The Violence Continuum:  
Australian Aboriginal male violence  
and generational post-traumatic stress

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Declaration

I declare that this thesis is my own work and does not incorporate, without acknowledgement, any material previously submitted for a degree in any University or other educational institution. Nor does it contain, to the best of my knowledge and belief, any material previously published or written by another person except where proper reference is made in the text.

The views expressed in this report are not necessarily those of the Justice and Correctional Services Departments who approved this research project.

C L Atkinson 2008
Dedication

I dedicate this thesis both to my husband Dave, whose support through the journey of this PhD has been inspiring, and to my brothers, the Aboriginal men, who shared with me their life Stories. Thank you; I feel honoured and privileged.
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Abstract

This research explores the contention that the history of widespread traumatic stressors and the generational transmission of these traumatic stressors throughout the Australian Aboriginal population are manifested in a series of social problems. The high levels of violence we are now witnessing in some Aboriginal families and communities, which in turn contribute to the high incarceration rates of Aboriginal men for violent crimes, are seen as one of the most serious symptoms resulting from these traumatic stressors. This research aimed to establish if Aboriginal men who are considered violent have histories of traumatic stressors and demonstrate psychological symptoms associated with trauma stress, as well as whether they have experienced generational patterns of traumatic stressors and dysfunction.

Using a cross-cultural, multi-methodological, and multi-method Indigenist approach, this research developed a cross-cultural instrument, capable of measuring traumatic stressors and trauma-related symptoms relevant to Australian Aboriginal peoples. This was then employed to investigate the relationship between violence and generational post-traumatic stress among 58 Aboriginal males who had been incarcerated for committing violent crimes.

The cross-cultural instrument, titled the ‘Australian Aboriginal Version of the Harvard Trauma Questionnaire’ (AAVHTQ), was developed in the first phase of the research. This was achieved through documenting trauma symptoms, as defined by the DSM-III-R for post-traumatic stress disorder (PTSD) including identifying specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples, by extracting key themes through thematic analysis of major seminal reports and focus group discussions with key informants. The AAVHTQ was then field tested on 58 Aboriginal men incarcerated for committing violent crimes to establish if the research participants met the clinical criteria for PTSD, and to investigate the nature, level of exposure and frequency of traumatic stressors experienced and to identify the prevalence of specific types of trauma symptoms. Additionally, the research explored patterns of generational trauma and violence through the construction of geno-histograms obtained through semi-structured, in-depth interviews, which allowed detection of changes in the rates of traumatic stressors and dysfunctional behaviours between the current and older generations.

The research found that over half (58.6%) of the study population were PTSD symptomatic (according to the AAVHTQ) and that the majority had been exposed to a
significantly high number of traumatic stressors. The more traumatic stressors endorsed, or the more cumulative the amount of traumatic exposure, the more likely the participants were PTSD symptomatic. Research participants who endorsed traumatic stressors associated with low formal and informal social support and/or a lack of personal and social identity, and who had been sexually abused and/or suffered from symptoms associated with precarious mental health, low self-esteem and social isolation were significantly more likely to be PTSD symptomatic and appeared to resort to violence to release their trauma.

Qualitative and quantitative data highlighted the endemic nature and normalisation of family violence, grief and loss, and alcohol and drug misuse as both symptoms of and causes of traumatic stressors. Traumatic stressors relating to institutional violence, fractured families, acculturation (colonisation) and racism were also identified as significant traumatic stressors through the qualitative results. Significant increases in traumatic stressors and dysfunctional behaviours were also established in the research participants’ current and older generational histograms, lending support for the notion of generational trauma and dysfunction.

These results suggest that the high rates of Aboriginal men being incarcerated for crimes of violence could be due to a history of widespread traumatic stressors that are being transmitted across the generations, and which will continue to increase across successive generations without effective intervention.

The results of this research have important implications for the development of targeted assessment and treatment for Aboriginal males who have been convicted of violent offences and providing a well-validated measure that would be useful in assessing the success of such interventions, as well as for potentially addressing issues of violence across Aboriginal families and communities throughout Australia.
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List of definitions, terms and statistical symbols

Aboriginal/Aboriginality — The definition used by the Commonwealth Government is ‘... a person of Aboriginal or Torres Strait Island descent who identifies and is accepted as such by the community with which he or she is associated’ (Australian Institute of Health and Welfare, 2003). The term Aboriginal ‘peoples’ will be used throughout this research to reflect the diversity of groups that this term represents and to maintain standardisation with the Aboriginal and Torres Strait Islander Commission’s preference for this term. The term ‘Indigenous’ will also be used interchangeably with ‘Aboriginal’ throughout the thesis. Where the word ‘Aboriginal’ appears in this thesis, it should be taken to include Torres Strait Islanders unless explicitly stated or inferred to the contrary.

Acculturation — is the psychological and social counterpart of cultural diffusion. Originally, ‘acculturation’ referred to the colonial racist idea that so-called ‘savages’ and ‘lower peoples’ experience mental evolution when they imitate so-called ‘civilised’ or ‘higher peoples’ (Powell, 1883).

Balanda — the word ‘Balanda’ derives from the Macassan word meaning ‘Hollander’ and has become an Aboriginal word to denote non-Aboriginal people in the ‘Top End’ of the Northern Territory (Trudgen, 2000).

Colonisation — the policy of acquiring and maintaining colonies for exploitation. There are generally three levels of colonisation: physical violence, structural or institutional violence, and psychosocial dominance (Atkinson, 2002; Baker, 1983).

Communities — bodies of Indigenous people living in an urban setting, a remote mainland settlement, or on an island.

Complex PTSD — complex PTSD (sometimes called ‘disorder of extreme stresses) is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse (Herman, 1992).

Cultural idioms of distress reactions — the language used to express specific stress reactions evident in a particular cultural group

Cultural imperialism — is the practice of promoting, distinguishing, separating, or artificially injecting the culture or language of one nation into another. It is usually the case that the former is a large, economically or militarily powerful nation, and the latter is
a smaller, less affluent one. Cultural imperialism can take the form of an active, formal policy or a general attitude. The term is usually used in a pejorative sense, usually in conjunction with a call to reject foreign influence (Tomlinson, 1991).

**Dysfunctional**—‘dys’ means painful or difficult, and ‘dysfunctional’ is used to refer to individuals, families and communities unable to function because of pain and social disarray (Collins English Dictionary, 2007).

**Family violence**—family violence is the preferred term used to describe ‘the matrix of aggressive behaviours which centre around family relationships … and (because) … ‘domestic violence’ … was seen as a non-Aboriginal construct’ (Blagg et al., 2000, p. 2). The concept of family violence ‘embodies a narrative about the collective suffering of a people, rather than being simply a term defining a discrete social problem or a specific set of power relationships’ (Blagg et al., 2000, pp. 2–3). Family violence encapsulates not only the extended nature of Indigenous families, but also the context of a range of violence forms occurring frequently between kinspeople in Indigenous communities (Memmott, Stacy, Chambers, & Keys, 2001). Perpetrators and victims of family violence can include parents, uncles, aunties, (step) children, (step) siblings, cousins, grandparents, in-laws and distant relatives. An individual can be a perpetrator and a victim at the same time in a family situation (Memmott et al., 2001). Mow’s definition of family violence is one that is still referred to in the contemporary literature:

> Family violence or interpersonal violence is expressed in a variety of ways, including: the beating of a wife or other family members, homicide, suicide and other self-inflicted injury, rape, child abuse, child sexual abuse, incest and the sale of younger family members for misuse by others as a way of obtaining funds for drink or gambling (Mow, 1992, p. 10).

Family violence not only includes serious physical injury alone but also verbal harassment, psychological and emotional abuse, and economic deprivation (cultural and spiritual), which although as devastating, are even more difficult to quantify than physical abuse (Mow, 1992, p. 10). Family violence includes inter-generational violence and abuse and recognises all victims, whether they are affected directly or indirectly.

**Generational trauma**—encompasses both inter- and trans-generational trauma definitions.
Historic trauma — refers to the collective emotional and psychological injury, both over the life span, and across generations, resulting from a cataclysmic history of genocide or forced subjugation in colonial conquest (Muid, 2006).

Imperialism — the policy or practice of extending a country’s influence over other territories and people by conquest, colonisation or economic domination (Collins English Dictionary, 2007).

Inter-generational trauma — the prefix ‘inter’ means ‘to place’, ‘bury’ and/or ‘between’, or ‘among’. Inter-generational trauma is trauma passed from one generation to the next, in the context of social learning or modelling from parental behaviour that is based on traumatic experiences. Inter-generational trauma is trauma transmitted across generations in a variety of ways: historical trauma, which includes the genocidal impacts of colonisation; kin group trauma, which includes the diseases and massacres of first contact, removals to reserves, and removals of children; extended family trauma, where the distresses of the other levels of trauma are now being articulated in homicides, domestic violence, rape, child physical and sexual abuse and neglect, and alcohol and drug abuse; and individual trauma, which includes suicides and suicide attempts, mental illness, and individual victimising experiences from the above (Atkinson, 1997).

