FEATURE ARTICLE:
TRAUMA AND ATTACHMENT IN AUSTRALIAN POPULATIONS
PART 2

Westerman, T.G & Atkinson, J (2016). Trauma and Attachment in Aboriginal People (Part II): Jilya e-magazine, Edition 2 (Part 2). Is there a case for a different aetiology and what programs exist to address trauma and attachment in Aboriginal people

This article was adapted from an original article by Judy Atkinson (2013) CITATION: Trauma-informed services and trauma-specific care for Indigenous Australian children, Atkinson, J., (2013), Closing the Gap Clearinghouse Resource sheet no. 21 produced for the Closing the Gap Clearinghouse Judy Atkinson July 2013

In the last edition of Jilya we learnt that strong child-caregiver bonds and secure family environments are a critical means through which cycles of deep historical and intergenerational trauma can be healed. But how relevant are conventional concepts of attachment and trauma to Aboriginal people in Australia? How can trauma and attachment disruption be transmitted from generation to generation and most importantly - is there a specific aetiology that must be considered with Aboriginal people?

In this edition of Jilya we explore some of the mechanisms of intergenerational trauma transmission and attachment disruption, beginning with individual-level factors and broadening out to cultural, spiritual and structural elements. We also take a look at some Australian and internationally-based attachment-focused programs and the extent to which they focus on the different levels of intervention and prevention. This provides us with a very good opportunity to consider how best to assist at-risk individuals, families and communities to heal from trauma and attachment disruption.

Trauma and attachment Revision

As discussed in the previous edition of Jilya, trauma in the current context refers to an event that is psychologically overwhelming for an individual. The event involves a threat (real or perceived) to the individual's physical or emotional wellbeing. The person's response to the event involves intense fear, helplessness or horror, or for children, the response might involve disorganised or agitated behaviour (Briere & Scott 2006; Courtois 1999; Guarino et al. 2009).

In 2011, Indigenous children were 5.4 times as likely as non-Indigenous children to experience a hospital separation for assault, eight times as likely to be the subject of substantiated child abuse or neglect and 15 times as likely to be under juvenile justice supervision (AIHW 2011). Secondary exposure to trauma is also a reality for some Indigenous children. Much has been written about the trauma that results from the colonisation of Indigenous populations (see Atkinson 2002, 2008; Atkinson & Ober 1995; Baker 1983; Brave Heart-Jordan 1995; Duran & Duran 1995; Hunter 1998; Milroy 2005; Napoleon 1991; Wesley-Esquimaux & Smolewski 2004). A key consequence is intergenerational trauma. Trauma can be transferred from the first generation of survivors that have experienced (or witnessed) it directly in the past to the second and further

generations of descendants of the survivors (Atkinson et al. 2010). This concept will be explored further in this edition as 'cultural pananoia' and further articulated as acculturative stress (Berry & Kim, 1988; Westerman, 2013).

What do we know about Attachment Theory within an Aboriginal context

Given the multiple pathways in which negative emotions and stress impact health, healthy attachment relationships during childhood offer substantial protection. The regulation of emotions during infancy and childhood sets the stage for experiencing less stress over the entire lifetime, gives children the foundation to develop coping skills and emotion regulation abilities, and reduces the likelihood that the child will engage in health threatening behaviours during adolescence and adulthood. The Aboriginal and Torres Strait Islander Healing Foundation Development Team (2009:4) sum up the situation as follows:

many of the problems prevalent in Aboriginal and Torres Strait Islander communities today—alcohol abuse, mental illness and family violence ... have their roots in the failure of Australian governments and society to acknowledge and address the legacy of unresolved trauma still inherent in Aboriginal and Torres Strait Islander communities.

As discussed in the previous edition of Jilya at a theoretical level there is a good argument for the reconfiguration of attachment classification within an Aboriginal context and whilst the research supporting this is limited this exploration is an essential starting point to understanding attachment within an Aboriginal context. The ability to treat attachment disorders represents a very real and opportunity to halt the progression of transmission of intergenerational trauma. It is argued that this is a research concept which has failed to permeate through the Indigenous trauma field to the extent to which it should have. Early intervention and preventative efforts around such transmission will continue to be limited in their focus until this is able to occur. If attachment theory becomes questionable and programs which have demonstrated their efficacy in addressing attachment disorders become unavailable to an entire cohort who demonstrate clear risk factors for trauma then quality research needs to address this.

What value does exploring attachment specific to Aboriginal people provide

The need for empirical testing of an attachment model and developing and testing of an attachment program specific to Aboriginal people is vital for a multitude of reasons. For professionals who provide programs (e.g., counselling, family support, parent education, childcare) for families with children under the age of three from many cultures and contexts, and promote care-giving practices that encourage positive parent-infant relationships there is a need to understand different cultural views of attachment and bonding to ensure that misdiagnosis of attachment disorders do not occur. In addition understanding the focus of attachment treatment intervention should be free of cultural bias. Importantly though there is a very clear ethical consideration in being able to adopt a culturally inclusive set of attitudes, knowledge and skills when promoting culturally appropriate attachment-based parenting behaviours (i.e., best practices) in research and intervention (Bowlby, 1969). It is essential that infant mental health professionals provide culturally sensitive services by learning how different care-giving practices fit into the cultural contexts that they work in (Barrera & Corso, 2003). Promoting practices based on one culture may lead to under- or over-referrals based on diagnoses of inhibited and disinhibited attachment as we explored in the previous edition of Jilya, due to a number of cultural issues (i.e. skin relationships; gender issues; hierarchy issues) which can result in differential diagnosis.

In addition, if parenting practices are only understood from one cultural viewpoint there is a risk of under-serving populations that have different cultural backgrounds over-identifying parents as having poor attachment relationships with their children and/or castigating them for their cultural beliefs and practices (Yeo, 2003). This has certainly been the case in Australia with policies of assimilation specifically focusing on parenting of Aboriginal children and removing them specifically for these parenting

differences and creating the stolen generations of Aboriginal people. These impacts continue until this day. It has also created a situation in which Aboriginal children currently constitute 35% of children living in out of home care in Australia which is almost 10 times the rate of non-Indigenous children. In Western Australia it is far worse with 53% of Aboriginal kids in foster care.

In addition to this and according to the Australian Institute of Family Studies, a vast number of children in foster care experience multiple placement changes. In a study profiling children in out-of-home care in South Australia, Delfabbro, Barber, and Cooper (2001) found that 20% had between three and five placements, 18% had between six and nine placements, and 24% - almost a quarter of all children - had experienced ten or more previous placements during their time in care. Unfortunately we are looking at generations of these adverse outcomes continuing as one generation continues to pass the impacts of assimilation and now multiple foster care placements into future generations.

Securely attached children have better health, education, employment and mental health outcomes than children with disrupted attachment. Placement instability has significant adverse effects on children. A number of studies have found associations between continued instability and adverse psychosocial outcomes, such as emotional difficulties, behaviour problems and poor academic performance.

What is clear is that within Australia there has been a virtual absence of 'testing' of conventional attachment theory and its relevance for Aboriginal Australian families. There is, however some emerging research which both challenges and supports a cross cultural model of attachment which provides an important basis for program development and which will be explored here. Additionally, there are some clear risk indicators that are unique to the development of 'cultural attachment' which will be discussed as important components for inclusion in a culturally specific attachment intervention program in this edition.

Classic Attachment Theory: Bowlby and Ainsworth and strange situation review

John Bowlby (1969, 1973, 1980) is credited with developing attachment theory. He argued that attachment was primarily biological in its basis and the instinct a reliable, predictable relationship with the primary caregiver. His early research noted a number of attachment based behaviours in infants which included crying, clinging, following and smiling which he argued were a by-product of trying to keep the primary caregiver close by. He further observed that these behaviours became more evident when distance from the mother or attachment figured exceeded a certain time and space threshold. The caregivers reaction to these attachment behaviours therefore resulted in the foundation of attachment or what Bowlby referred to as "internal working model" which were seen as relatively fixed and lasting. It therefore impacts on the development of healthy attachment to one's own children and in the development of healthy, robust adult relationships into the future.

Following Bowlby's research, Mary Ainsworth and her colleagues (Ainsworth et al., 1991) began observing infant exchange with the primary caregiver (mostly the mother) and developed the Strange Situation Procedure (SSP) to classify attachment. These included three main attachment styles, including secure (type B), insecure avoidant (type A) and insecure ambivalent/resistant (type C). She concluded that these attachment styles were the result of early interactions with the mother. A fourth attachment style known as disorganized was later identified by Main, & Solomon (1990). These attachment categories have been defined as follows:

A: Insecure Avoidant

Insecure avoidant children do not orientate to their attachment figure while investigating the environment. They are very independent of the attachment figure both physically and emotionally (Main & Cassidy, 1988). They do not seek contact with the attachment figure when distressed. Such children are likely to have a caregiver who is insensitive and rejecting of their needs (Ainsworth, 1978). The attachment figure may withdraw from helping during difficult tasks (Stevenson-Hinde, & Verschueren, 2002) and is often unavailable during times of emotional distress.

B: Secure Attachment

Interestingly, those children who were classified as securely attached comprised the majority of the sample in Ainsworth's (1971, 1978) studies. As it sounds, these children feel confident that the attachment figure will be available to meet their physical and emotional needs. They therefore learn to use the attachment figure as a safe base from which to explore the environment and are confident in seeking the attachment figure in times of distress or emotional need (Main, & Cassidy, 1988).

Importantly, as securely attached are easily soothed by the attachment figure when upset or distressed they then resultantly to self soothe and regulate emotions in a consistent manner. According to Bowlby (1980) an individual who has experienced a secure attachment 'is likely to possess a representational model of attachment figures(s) as being available, responsive, and helpful' (Bowlby, 1980, p. 242).

C: Insecure Ambivalent / Resistant

The third attachment style identified by Ainsworth (1970) was insecure ambivalent (also called insecure resistant). Here children adopt an ambivalent behavioural style towards the attachment figure. This means that the child will exhibit clingy and dependent behaviour, but will also be rejecting of the attachment figure when they engage in interaction. This means that the child does not develop feelings of security from the attachment figure. Accordingly, they exhibit difficulty moving away from the attachment figure to exploring novel surroundings. When distressed they are difficult to soothe and are not comforted by interaction with the attachment figure. This behaviour results from an inconsistent level of response to their needs from the primary caregiver.

D. Disorganised Attachment.

Subsequent to these classifications, Main and Solomon (1990) identified a fourth attachment classification which they argued is defined by having a distinct lack of organized approach to meeting their attachment needs. This characterises the attachment behaviour of the child who has not had sufficient consistency in caregiving to be able to develop a coherent (organised) attachment representation. A child with disorganised attachment may be afraid to directly approach their caregiver because they cannot predict what the caregiver will do. This lack of a predictable, coherent attachment behaviour was reflected in inconsistent attachment behaviour in the Strange Situation (Main & Solomon, 1990).

The failure to develop an organised attachment expectation (internal working model) results from a relationship with a caregiver that is simultaneously a source of both comfort and fear; leaving the child in an impossible bind. Because of this experience, a child seeks proximity and yet avoids it; exhibiting contradictory behaviour such as freezing and fearful apprehensive approaches toward their caregiver (Main & Soloman, 1990; Zilberstein, 2006). Children exhibiting disorganised attachment are thought to be at an increased risk of developing psychopathology over time—possibly due to an internalised representation of behaviour and emotions that remains dis-integrated and lacks coherence (Zilberstein, 2006) and an inability to meet their need for comfort and security.

The rates of disorganised attachment are also much higher in high risk populations generally (between 25–50%, compared with 15% in low risk populations) (Bakermans-Kranenburg & van Ijzendoorn, 2007; Hesse & Main, 2006; Rutter, 2008; Shemmings & Shemmings, 2011; van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Unfortunately we are seeing this as a predisposition in Aboriginal children with data continuing to support the concept of abuse occurring within Aboriginal families though generations. The origins of this being in assimilation, removal from parents and communities and the resultant research evidence that provides strong evidence for the parental and environmental modelling of trauma as intergenerational trauma.

Theoretical Evaluation of Attachment Theory

Whilst attachment theory has mostly stood up to empirical validation and testing, there are of course, protagonists of this approach. For instance Kagan (1995) argues that the relationship between parental sensitivity and the resultant attachment style of the child is only weak and that this focus on maternal sensitivity is only part of the picture. Fox (1989)

argued that children with different innate (inborn) temperaments will have different attachment types. Fox (1989) classified these temperaments as 'Easy' (those who eat a sleep regularly and accept new experiences) are more likely to develop secure attachments. Babies with a 'slow to warm up' temperament (those who took a while to get used to new experiences) are likely to have insecure-avoidant attachments, and babies with a 'Difficult' temperament (those who eat and sleep irregularly and who reject new experiences) are likely to have insecure-ambivalent attachments.

