during 2005–06 were identified as being Aboriginal and Torres Strait Islander⁴³ (44.9 per 1,000 population compared with 2.9 per 1,000 population for non-Aboriginal young people Australia-wide).⁴²

Another review notes that prison data give a more severe picture of mental illness and impairment for Aboriginal and Torres Strait Islander prisoners than general population data.⁴⁴ A local prisoner health study found that one-in-seven Aboriginal and Torres Strait Islander men and one-in-five Aboriginal and Torres Strait Islander women prisoners reported having been hospitalised at least once in the past for psychiatric reasons. Particularly high rates of substance misuse, post-traumatic stress disorder, acquired brain injury and comorbidity were evident or inferred for Aboriginal and Torres Strait Islander prisoners. A strong link between substance misuse and offending was evident, especially crimes involving assault. Contradictory findings for depression, upon closer analysis, revealed a pattern of under-diagnosis, wherein the symptoms needed to be more extreme before services were accessed or made available to Aboriginal and Torres Strait Islander prisoners. It was also considered likely that Aboriginal and Torres Strait Islander prisoners experienced higher rates of subjective distress, not adequately picked up by current systems of assessment and diagnosis, relating to loss of identity, acculturation stress and/or 'spiritual sickness'.⁴⁴

Overall, the findings in the report by Jones and Day pointed to the need for more culturally attuned mental health assessments and responses for Aboriginal and Torres Strait Islander peoples involved in the criminal justice system, and a much higher standard of culturally appropriate data collection in the mental health field⁴⁴ (refer to Chapter 10, Heffernan and colleagues; and Chapter 30, Hovane and colleagues).

There has been a range of innovative programs devised for Aboriginal and Torres Strait Islander adolescents within the juvenile justice system that may provide models generally for the improved care of Aboriginal and Torres Strait Islander peoples within prisons, who may be vulnerable to mental illness. Stathis and colleagues describe a program conducted in a prison for Aboriginal and Torres Strait Islander adolescents that was coordinated across a number of departments.⁴⁵ Education Queensland provided substance use information to all adolescents attending the prison school. The Queensland Department of Communities offered psycho-educational programs as part of regular life skills programs, and clinical treatment was offered to young people identified as suffering from significant substance misuse disorders. The recruitment of an AMHW to the team was a further incentive for Aboriginal and Torres Strait

Islander adolescents to engage in the program.^{45, 46} In addition, the AMHW was able to assist the other clinicians with the definition of cultural issues affecting the adolescents, allowing them more accurately to define issues of mental illness and personality dysfunction. The AMHW also engaged the adolescents in concepts of emotional and spiritual wellbeing. Other strategies such as the use of a 'buddy system' have also been suggested to assist adolescents adjust to custody.⁴⁷

Treatment

It is not within the scope of this chapter to critically review therapies currently available for the treatment of mental illness. Australian practice guidelines developed by the RANZCP are a good initial reference point for this issue, and clinicians should be able to discuss their proposed treatment with affected individuals and their families in the context of these guidelines.⁴⁸ People affected by severe mental illness such as psychosis, severe depression and mania, may be at risk of death or serious injury to themselves by accidents or suicide. They may also be a danger to others, through fear or aggression. Urgent medical attention should generally be sought to help the person affected by these disorders. It is not inevitable that the person who is affected by mental illness will be admitted to hospital—they may be able to be treated in their community with the help of family, AMHWs and Mental Health Services. People affected by mental illness and their families may be aware of National Standards in Mental Health, which emphasise treatment in the least restrictive environment for people affected by mental illness.⁴⁹ Other publications such as the CARPA manual also have protocols for treating Aboriginal people with mental illness in their community.⁵⁰ However, if the mental illness is severe and the person suffering from it may be a danger to themselves or others as a result of their illness, the person may need to be treated involuntarily under the *Mental Health Act 1996* for a period before returning to their community and family.