Kindling phenomenon — the biology of trauma has one additional painful outcome for many victims, young and old. It is known as kindling and refers to a phenomenon in which small amounts of norepinephrine may produce an emergency response as intense as the original event to some other relatively minor event. It is like a bad case of ‘frayed nerves’. These post-trauma arousal states seem to result from permanent changes in the limbic system due to the continuous presence of norepinephrine in the brain during the original crisis. Kindling is painful because its easily induced state of intense arousal may be produced by small increments in norepinephrine associated with both pleasant and unpleasant events (Raymond & Flannery, 1999, p. 85).

Post-traumatic stress disorder (PTSD) — is described in the DSM-IV as ‘the development of characteristic symptoms following exposure to an extreme traumatic stressor’ (American Psychiatric Association, 1994, pp. 424-429).

Racism/institutional racism — defined by Pettman as ‘... an ideology and a whole set of social relations which are historically generated and materially based and which reinforce or deny rights and social interests. The particular structure of race power in
society locates everyone, those who are privileged, as well as those who are penalised, by their socially allocated race. Racism in this understanding is both a discourse-language, images and explanations [of] abhorrence and cultural difference and material relations between people who are socially constructed as different’ (1992, p. 56).

Institutional racism is held in the ideologies, policies, practices and procedures of societal institutions, and leads to the naturalising, normalising and depoliticising of discrimination and control of subjugated groups. Institutional racism operates differentially at a range of sites including health, education, employment, housing, law and decision-making processes, reflecting the values, belief attitudes and interests of the dominant culture and perpetuating the inequitable control and distribution of resources and access to services (McConnochie, Hollinsworth & Pettman, 1989; Pettman, 1992).

**Sorry business** — the ceremonial and psychological process and practice with which individuals and groups engage, while grieving after the death of an individual. Sorry business is central to ensuring the continuing life journey of the person who has died into other stages of that person’s spirit journeying (Aboriginal and Torres Strait Islanders Online — Message stick, last updated July, 2007).

**Statistical symbols**

*P* — **probability value** — a number that reflects the likelihood that statistical results have occurred by chance. Results with p values equal to or less than .05, .01 or .001 are labelled as statistically significant. It is also known as the ‘level of significance’.

*T* — **t-test** — the t-test is used to determine whether there is a significant difference between two sets of scores. The independent group’s t-test was used in this research to determine whether the difference between the means for two sets of scores is significant.

*χ²* — **chi-squared** — chi-square tests used in this research are for independent or relatedness, and apply to the analysis of the relationship between two categorical variables.

**Trans-generational trauma** — the prefix ‘trans’ is from the Latin meaning ‘across or crossing’, ‘through’, ‘beyond’, ‘on the other side’, or ‘changing thoroughly’. Trans-
generational trauma is trauma transmitted across a number of generations, for example from a grandparent through to a grandchild (Atkinson, 2002).

**Trauma** — trauma represents ‘an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience which shattered the survivor’s sense of invulnerability to harm’ (Figley, 1985, p. xviii).

**Traumatic stressor** — a traumatic stressor is an event, or series of events, that may cause moderate to severe stress reactions.

**Trauma symptoms** — PTSD symptoms as defined by the DSM-III-R including specific cultural idioms of distress reactions evident in Australian Aboriginal peoples.

**Violent offender** — legal categorisation of a violent offender is usually based on offences against the person (as distinct from property offences) that are regarded as violent crimes. For the purpose of this study, a violent offender is one who has committed homicide, assault, sexual assault or theft, robbery and break and entry that involved violence against the person.
CHAPTER ONE

Introduction

The psychological impact of the experiences of dispossession, denigration and degradation are beyond description. They strike at the very core of our sense of being and identity ... throughout Aboriginal society in this country are seen what can only be described by anyone's measure as dysfunctional families and communities, whose relationships with each other are very often marked by anger, depression and despair, dissension and divisiveness. The effects are generational ... I recognized all the things that had happened to me through my grandparents, and their parents; their brothers and sisters who I had known as a child; through my mother and her siblings; through my cousins and my siblings. I recognized the things that happened to the thousands of other Aboriginal families like our family, and I marvelled that we weren't all stark, raving mad (O'Shane, 1995, pp. 151–3).
Chapter One: Introduction

Research issue

According to the National Prison Census (1996–2006), crimes of violence, including homicide, assault and sexual violence, are committed at proportionally higher rates by Aboriginal peoples in Australia, compared to non-Aboriginal peoples. A reduction in these rates has not been achieved during this period, with rates of assault in particular increasing steadily since 1996 (ABS, 2006). Additionally, re-imprisonment rates for violent crimes are proportionately higher for Aboriginal peoples compared to non-Aboriginal peoples, and these rates have increased steadily since 1996 (ABS, 2006).

The Ways forward report (Swan & Raphael, 1995), the Aboriginal and Torres Strait Islander women’s task force on violence report (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000), the Bringing them home report (Human Rights and Equal Opportunity Commission, 1997) and the Final report of the Royal Commission into Aboriginal deaths in custody (RCIADIC, 1991) all suggest that multiple losses and traumatisation (such as the colonisation process, being driven from home and land, having families and tribal communities broken up, and the forced separation of children from parents), ongoing discrimination and racism both at the social and structural levels, and deprivation and premature mortality have all contributed to a variety of chronic traumatisation symptoms, such as violence and family breakdown.

Furthermore, the generational transmission of traumatic stressors is considered to contribute towards the perpetuation of the cycle of violence evidenced in the crisis levels of family violence in Aboriginal communities and the high incarceration rates of Aboriginal peoples for violent crimes. The prevailing opinion in the recommendations from the four reports is that these problems need to be regarded as a form of post-traumatic stress disorder (PTSD). However there has been no comprehensive attempt to assess or investigate the consequences of repeated exposure to traumatic stressors in terms of post-trauma morbidity, such as PTSD, specifically in terms of addressing Aboriginal violent offending (Swan & Raphael, 1995).

Aims of the research

The primary purpose of the research is to explore the relationship between violence and generational post-traumatic stress in the context of Aboriginal males who have been convicted for violent crimes. A secondary purpose, which was developed in the
preliminary stages of the research and used for the primary purpose, was the development of a cross-cultural instrument called the 'Australian Aboriginal Version of the Harvard Trauma Questionnaire' (AAVHTQ). The AAVHTQ has the potential to measure traumatic stressors and trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions relevant to Australian Aboriginal peoples.

The primary objectives of the research are to:

1. Document trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples, for the purpose of developing the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ), a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples.

2. Establish if the study population in this particular research has been exposed to traumatic stressors and violent events for the purpose of determining the nature, level of exposure and frequency of traumatic stressors experienced by the study population.

3. Establish if the study population in this particular research suffer from symptoms associated with PTSD, as defined by the AAVHTQ, for the purpose of determining if the study population is PTSD symptomatic and which symptoms are more prevalent.

4. Establish if there are patterns of generational trauma and violence (dysfunctional behaviours) amongst the study population for the purpose of establishing if there are changes in the rates of traumatic stressors and dysfunctional behaviours across the generations.

Outline of chapters

Chapter Two provides a comprehensive overview of the literature in relation to traumatic stressors and violence in Aboriginal Australia, and explores the relationship between the two concepts. The chapter begins by providing an overview of the current statistics on violent crimes in relation to both victims and perpetrators, highlighting the levels of violence in Aboriginal communities. The underlying causes of violence are discussed, focusing on the multiple levels of trauma spanning many generations as a
result of colonisation and continuing acculturation. Aboriginal men’s specific experiences of trauma are presented.

The trauma concept is defined by exploring PTSD, complex PTSD, dysfunctional community syndrome and historical trauma. Historical trauma is explored in relation to the generational transmission of trauma in Aboriginal Australia. The generational transmission of violence and abuse is explored, including discussions examining violence as both a symptom and cause of trauma; trauma expressed as anger, violence and criminal behaviour; and the relationship between alcohol and other drugs to violence and trauma. The chapter concludes by exploring methodological considerations and limitations when applying a Western concept such as PTSD to Australian Aboriginals. It is argued that there is a need to develop or adapt an instrument that measures trauma in Australian Aboriginals by ensuring that the cultural concept of the person and the cultural idioms of distress reactions and its social construction of reality in relation to trauma are adequately addressed.

Chapter Three presents the research methodology that outlines an Indigenist research approach as its foundational basis, focusing on deep listening and privileging Indigenous voices as the central philosophy that guides the research process. The philosophical framework adopted in the research presents a triangulated mixed-method approach, incorporating both qualitative and quantitative techniques focusing on ‘Stories’ as the primary validation tool. The qualitative data contextualises and validates the quantitative data. The methods, procedures and analysis of the development of the AAVHTQ are detailed, along with the procedures for selecting the research participants and the ethical and legal clearances obtained. The measurement instruments are presented, including detailed research procedures. The chapter concludes with details associated with both the qualitative and quantitative data analysis and presentation.

Chapter Four presents the results of a documentary analysis exploring the specific cultural idioms of distress reactions and specific traumatic stressors evident in Australian Aboriginal peoples. The Bringing them home report: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families (Human Rights and Equal Opportunity Commission, 1997), the Final report of the Royal Commission into Aboriginal deaths in custody (RCIADIC, 1991) and the Aboriginal and Torres Strait Islander women’s task force on violence report (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000) are all thoroughly analysed and descriptive summaries are provided. The major themes from these three reports are extracted and presented in a matrix that lists traumatic stressors and specific cultural
idioms of distress reactions referred to as “characteristics of distress” evident in Australian Aboriginal peoples. The “characteristics of distress” are then matched against the DSM-III-R PTSD symptom cluster. This matrix provides the basis for the focus group discussion used in the development of the AAVHTQ.

