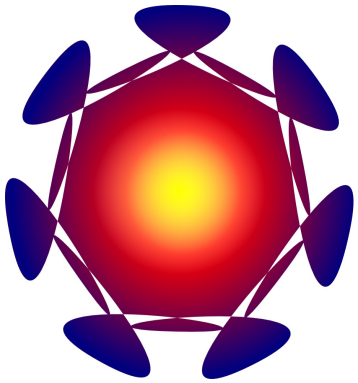

Educaring
a trauma informed approach to healing generational trauma for Aboriginal Australians

Presented by Judy Atkinson

"Aboriginal peoples, as individuals and within their families and communities, have been profoundly hurt across generations by layered historic, social and cultural (complex) trauma. 'Closing the Gap' on Aboriginal 'disadvantage', must acknowledge that where there is hurting, there has to be a healing. In healing, people's Trauma Stories become the centrepiece for social healing action, where the storyteller is the teacher and the listener is the student or learner. We need to learn how to listen. We need to want to listen" Emeritus Professor Judy Atkinson (2012).

We Al-li

In the Woppaburra language *'We'* means fire. Fire is an awesome force in the natural world and a powerful spiritual symbol. It has the potential to create, and to destroy. It can nourish and comfort or it can threaten and harm. It can give life and it can blind. Fire transforms solid forms into pure energy. In its most powerful form - the SUN - fire is a cosmic principle without which life would cease to exist.

Aboriginal people used fire to cleanse the earth, to make way for new spring growth. Looking after country was a sacred responsibility, as was looking after people. Fire was used in ceremonies to ensure procreation and regeneration of all life forms. Fire provides warmth where people can sit to share, resolve conflict and restore harmony. Certain people were the fire-keepers. The fire keeper was responsible to all others for keeping the fire alight. That person was often also the healer. A person came to the fire circle to consult the healer in times of ill-health. Aboriginal people could easily create the spark by rubbing two sticks together, but more often, when moving to a new camp, one person was responsible for carrying the embers which, when applied to dry tinder, would provide the evening campfire. The healing knowledge and the responsibility to keep the fire alight were part of the whole. Some Aboriginal people have fire ceremonies, where the sparks fall in great clusters and cleanse all participants.

'*We*' signifies the spirit of cleansing that is essential to healing and re-creation, regeneration. It also symbolises the spiritual and cultural strength of the Aboriginal life forms that have been kept alive since the beginning of time, and in particular over the last two centuries.

In the Woppaburra language *'Al-li'* means water. Water is the source of all life. Without water we die. Our bodies comprise 70% water. In spiritual literature water is often used as a metaphor to describe mystical states of conscious. The parallels drawn often derive from the pure fluid pristine qualities of water in its natural state and its lack of boundaries (all can be healed).

Once a place has been fired (cleansed), the rains come, green shoots give evidence of new life. One explanation of life says we are water. The water leaves the earth and returns again in the form of rain. Rain enters the ground, cleansing, creating new growth, sustaining all life forms. Some water runs into small streams which move across the landscape, creating waterways and pathways, interconnections. A small stream becomes a bigger stream, and finally a river, which eventually runs into the sea. The cycle of life continues.

'Al-li' signifies the essential life giving force of water. It acknowledges the healing that takes place in and with water. And for this region it acknowledges the waters that are a source of food and nourishment to us and our lands. This country is crisscrossed by water tracks that show the journeying of Moonda Nghadda the rainbow serpent, and of the creators. Aboriginal people celebrate our journeying as they conduct rainmaking ceremonies. After the sacred rituals of song and dance, people join together in great fun-filled water fights and all conflict is swept away in the laughter and fun that comes with the cleansing from water.

We respectfully acknowledge the Traditional Owners / Custodians of the land and seas on which this event is taking place and Elders both past and present.

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Workshop outline: Past Present Future

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11.00 –12.30	**Session 2: Presentation - Past** **Part 1:** Generational Trauma - Aboriginal peoples, families and communities. **Activity:** A Story Map – the trauma story	***Understanding Trauma*** *and Its Impact* *Support peoples* ***control*** *over their lives, strengthening their sense of* ***autonomy*** *and capacity to make right* ***choices***
Lunch	**Have you been listening?**	
1.30 – 3.00	**Session 3: Present** **Part 2:** The We Al-li model for education as healing **Activity:** The Healing Story – Educaring as trauma informed and trauma specific	***Sharing Power & Governance*** ***Integrating Care*** – maintaining a holistic view of needs, and maintaining communication within and among all systems.
3.30 – 5.00	**Session 4: Future** **Elders Circle** • *What have we learnt? How will we use what we have learnt?* • *What is missing – what more do we need to know?* **Post Evaluations** **Closure**	**Believing healing is possible.** **Sustaining recovery** through supportive families and communities.

Dadirri: Listening to one another

Dadirri. A special quality, a unique gift of the Aboriginal people, is inner deep listening and quiet still awareness. Dadirri recognises the deep spring that is inside us. It is something like what you call contemplation.

The contemplative way of dairy spreads over our whole life. It renews us and brings us peace. It makes us feel whole again. In our Aboriginal way we learnt to listen from our earliest times. We could not live good and useful lives unless we listened.

We are not threatened by silence. We are completely at home in it. Our Aboriginal way has taught us to be still and wait. We do not try to hurry things up. We let them follow their natural course - like the seasons. We watch the moon in each of its phases. We wait for the rain to fill our rivers and water the thirsty earth. When twilight comes we prepare for the night. At dawn we rise with the sun. We watch the bush foods and wait for them to open before we gather them. We wait for our young people as they grow, stage by stage, through their initiation ceremonies. When a relation dies we wait for a long time with the sorrow. We own our grief and allow it to heal slowly. We wait for the right time for our ceremonies and meetings. The right people must be present. Careful preparations must be made. We don't mind waiting because we want things to be done with care. Sometimes many hours will be spent on painting the body before an important ceremony.

We don't worry. We know that in time and in the spirit of Dadirri (that deep listening and quiet stillness) the way will be made clear.

> *We are like the tree standing in the middle of a bushfire sweeping through the timber. The leaves are scorched and the tough bark is scarred and burnt, but inside the tree the sap is still flowing and under the ground the roots are still strong. Like that tree we have endured the flames and we still have the power to be re-born.*

Our people are used to the struggle and the long waiting. We still wait for the white people to understand us better. We ourselves have spent many years learning about the white man's ways; we have learnt to speak the white man's language; we have listened to what he had to say. This learning and listening should go both ways. We would like people in Australia to take time and listen to us. We are hoping people will come closer. We keep on longing for the things that we have always hoped for, respect and understanding.

We know that our white brothers and sisters carry their own particular burdens. We believe that if they let us come to them - if they open up their minds and hearts to us. We may lighten their burdens. There is a struggle for us, but we have not lost our spirit of Dadirri.

