10

Trauma, Transgenerational Transfer and Effects on Community Wellbeing

Judy Atkinson, Jeff Nelson and Caroline Atkinson

OVERVIEW

This chapter focuses on how the effects of experiencing trauma are transmitted within and across generations, and how whole communities can be affected by a single experience of trauma by a single member of a community. The chapter introduces the reader to a selection of views and conceptions of trauma, theories of its transgenerational transfer, an explanation of the impact of lived or transferred trauma in the lives of Aboriginal and Torres Strait Islander families and communities, and an overview of dysfunctional community syndrome. It also explores the links between unresolved childhood trauma and participation in violence, sexually inappropriate behaviour, and incarceration as adolescents and adults. The second part of the chapter discusses the challenges associated with working in Indigenous communities; it provides an example of a program that is achieving positive results through education and community empowerment, and an appreciation of the need to embed trauma-recovery in all facets of service provision.

TRAUMA: EVENT, ENVIRONMENT, OR REACTION?

It remains contentious whether the word 'trauma' relates to an event, a series of events or an environment, to the process of experiencing the event or environment, or to the psychological, emotional and somatic effects of that experience. Briere and Scott (2006) argued that trauma should only be used to refer to 'major events that are psychologically overwhelming for an individual' (p. 3) and refer their readers to the DSM-IV-TR definition of 'extreme traumatic stressor' (American Psychiatric Association, 2005, p. 463) for clarification. Under the American Psychiatric Association classification, a stressor must be assessed as extreme[1] to qualify an individual for a diagnosis of Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD), but can be of lesser severity for a diagnosis of Adjustment Disorder (AD). The DSM-IV-TR's reliance on the extreme/not-extreme dichotomy assumes homogeneity in how people process events and the perceived severity of the experience across individuals. This assumption ignores individual differences and discounts the effects of previous histories or current living conditions.

Figley (1985) breaks his definition of trauma into two clear but related areas. He defines *psychological* trauma as 'an emotional state of discomfort and stress resulting from memories of

1   DSM-IV-TR's list of traumatic events include, but are not limited to, military combat, violent personal assault (sexual assault, physical assault, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness.

an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm' (p. xviii). He also defines trauma *behaviourally* as 'a set of conscious and unconscious actions and behaviours associated with dealing with the stresses of catastrophe and the period immediately afterwards' (p. xix). Figley's requirement that events be necessarily catastrophic, extraordinary and memorable to trigger a traumatic-stress reaction is consistent with the DSM-IV-TR's references to substantial severity. Scaer (2001) and van der Kolk (2007) concur with Figley by arguing that the inability to cope with highly traumatic events results in psychological and physiological effects that limit the ability to act or respond appropriately at the time of the event. Whether we focus on trauma as the event or as the experience of and reactions to the event is not the focus of this chapter. It is more important to understand that overcoming the effects of trauma-related illness requires addressing not only the illness (individual) but also the prevalence of events (community) that lead to re-experiencing, and poor mental health.

Trauma-related illness, identified in the DSM-IV-TR as PTSD, ASD, and AD, is conventionally managed by psychologists, usually through individual or group therapy and behaviour modification techniques. Leaving aside the usual criticisms about the effectiveness of mainstream psychology for Indigenous people (Hunter, 2003; Ranzijn et al., 2007), more recent reservations have been expressed about the ability of American Psychiatric Association constructs to capture the challenges facing Indigenous people living in today's society. Specifically, Atkinson, C. (2008), Atkinson, J. (1990, 2002), Cameron (1998), Milroy (2005) and O'Shane (1993) have argued that diagnoses such as PTSD are unable to conceptually capture the levels of chronic ongoing stress that Indigenous people experience in their everyday lives. The sources of this stress are argued to be multiple, repeated, and of great severity; and the levels of this stress are argued to be unacceptably high and compounded by (1) the inability to identify and overcome a single source of stress, (2) the presence of cumulative stressors, and (3) the realisation that many of these stressors are inflicted by people well known to the victims. Not only is there the problem of inadequacy at diagnosis but there are more substantial problems at the levels of treatment and control.