There have also been a number of innovative strategies to improve the outcome for people affected by mental illness. The Northern Territory AIMhi project has developed a *Story Telling Project* to improve compliance and reduce recurrence of mental illness for people living in remote communities, as well as attempting to reduce the stigma in the community for people affected by mental illness.⁵¹ The developed stories are produced in collaboration with a range of clinicians, service providers and the communities concerned. These programs work on a concept of improving mental health through strength in spiritual, physical, family, work, social, mental and emotional components of the life of the person affected. The stories emphasise the importance of culture and of the Aboriginal and non-Aboriginal way of working together to improve the outcome for the person. The stories developed were then used to preface a further intervention strategy of motivational interviewing, problem-solving therapy and chronic disease self-management, to improve outcomes for a group of people suffering from severe mental illness.⁵² Other resources include the DVD collection of personal stories of Aboriginal and Torres Strait Islander peoples, in addition to a guide for the care of Aboriginal and Torres Strait Islander peoples experiencing severe mental illness produced by ORYGEN.^{53, 54} The use of these resources to inspire and educate Aboriginal and Torres Strait Islander peoples, their families and service providers is a welcome trend.

CONCLUSION

This chapter demonstrates that mental illness was present in Aboriginal and Torres Strait Islander culture prior to European colonisation of Australia but was, most likely, a fairly rare occurrence. The much greater prevalence of mental illness in the Aboriginal and Torres Strait Islander population currently is a reflection of the significant disruption to Aboriginal and Torres Strait Islander society and has a strong context of social and emotional deprivation. Management of the issues of mental illness requires a strong emphasis on cultural safety, along with the recognition of family, culture and community in any healing process.

REFLECTIVE EXERCISES

1. Discuss how the significant changes to Aboriginal and Torres Strait Islander culture and society since European colonisation have led to changes in patterns of mental illness.
2. Discuss how you may go about the assessment of an Aboriginal and Torres Strait Islander person who is referred to you by another clinician for assessment of 'depression'.
3. Discuss how the experience of an Aboriginal and Torres Strait Islander person suffering from mental illness may affect that person's family, and ways that you as a clinician may assist the family.

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). 2013.
2. Chang D. An introduction to the politics of science: culture, race, ethnicity, and the supplement to the Surgeon General's report on mental health. *Culture Medicine and Psychiatry*. 2003; 27:373-83.
3. Clear G. A re-examination of cultural safety: a national imperative. *Nurs. Prax. N. Z.* 2008; 24(2):2-4.
4. Morgan S. Orientation for general practice in remote Aboriginal communities: a program for registrars in the Northern Territory. *The Australian Journal of Rural Health*. 2006; 14(5):202-8.
5. Helen Milroy. In: Personal communication. 2012
6. Lette H, Wright M, Collard S. Aboriginal youth: Mental health. In Dudgeon P, Garvey D, Pickett H, editors. *Working with Indigenous Australians: A handbook for psychologists*. Perth: Gunada Press; 2000.
7. Hunter E. Mental health. In: Thomson N, editor. *The Health of Indigenous Australians* Melbourne: Oxford University Press; 2003.
8. Sheldon M. Psychiatric Assessment in remote Aboriginal communities of Central Australia. CAMHSNET Nexus; 2005.
9. Parker R. The Royal Australian and New Zealand College of Psychiatrists Statement on Indigenous Mental Health Workers. *Aboriginal and Islander Health Worker Journal*. 2003; 27(1):3-6.
10. World Health Organization. In: *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. 1992. Geneva.
11. Pink B, Allbon P. In: *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*. 2008. Canberra: Australian Bureau of Statistics.
12. McKendrick J, Cutter T, Mackenzie A, Chiu E. The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population. *The Australian and New Zealand Journal of Psychiatry*. 1992; 26:40-7.
13. Jorm A, Bourchier SJ, Cvetkovski S, Stewart G. Mental health of Indigenous Australians: a review of findings from community surveys. *Medical Journal of Australia*. 2012; 196:118-121.
14. Jones I, de la Horne D. Diagnosis of psychiatric illness among tribal Aborigines. *Medical Journal of Australia*. 1972; 1:345-49.
15. Cawte J. The devil's dozen: Thirteen Aboriginal depressions. *The Aboriginal Health Worker*. 1987; 12:19-28.

