indigenous PSYCHOLOGICAL SERVICES

JILYA

Issue 1
October 2016

DR TRACY WESTERMAN
Talks about IPS membership and her passion for Aboriginal mental health

PROFESSOR YIN PARADIES
Discusses the impacts of racism on the health and wellbeing of Indigenous Australians

FEATURING EMERGING LEADER DR MARJAD PAGE
An Indigenous GP from Mount Isa shares his inspiring story of his work and life in Mt Isa

We explore concepts of trauma and attachment in Aboriginal people in the first article of a two-part series

ANDY REED
Provides our first piece on "Talking Two Way"
A non-Indigenous perspective on working in a remote Aboriginal community as a young idealistic school teacher

We look at how Hope for Health is improving community wellbeing through traditional and Western nutritional knowledge

MESSAGE FROM THE MANAGING DIRECTOR

Dr Tracy Westerman

I am thrilled to welcome you all as members of IPS, an idea which started around seven years ago and which has finally come to fruition. The concept of the membership is to meet a gap in the Aboriginal mental health space which historically has had limited intellectual, personal and professional commentary. The e-magazine is titled Jilya (which means "my child" in my Njamal language). The concept of a focused response to finding solutions to the most complex of mental health issues via the merging of clinical and cultural best practice is something that I have always felt so passionate about – hence this is like "my child". This focus has been borne out of the divide I have witnessed between the obvious passion that exists from those who work in this field and the reality that our people remain severely over represented in health, mental health, and justice, welfare and suicide statistics. In addition to this, are the absence of evidenced based programs which have demonstrated their efficacy with Aboriginal people, have measurable outcomes and have been replicated across different Aboriginal groups. It is clear that there are many programs that are making a difference every day. Our goal is to bring this information to our membership and apply scientific rigour to an area that has been bereft of this as well as also celebrating those who have taken up the challenge of working to the benefit of our people and who offer us insights into these journeys. We believe that this is an essential starting point in challenging the concept that successful treatments cannot occur with Aboriginal people across the spectrum of mental health needs from early intervention, prevention, postvention and particularly in evidenced based therapies. The only method of challenging mainstream is to provide evidence of effectiveness that is impossible to refute!

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This leads me into the first two themes of the Jilya magazines, that being attachment and trauma. We will highlight the conceptual challenges and limitations of these two constructs in the evident failure to explore a cultural view of trauma and how this impacts upon assessment and treatment. More specifically the concept of racism as a factor in the development and maintenance of trauma is an area which is as important as it is unfortunately neglected. The failure to operationalise racism as a construct is something that has been of interest to me for some time as it is clear that this provides us with the best opportunity to halt the transmission of intergenerational trauma. It is also clear that it greatly assists in the development of programs which are capable of identifying and addressing such transmission. We see for example that the generation who were not directly removed experience more of the negative health and mental health related impacts that the previous generation. The most sobering depiction of the ongoing impacts of inter-generational trauma for me is the diagram which shows the life expectancy of Aboriginal Australians compared to those in third world countries

"You have a better chance of surviving as a child born in a third world country than being born as an Aboriginal Australian. Research has developed a term specifically to describe the Aboriginal Australian life expectancy – that is fourth world conditions – we live in third world conditions in a first world country"

In terms of finding some causal explanations we turn to racism as a concept and more specifically as a variant in trauma and attachment disorders. Professor Yin Paradies is our first expert and provides an inspirational opinion piece and our first discussion forum on the impacts of racism and impacts on Aboriginal Australians and is a world leader in this much neglected field. Professor Paradies' research has been able to determine the health and mental health based impacts of these experiences and we are privileged to provide this for you. We also know that experiences associated with racism are likely to lead to negative 'black' identity formation (Cross, 1971) and poor self-concept which is then passed onto future generations (Westerman, 2003) which is explored in our analysis of

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attachment theory and relevance within the Aboriginal Australian context.

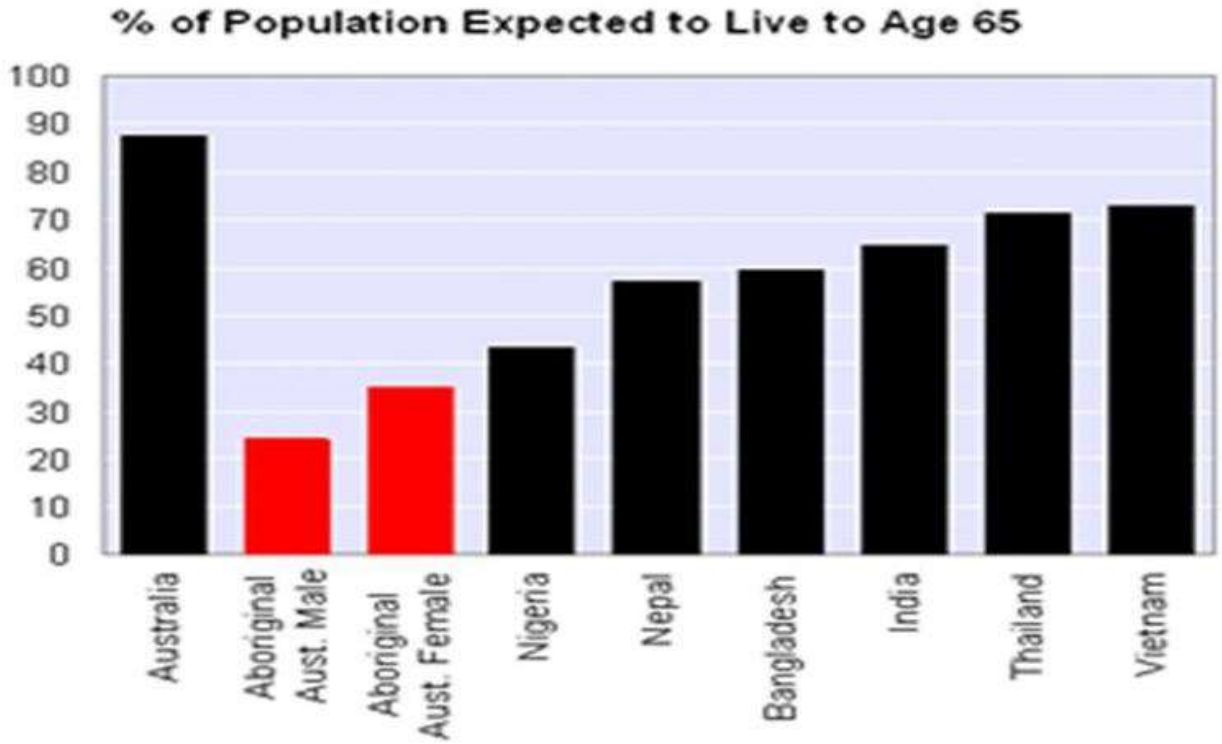
Cross (1971) first described the process of Black Identity Formation and was largely concerned with racial/ethnic identity theory and the negative effects of Western thought and science on the psychology of black people. It offers an important construct for therapists who work with Aboriginal people who are struggling with a sense of cultural identity. Positive cultural identity has known links to positive mental health, health and education outcomes and approaches that facilitate this development have the potential to address significant risk factors in the development of attachment and trauma.

The next issue of Jilya will explore within group racism otherwise known as lateral violence an area which has only just been receiving the attention it needs. This refers to racism towards our own mob which has been an 'untouchable' subject but which requires more exploration. Statistics are showing us that up to 95% of Aboriginal people experience lateral violence. The Emerging Leaders focus is part of this desire to stem this flow – to ensure that we celebrate each other as a method of disrupting the flow of lateral violence into the next generations. Dr Marjad Page is our first 'emerging leader' and he represents all that is great and positive about the possibility of change. I am sure that the people of Mount Isa would never thought that this was possible in one generation. We need to celebrate the achievements of this generation, support them, encourage them and nurture them. Hence, my 'Mentor Challenge' at the end of this message!

According to Richard Frankland Lateral violence includes: The organised, harmful behaviours that we do to each other collectively as part of an oppressed group: within our families; within our organisations and; within our communities. When we are consistentlyoppressed we live with great fear and great anger and we often turn on those who are closest to us

Jilya will also focus on programs which exist in environments in which there has historically been great need and limited success. This addition we highlight the Hope for Health retreats and applaud their ingenuity and drive in achieving such a great approach to health and wellbeing. We are excited about the potential for this program to address many of the chronic health

The intergenerational impacts



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needs which are often part of the differential diagnosis associated with mental health conditions. The section 'Talking Two Way" will provide non-Indigenous perspectives of working in remote communities and quite simply is there to encourage the journey. We are very passionate about debunking the myth that non-Indigenous people cannot be effective in working with Aboriginal people. We commence with Andy Reed, a young idealistic school teacher who probably had all of the odds stacked against him in terms of falling in love with Aboriginal culture when he moved from the big city of Melbourne to the remote community of Yakanarra. He simply wanted to make a difference and now blogs regularly about his experiences. I was inspired by his story due to its potential to encourage others to simply 'have a go' which is a great place to start. The focus of this is to share the merging of cultural and clinical expertise and evidence based practice with our members. To achieve this is to achieve equity in access to best practice mental health programs and services for our people. A truly exciting possibility and one which I hope you will all embrace as we try to navigate our way through this challenge.

"We are very passionate about debunking the myth that non-Indigenous people cannot be effective in working with Aboriginal people"

The launch of something so significant inevitably takes me back to my early days as a young idealistic 15 year old who decided emphatically that I 'wanted to be a psychologist'. Of course this was a very 'normal' thing for an Aboriginal kid growing up in the remote Pilbara area of Western Australia to do. It was even more daunting given that I had to do most of my study by 'school of the air' – effectively teaching myself. I still recall the day when I was offered a place at the University of Western Australia to study psychology. This was someone who had never seen a library; never caught a bus; and the first lecture I attended was around 100 times the population of my home town. The culture shock was significant. I lasted three years and it is fair to say, left with my tail between my legs questioning whether I could or wanted to be a psychologist. I spent seven years working through the regions of Kalgoorlie and central desert communities and finally was able to start to reconcile the benefit of science merged with culture…..

