PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

Australian Guidelines for the Treatment of
Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types
Aboriginal and Torres Strait Islander Peoples and PTSD

This *Aboriginal and Torres Strait Islander Peoples and PTSD* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with Aboriginal and Torres Strait Islander peoples. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*: www.phoenixaustralia.org/resources/ptsd-guidelines/.

Specialised training in cultural competency and safety has been developed for practitioners working with Aboriginal and Torres Strait Islander peoples and, wherever possible, practitioners intending to work with this population should receive such training. However, in circumstances where this is not possible, culturally informed care for Aboriginal and Torres Strait Islander peoples should be available within non-specialised primary and mental healthcare settings. The information presented here is intended to assist practitioners in these settings in their work with Aboriginal and Torres Strait Islander peoples.

The document *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*[1] is an excellent guide to working with this population. As well as comprehensive information on history and other contextual issues, the document provides practical advice for clinicians in mental health practice, as well as suggestions around broader service design issues. We strongly recommend that clinicians working with this population familiarise themselves with this text.

Background issues

Since white settlement in Australia, Aboriginal and Torres Strait Islander peoples have suffered separation from land, family, and cultural identity. This has resulted in multiple experiences of trauma, grief, and loss, which have affected people at the level of the individual, family, and community. In this process, some aspects of traditional kinship and community systems have been destroyed and, in some cases, formerly protective influences within those systems that functioned to buffer individuals and families from further trauma have been lost. Thus, the legacy of historical trauma is still apparent in the increased risk and incidence of traumatic exposure amongst Aboriginal and Torres Strait Islander peoples today. For example, Indigenous Australians are twice as likely to be the victims of violence or threatened violence than other Australians.[2] In effect, family and community functioning can continue to be compromised in each subsequent generation by social and psychological problems (such as substance use), leading to a vicious cycle of deteriorating conditions, pervasive social disadvantage and, for individuals, increased risk of further victimisation and traumatic exposure, antisocial behaviour, and reduced psychological resilience. Among Aboriginal and Torres Strait Islander men, for example, there appears to be a link between exposure to traumatic or violent events during childhood and the subsequent perpetration of violent crime.[3] Notwithstanding these comments, it needs to be acknowledged that Aboriginal and Torres Strait Islander peoples have shown remarkable resilience in surviving such historical and ongoing adversity and continue to display cultural strengths today.

Given this context, the notion of trauma and PTSD in Aboriginal and Torres Strait Islander peoples is inevitably complex. It is multigenerational and across all communities. Many Aboriginal and Torres Strait Islander persons presenting with mental health problems in both urban and rural/remote locations have multiple severe traumatic exposure within their family, community and personally that may include domestic violence, sexual abuse, murder, and suicide. In seeking to understand the impact of traumatic experiences on the individual, the practitioner should consider not just the nature or number of specific experiences, but the contextual factors that predispose and/or amplify the experience of, and response to, trauma. Traumatic experiences that are recurrent and difficult to talk about are likely to have the most profound impact. Therefore, even when the focus is on a specific recent event (for instance, a violent death), it is critical for the practitioner to explore the person's prior experience of traumatic events – particularly those that occurred in early life, such as physical and sexual abuse. This, of course, is true for any traumatised individual but it is of particular importance in disadvantaged sections of the community who may be at much higher risk for those experiences.

Due to the importance of extended kinship systems to Aboriginal and Torres Strait Islander peoples, a traumatic loss is likely to be felt broadly throughout the kinship group, rather than confined to the immediate nuclear family. For example, a person may have several 'mothers', or be considered a mother to several nieces/nephews/grandchildren. If this is not recognised, the intensity of the loss may be underestimated. In responding to this cultural context, it may be important to conceptualise interventions as being broader than simply the treatment of a single affected individual.