There are deep springs within each of us. Within this deep spring, which is the very spirit, is a sound. The sound of Deep calling to Deep. The time for re-birth is now. If our culture is alive and strong and respected it will grow. It will not die and our spirit will not die. I believe the spirit of Dadirri that we have to offer will blossom and grow, not just within ourselves but in our whole nation.

Edited version adapted from the writings of Miriam Rose Ungunmerr

Introduction

This workshop, and workbook is designed to provide information and activities which will help you consider better practice while working with Aboriginal and Torres Strait Islander peoples[1], in restorative justice. At the same time, it alerts us to a possible outcome of working in the trauma field – trauma informed principles and practice and trauma specific programs.

In the **first session** you will be asked to undertake a pre- evaluation as you start to think about your own awareness of trauma and its impacts in the lives of Indigenous Australian Peoples. This awareness is not only relevant to those Indigenous Peoples with whom we may come in contact with in our day to day life; it will increase our awareness of all peoples in relationship to their trauma stories as you come to know them more fully through their stories of pain, survival and growth.

You will be asked to consider: Past – Present – Future, in the design, development and delivery of services for and with Indigenous peoples that are trauma informed, by a culturally competent workforce who are able to provide culturally safe environments and work practice.

In **session two** we discuss generational trauma, sometimes called historic, collective-social, cultural, complex, and [in children] developmental trauma, in Indigenous lives and within families and communities. You will be asked to create a Trauma Story Map.

In **Session three** we then explore an educaring approach in healing trauma, as we build trauma specific competencies that will strengthen our capacity to make good choices for ourselves and those with whom we work. You are invited to map a healing approach to trauma, by building on from the Trauma Story Map, transforming it into a Healing Story.

Session four brings us more fully into the capacity of caring for self as we care for others, in our focus: believing - healing is possible and it happens in relationships of mutual care. In the 'Elders Circle', used as a communal deep listening tool and also as a culturally specific tool for evaluation, our discussion will centre on how we establish safe, authentic and positive relationships, in our workplace as we care for others, and in our private life as we care for ourselves.

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[1] Hereafter referred to as Indigenous Australian Peoples. The word Indigenous is used here as a recognition of the common experiences of Indigenous peoples worldwide, and in the similarities of healing or therapeutic practices across Indigenous cultures in spite of the diversity of our cultures. It honours the UN definition of Indigenous Peoples as a international legal term, recognising the rights of Indigenous Peoples.

Bruce Perry, MD, PhD, Senior Fellow from The ChildTrauma Academy in Houston, Texas writes:

Examination of the known beliefs, rituals, and healing practices for loss and trauma that remain from Aboriginal cultures revel some remarkable principles. Healing rituals from a wide range of geographically separate, culturally disconnected groups converge into a set of core elements related to adaption and healing following trauma. These core elements include an overarching belief system – a rationale, a reason for the pain, injury, loss; a retelling or re-enactment of the trauma in words, dance, or song; a set of somato-sensory experiences – touch, the patterned repetitive movement of dance and song – all provided in intensely relational experience with family and clan participating in the ritual.

The most remarkable quality of these elements is that together they create a total neurobiological experience influencing cortical, limbic, diencephlalic, and brainstem systems (not unlike the pervasive neurobiological impact of trauma):

- Retell the story.
- Hold each other.
- Massage, dance, sing.
- Create images of the battle.
- Fill literature, sculpture, and drama with retelling.
- Reconnect to loved ones and to community.
- Celebrate, eat, and share.

These Aboriginal healing practices are repetitive, rhythmic, relevant, relational, respectful, and rewarding; they are experiences known to be effective in altering neural systems involved in the stress response in both animals models and humans. The remarkable resonance of these practices with the neurobiology of trauma is not unexpected. These practices emerged because they worked. People felt better and functioned better, and the core elements of the healing process were reinforced and passed on. Cultures separated by time and space all converged on the same general approach ...

While these therapeutic practices may not at first seem "biological": be assured that they are not only likely to change the brain, but they will assuredly provide the patterned, repetitive stimuli required to specifically influence and modify the impact of trauma, neglect, and maltreatment on key neural systems.

Perry, in Malchiodi, A 2008, 'Creative Interventions and Childhood Trauma', in *Creative Interventions with Traumatized Children*, The Guilford Press, New York, pp. ix – xi)

Activity: Past Present future

You need to have paper and pencil or crayons close at hand. There are no right or wrong answers.

Find a comfortable position - lay down if you want - sit with your back resting against the wall or a chair - however you feel most comfortable.

As you listen to the music, close your eyes and breath in, feeling your breath. Notice the movement of your body as you take that breath in. Notice how you chest rises and falls. Now become focused. What do you know about Aboriginal worldviews – the healing rituals of Aboriginal peoples - **Past** – Before Cook. (Give people about two minutes to write or draw).

Come back to the music. Now move into the **Present.** What do you know about the impacts of colonisation as traumatisation, on Aboriginal lives, in families and communities? Write some words or draw a picture to show what you know, or feel what you know. (Give people about two minutes to write or draw).

Now we are going to vision the **Future**. Take time to draw or write some words about the future. What do you see of feel or want for the future? What skills do you have? What further knowledge and skills do you need to contribute to this future? From Mental Health background, you would have heard of a trauma informed, or a trauma specific approach to the needs of people and communities. (Allow people a few minutes to write or draw).

When you are ready turn to the person next to you, and share what you have drawn or written.

What more do you need to know; what skills do you need, to think, plan and work towards this future you vision.

Chapter one: Past

> *'(There are) families (in this region) where we can trace the trauma back five or six generations. The 1860's, the generation of our great-grannies, was for some the generation of first contact, the massacre times, the poisoned water holes, stock whips and hobble chains. The 1890's, the next generation saw the setting up and removal of people to reserves. The 1930's to the 1960's, the third generation, the period of assimilation, saw children forcibly taken from their families and placed in state run institutions. My generation has seen massive changes. And now there are my children and grandchildren. Through the generations we have seen too much violence, too much pain, too much trauma. In its multi-layered context, it sits on us like a rash on the soul, and it stays in our families and communities to destroy us. This violence comes as forms of self abuse, and abuse of others, as in alcohol and drug misuse, suicides and homicides, domestic violence and sexual assault.* (Atkinson 1994).

Much has been written about the generational layers of trauma resulting from colonisations within Indigenous[2] populations. (Aboriginal Healing Foundation 2004; Atkinson, C 2008; Atkinson J 2002; Baker 1983; Brave Heart-Jordan 1995; Duran & Duran 1995; Hunter 1998; Milroy 2005).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines Post Traumatic Stress Disorder (PTSD) as the trauma which occurs when:

> *The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others – and the person's response involved intense fear, helplessness or horror* (American Psychiatric Association - DSM-IV 1994).

Figley defines psychological trauma as:

> *An emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm* (Figley, 1985, p. xviii).