Obviously the journey that little kid with a dream to where I am now means that anything is now possible and that excites me for this current and future generations. When my mother was born, she was not a citizen of this country and did not become so until she attended Port Hedland court in 1964. Never in her lifetime would she have thought it possible to raise 5 children who have all achieved considerable success and had opportunities that she never had available to her. I was also VERY fortunate to have been looked after and mentored by so many of my people and also non-Aboriginal people who saw something in me and so my 'Mentor Challenge' below to you all!

Dr Tracy Westerman's Final Workshops for 2016

Sydney

Mental Health Assessment of Aboriginal Clients 22 & 23 November

Suicide Prevention in Aboriginal Communities 24 & 25 November

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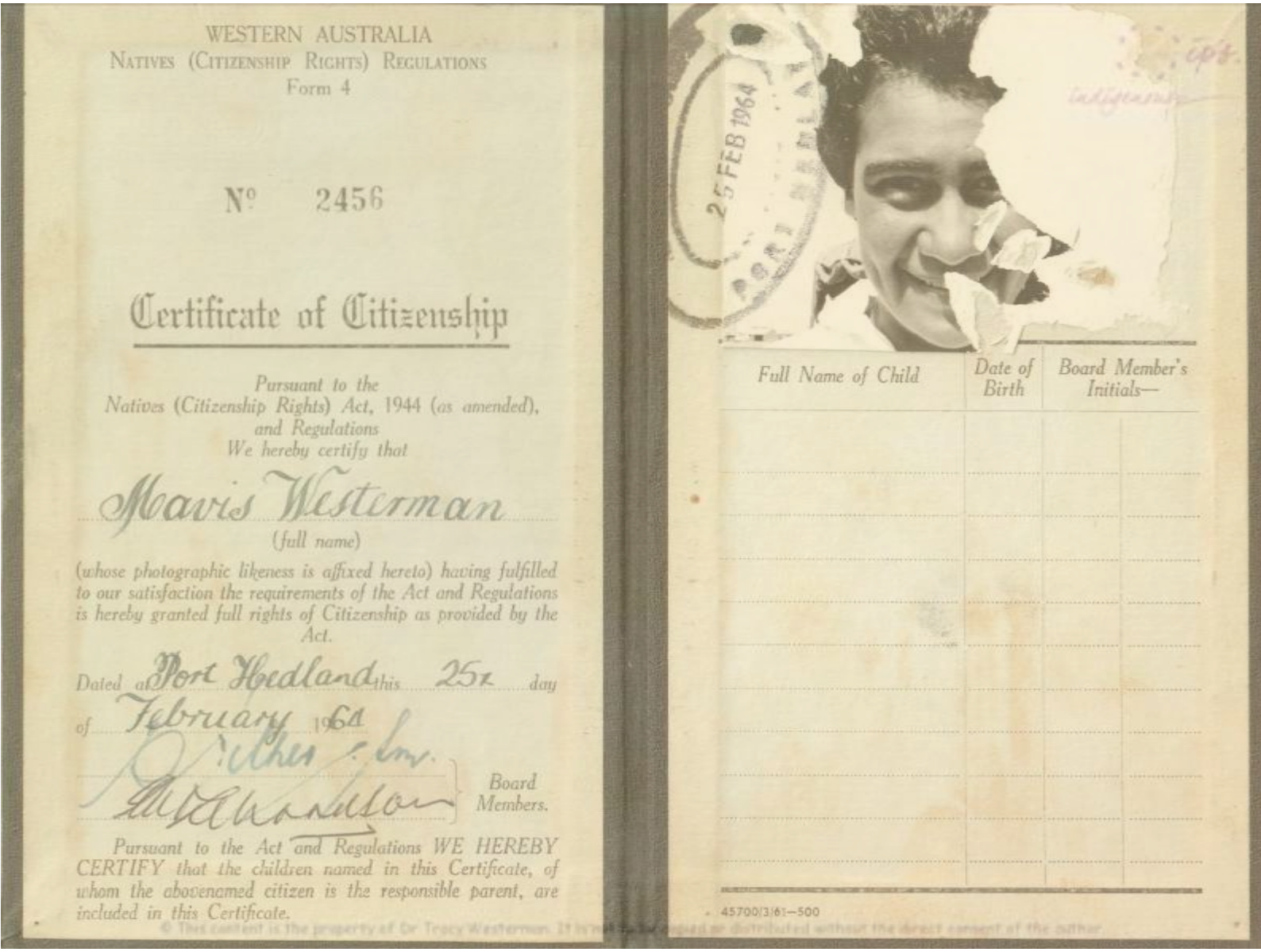
"When my mother was born, she was not a citizen of this country and did not become so until she attended Port Hedland court in 1964. Never in her lifetime would she have thought it possible to raise 5 children who have all achieved considerable success and had opportunities that she never had available to her."



WESTERN AUSTRALIA
NATIVES (CITIZENSHIP RIGHTS) REGULATIONS
Form 4

Nº 2456

Certificate of Citizenship

Pursuant to the
Natives (Citizenship Rights) Act, 1944 (as amended),
and Regulations
We hereby certify that

Mavis Westerman
(full name)

(whose photographic likeness is affixed hereto) having fulfilled to our satisfaction the requirements of the Act and Regulations is hereby granted full rights of Citizenship as provided by the Act.

Dated at Port Hedland this 25th day
of February 1964

Board Members.

Pursuant to the Act and Regulations WE HEREBY CERTIFY that the children named in this Certificate, of whom the abovenamed citizen is the responsible parent, are included in this Certificate.

25 FEB 1964

Full Name of Child	Date of Birth	Board Member's Initials—

45700/3/61—500

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TALKING TWO WAY

Andy Reed was based in Yakanarra, a small Aboriginal community in the Kimberley region of WA, for two years as a high school and music specialist teacher. After returning to Melbourne, he created a blog 'Sweet Home Yakanarra' to document his experiences. He is currently studying Anthropology and Australian Indigenous Studies at Monash University and hopes to complete an Honours around Indigenous Education. Andy visits Yakanarra every year to run a holiday program.

By Andy Reed

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In 2013 I returned to Australia from a two year trip around Europe. I had worn out my working holiday visa through joining the masses of antipodeans residing in London, living out what seemed to be some sort of cultural rite of passage for Australians. When the visa had expired I was disheartened by the idea of returning to my life in Melbourne; one unit of the privileged, colonial offspring, re-joining the pack? I felt that there had to be more for me waiting back home in the 'lucky county' than this.

Now that I am living back in the 'real world' I get asked quite regularly: 'What made you

want to live and work as a teacher in a remote Indigenous community for two years?' It's at this early juncture in the story that it becomes really clear to me the answers. There was a restlessness; a desire to know more about my own country; a book called the Secret River and the realisation that I was 28, an

I couldn't handle hearing another conversation or reading another article about Indigenous affairs in Australia until I had actually met an Indigenous person. It was time to detribalise. I wanted to feel like a foreigner in my own country and to be as far from home as I could without needing my passport or applying for

Australian citizen, and had never actually shared a conversation/laugh/story/brief moment in time with an Indigenous Australian person.

In addition, I feel I was in need of some answers. The negativity and stigma around Indigenous Australians was something I commonly heard from a variety of different sources throughout my life and it always confused me: If you have never had any contact with an Indigenous person, you actually don't know much about it all, right? From a young age, up and until my late twenties there was this, what seemed to me, misinformed opinion of Indigenous Australians surfacing more and more. People from all walks of life spilling misinformation and polluting the air over some beers at the pub/in their workplace/at a hostel; reciting something they read online or heard from a friend. But I kept asking myself: how do you pass judgment on something you have never actually experienced or seen?

a visa. I wanted an experience that would be like no other I had felt thus far in my life, and from my time living with the Indigenous people of Yakanarra community in the remote Kimberly desert, I would have an experience that I would wish for every Australian at some point in their life. One that will put to rest all of your cultural conditioning around Indigenous Australia

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and will allow you to see this country and all its people, far more complete.

With just enough time for Christmas and some drinks with old friends after returning home from Europe, it wasn't until I was actually driving my trusty Landcruiser on the open road that I had any real feelings about what the next year of my life might be like. Once they found out where I was going, random roadhouse workers and caravan caretakers on the way up north didn't help my musings, passing on the full array of horror stories of people that moved into remote Australia - I was starting to believe the movie, Wake in Fright, might have been based on a true story! Crocodile attacks, racist brawls and stories of people losing their minds from the isolation and heat, or whitefellas fleeing communities in fear of their safety, and teachers lasting less than a week in Indigenous classrooms before going home everyone had a story to tell.A fear of the unknown started to come on strong as I was watching the terrain change from greys and dull greens into reds, bright blues and vivid greens. What were the people of Yakanarra going to be like? Would they accept me into their community? Would they be able to understand me when I spoke? I knew that English wasn't their first language. What was I going to teach them? Would they feel hostile towards me for coming and living on their land?

Most of these questions were answered very quickly during the days after I entered the gates of Yakanarra however, others changed and evolved as my perspective shifted over the two years living with the mob. I find it equal parts amusing and alarming now, how little I knew before my time living and working with the people of Yakanarra community. I quickly realized that I was now the 'Other', the uninitiated, the un-educated and that my skill set – although I was well educated and reasonably well rounded from a mainstream perspective –could not have ever prepared me for the next two years of my life. I was in the deep end, swimming in unchartered waters, or any other whitefella analogies that you care to throw out there. There was a part of me rushed with adrenaline whilst simultaneously feeling slightly overwhelmed and dumbfounded by how much I needed to learn.

I decided that I would work on an approach to living and functioning in my new environment and I liked the idea of 'adjusting my lens.' It was a practice that I actively engaged in for the entire time I was living in Yakanarra. I couldn't view this experience through the lens that I had been looking through my entire life – why would I? It would only cloud my view and confuse things in this vastly different place that I was now living in. I'll confess, this was a process and not something that happened quickly but with time, patience for myself and from the community along with a large dose of empathy, I began navigating my way through the many obstacles and hurdles that would arise when you move your life into a remote Indigenous community.