In conclusion, the most complete explanation of why children develop different attachment types would be an interactionist theory. This would argue that a child's attachment type is a result of a combination of factors – both the child's innate temperament and their parent's sensitivity towards their needs.

Belsky and Rovine (1987) propose an interesting interactionist theory to explain the different attachment types. They argue that the child's attachment type is a result of both the child's innate temperament and also how the parent responds to them (i.e. the parents' sensitivity level).

Additionally, the child's innate temperament may in fact influence the way their parent responds to them (i.e the infants' temperament influences the parental sensitivity shown to them). To develop a secure attachment, a 'difficult' child would need a caregiver who is sensitive and patient for a secure attachment to develop. There have unfortunately been limited studies on the temperaments of Aboriginal children or the common parental responses to the child's need and these studies are clearly needed.

It is of note that a recent study by Little, Sanson & Zubrick (2012) noted that there was evidence that Indigenous **children, experienced higher** levels of emotional and behavioural problems. It would certainly be interesting to explore the origins of this. Those communities that remain relatively culturally 'intact' in comparison to those communities who have experienced higher levels of acculturation and acculturative stress may have more resilience to the development of emotional and behavioural disorders to the intactness of parental bonds and security that this offers both the child and the parent.

Attachment Assessments

Attachment research has primarily utilised Eurocentric approaches to assessment of attachment and have mostly utilised Ainsworth Strange Situation Procedure or the Attachment Q-sort (Waters & Deane, 1985). These methods seek to explore the quality of attachment between primary carer and infant. Both of these attachment assessments have limitations for use with non-Western and Indigenous populations (Nakagawa, Teti & Lamb, 1992).

Relevance of Attachment to Cultural differences in parenting

The term "Aboriginal" refers to all original peoples in Australia. Three separate groups are recognized within this context including those who identify as Aboriginal Australian, Torres Strait Islanders and South Sea Islanders. It is important to note that these groups are made up of diverse peoples, each with their own unique histories, spiritual beliefs, languages and cultural practices. Further, parenting practices and parenting styles among different Aboriginal groups, communities or families should not be considered to be homogeneous. It is also clear that culture changes over time and parenting practices within each culture also change slightly over each generation. However, there is good evidence that the biological function of the attachment relationship is the same across cultures and generations and serves to provide safety, comfort and stress reduction to the infant. For example, evidence shows that the quality of the infant's attachment relationship influences the level of cortisol secretion in response to stress (Repetti, Taylor, & Seeman, 2002). Infants who are in reliable healthy relationships show lower increases in cortisol in response to a stressful situation compared to infants in less healthy relationships (Luijk, et al., 2009).

Culture and Attachment

While research on the appropriateness of attachment theory outside of Western cultural parenting practices has been limited (Christensen & Manson, 2001; Neckoway, Brownlee, & Castellan, 2007), attachment is not about parenting styles, values, or even about different parenting behaviours.

Attachment behaviours may look different across different cultures but they achieve the same function.

Based upon the available literature (all of which is international), there are some aspects of attachment which are considered to be consistent or universal between cultures while some appear to be more culture specific. Although there is sufficient evidence that the distribution of attachment classifications is consistent between cultures (i.e., 60% secure, 40% insecure), it is perhaps more worthwhile to the culture specificity argument that it is the expression of attachment in terms of parent and child behaviour is the most likely to vary between cultures and the quality of the different expressions of attachment styles. There is evidence that secure infant attachment is the most adaptive and prevalent form of attachment but the variability in the rates of insecure classifications in diverse contexts suggests a closer look at both infant and maternal behaviours in diverse contexts warrants exploration.

For example, the expression of sensitive and responsive parenting can vary (van Ijzedoorn & Sagi-Schwartz, 2008) with some cultures promoting independence and some inter-dependence (van Ijzedoorn & Sagi-Schwartz, 2008). Similarly, there are cultural differences in the way a child's behaviour is evaluated. In Western culture, attachment security and social competence is viewed in terms of the child's initiative and capacity for self-expression. In Aboriginal cultures inter-dependence, rather than independence, may be more valued and the expression of some strong feelings may be discouraged. Therefore, it is important to recognise that "successful" child rearing is determined by cultural and social values.

Factors shown to impact on attachment

Low socio-economic status has been associated with higher rates of insecure attachment in children due to the risk factors associated with poverty which have been show to negatively impact on the parent-infant relationship (Belsky & Fearon, 2002). These factors include racism which will be considered here as a number of different components. These include acculturation, identity formation and acculturative stress as variants in the parental bond and parenting style. These factors will be explored in terms of the individual, the collective as well as external variables. It is argued that there is a significant role in the realities of cultural change and adaptation to external factors such as policies of removal and assimilation. The question then becomes – are current 'Aboriginal parenting practices' a representation of traditional parenting practices or the result of loss of primary attachment figures and parental models? The section on acculturation discusses this issue.

The group versus the individual in attachment theory

Attachment theory is often criticised for its emphasis on the independence for the purpose of achieving the future goal of separation and autonomy. However, those in collectivist societies may actually have different parenting goals.

In addition, most research has explored attachment between a child and one parent; there has been very little exploration of the child's ability to form multiple attachments as discussed in the previous Jilya from a very early age. Although early attachment writing emphasised an infant's preference for a primary caregiver, subsequent reviews have challenged this idea (e.g., Lamb (2012). This research suggests that very young children can form attachment bonds to multiple caregivers simultaneously. The literature on cultural expression of attachment (Ryan, 2011), on shared caregiving (Howes & Spieker, 2008), and on attachment in middle childhood (Kobak, Rosenthal, Zajac, & Madsen, 2007; Laible, 2005) also questions the notion of a primary attachment figure.

When considering the attachment needs of Aboriginal and Torres Strait Islander children and their caregivers, it is important to look beyond the dyadic model of attachment and consider the broader importance of multiple attachment relationships for children, and the significant importance of extended family and kinship networks for children. Therefore, it is important to be aware of cultural values and ideals regarding parenting when considering if a child's attachment experience has been compromised.

Amongst Indigenous groups generally, there are a complex

system of relationships that exist and which are specific to the attachment needs of the child. It is often then the case that the child is taught to organise a whole range of attachment figures specific to emotional needs and this is consistently reinforced throughout the life of the child via the kinship structures. The commonality amongst Indigenous groups lies in the importance of the extended family and the unity of the relationship to the land and to kin. Relationships with people are considered to be structured and based in Aboriginal Law and the Dreaming. Children are taught about mutual co-operation, about special duties to some extended family group, about taboos and about relationships which have special ritual significance. Behaving properly within the cultural context, to other people is an important aspect of Aboriginality and importantly, to the development of 'cultural attachment behaviours'.

In terms of attachment classification then these cultural differences can be the source of misdiagnosis of the different attachment types. For example, skin relationships which also determine avoidance relationships amongst Aboriginal people and dictate contact due to cultural issues can be misclassified as Insecure Ambivalent / Resistant. It can also be the source of misunderstanding and misrepresentation (ie. behaviour considered to be inappropriate in one culture but appropriate in another). For example, the family home may be the scene of many comings and goings where people move around, and numerous people may pick up a child from school/ day-care etc. Collectivist cultures such as Aboriginal cultures in which parenting is a 'shared' or community responsibility understandably increases the likelihood that secure attachment will be developed in the child.

For example, part of growing up in a collectivist culture means that Aboriginal infants may be breastfed and cared for by several women interchangeably. Under bonding and attachment theory, the practice can be viewed negatively as indiscriminate attachment (Yeo, 2003). Skin and avoidance relationships can be seen as inhibited attachment. Similarly, issues of child neglect can often be considered as a matter of parental culpability, rather than as a shared responsibility between parents, families, community and society (Scott, Higgins, & Franklin, 2012; Yeo, 2003).

Maternal sensitivity

In relation to attachment type, however, the emotional responsiveness of the mother to the child's specific needs (attachment type) is a further area of cultural difference that has been demonstrated to impact upon attachment expression. The main difference that has been seen in maternal sensitivity in non-Western studies seems to be the issue of maternal control. This refers to the extent to which a parent either directs ('interferes' with) or allows the infant to control his or her own actions (i.e. cooperation). Aboriginal parenting styles allow for 'natural growth' – which is specific to allowing independence in learning, or less boundaries and control on behalf of the parent.

In families, it is often assumed that babies and children are best able to express their own needs and that adults are there to attend to those needs. Among traditionally oriented and some suburban families there is group care of babies and young children. This means that a baby is likely to be held by someone nearly all of the time. A child may relate to several aunts as 'Mum' and be fed or put to bed in several different households as a normal experience (Scheppers, 1991).

Independence, interdependence care and autonomy

One of the strengths of a collective community approach to raising children is that parents and carers have the security and confidence to allow their children the freedom to explore the world on their own terms. For Australian Aboriginal families, the risks associated with children's activities are accepted as a natural part of growing up (SNAICC, 2011). Aboriginal carers actively encourage independent play so that children can learn a range of important life skills, including the capacity to learn responsibilities to care for and protect one another (Yeo, 2003). To deny a child this independence would be considered a breach of parental responsibility under traditional Aboriginal culture and Law (Lore/The Dreaming/Dreamtime) (SNAICC, 2011; Yeo, 2003).

One of the more notable differences between Aboriginal and White Australian reared

children is the Aboriginal children's high levels of independence (Kearins, 1984) from the primary caregiver but interdependence on other caregivers. The focus of this type of parenting is on the future competence of the child around self-expression and social interaction as well as autonomy. The group harmony and cohesion becomes more essential to individual caregiver bonds.

Kinship attachment and hierarchical organisation of attachment

The peer group then becomes the most important source of attachment development for the child as soon as they are 'capable' or independence, generally around 18 months to 2 years of age. Hierarchies are established early to ensure that there is independence in learning but safety in the group providing a secure base. The infant caregivers then naturally anticipate infant's needs by what seems to be a biologically based inclination to respond in accordance with kinship but importantly emotionally simpatico between caregivers and infant. Aboriginal communities believe that it takes a whole community to raise a child and this means that it is commonplace for different caregivers to respond to the different emotional needs of the child – the collective arguably making it more likely that the child's innate temperament and personality style which is of biological and genetic origin can then be 'assisted' or responded to by a range of external caregivers. This arguably increases the likelihood that temperaments that are difficult or hard to warm up will be managed or 'altered' by the environments increased capacity to respond to their entire range of emotional needs of the child.

Since the child does not attach exclusively to the mother, nor equally to each member of the group, a kind of balance then starts to emerge between the child as a separate individual in relation to its mother and as a member of a group.

Ways of passing the spirit of Aboriginal culture to children

Evidence suggests that engaging in spiritual practices is associated with improved physical and mental health. Improvements in immune system function, lower blood pressure and lower rates of heart disease, stroke and kidney failure are just some of the physical benefits from engaging in spiritual practice. Mental health benefits include a greater sense of responsibility, increased self-control and greater tolerance (McEwan et al., 2009). Spiritual engagement is also shown to be a protective factor against adolescents' risky behaviours (Rostosky, Danner, & Riggle, 2007).

For Aboriginal families, spirituality is a key cultural characteristic that embodies the interconnectedness of life's dimensions. The sacred connection to the Dreaming provides guidance for families and communities in raising children and helps to instil the shared values of interdependence, group cohesion and community loyalty. These qualities help to provide a safe environment for raising children and help both adults and children to understand the importance of caring for and protecting one another.

Acculturation and parenting

Durkheim (1951) first raised the notion of anomie to describe situations where individuals sense their own norms and values are no longer relevant, and their ties to society are thereby weakened and lost (Westerman, 2003). Aboriginals have been proposed to be psychologically vulnerable to mental health problems as a result of devaluation in the Aboriginal sense of community (Durkheim, 1951). Evidence also suggests that simple membership in an ethnic minority group contributes significantly to the relatively high rates of distress (Cawte, 1969; Ruth, 1990), with studies demonstrating that other indigenous colonised cultures experience similar disproportionately high rates of distress as Aboriginal Australians (Berry, 1988; Johnson, 1994).

In addition to this, acculturation has been linked to the development of mental ill health for indigenous and minority populations (Berry & Kim, 1988). Specifically, those indigenous people who have high levels of acculturation with the dominant culture, and at the same time, have a low level of contact with their traditional culture are most likely to experience acculturative stress and mental ill health (Berry, 1988; Vicary, 2002). As we learnt in the first edition of Jilya, the devastation of government policies of assimilation which resulted in the removal of Aboriginal children from their parents has had a devastating impact upon the health and

wellbeing of Aboriginal people. The destruction of parental bonds and placement of Aboriginal children in missions clearly has had a significant impact upon the development of attachment in those directly impacted and continues to this day. There is a growing body of empirical evidence which supports the fact that Aboriginal people significantly benefit from maintaining a strong sense of cultural connection (Chandler, & Lalonde, 2008).