The individual and community costs of unresolved trauma

Van der Kolk (2007) argued that childhood trauma was probably today's single most important public health challenge and a challenge that could be overcome by appropriate prevention and intervention. His work provided a comprehensive insight into effects of experiencing trauma in childhood, demonstrating links with ongoing physical health problems, with intra- and intergenerational transference of negative attitudes and troubled behaviour, and with the transference of historical trauma across family and communal systems. Van der Kolk argued that childhood trauma violated a child's sense of safety and trust and reduced their sense of worth, that it established and/or increased their levels of emotional distress, shame and grief, and increased the proportion of destructive behaviours in the child's normal repertoire. 'Destructive' behaviours included unchecked 'aggression, adolescent suicide, alcoholism and other substance misuse, sexual promiscuity, physical inactivity, smoking, and obesity' (pp. 226–27). Survivors of childhood trauma were also shown to be more likely to have difficulty developing and maintaining relationships with caregivers, peers and marital partners. He also argued that adults with a childhood history of unresolved trauma were more likely to develop lifestyle diseases (heart disease, cancer, stroke, diabetes, skeletal fractures and liver disease) and be likely to enter and remain in the criminal justice system. Van der Kolk's findings highlight the need for the early identification of children who are being offended against, to support these children and to eradicate the behaviours that are compounding their already serious conditions.

Atkinson (2008) recently investigated the link between being a victim (direct or indirect experiencing) of childhood trauma and being a perpetrator of higher-level violence in adulthood. The results of her study showed that a statistically significant proportion of her sample (Indigenous men who were incarcerated for violent offending) reported experiencing traumatic and violent events in their youth, and doing so frequently. The results also revealed a positive statistical association between

the number of traumatic stressors or cumulative degree of traumatic exposure and the likelihood of displaying PTSD symptomology.[2] Atkinson argued that the normalisation of family violence and the high prevalence of grief, loss and substance misuse were as much symptoms as causes of traumatic stress. One of the most alarming aspects of Atkinson's study was the consistency of identifying as being victims of particularly severe child sexual abuse from early ages. This abuse, which often began in early childhood (victim) and continued until maturity, triggered the later acting out (perpetrator) on members of extended family and others. Atkinson's research also identified a substantial lack of services that effectively supported victims of abuse and interrupted its intergenerational progression. Atkinson concluded that the link between childhood trauma and adult offending was mediated by the presence of unresolved trauma and undiagnosed PTSD.

The intergenerational transmission of trauma

Blanco (in Levine & Kline, 2007) developed a five-generation account of the effects of violence on subsequent generations in South America that can be mapped onto the history of Indigenous Australia:

1st Generation: Conquered males were killed, imprisoned, enslaved or in some way deprived of the ability to provide for their families.[3]

2nd Generation: Many men overused alcohol and/or drugs to cope with their resultant loss of cultural identity and diminished sense of self-worth. Unfortunately, government responses to emerging substance misuse problems have not always been effective and have directly and indirectly led to the traumatisation of individuals who had not been previously affected, and the exacerbation of trauma in those already suffering the effects of trauma-related illnesses. The Queensland Government's solution to their developing substance-use problem was to pass the *Aborigines Protection of Alcohol and Opium Act 1897*, which enabled Indigenous offenders to be removed to and forced to remain on reservations, though without the support they required to overcome their substance-use issues.

3rd Generation: The intergenerational effects of violence manifest in the increased prevalence of spousal abuse and other forms of domestic violence. The breakdown in the family unit that accompanied this violence 'required' caring governments of the day to remove 'at risk' children from their mothers and place them in the care of suitable, in many cases non-Indigenous, families. Unfortunately, the compassion shown for the children was not replicated in the case of the mothers, whose situations were not improved by government intervention.

4th Generation: Trauma begins to be re-enacted and directed at the spouse and the child; signifying a serious challenge to family unit and societal norms of accepted behaviour.

5th Generation: In this generation, the cycle of violence is repeated and compounded, as trauma begets violence, with trauma enacted through increasingly severe violence and increasing societal distress.

