Transgenerational Trauma, Suicide and Healing from Sexual Abuse in the Kimberley Region, Australia

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Abstract

It is contended that transgenerational trauma — the transfer of the impacts of historical trauma and grief across successive generations of Aboriginal people — is manifest in the current social issues of interpersonal violence, suicide and sexual abuse in remote communities and towns of the Kimberley region. For Aboriginal youth, exposure to multiple layers of trauma results in a cumulative effect on the emergence of trauma symptomatology, which includes an increased risk of self harm, destructive behaviour and suicide. Research conducted in this region between 2000 to 2002 found support for a relationship between Aboriginal youth suicide, trauma exposure and post traumatic stress disorder. These findings were echoed in the daily work of staff with the Kimberley Aboriginal Medical Services Council (KAMSC) Regional Centre for Social and Emotional Well Being, who had become increasingly aware of the interaction between child sexual abuse and youth suicide. At this time a young Aboriginal woman asked KAMSC to *"do something"* about child sexual abuse in her community, and started what became a powerful movement for the prevention of child sexual abuse, leading to the development of the KAMSC *"We're Not Gammin"* [1] sexual assault and child sexual abuse package.

Theoretical Underpinnings

Transgenerational trauma has only begun to be recognized in application to Aboriginal people of Australia over the last five to ten years. This is due in part to the work of Indigenous academics and practitioners who have been able to illustrate through therapeutic experience, research and writing the nature of intergenerational and transgenerational trauma transmission amongst successive generations of Aboriginal families (see Raphael, Swan and Martinek, 1998; Atkinson, 2002a; 2002b; Milroy 2005). This work builds on the findings of several seminal reports, including the *Royal Commission Into Aboriginal Deaths in Custody, Regional Report of Inquiry into Underlying Issues in Western Australia* (Dodson, 1991), the *Bringing Them Home Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (Human Rights and Equal Opportunities Commission, 1997), and the Queensland *Aboriginal and Torres Strait Islander Women's Taskforce on Violence Report* (1999).

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1   Gammin' is a local Kimberley term for "lying," "liar," or "putting on a false front." In this context, it implies that we are very serious about preventing sexual child abuse.

This work stems from an *a priori* acknowledgement of the impacts colonial and post-colonial periods (1788–1960s) have had on Aboriginal people. Milroy (2005) noted that when considering these impacts from a psychological perspective, the historical denial of Aboriginal humanity, existence and identity emerge as critical themes. These themes continue to inform relationships between Aboriginal and non-Aboriginal society today, through social and economic marginalization, institutionalized racism, and the failure of the wider Australian society to fully recognize the critical impact of historical unresolved trauma and grief,[2] thus further invalidating the experiences of Aboriginal people. Milroy (2005) also observed that the recent introduction of *"Mutual Obligation"* agreements between Aboriginal communities and government, continues to retain the vehicle for action within policy and legislative control.

Across the 19th century, the periods of initial frontier conflict, massacre and segregation were the first wave[3] of historical violence, trauma and grief. The periods that followed of Aboriginal child removal and institutionalization, with unprecedented government intervention in the intimate workings of Aboriginal families (Haebich, 2000), represent the second wave of historical trauma and grief. The *Bringing Them Home Report* (Human Rights and Equal Opportunities Commission, 1997) estimated that between 1 in 3 and 1 in 10 Aboriginal children were removed from maternal care over the period of 1910 to 1970. This report also determined that the impacts of Aboriginal child removal policies did not stop with the children that were removed, rather that these impacts had continued to *"resound through the generations of Indigenous families,"* and the effects were *"inherited by their own children in complex and sometimes heightened ways"* (p. 222).

Atkinson (2002a, 2002b) has commented on the role government intervention has played in compounding and setting in place the chronic conditions of ongoing victimization and traumatization for Aboriginal people. This can be seen in the periods of State sanctioned Aboriginal child removal, and later in the 1940s–1960s in the policies of assimilation that continued to fracture and disenfranchise Aboriginal families (Haebich, 2000). The mechanisms of oppression that were enacted during these periods (i.e., violence

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2   The theoretical underpinnings of this paper also draw internationally on the luminous work of Yellow Horse Brave Heart and DeBruyn (1998), who described the successive waves of historical violence and resultant historical unresolved trauma and grief amongst Native American Indian peoples.