In the previous edition of Jilya, discussion occurred about the Acculturation Scale for Aboriginal Australians (Westerman, 2003) which is a psychometrically developed tool capable of gauging the extent of cultural change made by the individual. This work was based upon the concept of operationalising the core concepts of cultural identity to enable therapeutic intervention to occur for clients depending upon their 'internal working model' of cultural attachment. Cultural attachment theory, a relatively new field of inquiry attempts to articulate the cultural specificity argument regarding the causes of the possible variants in attachment theory and attachment classifications. Acculturation is a possible missing piece in the puzzle of better understanding the origins of attachment and parental bonds – acculturation determines whether it is a product of cultural change or whether the attachment bonds that are evident in Aboriginal parents are a by product of loss of cultural connection as a result of assimilation policies. The possibility of determining differences in parenting and attachment bonds in communities who have had limited cultural change compared to those who have had significant cultural change and acculturative stress would be an extremely important area of research.

It is then possible that these two cohorts could be tested at an empirical level utilising Ainsworth's SSP to determine the causal pathways to what we are seeing with significant loss of parental attachment and bonding between Aboriginal parents and their children. Until this can occur however, we can only offer a two-fold response to better understanding attachment from an Indigenous perspective. First, we can better understand the differences in parenting practices for those who undertake structured observations such as the SSP and provide an opportunity to interpret maternal and infant bonds under a very specific cultural lense to avoid misclassification of attachment styles based upon these differences. Second, provide practitioners with cultural identity models and tools to ensure that cultural connection is able to offer at least differential interpretation of cultural differences manifesting as attachment disorders. This also ensures that acculturation and identity formation remain front and centre of intervention programs for Aboriginal people. The ASAA was developed based upon the concept of determining 'cultural connection' as an internal working model. It was based on the concept of cultural change or acculturation which has been explored in the cross cultural literature for some time.

For example Chandler & Proulx, (2007) looked at acculturation relative to suicide risk and psychological distress at both an individual and community level and proposed that there were four main response patterns that were evident as part of acculturation (refer to Box 1) according to Berry (1980). Chandler & Proulx (2007) found that there was an

1. **Assimilation** involves replacing one's first culture with a second. The person identifies mostly with the dominant culture - important factor is the **political environment** - forced assimilation reflects the ideology of the dominant culture and **not** the individuals choice
2. **Separation** relates only to the behaviours and beliefs of their traditional culture and not the dominant culture
3. **Integration** involves acquiring a second culture whilst retaining the beliefs, practics and knowledge of culture of origin - also referred to as biculturalism
4. **Marginalisaiton** rejects the behaviours, beliefs associated with dominant and traditonal culture. Most susceptible to psychological and adjustment disorders - those caught between two cultures

Box 1: Response patterns to cultural change

inverted-U relationship between acculturation and risk. That is, that those who remain highly separate from mainstream culture and those who choose to assimilate into mainstream have the lowest rates of suicide and distress. It is those who are highly marginalised or do not fit into any culture who have the highest rates of distress. Those who integrate (take on both worlds) also have the lowest rates of distress overall. It is therefore proposed that given this established connection between cultural change and risk that this model and the ASAA may offer a similar opportunity to best understand the role of cultural change in the development of attachment bonds.

According to the research in this area the key is to identify what model of acculturation best describes your client and possibly other generations within the family. Focused treatment can therefore occur specific to the response to acculturation that best fits family and community. The ASAA assists in determining this response pattern and articulates the direction of treatment and intervention (see Westerman, 2013). An essential variable in the acculturation process is cultural orientation as we have seen. Several scholars have proposed a type of bicultural model (Berry, 1980). The approach chosen by the acculturating person may have important mental health consequences. Because integration involves both maintaining one's culture of origin and developing positive relationships with people within the mainstream culture, it is presumed to be associated with less stress and conflict than marginalisation, which Chandler refers to as essentially having 'no culture' or deculturation (refer to acculturative stress and lateral violence below).

Acculturative Stress

Racism is deeply traumatic and manifests as such. It comes in many forms, some overt and some far more insidious: the overarching threat of harassment and discrimination; witnessing ethno-violence or discrimination of another person or experiencing it personally; historical or personal memory of racism; institutional racism and micro-aggressions (Helms, Nicolas & Green, 2012). These everyday experiences permeate the lives of many Aboriginal people, potentially leading to a sense in some of 'cultural paranoia' (Westerman, 2013 - Bowraville paper, p. 8); this is where a person is hypervigilant to the threat of racism and perceives its presence everywhere. One must ask, of course, if this paranoia is not unjustified. Aboriginal people are subjected to racism perhaps more than any other group of people in the country. Racism is indeed as damaging as physical or life-threatening assault (Westerman 2003) and maintains a chronic collective, cultural trauma (Salzman & Halloran, 2004) within Aboriginal communities. It attacks and threatens a people's culture, thereby striking at the very source of their existential meaning (Salzman & Halloran, 2004). Understanding the dynamics of racism is therefore crucial to contextualising the experience of Indigenous people, in Australia and in settler-colonies internationally (Paradies, 2016).

The contribution of acculturative stress on the development of attachment style in Aboriginal people is an area which shows considerable promise. Westerman has developed an Acculturative Stress Scale for Aboriginal Australians (ASAS: Westerman, 2003) as a method of measuring and gauging these impacts. Acculturative Stress refers to stressors related to the process of acculturation. Often there are a particular set of stress behaviours that occur during acculturation, such as lowered mental health status (acculturation stress syndrome – i.e. confusion, anxiety and depression) feelings of marginality and alienation, heightened psychosomatic symptom level, and identify confusion (Westermeyer, 1989)

As the origins of attachment for Aboriginal children appears to be more externally driven, then it flows that external forces such as racism is important to incorporate as a mechanism by which internal working models of attachment are formed for Aboriginal people and then passed onto their children (Westerman, 2013). Certainly, this is not a new concept with Klonoff, Landrine & Ulmaine (1999) found that racist events accounted for 15% of the variance in psychological symptoms of African Americans. There is simply a higher risk of developing mental health and emotional wellbeing problems for those groups who experience racism. Priest and Paradies (2010) found that racism explained a third of the depression and over half of

the chronic stress experienced by Aboriginal people. Acculturative stress has a strong relationship with depression, anxiety and particularly PTSD (Klonoff, Landrine & Ulmaine, 1999)

Importantly there are also intergenerational impacts - young people develop negative psychological adjustment into adulthood when acculturative stress is evident in their families of origin. For example, there is emerging research which postulates on the concept of COLLECTIVE post trauma, the origins of individual resilience or capacity to manage trauma responses having their origins in experiences of racism, but more importantly on sustained and ongoing marginalisation of Aboriginal people within the Australian psyche.

How Chronic Collective Trauma impacts on Trauma and Attachment

Although traumatic events invariably cause both physical, cognitive, behavioural and psychological reactions, the term chronic collective trauma is more commonly applied to the psychological effects shared by a group of people of any size, and must be distinguished from individual trauma as in PTSD Such patterns of psychological distress occur predominantly in those unique instances in which multiple traumas has occurred and is associated with experiences of marginalisation, oppression and living with suffering over extended periods of time. In these cases communities are overwhelmed, feel existentially unsafe, and find the world profoundly and imminently dangerous. This is often accompanied by such feelings as terror, hopelessness, helplessness, worthlessness, despair, distrust, rage, and guilt. Some of the noted impacts of chronic collective trauma (according to Ratnavale, 2007) include:

- **Deep mistrust of self, others, even family**
- **Fear and anticipation of betrayal**
- **Shame and humiliation**
- **Cultural genocide, losing traditional values, desecrating land and institutions**
- **Violence against women**
- **Self-directed violence-suicide, risk-taking behaviour**
- **Substance abuse**
- **Unremitting grief**
- **Intergenerational conflict-role diffusion, sexual abuse, other boundary violations**
- **Dependency- hostile or pathological**
- **Leadership vacuum**
- **A Conspiracy of silence - overall attitude of secrecy**

Trauma is POLITICAL (i.e. the link between societal response and magnifying trauma) (Burstow, 2003)

What is known that there is an extensive history of officially mandated institutions of help, especially arms of the state, contributing extensively to trauma in the Aboriginal population (Burstow, 2003). Governments or governing councils might provide maximum or minimum help. Insofar as people are not helped or helped inadequately, the trauma takes on whole new dimensions. Magnification of trauma by others and by society at large occurs in manifold ways, including denying the impact of the critical incident, minimizing its severity and impacts, failing to accommodate, and failing to help. In this light, the failure of successful governments to acknowledge the impacts of removal policies and to in fact deny to existence of the stolen generations contributed significantly to the ongoing trauma response. What is particularly significant to questions of radical praxis, trauma is magnified exponentially in the name of help, especially by those helping institutions that occupy central locations in the relations of ruling. Moreover, trauma is systematically produced by them (Burstow, 1992). It is argued that this has the potential then to manifest as a collective disorganised attachment – which as we have learnt, results at an individual level when the person who is supposed to be your protector becomes the abuser. At a collective level for Aboriginal people the experience of government, police and our political leadership is to continue to institute behaviours towards Aboriginal people which mostly continue the cycle of racism and trauma. The recent examples of the Northern Territory Intervention, alcohol restrictions and other programs which identity racial identity as a sole reason for an assumption of quarantining welfare payments and removing human rights understandably continues the cycle of mistrust.

Additionally, statistics have consistently demonstrated the over-representation of Aboriginal people as offenders and provide support to the concept of phenomena of over policing. First, when apprehended by police, Aboriginal Australians are half as likely to be given a caution than non-Indigenous people and 'were nearly three times less likely to be cautioned when processed by police' than non-Indigenous youth. Additionally, Aboriginal people are 15 times more likely to be charged for swearing or offensive behaviour than the rest of the community. As an Aboriginal adult you are 14 times more likely to be incarcerated. Feeling a sense of safety and security when these realities persist for Aboriginal people becomes an extraordinary challenge.

Black Identity Formation – a model of identity development

The interest in the relationship between attachment and identity formation has been studied for some time. However, studies were hampered by the lack of a comprehensive measure of identity, and one of the goals of psychology has been to establish a model that can conveniently describe human identity development. Cross' (1971, 1978, 1991) model of Black Identity Formation offers a similar opportunity for treatments to be culturally focused in the sense that it articulates an empirical model of robust cultural identity. This has been adapted by Westerman for the Aboriginal Australian context (refer to Westerman, 2015) and offers an opportunity to address factors implicated in the development of robust cultural identity by articulating 'phases' of cultural identity formation. These phases have been articulated as follows (adapted from Cross, 1991):

Stage 1: Pre-encounter

The Aboriginal person has absorbed many of the beliefs and values of the dominant White culture, including the notion that "White is right" and "Black is wrong." Though the internalization of negative Black Stereotypes may be outside of his or her conscious awareness, the individual seeks to assimilate and be accepted by Whites, and actively or passively distances him/herself from other Blacks. It is not uncommon with Aboriginal Australian culture therefore to deny the impacts of racism on the developing self. In addition, there is an interesting aspect to this particular phase in which there can be manifestations of racism as trauma in that there is a repetition compulsion to repeat the patterns of ones' own trauma background. For example, those who experienced forcible removal 'willingly' taking their own children back to the missions in which they were taken following forcible removal from families. This is consistent with the post trauma response in which there is often a need to 'control' when trauma occurs. In terms of the neurobiological aspects of trauma, it is also the case that individuals are often 'drawn to what is familiar' and that is what has been embedded within their behaviour at a biological, innate level.

Early Black racial identity research, in particular, that conducted by Ruth Horwitz (1938), suggested the existence of Black self-hatred manifested in a preference for White over Black among African–American children (Horwitz 1938). Until the early 1970s, researchers corroborated these findings, producing data that seemingly indicated a swell of empirical support for the Black self-hatred hypothesis. Individuals show a strong preference for the values, beliefs, and features of the dominant culture over their own as a phase of development. Westerman (2015) compares this to the development that occurs in non-Aboriginal kids which is known as 'gender constancy' – that being that there is a realization within children at around six to eight years of age that gender is fixed (Kohlberg, 1984) and then becomes more inclined towards adopting certain gender specific roles but also importantly wanting a model of what they act like, think like and look like through the same sex role model. It is clear that there is also a parental reinforcement and social constructionism role to play in the development of gender constancy. It is also evident that for those who experience gender confusion, gender identity disorder or transsexualism then the internal working model would arguably follow the same path it is just that the orientation will be to the opposite gender. Taking this theory and applying it to the concept of racial identity and specifically the phase of black self-loathing it would follow that hatred becomes internalized prior to the establishment of 'cultural constancy', that being, that until the child is able to understand

that there cultural identity is 'fixed' then it becomes more likely that internalising of hateful messaging about Aboriginal culture (via media etc.,) will become a more dominant working model. It is argued that this occurs around the same age as awareness around gender permanency occurs. It has some support from research which indicates that Aboriginal children below eight years of age tend to have more of a negative sense of self construct.