On reflection, the experience was a mine field of potential awkward but often hilarious experiences. From cheekily asking my high school class who was dating who – only to be told that everyone in my class is family and that there was an incredibly complex kinship system to understand, to embarking on a hunting trip with the boys only to make it an hour in, drenched in sweat and sitting under the only tree for kilometers with a thumping headache and possible heat stroke.

In contrast, however, there were many trying times where it was much harder to activate my sense of humour. The sheer natural surroundings were so unforgiving, the desert heat and flies were unbearable at times. In addition, I now know, it is no easy task being the minority in a community. The frustration of being misunderstood or feeling excluded as an outsider was something I ruminated over regularly. However, here again is where adjusting the lens helped – I had no right to Indigenous knowledge, this experience wasn't just about me and what I could get out of it. It was about the community of Yakanarra having the patience and the humility to allow this white interloper from the city a chance to grasp just a tiny insight into what life is really like in remote Indigenous Australia. Despite me so badly wanting to breakdown cultural barriers or constructs such as race to arrive at a place where mainstream and Indigenous Australians could share the same space and time with no prejudice or anger… I needed to be aware that this is not about me and I should be humbled to learn what I can and feel privileged for every moment – flies and all.

Great interest overseas

Overseas visitors are greatly interested in Aboriginal culture and life. Between 85 and 95% of them want to experience it].

They look for an authentic experience with "the world's most ancient, living culture" and want to learn about traditional and contemporary practices.

Most Australians shun Aboriginal culture. In 2010, only 0.5% of domestic visitors sought an Aboriginal experience , in 2009 it was about 3% .

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There was most definitely a degree of culture stress occurring in my environment from being the outsider in the community. However, instead of falling prey to my knee jerk reaction to see something as wrong (which always caused me stress), I decided I would see it as interesting. By doing this and viewing the world through their lens for two years, the people of Yakanarra gave me such an incredible perspective and this allowed me to function and not flee for the comfort and security of my home back in Melbourne. The frustration around the community and within the Fitzroy Valley was palpable. I began to understand the high turnover of staff within schools or how people got tied-up in racist conversations at the pub or in the supermarket – the outsiders in these remote communities were not always coping with this culture stress. It was too much to bear, it was challenging too many of their beliefs and values and they didn't want to, or perhaps know how to, empathise with another way of knowing their beloved country, Australia.

the desire to spray some positivity and to share this experiential knowledge through shining some light into the misguided and ill-informed consciousness around Indigenous Australia. Lastly, I have come to realize the last thing the Indigenous of Australia need are fearless crusaders from all over the country flocking to the outback on a journey of self-discovery to try and 'fix the problem'.

An open mind, an empathetic approach, patience and time will be quite enough to pack in your suitcase for this trip. Leave your 'Plans to Save the World' at home. Develop an approach to how you plan to tackle things like culture stress, being the minority and realizing your way of knowing is very likely not going to align with the people you are working/socialising/ living with. Question and be critical of your

Here I found a large part of the reason why mainstream people fuel the negative stigma in remote Indigenous Australia – they cannot let go of learnt, colonial, belief systems and come to terms with the fact that, despite the fact we are all sharing this piece of dirt now called Australia, there is more than one way to live out a life on it. This xenophobia which we are prone to in the mainstream is crushing any chance for healthy cross-cultural interaction to take place and it saddens me deeply after my two incredible years living in Yakanarra.

Within the whirlwind two years I lived with the mob in Yakanarra I caught my first Barramundi, ate Goanna, Kangaroo and Boab nuts; I hunted wild pig and ate bush turkey. I travelled more kilometers, dodged more cattle and saw more awe inspiring sunsets than any other two years of my life. I had my values and morals challenged regularly and consequently saw my prejudices and misconceptions crushed. I have come out the other side of this experience with

reasons for wanting to work in an Indigenous community and in any way possible, educate yourself before you embark on your journey.

In hindsight, I did some of these steps to prepare myself but not enough. Cross-cultural experiences are vital for creating a society based on understandings of difference but they are also prone to failure even with good intentions and kind heartedness. Engage your empathetic capabilities and if you are heading remote, pack lots of Aeroguard, make sure you are with Telstra and if you are heading north don't forget your hat – I'll hopefully see you out there.

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IPS' Aboriginal Mental Health Cultural Competency Programs

IPS has been at the forefront of research, development and delivery of Aboriginal mental health cultural competency intervention programs (CCIPs) since 1998. Dr Westerman, developed the first scientifically validated measure of Aboriginal Mental Health Cultural Competence which is able to be completed online at (https://www.indigenouspsychservices.com.au/questionnaire.php). As an IPS member you also receive 10% off the price of any of these products.

The value of the CCP is that IPS is able to provide a baseline gauge of the cultural competencies of organisations and individuals. The CCP is completed on-line and a feedback report is provided that details an individual's 'baseline' skills across all five areas of cultural competency but also includes analysis of what the individuals scores mean in relation to their ability to work with Aboriginal clients. The report also provides specific strategies to ensure improvement of these skills deficits over time. Effectively the CCP feedback becomes a Cultural Supervision Plan which can be utilised by the participant as a blueprint for their cultural skills development needs into the future. Additionally, as the CCP has been normed, scores can also be compared to the 'average' level of cultural competency in the Australian workforce.

CAN ORGANISATIONAL CULTURAL COMPETENCY BE DETERMINED

Yes, IPS is also able to provide a measure or gauge of a whole of organisation level of cultural competency. Many organisations use this information as part of the Key Performance Indicators (KPIs) on an annual basis. It enables organisations to now only track improvements but also measure the impact of cultural awareness or competency strategies in the workplace.

For more information go to https://www.indigenouspsychservices.com.au/staticpage.php?static_id=8 for or contact IPS to discuss your organisations needs

THE EFFECTS OF RACISM ON INDIGENOUS AUSTRALIANS

By Professor Yin Paradies

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Situating racism within colonisation

Colonisation in relation to indigenous peoples encompasses practices, such as invasion, displacement, forced labour, removal of children, relocation, ecological & destruction, massacres, genocide, slavery, (un)intentional spread of deadly diseases, banning of indigenous languages, regulation of marriage, assimilation and suppression of social, cultural and spiritual practices (Paradies 2016a).

As noted by Rowse (2015), debates about the 'plight of indigenous peoples' fall into two divergent models. The first model appeals to a 'community of fate' rooted in an unbroken line of indigenous colonial disenfranchisement that requires "a massive and continuing project of social control" (Rowse 2015: 15)

In Australia (and elsewhere) colonialism is an ongoing process (Wolfe 1999) which Glenn (2015: 62) contends has "often swung (and still does) between the poles of elimination and coercive exploitation". Racism has similarly been defined as oscillating between extermination and exploitation (Hage 2015). And, in fact, it is largely through societal systems of racism that colonial structures maintain material and political privilege.

The first model fails to account for ebbs and flows in the 'fates' of indigenous people over space and time, and is particularly ill-suited to explaining pockets of 'indigenous flourishing' within settler-colonial states (Rowse 2015: 20). On the other hand, the second model disregards origins of the 'cycle of disadvantage' while also discounting colonisation as an ongoing system of oppression, thus fuelling a focus on individual responsibility and victim-blaming (Neale 2013).

Defining racism

Racism can be conceptualised as unfair and avoidable disparities in resources, power, opportunities or capacities based on ethnic, racial, religious or cultural differences. Racism can manifest through cognitive beliefs (e.g. stereotypes), feelings (e.g. anxiety) or behaviours / practices that are discriminatory. Although not mutually exclusive, racism can occur at three levels: internalised, interpersonal or systemic racism.

Internalised racism entails viewing one's own ethnic/racial group as inferior or considering one or more other ethnic/racial groups as superior (Paradies et al. 2009). Recognising and responding to internalised racism means grappling with how, for both Indigenous and non-Indigenous people, 'one's values, knowledge and life experience are heavily influenced by racism', often at an unconscious level (Ife 2013, p. 344).

Interpersonal racism can happen between people from within the same racial group (i.e. intraracial racism between two Indigenous people) or between people of difference racial groups (i.e. interracial racism involving an Indigenous person and a non-Indigenous person). In Indigenous communities, intraracial racism is also known as 'lateral violence' (Dudgeon, Garvey & Pickett 2000).

Systemic racism (also called institutional or organisational racism) encompasses a range of practices, policies or processes such as sub- standard health care for Indigenous people) (Berman & Paradies 2010). Efforts to 'help' Indigenous people participate in mainstream culture (e.g. the economy, education) often fail to account for the many ways in which Indigenous people are 'prevented from enjoying the full benefits of the dominant culture through racist exclusion' (Ife 2013, p. 201).

Indigenous people's experiences of racism

There is a considerable range in the reporting of racism among Indigenous Australians: between 16% and 97% (see specific studies detailed below). This is due to factors such as variations in specific geographical locations involved, the length of utilised surveys and differences in wording used. Although almost all representative surveys to date have focused on adults, the 2001–02 Western Australian Aboriginal Child Health Survey involved 1073 children (aged 12–17 years), of whom 22% reported racism experiences in the past six months (i.e. service refusal or bad treatment because of their Indigeneity) (Zubrick et al. 2005).

For example, a 2011 survey of 172 Indigenous university staff found that 60% experienced lateral violence in the workplace, mainly from other Indigenous colleagues (National Indigenous Unit of the National Tertiary Education Union 2011).

The 2002-03 National Aboriginal and Torres Strait Islander Social Survey asked Indigenous adults about experiencing discrimination as a personal stressor in the past 12 months: 18% of the 9400 participants reported such an experience (Australian Bureau of Statistics 2004). The 2004-05 National Aboriginal and Torres Strait Islander Health Survey included 5,757 Indigenous adults who were asked whether they felt treated badly because they were Indigenous in the past year: about 16% responded in the affirmative (Paradies 2007). A few years later, 27% of 7000 adults in the 2008-09 National Aboriginal and Torres Strait Islander Social Survey reported experiences of racism (Cunningham & Paradies 2013).

