Stress Points

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Australasian Society for Traumatic Stress Studies

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STRESS POINTS is the official electronic journal of the Australasian Society for Traumatic Stress Studies (ASTSS)

Stress Points is a quarterly ejournal produced by the Australasian Society for Traumatic Stress Studies (ASTSS). It aims to report and examine current developments in research, theory, clinical practice, social policy and inquiry in the field of trauma and posttraumatic mental health. Stress Points endeavours to be a forum for the multi-disciplinary exchange of ideas on posttraumatic mental health, with contributions and dissemination beginning with ASTSS members. Members and non-members can make contributions in the form of feature articles, reviews, interviews, research reports, meta-analyses or opinion pieces – all with the primary focus of trauma.

All contributions must be consistent with the stated mission of ASTSS: (1) to advance knowledge about the nature and consequences of highly stressful events, (2) to foster the development of policy, programs and service initiatives which seek to prevent and/or minimise the unwanted consequences of such experiences, and (3) to promote high standards and ethical practices in the trauma field. Furthermore, Stress Points serves as a major vehicle towards the goals of ASTSS: (i) providing quality services to ASTSS members, (ii) encouraging networking and development of ASTSS within the Australasian region, (iii) promoting standards of excellence in trauma research and practice among members, (iv) pursuing dialogue and links within the international trauma community, (v) encouraging exploration of different paradigms in research and practice, (vi) exploring the role of prevention in traumatology, (vii) seeking to influence the way traumatology is addressed in public policy and the media, and (viii) pursuing a role within the non-professional community through consultation and education.

Submissions are to be emailed directly to the editor at ejournal@astss.org.au. Address other correspondence to Bronwyn Tarrant, Stress Points Editor, ASTSS, Greenview Mental Health, Suite 9, 20 Commercial Road, Melbourne, Victoria, 3004.

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ASTSS
Australasian Society for Traumatic Stress Studies

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FROM THE PRESIDENT

JUSTIN KENARDY

Welcome to another year with ASTSS. It has indeed been a productive one. The main activity in 2013 was the joint ASTSS and ACPMH Masterclass and workshop by Professor Edna Foa. This was an extremely successful activity for us as it allowed us to bring Professor Foa's breadth and depth of experience and expertise in treatment of PTSD to our members, to raise the profile of ASTSS nationally, and to bring the issues surrounding PTSD to a broader audience through Professor Foa's engagement with the Australian media. Professor Foa is a masterful presenter and those who attended the full program will have taken away a very significant skill and knowledge set. For those ASTSS members who were not able to attend, the workshop was recorded on video and will be available on the ASTSS website. The activity also provided further proof of the value of the collaboration with ACPMH. I would particularly like to express my gratitude to Professor Grant Devilly for all of the work he did to make the visit by Professor Foa at success.

Many of the ASTSS Executive are now in planning mode for the next joint activity, which will be the biannual Australian Conference on Traumatic Stress - ACOTS. This will again be a joint partnership activity with ACPMH, and will be held in Melbourne on the 11th to 13th of September, so remember to mark those dates on your calendar. More information about the conference is included in this edition of Stress Points. As always keep up to date with ACOTS and ASTSS information via the website www.astss.org.au.

There have also been changes in the ASTSS Executive team. Unfortunately Dr Eva Alisic who was the Vice President and President Elect has been forced to resign due to family responsibilities. Dr Alisic, in the time she was in the position, made a number of significant contributions to ASTSS including an evaluation of member retention influences and needs, and engagement of younger members. Dr Alisic's contribution will be missed. However as one door closes; Dr Robyne Le Brocque has been elected to the position of Vice President. Dr Le Brocque brings a wealth of experience with ASTSS having served as Secretary for a number of years. Professor Grant Devilly, Past President and Executive Officer, will step down from that position to become the Queensland Chapter Representative. Daniel Torpy will step up to become Executive Officer. Also Sofia Fisher will step down as W.A. state Chapter Representative, so thank you Sofia for all of your hard work in this role.

While ASTSS has a significant role within the Australasian community, we have always been engaged on some level internationally. An exciting new development in this area has been the establishment of the Global Collaboration involving traumatic stress organisations around the world. ASTSS through Doug Brewer, immediate past president, has been deeply involved in this endeavour. While the group brings together organisations in a dialogue about common challenges, in practice the group has decided to focus efforts on the development of a response to child sexual abuse. To that end the group is developing interventions that could be delivered across cultures and countries. It is early days for the group, but ASTSS is definitely a key player.

Finally, I would like to draw your attention to one strong theme of this edition of *Stress Points*. Those of you who attended the Australian Conference on Traumatic Stress in Perth 2012 will recall the moving presentation given by Professor Pat Dudgeon on indigenous mental health. This is an issue that won't go away by itself. As Australians we must all, at some level, be engaged.

Justin Kenardy
President ASTSS.

ASTSS
Advancing Trauma Recovery and Research
Australasian Society for Traumatic Stress Studies

Editorial

By: Bronwyn Tarrant

This issue of *Stress Points* approaches three distinct yet interrelated themes.

The first paper introduces a ground-breaking global collaboration between the worldwide network of traumatic stress societies. This global initiative's primary activity was launched with the Canadian-based global health challenge in 2013. The paper, by Professors Schnyder and Olff, demonstrates this collaboration in action - co-authoring across European countries, and publishing in both the North American *Traumatic Stress Points* and this Australasian *Stress Points*. Dr Schnyder is the Head of University Hospital, Zurich, Department of Psychiatry and Psychotherapy, Switzerland. Dr Olff, from the Department of Psychiatry, Academic Medical Center, University of Amsterdam, is editor-in-chief of the *European Journal of Psychotraumatology*. The global collaboration has decided to first tackle the issue of child abuse.

The second paper moves from the global to the local and explores the Western Australian redress to the royal commission into institutional responses to child abuse. This paper reflects on the implications and outcomes of the royal commission into the perpetuating the protective roles of institutions regarding child abuse.

The third article tackles another manifestation of institutional of trauma - the contemporary use of seclusion and restraint in public mental health inpatient units. The paper describes in a sophisticated synopsis of the current national and international movement towards seclusion reduction. Consumer Academic, Cath Roper, a previous *Stress Points* contributor, has suggested that every episode of seclusion represents a failure of institutional treatment. This article by Ancelin McKimmie explicates the issues and some of the traumatic implications for those suffering mental health disorders.

The next three articles consider serious mental health issues in the Indigenous Australian population and their correlation with psychological trauma. Borderline personality disorder, suicide and psychosis are explored separately, yet together the three articles create a consistent picture of a traumatic genesis and perpetuation of mental health disorders - individual, transgenerational, and institutional.

Finally, we announce the recipient of the Australasian Society for Traumatic Stress Studies media award for 2013. Angela Pownall, of The West Australian newspaper, has taken out the award for a series of articles exposing dangerous flaws in Western Australia's mental health system.

So this edition of *Stress Points* explores trauma globally and locally – the theme for the 2014 Australasian Conference On Traumatic Stress. The ACOTS call for papers appears at the close of this edition. Closing date for ACOTS abstracts is March 13th 2014.

Finally, I wish you a safe and peaceful holiday season and a productive 2014.

Bronwyn Tarrant,
Editor *Stress Points*

The Global Initiative

By: Ulrich Schnyder & Miranda Olff

Trauma is a global issue. Terrorism, for example, is a phenomenon that can only be understood and dealt with constructively by adopting a global, culture-sensitive perspective. There is increasing consensus that the most pressing challenges in the field of traumatic stress can only be met if we understand trauma from a cultural perspective, in addition to the psychological, social, neurobiological, legal, political and other perspectives we used to take when looking at a specific aspect of trauma.

In 1991, the Society for Traumatic Stress Studies added an "I" for "International" to its name and became the ISTSS, as leaders of the organization had recognized the global dimension of trauma. Nevertheless, ever since, around 80 percent of ISTSS members are North American residents. As a consequence, the ISTSS annual meetings have always been held in the U.S. or Canada. Why is that?

Well, the answer is simple: holding the annual meeting anywhere outside North America would inevitably attract fewer participants. With more than 50 percent of ISTSS' income being generated by the annual meeting, this would create a major financial challenge to the organization. So, with a majority of its members being North American, and its annual meetings invariably held in North America, and despite an increasing number of ISTSS sponsored activities on a global level, the ISTSS was perceived by many of our colleagues worldwide as not being truly "international."

In 2010, the Board of Directors of ISTSS developed a set of global values and visions to inform a new strategic plan. As one out of six strategic goals, the Board of Directors recognized that traumatic stress is a global issue, that we seek to have a stronger global impact on trauma related issues, and that we could speak with a stronger voice if we represented larger numbers of trauma professionals around the world. We committed to value worldwide collaboration over competition and to try to ensure that the needs of all nations are met. Finally, we agreed we are responsible to attend to those who are without local trauma support.

This strategic goal was voted a high priority for ISTSS by the Board of Directors. As a result, the "Global Initiative" was created. A project team was charged to invite broad input from key stakeholders to discover stakeholder views, priorities and preferences; learn about current best practices in global relationships, what others are successfully doing and what is possible in order to make as informed a recommendation as possible; make recommendations for alternative business models to consider; and, in consultation with stakeholders, examine these alternative models and build consensus around proposals that can be supported by all.

The project team, comprised of representatives from ISTSS and the majority of its affiliate societies, first tried to identify various options for a new organizational structure for ISTSS. One model considered was a global collaboration of organizations with an interest in advancing the field of traumatic stress, with a confederation structure that would include the ISTSS, its current affiliates, plus potentially other associations.

A second model considered was the "Global Society for Traumatic Stress Studies," a new umbrella organization i.e., a federation much along the lines the ESTSS is currently structured. A third model was the creation of a North American section or affiliate of the (otherwise unchanged) ISTSS – a section that would meet the needs of the U.S.-based constituency of the ISTSS. While the ISTSS Board of Directors strongly encouraged the project team to further develop the various options, other stakeholders were much less enthusiastic about changing the organizational structure of ISTSS.