Hence trauma, as defined by Figley, is *"A set of conscious and unconscious actions and behaviours associated with dealing with the stresses of catastrophe and the period immediately afterwards" (Figley, 1985: xix).*

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[2] The word Indigenous is used to honour the United Declaration of the Rights of Indigenous peoples as a diverse collective of people, recognised under the U.N. determination. The terms Aboriginal peoples, and Aboriginal and Torres Strait Islander peoples are also used in this document.

When the traumatic experience involves another person inflicting pain for their own pleasure or selfish reasons, the survivor's beliefs about humanity and the goodness in people are destroyed. This profoundly affects their identity, resulting in negative effects in mind, body, soul and spirit.

Regardless of its source, an emotional trauma contains three common elements:

- It was unexpected.
- The person was unprepared.
- There was nothing the person could do to stop it from happening.

Simply put, traumatic events are beyond a person's control. It is not the event that determines whether something is traumatic to someone, but the individual's experience of the event.

However, the PTSD construct fails to describe the nature and impact of severe, multiple, repeated and cumulative chronic ongoing stress, where there is no one specific stressor or where there are many possible cumulative stressors, deliberately inflicted by people; a situation that is common within the lives of Aboriginal and Torres Strait Islander peoples and communities (Atkinson, C, 2008; Atkinson, J, 1990, 2002; Cameron, 1998; Milroy 2005; O'Shane, 1993). Such experiences have been generational, and cumulative over time and space, and are compounded by poverty, poor housing, illhealth, poor education - employment opportunities, and marginalisation through racism and prejudice. Today there is much more understanding how these adverse social situations are both cause and effect in generational trauma.

More recent research shows that trauma is a complex mixture of psychological, physiological and social responses to highly stressful experiences, which overwhelms the individual or a group's ability to cope after what is perceived to be a life threatening event or events (Scaer 2001; van de Kolk 2007).

Trauma can create experiences of:

- Loss of safety, coherency, boundaries, orientation to time and space, of integrity, trust, resilience, control, competence, connection to one's own life-force and source.
- Fear of inadequacy/adequacy, threat of death, a fusion to and obsession with threat, and confusion in general.
- Powerlessness with a sense of being defeated, subjugated and dominated.
- Helplessness, with a sense of failure and resignation to incapability.

- Contraction with a compression, which can lead to depression.
- Exhaustion and a collapsing of one's stamina, a dis-spiriting process.
- Frozenness / Fixity and a numbness of emotional, physical and mental proportions.

Traumatic events happen to all people at all ages and across all socio-economic strata in our society. These events cause terror, intense fear, horror, helplessness, and physical stress reactions. The impact of such events does not simply go away when they are over. Instead, traumatic events are profound experiences that change the way people see themselves and their worlds.

Such trauma has been given many names: collective; historic; social; cultural, complex; inter- or transgenerational and for children, developmental. We focus specifically here on collective – social trauma; historic - cultural trauma; complex trauma, when developing a trauma informed program and trauma specific service practice.

Collective – social trauma

Collective – social trauma describes the psychological blow resulting from traumatic events shared by a group of people, including whole social groups. It may involve collective or shared traumatic memory. Closely related to the concept of colonisation as historic trauma, collective trauma comes from war zone effects and natural disasters. Kai Erikson (1994) defines collective trauma as the 'blow to the basic tissues of social life that damage the bonds attaching people together and impairing the prevailing sense of community" (p. 233), 'a gradual realization that the community no longer exists as a source of nurturance and that part of the self has disappeared' (Erikson, 1976). The applicability of this thinking has been explored in relation to understanding Aboriginal & Torres Strait Islander people's traumatic experience (Krieg, 2009). Such trauma when experienced by an entire society, can engender collective feelings resulting in a shift in that society's culture and mass actions.

Ratanvale proposed a series of signs and symptoms common to collective trauma:

- deep mistrust of self, others, even within family;
- self-directed violence-suicide, risk-taking behaviour;
- substance misuse;
- violence against women;
- unremitting grief;
- shame and humiliation;
- intergenerational conflict;

- role diffusion, including sexual abuse and other boundary violations;
- cultural genocide, losing traditional values, desecrating land and institutions;
- leadership crisis;
- a conspiracy of silence - an overall attitude of secrecy (Ratnavale, 2007) sited (Krieg, 2009).

This list of signs and symptoms is consistent with the experience of many Aboriginal communities suggesting that the concept of collective trauma is relevant to the experiences of Indigenous Australian peoples. It differs from the individualistic nature of Post Trauma Stress Disorder and requires an approach with collective and community components.

Following from this work, Indigenous peoples have named their experiences as historic and cultural trauma.

Historical – cultural trauma

Historical – cultural trauma can be defined as *'the collective emotional and psychological injury both over the life span and across generations',* (Muid, 2006, p. 36), the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes.

Salzman and Halloran (2004), describe the destruction of cultural worldviews which have sustained Indigenous peoples for millennia; a collective experience across diverse cultures and peoples: the Yup'ik of Alaska; Navajos and Athabaskan Indians; Hawaiian Natives; Maori in New Zealand, and Aboriginal Australians, all having experienced similar physical, social, behavioural and psychological symptoms (eg high rates of suicide, alcoholism and accidental deaths, p 233).

Duran and Duran (1995) also suggest that historic trauma becomes embedded in the cultural memory of a people and is passed on by the same mechanisms by which culture, generally, is transmitted, and therefore becomes 'normalised' within that culture.

> *The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effect of the original trauma, which a parent or other family member has experienced. Even where*

> *children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality* (Milroy, 2005, p. xxi).

This new model of historic trauma, includes concepts of dysfunctional community syndrome (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Duran, Duran, Brave Heart & Davis, 1998; Muid, 2006; Ralph et al., 2006; Robertson, 2006; Whitbeck, Adams, Hoyt & Chen, 2004).

Dysfunctional community syndrome is defined as a:

> *situation whereby multiple violence types are occurring and appear to be increasing over generations, both quantitatively (numbers of incidents) and in terms of the intensity of violence experiences, for example, victims of sexual abuse include very small children; pack rape is being committed by boys as young as 10 years old (*Memmott et al., 2001, p. 51).

Memmott et al. (2001) suggested that a typical cluster of violence types in a dysfunctional community would include male-on-male violence, female-on-female violence, male on female violence, child abuse, alcohol violence, male suicide, pack rape, infant rape, rape of grandmothers, self mutilation, spousal assault and homicide.

When a community deteriorates to the point of dysfunctional community syndrome, it has devastating immediate and generational effects on the members of that community, particularly the children (Memmott et al., 2001). Exposure to community violence results in greater emotional distress and antisocial behavioural problems, and has emerged as an independent risk factor for problems such as depression, anxiety and aggression in youth (Scarpa, 2001).

The theory that the current levels of violence are a result of trauma experienced since colonisation and passed through the generations is supported by Ralph, Hamaguchi and Cox (2006), who found that the high rates of suicide among the Kimberley's young people, which were previously thought to be a result of depression (a common response to trauma) are more likely caused by exposure to trauma.