Nationally representative surveys include early work by Dunn & Geeraert (2003), which found around 30% of Indigenous adults in a 2001 survey reporting racism experiences.

More localised area-based studies, such as the 2006-08 Aboriginal Birth Cohort study in the Northern Territory,

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found about a third (32%) of 345 Indigenous adults had experienced racism (Priest, Paradies, Gunthorpe, Cairney & Sayers 2011), while the vast majority (97%) of 755 Indigenous adults participating in a study across four Victorian communities had experienced racism at least once in the past year (Ferdinand, Paradies & Kelaher 2012). Based on the 'LEAD' survey, this study also found that almost three quarters of the respondents anticipated, sometimes, often or very often, that others would say or do something racist. In addition, about two thirds of participants attempted to avoid specific situations because of racism, sometimes, often or very often. Nearly 70% of Indigenous adults in this study noted that they sometimes, often or very often worry about racism.

The most prevalent forms of racism experienced by Indigenous Victorians in the

LEAD study were race-based teasing, jokes, exclusion or stereotypes. However, more than half also reported severe manifestations of racism, including property vandalisation, with two thirds having been spat at or had something thrown at them (Ferdinand, Paradies & Kelaher 2012).

In addition, lateral violence has been examined through several qualitative studies (Bennett 2014; Boladeras 2002; Dudgeon, Garvey & Pickett 2000; National Indigenous Unit of the National Tertiary Education Union 2011). In an Indigenous context, lateral violence often centres on Indigenous authenticity (e.g. skin colour or cultural knowledge) and can manifest as innuendo, exclusion, insults, sabotage, undermining, scapegoating, backstabbing or failure to respect privacy (Bennett 2014).

The widespread presence systemic racism for Indigenous people has been documented in areas such as employment (Booth, Leigh & Varganova 2012), housing (Equal Opportunity Commission of Western Australia 2004), education (Bodkin-Andrews, Denson & Bansel 2013), politics (Augoustinos, Tuffin & Rapley 1999), media (Cunneen 2001), welfare (Sanders 1999) and law enforcement (Blagg, Morgan, Cunneen & Ferrante 2005). For example, in comparison to non-Indigenous youth who commit the same crime, Indigenous youth are 2-3 times more likely to be arrested and charged with an offence in Victoria (The Department of Justice 2005, 2006). A further example pertains to a study in which 4000 fictional resumes were sent in response to job advertisements. Despite these resumes detailing equally qualified and experienced applications, resumes with Indigenous names attracted 35% fewer interviews than resumes with Anglo names (Booth, Leigh & Varganova 2012). A more recent study using a similar method found evidence that Black people (including Indigenous Australians) were also discriminated against on public transport (Mujcic & Frijters 2013).

The impacts of racism on Indigenous health

Overall, racism can result in negative health impacts through several key pathways:

- **Cognitive, emotional and physical strain, stress or damage impacting upon spiritual, social, physical and mental wellbeing;**
- **Heightened contact with health- damaging exposures (e.g. toxic substances);**
- **Reduced engagement in adaptive behaviours (e.g. physical activity);**
- **Compromised access to key health- promoting settings (e.g. education);**
- **Attenuated benefit from everyday routine activities (e.g. sleep); and**
- **Maladaptive behaviours (e.g. alcohol and drug use) (Paradies et al. 2013).**

In the Australian Indigenous context specifically, there is evidence supporting most of these pathways. Among adults, racism has been assocaited with: poor self-assessed health status, psychological distress, diabetes, smoking and substance use in the 2004-05 National Aboriginal and Torres Strait Islander Health Survey; poor self-assessed health status and depression in the Darwin Region Urban Indigenous Diabetes study (Paradies &Cunningham 2012a & 2012b); mental ill-health in the Adelaide Indigenous Urban Location and Health project (Ziersch et al., 2011); reduced general physical and mental health in a Western Australian study (Larson et al., 2007); and poor oral health outcomes among pregnant Indigenous women in South Australia (Ben et al. 2014a & 2014b).

Among Indigenous youth, racism has also been associated with increased alcohol, tobacco and marijuana use alongside emotional/ behavioural difficulties and suicidal thoughts in the Western Australian Aboriginal Child Health Survey (Zubrick et al., 2005); anxiety, depression, suicide risk, mental ill-health and poor oral health in the Aboriginal Birth Cohort study (Jamieson et al., 2011; Priest et al., 2011) ; and poor general/mental health and depression among Indigenous youth in Victoria (Priest et al., 2011).

Although there are numerous studies examining systemic racism within healthcare settings (e.g. Cunningahm 2002; Coory & Walsh 2005; Condon 2014), there is much less scholarship examining the health impacts of systemic racism per se in the Australian Indigenous context. Another fruitful avenue for future research is to examine the health impacts of colonisation, operationalised as historical loss, trauma, consciousness or as collective, intergenerational or multigenerational trauma, with research on this topic now emerging in North America (Paradies 2016a).

For example, a recent study found that a higher level of historical trauma among Native Hawaiian students was directly associated with reduced substance use but

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alsoindirectly associated with increased substance use through higher levels of self-reported discrimination (Pokhrel and Herzog 2014), with Bombay et al. (2014) also noting a correlation between historical trauma and increased reports of racism. As suggested by Pokhrel and Herzog (2014), historical trauma may strengthen ethnic/ cultural identity, which, itself, has been associated with both greater self-reported racism and attenuation of its detrimental health impacts (Brondolo et al. 2009).

Other emerging work has detailed an association between experiences of racism and PTSD among Aboriginal Canadians (Currie 2012), whilst in Australia, a recently completed PhD found links between historical loss and trauma symptoms as well as between racism and trauma (Gee 2016). This thesis also demonstrated the beneficial impacts of resilience to trauma on health outcomes, something also demonstrated among First Nations peoples in the U.S., where one study found that cultural resilience compensated for the detrimental effect of racial discrimination on stress (Spence et al. 2016).

Indigenous responses to racism

There are a number of possible reactions and responses to racism (cognitive, affective, and behavioral), but, to date, there has been relatively little focus on associations with health (Brondolo et al., 2009). Although not all studies have found a significant relationship (Benjamins, 2013), research generally indicates that avoidant/passive coping tends to exacerbate the detrimental health impacts of racism while active coping ameliorates the ill-health effects of racism. More recent studies have begun to highlight the complex interplay between racial identity, racism, and coping (Paradies 2016b). In Australia, evidence from the Localities Embracing and Accepting Diversity (LEAD) project, found that among 755 Aboriginal respondents, accepting racism or just putting up with it were associated with higher levels of psychological distress (Ferdinand, Paradies & Kelaher 2012)

Culturally competent practice in response to racism

There are five key principles to reducing individual and inter-personal racism:

1. Present accurate information and foster awareness;
2. Promote egalitarian values and recognise incompatible beliefs;
3. Enhance empathy and perspective- taking
4. Increase comfort with other groups and reduce anxiety; and
5. Cultivate positive social norms and increase personal accountability (Paradies et al. 2009).

Reducing racial bias specifically can be achieved by:

- Developing motivation to avoid racial bias;
- Increasing perspective-taking and empathy;
- Understanding the psychology/ history of racial bias;
- Enhancing confidence and regulating emotional responses; and
- Focusing on individual patients apart from their social group (Chapman et al. 2013).

In a PhD thesis from the U.S., Elliot (2008) found that it is important to validate racist incidents at face value as a subjective experience that 'hurts' regardless of their 'objective' validity; remember that neither you nor those experiencing it are responsible for fixing racism, but rather for finding ways to cope with it; and accept expressions of anger and frustration as appropriate responses to racism. More recently, Malott & Schaefle (2015) suggest the need for foundational cultural awareness, knowledge, and skills, together with an understanding of racism as systemic issue to inform development of effective interventions adapted to the clients' preferences.

Structural changes to address racism

In relation to organisations, there are five key areas for addressing systemic racism:

1. Organisational accountability;
2. Human resources;
3. Partnership with community;
4. Research and evaluation; and
5. Anti-racism/cultural competence training.

Organisational accountability involves incorporating non-discriminatory standards across strategic plans, policies and performance indicators as well as developing non-discriminatory forms, guidelines, resources and protocols and auditing plans, policies, processes and practices. Such accountability requires visible and strong organisational leadership to combat racism and foster non-discriminatory social norms; efforts to foster positive intergroup contact in workplaces; and symbolic activities, such as welcome to country protocols and Aboriginal and Torres Strait Islander flags (Paradies et al. 2009; Trenerry, Franklin & Paradies 2010).

The organisation should conduct employee/ client satisfaction surveys, interviews and ongoing feedback sessions to respond to racist incidents and disparities (as well as implementing resolution and grievance procedures) and monitor complaints/feedback received, policies and procedures, hiring, promotion, performance reviews, salary levels, training, mentoring, turnover, absenteeism, mentoring and staff seniority by Aboriginal status (Paradies et al. 2009; Trenerry, Franklin & Paradies 2010).
Sufficient resources should be available to plan and implement collaborative activities; construct a collective organisational vision and clear communication strategy; and ensure transparent, accountable and responsive orientations to community needs. Local

knowledge and expertise should be drawn upon when forming community partnerships while remaining cognisant

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that there is no single 'Aboriginal community' but rather many Aboriginal people with a range of views, needs and ideas (Paradies et al. 2009; Trenerry, Franklin & Paradies 2010).

Anti-racism training requires formal stand- alone courses as well as informal mentoring and on-the-job training. It should focus on attitudes, beliefs and behaviours and incorporate both cultural awareness to facilitate improved communication and interaction with Aboriginal people as well as examination of one's own prejudices and ways to address racism in the workplace (see, for example, Ferdinand et al. 2014).