Stage 2: Encounter

This phase is typically precipitated by an event or series of events that forces the individual to acknowledge the impact of racism in one's life. For example, instances of social rejection by White friends or colleagues (or reading new personally relevant information about racism) may lead the individual to the conclusion that many Whites will not view him or her as an equal. Faced with the reality that he or she cannot truly be White, the individual is forced to focus on his or her identity as a member of a group targeted by racism. Unfortunately, at this stage there is keen awareness of the dominance of the dominant culture. Often results in complete compliance with the dominant culture as a result of internal oppression as the extent of racism becomes overwhelming for the individual. It is common therefore for the bystander effect to be a common feature of this stage and one in which we see examples of with black minority populations word wide. The bystander effect talks to a social psychological phenomenon that refers to cases in which individuals do not offer any means of response or help or respond to a victim or victimisation. The probability of intervening is inversely related to the number of bystanders. In the case of black minorities examples include Apartheid in South Africa; the Northern Territory Intervention and a raft of other human rights violations that seem to occur whilst people 'stand by'. Other behaviours are that these individuals may also subconsciously reject work and academic achievement as a self-fulfilling prophecy - 'fit the expected stereotype' and 'prove identity'(believing historically Aboriginal people don't do well in these areas). This stage can often be characterised by racism towards the dominant society.

Stage 3: Immersion/Emersion

This stage is characterized by the simultaneous desire to surround oneself with visible symbols of one's racial identity and an active avoidance of symbols of Whiteness. As Thomas Parham describes, "At this stage, everything of value in life must be Black or relevant to Blackness. This stage is also characterized by a tendency to denigrate white people, simultaneously glorifying Black people…" (1989, p. 190). As individuals enter the Immersion stage, they actively seek out opportunities to explore aspects of their own history and culture with the support of peers from their own racial background. Typically, White-focused anger dissipates during this phase because so much of the person's energy is directed toward his or her own group and self-exploration. The result of this exploration is an emerging security in a newly defined and affirmed sense of self.

Stage 4: Internalization-Commitment

While still maintaining his or her connections with Black peers, the internalized individual is willing to establish meaningful relationships with Whites who acknowledge and are respectful of his or her self-definition. The individual is also ready to build coalitions with members of other oppressed groups. Those at the fifth stage have found ways to translate their "personal sense of Blackness into a plan of action or a general sense of commitment" to the concerns of Blacks as a group, which is sustained over time (Cross, 1991, p. 22). Whether at the fourth of fifth stage, the process of Internalization allows the individual, anchored in a positive sense of racial identity, both to perceive and transcend race proactively.

Most models present a linear progression through the stages, meaning that individuals start at the beginning then move to the final stage. In reality these are much more fluid (a person may reach the final stage of internalisation in Cross's model, but might experience something that results in regressing back to the encounter or immersion-**e**mersion stage (Parham, 1989). Remember the reason why Helms (1995) uses the term "statuses" instead of "stages" is because more recent research indicates that racial identity is actually multi-dimensional rather than one-dimensional with many factors contributing to ones sense of identity. The environment

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-informed care 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 victims/survivors of trauma manage and express their traumatic life experience/s and identify the supports and interventions that 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, victims/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 caregivers) 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.
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	Trauma-informed services empower individuals, families and communities to take control of their own healing and recovery. They adopt a strengths-based approach, which focuses on the capabilities that individuals bring to a problem or issue
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 of 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 et al. 2009	

Box 2: Berry Street
Berry Street in Victoria offers the Take Two program to both Aboriginal and non-Aboriginal clients involved in the child protection system, placing it more at the level of postvention. Berry Street has adopted Bruce Perry's Neurosequential Model of Therapeutics (NMT) (Perry & Hambrick, 2008), which comprehensively maps chronological trauma-based interruptions to the child's development and targets therapy to redress 'missed tasks'. Clinicians work therapeutically with the caregiver and the child/young person to improve the quality of their relationship. They also aim to establish a care team or "therapeutic web" around the child/young person to ensure that the complexity of need is adequately addressed. Take Two involves a partnership with the Victorian Aboriginal Child Care Agency (VACCA), which has provided input on adapting the program to Aboriginal clients. This includes a dedicated Aboriginal team within Take Two, which provides culturally sensitive support to families and communities along with professional development to the wider organisation and external stakeholders (Frederico, Jackson & Black, 2010).

seems to be a vital component becomes vital to the movement from phases which is articulated by both Westerman (2015) and Helms (1995).

Predictors of identity formation

It is an interesting argument that argued that although Impacts can be multi-layered – how they manifest depends upon a number of factors including:

- Early experiences – the impact of templates and trauma related to racial identity is crucial to a positive internal working model and sense of positive racial identity. For example, experiences of removal and how racial identity and the extent to which the environment either cultivated a positive or negative sense of Aboriginality and whether hatred became internalised based upon these environmental cues
- Whether racism is able to be managed and understood as being reflective of 'others' and not of something inherently 'wrong' in the self. Whether this leads to a form of 'psychological 'splitting' of identity formation and the racism is internalised and personalised as opposed to being understood as being reflective of some form of 'damage' that has occurred by the protagonist in the source of the racism
- Lateral violence propensity which speaks to racism from within your own cultural group. The impacts of this are significant but there is a need to further understand how it effects identity formation. One would assume that environment is crucial again to this ability to make sense of racism in a way that does not impact upon racial identity formation and more specifically group membership. Aligned parental beliefs and values being a key aspect of this in terms of attachment bonds,

In sum the combination of understanding acculturation, Black Identity Formation and acculturative stress may provide a crucial component to the development of an Aboriginal specific attachment model. The ASAA and ASAS both provide the 'how to' in terms of ensuring treatment outcomes are able to incorporate cultural identity formation into treatment plans and a more comprehensive understanding of the factors which combine to either buffer the risk of attachment disorders. It is an area which clearly warrants empirical consideration.

Trauma and attachment - informed services

Trauma-informed services directly deal with trauma and its effects. They look at all aspects of

Box 3: Circles of Security (COS)
COS is an early intervention attachment-based parenting program with a presence in australia and internationally. The program applies classical attachment theory and targets parents of children aged between 1-5 years. COS is well evaluated and has shown success in improving caregiver-child attachment bonds for a range of circumstances, including parental substance abuse (Horton & Murray, 2015), mothers in a jail-diversion program (Cassidy et al., 2010) and mothers with mental illness (Ramsauer et al., 2014). The program can be delivered in groups, pairs or individually depending on the needs of the family. This program has been adapted to Aboriginal families through the Boomerangs Parenting Program in NSW, which also incorporates elements of the Marte Meo Program. Use of video recording of parent-child interactions. Applied Ainsworth's Strange Situation. Educational sessions, camp program. Evaluated favourably with three case studies (Lee et al., 2010).

Box 4: The Positive Parenting Program (PPP)
The Positive Parenting Program (PPP) is another international, evidence-based service aimed at promoting healthy parenting strategies for caregivers of children aged from birth up to 16 years. The program applies social learning, cognitive behavioural and developmental theory to frame support across the spectrum of 'normal' parenting challenges through to at-risk families experiencing more complex issues. Trained facilitators deliver the program to families in a range of settings, from health institutions to homes. PPP offers a program specifically for Australian Aboriginal families, Indigenous Triple P, which it states has been developed in partnership with Aboriginal elders and health services to enhance its cultural resonance.

their operations through a 'trauma lens'. Their primary mission is underpinned by knowledge of trauma and the impact it has on the lives of clients receiving services (Harris 2004). Every part of the service, management and program delivery systems are assessed and modified to include an understanding of how trauma affects the life of individuals seeking support and the workers delivering the care.

Table 1 identifies the principles that inform the function of trauma-informed services. These principles are based on the work of acknowledged trauma experts (Bloom 2011; Harris & Fallot 2001) and feedback from service providers and their clients (Guarino et al. 2009). All services supporting children, young people and adults alike who are trauma victims/survivors need to consider the applicability of these principles to their operations.

There is evidence that some organisations and practitioners (who work with a range of target audiences including children) are becoming trauma-informed by delivering on one or more of these principles.

So, how can we extrapolate this additional theory into trauma and attachment programs

What is clear is that many children do not have all of the opportunities to help them meet their potential. The high level of distress in some Indigenous families suggests that children and adolescents are at risk of exposure to a toxic mix of trauma and life stressors. The effects of this exposure can be severe and long lasting. Brain development can be impaired, insecure attachments can result and self-destructive behaviours can develop. Consequently, trauma-informed policies and services are needed along with trauma-specific care.

Programs addressing bonding and attachment

An attachment-centred therapeutic approach addresses a crucial protective factor against the effects of intergenerational trauma (Wright et al., 2015). There are a number of programs, both locally and internationally, which focus on attachment. They operate along the spectrum of early intervention and prevention through to postvention support, where families have come into contact with child protection services. Programs in Australia that specifically address parental attachment and bonding include Berry Street Victoria, Positive Parent Program (PP) and Circles of Security. A summary of each appears in boxes 1-8.

Aboriginal Family Support Services

The programs and services of the Aboriginal Family Support Services (AFSS) focus on ensuring staff respond to the needs of clients with an enhanced awareness and acknowledgement of trauma and its impacts. To achieve this aim AFSS: ensures staff and work environments are culturally sensitive and competent; develops frameworks to receive and support clients feedback, choice and autonomy; and builds close and respectful partnerships with other service providers and systems to provide integrated services for individuals, families and communities. AFSS also obtained a grant to purchase books and resources in the area of healing of trauma (AFSS 2012).

Culturally sensitive trauma-related practice tools

The Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) is a culturally competent measure of specific traumatic stressors and trauma symptoms (DSM-III-R criteria for post-traumatic stress disorder - PTSD). The questionnaire includes specific cultural idioms of distress reactions relevant to Australian Aboriginal people (Atkinson 2008).

Community designed and driven healing projects

Box 5: Examples of trauma-informed services and tools

Aboriginal Family Support Services

The programs and services of the Aboriginal Family Support Services (AFSS) focus on ensuring staff respond to the needs of clients with an enhanced awareness and acknowledgement of trauma and its impacts. To achieve this aim AFSS: ensures staff and work environments are culturally sensitive and competent; develops frameworks to receive and support clients feedback, choice and autonomy; and builds close and respectful partnerships with other service providers and systems to provide integrated services for individuals, families and communities. AFSS also obtained a grant to purchase books and resources in the area of healing of trauma (AFSS 2012).

Culturally sensitive trauma-related practice tools

The Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) is a culturally competent measure of specific traumatic stressors and trauma symptoms (DSM-III-R criteria for post-traumatic stress disorder —PTSD). The questionnaire includes specific cultural idioms of distress reactions relevant to Australian Aboriginal people (Atkinson 2008).

Community designed and driven healing projects

In October 2010, following an open tender process, the Aboriginal and Torres Strait Islander Healing Foundation awarded funds to 21 Indigenous-controlled agencies to create and deliver their own healing projects. Projects include the development of local healing centres, individual and group counselling and healing camps on Country. In the January to June 2012 reporting period, 17 of the initial projects continued to operate. Projects have reported on agreed national outcomes (such as strengthened connection to culture) and contributed to case studies. A Healing Foundation report provides insights into existing healing work and its perceived effectiveness (see Aboriginal and Torres Strait Islander Healing Foundation 2012). <http://www.healingfoundation.org.au/our-work>.

Information exchange

The Australian Child & Adolescent Trauma, Loss and Grief Network has a section committed to sharing information and background materials about child and adolescent trauma, loss and grief from an Indigenous perspective. A key resource includes interviews with five members of the Footprints in Time Steering Committee on what is known about grief and loss and how to support children to cope with adversity.

<http://www.earlytraumagrief.anu.edu.au/Indigenous-children-and-families>.

The network is also developing the Aboriginal and Torres Strait Islander Families and Communities Hub. Resources on topics such as healing, sharing wisdom, trans-generational trauma, resilience and cultural awareness will be identified and developed in collaboration with key partners. Partners include the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Secretariat of National Aboriginal and Islander Child Care (SNAICC). There

is also an online space or gallery, Resilience through the Arts, where Indigenous artists can present their work on a rotational basis.