> *It was contended that Aboriginal youth in the Kimberley region might experience several layers of trauma, through their own direct and secondary exposure as set against a backdrop of historical unresolved trauma and grief. These layers of trauma are thought to be cumulative in the manner in which they inform the adolescents' experience, and continue to adversely reinforce the basic assumptions that are violated by chronic trauma exposure; that the world is meaningful and safe, that the self is worthy, and that others can be trusted. It was thought that the current rate of suicide amongst Aboriginal adolescents in the*

> *Kimberly region may be the youths' contemporary expression of distress in response to chronic trauma exposure, as underpinned by the legacy of historical unresolved trauma and grief* (Ralph et al., 2006, p. 123).

In fact, Ralph et al. (2006) found a clear link between levels of trauma exposure, PTSD and suicide, particularly for young Aboriginal girls, generally resulting from childhood experiences of abuse.

Complex trauma

Complex trauma has been described by Herman (1992: 1997), van de Kolk (2005), and others, as the pervasive effects that exposure to repeated or chronic trauma sometimes has on an individual's physical, emotional, intellectual, and psychological functioning. Such trauma exposure includes child removals, child abuse and neglect, living in poverty, and witnessing violence. It is important to understand the pervasive effects of trauma within biological functioning. More recent research shows that trauma is a complex mixture of psychological, physiological and social responses to highly stressful experiences, which overwhelms the individual or a group's ability to cope (Scaer 2001; van de Kolk 2007). People may have fight-flight-freeze responses to uncontrollable and repeated stressors resulting in chronic over-activation of the autonomic nervous system.

Children and Developmental Trauma

Bessel van der Kolk, in his most recent research on the developmental impact of childhood trauma, writes: '*Childhood trauma including abuse and neglect, is probably the single most important public health challenge … a challenge that has the potential to be largely resolved by appropriate prevention and intervention* (van der Kolk 2007 p. 224).

His work shows both long term negative health outcomes, as well as generational transference of attitudes and behaviour and hence, historical trauma transference across family and communal systems. According to van de Kolk childhood experiences that are traumatising:

- violates a child's sense of safety and trust, of self worth, with a loss of a coherent sense of self; triggers emotional distress, shame, grief, self and other destructive behaviours;
- In adolescents - can result in unmodulated aggression, difficulty negotiating relationships with caregivers, peers and marital partners; demonstrates outcomes showing adolescence links to suicide, alcoholism and other drug misuse, sexual promiscuity, physical inactivity, smoking and obesity;
- Adults with a childhood history of unresolved trauma are more

> likely to develop: heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease; and finally, people with childhood histories of trauma make up almost our entire criminal justice populations (ibid pp 226 – 227).

Sources of childhood trauma may include:

> … *neglect, physical abuse, psychological abuse, sexual abuse, witnessing of domestic abuse and other violence, community violence, school violence, traumatic loss, medical trauma, natural disasters, war, terrorism, refugee trauma, and others* (National Child Traumatic Stress Network, 2005).

Children may express their fear, helplessness and sorrow as disorganised or agitated behaviour.

Previously it was believed that early trauma had little impact on the child, however it is now recognized that early trauma has the greatest potential impact, by altering fundamental neurochemical processes, which in turn can affect the growth, structure, and functioning of the brain (Schwartz and Perry, 1994).

Further, repeated exposure to trauma, in early childhood may result in a situation-specific "state" becoming a more permanent "trait" (Perry et al, 1995) – e.g., an ongoing neurobiological adaptation, rather than an acute, adaptive response specific.

Hodas (2006) describes the following age specific trauma responses in children. Children aged 5 years and younger will show fear of being separated from the mother or primary caretaker, and excessive clinging; crying, whimpering, screaming, trembling and frightened facial expressions; immobility or aimless motion; and may show regressive behaviours, such as thumb sucking, bedwetting, and fear of darkness. (pp. 8-9)

Children aged 6 to 11 years may demonstrate internalized symptoms such as extreme withdrawal; emotional numbing or "flatness"; irrational fears; somatic complaints; depression; anxiety; guilt; inability to pay attention; other regressive behaviours, including sleep problems and nightmares. Or they may demonstrate externalizing behaviours, such as irritability; outbursts of anger and fighting; school refusal (p.9).

Adolescents aged 12-17 years may show *internalising symptoms*: Emotional numbing; avoidance of stimuli; flashbacks and nightmares; confusion; depression; withdrawal and isolation; somatic complaints; sleep disturbances, academic or vocational decline; suicidal thoughts; guilt; revenge fantasies. Or they may show e*xternalizing behaviours*: Interpersonal conflicts; aggressive responses; school refusal or avoidance; substance abuse; antisocial behaviour (p.9).

It is possible to make some generalizations specific to type of trauma.

- Physical abuse tends to be linked most commonly to externalizing behaviours, although there is increased risk for anxiety and depression as well.
- Sexual abuse tends to be linked most commonly to internalizing symptoms, although externalizing behaviours may also occur, particularly with older children and adolescents.
- Severe physical abuse during the preschool period tends to predict externalizing behaviour and aggression.
- Severe neglect during this same period has been associated with internalizing symptoms and withdrawal (Caporino et al, 2003, p. 73).

These experiences happen during the developing years of infancy, childhood and adolescence, and are perpetrated by trusted adults and/or older figures in the person's life. Given that children are completely dependent on the adults in their lives for survival, trauma that occurs at this stage of life deeply impacts identity and shapes beliefs about self and the world. Development is severely negatively affected, resulting in many problems in most areas of life that continue through all the stages of development into adulthood.

Gender is also a variable. Females tend to develop internalizing symptoms and become passive while males tend to externalize and turn to risk taking activity and aggression (Schwartz and Perry, 1994).

At the physiological level, females tend to use dissociation - the surrender response as their primary defence, while males tend to use an active emergency response (the flight-and-fight response) and become hyper-aroused (Perry et al, 1996).

Increasing number of females with a history of trauma in the juvenile justice and prison system reflects the vulnerability of many females to develop externalizing behaviours, including drug and alcohol abuse, as they get older (Hennessey, 2004).

Trauma survivors are at risk of being re-traumatized in every social service and health care setting. This is due to a lack of knowledge about the effects of traumatic events and a limited understanding of how to work effectively with survivors. When re-traumatization happens, the system has failed survivors and leaves trauma survivors feeling misunderstood and unsupported, which perpetuates a damaging cycle that prevents healing and growth. This can be prevented with basic knowledge and by considering trauma-informed language and practices.

Generational trauma

Blagg (2000) suggests that the 'notion of intergenerational trauma or 'trauma lines' is useful in describing the cultural transmission of destructive patterns of behaviour', where violence coming into a family, is internalized, and transmits across and through future generations. This process of transmission is not just occurring from the past to the present. It also flows from the present to the future.