Blanco's depiction of the absolute breakdown of functional society within a five-generation time-span shows strong similarities to progression mapped in Atkinson's (2002) six-generation traumagram. Atkinson successfully linked the historical events associated with the colonisation of Aboriginal lands ('accidental' epidemics, massacres, starvations, and the removal of people to reserves) to increases in the rates of family violence, child sexual abuse and family breakdown in Indigenous society. She traced one family line across six generations, listing the known memories of being victims of sexual and/or physical violence, being a perpetrator of violence, suffering from mental health illness, attempting suicide, and having substance misuse problems. Her ability to trace the one family across several generations provided a unique line of evidence

---

2 Atkinson (2008) developed the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) as a more culturally competent measure of specific traumatic stressors and trauma symptoms (DSM-III-R criteria for PTSD). This questionnaire included specific cultural idioms of distress reactions that are relevant to Australian Aboriginal peoples (Atkinson, 2008).

3 Intergenerational transmission of trauma occurs through directly experiencing trauma or through visually or aurally sharing the traumatic experiences of others.

to support the view that the presence of unacknowledged or unresolved trauma in previous generations was linked to dysfunction in later generations of an extended family.

Atkinson's research provided evidence of a link between the imposition of government policies and interventions and variations, usually upwards, in behaviours associated with trauma experiences in Aboriginal people. She argued that the removal of Aboriginal children was not only a racist policy but also reflected a desire to 'breed them out'. These policies and interventions that arguably did so much damage were often presented as bureaucratic generosity to people who were frequently living in clear distress. For example, a widow having her children removed 'for their own good' rather than providing support for the family's immediate crisis or a couple forced to live in extreme poverty by the instruments of the state and then having their children removed because of their imposed poverty. There is little doubt that Atkinson's work was primarily focused on investigating the link between unresolved trauma and generational wellbeing, but it was also pivotal in exposing the role of government inactivity and intentional racism in the plight of Australian Aboriginal people.

Historical trauma and the breakdown of family and community

Historical trauma is defined as 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 as 'collective emotional and psychological injury … over the life span and across generations' (Muid, 2006, p. 36). Milroy (2005) gave a comprehensive explanation of how trauma is transmitted across generations and the role of community networks in this transmission:

> 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. (p. xxi)

Duran and Duran (1995) suggested that historical trauma becomes embedded in the cultural memory of a people and is passed on by the same mechanisms by which culture is generally transmitted, and therefore becomes 'normalised' within that culture. This model of historical trauma provides a link between the intergenerational transmission of trauma and 'dysfunctional community syndrome' (Duran et al., 1998; Muid, 2006; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Ralph et al., 2006; Robertson, 2006; Whitbeck et al., 2004). Memmott et al. (2001) defined dysfunctional community syndrome (DCS) 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. (p. 51)

Memmott et al. (2001) suggested that the typical cluster of violence types in a dysfunctional community would include male-on-male violence, female-on-female violence, child abuse, substance use-related violence, male suicide, pack rape, infant rape, rape of grandmothers, self-mutilation, spousal assault and homicide. They further argued that when a community deteriorates to the point of DCS, it has devastating immediate and generational effects on the members of that community, particularly the children. Exposure to community

violence results in dangerously high levels of emotional distress and antisocial behavioural problems, and has been identified as an independent risk factor for problems such as depression, anxiety and aggression in youth (Scarpa, 2001).

Ralph et al. (2006), investigating proposed links between depression and the high youth suicide rates of the Kimberley region of Western Australia, concluded:

> Aboriginal youth in the Kimberley region may 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 Kimberley 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. (p. 123)

In fact, Ralph et al. demonstrated a clear link between being exposed to trauma and developing PTSD symptoms and suicidal ideation, particularly in young Aboriginal girls who identified as being victims of childhood abuse.

Child sexual abuse, trauma, and recovery

While there is evidence that at least 40% of all psychiatric inpatients have histories of sexual abuse in childhood (Putnam, 1997), the sexual abuse of children does not occur in isolation. Other stressors and trauma are generally present within a family or social group in which the abuse is occurring. Giller (1999) argued that about a third of abused children display few or no symptoms and that a large proportion of children who do become symptomatic are able to recover. Fewer than one in five adults who were abused as children show serious psychological distress. According to Giller (1999), 'Acute psychological distress is associated with more severe abuse: longer duration, forced penetration, helplessness, fear of injury or death, perpetration by a close relative or caregiver, coupled with lack of support or negative consequences of disclosure' (p. 1).