In October 2010, following an open tender process, the Aboriginal and Torres Strait Islander Healing Foundation awarded funds to 21 Indigenous-controlled agencies to create and deliver their own healing projects. Projects include the development of local healing centres, individual and group counselling and healing camps on Country. In the January to June 2012 reporting period, 17 of the initial projects continued to operate. Projects have reported on agreed national outcomes (such as strengthened connection to culture) and contributed to case studies. A Healing Foundation report provides insights into existing healing work and its perceived effectiveness (see Aboriginal and Torres Strait Islander Healing Foundation 2012). <http://www.healingfoundation.org.au/our-work>.

Information exchange

The Australian Child & Adolescent Trauma, Loss and Grief Network has a section committed to sharing information and background materials about child and adolescent trauma, loss and grief from an Indigenous perspective. A key resource includes interviews with five members of the Footprints in Time Steering Committee on what is known about grief and loss and how to support children to cope with adversity.

<http://www.earlytraumagrief.anu.edu.au/Indigenous-children-and-families>.

The network is also developing the Aboriginal and Torres

Box 6: Yarning up on Trauma - an example of Take Two's work with Aboriginal services and communities

Yarning up on Trauma is an education package and approach to understanding trauma and attachment for Aboriginal children, Aboriginal communities and those working with the Aboriginal community. Take Two clinically trained facilitators (one Aboriginal and one non-Aboriginal) typically deliver the program. It is designed to provide workers with knowledge and understanding of:

- the effects of trauma on their clients, themselves as Aboriginal people, Aboriginal communities and their work environments
- appropriate interventions based on trauma and attachment theories.

From 2006 to 2008, approximately 240 participants attended the training. An analysis of post-training surveys revealed that the vast majority of participants found the content 'definitely or mostly' helpful. A year after training delivery, trainers have received feedback from community members about the ongoing application of their learning. Further, Yarning up on Trauma has directly informed training within the Victorian-based Berry Street, Take Two partnership with the Bouverie Centre.

Further evidence of whether, and on what basis, this package contributes to reductions in the trauma symptoms of children are needed in order to confirm this promising practice as a 'best-practice' model that other trauma-specific services should consider.

Source: Coade et al. 2008; Frederico et al. 2010

Box 7: Yorgum—promising examples of adopted therapeutic approaches

Yorgum's practitioners draw on a range of therapeutic approaches to work with various clients, including:

- sand-play therapy (particularly with children)
- art therapy (adults and children)
- yarning therapy (based on the principle that telling the story is part of the therapeutic process, where enabling the client to share their story validates their experiences)
- one-on-one counselling
- group work and education workshops.

Practical supports and referrals to other services are also provided in ways that empower clients to take control and do things for themselves.

The services provided by Yorgum represent promising practices as they are yet to be formally evaluated. However, anecdotal accounts suggest that Yorgum is delivering a much sought-after program. Internal reviews of the service (not publicly available) have also contributed to continued funding by government agencies.

For further information visit <http://www.yorgum.com.au> and <http://www.aifs.gov.au/afrc/pubs/newsletter/frq017/ frq017-6.html>.

Strait Islander Families and Communities Hub. Resources on topics such as healing, sharing wisdom, trans-generational trauma, resilience and cultural awareness will be identified and developed in collaboration with key partners. Partners include the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Secretariat of National Aboriginal and Islander Child Care (SNAICC). There is also an online space or gallery, Resilience through the Arts, where Indigenous artists can present their work on a rotational basis.

Although the development of trauma-informed services is critical, more support is needed. Some Indigenous Australian children also require individual therapeutic care that is trauma-informed (that is, trauma-specific care).

Trauma-specific care

Trauma-specific care consists

of the specific actions taken to deal with the consequences of trauma in individuals and to facilitate their healing. These actions need to focus on developing understanding of, and appropriate responses to, the complex psychobiological and social reactions to trauma and less on recounting and categorising the trauma events (Briere & Scott 2006; Scaer 2007; van der Kolk 2007).

There is no single way to provide trauma-specific care. Instead, practitioners and service providers, through consultation and feedback with trauma experts and clients, need to identify the strategies and practices best suited to the needs and circumstances (including geographic location) of the individuals, families and communities they seek to support. This section shares approaches documented by individuals and service providers working with and for victims/survivors of trauma.

As highlighted earlier, this section draws mainly on documented practice wisdom. Further research is needed to enhance understanding of: the level of the need for trauma recovery in the Indigenous Australian community (Vicary & Bishop 2005); the risk and protective factors associated with Indigenous social and emotional wellbeing (Kelly et al. 2009); and the efficacy of available trauma-specific care programs and practices. Such research will be enabled through adequate funding for an evaluation component for the existing (often small-scale) programs (Kowanko et al. 2009). The Canadian experience exemplifies the importance of building a strong evidence base of innovative and effective strategies in this area (Archibald 2006), while respecting the intellectual property of traditional healing practices (Quinn 2007). With ongoing support, the Aboriginal and Torres Strait Islander Healing Foundation has the potential to follow the lead of the Canadian Aboriginal Healing Foundation in producing a wealth of information that will help inform future trauma-specific models of care.

Cultural approaches to trauma and attachment -specific care

Trauma-specific care must consider cultural factors. Culture plays a role in the type of trauma that individuals may experience, the risk for continued trauma, how individuals handle and express their experiences and which type of care is most effective (Guarino et al. 2009).

One powerful means of recognising culture is the development of Indigenous-specific approaches to care. Two Indigenous-specific programs that work with children were identified: the Take Two Aboriginal Team and Yorgum.

Take Two is a Victorian-based therapeutic service for children who have suffered abuse and neglect. It undertakes therapeutic

Box 8: We Al-li: healing people, sharing culture, regenerating spirit

A key component of We Al-li is Working with Children—Prevention and Healing (formerly The Child Learns). First developed and run in 1994, this workshop/unit explores:

- cultural safety when working with children who have been hurt
- child development and childhood trauma—theories, processes and effects
- emotional first aid and emotional release work through sensory and tactile work, narrative, dance, movement, play therapy, nature discovery, storytelling and performance
- applying skills for working with children that promote positive spiritual and cultural growth and identity
- understanding the importance of establishing our own trigger points when working with children and apply self-care strategies to prevent burnout (We Al-li workbook 2002–12).

Other We Al-li workshops include Lifting the Blanket—Trauma and Recovery, Prun—Managing Conflict and Journey to the Crocodile's Nest—Loss and Grief.

Although reviews and post-course evaluations of We Al-li have been undertaken (see below), ongoing research is required in order to determine whether this promising practice represents a best-practice model for services to consider.

For further information visit <http://www.wealli.com.au>

interventions to achieve positive outcomes, such as recovery from trauma. Partners include Berry Street, Austin Health, Child and Adolescent Mental Health Service (CAMHS), La Trobe University School of Social Work and Social Policy, Mindful (Centre for Training and Research in Developmental Health) and the Victorian Aboriginal Child Care Agency (VACCA). Given the disproportionate number of Aboriginal children within the Take Two program, the service created the Take Two Aboriginal team in 2004. The functions of the Aboriginal team include clinical work, program and research development and training and practice development (see Box 6) (Frederico et al. 2010).

Yorgum is an Aboriginal child and family counselling service operating in metropolitan Perth and parts of south-west Western Australia. The service draws on a range of therapeutic approaches, grounded in Aboriginal philosophies, to deliver trauma-specific care to local Aboriginal communities. Its practices acknowledge the connection between the negative impact of historical and complex trauma and family breakdown, poor parenting skills and capacity and substance misuse, violence and abuse. Crucial to Yorgum's work are the connections it makes with other services, such as Link-Up for the Stolen Generations. These connections enable Yorgum to deliver integrated, holistic support (see Box 7).

Initiatives such as Take Two and Yorgum require appropriately skilled workers. Hence this section is supplemented with a discussion of two training courses designed by, with and for Indigenous practitioners:

We Al-li and Nunkuwarrin Yunti. We Al-li is designed both to support workers to heal their own trauma and to prepare these workers to support children and other target groups in their recovery. Nunkuwarrin Yunti delivers a counselling-related diploma, particularly suited to Aboriginal workers, that explores responses to trauma.

We Al-li (the Woppaburra terms for fire and water) is a community-based response to the violence and trauma experienced by some Indigenous Australians and the need to develop healing activities. Established in 1993, the program consists of a series of workshops that incorporate Indigenous Australian cultural practices and therapeutic skills. The workshops are designed to provide personal and professional development for practitioners working in the areas of trauma, family violence and positive parenting. One workshop focuses on working with children (see Box 8).

We Al-li has been evaluated. All nine workshops were assessed in 1995 as part of a doctoral study (Atkinson 2001). The evaluation sought feedback from program participants who included Aboriginal workers from alcohol rehabilitation, child-care and youth services. It found strong support for the program's focus on cultural tools for healing. Participants identified the strongest tools as:

story, art, music, theatre, dance, always placing the trauma stories of people and place as the centre- piece of our work. The storytellers were our teachers and we learnt as we listened. These stories were not just about individuals but linked social groups across history and country. The stories were about the storyteller(s') culture and identity (Atkinson 1995; Atkinson forthcoming).

When We Al-li was incorporated into the Masters of Indigenous Studies at Gnibi College of Indigenous Australian Peoples at Southern Cross University, it was reviewed as an academic program every 3 years. The reviews considered the underpinning educational theory and program fidelity (that is, are units of study implemented as intended?). The results of these reviews have not been officially published.

We Al-li is now delivered at a community level. Anecdotal accounts from feedback forms (which have been collected over a number of years) suggest reductions in the trauma symptoms experienced by participants at course completion. The results of these post-course evaluations are yet to be published.

Nunkuwarrin Yunti (taken from the dialects of the Ngarrindjeri and Narungga people and meaning 'working together') is an Aboriginal and Torres Strait Islander community controlled organisation. It delivers a diverse range of health-care and community support services in and around Adelaide, South Australia.

Nunkuwarrin Yunti is the registered training provider for the Diploma of Narrative Approaches for Aboriginal People (counselling, group and community work). The diploma is particularly suited to Aboriginal workers who are employed in various social and emotional wellbeing job roles in which counselling duties compromise a significant part of their work. This training is made up of 17 units of competency. Five units focus specifically on narrative counselling. The others cover comorbidity, advocacy, crisis work, domestic and family violence, health promotion, strategic approaches to Aboriginal and Torres Strait Islander health, social and emotional wellbeing assessment and intervention and responses to trauma.

No evaluations of the course were identified. However, information regarding the design and operation of the course is available from the People Development Unit at Nunkuwarrin Yunti

(see: <http://www.nunku.org.au/index.php?option=com_task=view&id=29&Itemid=45>)

Neuroscience and trauma-specific care

Perry & Pollard (1998) and Perry (2009) advocate an approach to clinical work with child victims/survivors of trauma that is informed by neuroscience. Neuroscience deals with the structure or function of the nervous system and brain.

The approach designed by Perry involves:

- assessing the key systems and areas of a child's brain that have been impacted by trauma
- selecting and sequencing developmentally appropriate therapeutic, enrichment and educational activities to help the child re-approximate a more standard or typical development trajectory (Perry 2009).

For example, an assessment might reveal that a 10 year old child victim/survivor of trauma has the self-regulation skills of a 2 year old, the social skills of a 5 year old and the speech and language capability of an 8 year old. This assessment informs the design of specific therapeutic intervention for the child. It would start with the lowest (in the brain) undeveloped/abnormally functioning set of problems and move sequentially up the brain as improvements are observed. In the case presented, this might involve initially focusing on the poorly organised brainstem and related self-regulation by using drumming or massage. Once there is improvement in self-regulation, the therapy would move to more relational-related problems (limbic), using activities like play or art (Perry 2009). Table 2 provides the theoretical framework for the approach.

Neurofeedback (EEG biofeedback)

Neurofeedback can be applied effectively in the treatment of complex and developmental trauma in multicultural populations. It can create a significant change in symptoms such as chronic central nervous system overarousal, mood dysregulation, substance addiction, memory and concentration difficulties, depression, anxiety, interpersonal difficulties, sleep disturbances, impulsivity, somatic complaints and disintegrated self-concept (e.g., Aroche, Tukelija & Askovic, 2009; Askovic & Gould, 2009; Dehghani-Arani, Rostami & Nadali, 2013). Over the last decade, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) has successfully integrated neurofeedback into counselling with refugee and asylum seeker adults and children. These individuals come from a vast range of cultural backgrounds and have often experienced intergenerational trauma, dispossession and displacement, culture stress and, frequently, disruptions in family bonding and attachment patterns. Neurofeedback has also shown encouraging results in the treatment of problem drinking in a sample of Native American Diné people (Kelley, 1997) and in ameliorating symptoms of anxiety and other forms of psychological distress in Canadian First Nations, Inuit and Méti peoples (Hardt, 2012).