Chapter Five presents the results of the focus group discussions with seven participants who had experienced violence and traumatic stressors, and who were professionals familiar with the culture, language and mores of Aboriginal society. The focus group discussions provided expert and experiential advice, guidance and knowledge that informed the development of the AAVHTQ and also addressed any concerns that focus group participants had with the research. The results from the focus group discussions involved merging the results from the documentary analysis with linguistic and semantic modifications provided by the Katherine Regional Language Centre (KRLC), Diwurrwurrwuru – Jaru (meaning letter-stick story). A matrix of results is provided, which includes all the processes that took place in the development of the final AAVHTQ.

Chapter Six presents the results of the quantitative and qualitative data analysis derived from semi-structured, in-depth interviews focusing on violence and trauma themes. The reliability and validity of the AAVHTQ is established in this chapter using both qualitative and quantitative techniques. The qualitative data is emphasised in this chapter through the use of ‘Stories’ as the primary validation tool and to provide a deeper understanding of the traumatic stressors and trauma symptoms endorsed in the AAVHTQ. The AAVHTQ was used to investigate the nature, level of exposure and frequency of the trauma/s experienced, and to establish if the research participants were suffering from trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reaction. Patterns of generational trauma and violence are explored through the construction of geno-histograms compiled through semi-structured, in-depth interviews, which allowed for the detection of changes in the rates of traumatic stressors and dysfunctional behaviours between the current and older generations. Finally, qualitative themes focusing on positive ways forward from the perspectives of the research participants are presented.

Chapter Seven discusses the results of the study in relation to the key findings. The cultural idioms of distress reactions and traumatic stressors that were identified through the documentary analysis and focus group discussions, and which were used to develop the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) and to assess the reliability and validity of this instrument, are discussed. The nature and
prevalence of traumatic stressors and traumatic symptoms relevant to the study population are discussed in relation to PTSD status. Patterns of generational trauma, violence and dysfunction, and potential ways forward from the perspective of the research participants (in terms of ‘breaking the cycle’ of violence and trauma) are presented. The limitations and strengths of the study, including potential directions for future research, are discussed. Finally, some potential implications of the research findings and some concluding remarks are presented.
I work with families where we can trace the trauma back five or six generations. The 1860’s, the generation of our great-grannies, was for some the generation of first contact, the massacre times, the poisoned water holes and stock whips and hobble chains. The 1890’s, the next generation saw the setting up and removal of people to reserves. The 1930’s to the 60’s the third generation, the period of assimilation, saw children forcibly taken from their families and placed in state run institutions. My generation have seen massive changes. And now there are my children and grandchildren. Through the generations we have seen too much violence, too much pain, too much trauma. In its multilayered context, it sits on us like a rash on the soul, and it stays in our families and communities to destroy us. This violence comes as forms of self abuse and abuse of others, as in alcohol and drug misuse, suicides and homicides, domestic violence and sexual assault (Atkinson, 1994, pp. 11–12).
Chapter Two: Literature review — trauma and violence in Aboriginal Australia

Introduction

This chapter examines the literature in relation to trauma and violence in Aboriginal Australia. The literature covering the nature and experience of trauma generally, and specifically the trauma that afflicts Australian Aboriginals, and in particular Aboriginal men, is examined with the view to determining how this trauma is measured, how it is inflicted and, in terms of inter-generational trauma, how it is transmitted. In doing so, the scale and types of violence afflicting Aboriginal communities, as well as the impact of the resulting contact with the criminal justice system, are examined.

Aboriginal people are over-represented as both victims and perpetrators of all forms of violent crime in Australia, particularly in regard to interpersonal violence or family violence (AIHW, 2007; SCRGSP, 2007). This chapter provides an overview of the current statistics highlighting the disproportionate occurrence of violence in Aboriginal communities, including victimisation rates for physical or threatened violence; hospitalisation rates for assault, in particular family violence-related assault; homicide; and substantiated child abuse and neglect data, all of which provide an indication of the extent of abuse. Data relating to the sexual assault of women and children is also provided, highlighting the disproportionate rate at which Aboriginal boys are raped compared to other Australian males. The reality of the over-representation of Aboriginal peoples, particularly men, who are imprisoned and reimprisoned for crimes of violence including homicide, assault and sexual assault is discussed in relation to trauma behaviours and the increased contact of Aboriginal peoples with the criminal justice system resulting from the processes of ongoing colonisation.

Although the link between Aboriginal violent offending and generational trauma has been mentioned in reports such as the RCIADC, the research to date has been insufficient to establish a link between the traumatising effects of colonisation and the high levels of violence being experienced by Aboriginal peoples. The concept of multiple originating causes of violence is introduced; however the chapter focuses on the underlying causes of violence, which are the deep historical circumstances of Indigenous peoples that make them vulnerable and lead to their enacting, or becoming the victim of, violent behaviour. The impact of colonisation on Aboriginal men is examined in the context of institutional removal and other post-colonial policies and how
these have led to a self-destructive cycle of loss of identity and purpose that fuels anger and trauma behaviours, such as acts of violence and alcohol and drug misuse.

Trauma is defined by presenting PTSD, complex PTSD, dysfunctional community syndrome and historical trauma as concepts worthy of consideration. Historical trauma is highlighted as particularly relevant to the Australian Aboriginal experience, with successive governmental policies inflicting new or renewed traumas on Aboriginal peoples. The transmission of violence and abuse is discussed in terms of suggesting that the traumatic experiences of the past can affect the behaviour of the current generation. Comparisons are made with the impact of colonisation on the indigenous populations of Canada, the USA and New Zealand in terms of trauma and violence.

Within the context of the discussion of trauma and violence, the transmission of violence and abuse across and down the generations of Australian Aboriginals is examined, specifically the impact on the development of those children who are subjected to trauma, as well as the normalisation of violence in some Aboriginal communities as a result of the exposure to constant high levels of violence. The literature suggests that violence is both a symptom and a cause of trauma, contributing to the anger and violence that leads to criminal behaviour. The relationship between alcohol and other drugs to violence and trauma is explored in detail. Finally, some potential methodological considerations are presented, including a discussion regarding the limitations, challenges and solutions to PTSD measurement instruments, emphasising the need to develop or adapt an instrument that genuinely measures trauma in Australian Aboriginals by ensuring the cultural concept of the person, and the cultural idioms of distress reactions and its social construction of reality in relation to trauma are addressed.

**Levels of violence**

Although the statistics are imperfect and difficult to determine due to under-reporting by victims, according to Memmott, Stacy, Chambers & Keys, ‘... they are sufficient to demonstrate the disproportionate occurrence of violence in the Indigenous communities of Australia and the traumatic impact on Indigenous people’ (2001, p. 6). Violence is perceived as a major problem in Indigenous communities by both non-Aboriginal and Aboriginal peoples, and is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole (Al-Yaman, Doeland & Wallis, 2006; Memmott et al., 2001). According to Al-Yaman et al. (2006) and Memmott et al. (2001), it is apparent that the rates of violence are increasing and the types of violence are worsening in some Indigenous communities and regions.
In 1988, the Queensland Domestic Violence Task Force estimated that 90% of all Aboriginal families were affected by family violence (1988, p. 256). It is not unreasonable to suggest that this estimate is still relevant when looking at the various statistics available on violence in Aboriginal communities. Indigenous Australians are over-represented as victims of all forms of violent crime in Australia, and these rates are likely to be an underestimate of the true level of violence experienced by Indigenous peoples (AIHW, 2007; SCRGSP, 2007).

In 2002, one quarter of Indigenous people reported that they had been a victim of physical or threatened violence in the previous 12 months, nearly double the rate reported in 1994 (13%). The levels of reported victimisation were higher among young people, with young men aged 15–24 years having the highest levels of reported victimisation (36%). After adjusting for age differences between the Indigenous and non-Indigenous populations, comparisons from the ABS General Social Survey indicate that Indigenous people aged 18 years or over experienced double the victimisation rate of non-Indigenous people (ABS, 2005, p. 15).

In 2004–05, Indigenous people were hospitalised for assault at 17 times the rate of non-Indigenous people (SCRGSP, 2007, p. 20). Indigenous females were 44 times as likely to be hospitalised for assault as non-Indigenous females. From the available data, Indigenous people are more likely than non-Indigenous people to be victims of family violence-related assault (SCRGSP, 2007, p. 22). Aboriginal females and males were, respectively, 35 and 22 times as likely to be hospitalised due to family violence-related assaults as non-Aboriginal females and males (Al-Yaman et al., 2006, p. 32). One in two hospitalisations for assault (50%) for Aboriginal females was related to family violence, compared to one in five for males (Al-Yaman et al., 2006, p. 32). Most hospitalisations for family violence-related assault for females were a result of spouse or partner violence (82%), compared to 38% among males (Al-Yaman et al., 2006, p. 32).