16. Morice R. Know your speech community. *Aboriginal Health Worker*. 1986; 10:12-32.
17. Brown A, Scales U, Beever W, Rickards B, Rowley K, O'Dea K. Exploring the expression of depression and distress in Aboriginal men in central Australia: a qualitative study. *BMC Psychiatry*. 2012; 12 (97).
18. Ketchell M. In: Grief, loss and the healing, a brief awareness: 'Mifla Way-Ilan Pasin or Our Way-Island Protocol.' 2004 Unpublished.
19. Australian Institute of Health and Welfare. In: The health and welfare of Australia's Aboriginal and Torres Strait Islander people an overview 2011. Canberra: AIHW.
20. Eastwood JG, Phung H, Barnett B. Postnatal depression and socio-demographic risk: factors associated with Edinburgh Depression Scale scores in a metropolitan area of New South Wales, Australia. *The Australian and New Zealand Journal of Psychiatry*. 2011; 45(12):1040-6.
21. Campbell A, Hayes B, Buckby B. Aboriginal and Torres Strait Islanders women's experience when interacting with the Edinburgh Postnatal Depression Scale: A brief note. *Australian Journal of Rural Health*. 2008; 16:124-131.
22. Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM et al. The West Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People. Perth: Curtin University of Technology and the Telethon Institute for Child Health Research, 2005.
23. Trewin D, Madden R. In: The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. 2005. Canberra: Australian Bureau of Statistics.
24. Hunter E, Reser J, Baird M, Reser P. An analysis of suicide in Indigenous communities of North Queensland: The historical, cultural and symbolic landscape. Canberra: Mental Health/Health Services Development Branch, Commonwealth Department of Health and Aged Care; 1999.
25. Eastwell H. The low risk of suicide among the Yolngu of the Northern Territory: the traditional Aboriginal pattern. *The Medical Journal of Australia*. 1988; 148:338-40.
26. Meggitt MJ. The desert people. Sydney: Angus Robertson; 1962.
27. Kidson M, Jones I. Psychiatric disorders among Aborigines of the Australian Western Desert. *Archives of General Psychiatry*. 1968; 19:413-17.
28. McKetin R, Lubman DI, Baker AL, Dawe S, Ali RL. Dose-related psychotic symptoms in chronic methamphetamine users: evidence from a prospective longitudinal study. *JAMA psychiatry (Chicago, Ill.)*. 2013; 70(3):319-24.
29. Paparelli A, Di Forti M, Morrison PD, Murray RM. Drug-induced psychosis: how to avoid star gazing in schizophrenia research by looking at more obvious sources of light. *Front. Behavioural Neuroscience*. 2011; 5(1):1-9.
30. Parker R, Milroy H. Schizophrenia and related psychoses in the Aboriginal population of Australia. *The Aboriginal and Islander Health Worker Journal*. 2003; 27(5):17-19.
31. Jones I, de la Horne D. Psychiatric disorders among Aborigines of the Australian Western Desert. Further data and discussion. *Soc. Sci. Med.* 1973; 7:219-28.
32. Eastwell HD. Associative illness among Aborigines. *The Australian and New Zealand Journal of Psychiatry*. 1976; 10:89-94.
33. Eastwell HD. Projective and identificatory illnesses among ex-hunter-gatherers: a seven-year survey of a remote Australian Aboriginal community. *Psychiatry*. 1977; 40:331-43.