Treatment ideally begins with an electroencephalographic (EEG) assessment, which maps electrophysical activity across the client's brain. This provides a sense of global and focused brain activity and communicates the state of central nervous system functioning. The EEG also highlights potential directions for treatment and protocols for neurofeedback are developed to target areas of the brain in need of greater regulation. Through

Table 2: Theoretical framework for optimising child neurodevelopment

Develop-mental age	Sensitive brain area	Critical functions	Primary goal of development	Optimisng experiences	Enrichment activities
0-1	Brainstem	Regulation of arousel	State regulation Flexible stress response	Rhythmic and patterned sensory input Auditory ortactile	Massage Rhythm Touch
1-2	Midbrain	Integration of multiple sensory inputs Motor regulations	Sensory integration Motor control affiliation	More complex movement Simple narrative	Music Movement Touch
1-4	Limbic	Emotional states Social language Interpretation of social information	Emotional regulation Attachment Empathy	Comples movement Narrative Social experiences	Dance/play Art Nature discovery
2-6	Cortex	Abstract cognitive functions Social/emotional integration	Abstract reasoning Creativity	Complex conversation Social and emotional experiences	Story telling Drama Exposure to performing arts

Source: Adapted from Guarino et al. 2009

the use of specialised software, clients receive feedback about their brain's activity and learn to regulate its functioning. This involves a process of operant conditioning. When the brain holds a state of balance, the client is typically rewarded with a series of sounds and a 'game' or graphic displayed on a computer screen progresses. However, if the brain produces dysregulated activity, it is inhibited – the game freezes and the rewards stop. Neurofeedback capitalises on the brain's capacity for neuroplasticity; new patterns of functioning tend to hold even after the conclusion of treatment. This is unlike pharmacological treatment, in which symptoms usually return once medication is withdrawn.

Because neurofeedback addresses neurobiological dysregulation, which is a core feature of trauma and attachment disruption, it could form a highly effective component of holistic support for Aboriginal Australian families, both caregivers and children of various ages. The training can be tailored to have greater cultural resonance for clients. To be optimally effective, neurofeedback should be an adjunct to a holistic treatment approach, including counselling. As with any biofeedback modality, neurofeedback can rapidly orient people toward their physiological functioning. When we have long-held states of fear and survival, visceral awareness can be experienced as terrifying and at times destabilising. We must be careful to allow people with trauma to relearn the language of their body and begin to regulate it gradually. Such change often requires individuals to navigate a new emerging self-concept as they expand into the spaces offered by safety.

Heart rate variability (HRV) biofeedback training

Heart rate variability (HRV) refers to the amount of fluctuation in space between heart beats and is reflective of nervous system functioning (Billman, 2011).

Box 9: Anecdotal accounts of healing activities with cultural links

Story telling, sand play and continuity of being among Anangu Pitjantjatjara girls (South Australia)

Story telling encompasses the rhythmic beating of a stick and making marks on the sand, along with gestures and words or song. Anangu Pitjantjatjara girls start this form of play at a young age. It is highly gender specific; boys are discouraged from its use.

In this case, the cultural context provides a particular 'meaning-making' system for the girls. Within this system, girls start to develop their own sense of self and space. Their early experiences—such as connections with and separation from the mother—can be reflected in the play. What occurs is the interplay of culture and child development. Children use and internalise what is provided within their cultural context and in turn contribute to their culture through their own playful and exploratory experiences.

Although not specifically named as trauma-specific care, this activity has the elements of a cultural trauma healing activity significant to children. It is included because the author of this paper adopted a similar technique when working with a group of Anangu Yankunytjatjara girls after a distressing experience for the girls and their community.

For further information: <http://www.healthinfonet.ecu.edu.au/key-resources/bibliography/?lid=14296>.

ArtThink (South Australia)

Specifically for Indigenous and culturally and linguistically diverse groups, ArtThink assists communities to discuss and respond to mental health issues through art. It aims to improve mental health literacy (including understanding of conditions such as post-traumatic stress), grow participants' confidence to respond effectively to mental health issues and decrease stigma associated with mental illness.

Art-based educators invite participants to express their understanding of mental health issues using different art forms, such as painting, stories or theatre.

For further information: <http://www.artthink.com.au/>.

When our heart's rhythm is ordered, we are in a coherent state. Coherence represents regulation, the order of disparate yet interdependent functions into a whole system, such as in the human body. It is experienced subjectively as a state of wellbeing and balance; of connectedness to self, to others and to the earth. A coherent state is elicited through emotions such as love, gratitude, compassion and care (McCraty & Childre, 2010) – emotions which are fundamental to healthy child development. Coherence is not the same as relaxation; one can be in a coherent state and continue to conduct tasks of everyday living. This does not tend to occur during relaxation, which implies a brief, focused period of relief.

Heart rate coherence is trainable. HRV biofeedback training typically uses software and an infrared sensor attached to the ear or finger to measure blood flow. This activity is then shown to the client on a screen, allowing him or her to regulate HRV using breath and awareness. The result of training is a kind of 'tuning' of the body's essential rhythms, gradually resetting the baseline to one of a more balanced nervous system. An individual's ability to regulate stress is slowly restored, or established in those who have histories of developmental trauma.

HRV training has shown effectiveness in treating various mental health issues. It significantly reduced PTSD symptoms in a sample of returned US combat veterans (Ginsberg, Berry & Powell, 2010), as well as reduced symptoms of PTSD, anxiety and substance cravings in people undergoing residential treatment for substance dependence (Zucker et al., 2009). Siepman et al. (2008) found that HRV training lifted symptoms of depression and anxiety in clients with moderate to severe depression, which occurred after only six sessions of training over two weeks. Further, a study by Lloyd, Brett & Wesnes (2010) found that HRV training resulted in improved cognitive functioning, language processing and behaviour in early adolescents with ADHD.

The respiratory sinus arrhythmia (RSA) is a reflection of HRV in relation to breathing. RSA, which is influenced during HRV training, refers to our heart rate's natural increase as we inhale

Box 10: Example of a care model informed by the ecological perspective

Overt problem:

- Child exhibiting disorganised or agitated behaviour (which, as highlighted earlier, can be symptomatic of trauma).

Identified issues:

- Child demonstrating insecure attachments and not attending school. Family history of trauma. Also experiencing homelessness and unemployment. Community experiencing internal conflicts and high levels of substance misuse and high levels of mental illness.

Identified support and assistance:

- Child: counselling, in-school support
- Family: interventions focused on parenting skills, healing and recovery and addictions. Referrals to housing support and employment agencies.
- Community: community mediation and increased access to rehabilitation and mental health services.

Source: Adapted from Leon et al. 2008.

and decrease as we exhale. Research has found that RSA can be a biomarker for regulatory disorders in infants (Dale et al., 2011; Porges & Furman, 2011). It is a measure of vagal nerve regulation of the heart, which influences the infant's capacity for self-regulation and social engagement. If caregivers are in a better state of regulation, which can be facilitated through HRV training, their capacity for attunement to their children is increased. Children and young people can also benefit from the training, helping to establish central nervous system balance.

Preliminary efforts to integrate this approach into a variety of settings, including therapeutic preschools, shows promise for helping to heal traumatised children. However, further clinical and research efforts are needed in this area to better understand impacts (Perry 2009).

It is unclear from the available literature whether and how cultural differences influence the implementation of this framework. However, Perry (2009) has suggested the theoretical framework aligns with Indigenous cultural practices (see below).

Links between the theoretical framework for optimising child neurodevelopment and Indigenous healing rituals

A key principle underpinning the theoretical framework for optimising child neurodevelopment is that activities are most effective when implemented with focused repetition targeting the neural systems one wishes to modify (Perry 2009). Accordingly, Perry suggests that Indigenous healing rituals have the capability to promote healing and recovery because they:

assuredly provide the patterned, repetitive stimuli—such as words, dance or song—required to specifically influence and modify the impact of trauma, neglect, and maltreatment on key neural systems (Perry 2008:xi).

Additionally, Perry emphasises the power of relational health to promote healing and recovery and the need to incorporate social connections into therapeutic work. He reports that 'healthy relational interactions with safe and familiar individuals can buffer and heal trauma-related problems' (Perry 2009: 248). Given the relational aspect of Indigenous healing rituals, this finding also points to the capacity of traditional practices to promote healing and recovery. As Perry explains, healing rituals are:

all provided in intensely relational experience(s) with family and clan participating in the ritual:… retell the story, hold each other, massage, dance, sing, creating images of the battle in literature, sculpture and drama, reconnecting to loved one and to community, celebrate, eat and share (Perry 2008).

This overlap suggests a convergence between modern concepts of neurodevelopment and the traditional healing practices of Indigenous people. However, further research is needed to understand whether and how Indigenous healing rituals support healing and recovery, and what factors facilitate or impede the use of such rituals for Indigenous families and communities.

Other potentially promising approaches to trauma-specific care

Other approaches emerge in the available literature as potential strategies for supporting victims/survivors of trauma. These are an ecological approach to the identification and treatment of trauma, physical activity to promote recovery and therapeutic residential care.

An ecological approach involves taking into consideration the interaction within and between various systems in a child's life in order to identify trauma risk factors. It requires practitioners and service providers to keep a broad, rather than narrow, view of issues and recognise that the trauma experienced by children may be the result of a combination of factors related to the child, their parents and carers and their environment. Therefore, their trauma-specific care needs to seek to tackle issues or problems in all the systems that are negatively affecting the child's situation (Leon et al. 2008; Phenice & Griffore 1996).

There is a small, but emerging, evidence base in support of an ecological approach to trauma-specific care. Further research is needed to measure impacts and outcomes (Leon et al. 2008).

Physical activity is the other approach. When seeking to enable trauma recovery in children, interventions are often drawn from the domain of therapy (cognitive behavioural therapy, eye movement desensitisation and reprocessing (EMDR), pharmacotherapy, etc.). However, physical activity could represent another important means of supporting the recovery of children who are victims/survivors of trauma. Ahn and Fedewa (2011) analysed the findings of 73 studies examining the relationship between children's physical activity and mental health outcomes. The authors found that increased levels of physical activity had significant effects in reducing depression, anxiety, psychological distress and emotional disturbance in children (Ahn & Fedewa 2011).

Therapeutic residential care is intensive and time-limited care for a child or young person in statutory care. Such care is designed to respond to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment and developmental needs (National Therapeutic Residential Care Working Group, cited in McLean et al. 2011). The eight Australian child protection jurisdictions offer therapeutic residential care services. Australian and international research suggests this model represents optimal therapeutic care for children in the out-of-home care environment (McLean et al. 2011).

Supporting family and community

Finally, those working in the field of trauma recovery and healing may benefit from exploring current approaches to caring for adults and communities who have experienced trauma. Although it is outside the scope of this paper to explore initiatives for these groups in detail, useful resources are available. Refer to the extensive resources provided in Atkinson, J (2013) which has a online resources section and highlights practice guidelines designed for mental health professionals who directly engage in treatment of adults (aged 18 and over) with the lived experience of complex trauma (Kezelman & Stravropoulos 2012). In addition this article refers to A Closing the Gap Clearinghouse resource sheet Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, examines the Family Wellbeing course, a cultural healing program that aims to enhance participants' capacity to deal with the day-to-day stresses of life and to help others. This resource sheet also examines how parenting initiatives, such as Indigenous adaptions of Triple P-Positive Parenting, can enhance the quality of the parent–child relationship and in turn positively impact on children's emotional development. Finally, there is a growing body of literature on international experiences of community-based healing/trauma interventions following events such as mass torture or natural disasters (see Ertl et al. 2011; Hobfoll et al 2007; Reyes & Jacobs 2006).

Recent government initiatives

The section below is designed to provide further context for the reader regarding a range of national initiatives that are currently in place. These initiatives are not examined within the body of the paper.

The Aboriginal and Torres Strait Islander Healing Foundation

The community-based healing programs supported by the Aboriginal and Torres Strait Islander Healing Foundation aim to improve the emotional wellbeing of Indigenous people, in particular members of the Stolen Generations, and to provide appropriate training for people delivering the healing. The Foundation has been funded $53 million for 8 years until 2016–17.

Programs supported by the Foundation aim to improve mental health in Indigenous communities by providing healing services and access to traditional healing, education about trauma and how to manage grief and loss more effectively, as well as a professional workforce that can better respond to loss, grief and trauma in these communities.

Topics dealt with include suicide prevention, depression, violence, incarceration, substance abuse, intergenerational trauma, and pathways to healing.

Renewal of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework

The Commonwealth Department of Health and Ageing is leading the renewal of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework, and a cross jurisdictional and expert working group is guiding its development.