The effects of unresolved loss, grief, victimization, and traumatisation on Aboriginal people, termed generational, intergenerational or multigenerational grief, has been described by the Aboriginal Healing Foundation as occurring:

"*… when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next. What we learn to see as "normal" when we are children, we pass on to our own children. Children who learn that physical and sexual abuse is "normal" and who have never dealt with the feelings that come from this, may inflict physical abuse and sexual abuse on their own children. The unhealthy ways of behaving that people use to protect themselves can be passed on to children, without them even knowing they are doing so." (3)*

The Western Australian Aboriginal Child Health Survey (Zubrick et al 2005) found high levels of stress within Aboriginal families across Western Australia, who were at 'high risk of clinically significant emotional or behavioural difficulties'. The factors most strongly associated with 'high risk of clinically significant emotional or behavioural difficulties for those children' were:

- Poor physical and mental health of carers compounded by drug misuse including tobacco and alcohol, and of the child (particularly hearing, speech and vision impairment;
- Multiple family life stress events, reflected also in high residential mobility;
- Poor quality of parenting and poor family functioning;
- Sole parent care or non-original parent care, with often the primary carer (birth mother) having been forcibly separated from their natural family;
- Exposure to racism, discrimination and social marginalisation, including socially disadvantaged or excluded communities;
- Economic deprivation (poverty, unemployment, substandard or lack of housing;

- Generational trauma (abuse or neglect) experienced by parents or care-givers, which in turn has influenced their parenting capacity (Zubrick et al 2005.

Merida Blanco, a cultural anthropologist spent her life studying generational trauma in South American Indigenous groups. In her unpublished intergenerational diagram, which spanned five lifetimes following violence perpetrated by one social group against another, she demonstrated in the first generation to be conquered, the males were killed, imprisoned, enslaved, or in some way deprived of the ability to provide for their families. In the second generation many of the men turned towards alcohol or drugs, as their cultural identity was destroyed with a predictable, accompanying loss of self-worth. In the third generation, spousal abuse and other forms of relationship violence began to evolve. By this generation, the connection to its antecedent from societal trauma, only two generations, was weakened or lost. In the fourth generation, traumatic re-enactment meant that abuse moves from spousal abuse to child abuse or both. In the fifth generation, the cycle repeats itself, as trauma begets violence, with more traumatic enactment and violence, with increasing societal distress (Levine 2007 p 438)

Blanco's work shows similar outcomes to research by Atkinson (2002) demonstrated in a six-generational 'trauma-gram', which links the historical events of frontier intrusion into Aboriginal lands with its resultant epidemics, massacres, starvations. Government response to this first layer of trauma was to implement bureaucratic processes that re-traumatised those already in severe distress.

In Queensland for example, the legislation that enabled the state to remove people to reservations, was called the Aborigines Protection of Alcohol and Opium Act 1897. The removal of children from their families was conducted under a period of intense government surveillance of Aboriginal lives and families.

On to the third level, which acknowledges the intensity of present-day government attempts to rectify past wrongs, while making no allowance for the levels of traumatisation in the lived reality. Fourth, fifth and sixth generational levels show increases of intra-family violence, illhealth, poverty and distress in its multiple complexity and compounding effects.

The trauma-gram traces one line of a family across generations, listing the known memory or experience (documented or narrated within the family) of sexual violence, being victim of physical violence, perpetrating violence, diagnosed mental illness, suicide attempts and alcohol and / drug misuse.

It is clear that trauma, unacknowledged and unattended to, compounds and compacts, increasing the likelihood of further

traumatic events occurring on and by individuals; within families, and across social groups and generations. (Atkinson, 2002 p 185).

Government policies formulated to respond to human trauma tragedies, effectively increased and compounded the trauma, by its severe regulation of the Aboriginal body-mind-spirit. (Atkinson 2002) The removal of Aboriginal children was not only a racist policy of 'breeding them out', but a bureaucratic response to people who were often living in clear distress … a widow having her children removed 'for their own good' without support for their immediate crisis needs; a couple forced to live in extreme poverty by the instruments of the state, having their children removed because of judgement about their poverty. The past lives within us, until acknowledged and healed.

Power

All people have basic needs. Some of these needs we can provide for ourselves and some others provide for us.

An individual is dependent when s/he must rely on another individual for any of these basic needs. We can also say that a person has power over another whenever s/he has the ability to provide or withhold any of these needs.

The needs are:

- ***Food, water, clothing.***
  For physical well-being, we all need to eat good food, drink clean water and be properly clothed.

- ***Safe shelter, protection.***
  We all need to feel safe in the place where we live, to not be subject to threats to our physical/emotional well-being.

- ***Emotional support, loving touch.***
  Every human being needs affection, care, love, support and acceptance in order to grow.

- ***Relevant knowledge for life.***
  In order to exercise choice or free will, for dignity and identity, leisure and joy, we need access to information.

If we are trying to determine whether an individual (ourselves or someone else) is in a position of power, we need only to ask whether they can control any or a combination of these four factors.

Activity: Power

Power itself is neither good nor bad; it is how it used that matters. It can be used abusively or it can provide life-affirming experiences.

Which people in our society have a lot of power?

- Who has very little power?
- How much power do children have?
- The elderly?
- People with disabilities?
- Men / Women?
- Aboriginal Australians?
- Other minorities? Immigrants?

How much power do you have?

Do you use what power you have with a full knowledge of the responsibilities power brings?

Discuss how you see power being used in your workplace, in your community, and how you see power being misused. Is power misused within the Mental Health Professional? (Adapted from Nechi Institute).

Chapter two: Present

We Al-li an Indigenous model for trauma healing

The We Al-li program was designed and developed in the mid 1990's in central Queensland, by Aboriginal people, as a response to the generational trauma of their lives. They saw this trauma as contributing to ill-health, individual, family and community distressed functioning, alcohol and drug misuse, personal, inter- and intra-family violence, rape, child abuse and neglect, youth and adult suicide and suicide attempts, and self injury. These are all major health issues impacting on the health care and criminal justice systems of Australia and thus impede educational attainment, and effects opportunities for meaningful employment in the long term.

The We Al-li program is built on the principles of integrating Indigenous cultural processes for conflict management and group healing, Eastern and Western therapeutic skills for trauma recovery, with action or experiential learning practices. Under Western academic definitions the approach is cross-disciplinary, in other words, an integration of a number of disciplines. Under Indigenous definitions the approach is holistic. These methods have been blended into workshop programs which provide transformational learning, reflective discussion, and emotional literacy within a training syllabus for multi-skilling of workers in the trauma recovery field, including healing from domestic violence, sexual assault, childhood trauma, and alcohol, drugs and other addictions. These skills apply equally to Indigenous and non-Indigenous workers.

The program is grounded within human rights and social justice. The human right of all people to live free from violence and attain maximum health and wellbeing; and the right to heal from trauma.