34. Morice R. Personality disorder in transcultural perspective. *The Australian and New Zealand Journal of Psychiatry*. 1979; 13:293-300.
35. Hart C, Pilling A, Goodale J. *The Tiwi of North Australia* (3rd Ed). New York: Holt, Rinehart & Winston; 1988.
36. Hiatt L. *Kinship and conflict: A study of an Aboriginal community in Northern Arnhemland*. Canberra: ANU Press; 1965.
37. Strehlow T. *Geography and the totemic landscape in Central Australia: A functional study*. In: Berndt RE, editor. *Australian Aboriginal Anthropology*. Canberra: Australian Institute of Aboriginal Studies; 1970.
38. Royal Australian and New Zealand College of Psychiatrists. Carers. [Internet]. 2008 Available from: <http://www.aph.gov.au/House/committee/fchy/carers/subs/sub672.pdf>.
39. Dillon MC, Westbury ND. *Beyond humbug: Transforming government engagement with Indigenous Australians*. West Lakes, SA: Seaview Press; 2007.
40. Crawford F, Dudgeon P, Garvey D, Pickett H, editors. *Interacting with Aboriginal communities*. Perth: Gunada Press; 2000.
41. McKelvie G, Mallard J, editors. *Working therapeutically with Aboriginal families*. Perth: Gunada Press; 2000.
42. Butler T, Allnutt S, Kariminia A, Cain D. Mental health status of Aboriginal and non-Aboriginal Australian prisoners. *The Australian and New Zealand Journal of Psychiatry*. 2007; 41(5):429-35.
43. Australian Institute of Health and Welfare. In: *Juvenile Justice in Australia 2005–06*. Canberra; 2007.
44. Jones R, Day A, Justice S. In: *Indigenous mental health in the criminal justice system: A review for the Justice Mental Health Strategy, Justice Health and Indigenous Issues Unit*. 2008. Melbourne: Victorian Department of Justice.
45. Stathis SL, Letters P, Doolan I, Whittingham D. Developing an integrated substance use and mental health service in the specialised setting of a youth detention centre. *Drug Alcohol Rev*. 2006; 25(2):149-55.
46. Stathis S, Letters P, Dacre E, Doolan I, Heath K, Litchfield B. The role of an Indigenous Health Worker in contributing to equity of access to a mental health and substance abuse service for Indigenous young people in a youth detention centre. *Australian eJournal for Advancement of Mental Health*. 2007; 6:1-10.
47. Troth G, Grainger J. The psychological impact of custody on the Aboriginal adolescent. *Psychiatry Psychology and Law*. 2000; 7(1):89-96.
48. Royal Australian and New Zealand College of Psychiatrists. *Guides for the Public*. [Internet]. 2008 [cited November]. Available from: <http://www.ranzcp.org/resources/clinical-practice-guidelines.html>
49. *National Standards for Mental Health Services*. 1996. Canberra: AGPS.
50. CARPA. *Standard Treatment Manual* (3rd Ed.). 1997.
51. Nagel T, Thompson C. AIMHI 'Mental Health Story Teller Mob': Developing stories in mental health. *Australian eJournal for the Advancement of Mental Health*. 2007; 6:1-6.
52. Nagel T, Robinson G, Trauer T, Condon J. An approach to treating depressive and psychotic illness in Indigenous communities. *Australian Journal of Primary Health*. 2008; 14:17-24.
53. ORYGEN. *Discussing suicide: Brian's story*. 2008.
54. ORYGEN. (Centre). *Mental health first aid for psychosis in Aboriginal and Torres Strait Islander communities*. 2008.

Harmful Substance Use and Mental Health

Edward Wilkes, Dennis Gray, Wendy Casey, Anna Stearne and Lawrence Dadd

OVERVIEW

In this chapter, we briefly examine harmful substance use and mental health among Aboriginal Australians. We explore a range of issues including current substance use and related harms, social and emotional wellbeing and comorbidity, and the social determinants of mental health and harmful substance use. We examine the range of services that have been developed to address these issues, through the National Drug Strategy's demand, supply and harm reduction framework. We argue that a multi-systemic strategy is required that addresses issues of cultural security, evidence-based practice to enhance treatment outcomes, better service coordination, and attention to the development of the Aboriginal substance use and mental health workforce. Some evidence-based treatments to help with mental illness and harmful substance use are adaptable to work with or along-side local, culturally appropriate, interventions. However, we reiterate that until the social and structural determinants of good mental health are addressed, the comorbidity of harmful substance use and mental health among Aboriginal Australians will linger.

This chapter will explore these issues in more detail and focus specifically on four important areas of concern. What are the problems? What are the underlying issues? What is, and can be done, to address harmful substance use among Aboriginal people? What else needs to be done?

THE BACKGROUND

For over 200 years, colonisation, racism and domination have left a legacy of marginalisation and mental anguish that is still with us today. Few Aboriginal Australians have been spared that anguish or the self-destructive behaviour associated with the harmful use of alcohol and other psychoactive substances. While harmful use of alcohol and other substances is represented as the problem of Aboriginal Australia, the source of all or most of its ills, especially poor physical and mental health, is influenced by many factors—including as an escape mechanism and a focus of socialising—and the causes and effects of alcohol and other drug use need to be better understood. Otherwise, there is a great risk that policy interventions will be simplistic and ineffective and the current opportunity for change will be lost.

The search for effective answers to today's problems with the harmful use of alcohol and other substances must start with the facts—each Aboriginal person has a lived experience and story that should be told by them. The experience of assimilating into Western ways or retaining Aboriginal ways creates anxieties that reverberate through the families that make up the Aboriginal Australian world. While Australia now has racial vilification laws, Aboriginal Australians are still made to feel uncomfortable or denied access to public places where others are welcomed.