The aim of anti-racism training is to ensure that individuals:

1. Understand stereotyping, prejudice and bias and how to respond to racism;
2. Acknowledge and examine one's own racial identity and biases/prejudices but be willing to 'make mistakes' from a stance of cultural humility;
3. Apprehend affirmative action and diversity (e.g. similarities between and differences within groups);
4. Practise and promote empathy for (and dispel false beliefs about) diverse groups in society;
5. Support others to practise values such as a 'fair go' for all Australians and advocate for a more inclusive Australian identity; and
6. Foster opportunities for positive engagement between people from various religious, cultural, ethnic and racial groups (Paradies et al. 2009; Trenerry, Franklin & Paradies 2010).

In the next edition of Jilya we are excited to have Professor Gracelyn Smallwood provide an expert opinion piece for us.

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EMERGING LEADER

Dr Marjad Page

Emerging Leaders features young Indigenous people who are making an outstanding contribution in their communities, whether in academia, practice or community-led initiatives. This is part of the concept of Jilya, which is to nurture, promote and be proud of our next generation of future leaders. Our Managing Director, Dr Tracy Westerman has also challenged our members to mentor an Aboriginal person as a method of addressing lateral and other forms of racism. Future generations can then live without the struggles of previous generations.

Leaders talk about their work and their vision, the people in their life who have inspired them and how they overcame any challenges they faced. In our first Emerging Leaders article we talk with Dr Marjad Page, who is a Kalkadoon, Waanyi and Gangalidda boy, a Christian man and a General Practitioner hailing from Mount Isa in Queensland's north-west.

Marjad remembers when his dad, Ricky, worked for a few years in the mines to support the family. This was to have a significant influence on Marjad's future path, as one of the primary means in the town of feeding a family was associated with the degradation of traditional lands.

"He felt it was like punching your mother in the face", says Marjad of his dad's personal conflict about his work.

When Marjad was around 7 or 8 years old, Ricky told his son that he was not to work in the mines.

"He knew there was something better out there for me."

Marjad was guided towards an interest in health from an early age,
beginning when his great-grandmother foresaw that he would become a doctor. He also grew up witnessing

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the impacts of poor health on his people.

"I would see people going into the hospital and not coming out. I asked myself, 'what is it about these white walls'? It dumb founded me."

Marjad eventually left to begin university studies in Canberra, before going on to the Central Queensland University and later completing medical training at James Cook University. He was aware that the medical field would not necessarily teach culturally sensitive notions of health and healing, but was determined to continue.

"I knew that I had a job to do."

Marjad also realised that many non-Indigenous members of the medical profession had good intentions, though needed help to understand the dynamics of working with Aboriginal people's health.

"The people in the hospitals had big hearts, I felt like they cared."

However, Marjad has also encountered many difficulties within the health system.

"There is lots of institutional racism and, at times, sincere ignorance and conscientious stupidity.

"The local mob aren't understanding the education they're given about their health."

Marjad says that one way to address these issues is by having more Indigenous health professionals, who can actively change health care delivery from within. Marjad believes that there are now more opportunities for Aboriginal people to do just this.

"If you're an educated black person, you're in demand".

Another important part of more effective health care for Aboriginal people is a recognition of culture.

"Culture has an over-arching, endless source of meaning for Aboriginal people.

"You have to understand a people to help a people. We learned by stories."Marjad has taken this principle into his work with parents and babies, creating an antenatal Dreamtime story to help teach Aboriginal patients about good maternal and child health. He identifies that using stories such as these immediately acknowledges the importance of being Aboriginal and takes patients' cultural background seriously.

"I can take them on a journey", says Marjad of the program's approach. "People are competent once the information is presented in a culturally appropriate way."

When asked about the people who have inspired him and kept him focused, Marjad immediately discusses his family.

"My mother was a calming influence on me and my dad provided me with motivation. Dad gave me a sword and mum made sure it was ready to go."

Marjad also remembers his nan and pop as big supporters of his parents. However, he says that it's not just about immediate family; there are many people in a community who help make you who you are. There was Stretch the basketball coach who helped teach Marjad the importance of honesty and hard work. Scott and Karen Longdon at Central Queensland University also provided crucial academic support.

"They taught me how to get through university. I was so raw when I went".

Marjad remains humble about his achievements, instead crediting the support of those around him and acknowledging the enormous intelligence, talent and passion of Mount Isa's community members. When asked what advice he would give to Aboriginal people considering entering the health or medical professions, Marjad talks to the importance of standing strong in your sense of self.

"Give it a go, but know who you are and what you stand for. Stay grounded."

DID YOU KNOW:

103 Is the Rank of Aboriginal Australians on the United Nations Index of Human Development (which considers life expectancy, literacy and standard of living)

4 is the Rank of all Australians on the United Nations index.

Having more Indigenous doctors such as Marjad helps us to close this gap

Marjad has observed that bad decisions can be made when Indigenous and non-Indigenous people are not connected to their community and do not know what is happening on the ground. For this he offers a second important piece of advice.

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"Don't lose touch with your community, keep your finger on the pulse."

In the next edition of Jilya we talk to young Aboriginal mental health worker Kristen Ella who is doing great things in this field. We continue to celebrate our emerging leaders…

The Number of registered Indigenous doctors has doubled in the past decade, boosting efforts to improve the health of Aboriginal and Torres Strait Islander communities. The Australian Indigenous Doctors' Association has reported that 204 Indigenous medical doctors are now registered to practise - up from 90 in 2004 - and there are currently 310 Indigenous students studying medicine.

This is worth celebrating

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FEATURE ARTICLE: TRAUMA AND ATTACHMENT IN ABORIGINAL POPULATIONS

By
Dr Tracy Westerman *(PGDipPsych, MPsych,PhD)*
Steve Meyer *(BAppPsych, GradDipPsych)*

PART 1: CONCEPTS AND DEFINITIONS

Strong child-caregiver bonds and secure family environments are a critical means through which cycles of deep historical and intergenerational trauma can be healed. But how relevant are conventional concepts of attachment and trauma to Aboriginal people in Australia? How can trauma and attachment disruption be transmitted from generation to generation and most importantly - is there a specific aetiology that must be considered with Aboriginal people? What makes for a culturally sensitive therapeutic program and what's already out there? Finally, what are some current and emerging approaches to strengthening attachment and addressing trauma? These questions will be explored across a two-part series on trauma and attachment in Aboriginal Australian communities in this edition of Jilya and the next.

Background

Indigenous peoples globally face the impacts of intergenerational trauma, resulting from experiences of colonisation and enduring structural violence (Kirmayer, Gone & Moses, 2014). It is clear that those who have been colonised consistently experience the highest rates of suicide and mental ill health. For Aboriginal Australians the additional impacts are in policies of assimilation which resulted in the direct destruction of parental and attachment bonds, the impacts of which remain to this day. The Stolen Generations which represent those who were removed represent a significant cause of this trauma. According to Atkinson, in 2008, an estimated 8% of Indigenous people aged 15 and over reported being removed from their natural family and 38% had relatives who had been removed from their natural family (ABS 2009). This trauma can pass to children (inter-generational trauma) and lead to ongoing attachment disruption.

In addition to these factors, there is also research which supports the fact that experiences of racism and the compounded nature of this impacts upon Aboriginal people and communities in a similar way to a traumatic event otherwise known as 'cultural paranoia' or acculturative stress (Bryant-Davis & Ocampo,

2005; Helms, Nicolas & Green, 2012; Paradies, 2006). Such trauma is extraordinarily complex and can reverberate across individuals as well as communities as experiences of racism have been demonstrated to result in the increased likelihood of trauma responses (Aguiar & Halseth, 2015; DeMaio et al., 2005; Fast & Collin- Vézina, 2010; Ryan, 2011). Those impacted often experience a raft of inter-related and comorbid issues such as interpersonal violence, substance abuse and various mental health problems including depression, anxiety (Denham, 2008; Schimmenti & Bifulco, 2015) and increased risk of suicide (Priest et al., 2011). This has a clear impact on the wellbeing of these individuals and the health of the family environment, as well as caregivers' capacity to develop secure attachments with their own children. However, it is also clear that there are significant individual and community factors that are able to moderate these impacts which warrant exploration and provide opportunities for a reconceptualization of trauma and attachment theory. This in turn provides us with opportunities to incorporate such cultural issues within the treatment of attachment at the individual and community levels.

In 2013-14, Aboriginal children and young people represented 35% of all children placed in out-of-home care; almost 10 times the rate of non-Indigenous children (AIHW, 2015).

This appalling statistic compels us to deconstruct not just individual and family- level contributing factors, but also the multiple contemporary and historical causes of trauma and attachment disruption in Aboriginal communities. We must ask if conventional definitions of trauma and attachment are useful to Aboriginal families, as the manner in which we conceptualise these phenomena contributes to child

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protection and therapeutic decision making. It also impacts upon communities' own narratives of their history and experiences. It is clear, however, that incorporating racism as a component of the trauma sequelae provides at least a starting point for exploration of a different aetiology for the development of trauma. In addition to this, notions of causality as well as culture-bound syndromes as differential diagnosis must also better explored and understood.

It is surmised that these factors may provide an essential starting point to a more complete picture of attachment and trauma, and vitally provide opportunities for prevention and early intervention efforts to be more clearly directed towards protecting individuals and communities from these impacts (Westerman, 2012). This article intends to explore issues of aetiology, with our next article in the second edition of Jilya exploring how such factors have been incorporated in successful treatment programs.

Revisiting conventional definitions of attachment

The transmission of intergenerational trauma is multi-factorial, involving biological, psychological, cultural, spiritual and structural elements. Attachment bonds, which are influenced by all of these factors, are perhaps one of the most researched key mechanisms in Western psychology. Attachment can be directly observed and changes can be measured, making it a useful construct for both clinical and research settings. Classical attachment theory considers attachment as the bond between a primary caregiver and a child (e.g., Ainsworth & Bowlby, 1991; Bowlby, 1969). This relationship provides a secure base for the child as he or she develops. Patterns of attachment have implications across the life span, with experiences in the first two years of life being the most critical. When a caregiver is attuned and consistent, the child develops 'secure attachment'. This results in the capacity for self-regulation and a conceptualisation of the world as an essentially safe place. The child is then able to form healthy relationships with others into adulthood; this is linked with a range of positive outcomes including better health, education, mental health and other positive outcomes for the individual (reference). However, when caregivers have unresolved trauma, their capacity to be consistently nurturing can be impacted (Murphy et al., 2013). Simply put, the attachment style of the parent has the potential to indelibly impact upon the attachment style of the child (Rahim, 2014). The likelihood of secure attachment stems from the parent's capacity to respond to the whole range of positive and negative emotions in the child. The more this capacity is restricted, the greater the probability that attachment will be impacted upon.