The first and most essential step to trauma recovery is to create a safe environment for people to heal. Issues of safety are therefore of vital importance. In such safe places people can enter the first stage of a trauma recovery processes 'Finding and Telling the *Story*'. The word *Story* is used here from the work of Karen Martin:

> *Stories have power and give power. Stories are our law. Stories give identity as they connect us and fulfil our sense of belonging. Stories are grounding, defining, comforting and embracing. Stories vary in their purpose and content and so Stories can be political and yet equally healing. They can be shared verbally, physically or visually. Their meanings and messages teach, admonish, tease, celebrate, entertain, provoke and challenge (Martin, 2002, p.46).*

Your Story and My Story connect us, building reciprocity and relatedness – a communal Story.

Workshops provide activities that promote telling and interlinking individual and collective stories or life experiences. Workshop modalities introduce participants to various skills to facilitate the stages of an incremental healing process:

Creating a Safe Place
Finding and Telling the stories.
Making sense of the stories.
Feeling the feelings.
Moving through the layers of loss and grief, to acceptance.
Reclaiming cultural and spiritual identities.

Dadirri, a ceremonial contemplative deep listening, is used to support the process of listening and learning. Many strategies are used: narration, reflective discussion, art, dance, music, symbols, ritual, drama, bodywork, and group process in emotional regulation and release work. In this process, Indigenous healing theory and practice is continually being redefined and redeveloped.

The series of workshops embraces the concepts and principles, which complement Indigenous understandings and learning that are understood to be a life-long process. All adults have the right to continuing educational opportunities as part of their own personal growth and career development. The educational approach involves the assumption that each person has the potential of knowing him/herself and is capable of making life choices that will best enhance growth and meaning. It is based on an educational philosophy that is fundamentally derived from the Latin roots of the word 'education' (ex - educare: to lead out from).

As a consequence of this educational philosophy, all workshops offered are a blend of the experiential and the didactic, with an heuristic application for problem solving. It is assumed that all personality growth and development occurs in the context of relationships - first in the family, then in other combinations of friends, social networks, educational and work acquaintances. Thus all courses will be oriented towards the group process that will illuminate the individual person's life at home, in the community, in society and at work.

The course presents not so much old theories, but Indigenous and non-Indigenous healing practice from which new theories are presently evolving. It moves beyond the medical and professional health services delivery approach to health, into a socio-cultural model which skills and empowers workers for personal and community developmental approaches for individual and group well-being.

A healthy community is one where, among other things, the social and emotional needs of the individuals and the families within the community are being met. This fundamentally involves 'quality of experience' over 'quality of life'.

We Al-li provides participants with skills and understanding, helping people to heal together, so that people in a community can move through the incremental stages of healing to reconciliation within the self, and with each other.

We Al-li use cultural tools for healing. The strongest cultural tools have been found to be narrative processes or Story telling, art, music/dance, theatre, *dadirri* and reflective discussion, as well as the creation of, and participation in ceremony.

The use of story or narrative, not just in the spoken word, but in art, clay work, theatre, dance and music all of which allow the life experiences of people to be contextualised and 'made sense of', while being shared with the larger group, in the circle. A series of action-learning experiences have been created to help the stories flow naturally from people: lifting the blankets, Past-Present-Future, story maps, loss history graphs are different experiential modalities. developed and used in the workshops.

> *With the first workshop, Lifting the Blankets, all the hurts came up. We saw them in the blankets, and we wrote them on the wall. Some, you wouldn't even of thought of naming yourself. I think sometimes we just look at ourselves, this is what happened to me. But now I could see the whole picture. The men there, and the other women, all of us, we all shared our experiences. I was sexually abused as a child and I thought that was a separate issue but now I could see that other people also had that happen to them. I could see that it was part of a bigger picture. The loss history graph was really powerful. When I put down all the different things in my own personal story, things that had happened to me, the people who had died, I didn't feel bad, just stronger that I had survived all this. And lighter because it was really like those blankets had been lifted. Also I could understand why sometimes I find it hard to cope. Now I understand why and I make decisions to take more care of myself. I can say No louder (Priscilla Iles in Atkinson, Fredericks and Iles: 1996).*

Art as healing

Some people who are traumatised are unable to verbalise their feelings, so art was used to allow the story to be told in a way that

provided another level of expression and self-exploration. Art is also used to integrate the healing. Group paintings helped the group to start to work together as they blended their individual stories into a whole. Conversation happened naturally as people painted together.

Art is a language of its own. Humans use art as a mode of expression across all cultures. It is an effective tool for healing, used by people of all cultures in all ages. During the We Al-li activities art becomes a powerful tool of expression and integration.

This isn't 'art therapy'. The art process is healing in itself. Art does not require verbal reflection or interpretation. In the creation of images, symbols and collages, natural resistance can be overcome.

It is possible to review a person's art over a period of eighteen months to two years and actually see the depicted changes in the person, yet no verbal formal therapy has taken place. People can participate deeply, effectively and safely in healing through art, because art speaks of the inner needs and experiences. A young man in prison, after attempting suicide, for three months and in the deepest despair, painted the most beautiful paintings as he went within himself to find a new direction in his life.

> *I lose myself in the painting and time stands still. When I come out something has changed me in [Anon].*

Music and dance

Similarly, it has been found some people are able to dance (or move the story through their body. Dance is also used to help people feel what is insider them, and express those feelings in creative movement. Another young man approached music and dance as means of expression of his deep inner feelings:

> *I'm in training - I'm using all my anger - all my emotions - the stress and the pain and the shit I got to go through - I use it all for my dancing. Like We Al-li says, we use our anger, we recycle it, we use it as power for us. These people showed me a different life … to make beautiful things out of your anger, out of your hate, out of your sadness [Anon].*

Community Theatre

Drama has proved to be an excellent tool to allow safe learning to occur, both in individuals and within communities, to create further points for discussion, and to provide deeper understanding of the trauma story. Often in role-playing, either as participants or as

audience, people will have flashes of insight essential to understanding behaviour, including their own. A safe learning environment can be created through community theatre, for insight that can be painful yet empowering for change.

Emotional Regulation and Emotional Release

Creating a safe place for feelings to be felt, expressed and released is essential. Our experience is that many Aboriginal people have layers of unexpressed anger and grief stored in their body, and these feelings are the root cause of much of our distress, criminal behaviour and physical and mental illness. The *Prun* and other ceremonial conflict processes where deep feeling were expressed, were re-created in *We Al-li*, and the anger – grief workshops became the ones people wanted the most.

Body work

Massage, breath, and other sensory based body therapies, which provide body-awareness proved to be valuable tools in healing work, allowing the felt-sense to be explored in safety.

The use of these multiple pathways and cultural healing tools provides holistic integration and they are most effective within a group process, which appears to be stronger, for Indigenous people, than is individual work. The most important tools used, however, are the processes of *dadirri* and reflective discussion.