Therefore, we adapted our strategy and began thinking more pragmatically, asking ourselves what we might actually be doing if one of the envisioned structural models were fully implemented. Keeping in mind the initial purpose of the Global Initiative (greater global impact, greater peer-to-peer balance among societies, addressing U.S. specific needs), and applying the principle of "form follows function," the project team developed three concrete action packages:

No-cost membership: A new membership category for ISTSS, offering a restricted range of benefits, to meet the basic communal needs of isolated, low-income professionals worldwide, while offering a valuable connection for more affluent professionals

who have their primary memberships in other organizations. No-cost membership would increase the impact of programs and services provided by ISTSS and partnering organizations by engaging with a larger community of professionals who have an interest in traumatic stress. “Affiliated” no-cost ISTSS membership would apply to dues-paying members of affiliated organizations. “Corresponding” no-cost ISTSS membership would apply to those with no paid membership in either ISTSS or an affiliated organization. Details and implementation of these new membership options must involve consultation and coordination with affiliated organizations.

ISTSS meetings outside North America: One-day educational meetings would be held in locations around the world, in collaboration with local societies when feasible. In addition, larger ISTSS regional conferences on traumatic stress would be offered in places where no strong STSS representation exists. This type of meeting would be used to facilitate formation of new traumatic stress organizations.

Global Collaboration: The idea of this action package was to convene organizations interested in traumatic stress and to work alongside each other on an equal basis. Participants would identify objectives, facilitate development and coordinate activities of global importance. Organizations would be free to determine whether or not to be involved in particular initiatives. This effort would begin with ISTSS and its affiliate societies, but is intended to encompass the broader trauma community in the future.

In May 2012, the three action packages were approved, with minor amendments, by the Board of ISTSS. At its annual meeting in Los Angeles in October 2012, the ISTSS hosted the first one-day meeting of the Global Collaboration. Representatives from ISTSS and its affiliate societies engaged in a lively and inspiring discussion. In a historic moment, the group achieved agreement to work collaboratively focusing on one global issue to start–childhood abuse and neglect and the latent impact of that abuse.

Childhood abuse and neglect is clearly a global public health problem that requires a global solution. The Global Collaboration decided to collect guidelines from around the world that would provide the basis for a synthesized core guidelines for prevention and treatment that can be customized for specific cultural contexts. The guidelines will primarily be aimed at professionals. In addition, the Collaboration will compile an information guide aimed at those affected by childhood abuse and neglect. This will raise awareness of the issue, improve the way individuals of all ages who are affected by child-hood abuse and neglect are detected, supported, assessed and treated, leading to significant improvements in health and wellbeing.

Capitalizing on the latest developments in technology, the Collaboration aims to disseminate these guidelines using an application for mobile electronic devices that will allow for worldwide distribution and cultural customization. The Collaboration is currently working together to develop a proposal to secure funding to develop the guidelines and the application. Furthermore, participants agreed to discuss with their societies and boards the various ways they can and will join ISTSS in contributing to this effort.

On November 1, 2013, the ISTSS Board of Directors committed to:

- Continue to enable this collaboration
- Provide limited financial support for administrative services and conference calls
- Participate in the collaboration
- Seek opportunities to align with the objectives of the collaboration in any number of ways as they present themselves

The Global Collaboration is chaired by ISTSS vice-president Miranda Olff. The next in-person meeting will take place during the 13th ESTSS conference in Bologna in June 2013. If you are interested in contributing to this exciting project, please contact Miranda Olff.

We are truly delighted and grateful to see the Global Initiative coming to fruition. We wish the Global Collaboration all the success it deserves. Trauma is a global issue.

Ulrich Schnyder, MD
Miranda Olff, PhD

Reflections from the Redress WA Experience in Light of the Royal Commission into Institutional Responses To Child Sexual Abuse

By: Gail Green, Dion Leeuwenburg, Janice MacKenzie & Julie Watts

The Royal Commission into Institutional Responses to Child Sexual Abuse (RC) (click) instituted by the Commonwealth Government of Australia, commenced hearings in May, 2013. Previously three states, Queensland, Tasmania and Western Australia, had undertaken Redress schemes for people who had experienced neglect and abuse as a child whilst in the care of the State. The Redress programmes followed the reports of the Senate Inquiries: 2003-4 "Forgotten Australians: a report on Australians who experienced institutional or out-of-home care as children" and 2005 "Protecting vulnerable children: a national challenge" (Parliament of Australia, 2009).

The RC Letters Patent are focused on how organisations managed and responded to claims of sexual abuse and any related unlawful or improper treatment of children and whether that response was sufficient (Royal Commission into Institutional Responses to Child Sexual Abuse, 2013). Evidence will be partly supplied by victims of child sexual abuse whilst in institutions. Whereas the focus of the Redress Schemes was to apologise and provide a degree of recompense to children who had experienced neglect, physical, sexual and emotional abuse whilst in the care of the states.

The New South Wales Special Commission of Inquiry into matters relating to the Police investigation of certain child sexual abuse allegations in the Catholic Diocese of Maitland-Newcastle (click) commenced May, 2013 and the Victorian Government announced a Parliamentary Inquiry into the handling of child abuse by religious and other organisations (click). Vulnerable people attended and presented to the commissions and inquiries.

The authors have reflected on the work they did in Western Australia assisting applicants to the Redress WA Scheme over a 12 to 30 month period. The article is brief, looking at systemic errors, some of the difficulties for applicants, and brief counselling techniques which assisted in creating change. These reflections may provide assistance throughout Australia to those involved in the government investigations and providers who will have contact with:

- the individuals who address or have submissions to the government investigations,
- the wider community of abused sufferers,
- their families and friends, and
- professional supporters who will be affected by the media exposure.

Commissions and Inquiries can become a turning point for positive change however, if the process is not conducted with skill and empathy a vulnerable population is at risk of re-traumatisation and even of suicide and self-harm. Appropriate concepts need to be embedded in all public statements and verbal and written communications with individuals including how questions are asked, in relationships developed when stories are recorded, and even how phones are answered because the impact upon a vulnerable person can be central to creating positive or negative change.

Publicity

Poor planning and ineffective publicity can create unintended consequences. In the case of Redress WA a year, from May 2008 until April 30 2009, was allocated for applicants to make a claim. In March 2009, 2100 inquiries had been received with a further 600 expected by the closing date (The West Australian, 2012). Initially full page advertisements were placed in newspapers. It would appear the advertisements had little impact for two reasons; poor design and a vulnerable population which may not read newspapers. In April 2009 (two months before the original closing date) radio and television advertising occurred; the inquiries rocketed from 2100 to 10,200 of which 5900 were eligible (Ellery, 2012) and the support system was overwhelmed.

More recently the reporting of the Royal Commission has referred only to further information being available on the RC's web site. Many victims are unlikely to access the internet and if they do, may not have the skills to find the appropriate websites.

Shifting the goal posts

The WA Labor Party proposed the Redress WA Scheme in 2007 budgeting for the initial funding. A top level ex-gratia payment of $80,000 was nominated. The Labor Party lost the next election. The Liberal Party decided to legislate the Scheme but, at a later period, after the Scheme had been opened to applicants, refused to provide a second stage of funding. Consequently in March 2009 a four level payment system was instituted reducing the publicised ex gratia payment of $80,000 to:

- Level 1 up to $5000
- Level 2 $13,000
- Level 3 $21,000
- Level 4 $45,000

The level of anger generated by altering the payment figure from $80,000 to $45,000 was palpable (Ellery, 2012). Applicants and advocates had their expectations dashed and were overwhelmed by the effects of re-traumatisation.

Applicants, many of whom had experienced significant trauma, expressed high levels of anger and frustration toward the Government at the reduction in ex-gratia payments. Many applicants stated the reduction perpetuated thoughts and feelings of distrust and anger towards the Government. For some the changes maintained feelings of worthlessness, hopelessness, of being tricked and then being betrayed.

Financial remuneration is not a consideration of the Commissions or Inquiry however; the significant trauma caused when Redress WA altered the payment level is a warning that altering core promises and parameters may cause unexpected personal and social damage.

Timing

Another decision that may have far reaching consequences has to do with the timing or order of processes. In the case of the Redress WA Scheme applications were not assessed in the order of receipt. Applications were randomly selected for processing meaning that some early applicants were kept in a state of heightened anxiety for up to 18 months whilst some later applicants were processed almost immediately. For the RC, it would be equivalent to people nominating to make a submission today and being asked to wait for half of the proposed length of time of the Commission before giving evidence. Without support, this would be difficult for many people. Redress WA did have an appropriate positive practice of contacting applicants before receiving notification of their payment options. Some were terrified of opening the registered mail.

Eligibility

The Western Australian State Government confirmed on September 2, 2011 the last ex-gratia payment of 5,333 had been made (McSweeney, 2011). Over 500 applicants were determined to be ineligible because they did not meet the criteria for payment under the Redress WA Scheme.

- Many were not advised until near the end of the Scheme. Some applicants experienced re-traumatisation when relating their distress, only to be told many months later they were not eligible.
- Each Commission, Inquiry or Scheme will have different criteria. Applicants will find it hard to establish whether their experience meets the criteria. This information needs to be shared repeatedly and very clearly. In the Redress WA Scheme it was often impossible to define a child's status without access to records. This meant an applicant may have been abused when fostered only to find the status of the placement did not meet the protocol.
- No allowance was made for people who were ineligible to access counselling or support.

Transparent decision making

The authors felt the Redress WA programme contained a number of unstated factors which appeared to play a part in decision making.

- Discussion about, and measurement of abuse, trauma and its consequences are extremely subjective. Many applicants did not fully understand the actuarial nature of the assessments in the Redress Scheme, requiring some measurable evidence of abuse. Many did not feel capable of providing this evidence either because they had never articulated it before or had not connected "symptoms" to their abuse as children.
- Siblings from the same family sometimes received different levels of payments as a result. Although raised in the same environment of abuse, placed in various institutions, having the willingness or inability to speak of sexual abuse, then receiving different levels of ex-gratia payments created further anger and feelings

of distrust. Two siblings from the same family received $45,000 and $13,000 respectively. This disparity created guilt and resentment, and revived feelings of rejection and shame. The result was not redress, but re-traumatisation. Another level of anger and despair was created in families, many affected by transgenerational neglect.