Memmott et al. (2001, p. 8) suggested that the rate of death from interpersonal violence in Indigenous communities is 10.8 times higher than that of the non-Indigenous population. Of the 245 homicides in Australia in 2004–05, Aboriginal peoples accounted for 15% of homicide victims and 16% of homicide offenders (SCRGSP, 2007, p. 20). The homicide rate in the Indigenous population was 5 to 15 times the rate in the non-Aboriginal population in Queensland, Western Australia, South Australia and the Northern Territory between 2001 and 2005 (SCRGSP, 2007, p. 20). Overall, Aboriginal
peoples account for 14% of homicide victims, according to the 2004–05 National Homicide Monitoring Program (NHMP) annual report (Mouzos & Houliaras, 2006, p. 12). Over this period, Aboriginal men accounted for 13% and Aboriginal females 17% of homicide victims in Australia (Mouzos & Houliaras, 2006, p. 12). The Northern Territory, with the highest proportion of Indigenous inhabitants, also recorded the highest proportion of Indigenous homicide victims (Mouzos & Houliaras, 2006, p. 12). Almost three in five male homicide victims and all the female homicide victims in the Northern Territory were Indigenous (Mouzos & Houliaras, 2006, p. 12).

The substantiated child abuse and neglect data provides some indication of the extent of abuse, neglect and/or harm to children in the family environment although it is important to take into account the greater proportion of children and young people in Indigenous compared to non-Indigenous families. Nationally, the rates of Aboriginal children entering the child protection system are higher than the rates for other children (Trewin & Madden, 2005, p. 210). In 2003–04, the rate of Aboriginal children who were the subject of substantiated cases of child abuse and neglect was higher in all states and territories except Tasmania, and data were not available for New South Wales (Trewin & Madden, 2005, p. 210). In Victoria, the rate was nearly ten times higher; while in Western Australia and South Australia, the rate for Aboriginal children was eight times the rate of other children (Trewin & Madden, 2005, p. 210). The rate of substantiated child protection notifications for Aboriginal children has increased substantially in all jurisdictions except Western Australia since 1998–99 (AIHW, 2007, p. 3). In 2005–06, Aboriginal children were nearly four times as likely as other children to be the subject of a substantiation of abuse or neglect (SCRGSP, 2007, p. 20).

Sexual violence is also a major issue in some Aboriginal communities. Sexual assault of women and children is endemic and inter-generational in some Aboriginal communities, with the rate of child sexual abuse of Aboriginal children significantly greater than that of non-Aboriginal children (Gordon, Hallahan & Henry, 2002; Mouzos & Makkai, 2004; NSW Aboriginal Child Sexual Assault Taskforce, 2006). Memmott et al. (2001) reported that the sexual assault of very small children appears to be increasing in a number of communities. The sexual abuse of Aboriginal children increased in 2005 to 262 per 100,000 population; up from 179 per 100,000 population in 2004 (NSW Aboriginal Child Sexual Assault Taskforce, 2006). This represents a rate of child abuse double that of non-Aboriginals.

The sexual abuse of young Aboriginal women is taking place throughout Western Australia on a regular basis, yet is very rarely reported (Hope, 2001, p. 29). The
Aboriginal Justice Advisory Council’s report, *Speak out, speak strong* (2002), reported that approximately 70% of Aboriginal women in New South Wales prisons had been sexually assaulted as children and that more than 40% also reported being sexually assaulted as adults. The Gordon report cited a Queensland study reporting that 55% of the 400 women surveyed had an unwanted sexual experience before they were 16 years old (Gordon et al., 2002, p. 42). Data collected by New South Wales Government agencies show that Aboriginal females are almost two and half times more likely to be victims of child sexual assault than non-Aboriginal females, and these statistics are most likely under-reported due to the shame attached to the assaults (NSW Aboriginal Child Sexual Assault Taskforce, 2006, p. 4). The Aboriginal and Torres Strait Islander women’s task force on violence report (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000) suggests that 88% of rapes in Indigenous communities go unreported.

Although the rate of sexual offending against Aboriginal girls is much higher than for either non-Aboriginal girls or Aboriginal or non-Aboriginal boys (Gordon et al., 2002), the Aboriginal and Torres Strait Islander women’s task force on violence report indicated that:

*The sexual abuse of young males is increasing, and remains largely unreported, because of the hidden nature of male to male sexual attackers and the shame that is often expressed by victims* (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. xv).

It has been reported that Aboriginal boys are ten times more likely to be raped than other Australian males (AAP in SMH, 2006). The shame attached to sexual assault and the reluctance of Aboriginal communities to engage with government agencies suggest that the real rate of sexual assaults in some Aboriginal communities would be much higher.

Indigenous Australians are also over-represented as perpetrators of all forms of violent crime in Australia (SCRGSP, 2007). The Royal Commission into Aboriginal deaths in custody (RCIADC) found that 53% of the men and women who died in custody were in jail because of violent crime: 9% for homicide, 12% for crimes of serious assault, and 32% for crimes of sexual violence (RCIADC, 1991). Despite a reduction in Indigenous deaths in custody since the peak in 1997, in 2004 six of the seven Australian Aboriginals who died in prison had been convicted of violent offences (Judo & Veld, 2005).
However, although the RCIADC (1991) made 339 recommendations, there were no specific recommendations around the needs of Aboriginal violent offenders.

The RCIADC stated that a priority was to reduce the incidence of Aboriginal involvement within the custodial system (1991). However the rate of Indigenous imprisonment remains very high. Indigenous imprisonment rates increased by 32% between 2000 and 2006 (SCRGSP, 2007, p. 23). Over this period, the imprisonment rate increased by 34% for Indigenous women and by 22% for Indigenous men (SCRGSP, 2007, p. 23). In 2006, Indigenous people were 13 times more likely than non-Indigenous people to be imprisoned (SCRGSP, 2007, p. 23).

More specifically, from 1996 to 2006, the rates of Indigenous compared to non-Indigenous prisoners who have been imprisoned where the most serious offence related to a crime of violence (specifically homicide, assaults and sexual offences) show a significant over-representation (Table 1). For example in 2006, Indigenous persons were 9.7 times more likely to be imprisoned for homicide, 45.3 times more likely to be imprisoned for assault and 13.3 times more likely to be imprisoned for sexual offences than non-indigenous persons (Table 1). The rate of Indigenous imprisonment has increased for homicide and assault (Table 1). Although there was a reduction in the rate of Indigenous imprisonment for sexual offences from 1996 to 2001, it has increased in 2006 (Table 1). The rate-ratio of Indigenous to non-Indigenous peoples who have been imprisoned where the most serious offence related to assault during this period also increased, but the rate-ratio for homicide and sexual offences has remained relatively stable, as shown in Table 1.

<table>
<thead>
<tr>
<th>Offence/charge</th>
<th>1996</th>
<th>2001</th>
<th>2006</th>
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<tbody>
<tr>
<td></td>
<td>Indigenous</td>
<td>Other</td>
<td>Rate-ratio</td>
</tr>
<tr>
<td>Homicide</td>
<td>93.6</td>
<td>9.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Assaults</td>
<td>303.7</td>
<td>9.8</td>
<td>31.1</td>
</tr>
<tr>
<td>Sexual offences</td>
<td>173.5</td>
<td>12.7</td>
<td>13.7</td>
</tr>
</tbody>
</table>


Additionally, the reimprisonment rates of Aboriginal compared to non-Aboriginal prisoners who have been charged with a crime of violence (specifically homicide, assault and sexual offences), over the period 1996 to 2006 show a significant over-representation (Table 2). For example in 2006, Indigenous persons were 16.6 times
more likely to be reimprisoned for homicide, 67.1 times more likely to be reimprisoned for assault and 29.2 times more likely to be reimprisoned for sexual offences than non-indigenous persons (Table 2). The rate of Aboriginal reimprisonment has increased for assault, but has stayed relatively stable for homicide (Table 2). Similar to imprisonment rates, there was a reduction in the rate of Aboriginal reimprisonment for sexual offences from 1996 to 2001, but an increase in 2006 (Table 2). The rate-ratio of reimprisonment for Aboriginal compared to non-Aboriginal peoples for assault during this period also increased, but the rate-ratio for homicide and sexual offences have remained relatively stable, as shown in Table 2.

| Table 2: Prior adult imprisonment under sentence rates for prisoners’ per 100,000 adult population, and rate-ratios, by most serious offence/charge and identity — Australia, for 30 June 1996, 2001 and 2006 |
|---|---|---|---|---|---|
| Offence/charge | Indigenous | Other | Rate-ratio | Indigenous | Other | Rate-ratio | Indigenous | Other | Rate-ratio |
| Homicide | 65.3 | 4.3 | 15.3 | 73.2 | 4.3 | 16.9 | 72.1 | 4.3 | 16.6 |
| Assaults | 236.3 | 5.4 | 43.5 | 265.7 | 4.8 | 55.4 | 372.0 | 5.5 | 67.1 |
| Sexual offences | 119.0 | 4.5 | 26.5 | 99.0 | 3.7 | 26.5 | 117.4 | 4.0 | 29.2 |


* Rate-Ratio indicates the propensity of Indigenous persons to be imprisoned compared to other persons.