3   See fn 2.

that is physical, structural and psychological) and reactions to repeated trau-
matic loss and grief (i.e., anger, shame, perpetual grief, substance abuse) can
become internalized, and through repetition normalized (Atkinson, 2002a).
In this manner, transfer of elements of the historical trauma and reactions
may occur between generations (intergenerational trauma) and across suc-
cessive generations (transgenerational trauma), until redressed by individual,
family and community healing. Atkinson (2002a) stated that this resulted in
the profound hurt of *"people living with multiple layers of traumatic distress,
chronic anxiety, physical ill health, mental distress, fears, depression, substance
abuse, and high imprisonment rates"* (Atkinson, 2002a: 70). The psychic pain
of successive layers of trauma may remain hidden in individuals who are iso-
lated by their experiences in spite of living within families or communities
suffering from the same or similar traumatic events (*Aboriginal and Torres
Strait Islander Women's Taskforce on Violence Report*, 1999). The expression of
layers of trauma through violence against others and self (see Atkinson, 2002),
self medication through substance misuse (see *Aboriginal and Torres Strait
Islander Women's Taskforce on Violence Report*, 1999) and associated injuries
and accidents (Atkinson, Gray and Bridge, 1999) speaks volumes. As Abrams
(1999: 227) sagely wrote of survivors of the Jewish holocaust, the *"isolation
and wordlessness of trauma victims persist, while the symptoms serve as a form
of speech. Family patterns, repetitions and interconnections also speak."*
    As Milroy (2005: xxi) stated

> Given that the traumas of separation, social control and exclusion have been
> sustained over several generations and that almost the entire Aboriginal popula-
> tion was affected, the ability of individuals to psychologically integrate and for
> families and communities to collectively resolve these experiences in the face of
> ongoing denial of history[4] is extraordinarily difficult.

The subsequent transgenerational effects of historic trauma on Aboriginal
children were described by Milroy (2005) to be seen through impacts on at-
tachment relationships with caregivers and on parenting and family func-
tioning, the association with parental physical and mental illnesses, and dis-
connection and alienation from extended family, culture and society. Milroy
noted that these effects are exacerbated by chronic exposure to continuing

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4   Stanner, in 1968, coined the term the "Great Australian Silence" in reference to the selective edit-
        ing out of the impact of historical events on Aboriginal peoples. Although numerous historians,
        Aboriginal authors and national Inquiries have sought to redress this imbalance, defensiveness,
        indifference, denial, and minimization of past harms persist amongst non-Aboriginal sociopoliti-
        cal and sociocultural views. See Manne (2001).

high levels of stress and trauma, which include multiple bereavements and other losses. In addition, these effects are also compounded by secondary traumatization, where children witness the on-going effects of the original trauma on a parent or family member. Milroy (2005: xxi) concluded that

> Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality.

The *Aboriginal and Torres Strait Islander Women's Taskforce on Violence* (1999), explained transgenerational trauma through submissions by "*those that had lived it.*" Citing evidence from an elderly Community woman of the historical trauma her family had experienced through massacre, dispossession, slavery, rape and violence in the missions:

> How can anyone forget that? And why should we forget? We pass it on to our kids just like my parents passed it onto me. It stays with you 'til you die. I've seen pain all my life. (p. 46)

And later, in relation to current forms of chronic trauma exposure children and youth witness through interpersonal violence, substance abuse and suicide, which the Taskforce recognized to be both the cause and the effect of transgenerational trauma:

> How are they going to get [out] of those memories? Us old ones can't forget our memories. How do we expect the little ones to forgive and forget? What those little ones are going through is adding to the bad memories we've given them from our stories. (p. 46)

In 1999, a qualitatively based social research project was conducted by the Kimberley Aboriginal Medical Services Council. The project aimed to contextualize the experiences of Aboriginal youth, in an attempt to elucidate causation for the disproportionate rate of Aboriginal youth suicide in the region (in 1998 the suicide rate for Aboriginal youth was found to be 12 times that of the national per-capita rate). The methodology was unique for its time, with an Aboriginal youth team informally interviewing and holding workshops with Aboriginal youth (12–25 years) in a diversity of community based settings across the Kimberley region. This provided the youth with an opportunity to voice what they considered to be the most critical issues im-

pacting on their own lives and their peers. The resultant *Choose Life Report* (KAMSC, 1999), presented the issues as identified by the youth, and speaks overwhelmingly of the traumatic environments in which many live.