Presentation

Aboriginal and Torres Strait Islander peoples' understanding of mental health can differ markedly from that of the non-Indigenous population and often mental illness is not viewed as a condition requiring treatment. Furthermore, in the event that mental illness is recognised as a problem, its management generally falls to the person's immediate family in the first instance, followed by the extended family and, if necessary, community elders.[4] Hence, by the time many Aboriginal and Torres Strait Islander people present to services, their condition is likely to be very serious. It is not uncommon for the individual to be in crisis at first contact with presentations of acute distress, including interpersonal chaos, self-harm and depression. Indeed, Indigenous Australians are hospitalised for mental health problems at nearly twice the rate of other Australians and suicide is also more prevalent in this population (particularly among males, and females under the age of 25).[2]

Substance abuse/dependence is very often the presenting problem, with abused substances including alcohol, illicit drugs, and prescribed medications, such as analgesics. It is common to see high levels of dissociative symptoms and prominent auditory and visual phenomena that could be mistaken for psychosis. In many cases, PTSD co-exists with prolonged grief/depression. While some people experience textbook PTSD symptoms, many more present with the range of additional symptoms associated with chronic and complex trauma (i.e., enduring patterns of social, psychological and behavioural difficulties, usually compounded by substance use). Further, culture-bound expressions of distress are often interpreted by non-Indigenous people as anger. The complexity of these presentations can lead to a diagnosis of personality disorder, with PTSD being overlooked. Clinicians should be aware that many Aboriginal and Torres Strait Islander women and men in refuges and in prison have PTSD. In fact, one study found PTSD to be second only to substance use disorders in terms of prevalence among incarcerated Aboriginal and Torres Strait Islanders, affecting almost one third of women and 12 per cent of men.[8]

Assessment

Access, engagement, and trust in the therapeutic setting are complicated for Aboriginal and Torres Strait Islander peoples by a number of factors. These include the complexity of the trauma (particularly community level trauma), cultural factors, and the historical legacy of mistrust of authorities. The potential for stigma and discrimination associated with mental health treatment to pose a barrier to engagement should be considered. Experiences of chronic loss mean that issues of abandonment and (the potential for) shaming may be heightened. Assessment recommendations regarding the need to allow more time and attention to the therapeutic relationship for people who have experienced prolonged and repeated trauma would generally apply to this group.

Due to the complexity of the presenting problems for this population, PTSD is often overlooked. A culturally appropriate assessment is required for any diagnosis to be reliable. If no suitably trained practitioner is available, consultation with an Aboriginal and Torres Strait Islander mental health worker is highly recommended.

Issues of eldership, traditional law, and taboo need to be understood, at least to some extent, for reliable assessment. The Working Together document[1] provides excellent advice on this issue. The following general practical advice, developed by Medicine Australia, may be useful also.[6]

- Allow plenty of time.
- Gain permission from the person (and others in attendance) for the interview.
- With empathy, explain purpose of questions, the timeframe of the assessment, and potential outcomes.
- Identify relationships between the person and others present and be aware of their significance.
- Check with the person whether they prefer to be interviewed with/without significant others present.
- Observe cultural norms (e.g., eye contact, seating arrangements).
- Do not refer to a dead person by name.
- Do not refer to certain close relatives by name (e.g., a Torres Strait Islander male may not refer to his brother-in-law by name).
- Do not criticise an elder or other members of the extended family.
- Be cautious of confiding certain personal information to a member of the opposite sex (to the client), as men's and women's business are usually kept separate.
- Anxiety can be generated by interviewing someone in a confined space.
- Spiritual experiences are not necessarily hallucinations or delusions.
- Be aware of possible somatisation symptoms.
- Allow for reflection, periods of silence and any questions.
- Minimise the use of direct questions.
- Advise the person of confidentiality.

The assessment of PTSD should not be limited to a recent traumatic event, but should take into account previous traumatic experiences. Even if the person's PTSD or presentation for treatment has been triggered by a recent event, it is often the case that a recent loss or trauma brings up unresolved past events. The potential impact of the traumatic experiences of previous generations on members of the current generation, either directly (e.g., family environments characterised by psychosocial problems, violence, impaired parenting), or indirectly (e.g., vicarious traumatisation), should be considered.

Further, given the high physical health morbidity among disadvantaged groups, even in young people, careful screening or review of general health status may be important, especially if pharmacological treatment is likely to be prescribed, or if there is a lack of progress in treatment. Diseases such as diabetes, renal failure, chronic infection, anaemia, etc., can complicate recovery from traumatic events and vice versa.