Although both Aboriginal men and women are represented in the statistics in Table 1 and Table 2, it is Aboriginal men who have significantly higher imprisonment rates for homicide and assault, compared to Aboriginal women (Table 3). However, it should be noted that imprisonment rates for Aboriginal women for homicide and assault are on the increase and therefore the rate-ratio between Aboriginal men and women is decreasing (Table 3).

| Table 3: Rates of Indigenous prisoners per 100,000 adult population, and rate-ratios, by most serious offence/charge and gender — Australia, for 30 June 1996, 2001 and 2006 |
|---|---|---|---|---|---|
| Offence/charge | Male | Female | Rate-ratio | Male | Female | Rate-ratio | Male | Female | Rate-ratio |
| Homicide | 180.0 | 15.5 | 14.4 | 192.0 | 23.1 | 8.3 | 201.0 | 22.3 | 9.0 |
| Assaults | 596.8 | 28.3 | 21.1 | 645.4 | 48.5 | 13.3 | 901.8 | 76.9 | 11.7 |


* Rate-Ratio indicates the propensity of Indigenous males to be imprisoned compared to Indigenous females.

Reimprisonment rates for Aboriginal men compared to Aboriginal women are also significantly higher for homicide and assault (Table 4). Much the same as imprisonment rates, the reimprisonment rates for Aboriginal women for homicide and assault are on
the increase, and therefore the rate-ratio between Aboriginal men and women is decreasing (Table 4). A comparison of rates of imprisonment and reimprisonment for Aboriginal male and female prisoners with a most serious offence of sexual assault was not possible, as female rates are so small that they fall below the threshold for public release.

Table 4: Prior adult imprisonment under sentence rates for Indigenous prisoners’ per 100,000 adult population, and rate-ratios, by most serious offence/charge and gender — Australia, for 30 June 1996, 2001 and 2006

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<tbody>
<tr>
<td>Homicide</td>
<td>126.8</td>
<td>7.5</td>
<td>16.9</td>
<td>139.4</td>
<td>11.2</td>
<td>12.5</td>
<td>136.9</td>
<td>11.5</td>
<td>11.9</td>
</tr>
<tr>
<td>Assaults</td>
<td>468.2</td>
<td>18.3</td>
<td>25.5</td>
<td>518.7</td>
<td>29.1</td>
<td>17.8</td>
<td>718.1</td>
<td>47.9</td>
<td>15.0</td>
</tr>
</tbody>
</table>


* Rate-Ratio indicates the propensity of Indigenous males to be imprisoned compared to Indigenous females.

Regardless of the increase in imprisonment and reimprisonment rates for homicide and assault for Aboriginal women shown in Tables 3 and 4, it is Aboriginal men who have been, and continue to be, the main perpetrators of violence against women and children (Cunneen, 2002) and, subsequently, they are over-represented in all forms of violent crime. It is for this reason that the research will focus on the violent behaviours of Aboriginal men.

The RCIADC found that 43% of Aboriginal peoples who died in custody had been previously placed in institutions as children and had histories of physical, psychological and sexual abuse (RCIADC, 1991). More recent statistics indicate that there is a similar trend among Aboriginal peoples who reported being the victim of physical or threatened violence, with reported rates higher among those who had been removed from their natural families (38%, compared with 23% among those not removed), and among those who had experienced a high number of stressors (50% of those with 11 or more stressors, compared to 8% among those with none) (ABS, 2002).

The RCIADC report (1991) began to correlate a link between trauma behaviours, such as violence, and the ongoing colonising process. Preliminary links were made to theorise and explain over-representation in the custodial system as a direct result of the multiple generational traumas brought about by the colonising process and perpetuated by the unfair treatment of Aboriginal peoples in the criminal justice system (RCIADC, 1991). However the link between Aboriginal violent offending and generational trauma has not yet been established.
Underlying causes of violence

The literature supports the notion that there are multiple originating causes responsible for the levels of violence experienced by and from Aboriginal men (Al-Yaman et al., 2006; Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Hunter, 1994; Memmott et al., 2001; Milroy, 2005). Barbara Miller highlights a number of causal factors that may be responsible for Indigenous personal violence:

... socialisation, structural variables and parenting style factors such as compensatory machoism (an attitude that boys can develop in absent-father households); a view of the environment as sentencing due to discrimination; availability of aggressive models; learned helplessness and lack of perceived control over the environment; the development of aggressive habits and beliefs, poor self-esteem; psychological reactive and confrontational coping mechanisms, all contribute in varying ways to Aboriginal intercultural aggression and violence. Socialisation of Aboriginal children, in particular boys, in a colonised discriminatory environment has led to the above individual factors interacting with frustration and conflict to cause aggression and violence (Miller, 1990, p. 314).

Memmott et al. (2001) suggested that the causes of violent behaviours by Aboriginal men are best considered in three categories, based on whether they have precipitating, situational or underlying causes.

Precipitating causes are defined as one or more particular events that trigger a violent episode by a perpetrator (Memmott et al., 2001). This may be a social event that triggers violent behaviour, such as failure to pay a debt, or a situation that elicits jealousy or payback obligations (defined as paying someone back for a grievous act that they did to someone else). The trigger events may, on their own, not appear to warrant a violent reaction; however it is important to realise that it is the combined effect of a precipitating cause with both situational factors and underlying issues that leads to a bout of violence of some kind (Memmott et al., 2001).

The second category of potential causes of violent behaviours covers situational factors, which include poverty, disadvantage, and alcohol and drug abuse. The Aboriginal and Torres Strait Islander women's task force on violence (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000) reported that there is an association between violence in Indigenous communities and high unemployment,
poor health, low educational attainment and poverty. The literature also commonly draws an association between violence, including child sexual abuse, in Indigenous communities and alcohol and drug abuse (Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Fitzgerald, 2001; Gordon et al., 2002; Memmott et al., 2001; Northern Territory Government, 2007). Alcohol has been found to play a major role in violence in Aboriginal communities, with 65% of Indigenous homicides in the period 2002–03 involving both the victim and offender having consumed alcohol at the time of the offence — almost three times the rate for non-Indigenous homicides — and four out of five Indigenous homicides involving either the victim or the offender, or both, drinking at the time of the incident (SCRGSP, 2005, p. xii).

The third category identified by Memmott et al. (2001) as potential causes of the high levels of violence in some Indigenous communities is associated with underlying factors. The underlying factors are described by Memmott et al. as ‘... the deep historical circumstances of Indigenous people, which make them vulnerable, leading to their enacting, or becoming the victim, of violent behaviour’ (2001, p. 11).

Patterns of contemporary violence among Aboriginal people have their origins in the violent dispossession of land by Europeans in the early contact period. Ongoing cultural dispossession and its consequences, taking different forms over the past 200 years, have impacted on Indigenous people socially, economically, physically, psychologically and emotionally, to the point that, today, violence in some Aboriginal communities has reached epidemic proportions (Memmott et al., 2001, p.11).

Gordon et al. (2002) suggested that colonisation and continuing acculturation has resulted in unresolved grief that is associated with multiple levels of trauma spanning many generations. Some of the ‘layers of trauma’ include colonial aggression involving labour exploitation, denial of the most basic human rights, and the violent dispossession of land, which sometimes involved massacres, poisoning, rapes and ongoing racism (Gordon et al., 2002).

Later attempts at protecting Indigenous people through state and Commonwealth policies, such as the large-scale removal of children and enforced assimilation, only served to deepen the psychological trauma (Hunter, 1994). Enforced bans on practising Indigenous cultural beliefs, which resulted in a loss of culture, spirituality, language, relationships with land, and traditional law, resulted in a complete breakdown of social
structures (Hunter, 1994). To these stressors were added the traumas of the emotional, physical and sexual abuse often suffered in institutions and foster homes (Hunter, 1994). Policies that attempted to breed out Indigenous peoples, combined with policies designed to control every aspect of Indigenous life and the forced removal of children into white foster homes or institutions can only be seen as genocidal (Raphael, Swan, & Martinek, 1998).

The effects of the forced separation of children from their families is still ongoing, with Link-Up, an organisation dedicated to helping lost family members reunite, reporting that their oldest client ‘… is 107 years old and the youngest is still being born’ (Kendall, 1994).

Current welfare and social programs still result in the removal of children from families, yet fail to acknowledge that the often appalling conditions in which some Indigenous people live may be the result of the past and present trauma that have rendered family and the community powerless and dysfunctional (Raphael et al., 1998). An examination of the Stolen Generations allows the identification of the stressors they experienced, as well as the development of a framework from which to examine inter-generational trauma against the context of trauma suffered by wider Indigenous communities (Raphael et al., 1998).

Combined, all of these things have had disastrous impacts on the mental well-being of Indigenous peoples and societies, and have contributed towards a range of social problems in contemporary Aboriginal communities (Memmott et al., 2001; Raphael et al., 1998).

*The high incidence of violent crime in some Indigenous communities, particularly in remote and rural regions, is exacerbated by factors not present in the broader Australian Community … Dispossession, cultural fragmentation and marginalisation have contributed to the current crisis in which many Indigenous persons find themselves; high unemployment, poor health, low educational attainment and poverty have become endemic elements in Indigenous lives …* (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. ix).

The social problems that have developed as a result of the layers of trauma and violence are themselves also causes of violence.
High unemployment, low socio-economic status, poor housing and overcrowding, poor health, high mortality, poor governance in local communities, and a lack of support services are all likely to contribute to the higher levels of conflict and violence (Al-Yaman et al., 2006, p. 3–4).