Attachment begins before the child is born. Rossen et al. (2016) examined the role of antenatal bonding, substance misuse and mental health issues in postnatal attachment patterns at eight weeks. The study drew from a sample of 372 Australian mothers from three metropolitan hospitals. It was revealed that the strength of the bond between the mother and child at all prenatal stages reliably predicted the strength of postnatal attachment. Symptoms of depression in the second and third trimester and stress in the second trimester were associated with poorer mother-child bonding at 8 weeks. These results highlight the importance of ensuring good maternal health during pregnancy as a means of promoting secure postnatal bonding and attachment, as has been suggested in other research (Roy, 2014).

DSM-5 classification of attachment disruption and childhood trauma

According to the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5), attachment disruption tends to result in two main categories of behaviour: emotionally withdrawn and inhibited; and indiscriminately social and uninhibited (Zeanah & Gleason, 2015). Based on these categories, Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED) are two commonly diagnosed outcomes of severe attachment disruption.

Young children with RAD exhibit a lack of connection to a primary caregiver and a tendency not to seek comfort when distressed. These children have difficulty demonstrating reciprocity in social exchanges. Their emotional landscape is dominated by fearfulness and irritability and experiences of positive emotions are usually fleeting. Children diagnosed with DSED are observed to indiscriminately or inappropriately approach unfamiliar adults and are often willing to wander off with them. Interpersonal and behavioural difficulties appear to continue in these children as they grow into adolescence (Zeanah & Gleason, 2015).

Alternative perspectives to DSM-based attachment disorders in children

Van der Kolk (2005) proposes Developmental Trauma Disorder to extend upon DSM conceptualisations and describe the symptoms experienced by children subjected to chronic trauma and attachment disruption. This recognises that while many of these children are diagnosed with PTSD or attachment disorders, these categories do not account for the developmental impacts and complexity of childhood trauma (D'Andrea et al., 2012; Ford et al. 2013; Perry & Hambrick, 2008; Rahim, 2014). A perspective such as Developmental Trauma Disorder moves us closer to contextualising the behaviour of Aboriginal children and young people affected by early trauma.

Children with Developmental Trauma Disorder feel intense emotion such as rage, betrayal, shame, fear and defeat. They attempt to

prevent these emotions by avoiding associated situations and experiences. Children may behaviourally (and unconsciously) re-enact their traumas in an attempt to resolve them or to establish a sense of control, by using aggressive behaviours and other forms of acting out or through 'freezing' and avoidance reactions. Such chronic

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levels of trauma often further result in somatic symptoms such as abdominal pain and headaches (Van der Kolk).

Van der Kolk (2005) discusses how children with complex trauma become hypervigilant and sensitised to threat. They may perceive danger in their environment even where there is none. This can result in heightened emotional and physiological reactions to apparently minor stimuli, followed by difficulty with calming and re-settling the nervous system. Children with Developmental Trauma Disorder form the view that the world is not safe and anticipate the recurrence of traumas. They can have great trouble forming and maintaining trust in caregivers and may make negative attributions about themselves. These children frequently come to orient their relationships around the expectation and avoidance of victimisation or abandonment.

Neurobiological perspectives on attachment in children

The neurobiology of trauma assists us to understand some of the 'universalities' of brain development which may interact with culturally-based manifestations of trauma.

Neurosequential model of development

Perry and Hambrick (2008) suggest that the brain follows principles of hierarchical organisation, where certain developmental tasks precede others and are in fact necessary for subsequent tasks to unfold. Evolutionarily older parts of the brain responsible for more basic functions such as balance, movement and coordination develop first, with higher cortical functions such as decision-making, judgement and reasoning developing last. Secure attachment experiences allow the brain to achieve healthy development outcomes and enable children to continue into good mental health and functioning.

However, children subjected to early trauma from insecure or abusive environments are at risk of developing problems in global development. This involves changes in neurochemical activity (e.g., in serotonin, dopamine and norepinephrine), which in turn affects the functionality of entire integrated biological systems and networks regulating attention, mood, memory and central nervous system arousal. As a result, children may have issues with behaviour, learning, motor skills, emotional control and social engagement. The child's developmental history is therefore critical to treatment planning. Therapeutic support must consider which hierarchical tasks of development need to be addressed first to effect change more globally. There is then less initial emphasis on conventional cognitive- focused interventions, which attempt to effect change through neurological systems (e.g., language, memory and attentional networks) that are not fully 'online' in children with developmental trauma.

Polyvagal perspective

Porges' polyvagal theory (Porges & Furman, 2011) holds that initially, feeding and ingestive behaviours are the primary means through which an infant's physiological state is regulated. This calls on more primitive circuitry between the brainstem and viscera. By around six months of age, the cortex begins to develop greater control over the brainstem. Feeding then gives way to reciprocal social interaction between the infant and caregivers as the primary regulatory mechanism. Our nervous systems have thus evolved not just to avoid danger, but to function socially in safe environments.

The respiratory sinus arrhythmia (RSA) reflects the state of vagal nerve regulation of the heart and provides a sensitive measure of an infant's emerging capacity for self-regulation (Dale et al., 2011). RSA is a 'naturally occurring rhythm in the heart rate pattern that oscillates at approximately the frequency of spontaneous breathing' (Porges & Furman, 2011, p. 110). Ideally, infants display a higher baseline RSA which consistently lowers during feeding and re-establishes afterwards. The RSA is most critically established from 30-32 weeks of gestational age up to the first six months of life. The number of myelinated vagal fibres then increases significantly from six months of age through to adolescence, which enables greater capacity for regulation of physiological and emotional state.

An infant's capacity for self-regulation is a key outcome of attachment. RSA and vagal function are affected by factors such as illness, environmental stressors and the stability of reciprocal social interaction with caregivers. Babies who are born preterm (i.e., before 30 weeks gestational age) tend to have a poorly developed myelinated vagus, meaning that they are largely unable to regulate their internal state and rely completely on their sympathetic nervous system for survival (Porges & Furman, 2011). Infants who experience such interruptions to their developmental trajectory require a particular increase in skin-to-skin contact and consistently safe, attuned interaction with caregivers to establish 'normal' physiological balance. Without these conditions, it is possible that the infant will continue to experience physiological, emotional, social and behavioural dysregulation into childhood, adolescence and adulthood.

Differential diagnoses – conventional classifications

Behavioural spectrum disorders

Complex developmental trauma and attachment disruption may share significant symptom overlap with DSM disorders such as ADHD, Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD). These diagnoses are not fundamentally trauma-sensitive (Ford, 2002; Greenwald, 2002; Schmid, Petermann & Fegert, 2013) and are often made principally on the

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basis of behavioural observation. This locates children's experiences as individual- level psychopathology, omitting broader contextual causes and important biomarkers of underlying physiological state. For example, research on electroencephalographic (EEG) phenotypes has revealed significant variation in underlying EEG patterns associated with ADHD-type presentations; behaviour-based assessment alone therefore cannot accurately pinpoint the biological sources of the presentation nor necessarily predict medication response (Arns et al., 2008; Gunkelman, 2006, 2014; Ogrim, Kropotov & Hestad, 2012; Olbrich, van Dinteren & Arns, 2015). There is ample established and emerging knowledge of biological, sociocultural and structural determinants of trauma to justify more holistic modes of assessment and a departure from behaviourally-centred categories of dysfunction, particularly in the case of Aboriginal children and young people.

Foetal Alcohol Syndrome (FAS)

Foetal alcohol syndrome (FAS) represents one of the more severe manifestations of a continuum of disorders that occur from prenatal alcohol exposure. In addition to characteristic alterations in facial structure, FAS can yield symptoms similar to developmental trauma and attachment disruption. This may include dysregulated CNS functioning and behavioural issues, cognitive delays and learning difficulties, impaired memory and concentration, difficulties with social interaction, communication and visual- motor integration, and increased vulnerability to psychiatric disorders (Fitzpatrick et al., 2012; Mattson, Crocker & Nguyen, 2011). There is very little information available about the prevalence of FAS nationally in Australia, though one study suggests that in some remote Aboriginal communities in WA it could be as high as 120 per 1000 births (Fitzpatrick et al., 2014). Aboriginal women are much less likely to drink during pregnancy than non-Indigenous women; the damage occurs because those women who do drink, tend to do so frequently and at high-risk levels (Fitzpatrick et al.).
Cultural differences in attachment

Mainstream attachment theory often fails to view attachment causal pathways through the lens of racism.

Additionally, there are a multitude of cultural issues which continue to be excluded from the conceptualisation of attachment and which require consideration. These include the concept of attachment to a primary carer (often the mother); the differential diagnostic issues that are created as a result of failing to understand cultural differences in attachment bonding and parenting; different attributions and manifestations of mental illnesses (e.g., culture bound syndromes); and finally, the impacts of racism on attachment. All of these issues will be discussed in this section with a view to providing an important framework for a more complete picture of the limitations of attachment theory when used with Aboriginal people.

The concept of the attachment relationship has been defined as being primarily between a child and one main caregiver, which is fundamentally Western. This limits its generalisability to traditional child rearing practices in many collective cultures, including those of Aboriginal Australians. Whilst there is no known research which has conceptualised or empirically validated an attachment schema or attachment type in Aboriginal people, what is known is that the scarcity of research on attachment in Aboriginal Australian societies greatly restricts the capacity to develop therapeutically effective programs addressing attachment disruption.