Of greater concern, the evidence shows that as many as one-third of child victims of physical (including sexual) and psychological abuse grow up to experience parental difficulties or become abusive of their own children; one-third of previously abused parents do not have this experience; but the remaining third remain vulnerable and, under stress, have an increased likelihood of becoming abusive (Oliver, 1993). According to Green (1993), 'There is considerable evidence that the abused child is at risk for re-enacting the original violent interaction with his parents in subsequent relationships with peers and offspring, supporting a theory of intergenerational transmission of violence' (p. 582).

The NSW Aboriginal Child Sexual Assault Taskforce (2006) identified the normalisation of violence that only comes with generations of abuse as a determining factor in the rates of physical and sexual violence. One participant in the inquiry stated: 'The trauma of child sexual assault makes it very difficult for people to develop healthy relationships…because you've got, you know, children being raised like three generations in a row where sexual and family violence has been part of their life' (Transcript 24, p. 61). According to Atkinson and Atkinson (1999), the endemic nature of family violence over a number of generations has resulted in a situation where 'violent behaviours become the norm in families where there have been cumulative intergenerational impacts of trauma on trauma on trauma, expressing themselves in present generations as violence on self and others' (p. 7).

The information included in this section is intended to provide a basis for understanding some of the more salient challenges facing Aboriginal and Torres Strait Islander people living in contemporary society. The authors acknowledge that there are many non-Indigenous individuals

and families who face identical challenges and who, like their Indigenous counterparts, have reason to feel unsupported by their governments. The next part of this chapter will focus on the challenges of working in communities to support positive change and will provide an example of one program that is using community resources to their greatest potential.

The challenges of community recovery

The single most difficult challenge facing a service provider who is responsible for working with a remote Indigenous community to overcome its problematic behaviours is establishing a space that encourages and supports open communication. While this is a challenge for all, it is infinitely more difficult when the service provider is not known by community members and is unfamiliar with the complex relationships that exist in communities. This problem is further compounded if the visiting service provider is non-Indigenous. From our experience, it is our understanding that it can take up to a year to establish a quality of relationship that will enable in-depth therapeutic work to commence and much longer to contemplate deeper issues (violence against and neglect of children and domestic violence) and challenge more serious behaviours. This estimate may be excessive, but the negative history of service provision in most Indigenous communities must be considered.[4]

Developing a new relationship between parties when there has been no history of mistrust or unmet expectations is not difficult if people are honest and consider each other's views and feelings. Trust between parties develops as a function of the degree of consistency in the nature of interactions (honesty, openness and dependability), the depth of familiarity between the parties, and as a function of time. Unfortunately, there would be many Indigenous community members who have heard numerous accounts of failed relationships with service providers. Whether responsibility for these failures lay with the practitioners or the underlying system will be discussed at a later stage. The important aspect of this history is its limiting effect on the probability of developing new trusting relationships between communities and service providers, and how that affects people in genuine need of care and assistance. The default perception of a new service provider in most communities is more likely to be one of mistrust over ambivalence, especially if the service provider is non-Indigenous and comes with new ideas, new plans and an inability to learn from their new environment. So how does a service provider overcome this very important challenge?

Entry into a community to provide therapeutic services should be prefaced by a series of consultations with as many community people as possible and preferably by the invitation of community members who are familiar with the provider's work. This is not always possible so there needs to be a process of introduction and familiarisation that goes some way towards overcoming the potentially limiting effects of previously failed interactions. From the outset, it is advisable that service providers recalibrate their expectations around timing and achievement. Achieving and supporting positive change in Indigenous communities unfolds slowly, at a much more leisurely rate than happens elsewhere, and necessitates a long-term commitment from service providers. Because of the slowness of change in these communities and the failure to recognise this, there has been a history of prematurely terminated programs and failed expectations. An essential part of any successful community program is having local people support and become active participants in the change process. This requires, in many cases, that people alienate themselves from the normal activities of the community, align themselves with outsiders, and be isolated accordingly by their own family members. When a program is prematurely terminated and its service providers geographically remove themselves, those who supported the initiative are left to face ridicule and torment for being so trusting. There are many community members who identify as casualties and who actively dissuade their family members from participating in any further programs.

---

4 Community does not necessarily refer to a place but to a network of people who are in regular contact and live as a collective of similarly-minded people.