The contextual experience of Aboriginal adolescents in the Kimberley were self defined by the youth across four broad areas, relating to self and relating to others as set in the local living environment and as influenced by the poor or unacceptable behaviour of others. The Aboriginal youth perceived the local living environment to be unsafe, with run down facilities, little privacy in the home, inadequate access to public facilities and increased exposure to criminal activities, drunkenness, drug taking, drink driving and gambling. Relationships with others were marked with family deaths, domestic violence, sexual abuse, child abuse, gang fighting, authoritative parenting or an absence of parental care; amongst the peer group, by premature and intermittent relationships, casual sex (with little sexual education), inter-group prejudice, bullying and teasing. The youth defined their own and their peers' personal well being as influenced by a lack of self esteem, a sense of failure and boredom, with limited education and training opportunities and/or achievement (KAMSC, 1999: 28).

This largely sets the scene for the chronic form of trauma exposure many Kimberley Aboriginal adolescents experience, either through direct victimization, or witnessing the impact of victimization on others, within the home and within their community. There are three main types of trauma exposure relevant to that which the Aboriginal youth reported: chronic community violence, family violence and child maltreatment. The other types of trauma exposure reported by the Aboriginal youth, relating to family deaths, accidents and drink driving are evident in the disproportionately high mortality and morbidity rates of disease and injury experienced by Aboriginal people in the region (see Atkinson, Gray and Bridge, 1999). Violent deaths through homicide and suicide are also considered here as forms of exposure to extremely violent traumatic incidents.

The findings that many Aboriginal youth in the Kimberley region were exposed to chronic trauma were later interpreted in the *Kimberley True Words Real Life* research project from the perspective of transgenerational and intergenerational trauma. It was contended that Aboriginal youth in the Kimberley region may experience several layers of trauma, through their own direct and secondary exposure as set against a backdrop of historical unresolved trauma and grief. These layers of trauma are thought to be cumulative in the manner in which they inform the adolescents' experience, and continue to adversely

reinforce the basic assumptions that are violated by chronic trauma exposure; that the world is meaningful and safe, that the self is worthy, and that others can be trusted (McCann and Pearlman, citing Epstein, 1988). It was thought that the current high rate of suicide amongst Aboriginal adolescents in the Kimberley region may be the youths' contemporary expression of distress in response to chronic trauma exposure, as underpinned by the legacy of historical unresolved trauma and grief. Contemporary trauma exposure was directly measured through the adolescents' self report of direct and secondary exposure to traumatic life events. The symptomatology of post traumatic stress disorder, suicidal ideation and attempts, depression, substance misuse, anger, shame and hopelessness were also measured, as offset by the measurement of the protective aspects of identity, coping strategies and self esteem. It is important to note that the theoretical underpinnings discussed in this section went beyond the research process, and continued to inform the manner in which we understood and worked to prevent the high rates of Aboriginal youth suicide, as well as providing the basis for the emerging effort within the Kimberley Aboriginal Medical Services Council (KAMSC), Regional Centre for Social and Emotional Well Being to address issues of child sexual abuse in the region.

THE KIMBERLEY REGION OF WESTERN AUSTRALIA

The Kimberley is the northernmost region of Western Australia, with a land mass area of 420,000 square kilometres (approximately twice the size of Victoria, Australia, and three fifths the size of Texas). Aboriginal and Torres Strait Islander people constitute a minority of Australia's total population at 2.4%.[5] However, in the Kimberley, 14,000 (33%) of the 41,000 residents in the region identified as Aboriginal and Torres Strait Islander in the last Census count.[6] There are six main towns servicing numerous remote communities, accessible during the dry season by unsealed road, with many isolated during the wet season. The remote communities are either the remnants of missions, reserves and station sites, or areas where people have moved back to traditional lands. Native Title has been recognized over 30% of the landmass area of the Kimberley region (Kimberly Land Council, 2006). Several other applications for recognition of Native Title across the region are before the Native Title Tribunal at present (National Native Title Tribunal, 2006).

