

# Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD



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

**This *Aboriginal and Torres Strait Islander Peoples* information sheet addresses background issues and provides presentation, assessment and treatment advice for practitioners working with Aboriginal and Torres Strait Islander peoples.**

Specialised training in cultural competency and safety has been developed for practitioners working with Aboriginal and Torres Strait Islander peoples, and practitioners intending to work with this population should receive such training. Culturally informed care, including the use of cultural mentors or related secondary consultations 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*<sup>1</sup> 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 colonisation in Australia, Aboriginal and Torres Strait Islander peoples have suffered dispossession of land, separation from family, and the loss or fragmentation of cultural practices and knowledge systems. This resulted in multiple experiences of trauma, grief, and loss, which have affected people at the level of the individual, family, and community. In some cases, kinship and community systems have been so compromised that until these unaddressed social justice issues and collective systems of resilience are able to be restored the protective influences within those systems that functioned to buffer individuals and families from further trauma remain severely impacted. 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, Aboriginal and Torres Strait Islander peoples are twice as likely to be the victims of violence or threatened violence than other Australians.<sup>2</sup> In effect, successive waves of structural violence that included policies of removal in combination with intergenerational poverty and social exclusion, has meant that for those most vulnerable families and communities, functioning can continue to be compromised in each subsequent generation by social and psychological problems, leading to a vicious cycle of deteriorating conditions, pervasive social disadvantage and, for individuals, increased risk of

further victimisation and traumatic exposure.<sup>3</sup> Despite these legacies of colonisation and ongoing adversity, the resistance and resilience of Aboriginal and Torres Strait Islander peoples is undeniable, and their ancient knowledge systems remain one of the oldest in the world.

Given these contexts, the notion of trauma and PTSD in Aboriginal and Torres Strait Islander peoples is inevitably complex. It extends beyond individual experiences of trauma, to encompass intergenerational trauma, and in some cases, collective trauma that affects whole communities. Often Aboriginal and Torres Strait Islander persons presenting with mental health problems in both urban and rural/remote locations may have experienced multiple or cumulative traumatic exposure within their families or communities, including interpersonal violence 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 among vulnerable populations which 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', 'fathers' and other similar primary carer roles, and in reciprocal fashion, they will be considered to have multiple maternal, paternal and other types of cultural and kinship attachment roles for nieces/nephews/grandchildren. If this is not recognised, the significance and 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<sup>4</sup>. Often, by the time many Aboriginal and Torres Strait Islander people present to services, their condition is likely to be very serious. Hence, for example, it is not uncommon for the individual to be in crisis at first contact, with presentations of acute distress, multiple social adversities, complex interpersonal difficulties, depression, and potential self-harm. 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).<sup>2</sup>

Similar to other populations, substance misuse/dependence, including alcohol, illicit drugs, and prescribed medications, such as analgesics, can often be a co-occurring presenting problem alongside PTSD. It is also not uncommon 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. For example, several studies have identified that Aboriginal and Torres Strait Islander people also present with trauma-related patterns of distress that include affect dysregulation, disturbances in relationships, and cultural idioms of distress such as fragmented cultural identity, disconnection to spirit, historical grief and loss, and disconnection to community.<sup>5,6</sup> Further, culture-bound expressions of distress are often interpreted by non-Indigenous people as anger. The complexity of these presentations can lead to a misdiagnosis 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.<sup>7</sup>

## Assessment

Access, engagement, and trust in the therapeutic setting can be 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, experiences of racism, and the historical legacy of mistrust of authorities due to sanctioned policies of removal well remembered within families. 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 such as complex grief, 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 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<sup>1</sup> provides excellent advice on this issue. The following general practical advice, developed by Medicine Australia, may also be useful.<sup>8</sup>

- 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., multi-generational childhood removal from natural family, community and family environments characterised by psychosocial problems and social disadvantage, violence, loss of parenting skills or resources), 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 is 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, etcetera, 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.

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 strongly recommended.