- "Copers" were penalised. It is known some applicants who were more successful in life or who had managed eventually to find outwardly an equable style of living were penalised even though they had sometimes experienced horrific abuse or very distressing family disturbances when in the care of the State.
- It was noticeable that some applicants associated with institutions who had either already instituted a form of redress or had received public acknowledgement such as the Roman Catholic Church's Towards Healing programme and the Child Migrant Scheme received high levels of payment.
- The anecdotal reports of applicants who had experienced severe abuse but who completed their own reports did not receive high levels of payment.
- It did appear that fully supported referenced applications were more successful.
- Some applicants saw advocates who were not fully versed in childhood trauma and therefore may have had more limited reports written with financial consequences.
- Some applicants used lawyers who charged fees thereby reducing the payment received.

Advocacy versus counselling

The Redress WA contract with advocates and counsellors was worded to provide report writing and counselling separately. Many advocates or counsellors were able to integrate counselling into the process, however, anecdotal reports of advocates asking if applicants wished for counselling as a separate item generally experienced negative responses. Anger towards and distrust of government systems is not easily overcome in a brief period of association.

Therapeutic assessment

Redress WA contracted 26 established services to conduct advocacy and counselling assistance. (McSweeney, 2011). The services used employed staff or sub-contractors. The Redress WA contract allowed report writers to spend up to 12 hours per applicant on interviewing and writing up a report. The writers did, for most applicants, turn the "application process" into a "therapeutic assessment" which provided a strong counselling-based influence in a very brief period of association.

One factor enabling this was one of the authors' involvement in ASTSS. Gail Green was aware of PTSD tests/assessment tools which could be used to assist in providing some level of objectivity of damage for applicants. The PCL-C and the DASS21 tests were chosen as they could be administered by all helping professions and were simple to use and score. Thanks to Associate Professor Grant Devilly, sub-contractors associated with CBERS (REDRESS) were able to access his electronic scoring tools. Scores and also brief information about the tests were added into all the reports and report writers were able to make reference to beliefs, thoughts and behaviour which bore out the test outcomes in the body of the report.

Other factors enabling therapeutic assessment were:

- the stated aim of Redress WA to say sorry for all that was done,
- understanding the therapeutic value of saying sorry,
- accepting as valid all of the applicants' experiences,
- the report writers' knowledge of the history of abuse in care in Australia
- psychoeducation, particularly about attachment theory, the widespread effects of grief, the effects of trauma on the limbic system and the knowledge that thought repetition and its opposite, secrecy, maintains anxiety and consequently the fight, flight and freeze responses.
- Incorporating and conveying an understanding of how the wider effects of the fight, flight and freeze responses are manifested as alcohol and drug dependency, poor schooling, risk taking, self-harm, anger, anxiety disorders such as agoraphobia, depression, disassociation, inability to love, poor decision making etc.

These factors combined to become a therapeutic process as the application's questions were answered, when administering the tools and taking the applicant's statement.

Even allowing for the limited time allocated to each client, the process of establishing rapport and trust is well known but for change to occur the client will

also need to desire or be ready, at both an intellectual and emotional level. Without these, change is difficult. A great deal of skill and perseverance is required during the development of a relationship so that exploration of life experiences can take place, making the relationship of events to outcomes clearer, and at the same time, working towards a more successful outcome. This process takes time and perseverance, particularly on the part of the client who finds this process difficult, frightening and often impinging on their sense of safety and therefore inducing desire for fight, flight or freeze responses.

In this case time allocated for each client was limited and applicants were often ambivalent about being re-immersed in their childhood trauma despite wanting to be involved in the process. Issues of trust and distrust are complex, however the above factors enabled advocate/counsellors to:

- emotionally hear and respond appropriately to applicants' stories
- elicit detail of the stories and in writing reports used the applicants' own words thereby acknowledging and accepting the applicants' world view,
- use the scope of the report writing to explore the applicant's understanding of how the trauma affected their lives.
- use the tools to show an understanding of the widespread results of trauma manifesting as PTSD, anxiety and depression and how it had impacted on function,
- illustrate with descriptive, emotive psycho-education the mental and physical responses in the brain and the body when the brain is affected by trauma and how they manifest as fight, flight and freeze reactions,
- enable the applicant to gauge their emotional age, allowing the report writer, with the applicant, to make some connections between their childhood experience and their adult self thus enabling a sense of distance from the childhood experience. This created a separation from the trauma and an opportunity to move forward, and
- assist applicants to understand there are known recovery processes.

Counsellors were able to express regret, to reiterate the apology aspect of Redress WA and to validate the applicants' experiences and to encourage applicants to review their previous shame and self-blaming thinking and behaviour. Most listened intently when these feelings were explained to be consequences of the abuse. By doing this the "unacknowledged wound" which has been a source of sorrow, fear, grief and anger was heard. This process reflects the 5 stages of apology of being heard and responded to appropriately.

During this therapeutic process the applicant is provided with the information to understand why they felt, thought and behaved as they did and to reframe their experience in the future. This enabled the applicant to go out the door with their story having a future as well as a past.

The fully referenced reports provided to Redress WA enunciated the applicant's traumatic childhood and discussed sequelae. Not only did the reports assist Redress WA but also proved a powerful therapeutic tool for applicants who were provided with a copy. It was concrete evidence 'someone' had understood their story, their experience, and the impacts on their lives. Applicants used the report to communicate to loved ones what happened to them and why they were as they were. It is not known how many applicants would have had a report such as this. Those who completed their own applications or had their applications conducted by non-professionals may not have had access to this additional information and therefore may have been less able to use the process therapeutically.

Consequently some applicants made significant changes in their lives daily lived. However others didn't. Other influences are co-morbidity and/or the issue of trust.

Boundaries: trust and distrust

"Core principles of trauma-informed care are 'safety', 'trustworthiness', 'choice', collaboration' and 'empowerment'." (Kezelman & Stavropoulos, 2012). The adult who has experienced childhood abuse experiences broken trust yet has a strong need for attachment resulting in personal boundaries which are regulated by fear and a need for love. Consequently applicants variously experienced:

- an expectation that Redress WA would somehow 'cure' their lives once they had told their story,
- re-occurring co-morbidity issues as they attempted to trust the advocate/counsellors
- a lack of support, with old wounds reopened by the application process left unaddressed.

The above principles are relevant when establishing

a relationship with any individual and are most important in this area of work.

Comorbidity

It is often forgotten that trauma symptoms rarely stand alone, they are most often further expressed in substance misuse, other mental illnesses, criminal behaviour and the like.

As stated the funding formula allowed limited time to spend with each applicant. To complete a report at least two face to face sessions were needed. The authors and others chose to contribute extra time and saw clients on three to six occasions, however, even with extra time it was impossible to ameliorate lifetime issues of co-morbidity which may have been triggered or exacerbated by re-experiencing the past.

Retraumatisation

Telling their story, often for the first time, sometimes for yet another time, was deeply retraumatising for many applicants. Hearing about the Redress Scheme or multiple Commissions and Inquiries and now almost daily reporting of people who have been abused, on radio, television or other media stirs up memories and feelings and many are repeatedly re-experiencing their trauma. Not surprisingly then, many viewed the change in ex-gratia payments as creating another layer of anger on top of that felt towards the 22 institutions named by applicants, the people who abused the applicants, the anger they felt against themselves and those around them who hadn't helped.

Potential for self-harm and suicide

There were unintended consequences for many people telling their stories. It is known some applicants used the ex-gratia payment for their alcohol and drug dependencies and several died doing this. The potential pitfalls of encouraging someone with long standing mental health and addiction issues to recount their history of abuse are a responsibility which needs careful ongoing consideration.

Educational and clinical supervision

All staff associated with all stages of the establishment, procurement and operation of any commission, inquiry, scheme or legal action need to have:

- extensive education regarding the widespread effects of childhood trauma,
- clinical supervision for all staff, and
- access to employee assistance programmes.

These measures would help towards

- maintaining for staff the integrity of the inquiries,
- ensuring that best practice quality assurance was delivered,
- understanding the tension between legal and therapeutic demands of the inquiries and the benefits and costs of each, and
- assisting in reducing vicarious and secondary trauma of applicants and staff.

Managing expectations

Some applicants came to the Redress process expecting it would change their lives, and some were bitterly disappointed when their life did not change appreciably. Others expected little to change and were surprised to find relief in being open about their history. It was difficult to predict these effects five years ago but now the authors feel that the potential negative outcomes of investigations could be taken into account more when planning and instituting commissions, inquiries and schemes associated with a vulnerable population.

It is true many people were very grateful for the personal assistance, the ex-gratia payments and the letters of apology they received. Many applicants used the money wisely and felt believed and validated. However, what may not have been adequately taken into account was that an implicit expectation was created that simply telling their story would change their daily lives. It was deeply saddening that some woke up at the end of the process with their lives still broken and deeply impacted by trauma.

Societal costs of trauma

During the last decade the profile of childhood abuse has been raised publicly. In this time awareness of the traumatic outcomes such as

- crime,
- alcohol and drug dependency,
- domestic violence,
- perpetrating further abuse,
- difficulties in schooling,
- poor parenting and relationship skills,
- negative mental and physical health outcomes, and
- transgenerational and intergenerational

issues has also been raised.

There have been major breakthroughs in the fields of neuroimaging, neuroscience, genetics and epigenetics, which have assisted in understanding the mechanics of what is happening for the individual during traumatic events. Nature and nurture are intertwined affecting families trans generationally.

Research shows in Canada, which has a similar history to Australia, a vulnerable group, the Indigenous population, experience substantially higher rates of depression (Stewart, Gucciardi, & Grace, 2004). Research into the development of the brain in children who have mothers who have depressive symptomology and low paternal involvement developed larger amygdalas and had increased levels of glucocorticoids (Lupien et al., 2011). Conclusions were that the development of a larger amygdala, particularly in the early years of life, and increased stress level hormones are risk factors for mental health problems by the age of 9 (Lupien et al., 2011). These are a few examples showing that if Australia really wishes to have a society with less mental health issues, less crime, less drug and alcohol dependency, violence, poor schooling, poor health and transgenerational issues that placing appropriate trauma informed policies in place into all government agencies and institutions is of paramount importance. Institutional commissions and inquiries could positively influence this outcome.