Treatment

In the review of evidence-based treatment for PTSD, no trials have investigated treatments specifically for Aboriginal and Torres Strait Islander peoples. In the application of these treatment Guidelines to Aboriginal and Torres Strait Islander peoples the practitioner is advised to consider the recommendations in combination with common sense and knowledge of traditional practices. The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. **Grade B**
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**
- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**
- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**

- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

Where available, appropriate partnerships with Indigenous mental health workers should be developed. In cases where this is not possible, consultation with Indigenous mental health workers or other practitioners with appropriate cultural training is recommended.

Within Aboriginal and Torres Strait Islander cultures, traditional therapies include the use of healers, rituals, and ceremonies. In working with an Aboriginal person or Torres Strait Islander with PTSD, practitioners should apply the Guidelines in a culturally sensitive way, with consideration given to what combination of traditional, pharmacological, and psychological approaches to treatment will be most effective for the individual.

In establishing treatment goals, practitioners should give consideration to a number of factors. First, the magnitude of trauma in Aboriginal and Torres Strait Islander families may be overwhelming to practitioners and lead them to feel powerless and be inclined to give up. Good supervision is essential and collaboration with an Aboriginal or Torres Strait Islander mental health professional is preferred. Second, with people who have experienced prolonged or repeated traumatic experiences, more preparatory work is required before trauma-focussed work begins. As such, unless the practitioner has the capacity to make a commitment to being available in the longer term, it is often more appropriate to address current life and behavioural problems, focussing on issues of structure and problem solving, rather than delving into a potentially long history of trauma. Third, specific cultural factors should also be considered. Issues of age, seniority, and gender impact on who should provide treatment and how the treatment should be given. If the practitioner is ignorant of, or disregards these traditions, the Aboriginal or Torres Strait Islander person may be less likely to engage effectively in treatment.

With regard to early interventions following traumatic events affecting whole communities, local and traditional Aboriginal peoples and Torres Strait Islander approaches should be identified and supported. Contemporary approaches such as psychological first aid may also be appropriate, provided they can be delivered in a culturally sensitive manner.

There are significant challenges in the application of these Guidelines to Aboriginal and Torres Strait Islander peoples. In addition to the historical and current sociopolitical factors referred to above, the pervasive and enduring social disadvantage and the prevalence and complexity of traumatic experience, geographical isolation and limited availability of appropriately trained mental health practitioners all combine to create considerable barriers to effective care for posttraumatic mental health conditions.

Working with children

As discussed above, transgenerational issues are significant in the Aboriginal and Torres Strait Islander population and thus require careful consideration by practitioners working with Indigenous children. As with adults, compared to the general population, Aboriginal and Torres Strait Islander children are more likely to experience mental health problems and commit suicide, but less likely to present to formal mental health services.[7] Exposure to trauma is also more common; for example, Indigenous children are five times more likely to be hospitalised for injuries occurring due to assault, and twice as likely to be hospitalised for burn or scald injuries.[8] Including family members in the assessment and treatment process may be particularly beneficial for this population, given the importance of family in the Indigenous community.[7] Issues of safety are, of course, paramount, and family involvement may not be appropriate in some cases.

Recommended reading

Dudgeon, P., Garvey, D., & Pickett, H. (2000). *Working with Indigenous Australians: A handbook for psychologists*. Perth: Gunada Press.

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This information was taken from the Aboriginal and Torres Strait Islander Peoples section (p.135-138) of the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Aboriginal and Torres Strait Islander Peoples section was developed by Phoenix Australia in collaboration with Professor Helen Milroy, Psychiatrist, Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia; Mr Tom Brideson, State-wide Coordinator, NSW Aboriginal Mental Health Workforce Program; Dr Ann Harrison, Psychiatrist, Winnunga Aboriginal Community Controlled Health Organisation; Professor Ernest Hunter, Psychiatrist, Adjunct Professor, James Cook University; Ms Joyleen Koolmatrie, Psychologist, Aboriginal Psychological Counselling and Consultancy; Professor Beverley Raphael, Psychiatrist, Population Mental Health and Disasters, Disaster Response and Resilience Research Group, University of Western Sydney; and Mr Richard Weston, Chief Executive Officer, Healing Foundation.

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