Pastoralist settlement in the Kimberley region began in the 1880s, with

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5   Australian Bureau of Statistics and Australian Institute for Health and Welfare, 2003.

6   Australian Bureau of Statistics, 2001.

waves of frontier violence extending until the 1930s (Jebb, 2002). Although expansion was impeded by the difficult terrain, and the resistance of several Aboriginal tribal groups, it was driven by State need for economic success, through the establishment of agricultural, pearling and, albeit briefly, gold-rush-based industries (Pederson and Woorunmurra, 1995). Researchers such as Jebb (2002) and Pederson (1995) were able to interview senior members of the remote Gibb River and Fitzroy Valley areas in the 1980s; these were the first and second generations of Aboriginal people exposed to the traumas of colonization in the region. These senior people shared their oral histories of "*white man coming*"; the events surrounding the massacres, the police round ups, blackbirding, leprosy patrols, camps on stations and rations, the reserves and the missions. Recorded through these oral histories were the complexities of Aboriginal and non-Aboriginal relationships through industry involvement and the impact of State intervention in every facet of Aboriginal people's lives in the Kimberley region, from the period of settlement, until the late 1960s.

In the Kimberley, during a bush healing-session with the family of a youth who had committed suicide, the most senior Elder shared his story with staff of the KAMSC Regional Centre for Social and Emotional Well Being. Moving through each wave of historical trauma to the present day, this most respected man recounted from his earliest memories as a small child the emotional impact of finding his father dead on the beach from European disease, the strangeness and cruelty of the missionaries, the separation of his family, his anger at the loss of cultural knowledge and traditions, the passing over of the World War Two aeroplanes, the impact on his family of violence, drugs and alcohol, and finally the suicide of his grandchild.

KAMSC has taken a proactive approach to understanding and preventing both youth suicide and child sexual abuse through the Choose Life Project over 1998–1999, and the Kimberley True Words Real Life research project over 2000–2001, as well as numerous other well being and mental health promotional projects.

KAMSC is a health resource body for a group of independent Aboriginal community-controlled health services in the Kimberley region of Western Australia.[7] First established in 1986, the governing Council comprises representatives of member Aboriginal Community Controlled Health Services (ACCHSs), health service communities and health committees from across the Kimberley. KAMSC programs consist of service elements which are pooled

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7   For more information see www.kamsc.org.au.

among the ACCHSs to improve efficiency, maintain specialized expertise or to address issues of regional coordination and policy. Cooperative services include administration and policy support; representation and advocacy at a regional, state and national level; public health programs; centralized purchasing of pharmaceuticals, medical and other supplies; a Registered Training Organization for Aboriginal Health Worker training (KAMSC School of Health Studies); the Regional Centre for Social and Emotional Wellbeing and Health Promotion Unit; and computer systems support/Information Technology. The cooperative strategy has been a highly successful one for Aboriginal people in the Kimberley. The success is measured by the expansion of Aboriginal Community Controlled Health Services in the region and the provision of improved access to quality primary health care. It is also reflected in the number of successful central resources which have been developed as well as the significant impact on Aboriginal health policy (www.kamsc.org.au, retrieved August 20, 2006).

Research Partnerships

> Ever since Captain Cook landed, they have been turning us upside down and researching us to death. (Arnold "Puggy" Hunter, 1999)

There is a very understandable hesitancy towards research and White researchers. The word "*research*" itself is dirt to many Indigenous people (Smith, 1991, quoted in Fielder et al., 2000). Hunter (1997) has described the progression of Indigenous research in Australia from the 1950s, where Aboriginal people were viewed with fascination as "*alien,*" to the observation-based approaches of the 1960s, speculation in the 1970s from a social disadvantage "*rejected*" frame of reference, to the emergence in the 1980s of "*consultation,*"[8] which later became collaboration in a culturally informed manner. In practice, however, it has not always been a smooth ride to achieve meaningful consultation and collaboration. As Fielder, Roberts and Abdullah noted (cited in Dudgeon, 2000: 351), of the modern non-Indigenous researchers *"Being ethically well intentioned does not necessarily mean being ethically well informed or working ethically in an indigenous context."*

A poignant example of this was presented to the visiting research team for the Western Australian Premier's Cabinet *Gordon Inquiry into Family*

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8   See NHMRC (2003), Guidelines for ethical research with Aboriginal peoples.