Conclusion

From the start of the Redress WA Scheme in May 2008, and Prime Minister Rudd's Apology to the Forgotten Children in November, 2009 there seemed to be a feeling of change in the wider community and amongst applicants about abuse and trauma. However this energy needs to be tempered by developing knowledge and awareness of potential negative outcomes when planning and undertaking commissions, inquiries and schemes associated with a vulnerable population.

The authors noted several key areas from their experiences with Redress WA which they consider were major challenges for staff, contractors and applicants. We are mindful of the potential to re-traumatise clients, and our experience has highlighted to us the 'retelling' of trauma and abuse without measured support and consistent government policy can potentially amplify a variety of longstanding and painful emotions including shame, abandonment, distrust, anger fear and hurt.

Our experiences with Redress WA has also made us aware there are significant risks for some applicants in recounting their narrative as many had co-morbidity with other issues including mental and physical health problems.

We would also highlight the importance of timely and widespread promotion of the Commissions and inquiries, allowing adequate time for service providers to fully support all members of the public who come forward to tell their stories. Consideration needs to also be made for an 'all inclusive approach', ensuring that there is wide eligibility and access for those wishing to tell their story. Furthermore, all outcomes need to be transparent. It is also critical that all staff are adequately trained in trauma, trauma informed care principles, and management of trauma sequelae.

Finally we showed only one example how of depression in a vulnerable traumatised population becomes transgenerational causing mental ill health. The re-traumatisation not only affects the individual but is a rippling pool which has genetic, environmental, emotional and physical effects on their immediate relationships and then the wider community.

The Royal Commission, the New South Wales Special Commission and the Victorian Government's Parliamentary Inquiry presented the wider community with opportunities for both public discourse and validation of those individuals abused as children. With thoughtful and planned support for traumatised and/or maltreated sufferers to tell their story, including follow-up support they have the potential for significant individual and national healing. The consequences of ignoring preventative responsibilities are fraught with sadness.

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Gail Green, BSW, Dip Ed
Dion Leeuwenburg, BSW
Janice MacKenzie, B.Couns,Dip.A&D
Julie Watts,B.Couns

Green, G., Leeuwenburg, D., MacKenzie, J. & Watts, J. (2014). Reflections from the Redress WA experience in light of the royal commission into institutional responses to child sexual abuse. *Stress Points, Summer,* 7-13.

Locked Up: Seclusion and Trauma in Modern Practice

By: Ancelin McKimmie

People admitted to acute psychiatric units may be acutely unwell, and their symptoms may be accompanied by behavioural disturbances. They may become distressed, aggressive, violent or a danger to themselves (Elder, Evans & Nizette, 2010). In these situations, hospitals can employ a range of containment methods to prevent adverse outcomes (Cleary, Hunt & Walter, 2010). One method is seclusion, which is the practice of placing a person, at any hour of day of night, alone in a room with the windows and doors locked from the outside (Victorian Mental Health Act, 1986). Seclusion is most frequently employed in the management of aggressive patients whose behaviour threatens physical violence to others, verbal abuse and property damage (Bowers et al, 2010).

Despite increasing scrutiny of seclusion from both within and outside the mental health profession, and a lack of evidence to support its effectiveness, seclusion remains a common practice (Happell & Koehn, 2010). In the current environment of mental health care in Australia, which promotes client autonomy and the use of the least restrictive interventions, seclusion is controversial. It is considered restrictive, controlling and coercive, and possibly inconsistent with Victorian human rights legislation and the United Nations resolution on mental illness principles. Research has linked seclusion to negative outcomes that detract from the quality of care, and demonstrated a close relationship between restrictive interventions and serious adverse effects (Donat, 2005; National Mental Health Working Group, 2005). The Australian Government has identified seclusion as a priority area for reducing harm in mental health care (National Mental Health Working Group, 2005). This essay challenges the complacency that exists in mental health institutions about the use of seclusion, arguing that such confinement of patients can have serious negative effects, infringes on human rights, and is not an evidence based practice.

Seclusion puts mental health patients at risk of significant physical and psychological harm, including re-traumatisation (Huckshorn, 2006). For example, seclusion can trigger responses to previous traumatic experiences in a person with a history of abuse (National Mental Health Working Group, 2005). These responses may be severe, such as dissociation and flashbacks, which can feature in post-traumatic stress disorder. Freuh et al (2005) investigated the frequency of traumatic experiences occurring within psychiatric settings. They found that clients may view restrictive measures as similar to their previous traumatic experiences, and that this can exacerbate the symptoms of a person's mental illness.

Many clients who undergo seclusion report experiencing negative emotions as a result. In qualitative studies into the effects of seclusion, feelings of anger, helplessness, powerlessness, humiliation and punishment are frequently reported. The majority also describe the experience as distressing, as it elicits feelings of fear and loneliness (El Badri & Mellsop, 2008; Hoekstra, Lendemejer & Jansen, 2004). Seclusion may also present a physical danger to patients, especially those who are disturbed or intoxicated, and have been administered sedatives (Bowers et al, 2010). Given its potential to cause such a range of harms, the employment of seclusion in such a vulnerable population must be questioned.

Mental health care should emphasise respect for the autonomy and dignity of clients, and practitioners and their patients need to develop a therapeutic relationship. The use of seclusion can readily undermine this relationship (Kontio et al, 2010). A client's opinion of the care they receive is diminished by seclusion (Donat, 2005), while enforcing the restriction on a patient can be a negative experience for staff (Moran et al, 2009). Apart from affecting the therapeutic relationship, this combination increased the likelihood that seclusion will be used, resulting in a vicious cycle. It was the position of the National Mental Health Consumer & Carer Forum (NMHCCF) (2010) that seclusion highlights a failure in care and treatment. It is particularly concerning that consumers of mental health services report that the use of seclusion makes them feel less likely to seek help in the future (Freuh et al, 2005; NMHCCF, 2010).

As a restrictive, controlling and coercive practice, the use of seclusion raises human rights issues. Routinely denying patients their freedom is arguably inconsistent with legislation at both state and international level. Section 10(b) of the Victorian Charter of Human Rights and Responsibilities Act (2006) directs that a person

must not be treated or punished in a cruel, inhuman or degrading way. Seclusion could constitute cruel, inhuman or degrading treatment; as mentioned previously, the majority of clients report that an episode of seclusion is degrading (Freuh et al, 2005). Section 10(c) of the Act directs that a person must not be subjected to medical treatment against the wishes of the person. Seclusion occurs against the client's wishes. Seclusion may also be inconsistent with several items of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991). Principle 1(2) directs that all persons with a mental illness shall be treated with humanity and respect for the inherent dignity of the human person. In qualitative studies, clients commonly report feeling that seclusion deprives them of their dignity (Donat, 2005; Hoekstra, Lendemeijer & Jansen, 2004). Principle 1(3) states that all persons with a mental illness have the right to protection from degrading treatment. Again, seclusion is inconsistent with this principle, as evidenced by clients' reports of the experience being degrading. Principle 8(2) states that every patient shall be protected from harm, including acts causing mental distress. Seclusion is known to cause psychological harm, even worsening symptoms of mental illness, and as mentioned previously, may be associated with threats to physical wellbeing (Bowers et al, 2010). These United Nations Principles recognise the undesirability of seclusion specifically, expecting it to be used only in exceptional circumstances, expressing stringent guidelines for its use, duration, documentation and the conditions which must be met.

The practice of seclusion lacks a solid evidence base and there are variations in the clinical standards governing its use. As such, the effectiveness of seclusion in the management of aggressive clients remains questionable (Moran et al, 2009). Empirical research is yet to provide evidence in support of a theoretical rationale for seclusion (Muir-Cochrane & Homes, 2001). A review by Salias & Fenton (2000) aimed to estimate the effects of seclusion and restraint compared with alternatives, but this review was unable to make any recommendations due to a lack of controlled trials. Instead, Salias & Fenton (2000) suggested that, given the invasiveness of the intervention and reports of serious adverse effects, its use should be minimised. In another review, Steinert et al (2010) aimed to identify quantitative data on the use of seclusion and restraint. They found that empirical data on the frequency and duration of these measures is very limited and concluded that it was difficult to support the use of seclusion and restraint as they lack supporting evidence. Currently there are no Australian standards on what appropriate use of seclusion is, or what constitutes inappropriate use (Mental Health Working Group, 2005). The Royal Australian and New Zealand College of Psychiatrists (2010) report variation in the clinical standards that govern the use of seclusion and guide its appropriate use. There are no random-control trials from which the effectiveness of seclusion can be analysed, so the decision to implement seclusion is based on factors that are not supported by a 'gold-standard' base of evidence (Happell & Harrow, 2010). The lack of evidence and inconsistencies in the use of seclusion call its therapeutic benefit into doubt. It cannot be said that the seclusion of patients in mental health care will lead to desired outcomes. Instead, evidence based practices proven to be effective in the provision of care should be considered.

Despite the controversy surrounding the use and appropriateness of seclusion it continues to be employed as a treatment option, even when preventative techniques are available. Restraint is perceived as an essential strategy in the management of violence and aggression, and the most common rationale justifying its use is that seclusion is a necessary intervention for the management of aggressive acts (Happell & Koehn, 2010; Happell & Gaskin, 2011). Aggression and violence are common occurrences in in-patient wards and seclusion is used by staff as a risk management strategy for these behaviors (Cleary, Hunt & Walter, 2010). In fact, staff view seclusion as one of their few options to manage violent patients and ensure safety (Happell & Harrow, 2010). There are, however, interventions which have been shown to be successful in significantly reducing the rates of seclusion, without a resultant increase in the incidence of violence and aggression (Smith et al, 2005). These interventions can be complex, incorporating multiple factors, such as policy change, improved patient-staff ratios, psychiatric emergency response teams and increasing advocacy efforts by consumers and carers (Smith et al, 2005). One intervention staff can employ is the use of advance crisis planning (Smith et al, 2005; Donat, 2005). This involves asking clients about circumstances that can trigger aggressive behaviours, and identifying how they would prefer these behaviours be managed. Including clients in planning decreases the need for restrictive treatment options, such as seclusion, as it empowers the client and ensures treatment is individualised (Donat, 2005). The National Mental

Health Working Group (2010) identified that a lack of staff knowledge and skills to prevent seclusion, or identify alternative interventions, are barriers to reducing seclusion use. Strategies suggested to overcome these barriers include education and training for aggression management, and the development of national standards (National Mental Health Working Group, 2010).