We are then left to look to two solid bodies of research that add to the conceptual framework. The first concerns attachment outcomes for those children who are raised in collective cultures, such as Aboriginal Australians, and those raised in Westernised cultures in which children are reliant on a nuclear family to

provide for all of their attachment and emotional needs. What is consistent in the research is that those cultures who 'share the parenting' of children consistently have a greater likelihood that the child will develop secure attachment. The early research of Kearins (1984) and Goodnow (1988) supports this assertion; they consistently demonstrated that childhood development is, amongst other things, more robust across most developmental milestones in Aboriginal cultures. Unfortunately, these differences in child-rearing are often seen as deficits in mainstream environments (Kearins); a clear understanding of Aboriginal Australians' attachment dynamics is therefore vital to thorough assessment and treatment.

Cultural Parenting Differences

The research tells us that traditional Aboriginal Australian approaches to child-rearing create ideal conditions for secure attachment outcomes (e.g., Kearins, 1984; Goodnow, 1988; Ryan, 2011; Lohoar, Butera & Kennedy, 2014; Yeo, 2003).

Aboriginal children traditionally have access to a greater number of primary attachment figures who persist throughout their lives and increase the likelihood that all of their emotional needs are able to be responded to in a manner that ensures secure attachment. The concept of a 'whole community raising a child' is consistent with Aboriginal parenting styles. It increases the likelihood of secure attachment, as there is an expectation that the emotional needs and therefore attachment bonds that develop are a shared community responsibility (Kearins; Westerman, 2003). In addition to this, there is a greater focus on what has been termed 'attachment parenting' or, more accurately, 'cultural attachment parenting', in which the

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closeness between children and multiple carers occurs throughout their lives.

Desired attachment outcomes can differ across cultures. So, in looking more closely at the strengths that are evident in Aboriginal parenting practices, we need to better understand how these differ compared with more Westernised styles of parenting. Broadly speaking, in Western societies development of the self is dependent on being individually- and task-oriented. These cultures value adults who display autonomy, independence and competence. On the other hand, many Aboriginal Australian cultures are emphasise experiential learning, interdependent relationships, the honouring of spiritual and cultural connections in the community and group cohesion (Ryan, 2011; Lohoar et al., 2014; Yeo, 2003). Prior to two years of age, children from a mainstream Western background are likely to be comforted by caregivers after they become distressed. Aboriginal caregivers, however, more often aim to prevent their child's distress before it occurs. Older children in Aboriginal societies tend to be more self- reliant and may play a significant role in the upbringing of other children in the family (Ryan).

These cultural differences present a challenge to typical assessment of attachment and bonding in Aboriginal clients (Yeo, 2003). For example, infants or young children may be observed to seek out multiple caregivers and be capable of organising a complex array of attachment figure/s depending upon the emotional and/or practical needs they fulfil. An Aboriginal parent will not be directive or autocratic (concertive) in their parenting behaviour with a child as the expectation is that the child needs to learn skills by group and not through a sole focus on an individual parent. Further, children are taught from a young age to look more to siblings and same aged peers than adults to learn and provide emotional regulation to them (Harris & Harris, 1971; Kearins, 1984; Westerman, 2003). While culturally appropriate for an Aboriginal family, these behaviours could be perceived through a Western lens as representing disrupted attachment patterns (Ryan, 2011). In addition, culturally there are significant problems with the classification of attachment disorders which will be discussed later in this article.

Measures such as the Adult Attachment Interview and the Strange Situation Test have been developed around Western populations and their observed attachment patterns. More culturally appropriate assessment tools are needed to better account for the dynamics in Aboriginal Australian communities. Further investigation is also required to understand the specific manifestations of attachment disruption in Aboriginal populations. This includes assessment of caregivers' early attachment experiences and descriptions of current caregiver-child bonding (Yeo, 2003). There is a danger of seeing cultural differences in parenting as a deficit. The reality of looking at cultural parenting through a mainstream lens increases the likelihood of misdiagnosis of attachment disorders and therefore limits the capacity to determine appropriate treatments and interventions.

A great risk in uncritically applying non- Indigenous paradigms such as attachment is that we colonise the knowledge systems around child-rearing already present within Aboriginal cultures. When working from our own cultural reference points, both personal and professional, we can easily fail to understand that there are multiple constructions of child rearing, some aspects of which are similar to ours and some which are not. This highlights our need to scrutinise the fundamental design of child protection systems, their decision- making frameworks and their position within a broader set of colonising structures. Further, we are challenged to genuinely situate conventional Western and Indigenous knowledge together. In this, each system seeks to understand the other, traversing often foreign conceptual territory and unpacking hidden assumptions about the worlds in which we and the other live.

Differential cultural diagnosis issues: Cultural differences presenting as 'attachment disorders'

Many aspects of Aboriginal kinship systems have significant potential to be viewed as attachment disorders when referencing the DSM criteria of inhibited and disinhibited outcomes. The nature of attachment assessment is a combination of assessment protocols and direct observation of the caregiver-child bond. The structure of kinship, gender relationships, skin relationships and hierarchies within Aboriginal communities all affect individuals' social behaviour. The rules governing these relationships may be invisible to those unfamiliar with it; as such, a person's social behaviour can be viewed out of its context and attributed to attachment outcomes. These dynamics are addressed briefly in this section and explored more fully in the next edition of Jilya.

First, kinship relationships are structured very differently in Aboriginal Australian societies compared with Westernised ones. Relationships are based on this unique structure rather than a subjective sense of 'bond'. For example, gender is a 'subculture' in Aboriginal communities and gender-directed relationships strongly influence the nature of individuals' interactions with each other. This separation ensures that the cultural decision making specific to 'men's and women's business' remains secret or sacrosanct. The natural separations between people created by this structure could be misinterpreted as 'inhibited attachment', as children may indiscriminately attach to those individuals who are an accepted source of affection and support. On the other side of the coin, to make up for this separation of the genders, Aboriginal children are established into hierarchies very early. They look more to peers for direction as opposed to looking to adult 'authority' figures. In school-age years this can be misinterpreted as behavioural issues and, due to the encouragement of close, often more tactile relationships within the same gender, can also look like disinhibited attachment (Westerman, 2003).

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A further complicating factor is the formulation of skin groups and associated relationships in many Aboriginal communities. Skin relationships (or 'skin system') refers to the complex system that determines how people relate to each other. It encompasses their societal roles, responsibilities and obligations. The kinship system determines who marries who, ceremonial relationships, funeral roles and behaviour patterns with other kin.

The behavioural outcomes of skin relationships could lead to a differential diagnosis of attachment disorder. For example, a child may eschew direct contact with various people in his or her community due to skin relationships which forbid close or direct contact between individuals. These are known as avoidance relationships. As these interactions can appear similar to attachment dynamics, observation must occur either by or with a cultural consultant who is 'vouched' for by the community as having essential cultural knowledge of these dynamics. This is essential in order to ascertain whether or not behaviours are culturally appropriate. Unfortunately, what further complicates this picture is that not all communities continue to operate within a 'skin system'. The assessor must then have the capacity to undertake a comprehensive and objective cultural map of the kinship structure operating within the community and the extent to which individuals have chosen to live within this structure. There may be many instances in which an individual has 'unwittingly' married someone for whom they are 'wrong way' (i.e., the 'wrong skin group') and may not have an awareness of this. The previous generation, who are aware of this 'taboo', may in turn have views about the relationship and particularly 'shun' the children of these relationships. Again, it is important to consult with a vouched- for consultant to determine if wrong way skin may be implicated in attachment assessment.

Finally, Aboriginal culture is hierarchical. Power and knowledge are not something that everyone simply has a 'right' to. Knowledge is looked after by certain people, which includes maintaining the secret nature of many ceremonial and other practices. It is taboo for someone of a lower level of power to approach a person of a higher hierarchy or attempt to question or converse with particular

individuals who hold more knowledge and/ or power. To attempt to do so often elicits 'avoidance language', which can persist within communities and give an impression of a disordered or avoidant attachment style. For example, an Aboriginal male who has gone through initiation will have a greater level of 'power' than a non-initiated male and this dictates relationship dynamics, including those between young people and classroom teachers. In the second edition of Jilya we will explore the concept of cultural mapping, the use of cultural consultants and acculturation as mechanisms by which assessment is able to ensure that these factors are excluded as differential diagnosis of attachment disorders.

Conventional trauma theory, historical trauma and Aboriginal Australians

Within health sciences discourse, there is a tendency to conceptualise trauma in colonised Aboriginal populations in reference to PTSD. This is problematic for a number of reasons. As discussed, one of these is that PTSD and other DSM-5 definitions are not useful for understanding the experience of children and young people affected by complex, intergenerational, developmental trauma and related attachment disruption. Marsella (2010) also discusses ethnocultural differences in both the underlying biological processes of trauma and individuals' subjective responses to traumatic events due to the cultural moderations of these factors. He identifies that many Western-based assumptions around trauma and its effects privilege the biomedical model and the expertise of those who work from it. This often involves a discounting of traditional healing methodology as well as spiritual and cultural aspects of health. It also fails to incorporate factors associated with individual and community experiences of racism as embedded in heightened levels of risk. Marsella notes that over time, there has been an expansion in the application of Western understandings of trauma to both natural disasters and man-made atrocities including war, assault and accidents. However, typical approaches to trauma treatment in these circumstances have shown limitations to their efficacy; we cannot therefore assume universality in the aetiology of trauma across cultures.

Marsella (2010) and Westerman (2003) also explore the concept of 'culture-bound disorders' as differential diagnosis to the PTSD and attachment sequelae.

These are manifestations of psychological distress that are recognised within a culture and may be unique to a certain population of people. One example in some Aboriginal cultures is the concept of being 'sung' or cursed (Westerman, 2003). An individual may perceive that he or she is the target of the malicious intention of another member of the community. The person might hear voices and experience a range of somatic symptoms, sometimes resulting in poor physical health. From a Western perspective, this could represent symptoms of a psychiatric illness. However, this phenomenon is accepted within many Aboriginal communities as a part of the culture and a direct consequence of one person's actions against another. The concept of culture-bound disorders emphasises that no psychological disorder is free from the effect of culture, given its influence on our perception of reality and how we interact with the world around us. The second issue of Jilya more fully explores the concept of cultural formulation of culture bound syndromes that may be implicated in the assessment of trauma and attachment disorders.