Violence in Aboriginal Communities (2002), by the KAMSC Moving Stories team in 2002. Moving stories is a project that uses playback theatre for cultural action in Kimberley communities. The team of actors and musicians illustrated locally felt anger regarding the Inquiry's consultative process; the "gardia" planes flying over and landing like "seagulls," the asking of highly sensitive questions in a too short a period of time given the complexity of the issue; the nodding of heads and acquiescence of local people (to move them along), and the possibility for this type of superficially gathered information to only scratch at the surface of the issue. The scenario depicted the two separate worlds of the researcher and the researched, and the differing perceptions and perplexities — little changed by the experience each has of the other. Sue Gordon, the Indigenous Magistrate heading the Inquiry (who was genuinely bound by pressing financial and time constraints), later used the symbolism of the "seagulls" to represent Government responses to social issues in Aboriginal communities.

The compromise, as defined by the late KAMSC Chairperson Arnold "Puggy" Hunter (1997) was to be *"not just participants in research,"* rather *"we are in charge."* This led to the development of a process of research partnerships, where clear collaborative processes were established at the outset with all stakeholders represented, and memorandums of understanding that clearly defined the equal sharing of information, repository of data and intellectual property issues addressed.

The research partnership established for the *Kimberley True Words Real Life* (KTWRL) research project involved the concrete application of what are often abstract ethical issues (Fielder et al., 2000). The translation of what looked so good on paper to everyday working reality was at times naturally tested. To give a brief example: shortly following the completion of the data collection the research partners were invited to present at a State conference. An abstract was written by the non-Aboriginal researcher, with her name appearing first and the Aboriginal project co-ordinators second. As a genuine misunderstanding of name protocols in research, the Aboriginal project co-ordinator, when reading the abstract, placed her name first. The researcher was distressed, feeling that her writing was being appropriated; the project co-ordinator was incensed, reacting to familiar professional non-Aboriginal ownership practices. This incident was painful for both parties, who having had a good working relationship suddenly felt equally fearful of the other's intentions. However, it did cause some useful self reflection on decolonizing research practices and the application of research partnerships where both

parties felt a tremendous investment in the work. It also illustrated (usefully, considering the underpinning theoretical conceptions of transgenerational trauma), how salient long-existing and entrenched feelings of exploitation and oppression are in non-Indigenous–Indigenous relations, particularly in the research field.

KIMBERLEY TRUE WORDS REAL LIFE RESEARCH PROJECT

As noted in the background sections, transgenerational trauma and the chronic trauma exposure many Aboriginal youth experience, became the conceptual framework through which the disproportionately high rates of poor social and emotional well being factors were understood. Without supporting data it was difficult to make this contention to the wider Australian society, which held implications for social policy making and project funding. There was a clearly identified need to quantify what made day-to-day sense; the actual rates of trauma exposure, the prevalence of post traumatic stress disorder (PTSD), how this related to suicide and other comorbidity factors, and what well being factors were protective for Aboriginal youth in the Kimberley region.

The collaborative research process drew on the health knowledge held by KAMSC senior Aboriginal health workers, health professionals, their families and the wider community. There was a paucity of psychometrically validated tests, and these were developed through focus groups from existing gold standards in psychological measurement. This required extensive review, and only those that presented sound face validity were accepted and later reworded into locally used youth language, that would be instantly recognizable to the participants. The final questionnaire booklet included measures of psychological well being; self esteem, hopelessness, coping skills, identity, anger and shame, and psychopathology; direct and secondary trauma exposure, post traumatic stress disorder (PTSD), suicidal ideation, depression, anxiety, alcohol and drug misuse. An abstract response scale, or a series of "bullseyes" that was appealing to the youth were designed by Brendan Cox of KAMSC. Following each item, the bullseyes visually represented an increasing strength of agreement with the statement (Hunter, 1993).