On entering the community it is essential that the service provider makes him or herself available to all community members to have informal discussions about the intentions of the visit; what is anticipated will happen over the longer term; how the process has worked or not worked in other communities; how local people can become involved and contribute to developing and implementing the program; and to share personal information that allows trust to develop and relationships to be built. It is essential that the service provider is honest in these early interactions and is willing to listen to what they are being told. If the intention of the visit is to support overcoming child sexual abuse, remember that there have already been many programs run in the community to combat this problem. If the intention is to overcome domestic violence it is again the case that this program is not the first and people are aware of this. Community people have the advantage of having seen the success or failure of many programs and are a rich resource of information for those astute enough to capitalise on it. Being open to the suggestions of community people not only makes this information accessible but also strengthens relationships and builds trust.

That an invitation has been extended by a community does not guarantee that everyone in the community will welcome or support the change process. There are likely to be individuals who prefer the status quo because of their vested interests in certain behaviours or situations, their inability to appreciate that there is a better way of living, or from their experience of previous programs that were abandoned or failed to achieve their promised outcomes. Consider the following advice: 'If a community is not vocal about changing their own circumstances and you cannot easily identify any natural leaders don't waste your time. If the community is using lots of gunja [marijuana] it is even more useless to attempt change' (personal communication, Komla Tsey, 2008).

We-Al-Li: A successful community-based program

Achieving sustained positive in-community change requires a substantial investment of resources, personnel and time, and many organisations cannot afford this investment. It is partly because of this demand that successful programs such as the Family Wellbeing Program (Tsey et al., in press) and the We-Al-Li Workshops (Atkinson & Ober, 1995) use the 'train the trainer' model to achieve and support community change over the longer term. These programs focus as much on the development of community strength, confidence and skills as they do on overcoming the behaviours and attitudes that lead to dysfunctional communities. By establishing and equipping a core group of community members with the skills necessary to direct vulnerable individuals away from antisocial and unlawful behaviour, substance and alcohol misuse and family violence and neglect, these programs are contributing to the development of safe, structured and stable Indigenous communities. These programs provide formal qualifications to their participants and enhance their ability to gain full-time employment either in their own or other communities.

The We-Al-Li workshops provide opportunities for interested community members to pursue formal qualifications up to doctoral level through the Gnibi College of Indigenous Australian Peoples at Southern Cross University. The successful completion of the community-based program (four units) allows its participants to graduate with an accredited Certificate of Community Recovery. The units offered in this course include Community Wellbeing, Indigenous Counselling, Trauma and Recovery, and Family Violence and Recovery. Completing these units allows participants to work through personal issues, to develop the skills necessary to initiate and support positive changes in the community, and to work with individuals as required. The premise that underpins Gnibi's in-community education is that there are eight factors that contribute to individual, family and community wellbeing and that achieving a balance between them is critically important. The factors include environmental wellbeing, spirituality, relationship wellbeing, physical wellbeing, emotional wellbeing, stress regulation, sexuality and life purpose. Education is provided in a familiar setting (usually an established meeting place), in an informal manner (focusing on non-judgmental group discussions), with an

emphasis on encouraging people to discuss their current situations and to understand how the eight factors contribute to their situation. Conversations about deeper, more sensitive issues are usually reserved for the art sessions where the groups create paintings and other artworks. These conversations usually result in good-natured explorations of the historical and current issues that are limiting personal growth and the achievement of a holistic sense of wellbeing.

Participants in the Certificate course are provided with:

1   an overview of five counselling techniques (narrative therapy, cognitive-behavioural therapy, somatisation, loss and grief counselling and art therapy) and instruction in how to combine them for the best outcome

2   instruction on the use of deep listening, the rules of conversation, and how to facilitate effective group discussions about sensitive topics

3   an overview of the issues pertaining to unresolved trauma, its effect on daily functioning, how to manage the rage that accompanies unresolved trauma, and how to make sense of themselves and their environment

4   an overview of the issues contributing to domestic violence, sexual assault, substance misuse, parental non-responsibility and child neglect.

Graduates with the Certificate of Community Recovery are presented with additional opportunities to extend and refine their skills and are assisted to develop and maintain support networks within their communities. Adopting a role as a support person is not easy and is quite often unrewarded, but there are a number of individuals who have participated in the We-Al-Li workshops who are providing services in their own communities, though without formal recognition or remuneration. An unexpected source of validation for the workshops came from a group of qualified practitioners who participated in the workshops as a part of their professional development. They all reported that the workshops allowed them to identify and work through personal experiences of trauma that they had previously 'shelved'. They further claimed that dealing with their trauma had allowed them to grow and to become more effective in the field and in their personal lives.