The social problems contribute to compounding the high levels of stress experienced by many Aboriginal peoples. The National Aboriginal and Torres Strait Islander Social Survey suggests that, overall, 82% of Indigenous people had experienced at least one stressor in the last 12 months, identifying the most frequent stressors as death of a family member or close friend (46%), serious illness or disability (31%), and inability to get a job (27%) (ABS, 2002, p. 7). However, for those living in remote areas, the most frequently reported stressors, after death of a family member or close friend (55%), were overcrowding at home (42%), and alcohol and drug-related problems (37%) (ABS, 2002, p. 7). The Western Australian Aboriginal Child Health Survey found that the levels of extreme stress are four times higher in Aboriginal families compared with other households, and that the average Aboriginal family is confronted with seven major negative events every year (Zubrick et al., 2005). These events include death, arrest and incarceration, hospitalisation, alcohol abuse, extreme violence, and severe financial strains (Zubrick et al., 2005). Researchers also discovered that the average Aboriginal family had experienced seven of the 14 major life stresses they were questioned about in the previous year. Overcrowding was also identified as an area of concern that causes considerable social problems (Zubrick et al., 2005). The researchers suggest that 15% of children were living in overcrowded homes, and almost one in four came from ‘poorly functioning families’ (Zubrick et al., 2005). In 2004–05, Indigenous adults were five times more likely to live in overcrowded homes than other adults (AIHW, 2007, p. 2).

Similarities exist between indigenous populations in New Zealand, Canada, United States of America and Australia. In all of these countries, Indigenous people are over-represented in the family violence records as both victims and perpetrators, and experience high levels of stressors compared with non-indigenous people (Al-Yaman et al., 2006). In addition, in each country colonisation is recognised as having had a severe negative impact on Indigenous people and is thought to be a major underlying cause of the high rates of stress and violence in these communities (Al-Yaman et al., 2006).

Furthermore, there is some evidence that Aboriginal family violence is a learned behaviour: ‘it was learned by Aboriginal people from the initial aggression of white
occupation, and has since been transferred throughout the fabric of Aboriginal society over several generations of exposure to male dominated colonial and paternalistic administrations (Hazelhurst, 1994, pp. 21–22). Hazelhurst goes on to say that ‘children who learn self-abuse and family abuse behaviours from their parent’s generation will apply it quite early in their own lives’ (1994, p. 25).

Atkinson provides a useful summary of the multiple causes and explanations of family violence in Aboriginal communities that incorporates precipitating causes, situational factors and underlying factors.

When we mix a traditional dispute resolution tool of personal confrontation and controlled violence; learned patterns of behaviour from the early frontier violence and dispossession; conditions that are violence provoking; with the high level of alcohol consumed by people who are frustrated, angry and feel powerless, we have a mixture of high volatility. Combine this with disruption to gender relationships, and it is understandable that violence within the family in Aboriginal Australia is endemic and at crisis level (Atkinson, 1989, p. 6).

**Aboriginal men’s experience of trauma**

The disruption of gender relationships in Aboriginal Australia must be understood in the context of Aboriginal men’s historical and ongoing disempowerment, and the gradual chipping away of their individual and collective sense of self-worth by the state (Atkinson, 2002; Gale, 1978; Memmott, et al., 2001). The impact on males is particularly marked when institutional separation is added to the high rate of incarceration amongst Aboriginal males and the dysfunction caused by alcohol and substance abuse (Hunter, 1994).

Aboriginal men in particular have been profoundly demeaned by mainstream society in their ability to be worthy people individually, in a family capacity as a parent, and as a husband or as a functioning member of society (Hunter, 1994; Mellor & Haebich, 2002; Memmott et al., 2001). Men have been systematically dishonoured and viewed as worthless in the eyes of non-Aboriginal society and by some Aboriginal women (Hunter, 1994; Mellor & Haebich, 2002; Memmott et al., 2001). Many Aboriginal people were taught to look down on their own people and, in particular, to fear Aboriginal men (Mellor & Haebich, 2002). For example, an extract from an interview with Penny Everaadt that was included in the publication Many voices: Reflections on experiences of Indigenous child separation recalls:
... The Matron told us never to marry an Aboriginal man because you’d have nothing. They drink and everything and so you’d have nothing. So a lot in Cootamundra Girls Home were scared of meeting with Aboriginal people. Then when we saw an Aboriginal person in Cootamundra we used to stand back behind the shop round the corner laughing ... They tried to make us non-Aboriginal (Mellor & Haebich, 2002, p. 182).

Aboriginal men were systematically demeaned and diminished in their ability to provide for their families, as the laws and policies of the day rendered them ‘incapable’ and ‘neglectful’, based on ‘white’ ways of living (i.e., family home and husband as bread winner) (Mellor & Haebich, 2002). Fathers of children of ‘mixed descent’ were particularly vulnerable to having their children removed, as the parents were not considered to meet the criteria of being in ‘gainful employment’ or ‘conventional housing’.

... Women and children were often removed together, even where the male provider was known to be engaged in seasonal work (Mellor & Haebich, 2002, p. 151).

In many states Aboriginal parents had no right of appeal, as Indigenous children were automatically wards of the state unless a parent could prove otherwise (Mellor & Haebich, 2002). Letters of anguish from parents to have their children returned fell on deaf ears (Mellor & Haebich, 2002). The Native Administration Act 1936 in Western Australia encapsulated the official policy of the day: the ‘full-bloods’ would die out, while those of mixed descent would be ‘bred out’.

Legitimate children could be removed after the age of 14, but an illegitimate child, that is any child whose parents could not provide proof of marriage, could be removed at any age (Mellor & Haebich, 2002). This assumed a ‘white Christian marriage’ and disregarded the wife/husband union taken on under traditional cultural laws (Mellor & Haebich, 2002, p. 253). ‘Initially children were processed through courts as “neglected” but after the appearance of many well-dressed and cared for children, summary powers were granted to police in 1915, removing parents’ right of appeal’ (Mellor & Haebich, 2002, p. 254). The relentless efforts to ‘keep up appearances’ under white judgment took its toll on Aboriginal parents and further demeaned the man’s role in the family unit to protect his family and be respected for doing so. No matter what efforts were enacted, the goal posts were once again changed and feelings of powerlessness, hopelessness and despair encompassed Aboriginal families. This, combined with the
history of laws, acts and policies that took complete control of Indigenous lives, sometimes resulted in families becoming the self-fulfilling prophecies of the ‘neglectful parents’ (Hunter, 1994; Mellor & Haebich, 2002; Memmott et al., 2001).

The ongoing trauma of these experiences has impacted directly on the next generation through child rearing practices that fail to pass on cultural practices and knowledge, and that often include a lack of male role models (Hunter, 1994; Mellor & Haebich, 2002; Memmott et al., 2001; Milroy, 2005). These practices often lead to a sense of loss of identity, both in the community and in the individual, and are often closely linked to subsequent searches for family members by those taken from their communities early in life (Swan, 1988). The loss of such family attachments ‘may prevent these children from achieving their full potential, attaining cultural identity, developing a conscience, becoming self-reliant, coping with stress and frustration, and knowing the importance of family and relationships’ (Raphael et al., 1998, p. 333).

Memmott et al. (2001) suggest that feelings of powerlessness, helplessness, alienation and anger are common characteristics shared by many of the men who have died in custody. For some men, the only power they feel they have is that over young women, which expresses itself as physical, emotional and sexual violence (Atkinson, 1996). According to Martin (1988, p. 15), these are ‘disaffected, alienated, angry young men’, who are described as creating ‘tinderbox situations in remote communities’. Many Aboriginal men have lost self-respect and status. Gale states that:

\[ \text{The path now followed by so many of the men, from hotel to gaol, is but an inevitable consequence of their loss of status and purpose-society (Gale, 1978, p. 2).} \]

The historical dispossession of land and leadership has left men feeling they have few options:

\[ \ldots \text{anomie, poverty and the rigours of the struggle to survive, allow Aboriginal men to use force, arbitrarily, to inhibit and terrorise women, and to cast them as whipping posts for their frustrations (Langton, 1989, cited in Bolger, 1991, p. 53).} \]

The concept of underlying factors associated with the layers of trauma being a possible causative factor in the high incidence of violence in Indigenous communities, and the subsequent high incidence of incarceration of Indigenous peoples for violent crimes, was highlighted by Noritta Morseu-Diop in a paper titled You say you hear us, but are
you really listening or are we just noise in the distance? Noritta Morseu-Diop presented this paper at the ‘Best Practice Interventions in Correction for Indigenous People’ conference in Sydney in 2001 and stated:

There are many reasons for the high imprisonment rate of Indigenous people … One cannot ignore the impact and processes of colonisation and its devastating and intergenerational effect on the lives of Indigenous people throughout Australia today … the unresolved issues of trauma, loss and grief are in the centre of their lives and are the causes of the many other social issues and problems in the community. Whilst the many social issues/problems, such as family violence, crime/imprisonment, alcohol and drug abuse, suicide, low self-esteem, ill-health, self harming, etc., are in the periphery and are the symptoms (Morseu-Diop, 2001, pp. 2–3).

However, although the potential relationship between violence and violent offending as an expression of contemporary and inter-generational traumatic experiences has been identified by various authors, there does not appear to have been a systematic attempt to assess the nature of that trauma and the extent of traumatic disorders and generational patterns in our Indigenous men imprisoned specifically for violent crimes.