The healing work of We Al-li provides a simple shift in focus from the treatment of illness and dysfunction to promote health and well-being in family and community relationships. We Al-li seeks to move away from classifying, labelling, pathologising, and medicalising human bodies, minds. spirits and emotions, and criminalising human trauma behaviours. It seeks to promote a curiosity about the breadth, depth and diversity of the human subjective experience, acknowledge the untapped potential of personal resources and the formidable tenacity of the human spirit, for more than just survival.

Health and well-being is not about perpetual happiness, contentment, the absence of fear or even the absence of disease or pain. It is an unqualified embracing of life for its own sake. Quality of life is not about adherence to some conjured-up definition of normality or compliance. It is the experience and expression of what it means to be fully alive. One can be fully alive while in a wheel chair, lying on our death-bed, living below the defined poverty line - whether we are in ecstasy or despair.

> *Optimal health exists when a person experiences Self as an integrated whole that encompasses the body, the emotions, the mind and the spirit. This state of health, experienced as a pervasive sense of well-being, can only occur through connection with other Selves –'* ***without you there can be no me'****. To become whole, the Self needs to be experienced, expressed from the inside and recognised from the outside. Hence the critical context for both health and healing is the interpersonal (Self-Other) relationship (Fewster 2000: Health is Generated from Inside Out).*

We Al-li seeks to have people come to the knowledge that each person possesses the resources to promote and experience her or his sense of connectedness with Self, with others and with the world in general. In its state of unity, the natural order is neither hostile nor damaging to human life; so however disconnected or fragmented the person appears to be, the challenge remains the same – to access the resources for connection and health that lie within. Health is not a struggle against adversity but a life-long process of seeking and sustaining wholeness. Through participation in life, through Self-Other contact and by creating conditions in which connectedness can grow and flourish, healing occurs.

Chapter three: Future

Even though We Al-li has been delivered by Aboriginal peoples since the mid 1990's as a trauma informed educational program, with trauma specific units of study, it needs to be expanded. The question is can we move from single event – individual interventions, to whole of community interventions.

Trauma informed, and trauma specific programs and treatments are ones in which discussion of traumatic experience is a key therapeutic strategy (Nickerson, Bryant, Silove, & Steel, 2011), however which also have a political and social constructionist analysis. This is in contrast to therapeutic models which focus on psychosocial functioning and focus on a range of psychosocial stressors or issues (e.g. alcohol use).

Single Event - Individual Interventions

The area in psychology/psychiatry on which most research has been focussed, has been single event – individual interventions. Single or relatively few event interventions rely on the fear conditioning models of traumatic experience, and therapy is conceptualised a form of extinction learning in which conditioned fear responses are inhibited by new learning that ensures that associated cues are no longer signals of threat (Nickerson et al., 2011). The focus of treatment is on altering maladaptive thoughts held by trauma survivors in order to reduce distress and improve functioning (Foa, Steketee, & Rothbaum, 1989). These psychological focus therapies are often supplemented with a range of psychotropic medications mostly antidepressants (Australian Centre for Posttraumatic Mental Health, 2007).

This focus on single events and the consequent intervention strategies are of limited value when intervening in Aboriginal & Torres Strait Islander communities because the healing model needs to reflect a multiple and lifelong events profile of traumatic experience, be trauma informed in its development and designed and be trauma specific in its application across all community services.

Multiple Event Interventions

Given the extensive nature of traumatic experience of Indigenous Australia peoples and communities, the relevant area of international research is related to post conflict communities, many of which are

also post colonial communities (e.g. Timor Leste, Cambodia, Palestinian, Palestinian, all of Africa) and refugee experiences, where the traumatic load is extensive and also multigenerational. Recently there have been two comprehensive intervention approaches developing trauma informed models into post conflict or post disaster communities.

The first of these is the ADAPT (**A**daptation & **D**evelopment **A**fter **P**ersecution & **T**rauma) Model which has been developed over time from working with extensively traumatised populations including torture survivors (Silove, 1999, 2000, 2005; Silove & Steel, 2006). The second set of guidelines for intervening in post conflict and post disaster communities was loosely labeled the 'Five Essential Elements' and was developed by a large international 'expert group' (Hobfoll et al., 2007). The expert group reviewed the available literature in the area and concluded there was a lack of fundamental evidence on which to draw strong conclusions. Thus they used what literature was available and reviewed literature in parallel fields focussing on literature designed to producing stress-resistance or resilience to provide guidance where existing research was lacking.

Both these models address the need to respond to the collective and complex traumatic experiences, and not focus only on the individual. Both see such an approach as critical to the societal, community and individual recovery of whole populations. This broader view of trauma-informed intervention is relevant to Aboriginal and Torres Strait Islander communities where traumatic experience has a broad historical basis. Both are complementary to models that have been developed and are being run by Indigenous peoples, eg the We Al-li program.

The ADAPT Model

This model is based on the notion that significant traumatic experience impacts on five interrelated 'ecosocial systems'. Ecosocial systems are those for which there are mutually impacting individual and social influences. That is, the psychological and social factors strongly influence each other and interventions in one field may interact and produce change in the other. In particular many social interventions will go some way to healing individual effects of the trauma in some people, and assist with the identification of the small group that requires more intensive interventions.

The five interrelated systems are

1. Security/Safety,
2. Attachment,
3. Justice,

4. Role/Identity and
5. Existential Meaning.

There are a range of adaptive and maladaptive responses when each system is challenged (traumatised). For example, violations of 'human-rights' is a clear challenge to the concept of justice. Adaptive responses include anger and mistrust in justice, and systems of justice administration. Maladaptive response may include clinical anger, anger attacks and rage. These forms of anger are all associated with increased levels of violence particularly family and community violence.

Within the ADAPT model there are three broad intervention types, social, psychological and psychiatric. It is hypothesised that social interventions will help to solve a significant proportion of distress, and assist with the adaptive responses and potentially assist the more maladaptive responses. However, there will always be a small group that is substantially harmed by traumatic experience, loss and the Human-Rights violations that require greater support, either from the psychological and/or the psychiatric domains. So returning to the Justice example, social programs aimed at restoring justice may go some way to addressing anger and mistrust in the community and for some individuals. Justice examples include truth and reconciliation models, indictment and punishment of principle perpetrators, restorative justice models, developing capacity for forgiveness.

However for a smaller proportion specific interventions for anger may be required. Recent evidence suggests treating traumatic experience is an effective anger intervention (Cahill, Rauch, Hembree, & Foa, 2003). Given the assumption that social programs that go to addressing Injustice may go some way to assisting people to recover from the injustice they have experience it may go some way to preparing others to be able to benefit from psychological or psychiatric interventions. For example issues related to recognition and reconciliation may assist Aboriginal peoples to heal, or at least assist people to be ready to heal.

Five Essential Elements

Evolving from the work of the expert group were 5 essential elements to intervening in traumatised population in the medium term. The five principles are; To promote:

1. A sense of safety
2. Calming
3. Self and collective efficacy
4. Connectedness
5. Hope

It can be seen even though some of the labels are slightly different, there is substantial overlap with the ADAPT model, with safety being

the first issue for both. For the 5 elements model safety interventions can be at the individual, group, organisation, or community levels.