The Social and Emotional Wellbeing Program

In 2011, the Australian Government provided continued funding for the Social and Emotional Wellbeing (SEWB) Program. The objective of the SEWB Program is to enhance service delivery to Aboriginal and Torres Strait Islander people and communities, prioritising members of the Stolen Generations, through more flexible models of service delivery and increased capacity to meet demand for services. The program delivers:

- **Link-Up services in eight locations across Australia, which provide family tracing, reunions and counselling for members of the Stolen Generations.**
- **SEWB counselling services, which provide counselling support for Aboriginal and Torres Strait Islander people, prioritising members of the Stolen Generations, in over 90 Aboriginal Community Controlled Health Organisations across Australia. In 2012–13, there are more than 160 counsellor positions across all states and territories.**
- **SEWB workforce support and training through eight Workforce Support Units and nine Indigenous Registered Training Organisations across Australia.**
- **Support for the Stolen Generations peak organisations, the National Sorry Day Committee and the National Stolen Generations Alliance.**
- **National coordination and support including assistance to Link-Up services for family tracing through the Australian Institute for Aboriginal and Torres Strait Islander Studies.**

The Mobile Outreach Service Plus

The Mobile Outreach Service Plus (MOS Plus) provides an outreach service delivering culturally safe counselling and support for Aboriginal children and their families and communities in remote Northern Territory who are experiencing trauma associated with any form of child abuse or neglect. It also provides access to external professional development and community education to increase community members' and local agencies' understanding of child abuse and related trauma. MOS Plus is delivered by the Northern Territory Office of Children and Families in the Department of Education and Children's Services under the National Partnership Agreement on Stronger Futures in the Northern Territory.

Key elements of the MOS Plus model are that it:

- includes preventative and therapeutic interventions
- is available to children aged 0 to 17
- is culturally sensitive
- is accessible locally
- involves key individuals in the child or young person's family and community, and specialist staff such as Aboriginal Therapeutic Resource Workers and counsellors.

Conclusion

There remains a great need for quality research into the aetiology and presentation of developmental trauma, attachment disruption and historical trauma in Aboriginal Australian people, including the specific vulnerabilities that determine the development of ill health. From this, effective attachment-focused assessment and healing must be developed uniquely for Aboriginal Australian children and families, to best meet their needs and reduce the number of Aboriginal children in care. Working with issues of attachment and intergenerational trauma will always necessitate moving beyond parenting intervention alone. Effective programs encompass early intervention and prevention (with an emphasis on prenatal and early postnatal mother-child bonding) as well as postvention (where children have already entered out-of-home care). Therapeutic approaches must look to the wisdom of Aboriginal Australian systems of healing, which are embedded in a holistic understanding of self in relation to the environment, body, mind, community, family and spirituality. Western methods of support are situated alongside this, with a biopsychosocial-spiritual framework that considers epigenetics, neurobiology, psychoneuroendocrinology, and cross-cultural traumatology.

Many Indigenous Australian children grow up in safe homes and live in safe communities, but there are some who do not. Inter-generational trauma and distressing life events can cause childhood trauma. Although childhood trauma is a real problem that demands urgent action, it is important to acknowledge the strength and resilience of Indigenous people and culture in Australia in the face of extreme adversity. Protective attributes (such as strong kinships systems and connection to Country) have enabled many people to transcend painful personal and communal histories.

Trauma-informed services and trauma-specific care are important for those unable, or still working, to heal trauma. Although there are a growing number of early childhood programs specifically aimed at Indigenous children, most do not originate from trauma-informed services or incorporate trauma-specific care. Of the trauma-informed services and trauma-specific care that is available, most show promise for promoting healing and recovery but have not been formally evaluated, or the available evaluations focus on process and client satisfaction, rather than clinical outcomes (such as reduced trauma symptoms).

Trauma-informed services and trauma-specific care models reach into the hearts of children who are victims/ survivors of trauma and into those of their families. Practitioners and service providers write of providing education and therapeutic and enrichment initiatives designed to respond to children's needs including their neurodevelopmental growth. Many of their reported practices are grounded within the richness of children's cultural and spiritual heritage. Such culturally informed approaches recognise Indigenous worldviews for strengthening cultural and spiritual identity, in early childhood and across the lifespan.

Further trauma-informed services and trauma-specific care interventions will be strengthened by action at the policy level. All government and non-government agencies need to ensure their policy frameworks are trauma-informed. To date, there are some encouraging signs. For example, the National Mental Health Policy 2008 recognises that exposure to traumatic events places individuals at heightened risk of mental health problems and mental illness. However, further work is recommended to move away from a potentially piecemeal approach, in which individual frameworks or strategies highlight the effects of trauma, with no single policy presenting a coherent strategic plan of action for supporting trauma recovery.

Understanding the true nature of family functioning and child-rearing practices is important in both Aboriginal and non-Indigenous contexts. Yet caution must prevail when comparing Aboriginal knowledge to non-Indigenous understandings about raising children. For example, ideas about what constitutes adequate parental monitoring, as well as appropriate bonding and attachment, are not always compatible across these two cultures. The challenge for non-Indigenous policy-makers, researchers and service providers is to understand how knowledge can be more effectively shared as part of a collaborative approach to child safety and wellbeing.

References

AFSS (Aboriginal Family Support Services) 2012. Annual report 2011–2012. Adelaide: AFSS. Viewed 6 March 2013, <http://afss.com.au/Annual%20Report/AFSS%20Annual%20Report%202011-2012.pdf>.

Ahn S & Fedewa AL 2011. A meta-analysis of the relationship between children's physical activity and mental health. Journal of Pediatric Psychology 36(4):385–97. doi:10.1093/jpepsy/jsq107.

AIHW (Australian Institute of Health and Welfare) 2011. Aboriginal and Torres Strait Islander child safety. Cat. no. IHW 50. Canberra: AIHW. Viewed 6 March 2013, <http://www.aihw.gov.au/publication-detail/?id=10737418980>.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the Strange Situation. Hillsdale, New Jersey: Erblaum

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. American Psychologist, 46(4), 331-341.

Archibald L 2006. Final report of the Aboriginal Healing Foundation. Volume III: Promising healing practices in Aboriginal communities. Ottawa: Aboriginal Healing Foundation. Viewed 6 March 2013, <http://www.ahf.ca/publications/research-series>.

Arthur, N., & Collins, S. (2010). Culture-Infused Counselling (2nd ed.). Le counselling tenant compte des références culturelles (2ième éd). Calgary, AB: Counselling Concepts. ISBN: 978-0-9738085-1-3, 524 pages.

Askovic, M., & Gould, D. (2009). Integration of neurofeedback in the therapeutic work with torture and trauma survivors: A case study. Biofeedback, 37(2), 56-62.

Atkinson CL 2008. The violence continuum: Australian Aboriginal male violence and generational post-traumatic stress. PhD thesis. Darwin: Charles Darwin University.

Atkinson J 2002. Trauma trails, recreating song lines: the transgenerational effects of trauma in Indigenous Australia. North Melbourne: Spinifex Press.

Atkinson J & Ober C 1995. We Al-li 'Fire and water': a process of healing. In: Hazlehurst KM (ed.). Popular justice and community regeneration: pathways of Indigenous reform. Westport, CT: Praeger Press, 201–18.

Atkinson J, Nelson J & Atkinson C 2010. Trauma, transgenerational transfer and effects on community wellbeing. In: Purdie N, Dudgeon P & Walker R (eds). Working together: Aboriginal and Torres Strait Islander

Mental Health and Wellbeing Principles and Practice. Canberra: Australian Government Department of Health and Ageing, 135–144. Viewed 6 March 2013, <http://aboriginal.childhealthresearch.org.au/kulunga-research-network/ working-together/working-together-chapters.aspx>.

Baker DG 1983. Race, ethnicity, and power: a comparative study. London: Routledge & Kegan Paul.

Bakermans-Kranenburg, M. J. and Van IJzendoorn, M. H. (2007), Research Review: Genetic vulnerability or differential susceptibility in child development: the case of attachment. Journal of Child Psychology and Psychiatry, 48: 1160–1173. doi:10.1111/j.1469-7610.2007.01801.

Barrera, I., Corso, R. M., & Macpherson, D. (2003). Skilled dialogue: Strategies for responding to cultural diversity in early childhood. Baltimore, Md: P.H. Brookes Pub.

Belsky and Rovine (1987) Temperament and Attachment Security in the Strange Situation: An Empirical Rapprochement, Child Development, Vol. 58, No. 3 (Jun., 1987), pp. 787-795

Berry, J., & Kim, U. (1988). Acculturation and Mental Health. In R. Dasen, Berry., J & Satorius, N (Ed.), Health and Cross-Cultural Psychology: Toward Applications (Vol. I, pp. 207-235). Newbury Park: Sage.

Billman, G. E. (2011). Heart rate variability – a historical perspective. Frontiers in Physiology, 2(86), 1-13.

Bloom SL 2011. Sanctuary: an operating system for living organisations. In: Tehrani N (ed.). Managing trauma in the workplace: supporting workers and organisations. Hove, UK: Routledge.

Bowlby, J. (1969), Attachment and Loss: Vol. 1. Attachment. Penguin: New York.

Bowlby J. Attachment and loss: Vol I Attachment. New York: Basic Books; 1969/1982.

Bowlby J. Attachment and loss: Vol II Separation. New York: Basic Books; 1973.

Brave Heart-Jordan MYH 1995. The return to the sacred path: healing from the historical trauma and historical unresolved grief among the Lakota. PhD thesis. Northampton, MA: Smith College.

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

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. Violence Against Women, 9, 1293-1316.

Cassidy, J., Ziv, Y., Stupica, B., Sherman, L. J., Butler, H., Karfgin, A., et al. (2010). Enhancing maternal sensitivity and attachment security in the infants of women in a jail-diversion program. In J. Cassidy, J. Poehlmann, & P. R. Shaver (Eds.), Incarcerated individuals and their children viewed from the perspective of attachment theory. Special issue of Attachment and Human Development

Chandler, M. J. & Lalonde, C. E. (2008). Cultural Continuity as a Protective Factor against Suicide in First Nations Youth. Horizons --A Special Issue on Aboriginal Youth, Hope or Heartbreak: Aboriginal Youth and Canada's Future. 10 (1), 68-72.

Chandler, M. J., & Proulx, T. (2007). Identity in a Narrative Mode. Journal of Applied Developmental Psychology 28, (pp. 277-282). Elsevier.

Christensen, M., & Manson, S. (2001). Adult attachment as a framework for understanding mental health and American Indian families. The American Behavioral Scientist, 44, 1447-1465;

Courtois CA 1999. Recollections of sexual abuse: treatment principles and guidelines. New York: WW Norton& Company.

Cross (1971, 1978, 1991) from Talking about Race, Learning about Racism: The Application of Racial Identity Development Theory in the Classroom by Beverly Daniel Tatum in Geismar, K. & Nicoleau, G. (1993), Teaching for Change. Harvard Educational Review. Cambridge, MA.

Dehghani-Arani, F., Rostami, R., & Nadali, H. (2013). Neurofeedback training for opiate addiction: Improvement of mental health and craving. Applied Psychophysiology and Biofeedback, 38(2), 133-141.

Dale, L. P., O'Hara, E. A., Keen, J., & Porges, S. (2011). Infant regulatory disorders: Temperamental, physiological and behavioural features. Journal of Developmental and Behavioural Pediatrics, 32(3), 216-224.

Duran E & Duran B 1995. Native American postcolonial psychology. Albany, NY: State University of New York Press. Ertl V, Pfeiffer A, Schauer E, Elbert T & Neuner F 2011. Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial. Journal of the American Medical Association306(5):503–12. doi:10.1001/jama.2011.1060.

Frederico, M., Jackson, A., & Black, C. (2010). Take Two – Third Evaluation Report, LaTrobe University, viewed 15 February 2016 from http://www.berrystreet.org.au/Assets/606/1/TakeTwo_Evaluation_Report_3.pdf

Fox, N. A. (1989). Infant temperament and security of attachment: a new look. International Society for Behavioral Development, J yviiskylii, Finland.

Ginsberg, J. P., Berry, M. E., & Powell, D. A. (2010). Cardiac coherence and posttraumatic stress disorder in combat veterans. Alternative Therapies in Health and Medicine, 16(4), 52-60.

Guarino K, Soares P, Konnath K, Clervil R & Bassuk EL 2009. Trauma-Informed Organizational Toolkit for homeless services. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. Viewed 6 March 2013, <http://homeless.samhsa.gov/Resource/Trauma-Informed-Organizational-Toolkit-for-homeless-services-49573.aspx> and http://www.familyhomelessness.org/resources.php?p=sm>.

Hallett, D., Chandler, M. J., & Lalonde, C. (2007). Aboriginal language knowledge and youth suicide. Cognitive Development, 22 (3) (pp. 392–399).