Within Aboriginal and Torres Strait Islander cultures, therapeutic processes have always included the use of healers, rituals, and ceremonies. Hence, in working with an Aboriginal person or Torres Strait Islander with PTSD, practitioners should apply the Guidelines in a culturally sensitive way that includes potentially linking in with available Aboriginal workforce or organisations that can offer complementary cultural healing activities. This is particularly important given the emerging evidence base documenting the protective effect of cultural determinants with regards to Aboriginal mental health and social and emotional wellbeing, including PTSD symptom severity.<sup>9,10</sup> Consideration, therefore, needs to be given to what combination of cultural, 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 cultural protocols, 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, if possible local Aboriginal peoples and Torres Strait Islander leaders in the community should be engaged, and locally preferred 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 socio-political 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.<sup>11</sup> 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.<sup>12</sup> 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.<sup>11</sup> As with any other population, 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.

Human Rights and Equal Opportunity Commission. (2007). *Bringing them home: A guide to the findings and recommendations of the National Inquiry into the separation of Aboriginal and Torres Strait Islander Children from their Families*. See [http://www.hreoc.gov.au/education/bth/community\\_guide/index.html](http://www.hreoc.gov.au/education/bth/community_guide/index.html) Accessed February 2020

Milroy, H. (2005). Preface. In S. R. Zubrick, S. R. Silburn, D. M. Lawrence, F. Mitrou, R. B. Dalby, E. M. Blair, J. M. Griffin, J. A. De Maio, A. Cox & J. Li (Eds.), *The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research. See <http://aboriginal.childhealthresearch.org.au/kulunga-research-network/waachs.aspx> Accessed February 2020

Purdie, N., Dudgeon, P., & Walker, R. (Eds.). (2010). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Canberra: Australian Government Department of Health and Ageing.

Swan, P., & Raphael, B. (1995). *Ways forward: National Aboriginal and Torres Strait Islander mental health policy*. National consultancy report. See

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-w-wayforw> Accessed February 2020

## Source and contributors

The *Aboriginal and Torres Strait Islander Peoples* information sheet 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.

The section was substantially updated in 2019 by Dr Graham Gee, Clinical Psychologist, Murdoch Children's Research Institute.

## Citation

Phoenix Australia - Centre for Posttraumatic Mental Health. Specific Populations and Trauma Types: *Aboriginal and Torres Strait Islander Peoples* in Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder. Melbourne: Phoenix Australia; 2020.

## References

1. Purdie N, Dudgeon P, Walker R, eds. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Canberra: Australian Government Department of Health and Ageing; 2010.
2. Pink B, Allbon P. *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. Cat. no. 4704.0*. Canberra: Australian Bureau of Statistics; 2008.
3. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. *The Alcohol Use Disorders Identification Test: Guidelines for use in primary care*. 2nd ed. Geneva: World Health Organization, Department of Mental Health and Substance Dependence; 2001.
4. Isaacs AN, Pyett P, Oakley-Browne MA, Gruis H, Waples-Crowe P. Barriers and facilitators to the utilization of adult mental health services by Australia's Indigenous people: Seeking a way forward. *International Journal of Mental Health Nursing*. 2010;19(2):75-82.
5. Chamberlain C, Gee G, Brown SJ, et al. Healing the past by nurturing the future-co-designing perinatal strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma: Framework and protocol for a community-based participatory action research study. *BMJ open*. 2019;9(6):e028397.
6. Atkinson C. *The violence continuum: Aboriginal Australian male violence and generational post-traumatic stress*. [Unpublished Doctor of Philosophy thesis. ], Charles Darwin University, Australia; 2008.
7. Heffernan EB, Andersen KC, Dev A, Kinner S. Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. *Medical Journal of Australia*. 2012;197(1):37-41.
8. Armstrong T. Counselling interventions and indigenous mental health. 2012. Accessed 2013.
9. Ashbaugh AR, Houle-Johnson S, Herbert C, El-Hage W, Brunet A. Psychometric validation of the English and French versions of the posttraumatic stress disorder checklist for DSM-5 (PCL-5). *PloS one*. 2016;11(10):e0161645.
10. Gee G. *Resilience and Recovery from Trauma among Aboriginal Help Seeking Clients in an Urban Aboriginal Community Controlled Health Organisation*. [Unpublished Doctor of Philosophy thesis.], University of Melbourne 2016.
11. Williamson AB, Raphael B, Redman S, Daniels J, Eades SJ, Mayers N. Emerging themes in Aboriginal child and adolescent mental health: Findings from a qualitative study in Sydney, New South Wales. *Medical Journal of Australia*. 2010;192(10):603-605.
12. Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011. Cat. no. IHW 42*. Canberra: AIHW; 2011.