Addressing Individual and Community Transgenerational Trauma

Judy Atkinson, Jeff Nelson, Robert Brooks, Caroline Atkinson and Kelleigh Ryan

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.

Case Study Mitch

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.”

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 Scott⁴ 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)}

Figley⁷ 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(pviii)} 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(pix)} 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.

Scaer⁸ and Van der Kolk⁹ 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.

Atkinson¹⁰ 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 research¹⁰ 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

Atkinson¹⁰ 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 trauma⁹ 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 Taskforce¹⁸ 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

Atkinson¹² 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.

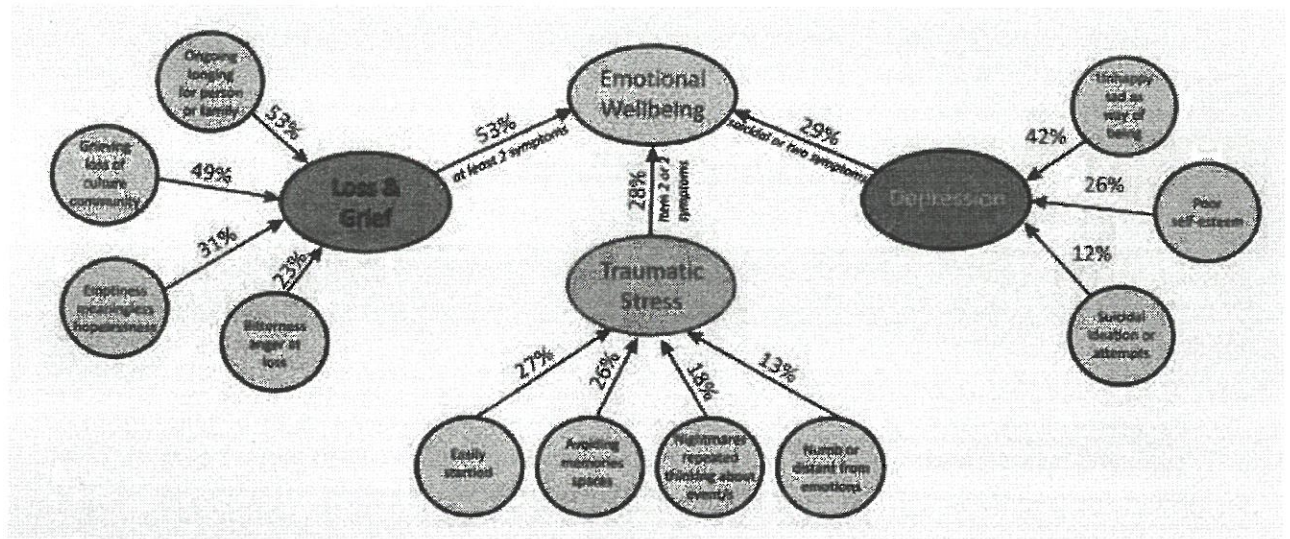
Historical Trauma and the Breakdown of Family and Community

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 Foundation²²

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 - traumatic removal - incomplete education and missed opportunities to learn - fractured identity - sense of powerlessness - multiple care experiences - lack of attachment - domestic violence - significant losses - hidden punishments and/or victimisation in institutions - multiple generation removal.^{22(p3)}	- a sense of control – autonomy - positive memories before removal - family tried to stay together - siblings stayed together - family visits with positive memories - developing a new loving family - having a mentor - having peer support - western education - learning to adopt responsibility - 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 Adaption After Persecution and Trauma (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

Silove²⁴ and Hobfall²⁵ 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 Lalonde²⁶ 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.

Silove²⁴ 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

<i>Pillar</i>	<i>Threat: Past Present and Future</i>	<i>Normative Psychological Response</i>	<i>Normative Adaptive Response</i>	<i>Negative Outcomes (if Adaptive Responses Fail)</i>
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 Silove²⁹

A recent report examining the protective capacity of resilience in children shows clearly that once there is substantial trauma, resilience is not protective²⁷ 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 Program³⁷⁻⁴¹ 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 Silove²⁴ and Hobfall²⁵ 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)¹⁶

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.