Harris M 2004. Trauma informed services. The evolution of a concept. Washington, DC: Cummunity Connections. Viewed 4 July 2012, <http://womenandchildren.treatment.org/media/presentations/c-1/Harris.ppt>.

Harris M & Fallot RD (eds) 2001. Using trauma theory to design service systems. New Directions for Mental Health Services 89.

Helms (1995)) from Sue, et al. (1998). Multicultural Counseling Competencies: Individual and Organizational Development. Sage Productions. Thousand Oaks, CA.

Hesse, E., & Main, M. (2006). Frightened, threatening, and dissociative parental behaviour: Theory and associations with parental adult attachment interview status and infant disorganisation. Development and Psychopathology, 18, 309–343

Hobfoll SE, Watson P, Bell CC, Bryant RA, Brymer MJ, Friedman MJ et al. 2007. Five essential elements of immediate and mid–term mass trauma intervention: empirical evidence. Psychiatry: Interpersonal and Biological Processes 70(4):283–315. doi:10.1521/psyc.2007.70.4.283.

Howes, C., & Spieker, S. (2008). Attachment relationships in the context of multiple caregivers. In J. Cassidy & P. Shaver. (Eds.), Handbook of attachment: Theory, research and clinical applications (2nd ed.) (pp. 317–332). New York: Guildford Press.

Horton, E., & Murray, C. (2015). A quantitative exploratory evaluation of the Circle of Security parenting program with mothers in residential substance-abuse treatment. Infant Mental Health Journal, 36(3), 320-336.

Hunter E 1998. Considering trauma in an Indigenous context. Aboriginal and Islander Health Worker Journal 22(5):8–18.

Kagan, J. and Fox, N. A. 2007. Biology, Culture, and Temperamental Biases. Handbook of Child Psychology. III:4.

Kearins, J. (1984). Child-rearing practices in Australia: Variation with lifestyle. Perth: Education Department of Western Australia.

Kelly K, Dudgeon P, Gee G & Glaskin B 2009. Living on the edge: social and emotional wellbeing and risk and protective factors for serious psychological distress among Aboriginal and Torres Strait Islander people. Discussion paper no. 10. Darwin: Cooperative Research Centre for Aboriginal Health. Viewed7 March 2013, <http://www.indigenouspsychology.com.au/publications>.

Kelley, M. J. (1997). Native Americans, neurofeedback and substance abuse theory: Three year outcome of alpha/theta neurofeedback in the treatment of problem drinking among Diné (Navajo) people. Journal of Neurotherapy, 2(3), 24-60.

Keriann Little, Ann Sanson and Stephen Zubrick (2012). Do individual differences in temperament matter for

Indigenous children? The structure and function of temperament in Footprints in Time. Family Matters No. 91

Kezelman CA & Stravropoulos PA 2012. 'The last frontier'. Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. Kirribilli, NSW: Adults Surviving Child Abuse. Viewed 7 March 2013,<http://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20 of%20Complex%20Trauma.pdf>.

Kobak, R., Rosenthal, N. L., Zajac, K. and Madsen, S. D. (2007), Adolescent attachment hierarchies and the search for an adult pair-bond. New Directions for Child and Adolescent Development, 2007: 57–72. doi:10.1002/cd.194

Kohlberg, L. (1984). The Psychology of Moral Development: The Nature and Validity of Moral Stages (Essays on Moral Development, Volume 2). Harper & Row

Kowanko I, Stewart T, Power C, Fraser R, Love I & Bromley T 2009. An Aboriginal family and community healing program in metropolitan Adelaide: description and evaluation. Australian Indigenous Health Bulletin 9(4). Viewed 7 March 2013, <http://healthbulletin.org.au/articles/an-aboriginal-family-and-community-healing-program-in-metropolitan-adelaide-description-and-evaluation/>.

Laible, D. (2005). Measuring attachment in middle childhood: Challenges and future directions. Human Development, 48, 183–187.

Lamb, M. (2012). A wasted opportunity to engage with the literature on the implications of attachment research for family court professionals. Family Court Review, 50(3), 481–485.

Law G 2000. Theoretical framework for optimising child neurodevelopment cited in Atkinson J 2001. Lifting the blankets: the transgenerational effects of trauma in Indigenous Australia. PhD thesis. Brisbane: Queensland University of Technology.

Lee, L., Griffiths, C., Glossop, P., & Eapen, V. (2010). The Boomerangs Parenting Program for Aboriginal parents and their young children. Australasian Psychiatry, 18(6), 527-533

Leon AM, Lawrence SA, Molina O & Toole E 2008. When children weep: integrating ecological thinking into child welfare. Illinois Child Welfare 4(1):144–65. Viewed 7 March 2013, <http://www.illinoischildwelfare.org/archives/volume4/icw4-leon.pdf>.

Lloyd, A., Brett, D., & Wesnes, K. (2010). Coherence training in children with attention-deficit hyperactivity disorder: Cognitive functions and behavioral changes. Alternative Therapies in Health and Medicine, 16(4), 34-42.

Luijk M, Roisman GI, Haltigan J, Tiemeier H, Booth-LaForce C, van IJzendoorn MH, Bakermans-Kranenburg MJ. Dopaminergic, serotonergic, and oxytonergic candidate genes associated with infant attachment security and disorganization? In search of main and interaction effects. Journal of Child Psychology and Psychiatry. 2011;52:1295–1307.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M.T. Greenberg, D. Cicchetti & E.M. Cummings (Eds.), Attachment in the preschool years: Theory, research and intervention (pp. 121–160). Chicago: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), Growing points of attachment theory and research. Monographs of the Society for Research in Child Development, 50 (1-2, Serial No. 209), 66-104.

McLean S, Price-Robertson R & Robinson E 2011. Therapeutic residential care in Australia: taking stock and looking forward. National Child Protection Clearinghouse issues no. 35. Melbourne: Australian Institute of Family Studies. Viewed 7 March 2013, <http://www.aifs.gov.au/nch/pubs/issues/issues35/index.html>.

McCraty, R., & Childre, D. (2010). Coherence: Building personal, social, and global health. Alternative Therapies in Health and Medicine, 16(4), 10-24.

Milroy H 2005. Preface. In: Zubrick SR, Silburn SR, Lawrence DM, Mitrou EG, Dalby RB, Blair EM 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, xiii–xxviii. Viewed 7 March 2013, <http://aboriginal.childhealthresearch.org.au/media/394828/western_australian_aboriginal_ child_health_survey_citations.pdf>.

Napoleon H 1991. Yuuyaraq: the way of the human being. Fairbanks: Center for Cross-Cultural Studies, University of Alaska Fairbanks. Viewed 7 March 2013, <http://ankn.uaf.edu/publications/>.

Neckoway, R., Brownlee, K. and Castellan, B. (2007). Is Attachment Theory Consistent with Aboriginal Parenting Realities. First Child & Family Review, 3(2).

Paradies, Y. (2016). Colonisation, racism and mental health. Journal of Population Research, 33(1), 83-96.

Perry BD 2008. Forward. In: Malchiodi CA (ed.). Creative interventions with traumatised children. New York: The Guilford Press, ix-xi.

Perry BD 2009. Examining child maltreatment through a neurodevelopmental lens: clinical applications of the neurosequential model of therapeutics. Journal of Loss and Trauma: International Perspectives on Stress & Coping 14(4):240–55. doi:10.1080/15325020903004350.

Perry BD & Pollard R 1998. Homeostasis, stress, trauma, and adaptation. A neurodevelopmental view of childhood trauma. Child and Adolescent Psychiatric Clinics of North America 7(1):33–51.

Porges, S. W., & Furman, S. A. (2011). The early development of the autonomic nervous system provides a neural platform for social behaviour: A polyvagal perspective.

Pompili M, Innamorati M, Szanto K, Di Vittorio C, Conwell Y, Lester, D et al. 2011. Life events as precipitants of suicide attempts among first-time suicide attempters, repeaters, and non-attempters. Psychiatry Research 186(2):300–5. doi:10.1016/j.psychres.2010.09.003.

Quinn A 2007. Reflections on intergenerational trauma: healing as a critical intervention. First Peoples Child & Family Review 3(4):72–82. Viewed 7 March 2013, <http://www.fncaringsociety.com/volume-3-number-4-2007>.

Ramsauer, B., Lotzin, A., Mühlhan, C., Romer, G., Nolte, T., Fonagy, P., & Powell, B. (2014). A randomized controlled trial comparing Circle of Security Intervention and treatment as usual as interventions to increase attachment security in infants of mentally ill mothers: Study protocol. BMC Psychiatry, 14(24), 1-11.

Reyes G & Jacobs GA (eds) 2006. Handbook of international disaster psychology. Volume 2: practices and programs. Westport, CT: Praeger Publishers.

Rostosky, S.S., Danner, F., & Riggle, E.D.B. (2007). Is Religiosity a Protective Factor Against Substance Use in Emerging Adulthood? Only If You're Straight! Journal of Adolescent Health, 40, 440-447.

Rutter, M. (2008). Implications of attachment theory and research for child care policies. . In J. Cassidy and P. R. Shaver (Eds), Handbook of attachment: Theory, research and clinical applications (2nd ed.) (pp. 958–974). New York: Guilford Press.

Ryan, F. (2011) Kanyininpa (Holding): A way of nurturing children in Aboriginal Australia. Australian Social Work (Special Issue), 64(2), 183–197. doi:10.1080/0312407X.2011.581300

Scott, D., Higgins, D., & Franklin, R. (2012). The role of supervisory neglect in childhood injury (CFCA Paper No. 8). Melbourne: Australian Institute of Family Studies. Retrieved from <aifs.gov.au/cfca/pubs/papers/a142582>.

Salzman, M. B., & Halloran, M. J. (2004). Cultural trauma and recovery: Cultural meaning, self-esteem and the reconstruction of the cultural anxiety-buffer. In J. Greenberg, S. L. Koole & T. Pyszczynski (Eds.), Handbook of experimental existential psychology (1st Edn) (pp. 231-246. New York, NY: Guilford Press.

Scheppers, A. (1994) Working with Aboriginal children and their families. In Briggs (ed) Children and families: Australian perspectives. New South Wales: Allen and Unwin.

Shemmings, D., & Shemmings, Y. (2011). Understanding disorganized attachment: Theory and practice for working with children and adults. London: Jessica Kingsley Publishers.

Stevenson-Hinde, J., & Verschueren, K. (2002). Attachment in childhood. status: published.

Stott, F., & Gilkerson, L. (2000). Meeting a Desperate Need: One Man's Vision of Training for the Infant Family Field. In Osofsky, J.D., & Fitzgerald, H.E., (Eds.), WAIMH Handbook of Infant Mental Health: Early Intervention, Evaluation, and Assessment. New York: Wiley.Greenspan, 1992;

SAMHSA (Substance Abuse and Mental Health Services Administration) Trauma-informed care and trauma services. Rockville, MD: SAMHSA. Viewed 27 June 2012, <http://www.samhsa.gov/nctic/trauma.asp>. Scaer RC 2007. The body bears the burden: trauma, dissociation, and disease. 2nd edn. New York: Haworth Press.

van der Kolk BA 2005. Developmental trauma disorder: toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals 35(5):401–408.

van IJzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity or the Adult Attachment Interview, Psychological Bulletin, 117(3), 387-403.

Vicary DA & Bishop BJ 2005. Western psychotherapeutic practice: engaging Aboriginal people in culturally appropriate and respectful ways. Australian Psychologist 40(1):8–19.doi:10.1080/00050060512331317210.

Wallin, David J. 2007. Attachment in Psychotherapy. New York: The Guilford Press.

Waters, E., & Deane, K. E. (1985). Defining and assessing individual differences in attachment relationships: Q-methodology and the organization of behavior in infancy and early childhood. In I. Bretherton & E. Waters (Eds.), Growing points of attachment theory and research. Monographs of the Society for Research in Child Development, 50(1-2, Serial No. 209), 41-65.

Wesley-Esquimaux CC & Smolewski M 2004. Historic trauma and Aboriginal healing. Ottawa: Aboriginal Healing Foundation. Viewed 6 March 2013, <http://www.ahf.ca/publications/research-series>.

Zilberstein, K. (2006). Clarifying core characteristics of attachment disorders: A review of current research and theory. The American Journal of Orthopsychiatry, 76, 55–64.

Yeo, S. S. (2003). Bonding and attachment of Australian Aboriginal children. Child Abuse Review, 12(5), 292-304.

Zubrick SR, Kelly K & Walker R 2010. The policy context of Aboriginal and Torres Strait Islander mental health. In: Purdie N, Dudgeon P & Walker R (eds). Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Canberra: Australian Government Department of Health and Ageing,43–62. Viewed 6 March 2013, <http://aboriginal.childhealthresearch.org.au/kulunga-research-network/working- together/working-together-chapters.aspx>.