Funding was obtained in early 2001 (Healthways Western Australia) and, with additional funding contributed by KAMSC, the research team was formed, including two Aboriginal research assistants who administered the

questionnaire regionally (Comalie Manolis and Mark Pariman). The rapport that the research assistants established with participants across school and community settings was reflected in the honesty of reporting. Several youth commented that they had never before confided such personal information, and that they felt they could trust the questionnaire and the process.

Youth that were identified through their responses in the questionnaire booklet as being at risk of self harm through suicide, or that had reported sexual abuse were later assessed by the research team using a brief suicide risk assessment (with additional inquiries relating to sexual abuse where needed). Approximately 150 of the Aboriginal youth (46%) and 100 of the non-Aboriginal youth (35%) were seen during the post testing procedures. In most cases it was clarified that the youth had experienced suicidal thoughts, but had adequate protective mechanisms to safeguard against suicide attempt. In other cases, where there was ongoing concern, the person was referred onto an appropriate local service. Cases of sexual abuse were treated on a case-by-case basis. In the majority of cases the sexual abuse was not current, and had been addressed. Referrals were made if the person needed further counselling. There were few cases where the sexual abuse was current, and assistance was given with the aim of referring onto local services that would be better able to maintain support.

All participants were given a "show bag" of mental health promotional material, which included contact details for local services and 24-hour crisis lines. A trial of the questionnaire and research process was conducted in house with youth aged children of KAMSC employees, followed by a pilot study in a remote community. Minor changes to the questionnaire were made on the advice of female Elders from the remote community. Wide-scale administration across the Kimberley region followed over April to August 2001, including participants from secondary schools, community services and Aboriginal organizations at six main towns and two remote communities.

KTWRL Research Project at a Glance

In the Kimberley region, 747 people took part, comprising 327 Aboriginal adolescents (12–18 years), 40 Aboriginal young adults (19–25 years), 77 Aboriginal adults (26+ years), and 283 non-Aboriginal adolescents.

The Aboriginal adolescents consistently reported poorer psychological well being than the non-Aboriginal adolescents, with lower self-esteem, a greater sense of hopelessness, increased use of maladaptive coping skills and a greater intensity of anger and shame feelings.

In comparison to the non-Aboriginal adolescents, the Aboriginal adolescents consistently reported increased exposure to both direct and secondary trauma. The Aboriginal adolescents were four time more likely to report that a family member had completed suicide (29% vs. 8%), and twice as likely to report involvement in mob fighting where they had been hurt (19% vs. 8%), witnessing family violence (64% vs. 48%) and to have been in a car with an adult drink driver (26% vs. 16%).

Variations in the prevalence of previous suicide attempts were found amongst the adolescents, with 28 (10%) of the Aboriginal adolescents (some as young as 12 years), and 17 (7%) of the non-Aboriginal adolescents reporting a previous suicide attempt. Low reporting of child sexual abuse was noted for both the Aboriginal and non-Aboriginal adolescents, at 5% and 7% respectively. These percentages were thought to be decreased due to barriers in reporting, namely shame and fear of the consequence of disclosure. For the Aboriginal adolescents this was highlighted by their increased use of the "Don't Want to Say" response option that was provided with these items.

The Aboriginal adolescents also reported increased levels of psychopathology symptoms, including suicidal ideation and depression. In relation to PTSD similar symptom levels were observed between the Aboriginal and non-Aboriginal adolescents. However, differences were apparent in the manner of reporting across the PTSD symptom items. The primary features of PTSD include initial exposure to a traumatic event/s, with the subsequent development of three symptom clusters; re-experiencing of the trauma, avoidance behaviour and psychological numbing, and hyper arousal/vigilance (Donnelly and Amaya-Jackson, 2002). The 4th edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 2000) recognizes the three symptom cluster as Criterion B, C and D. In the current research the Aboriginal adolescents reported with a greater frequency and intensity on the Criterion C items relating to avoidance and psychological numbing. The overall prevalence of the Aboriginal participants meeting these criteria for a diagnosis of PTSD by self-report was found at 14% for the adolescents, 16% for young adults and 21% for adults.