REFERENCES

1. Mollica R. *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Cambridge: Vanderbilt University Press; 2006.
2. Australian Bureau of Statistics. *Prisoners in Australia*. Canberra: ABS; 2012.
3. Mocarata K. Papua New Guineans against Domestic Violence. [as posted on the Facebook site] 2013, 16 January
4. Briere JN, Scott C. *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment*. Thousand Oaks, CA: Sage Publications; 2006.
5. *Diagnostic and Statistical Manual of Mental Disorders, Text Revision*. 4th ed. Washington DC: American Psychiatric Association; 2005.
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. 2013.

7. Figley C. *Trauma and its Wake: The Study and Treatment of Post-Traumatic Stress Disorder*. New York: Brunner/Mazel; 1985.
8. Scaer R. *The Body Bears the Burden: Trauma, Dissociation and Disease*. New York: Haworth Press; 2001.
9. Van der Kolk B. *Develop Aboriginal and Indigenous Community Health*. 2006;4(2):118-136.
10. Atkinson C. *The Violence Continuum: Australian Aboriginal Male Violence and Generational Post-Traumatic Stress* [Unpublished PhD thesis]: Darwin: Charles Darwin University; 2008.
11. O'Shane P. Assimilation or acculturation problems of Aboriginal families. *Australian and New Zealand Journal of Family Therapy*. 1993;14(4):196-98.
12. Atkinson J. *Trauma trails, recreating songlines: The transgenerational effects of trauma in Indigenous Australia*. Melbourne: Spinifex Press; 2002.
13. Kezelman CA, Stavropoulos PA. 'The Last Frontier' Practice Guidelines For Treatment Of Complex Trauma And Trauma Informed Care And Service Delivery. *Adults Surviving Child Abuse (ASCA)*. Sydney; 2012.
14. Bendall S, Jackson HJ, Hulbert CA, McGorry PD. Childhood trauma and psychotic disorders: a systematic, critical review of the evidence. *Schizophrenia bulletin*. 2008;34(3):568-79.
15. Putnam FW. *Dissociation in Children and Adolescents*. New York: Guilford Press; 1997.
16. Oliver JE. Intergenerational transmission of child abuse: rates, research, and clinical implications. *The American Journal of Psychiatry*. 1993;150(9):1315-24.
17. Green A. Childhood sexual and physical abuse. In: J. P. Raphael, editor. *International handbook of traumatic stress syndromes*. New York: Plenum Press; 1993.
18. Child Sexual Assault Taskforce. *Breaking the silence: Creating the future, addressing child sexual assault in Aboriginal communities in NSW*. Sydney, NSW: Attorney General's Department; 2006.
19. Atkinson C, Atkinson J. Talking about perpetrator programs. In: Thompson R, editor. *Working in Indigenous perpetrator programs: Proceedings of a forum, Adelaide 4 and 5 August 1999*. Darwin: Ministerial Council for Aboriginal and Torres Strait Islander Affairs; 2000.
20. Muid O. *Then I lost my spirit: Analytical essay on transgenerational theory and its application to oppressed people of color nations*. Ann Arbor, MI: UMI dissertation Services ProQuest; 2006.
21. Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM, et al. *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research; 2005.
22. Aboriginal and Torres Strait Islander Healing Foundation. *Looking Back to Build a Future Preliminary Findings: Risk, Resilience and Outcomes from Stolen Generations Oral Histories*. [Canberra]: ATSIF; 2013.
23. Ralph N, Hamaguchi K, Cox M. Transgenerational trauma, suicide and healing from sexual abuse in the Kimberley region, Australia. *Pimatisiwin, A Journal of Aboriginal and Indigenous Community Health*. 2006;4(2):118-136.