The sense of connectedness in the 5 elements model is equivalent to the attachment pillar in the ADAPT model. Re-establishing family and community connections is a major primary activity in post conflict and post disaster communities. The concepts of hope and existential meaning are substantially similar in that a sense of purpose, or a hopeful future, provides resiliency and reason to continue even when things seem overwhelming.

The sense of efficacy, both individual and collective is damaged by traumatic experience. Silove's model uses the concept of role and identity, where trauma and persecution "are seen to undermine the person's sense of identity, agency and control" (Silove & Steel, 2006). Agency and control and sense of efficacy are similar.

Calming is a concept unique to the Essential element model and is not specifically addressed in the ADAPT model. Calming is required as traumatic experience increases emotionality, including heightened and hyper arousal. Numbing as a defence against the heightened emotionality is also common. Thus, calming will assist both those who are showing overt arousal signs and those that have withdrawn from an emotionally changing world.

Justice is a concept unique to the ADAPT model. Thus combining these two contemporary and theoretical models produces six key components to designing interventions in post conflict and post disaster communities where there has been extensive traumatic experience often over long periods of time.

1. Safety and security
2. Calming
3. Justice
4. Connectedness/Attachment
5. Existential meaning and Hope
6. Role/Identity and Self and collective efficacy

Both models stress the need for community, or social interventions, with the implication that these should occur first, allowing the identification of the small group who needs more intensive psychological and/or psychiatric support (Hobfoll et al., 2007; Silove, 1999, 2005; Silove & Steel, 2006).

The We Al-li approach to community healing

These models fit closely to the whole of community engagement models developed by We Al-li.

The following whole of community healing approach has been compiled by combining the We Al-li model of educaring with the work of Silove and Hobfoll.

1. **Safety and Security:** Locate and support safe places and safe caring people, within communities. Build on those capacities and commitments. Help promote a sense of individual and collective safety and security, through community programs of mutual care and trust.

2. **Attachment, bonding and belonging:** Introduce an educaring program in communities, working with local people to deliver these packages, with educational modalities, to provide a calming approach through the structure of talking together to build community connections, communal attachment, community awareness of issues, without judgement, but with the desire to work together to support change and healing. The educational model of reflective discussions and practice, helps draw out what people already know and builds on a felt sense of competency and control.

3. **Justice, Fairness and Dignity:** Provide support and resources for people to build their community recovery. Such activities will include justice programs, promoting a sense of self and collective efficacy, fairness and dignity. In this support the development of partnerships between communities and professional workers from outside organisations.

4. **Valuing Self and Valuing Others:** Provide support for professional workers. Encourage inter-connectedness and social support in their roles and identities. Give value to the workers who are already doing the hard work, whether living within the community or those invited in to help in the recovery process. Value their contribution so that they can begin to value themselves. Ensure that in all of this the strengths and capacities of individuals, families, communities and workers are highlighted as all critical to the whole.

5. **Meaning and Coherence:** Provide trauma healing in early childhood programs and in schools for children and their parents; for young people, in youth focused creative activities; for men and for women, and for Elders, based on growing a felt sense of hope, coherence, and consistency, for capacity building in making meaning of life, while enriching cultural and spiritual identities. (Atkinson 2007; Hoboll 2007; Silove 2007

Table 1: Core values of trauma-informed services

Principle	Explanation
Understand trauma and its impact on individuals, families, and communal groups	This expertise is critical to avoid misunderstandings between staff and clients that can re-traumatise individuals and cause them to disengage from a program. Two strategies promote understanding of trauma and its impacts: trauma-informed policies and training Trauma-informed policies formally acknowledge that clients have experienced trauma, commit to understanding trauma and its impacts, and detail trauma-sensitive practices Ongoing trauma-related workforce training and support is also essential. For example, staff members need to learn about how trauma impacts child-development and attachment to caregivers. Appropriate support activities might include regular supervision, team meetings and staff self-care opportunities.
Promote safety	Individuals and families who have experienced trauma require spaces in which they feel physically and emotionally safe Children need to advise what measures make them feel safe. Their identified measures need to be consistently, predictably and respectfully provided Service providers have reported that creating a safe physical space for children includes having child-friendly areas and engaging play materials. Creating a safe emotional environment involves making children feel welcome (e.g. through tours and staff introductions), providing full information about service processes (in their preferred language) and being responsive and respectful of their needs
Ensure cultural competence	Culture plays an important role in how victim/survivors of trauma manage and express their traumatic life experience/s and which supports and interventions are most effective Culturally competent services are respectful of and specific to cultural backgrounds. Such services may offer opportunities for clients to engage in cultural rituals, speak in their first language and offer specific foods Culturally competent staff are aware of their own cultural attitudes and beliefs, as well as those of the individuals, families and communities they support. They are alert to the legitimacy of inter-cultural difference and able to interact effectively with different cultural groups.
Support client's control	Client control consists of two important aspects. First, victim/survivors of trauma are supported to regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy. Second, service systems are set up to keep individuals (and their care givers) well informed about all aspects of their treatment, with the individual having ample opportunities to make daily decisions and actively participate in the healing process Child deaths
Share power and governance	Power and decision-making is shared across all levels of the organisation, whether related to day-to-decisions or the review and creation of policies and procedures. Practical means of sharing power and governance include recruiting clients to the board and involving them in the design and evaluation of programs and practices
Integrate care	Integrating care involves bringing together all the services and supports needed to assist individuals, families and communities to enhance their physical, emotional, social, spiritual and cultural wellbeing
Support relationship building	Safe, authentic and positive relationships assist healing and recovery. Trauma-informed services facilitate such relationships. For example, by facilitating peer-to-peer support
Enable recovery	Trauma-informed services empower individuals, families and communities to take control for their own healing and recovery. They adopt a strengths-based approach, which focuses on the capabilities that individuals bring to a problem or issue

Source: Adapted from Guarino, Soares, Konnath, Clervil and Bassuk (2009)

Sitting with a Shattered soul. ... K. Steele

So how do you sit with a shattered soul?

Gently, with gracious and deep respect.
Patiently, for time stands still for the shattered, and
the momentum of healing will be slow at first.

With the tender strengths that comes from an openness
to your deepest wounding, and to your deepest healing.

Firmly, never wavering in the utmost conviction that
evil is powerful, but there is good that is more powerful still.

Stay connected to that goodness with all your being,
however it manifest itself to you.

Give freely. Take abundantly.

Find your safety, your refuge, and go there as you need.

Words won't always come;
sometimes there are no words
in the face of such tragic evil.
But in your own willingness to be with them,
they will hear you;
from soul to soul
they will hear for that which there are no words.

When you can, in your own time,
turn and face that deep chasm within.

Let go, Grieve, rage, shed.

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