Gender differences were observed, with the female Aboriginal adolescents reporting significantly greater levels of secondary trauma exposure than male Aboriginal adolescents, and increased symptom severity for PTSD, suicidal ideation, depression and anxiety. This trend was also observed amongst the non-Aboriginal adolescents, with a small cluster of female girls reporting

markedly higher PTSD scores than the males, which overall minimized the differences between the two identity groups on this variable.

Preliminary multiple regression analysis of the Aboriginal youth's responses (12–25 years) found that PTSD is predicted by levels of *secondary* trauma exposure and suicidal ideation. Further, suicidal ideation and a previous suicide attempt are predicted by levels of *direct* trauma exposure and PTSD. Both PTSD symptoms and suicidal ideation were influenced by well being factors, with PTSD related to coping skills and anger, and suicidal ideation related to both of these and hopelessness.

In a combined multiple regression model, with all of the psychopathology and well being variables thrown in the mix, there was an overwhelming trend amongst the Aboriginal youth for PTSD to be influenced by secondary trauma exposure; suicidal ideation; emotion-focussed, maladaptive, coping skills; and anger. Suicidal ideation and a previous suicide attempt were influenced by direct trauma exposure and PTSD (to the exclusion of all of the well being variables).

This pathway, recognizing trauma exposure and PTSD as causal factors for suicidal ideation and attempts, was an important distinction with repercussions in the Kimberley. The prevailing thought, prior to these findings, was that depression was the natural precedent to suicide, as is observed in western psychology. The plain-language report of the findings from the KTWRL research project was widely disseminated across the Kimberley in 2003, and was well received. A shift in thinking was seen, with service providers (mental health, education, justice) starting to talk in terms of trauma, and understanding social conditions in the context of transgenerational trauma. This was part of a wider shift in understanding, with several Indigenous leaders and academics at that time also speaking openly on the impact of historical trauma.[9]

From 1990–2000 completed suicides had been made almost exclusively by young Aboriginal men through hanging. The following five years saw the emergence of completed suicides amongst young Aboriginal women, also by hanging. In the administration of the KTWRL questionnaire it was noted that the Aboriginal youth rarely trusted or confided in anyone. Sharing emotional issues and creating a supportive network is commonly recognized as a protective factor for young women. The emergence of the young female Aboriginal suicides was also in the wake of regional child sexual abuse awareness and discussions that had led to proactive child sexual abuse prevention

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9   See National Press Club speech by Mick Dodson, 2003; publication of "Trauma Trails" by Judy
      Atkinson in 2002.

promotions, training and programs. It became increasingly evident to staff of the Regional Centre for Social and Emotional Well Being that the suicides were more often than not interrelated with child sexual abuse, and that the protective support networks were overburdened, with a collective experience of emotional pain reverberating across individuals, families, friends and communities. This proved fatal when combined with the young women's shift from non-fatal suicide attempts (e.g., pills, cutting) to hanging.

THE KIMBERLEY CHILD SEXUAL ABUSE PREVENTION MOVEMENT

In early 2002, a young Aboriginal woman approached the Regional Centre for Social and Emotional Well Being with the request to "*do something*" about the alarming level of child sexual abuse in her community. The RCSEWB asked another KAMSC staff member (originally from that community) for cultural guidance. We were instructed to talk with female Elders from the community, and an informal yet confidential meeting was held. The institutionalization of the abuse was discussed, where it was known that adults were abusing adolescents and children, and in turn the youth were abusing young children. These were difficult conversations, but the Elders advised that a bush meeting for all women to discuss these realities in a safe and open manner was needed. Staff in the RCSEWB were aware of the risks involved in "opening this can of worms" and also sought organizational support and direction from the KAMSC Chairperson.