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Historical trauma

In addition, DSM categories such as PTSD and complex PTSD are primarily concerned with individual experience. This does not acknowledge the collective element of trauma for Aboriginal people and the ongoing structural determinants of health and illness (Aguiar & Halseth, 2015; Westerman, 2013). Historical trauma (HT) is a concept that has gained significant attention in the literature in recent years, primarily in reference to Aboriginal peoples in Canada and the United States (e.g., Hartmann & Gone, 2014; Kirmayer et al., 2014; Waldram, 2014). The concept has also been discussed in relation to Aboriginal Australians people's experiences of intergenerational trauma (Atkinson, 2013), colonisation and racism (Paradies, 2016). Waldram (2014) describes historical trauma as 'an explanatory framework that places the plight of the individual within the collective, and the collective within historical processes that still remain in force' (p. 378). Historical trauma allows for a greater deconstruction of the causes of ill health among Aboriginal peoples, while at the same time providing a consideration of mechanisms of healing and resilience.

Hartmann and Gone (2014) define 'four Cs' of historical trauma. Colonial injury refers to the conquest, subjugation and dispossession inflicted by the colonising force. These injuries have a collective experience, with colonial injury impacting the identities, ideals and social lives of entire communities. Cumulative effects describe the accumulation of harm over time from continued oppression by dominant settler societies. Finally, cross-generational impacts are the legacies of risk and vulnerability transmitted to the next generation until healing interrupts the cycle. Experiential healing and sociostructural change are posited as the two main intervention strategies of HT (see article by Hartmann and Gone for further discussion).

There are a number of caveats around the use of a historical trauma framework with Aboriginal populations. Firstly, while HT has demonstrated resonance with some Aboriginal scholars and communities, it was borne from psychoanalytic work with Holocaust survivors (Hartmann & Gone, 2014). It has since been applied 'top-down' to Aboriginal populations, rather than Aboriginal communities themselves defining their experiences using their own language systems. Kirmayer et al. (2014) further point out that there are significant socio-cultural and psychological differences between the context and ensuing history of the Holocaust and that of colonised Aboriginal people, which makes a direct comparison inappropriate.

Denham (2008) importantly highlights the need to differentiate between historical trauma as a concept and the 'historical trauma response'. This acknowledges that individuals' responses to conditions of HT are diverse. We must avoid implicit assumptions of inevitable dysfunction and distress in all social groups affected by HT. Individuals and communities are able to remain resilient in the face of historically traumatic events, drawing upon cultural practices and healing mechanisms to reshape their narrative.

How racism as trauma can assist in our conceptualisation and treatment of of attachment and PTSD for Aboriginal people

The impacts of racism on the individual suggest that perinatal care may be a vital missing piece of the puzzle in protecting the health of Aboriginal mothers and the early environment that this creates in utero. International studies on the impact of racism on child health are more prevalent than Australian research, hence why the work of Yin Paradies (e.g., 2006, 2013) is so vital to this improved understanding. For example, there are numerous international studies which have linked the impacts of racism with transmission of intergenerational stress and trauma as early as in utero; consistently so for black and minority populations (Carter, 2007; C'de Baca, Castilla & Qualls, 2012). While there is growing acceptance that racial inequality does play a role in differential minority health outcomes, the assumption of inherent genetic differences between racial groups still exists. These arguments do not account for deep systemic inequalities established based on racist ideology and the fact that much of the socioeconomic disadvantages and stressful conditions brought about by social marginalisation can have lasting impacts on the overall health of people in marginalised groups. For those already susceptible to stress-related conditions, additional noxious experiences related to racial inequality can exacerbate health risks and illustrate the emerging cycle of racial discrimination across generations and can exacerbate already existing health risk brought about by their parents' experiences with discrimination.

Bryant-Davis and Ocampo (2005) noted similar courses of psychopathology between victims of violent crime and victims of racism. It is now considered that the impacts of compounded racism and the difficulty at the individual and community levels to manage such experiences manifests in the same manner as trauma. Emerging research has referred to this as 'cultural paranoia' and there are very few programs that incorporate both the identification and measurement of racism on PTSD and attachment and in treatment planning. Westerman (2003) has developed two separate tools that will provide the focus in the next edition of Jilya, that being the Acculturation Scale for Aboriginal Australians and the Acculturative Stress Scale for Aboriginal Australians. These two scales are both vital in terms of firstly measuring the extent of individual response to cultural change, and then the impact of racism and marginalisation on the individual. Westerman (2003) and Chandler (2000) have described individual and community response patterns to cultural change or acculturation which predicts mental health outcome for Aboriginal peoples. Whilst Chandler speaks of acculturation response patterns as being predictive of positive mental health outcomes, Westerman has operationalised this construct via the

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development of The Acculturation Scale for Aboriginal Australians and Acculturative Stress Scale for Aboriginal Australians, thereby enabling practitioners to both measure this impact and 'treat' the impacts of the acculturation process.

It is also clear that there are significant individual and community factors that are able to moderate the impacts of racism; to date these have attracted limited attention in relation to the potential for treatment focus. For example, Cross (1971) has described a model of black identity formation as the process whereby

marginalised or 'black' individuals progress through 'stages' of reconciling their cultural identity against the reality of living in a world that is predominantly white and Eurocentric.

Cross (1971) adapted by Westerman (2015) describes black identity formation as occurring through phases including

1. ***Pre-encounter***
2. ***Encounter/Dissonance***
3. ***Immersion/Emersion***
4. ***Internalization-Commitment***

Those individuals who predominantly perceive their identity in terms of internalisation and commitment have the best outcomes in relation to positive self concept and self worth and are able to then pass this onto their own children and within their relationships with others.

Finally, cultural attachment theory has attempted to deconstruct the concept of attachment and is built upon an existing framework (Simard & Blight, 2011), which supports Aboriginal cultural structure. Cultural attachment can reinforce cultural structure processes in the healthy development of Aboriginal children. Cultural attachment theory seeks to secure knowledge of family, extended family, community, and their relationship to each other and the world. Cultural attachment theory provides an Aboriginal child with the ability to have a secure base in which he or she can explore the world and provides the individual with cultural support, via the structures to successful transition to adulthood.

These four constructs will be further operationalised and explored in the next issue of Jilya, when our focus shifts to assessment and treatment of attachment disorders and trauma in Aboriginal people.

Conclusion

Conventional definitions of trauma and attachment have tended to be mono-cultural and are not adequately sensitive to Aboriginal cultures in Australia. Current definitions do not tend to capture the developmental impacts of childhood experiences of trauma, both in Indigenous and non-Indigenous populations; nor do they describe individual attachment responses and the extent to which culture is both proximal and distal to attachment classifications in Aboriginal people. It is crucial to acknowledge the broader social and structural elements of health and wellbeing alongside individual biological, psychological, cultural and spiritual levels of explanation. Despite its limitations, historical trauma emerges as a more holistic theoretical framework for understanding experiences of trauma in Aboriginal Australian communities.

At the same time, communities themselves need access to health science and academic discourse and the opportunity to understand and directly inform it with their own cultural frameworks. This includes developing common understandings of how family, child rearing, trauma and healing are conceptualised in Aboriginal communities and their place within broader cultural systems.

Join us in our next edition of Jilya, where we continue to explore some of the mechanisms of intergenerational trauma transmission and attachment disruption, beginning with individual-level factors and broadening out to cultural, spiritual and structural elements. We also take a look at some Australia-based attachment-focused programs and the extent to which they focus on the different levels of intervention and prevention. This provides us with a very good opportunity to consider how best to assist at-risk individuals, families and communities to heal from trauma and attachment disruption.

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Local Heroes presents stories of the strength, resource and initiatives occurring within communities all across Australia. We encourage members to tell us about the remarkable people or programs that are meaningfully impacting on Aboriginal people's health and wellbeing. We are especially interested in those people and stories which may not yet have found mainstream attention, but which can provide inspiration to others in the field.

HOPE FOR HEALTH

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Many remote communities experience limited commercial availability of quality, healthy foods. Traditional Aboriginal Australian hunter-gatherer diets, however, have an excellent nutritional profile. They are low in harmful fats, sugar and salt; high in lean protein and fibre; and foods are often consumed raw or prepared by baking, which preserves the nutritional content (Brand-Miller & Holt, 1998; Smith & Smith, 2003). Such a diet has been shown to be protective against cardiovascular disease and obesity and can ameliorate the symptoms of diabetes (O'Dea, 1984; 1991).

Hope for Health has incorporated the simple yet powerful concept of food as medicine into a community wellbeing initiative. A group of 28 community members, 6 of whom were men, were taken on a two week retreat on Elcho Island in August. The program centred around detoxification and nutrition as core components of wellbeing. The retreat used a framework combining traditional Yolgnu dietary knowledge and western alternative health approaches such as lymphatic massage, naturopathy and osteopathy. The women took part in art, craft, dancing and sessions with Aboriginal traditional healers, as well as regular physical exercise including beach walks and trampolining.

All information was presented in Yolngu Matha to ensure it was culturally contextualised.

Evaluation

Participants' blood glucose and blood pressure were measured twice daily throughout the retreat. Comprehensive pathology, collected by the local health clinic, was also conducted prior to the retreat and will be
repeated at 3, 6 and 12 months follow up to evaluate the effectiveness of the program. Future retreats will be guided by a committee of around 12 Yolngu women, who meet regularly to discuss ways to improve nutrition in their community as a whole and ensure that the program is ongoing.

More information about the Hope for Health program can be found at www.hopeforhealth. com.au

In the next edition we will do a focus story on Ngangkari (traditional healers) and the impacts of their work across Australia in dealing with complex health issue