In summary, seclusion can cause serious harm and its efficacy as an intervention in mental health care is questionable. Seclusion can be harmful for both those who experience it and the nurses who administer it; this can impact on nursing practice and impact on the quality of care provided. As it is such a restrictive, controlling and coercive practice, seclusion can be viewed as incompatible with human rights legislation. Infringements of human rights should lead practitioners to question the practice. Mental health workers can implement alternative strategies which reduce rates of seclusion. Seclusion will continue to be used while it is perceived as the only way to manage certain behaviours, but with education, training and research to develop evidence based alternatives, the practice of seclusion would be further reduced, if not eliminated. Such an outcome would result in higher quality mental health care and better health outcomes for clients.

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Ancelin McKimmie BA.,MNSc
University of Melbourne

McKimmie, A. (2014). Locked up: seclusion and trauma in modern practice. *Stress Points, Summer,* 14 - 17.

The Role of Psychological Trauma in Indigenous Australian Suicide

By: Sonia Baldock

In the decades before the 1980s, suicide among indigenous Australians was extremely rare (Hunter, 2007; Cox, 2010). Today a young indigenous Australian is more than four times more likely than a non-indigenous Australian to commit suicide (Australian Bureau of Statistics, 2010). This is a trend that demands explanation. The traditional indigenous Australian view of life and death is relevant to the discussion, and this essay will explore the topic briefly. It will then discuss the psychological trauma that has plagued indigenous Australians since colonisation, and the role that the memory of colonisation plays in suicide in Aboriginal communities today. Trauma informed care will be a focus, as will cultural understanding, rapport building with indigenous Australians, and empowering individuals and communities, based on a review of relevant literature.

Indigenous Australians: Life and Death

In traditional Aboriginal culture life is considered valuable and sacred (Hunter & Milroy, 2006). Life is closely connected to the environment and is celebrated as a part of creation (Hunter & Milroy, 2006). Life doesn't begin with birth and end with death, but instead every individual is a part of a larger story that begins with creation and ends in eternity (Hunter & Milroy, 2006). Within this view of life there is no room for self-annihilation, or suicide, because life embraces living out ones own part in that bigger story (Hunter & Milroy, 2006).

Death is also very important in Aboriginal culture, and the time leading up to death holds much significance (Trudgeon, 2010). Families will gather to sing their clan story to a dying relative (Trudgeon, 2010). This is done to remind the dying individual of their place in the clan and in the world around them (Trudgeon, 2010). "It is like reading a book about the history of the person, their clan and clan estates and how they fit into the scheme of things (Trudgeon, 2010, pg. 155)." The singing changes as the individual dies in order to help the spirit move into its traditional place of rest (Trudgeon, 2010). Suicide, then, is an abrupt interruption to the natural celebration of life and death in this culture.

Colonisation and Trauma

The European colonisation of Australia threatened indigenous Australians' right to exist freely and humanly, and to go on existing as an Aboriginal people (Kuipers, Appleton & Pridmore, 2012; Blair, Zubrick & Cox, 2005). It interrupted the greater story in which indigenous Australians see themselves a part, created a disruption of the generational cycle, and destroyed social links to the past (Hunter & Milroy, 2006; O'Loughlin, 2009).

The damage was inflicted by violence and death, and by policies and actions that continue to influence the social settings in which indigenous Australians live today (Garvey, 2008). The state took control and responsibility for indigenous Australians from birth. Many were born into institutional homes (Hunter & Milroy, 2006). This practice caused irreversible damage to indigenous family and kinship structures, and to cultural continuity, purpose and integrity (Hunter & Milroy, 2006). One man who was taken from his family at birth described life as a jigsaw puzzle, and that when you lose one piece, for example a person, that piece cannot be replaced and the puzzle is left incomplete (Cox, 2010). This man never knew his parents and his children are all in white foster families. As a result, he admits to wanting to end his life on a daily basis (Cox, 2010).

Indigenous Australians were raised in residential schools and foster care were frequently refused the right to speak and learn their native language. This damaged the social links to their history irreparably (O'Loughlin, 2009). Right now, with each new generation, more Aboriginal culture and identity is lost. (Trudgeon, 2010).

Intergenerational Trauma

In indigenous populations, the ongoing symptoms of the political and cultural impact of colonisation include chronic unemployment, poverty and alcohol abuse. Recent research suggests that such adverse life events play a large part in suicidal behaviour (Kuipers et al., 2012; Foster, 2011). Indigenous teenagers today are the first generation to be raised in a world in which instability, substance abuse, depression and suicide are normative (Hunter & Milroy, 2006). Children of past

generations grew up seeing fear on their mother's faces, and witnessed atrocities such as large scale racial violence (Hunter & Milroy, 2006).

We have learned recently that it is possible for severely traumatised individuals to transmit their trauma to future generations (Eizerik, 2010). One of the most important factors in this transmission is the inability of survivors of trauma to remember, mourn and to symbolise their experience (Connolly, 2011). This causes a discontinuity between past, present and future and deeply affects the ability of survivors and their children to create meaningful narratives that give them a sense of identity (Connolly, 2011).

Prevailing attitudes among non-indigenous Australians foster this disfunction. While non-indigenous Australians commemorate past communal trauma regularly, most notably on ANZAC and Remembrance Day, they insist that indigenous Australians should forget their past and move forward (Trudgeon, 2010). For a people who continue to be directly affected by the impact of past policies and actions against individuals, families and communities, this act of repressing past trauma only serves to pass it on to future generations (Garvey, 2008; Connolly, 2011).

Suicide

Suicide in Aboriginal communities is frequently an expression of despair and helplessness in a people who have lost the sense of where they fit in the Aboriginal story, and have been disempowered by the Australian class structure (Hart, 2010). Today's teenagers are children of the stolen generation, and are growing up amidst much death and disability (Hunter & Milroy, 2006). Suicide is highly visible and so common in indigenous communities now that there is a sense of desensitisation, and of suicide having become normalised (Farrelly, 2008). One recent study found that out of four completed suicides of young people, three of them had direct or indirect experience of suicide or suicidal behaviour (Hunter & Milroy, 2006). Many young indigenous people's early development includes exposure to the threat or completion of an act of suicide (Hunter & Milroy, 2006). Victims often feel that the only control they can exert over their lives is to end it early (Hunter & Milroy, 2006).

Trauma Informed Care

Based on the knowledge that indigenous Australians continue to experience trauma, either directly through the impact of social and political issues, or inter-generationally, mental health practitioners who work with indigenous Australian communities must aim to provide trauma informed care (Green, 2011). They need to recognise when symptoms of trauma exist in the individual and community, acknowledge the role that trauma has played in the community's history, and also acknowledge how the associated interruption in culture has shaped the inner lives of people experiencing pain and disconnection (Farrelly & Lumby, 2009; Farrelly, 2008; Trudgeon, 2010). The impacts of past policies and actions against indigenous Australian individuals, families and communities continue to affect indigenous Australians today (Garvey, 2008; Trudgeon, 2010). Such a horrendous past cannot be erased, and its effects need to be acknowledged and accepted (Garvey, 2008; Trudgeon, 2010). Children are growing up with the stories of the atrocities committed against their ancestors and parents. Denying them these stories will only compound the sense of loss of culture and history (Trudgeon, 2010; Connolly, 2011).

Mental Health First Aid was developed to help provide appropriate care to an individual who is either developing a mental health problem, or who is in a mental health crisis (Hart, Jorm, Kanowski, Kelly & Langlands, 2009). A specific indigenous Australian Mental Health First Aid has also been developed, in consultation with Aborigines who are experts in mental health, to address more sensitively the issues Aborigines face with regards to psychological trauma (Hart et al., 2009; Garvey, 2008). People trained in this specialised Mental Health First Aid will discuss with patients issues of dispossession, violence, trauma, loss, and the endurance of racism (Hart et al., 2009; Garvey, 2008).

Cultural Understanding

Cultural awareness, a knowledge of indigenous Australian history, and a preparedness to be flexible are crucial to the provision of adequate care (Westerman, 2010). Many indigenous Australians comment that people from outside their communities, including mental health practitioners, fail to adequately understand the social world beyond the institution in which they work (Cox, 2010). In order to provide care that addresses the spiritual and emotional wellbeing of indigenous Australians, practitioners need an approach that is broader than that of standard medical psychiatry (Cox, 2010). Arguably, the first step needs to be a serious reflection on the practitioner's own cultural values, beliefs and

attitudes, and the affect these may have on other cultures (Farrelly & Lumby, 2009). All people who care for indigenous Australians experiencing psychological trauma should undertake training in cultural awareness so that the care they give is culturally appropriate (Farrelly & Lumby, 2009). The cultural values and beliefs of indigenous Australian communities should be incorporated into the design, delivery and evaluation of such services (Farrelly & Lumby, 2009). With cultural understanding comes an awareness of indigenous Australians concepts of healing (Atkinson, 2002). Atkinson (2002) speaks in her book of including in her treatments an Aboriginal cultural belief of healing, the 'dadirri':

> "The principles and functions of dadirri are: a knowledge and consideration of community and the diversity and unique nature that each individual brings to community; ways of relating and acting within community; a non-intrusive observation, or quietly aware watching; a deep listening and hearing with more than the ears; a reflective non-judgmental consideration of what is being seen and heard; and having learnt from the listening, a purposeful plan to act, with actions informed by learning, wisdom, and the informed responsibility that comes with knowledge"
>
> (p. 161)

The emphasis here is on the community and ancestral memory (Atkinson, 2002). It incorporates a reflective discussion that includes storytelling, drawing, writing, dancing and drama. It attempts to understand the history of colonisation, and the impact it had on indigenous Australian communities (Atkinson, 2002).