That the We-Al-Li workshops are able to improve the effectiveness of service provision in Indigenous communities through their effect on established practitioners and community members demonstrates their capacity to initiate and support change. They further show that trauma is an all-encompassing pathology that does not spare its victims regardless of their status, their profession or their identity as Indigenous or non-Indigenous. Members of different practitioner groups have all suggested that in the interest of the sufferers of trauma-related illnesses, all mental health practitioners be required to work through their own trauma issues before being accredited to work in the field.

CONCLUSION

This chapter has provided a brief overview of the understandings of trauma, and how the different forms of trauma impact on Australian Indigenous people. The authors have given special consideration to the transgenerational nature of trauma. In order to understand dysfunctional community syndrome, the consequences of colonisation expressed in trauma have been examined in some detail. The links between unresolved childhood trauma, violence, inappropriate sexual behaviours and incarceration have been examined. Importantly, the challenges of engaging with Indigenous communities are discussed and examples of successful programs for community empowerment are outlined. While this chapter focused on a perspective of life in Indigenous Australian communities that is disadvantaged and fraught with dysfunction, this reflects the reality of some people and is mitigated by the fact that empowering solutions are available. However, these solutions are not simple and require full and long-term commitment by communities themselves and government. The bleak life of some Indigenous

people and communities is a reality that can be changed if appropriate preventions and interventions are identified and implemented in culturally appropriate and safe ways.

Reflective exercises

1   There are many factors that contribute to the traumatisation of individuals and communities. Demonstrate your knowledge of what these factors are, how they are associated, and how you would develop a service plan.

2   It is common to hear service providers arguing that improving the education and quality of life of children is the only way of overcoming chaos and dysfunction in Indigenous communities. Discuss this statement focusing on the child–family and child–community relationships.

3   If the evidence that links being exposed to violence in childhood to perpetrating violence is adulthood is accepted, and we acknowledge the prevalence of violence, how do we intervene to break the cycle?

4   Discuss the transgenerational nature of trauma.

References

American Psychiatric Association (2005). *Diagnostic and statistical manual of mental disorders* (4th Ed., Text Revision). Washington, DC: Hutnor.

Atkinson, C. (2008). The violence continuum: Australian Aboriginal male violence and generational post-traumatic stress. Unpublished PhD thesis. Charles Darwin University, Darwin.

Atkinson, C., & Atkinson, J. (1999). Talking about perpetrator programs. In R. Thompson (Ed.), *Working in Indigenous perpetrator programs: Proceedings of a forum*. Adelaide: Ministerial Council for Aboriginal and Torres Strait Islander Affairs.

Atkinson, J. (1990). Violence in Aboriginal Australia: Colonisation and gender. *Aboriginal and Islander Health Worker Journal*, *14*(1) (part 1) and (3) (part 2).

Atkinson, J. (2002). *Trauma trails, recreating song lines: The transgenerational effects of trauma in Indigenous Australia*. Melbourne: Spinifex Press.

Atkinson, J., & Ober, C. (1995). We Al-li—fire and water: A process of healing. In K. Hazelhurst (Ed.) *Popular justice and community regeneration: Pathways to Indigenous reform* (pp. 201–18). Westport, CN: Praeger Press.

Bradshaw, G. A., Schore, A. N., Brown, J. L., Poole, J. H., & Moss, C. J. (2005). Elephant breakdown. *Nature*, *433*(7028), 807.

Briere, J. N., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.

Cameron, S. (1998). Aboriginal experiences of psychological trauma: Personal, intergenerational and transgenerational. Unpublished Master's thesis, Victoria University, Melbourne.

Champion, H. R. (2008). A lessons-learned legacy. *Journal of Trauma: Injury, Infection, and Critical Care*, *64*(2), S2–S3.

Danieli, Y. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.

Duran, E., & Duran, B. (1995). *Native American post-colonial psychology*. Albany, NY: State University of New York Press.

Duran, E., Duran, B., Brave Heart, M. Y. B., & Yellow Horse-Davis, S. Y. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341–54). New York: Plenum Press.