24. Silove D. From trauma to survival and adaptation: Towards a framework for guiding mental health initiatives in post-conflict societies. In: Ingleby D, editor. *Forced migration and mental health: Rethinking the care of refugees and displaced persons*. New York, NY: Springer Publishing Co; 2005.
25. Hobfoll SE, Watson P, Bell CC, Bryant RA, Brymer MJ, Friedman MJ, et al. Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry*. 2007;70(4):283-315; discussion 316.
26. Chandler MJ, Lalonde CE. Cultural Continuity as a Moderator of Suicide Risk among Canada's First Nations. In: L Kirmayer, G Valaskakis, editors. *The Mental Health of Canadian Aboriginal Peoples: Transformations Identity and Community*: University of British Columbia Press; 2009.
27. Sameroff AJ, Rosenblum KL. *Psychosocial Constraints on the Development of Resilience*. Centre for Human Growth and Development, University of Michigan, Ann Arbor, Michigan, USA, New York Academy of Sciences; 2006.
28. Silove D, Steel Z. Understanding community psychosocial needs after disasters: Implications for mental health services. *J Postgrad Med*. 2006;52(2):121-125.
29. Silove D. Adaptation, Ecosocial Safety Signals, and the Trajectory of PTSD. In: Kirmayer L, Lemeleson R, Barad M, editors. *Understanding Trauma Integrating Biological, Clinical, and Cultural Perspectives*. Cambridge: Cambridge University Press; 2007.
30. Chandler MJ, Lalonde CE, Sokol BW, Hallett D. Personal persistence, identity development, and suicide: a study of Native and Non-native North American adolescents. *Monographs of the Society for Research in Child Development*. 2003;68(2).
31. Silburn SR, Zubrick SR, De Maio JA, Shepherd C, Griffin JA, Mitrou FG, et al. *The Western Australian Aboriginal Child Health Survey: Strengthening the Capacity of Aboriginal Children, Families and Communities*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research; 2006.
32. Tsey K, Whiteside M, Haswell-Elkins M, Bainbridge R, Cadet-James Y, Wilson A. Empowerment and Indigenous Australian health: A synthesis of findings from Family Wellbeing formative research. *Health and Social Care in the Community*. 2010;18(2):169-179.
33. Tsey K, Whiteside M, Daly S, Deemal A, Gibson T, Cadet-James Y, et al. Adapting the 'Family Wellbeing' empowerment program to the needs of remote Indigenous school children. *Australian and New Zealand Journal of Public Health*. 2007;29(2):Article first published online: 25 SEP 2007.
34. Tsey K, Whiteside M, Deemal A, Gibson T. Social determinants of health, the 'control factor' and the Family Wellbeing Empowerment Program. *Australasian Psychiatry*. 2003;11(1):S34-S39.
35. Tsey K, Every A. Evaluating Aboriginal empowerment programs: the case of Family WellBeing. *Australian and New Zealand Journal of Public Health*. 2000;24(5):509-514.
36. Frederico M, Jackson A, Black C. *Take Two: More than Words. The Language of Relationships*. Melbourne: La Trobe University; 2010.
37. Atkinson J. Finding our Relatedness Stories: Psychology and Indigenous Healing Practice. In: Ranzin R, McConnochie K, Nolan W, editors. *Psychology and Indigenous Australians*. United Kingdom: Cambridge Scholars Publishing; 2008.
38. Atkinson J. Indigenous Approaches to Child Abuse. In: Altman J, Hinkson M, editors. *Coercive Reconciliation. Stabilise, Normalise, Exit Aboriginal Australia*. Carlton, Victoria: Arena Publications; 2007.

39. Atkinson J. Cyclone Caterpillar: Aboriginal Kids, a National Emergency, and the Rights of the Child. Human Rights, The Year in Review. Monash University. Melbourne; 2007.
40. Atkinson J, Graham J. Recreating the Circle of Well-being: A Tool for Changing the Health of Communities and Health Professional Education and Practice. In: Neylet D, Higgs J, editors. Change Imposed & Desired, ANZAME conference publication July 5th 8th 2002. Sydney: Faculty of Nursing, University of Sydney; 2002.
41. Atkinson J, Ober C. We Al-li - fire and water: A process of healing. In: Hazelhurst K, editor. Popular justice and community regeneration: Pathways to Indigenous reform. Westport, CN Praeger Press; 1995.
42. Atkinson J. Negotiating Worldviews - Indigenous Place in Academic Space. In: Rawlings-Sanaei F, Mason C, editors. Academic Migration, Discipline Knowledge and Pedagogical Practice Singapore: Springer Press; (In Press).
43. Swan P, Raphael B. In: Ways forward, vol. 1 & 2. National consultancy report on Aboriginal and Torres Strait Islander mental health. 1995. Canberra: Australian Government Publishing Service.
44. Townsend-Cross M. Respecting Children in Education, Our Children Our Future 3. Early Childhood Education Conference. 1–4 May, 2003 Adelaide, South Australia.
45. Nickerson A, Bryant RA, Silove D, Steel A. A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*. 2011;31(3):399-417.
46. Atkinson J. Trauma-informed services and trauma-specific care for Indigenous Australian children. Resource sheet no. 21. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. 2013.