Rapport

Establishing a rapport is essential to providing any patient with effective mental health care (Elder, Evans & Nizette, 2009). In the case of indigenous Australians, this process needs to include a discussion of the person's genealogy, as in Aboriginal cultures ancestral connections are central to a person's identity (Westerman, 2010). The practitioner must recognise that an indigenous Australian person goes beyond the individual, and includes where they fit in the greater story (Westerman, 2010; Hunter & Milroy, 2006). They should also be willing to self-disclose about their own family connections and background (Westerman, 2010). This helps the patient to "place" the practitioner and relate to them on a deeper level (Westerman, 2010).

Empowering Individuals and Communities

Often in the past, non-indigenous Australians have entered indigenous communities and imposed well-meaning interventions, which leave communities and individuals with a sense of disempowerment (Green, 2011; Trudgeon, 2010). This approach is counterproductive. The emotional and cultural well-being of indigenous Australian individuals usually relies upon the overall health and wellbeing of their community (Garvey, 2008). It follows that indigenous Australian communities should be directly involved in the development, programming and delivery of mental health services, allowing a sense of community ownership (Green, 2011; Trudgeon, 2010; Farrelly, 2005).

In the case of suicide, communities can be empowered through education about the warning signs displayed by suicidal individuals (Tighe & McKay, 2012; Hart et al., 2009). Tighe & McKay (2012) have begun to evaluate the effects of a specific suicide intervention called 'Alive and Kicking Goals'. Young members of the Broome Saints Football Club met with a mentor and formed a youth sub-committee that underwent training in suicide prevention and leadership skills. Members of the committee were taught how to recognise suicide risk factors and warning signs, healthy coping strategies, and ways to deal with at-risk youths in their community. This project was built upon a pre-existing community group, encouraged social inclusion and gave members a sense of purpose. It also introduced a safe place for people to talk about a taboo topic - suicide. The project is owned entirely by an indigenous community and recognises the need for Aboriginal people to do it their way (Tighe & McKay, 2012).

Conclusion

Suicide in indigenous Australian communities is tragic and a growing trend that needs to be stopped. Psychological trauma plays a very important role in the mental health of young indigenous Australians today, and in order to decrease the numbers of attempted and completed suicides in these communities, we must recognise and understand the impact of history on future generations. The problem cannot be solved with a blunt imposition of Western medical interventions. Mental health practitioner who work with indigenous Australian's need to learn more about their culture, beliefs, and history and how these inform the troubled behaviours of indigenous Australians

today. Ultimately, only the restoration of a sense of community and of individual strength and power can overcome the damage that colonisation has caused to these communities, their cultures and their stories.

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Sonia Baldock, BM,MM,MNSC
University of Melbourne

Baldock, S. (2014). The role of psychological trauma in indigenous Australian suicide. *Stress Points, Summer,* 18-22.

Indigenous Australians, Psychological Trauma and the Personality Disorders

By: Jessica Venables

Early psychological trauma is widely recognised as a contributing factor in the development of personality disorders, with research suggesting that neglect or abuse during childhood increases the likelihood of receiving a diagnosis in this category in excess of four times (Balls & Links, 2009). Trauma appears to play a particularly significant role in the aetiology of Borderline Personality Disorder (BPD), with as many as 85% of individuals diagnosed with BPD reporting a childhood trauma history (Venta, Kenkel-Mikelonis & Sharp, 2012). Early trauma is regarded to impair the development of key personality domains, perpetuating the unstable sense of identity and difficulties in emotional and behavioural regulation which characterise BPD (Perepletchickova, Ansell & Axelrod, 2012; Venta et al, 2012). While the discussion of the role of trauma in BPD aetiology has mostly focussed on the individual, any examination of trauma in relation to Indigenous Australians requires a revision of the notions of trauma traditionally defined by Western psychology (Krieg, 2009). Massacre, racism and the systematic removal of children from their parents as recently as the late 1960s have compounded to a transgenerational trauma, resulting in the fragmentation of both community and individual identity across multiple generations (O'Loughlin, 2009). The discussion of mass trauma in psychological literature has primarily focussed on the immediate aftermath of disaster, a definition which does not sufficiently contain the ongoing trauma to which Indigenous communities are subject (Krieg, 2009). Aspects of this trauma, such as discrimination and cultural suppression, have led to a mistrust of the dominant Western culture with the Indigenous population reporting a particularly low engagement with mental health services (Isaacs, Pyett, Oakley-Browne, Guis & Waples-Crowe, 2010). Despite this low engagement, mental disorders are recognised to be the second leading cause of disease burden to Indigenous Australians, surpassed only by cardiovascular disease (Isaacs et al, 2010). Low engagement may also contribute to a disproportionately high rate of suicide, with one survey suggesting that among Aboriginal people who had a diagnosable mental illness at the time of death, only 14% had sought mental health treatment (Isaacs et al, 2010). This highlights the urgency to address the issue of BPD among Indigenous Australians as even among the general population BPD is estimated to carry a lethality of around 10% by suicide (Soloff & Chiappetta, 2012). This paper will attempt to examine how the ongoing trauma experienced by Indigenous Australians may contribute to the development of personality disorders, in relation to several characteristics often observed in BPD – identity disturbance, aggression, self-directed violence and a pattern of volatile interpersonal relationships (Evren, Cinar, Evren & Celik, 2012; Venta et al, 2012). Lastly, it will propose how this discussion may inform clinicians when working with Indigenous Australians.

Identity disturbance in individuals diagnosed with BPD is often manifested by frequently shifting goals, values, career aspirations and relationship priorities (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000). While the causation of this unstable self image has been the topic of much debate, Indigenous psychotherapist and academic Tjanara Goreng Goreng provides a compelling theory as to its origin in Indigenous Australian subjects in the discussion of her own recovery from Dissociative Identity Disorder (Goreng Goreng, 2012). Removal from family and homeland, impersonal treatment and suppression of Indigenous culture has contributed to a physical, emotional and cultural disenfranchisement embodied by the notion of 'terra nullius', a sense of 'belonging to no one and nowhere' (Goreng Goreng, 2012; Petchovsky, San Roque, Napaljarri Jurra, & Butler, 2004). While child removal policies ended in the late 1960s, the healing of communities following some several hundred years of trauma is an ongoing project (Krieg, 2009). The premature deaths of many community members and annihilation of culture has cut the ties to a shared history, amounting to what has been described as a process of 'acculturation' where the collective identity of a community is left fractured and undefined (Goreng Goreng, 2012). Descriptions of traumatised communities make reference to role diffusion and boundary violation, the trauma cycle perpetuated through sexual abuse and interpersonal violence (Krieg, 2009). The difficulty of forming a functional individual identity in the context of a fractured community is clearly apparent (Petchovsky et al, 2004).

Unprocessed grief in response to past trauma and the loss of culture may also be related to mood

dysregulation contributing to inappropriate expressions of anger and acts of violence, behaviours also frequently observed in BPD (DSM-IV-TR, 2000; Wenitong, 2008). In a qualitative study interviewing nine survivors of the 'Stolen Generation', all subjects without exception identified difficulties controlling mood and unpredictable excessive anger as a major difficulty (Petchovsky et al, 2004). One interviewee spoke of 'mixed feelings, hatred', describing a propensity to 'go off with my relatives, even my children, for no apparent reason' (Petchovsky et al, 2004). Perhaps unsurprisingly, trauma during childhood is a widely recognised risk factor for engaging in aggressive behaviour, and such behavioural patterns appear to be far too easily transmitted across the generations (Perepletchikova et al, 2012). This is particularly apparent when examining the characteristics of Indigenous criminal offenders who in relation to non-Indigenous offenders are more likely to be younger at the time of offence, to have committed a violent crime and to report difficulties with family and living arrangements (Hsu, Caputi & Byrne, 2010).

In addition to outwardly directed aggression, individuals diagnosed with BPD frequently display violence towards the self in the form of deliberate self harm and suicidal gestures with up to 10% of individuals diagnosed with BPD ultimately completing suicide (DSM-IV-TR, 2000). While the high suicide rate among the Australian Indigenous population is frequently remarked upon, the link between recurrent self mutilating behaviour and eventual completed suicide demands closer investigation (Isaacs et al, 2010; Phillips, 2009). Studies on self mutilation among the general population have found that rates of deliberate self harm (DSH) are increased among individuals who have experienced childhood trauma (Evren et al, 2012). The child victim of trauma has few avenues to communicate their distress, often silenced by coercion or a fear of the consequences of speaking up (Yates, 2004). The practice of deliberate DSH may begin at a young age as a way to inscribe 'a voice on the skin', a way to express pain 'when the actual voice is forbidden' (Yates, 2004). DSH is also recognised to operate as 'a morbid form of self help', acting to neutralise mounting anger and anxiety, or to provide relief from the rapidly fluctuating emotions often associated with BPD (Evren et al, 2012).While the aforementioned study on victims of the 'Stolen Generation' did not specifically examine engagement in DSH, the interview process revealed that all nine subjects had experienced recurrent suicidal ideation, with five having attempted suicide (Petchovsky et al, 2004).

BPD is also characterised by a pattern of unstable interpersonal relationships which may be associated with an insecure attachment style where trusting others is difficult and the self is viewed unfavourably (Ball & Links, 2009; Venta et al, 2012). All but one interviewee in the study of 'Stolen Generation' victims cited a history of serial relationship breakdowns, their accounts providing compelling evidence as to how an insecure attachment style may develop in Indigenous subjects (Petchovsky et al, 2004). Reflecting on being taken from his family, one man described being 'struck by how bewildered and powerless his father was, and took his lack of resistance as proof that his father no longer cared for him' (Petchovsky et al, 2004). Such childhood experiences of trauma may influence the grown trauma victim's own parenting practices, with one interviewee describing a state of 'chronic tension, a terror of anything happening to my children' (Petchovsky et al, 2004). Such parental anxiety is easily transmitted to the child, with psychoanalytic writing on trauma highlighting the child's susceptibility to absorbing emotional cues from their parents (O'Loughlin, 2009). Furthermore, Indigenous children continue to confront the possibility of separation from their family, often due to the intervention of government services or the juvenile justice system (Fawcett & Hanlon, 2009). While it is not the purpose of this essay to debate the validity of removing Aboriginal children from their families with the justification of protecting them from abuse, it is clearly important to discuss whether current government policy risks replicating the trauma experienced by the 'Stolen Generation', cultivating a collective anxiety and insecure attachment style contributing to an epidemic of mental illness (Fawcett & Hanlon, 2009; Petchovsky et al, 2004).