**Defining the trauma concept**

The concept of trauma and its manifestation in increased levels of interpersonal violence on self and others that are being witnessed in some Aboriginal communities is becoming increasingly prevalent in the literature of Australian Aboriginal peoples (Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Gordon et al., 2002; Memmott et al., 2001; Milroy, 2005; Swan and Raphael, 1995; Ralph, Hamaguchi & Cox, 2006; Raphael et al., 1998). Definitions of trauma have evolved over the years in various disciplines in an attempt to represent the concept in a way that more fully describes the complex nature of this disorder.

Earlier concepts of trauma have defined it as ‘any injury, wound or shock, most frequently physical or structural, but also mental in the form of an emotional shock, producing a disturbance, more or less enduring, of mental functions’ (Drever, 1969, p. 303). Figley defined psychological trauma as ‘an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor’s sense of invulnerability to harm’ (Figley, 1985, p. xviii). Basically trauma is a painful emotional experience, or shock, that creates substantial and often lasting damage to the psychological development and well-being of the individual.
Trauma is qualitatively different from negative stressors, and is a very personal experience:

Trauma permanently changes one’s personal construction of reality. Particularly after trauma is inflicted by another human being, people may begin to appear less benevolent, events less random, and living more encumbered … and trauma is qualitatively different from stress, though one might consider both to be anchor points on a nonlinear continuum of negative experiences. Negative stressors leave an individual feeling ‘put out’, inconvenienced and stressed. These experiences are eventually relieved with the resolution of the stressor. In contrast, trauma represents destruction of basic organising principles by which we come to know self, others and the environment; traumas wound deeply in a way that challenges the meaning of life. Healing from the wounds of such an experience requires a restitution of order and meaning in one’s life. The wounds of trauma wear many masks: anxiety, panic, depression, multiple personalities, paranoia, anger, and sleep problems; tendencies towards suicidality, irritability, mood swings and odd rituals; difficulty trusting people and difficult relationships; and general despair, aimlessness and hopelessness (Root, 1992, cited in Cameron, 1998, pp. 6–7).

The Diagnostic and Statistical Manual of Mental Disorders (IV) states that a traumatic stress reaction may occur when a:

… person [has] experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others — and the person’s response involved intense fear, helplessness or horror (American Psychiatric Association, 1994, pp. 424–429).

Such an event is generally referred to as a non-ordinary human experience that would be distressing to most people, such as serious harm or threat to self, spouse, children, close relatives or friends; witnessing a serious accident or violence against another person, who, as a result, is either killed or seriously injured; or having one’s home or community suddenly destroyed (American Psychiatric Association, 1994).

A classic trauma text Trauma and its wake (Figley, 1986) suggests that a traumatic stress reaction is the first indication of the presence of a trauma. This reaction occurs in
the initial wake of a traumatic stressor or catastrophe, and is like the initial wake created by casting a pebble into a pond.

Waves radiate across the surface of the pond from the point of contact, and under certain conditions there is some discernible impact along the shore of the pond. Trauma — the point of penetration — and its wake — the psychosocial repercussions — are normal reactions to extraordinary circumstances (Figley, 1986, p. xvii).

Post-traumatic stress disorder (PTSD) could be viewed as the destruction resulting from the waves initially created by the pebble landing in the pond. Most survivors of trauma return to normal, given time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD.

**Post-traumatic stress disorder**

Discussions of the effects of trauma on Australian Aboriginal peoples usually centre on post-traumatic stress disorder (PTSD) (Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Gordon et al., 2002; Memmott et al., 2001; Milroy, 2005; Ralph et al., 2006; Raphael et al., 1998; Swan and Raphael, 1995). PTSD is an anxiety disorder that can occur when an individual experiences or witnesses a traumatic event which that person finds highly stressful (American Psychiatric Association, 1994). Clinically, such events involve actual or threatened death, serious physical injury, or a threat to physical and/or psychological integrity, to a degree that the usual psychological defences are incapable of coping with the impact (American Psychiatric Association, 1994).

The presence of a PTSD response is influenced by the intensity of the experience, its duration, and the individual person involved (American Psychiatric Association, 1994).

*Events that are threatening to life or bodily integrity that produce traumatic stress in its victim are a normal, adaptive response of the mind and body to protect the individual by preparing him or her to respond to the threat by fighting or fleeing. If the fight or flight is successful, the traumatic stress will usually be released or dissipated allowing the victim to return to a normal level of functioning. PTSD develops when: flight or flight is not possible; the threat persists over a long period of time; and/or the threat is so extreme that the instinctive response of the victim is to freeze* (Rothschild, 1998, pp. 1–2).
The characteristic symptoms of PTSD fit into three basic clusters: the re-experiencing cluster, the avoidance/numbing cluster, and the hyper-arousal cluster (American Psychiatric Association, 1994). The first set of symptoms involves reliving the trauma in some way, such as through nightmares or flashbacks, and becoming upset when confronted with a traumatic reminder or thinking about the trauma whilst trying to do something else (American Psychiatric Association, 1994). The second set of symptoms involves either staying away from places or people that act as reminders of the trauma, emotional detachment by isolating oneself from other people, or emotional numbing (American Psychiatric Association, 1994). The third set of symptoms includes things such as experiencing trouble falling asleep, hyper-vigilance (feeling on guard), irritability, or startling easily (American Psychiatric Association, 1994). To receive a diagnosis of PTSD, an individual has to persistently experience the traumatic stressor, persistently try to avoid stimuli associated with the stressor, experience an increased arousal, and finally, suffer from these symptoms for at least one month (American Psychiatric Association, 1994).

According to the National Centre for PTSD, those people most likely to develop PTSD are:

- those who experience greater stressor magnitude and intensity, unpredictability, uncontrollability, sexual (as opposed to non-sexual) victimisation, real or perceived responsibility, and betrayal
- those with prior vulnerability factors such as previous exposure to the trauma, personal or family history of family violence and abuse, and psychiatric dysfunctions, particularly depression, genetics, early age onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events
- those who report greater perceived threat or danger, suffering, terror, and horror or fear
- those with a social environment that produces shame, guilt, stigmatisation, or self-hatred.

However, the PTSD construct fails to describe the nature and impact of severe, multiple, repeated and cumulative chronic ongoing stress where there is no one specific stressor or where there are many possible cumulative stressors; a situation that is common in Australian Aboriginal peoples and communities (Atkinson, 1990, 2002; Cameron, 1998; O’Shane, 1993). Judith Herman (1997) criticised the PTSD construct for not taking into account severe traumatic experiences that have been repeated over time, particularly
multiple and cumulative trauma, and for not capturing the developmental effects of complex trauma exposure. Herman postulated that complex PTSD is a better diagnostic construct than PTSD for post-traumatic stress among different ethnocultural groups who have experienced severe prolonged traumatic experiences (1997).

**Complex PTSD**

Traumatic distress is considered more severe and longer lasting when the stressor is of human design (American Psychiatric Association, 1994). Prolonged stressors, deliberately inflicted by people, are far harder to reconcile than accidents or natural disasters (Herman, 1997). Most people who seek mental health treatment for trauma have been victims of violently inflicted wounds dealt by a person (Herman, 1997). If such wounds were inflicted as the result of a deliberate act within the context of an ongoing relationship, the problems are increased (DeAngelis, 2007; Herman, 1997; van der Kolk, 2005). The worst outcome results when the injury is caused deliberately by a person with whom the victim shares a dependent relationship, most specifically a parent-child relationship (DeAngelis, 2007; Herman, 1997; van der Kolk, 2005). More distress is associated with more severe abuse: that is, abuse of a long duration, involving forced penetration, helplessness, fear of injury or death, with perpetration by a close relative or caregiver, coupled with lack of support or negative consequences from disclosure (DeAngelis, 2007; Herman, 1997; van der Kolk, 2005).

Practitioners in the traumatic stress field have adopted the term ‘complex trauma’, as coined by Judith Herman, to describe the experience of multiple, chronic and prolonged developmentally adverse traumatic stressors, which are most often of an interpersonal nature and early life onset (van der Kolk, 2005). The American Psychiatric Association has chosen to name complex trauma as ‘disorder of extreme stress not otherwise specified’ (DESNOS) (American Psychiatric Association, 1994).

Complex PTSD covers physical abuse, emotional abuse, sexual abuse, domestic violence, family violence, torture, chronic early maltreatment in a caregiver relationship, and war:

> A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation (Herman, 1992, p. 121)
Complex PTSD captures a sufferer’s loss of trust, self-worth and their sense of safety, their tendency to be revictimised, and their loss of a coherent sense of self:

*People subjected to prolonged, repeated trauma develop an insidious progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is ‘not herself’, the victim of chronic trauma may feel herself changed irrevocably, or she may lose the sense that she has any self at all* (Herman 1992, p. 86).

However, Herman’s work was developed through clinical studies of mainly adult American female survivors of childhood sexual abuse and has not yet been tested on ethnocultural cohorts. Additionally, although complex PTSD or DESNOS seem to be more accurate descriptions of the complex nature of the stressor criteria for Australian Aboriginal peoples, they focus more upon situations of prolonged victimisation in captivity, as opposed to prolonged and repeated traumatisation or multiple, repeated and cumulative aspects of trauma common in many Aboriginal communities (Atkinson, 2002; Milroy, 2005). For example, there is no reference or regard given to traumatic experiences that may have been perpetrated across hundreds of years and that acknowledge the socio-political contexts of oppression and colonisation. Furthermore, these constructs fail to consider the community and societal effects in Aboriginal communities (which result from the nature of their extended and well-integrated family and kin systems) and the widespread violence and dysfunction that are experienced in some communities (Milroy, 2005).