Approximately 80 women and numerous children from four remote communities and outstations attended the bush meeting. The meeting had not been publicly advertised, relying on the strength of the "bush telegraph" to draw together the appropriate women. For administrative purposes the subject matter of the meeting was referred to as "Women's Business," yet all of the gathered women knew that the core issue for discussion was child sexual abuse, and many stated this as their reason for attending. Over four days the issue of child sexual abuse was discussed. This was often painful, as the discussion was shaped by the stories the women told of the impact sexual abuse had had in their families and their lives. The women were angry, not only about child sexual abuse, but also family violence and the general disempowerment of women in their communities. At times there was denial, with one community maintaining that abuse didn't happen there, but in "other communities." This was counteracted by the dynamic of the healing circle

that the women at the meeting had formed, with one woman eventually talking of sexual abuse within the community that was denying it occurred there. At one point the women asked the most senior female Elder from that area if child sexual abuse had ever been found in traditional practice (as this had recently been successfully argued in court leading to the acquittal of an alleged perpetrator). This most respected woman emphatically stated that *"Child Sexual Abuse is Not A Part of Our Culture,"* and this became the slogan for the child sexual abuse prevention movement in the Kimberley. The meeting ended with the women forming the Peninsula Women's Group — *Oorang Arl Arl Jugarda Bowra*, with the determination to stop child sexual abuse in their communities.

These women, empowered through the telling and sharing of their stories, led a powerful movement that saw over the following three years: Bush Meetings held annually, the development and publication of child sexual abuse prevention posters and pamphlets; improved relations with government and non-government agencies leading to better interagency responses, public marches against child sexual abuse in remote communities; a public forum in the Kimberley's central town, increased access to training in child sexual abuse prevention and counselling, the establishment of a regionally incorporated body, the writing and performance of songs about their plights as women, and most importantly — a marked increase in the number of child, adolescent and adult disclosures of child sexual abuse/assault.

For staff at the Regional Centre for Social and Emotional Well Being, the increase in disclosures highlighted the massive need for appropriate training and resources across all levels of the community. As was noted by one clinic staff member "You opened this can of worms and now *we* have to deal with it." This lead to the vision of the "We're Not Gammin" sexual assault and child sexual abuse resources as a holistic package including prevention, intervention and critical response resources for the whole of the community.

- Prevention *"Community Way"*: adaptation of the Western Australia Protective Behaviours Program as a series of children's books in a simple visual format accessible to children and adults alike. The focus was on the empowerment of the child and the whole family, who have the role of reinforcing the rights of the child, being the *"first stop"* for receiving disclosures, and are best placed for detecting child abuse. It was hoped that the Education Department would adopt the formal training, and conduct through early childhood and school systems.

- Intervention "*Community Way*"; a child sexual abuse prevention training package for parents, families and Aboriginal workers in all fields. Using plain language, with visual descriptions and prompts that can then be delivered informally in any community setting.

    The two components of the "*Community Way*" resources have been widely distributed across the Kimberley, in conjunction with training in the use of the resources, as well as being distributed to a wide range of organizations outside the Kimberley region in response to high demand.

- Direct Intervention Response: the KAMSC Sexual Assault and Child Sexual Abuse Policy and Procedures Manual, containing guides with step-by-step instructions for health workers, nurses and doctors on gathering forensic information and providing the best possible response presentations of sexual abuse.[10] The focus of this package is on the collection and secure storage of forensic evidence in remote areas, so all clinic staff, families and communities would feel confident in responding to these critical incidents. This component is in the final stages of production.

- Community Awareness and Acknowledgement; as discussed earlier through the continued use of bush meetings to raise the topic, generating awareness, action and healing for families of the abused and the perpetrator. The solutions exist in each community, and the movement need only be supported for positive changes to occur.

SUMMARY

Child sexual abuse is the core social and emotional well being issue impacting on Aboriginal communities. Government and non-government organizations must support the work and resources needed to address this issue. The resources and commitment needed are immense, as individual, family and community healing is required. Transgenerational trauma is very real, and is observed through these symptoms of violence, sexual abuse and suicide. The young Aboriginal woman who first approached the KAMSC Regional Centre for Social and Emotional Well Being, starting the entire child sexual abuse prevention movement across the Kimberley, committed suicide. The response had been too slow. Again, transgenerational trauma is very real, and without societal and political change will continue in perpetuity.

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10   Drawing on the specialist knowledge contained in the *Sexual Assault Referral Centre Manual*, Perth, Western Australia

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