Figley, C. (1985). *Trauma and its wake: The study and treatment of post traumatic stress disorder*. New York: Brunner/Mazel.

Giller, E. (1999). Passages to prevention: Prevention across life's spectrum. <www.sidran.org/index.cfm> (accessed 28 June 2009).

Green, A. (1993). Childhood sexual and physical abuse. In J. P. Raphael (Ed.). *International handbook of traumatic stress syndromes* (pp. 577–92). New York: Plenum Press.

Hunter, E. (2003). Staying tuned to developments in Indigenous health: Reflections on a decade of change. *Australasian Psychiatry*, *14*(1), 24–32.

Levine, P., & Kline, M. (2007). *Trauma through a child's eyes*. Berkeley, CA: North Atlantic Books.

Memmott, P., Stacy, P., Chambers, C., & Keys, C. (2001). *Violence in Indigenous communities*. Canberra: Commonwealth Attorney General's Department.

Mignone, J., & O'Neil, J. (2005). Social capital and youth suicide risk factors in First Nations communities. *Canadian Journal of Public Health*, *96*(S1), S51–S54.

Milroy, H. (2005). Preface. In S. R. Zubrick, S. R. Silburn, D. M. Lawrence et al. *The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research.

Muid, O. (2006). *Then I lost my spirit: An analytical essay on transgenerational theory and its application to oppressed people of color nations*. Ann Arbor, MI: UMI dissertation Services/ ProQuest.

NSW Aboriginal Child Sexual Assault Taskforce. (2006). *Breaking the silence: Creating the future, addressing child sexual assault in Aboriginal communities in NSW*. Sydney: NSW Attorney General's Department.

Oliver, J. E. (1993). Intergenerational transmission of child abuse: Rates, research, and clinical implications. *American Journal of Psychiatry, 150*, 1315–24.

O'Shane, P. (1993). Assimilation or acculturation problems of Aboriginal families. *Australian and New Zealand Journal of Family Therapy*, *14*(4), 196–98.

Panksepp, J. (2001). The long-term psychobiological consequences of infant emotions: Prescriptions for the twenty-first century. *Neuro-Psychoanalysis*, *3*, 149–78.

Putnam, F. W. (1997). *Dissociation in children and adolescents*. New York: Guilford Press.

Queensland Department of Aboriginal and Torres Strait Islander Policy and Development (2000). Aboriginal and Torres Strait Islander women's task force on violence report. Queensland.

Ralph, N., Hamaguchi, K., & Cox, M. (2006). Transgenerational trauma, suicide and healing from sexual abuse in the Kimberley region, Australia. Pimatisiwin, *A Journal of Aboriginal and Indigenous Community Health*, *4*(2), 118–36.

Ranzijn, R., McConnochie, K., Clarke, C., & Nolan, W. (2007). 'Just another white-ology': Psychology as a case study. *Counselling, Psychotherapy, and Health*, *3*(2), Indigenous Special Issue, 21–34.

Robertson, L. H. (2006). The residential school experience: Syndrome or historic trauma. Pimatisiwin, *A Journal of Aboriginal and Indigenous Community Health*, *4*(1), 1–28.

Scaer, R. (2001). *The body bears the burden: Trauma, dissociation, and disease*. New York: Haworth Press.

Scarpa, A. (2001). Community violence exposure in a young adult sample: Lifetime prevalence and socioemotional effects. *Journal of Interpersonal Violence*, *16*(1), 36–53.

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, *1*(1), 93–108.

Steenkamp, C. (2005). The legacy of war: Conceptualizing a 'culture of violence' to explain violence after peace accords. *The Round Table*, *94*(379), 253–67.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, *May*, 1449–62.

Tsey, K., Whiteside, M., Haswell-Elkins, M., Bainbridge, R., Cadet-James, Y., & Wilson, A. (In press). Empowerment and Indigenous Australian health: A synthesis of findings from Family Wellbeing formative research. *Health and Social Care in the Community*.

Van der Kolk, B. (2007). Developmental impact of childhood trauma. In L. Kirmayer, R. Lemelson, & M. Barad (Eds.), *Understanding trauma: Integrating biological, clinical and cultural perspectives* (p. 224). Cambridge: Cambridge University Press.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen. X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, *33*(3–4), 119–30.