The discussion of the complex aetiology of personality disorders in Indigenous Australians highlights the urgent need to promote engagement with mental health services and to deliver more effective and culturally appropriate treatment (Fielke, Cord-Udy, Buckskin & Lattanzio; Isaacs et al, 2010). Literature suggests that all Indigenous clients should be subject to trauma screening in order to uncover causative factors rather than merely identify the most superficial symptoms of mental illness (Green, 2011; Nadew, 2012). For example, one study of Indigenous Australians aged between 18 and 65 identified a 91% prevalence of alcohol abuse in individuals who met the criteria

for Post Traumatic Stress Disorder (Nadew, 2012). This suggests that individuals affected by trauma frequently self-medicate with alcohol, so practitioners must be vigilant to the likely presence of co-morbidities and not allow the often overwhelming symptoms of substance abuse to prevent a comprehensive mental health examination (Nadew, 2012). This is of particular pertinence to this discussion as BPD has been repeatedly associated with substance use disorders (Evren et al, 2012). It has also been suggested that an initial mental health assessment should reframe the question "What is wrong with you?" to instead ask "What happened to you?" as this may aid in decreasing feelings of stigmatisation as well as identifying the issues at the core of a client's presentation (Green, 2011).

Similarly, an approach to mental health interventions which demonstrates a greater cultural sensitivity will lead to less superficial treatment, with research suggesting that an awareness of the differences between Indigenous and mainstream Western concepts of mental health is of particular importance when working in this area (Nadew, 2012). The Indigenous concept of mental health is considered to be more holistic, incorporating the wellbeing of family, community and environment as well as that of the individual, perhaps better described by the term 'social and emotional well-being' (Jorm, Bourchier, Cvetkovski & Stewart, 2012; Nadew, 2012). For this reason, clients may respond better to treatment if they are encouraged to bring a support person such as a close friend or family member to appointments (Hart, Form, Kanowski, Kell & Langlands, 2009). There should also be an emphasis on encouraging activities which promote social connectedness and a sense of belonging and purpose such as community groups or sport (Hart et al, 2009). Finally, practitioners should work in an outreach capacity to the greatest possible degree as visibility within communities will promote positive engagement, foster trust and aid in combating the perception of mental health services as paternalistic and out of touch with the needs of Indigenous people (Fielke et al, 2009).

There are also several issues related to gender which are important to consider when working with Indigenous clients. It has been remarked that Indigenous people are often uncomfortable with the idea of discussing illness with members of the opposite sex so all efforts should be made for clients to be treated by practitioners of the same gender (Isaacs et al., 2010). This is perhaps a matter of particular importance when treating females with a history of sexual trauma (Isaacs et al., 2010). Conversely, Indigenous men may require extensive outreach support from male clinicians to feel reassured that seeking treatment for mental health issues is not emasculating, as health clinics are sometimes perceived in Indigenous culture to be a 'woman's place' (Isaacs et al., 2010).

While this paper has made some suggestions in regards to clinical practice when working with Indigenous clients, it is clear that far more needs to be done to promote engagement between Indigenous communities and mental health services. In 2009, the Australian Government acknowledged that the gap between life expectancy, educational outcomes and employment of Indigenous and non-Indigenous Australians had not narrowed over the past ten years, factors which may be directly linked to mental health status (Rigby, Duffy, Manners, Latham, Lyons, Crawford & Eldridge, 2011). We should aim for the early identification of mental health issues before self-medication with alcohol or illicit substances has formed a substance use disorder co-occurring with psychological distress, making mental health issues all the more difficult to untangle and treat effectively (Nadew, 2012). Early identification and treatment is particularly important in the context of disorders such as BPD which are associated with a high suicide rate (Soloff & Chiappetta, 2012). BPD is a complex disorder which often co-occurs with anxiety, depression, eating disorders and the aforementioned issue of substance abuse so practitioners must be alert to the possibility of comorbidities if patient outcomes are to be improved (DSM-IV-TR, 2000). It is also a disorder which often becomes apparent during the adolescent years so addressing the symptoms of emerging BPD in Aboriginal teenagers may have major implications for reducing the high rate of mortality associated with mental illness among the Indigenous Australians (Hart et al., 2009; Jorm et al., 2012; Venta et al., 2012). In 2001, 39% of Indigenous Australians were under 15 years old compared to only 20% of the non-Indigenous population (Hart et al., 2009). Such a statistic underscores the urgency of investing in holistic, culturally appropriate mental health care with a particular focus on youth engagement and the early identification of emerging mental health issues (Hart et al., 2009).

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Jessica Venables, BA.,MNSc

The role of psychological trauma confronting Indigenous Australians with psychotic disorders

By: Patriece Shelley

It is well documented that Indigenous Australians, comprising 2.5% of the Australian population, suffer a higher rate of poor mental health than non-Indigenous Australians (Pink & Allbon, 2008). An Indigenous Australian is defined as 'a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he [or she] lives' (Department of Aboriginal Affairs, 1981). Researchers have documented a significant increase in the prevalence of psychotic disorders amongst this population over the past two decades (Hunter et al., 2012). Using the formulation framework of the 4Ps (predisposing, precipitating, perpetuating and protective factors) attributed to Broder and Hood (Havinghurst & Downey, 2009) it will be argued that the cultural, spiritual, social and economic elements of Indigenous Australians can provide a basis for understanding the psychological trauma and ensuing psychosis which has impacted this population.

Prevalence of psychotic disorders

Psychotic disorders are classified by a complex range of symptoms including delusions (false fixed beliefs), hallucinations (sensory perceptions in the absence of external stimuli) disorganised speech and behaviour, and a range of cognitive issues such as emotional blunting (DSM IV-TR, 2000). Psychosis occurs in conditions such as schizophrenia, mania, severe depression or substance abuse. A study from the 1960s estimated a prevalence of schizophrenia among an Aboriginal tribe in Central Australia at 0.46% (Parker, 2010). This stands in contrast with more recent data from Hunter et al., (2012), which found that the Indigenous populations of Cape York and Torres Strait displayed a psychosis rate of 1.68%, which is more than triple the prevalence of schizophrenia in other populations (Saha, Chant, Welham & McGrath, 2005).

Hunter et al., (2012) also found that alcohol and cannabis use was common in this population, a factor that other studies have shown has a high correlation with psychosis (Bohanna & Clough, 2012; Nadew, 2012). These figures highlight that the experience of psychosis, particularly in relation to substance abuse, is a significant current issue for the Indigenous population. The rate of hospitalisation of Indigenous men and women between 2005-2006 for schizophrenia and delusional disorders was 2.7 and 2.5 times, respectively, greater than the non-Indigenous population in Australia, and 4.5 and 3.3 times greater due to psychoactive substances (Pink & Allbon, 2008). The development of effective clinical interventions for this group requires an understanding of underlying psychological factors.

The psychological trauma underpinning the psychotic disorder

Trauma is inconsistently defined in research literature. As discussed by Atkinson, Nelson and Atkinson (2010) Figley defined psychological trauma in 1985 as an 'emotional state of discomfort and stress resulting from the memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm' (pg.135). In the same report, this definition is supported by Van der Kolk (2007) and Scaer (2001) who argue that an individual's inability to cope with a traumatic event can have both psychological and physiological effects (Atkinson, Nelson & Atkinson 2010). Additionally, trauma can be carried from one generation to the next (Atkinson, Nelson & Atkinson, 2010).

According to these definitions, the source of trauma is not necessarily connected to a single event, but can also be a culmination of events. There is limited research into the exact causes of psychotic disorders in Indigenous populations. However, in other populations it has been shown that exposure to trauma correlates with episodes of psychosis (Scott, Chant, Andrews, Martin & McGrath, 2007) and exposure to persistent social adversity predisposes an individual to psychosis (Read & Bentall, 2012).

Psychotic disorders develop through a complex range of interactions. While it is not always possible to clearly identify the underlying cause, there exists a range of influences throughout life which will impact each individual differently. As discussed by Havinghurst and Downey (2009) when assessing clients who present with mental illnesses, appropriate interventions can be developed using the framework of the four 4Ps. Applying this framework to Indigenous socioeconomic and cultural experiences demonstrates that exposure to these experiences

perpetuates psychosis.

The Indigenous Australian population has experienced a disruption in the sense of community and their collective wellbeing; firstly as a result of the loss of native land as a result of the colonisation of Australia, and secondly as a result of the stolen generation (Purdie, Dudgeon & Walker, 2010). Colonisation has been linked to family breakdown within Indigenous society and increases in rates of family violence and child sexual abuse (Atkinson, Nelson & Atkinson, 2010). A 2009 survey of Indigenous Australians found that 50% of respondents had been impacted by 'the stolen generation', either directly or through the displacement of a family member. All of those who had been removed indicated experiencing higher-than-average levels of psychological distress (Kelly, Dudgeon, Gee & Glaskin, 2009).

Exposure to persistent social adversity, such as the isolation commonly experienced by Indigenous Australians, has been shown to predispose an individual to psychosis (Read and Bentall, 2012: World Health Organisation [WHO], 2012). The 'Indigenous' identity carries an inherent social disadvantage and is thus burdened with several predisposing factors for psychosis, including the experience of racism, lack of identity, lack of a sense of belonging and lack of opportunities. Racism, in particular, not only reduces opportunity for social acceptance and employment opportunities (exacerbating economic disadvantage), it also impinges upon the psyche directly. Repeated rejection, hostility and feelings of shame can undermine self worth and contribute to psychological distress (Purdie, Dudgeon & Walker, WHO, 2012).

All of these predisposing factors can lead to substance abuse as a coping mechanism, which becomes a precipitating factor to psychosis. Indigenous Australians suffer from substance induced psychosis at a rate much higher than the non-Indigenous population (Pink & Allbon, 2008). This is further supported by the work of Hunter et al., (2012), who observed higher incidences of psychosis in individuals who abused alcohol and/or cannabis.

Individuals who are treated for psychosis in a hospital environment can experience trauma from the hospital experience itself. As discussed by Doyle (2011), in remote hospital locations patients may be placed in seclusion for up to 24 hours prior to an assessment. While this measure is designed to keep the patient (and staff) physically safe, many Indigenous people from remote communities will find enclosed environment hostile and even the air conditioning strange. The alien environment, without access to toilets or warm blankets, and with ever-present observation, increases paranoia and anxiety (Doyle, 2011).

Following assessment or treatment, individuals may return to their community and find themselves further outcast, which perpetuates the cycle of trauma (Jones, 2009). The individual can feel a great deal of shame, which implies a loss of face within the Indigenous community, and consequently threatens relationships; an important aspect of Indigenous culture. In many instances they are kept separate from the community. For many the feeling of shaming their community and extended family is overwhelming, which may perpetuate the psychosis or result in them failing to seek treatment (Doyle, 2011).

Individual suffering from psychosis who are exposed to the cultural, social and economic depravation experienced by Indigenous Australians lack the critical protective factors against psychosis (Pink & Allbrod, 2008). On the other hand, the collective and resilient nature of the Indigenous community, feeling supported, having greater access to health services, improved living conditions, improved education, greater employment opportunities and economic prosperity are all known protective factors against the increased prevalence of psychotic disorders (Purdie, Dudgeon & Walker, 2010; WHO, 2012).

Work is already underway to address some of these issues, with a number of Government initiatives concerned with improving health and wellbeing, and addressing the human rights of the Indigenous population (Holland, 2013; Human Rights Commission of Australia, 2007). The prevalence of psychotic disorders and the underpinning psychological trauma experienced by Indigenous Australians however, suggests there is more work to be done (Pink & Allbon, 2008).

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Patriece Shelly, BSc,MNSc

Tenth Annual ASTSS Media Award

2013 Winner Announced

Angela Pownall of The West Australian newspaper has won the 2013 ASTSS Media Award for a series of articles exposing dangerous flaws in Western Australia's mental health system.

While reporting the story of teenage depression sufferer Alysha Devereux, Angela uncovered an acute lack of effective clinical intervention available to Western Australian teenagers who are at risk of suicide. When the story of Miss Devereaux's suicide attempt and recovery was published in late 2012, more families contacted Angela to share their experiences of frustration with their state's mental health system. Angela's work led to an independent inquiry and policy changes in Western Australia.

The media award judges were impressed with the sensitivity Angela showed to the fragile individuals involved in her investigation, as well as her persistence with a difficult and lengthy piece of journalism. They commend Angela for bringing about real change with her work, noting that this is a rare achievement indeed for a journalist. The judges also recognise that the state of mental health services is not a glamorous topic for a journalist to pursue, but that it represents a necessary discussion for the benefit of society.

2013 saw a record number of submissions for the media award. The judges offer special congratulations to two runners-up: Chris Johnston of The Age newspaper and Andrew Probyn of The West Australian.

Chris Johnston submitted a suite of articles covering a variety of trauma: a suburban suicide cluster, the story of a doctor who tended some of the victims of the 2002 Bali bombings, and the immediate aftermath of the murder of Jill Meagher in 2012. The judges appreciated the thoughtful approach to journalism Chris displayed in his interaction with the subjects of his stories, as well as a level of commitment that far exceeds the expectations held by any publication of a journalist at work. All of the judges commented on Chris's magnificent writing ability.

Andrew Probyn's submission was a single article which told the story of Cynthia Banham, an Australian who survived an Indonesian air disaster in 2007 and endured years of painful rehabilitation and treatment for her burns before becoming a mother in 2012. The judges were particularly impressed with Andrew's insightful and grounded approach to a story with enormous potential for sensationalism. They found the story very engaging, and welcomed the demonstration of a positive outcome for a victim of trauma.

As the winner of this award, Angela Pownall will receive $1000 from the ASTSS and the thanks and recognition due to any journalist who promotes trauma recovery through their work. The ASTSS congratulates Angela on a prize thoroughly deserved.

Entries for the 2014 ASTSS Media Award will open early next year. For details, please visit the ASTSS website at www.astss.org.au

Masters, A. (2014). Tenth annual ASTSS media award announced. *Stress Points, Winter,* 31.

Trauma & Conflict: Globally, Locally

Call for Papers

ACOTS 2014

18TH AUSTRALASIAN CONFERENCE ON TRAUMATIC STRESS

11th – 13th September, 2014

The Australasian Conference On Traumatic Stress (ACOTS) is a collaboration between the Australasian Society for Traumatic Stress Studies (ASTSS) and the Australian Centre for Posttraumatic Mental Health (ACPMH).

ACOTS 2014 is relevant to a broad range of people with an interest in trauma, including practitioners, researchers, consumers, service developers, and policy makers.

The conference theme is deliberately broad to bring together a variety of perspectives on trauma and to provide a stimulating exchange of ideas for all. Diverse sessions will examine current issues and interests in trauma research and practice.

Preconference Workshops

Thursday 11th September 2014

Conference

Friday 12th – Saturday 13th September 2014

Confirmed Keynote Speakers

Charles Hoge, MD, Colonel (retired)

MORE INFORMATION ON ACOTS 2014 (CLICK)

The ACOTS Scientific Committee cordially invites abstract submissions for the following types of presentation in 2014. Submissions may cover any topic relevant to the field of traumatic stress, with preference given to those consistent with the conference theme. Presentations will be scheduled for September 12th and 13th 2014.

Symposium: To consist of 3 to 4 papers plus questions or discussion on a theme, and should last 90 minutes in total.

Paper: To be of 15 to 20 minutes duration which will include time for questions. The Scientific Committee will group accepted papers into specific symposia.

Poster: To be displayed throughout the conference, with presenters expected to stand next to their poster to answer questions during the poster session.

Abstracts will be reviewed by the Scientific Committee; those chosen will be notified by the end of April 2014.

Submissions accepted online only at www.acots.org (CLICK)
Closing date for submissions – 31st March 2014

Trauma & Conflict.

Globally, Locally

Keynote Speakers & Pre-conference Workshops

ACOTS 2014

September 11th -13th

Keynote Speaker
Charles Hoge

Once a warrior – always a warrior: PTSD & combat stress from a medical and military / first responder perspective

Charles Hoge MD, Colonel (retired), has authored over 100 peer-reviewed articles, including over 20 publications in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, and *The Lancet*. His articles on PTSD and mild traumatic brain injury are the most cited of all medical articles from the wars in Iraq and Afghanistan.

For a decade, Dr Hoge directed the U.S. military's premier psychiatry and neuroscience research program at Walter Reed Army Institute of Research. He was deployed to Iraq in 2004 and Afghanistan (as a civilian) in 2011. A national expert on war-related mental health issues and TBI, Dr Hoge has testified to the US Congress on five occasions.

He is the author of the self-help book for veterans and families, *Once a Warrior—Always a Warrior: Navigating the Transition from Combat to Home*. He continues to work as a psychiatrist treating service members, veterans, and family members in the Washington, D.C. area.

Keynote Speaker
Paul Bolton

Mental health problems of refugees and other survivors of violence & displacement

Paul Bolton, MBBS MSc MPH is Associate Scientist in the Center for Refugee and Disaster Studies and the Department of International Health at the Johns Hopkins Bloomberg School of Public Health. His main area of expertise is implementation science research in low resource countries, specifically the use of mixed methods to: conduct needs assessments, design interventions most likely to be locally feasible and effective, monitor and improve interventions in the course of implementation, and evaluate their appropriateness and impact.

Dr Bolton is the primary author of the DIME manual (Design, Implementation, Monitoring, and Evaluation) which has been used to conduct program-relevant research with service providers in sub-Saharan Africa (Uganda, Rwanda, Mozambique, Zambia, and Angola), Latin America, Central and Southeast Asia, Eastern Europe, the Caribbean, and the Middle East. In the course of his work on implementation science research Dr Bolton has conducted RCTs on interventions for trauma-affected populations in Africa, Asia, and the Middle East.

MORE INFORMATION ON ACOTS 2014 (CLICK)

Trauma & Conflict:

Globally, Locally

Keynote Speakers & Preconference Workshops

ACOTS 2014

September 11th -13th

Keynote Speaker

Derrick Silove

Professor Silove specialises in the area of mass trauma, transcultural psychiatry, and refugee and postconflict mental health. He has played a key role in establishing services for traumatic stress amongst refugees and conflict-affected populations and in the anxiety disorders in general in Australia and internationally in postconflict societies such as Timor Leste. He has been a consultant for a range of international agencies including the WHO, UNHCR and World Federation for Mental Health.

Professor Silove's specific interests are in PTSD, anxiety disorders, adult separation anxiety disorder, asylum seekers, violence, war and postconflict mental health, developmental psychology, ethics, human rights and health.

He holds a number of NHMRC and ARC grants and partners an NHMRC Program Grant with leading researchers around Australia examining longitudinal impact of severe injuries. He has published over 300 journal articles, book chapters, mono-graphs and major reports. His team is at the forefront of research in the field of refugee and postconflict mental health worldwide.

Preconference Workshops

September 11th 2014

Charles Hoge
Evaluation and treatment of PTSD: Understanding core treatment strategies

Paul Bolton
Approaches to cross-cultural mental health research

Paul Scully
Supporting emergency service personnel

Sheryle Vilenica
Healing from childhood sexual abuse

Jane Shakespeare-Finch
Posttraumatic growth

Robyne Le Brocque
Supporting children in schools after trauma: Train the trainer

Australian Centre for Posttraumatic Mental Health

ASTSS Australasian Society for Traumatic Stress Studies

MORE INFORMATION ON ACOTS 2014 (CLICK)