**Dysfunctional community syndrome**

The concept of the widespread and collective effects of trauma upon entire communities was introduced by Lira, Becker and Castillo (1988). The Aboriginal and Torres Strait Islander women’s task force on violence (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000) found convincing evidence to justify the label ‘dysfunctional community syndrome’, which is increasingly being used to describe some Aboriginal communities.

*When a community has to deal with the tragic deaths of 24 young men in one year, most of which were suicides, there can be no stronger cry for help. Indeed, it is a deafening roar that something is desperately wrong. When the same community reports their men raping a three-year old child, who was raped by another offender ten days later, there is a crisis of huge proportions*
Dysfunctional community syndrome is defined as a:

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

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

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

Historic trauma
A new model is being introduced for trauma transmission, citing the presence of complex or endemic post-traumatic stress disorder in Australian Aboriginal communities. This new model includes concepts of dysfunctional community syndrome and has originated as a direct result of historic trauma transmission (HTT) (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Duran, Duran, Brave Heart & Davis, 1998; Muid, 2006; Ralph et al., 2006; Robertson, 2006; Whitbeck, Adams, Hoyt & Chen, 2004). There has been an increased focus on concepts of ‘historical trauma’ and ‘historical grief’ among researchers, clinicians and traditional healers that seeks to understand the inter-generational psychological consequences of years of genocide, ethnic cleansing, and forced acculturation (Duran et al., 1998; Muid, 2006; Ralph et al., 2006; Robertson, 2006; Whitbeck et al., 2004). Historical trauma (HT) can be defined as ‘the collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide’ (Muid, 2006, p. 36). Current synonymous terms include soul wound or a collective soul wound, historical legacy, American Indian holocaust, and
generational post-traumatic stress disorder (which includes both inter- and trans-generational trauma) (Duran et al., 1998).

Historical trauma is trauma that is multigenerational and cumulative over time; it extends beyond the life span. Historical trauma response has been identified and is delineated as a constellation of features in reaction to the multigenerational, collective, historical, and cumulative psychic wounding over time, both over the lifespan and across generations (Duran et al., 1998, p. 342).

The causes of HT are rooted in the legacy of genocide that has been part of the establishment of non-Aboriginal Australia, and the effects are unresolved trauma and increases in child abuse and family violence (Atkinson, 2002; Milroy, 1995; Ralph et al., 2006; Raphael et al., 1998). The concept of HT originated from the pre-eminent work of Dr Maria Yellow Horse Brave Heart and others, such as Walters and Simoni (2002) and Duran et al. (1998). While HT is primarily discussed in relation to American Indian peoples, it is being used more and more as a concept to understand the Australian Aboriginal experience (Atkinson, 2002; Milroy, 2005; Ralph et al., 2006).

The symptoms associated with generational post-traumatic stress disorder or HT run the gamut of those associated with post-traumatic stress disorder, to symptoms of unresolved grief:

Historic trauma (HT) is cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma experiences; the historical trauma response (HTR) is the constellation of features in relation to this trauma. The HTR often includes depression, self-destructive behaviour, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. It may include substance abuse, often an attempt to avoid painful feelings through self-medication. Historical unresolved grief is the associated effect that accompanies HTR; this grief may be considered fixated, impaired, delayed, and/or disenfranchised (Brave Heart, 2003, p. 7).

HT is passed inter-generationally: ‘The experience of historical trauma and inter-generational grief can best be described as psychological baggage … It is continuously being acted out and recreated in contemporary Aboriginal culture’ (Wesley-Esquimauz & Smolewski, 2004, p. 3) and thus the behaviour is recreated in the actions of each succeeding generation.
The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effect of the original trauma which a parent or other family member has experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality (Milroy, 2005, p. xxi).

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

**Historical trauma in Aboriginal Australia**

HT, or generational post-traumatic stress disorder, has only begun to be recognised as applicable to Australian Aboriginal peoples over the last five to ten years. This is largely due to the efforts of Indigenous academics and practitioners, who have been able to illustrate the nature of inter-generational and trans-generational trauma transmission amongst successive generations of Aboriginal families (Atkinson, 2002; Milroy, 2005; Raphael et al., 1998). Pat O’Shane stated that:

> From what we know of the effects generally of dislocation, dispossession and breakdown of social structures, we may infer that these assimilation practices … have had further [than high levels of mental illness], far-reaching ramifications on the behaviours of the individual family members, compounding the generational effects of the original dispossession of land, culture and children; and including not only the mental health and general health problems, but also child behaviour problems, and violence. It is no exaggeration to say that many Aboriginal families and communities spend their entire lives in crisis (1993, p. 197).

A psychology masters research project that aimed to investigate the meaning of the experience of psychological trauma for Aboriginal people, in the context of long-term effects of personal inter-generational and trans-generational experiences of trauma,
found that there were significant levels of traumatic symptoms among the ten research participants (Cameron, 1998). Atkinson (2002) found that the violence of contemporary Aboriginal communal environments contributes to the levels of trauma transmitted across generations as the result of colonising processes. According to Hazlehurst (1994), ‘it is the Colonial excesses, followed by the imposition of post-colonial “law and order” and “welfare policy” [that] have produced well recognized patterns of trauma and dislocation among all Indigenous populations and groups’ worldwide.

Aboriginal people just don’t know their trauma goes back to the invasion, we can trace it. Every tribe in Australia can take you to a place in their country where the white man came in and wiped out whole families. They can point out what waterholes were poisoned, where dozens of their tribe were shot, where people were rounded up and their children taken away. There’s ones still alive who can remember the chains around the necks of our men and what happened to the pretty girls when the coppers came. How can anyone forget that? And why should we forget? (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 46).

According to Atkinson (1996), the processes of colonisation involved a series of interlinking disasters impacting on the individual and collective psyche: epidemics; massacres; displacement from traditional lands; coerced removal of whole populations to reserves; the tearing apart of family groups; and the removal of children. It has been suggested by various authors that these interlinking and ongoing disasters all contributed to the physical, cultural and spiritual genocide of Aboriginal populations throughout Australia (Atkinson, 1996, 2002; Human Rights and Equal Opportunity Commission, 1997; Milroy, 2005; RCIADC, 1991; Swan & Raphael, 1995). According to experts in the field of human catastrophe and trauma studies, each of these disasters could separately evoke trauma in the people affected (Danieli, 1997; Epstein, 1979; Figley, 1985; Spiegelman, 1986, 1991; Vogel, 1994). When such experiences are interlinked historically and generationally however, the result on many individuals, families and communities may be layer upon layer of what would be similar to PTSD; in fact for some, they could result in a ‘fatal psychic trauma’ (Figley, 1985).

It is often easy for people to say the past is the past and you should forget about it, but the past is affecting us in the present (Aboriginal Legal Service of Western Australia, 1995, p. 190).

Judy Atkinson highlighted the generational processes of trauma:
The young have not been given a context or construct to understand the traumatic experiences of the old, which continue to govern the behaviour of many older generations. The violence therefore moves down the generations, changed yet formed by previous government and societal acts of violence. These are experienced as trauma, which continues into the present in further actions of violence within families and communities (2002, p. 225).

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

It was contended that Aboriginal youth in the Kimberley region may experience several layers of trauma, through their own direct and secondary exposure as set against a backdrop of historical unresolved trauma and grief. These layers of trauma are thought to be cumulative in the manner in which they inform the adolescents’ experience, and continue to adversely reinforce the basic assumptions that are violated by chronic trauma exposure; that the world is meaningful and safe, that the self is worthy, and that others can be trusted. It was thought that the current rate of suicide amongst Aboriginal adolescents in the Kimberly region may be the youths’ contemporary expression of distress in response to chronic trauma exposure, as underpinned by the legacy of historical unresolved trauma and grief (Ralph et al., 2006, p. 123).

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

Transmission of violence and abuse

Both clinical experience and family systems theory suggest that the traumatic experiences of past generations are likely to directly influence the behaviour of current generations through either modelling their dysfunctional behaviours or through exposure to traumatic experiences displayed in the violent and dysfunctional behaviours of the older generations (Boszormenyi-Nagi & Framo, 1965; Green, 1993; Steele, 1983; van der Kolk, 2003, 2005; Windom, 1989). There is evidence that as many as one-third of child victims of physical (including sexual) and psychological abuse grow up to experience parental difficulties or become abusive of their own children (Oliver, 1993).
One-third do not have this experience, but the remaining third remain vulnerable and, under stress, the likelihood of becoming abusive increases (Oliver, 1993). According to Green:

There is considerable evidence that the abused child is at risk for reenacting the original violent interaction with his parents in subsequent relationships with peers and offspring, supporting a theory of intergenerational transmission of violence (1993, p. 582).

The experience of childhood trauma may also be an important factor in the transmission of PTSD from parent to child (Yehuda, Halligan & Grossman, 2001).

There is evidence for inferring that being victimised by one’s caretaker would be traumatizing and could result in the development of PTSD or its symptoms. If this does occur, PTSD may be one of the mechanisms that accounts for the intergenerational transmission of violence. This is a line of inquiry worthy of pursuit. It appears to be the case that most child victims of abuse or neglect do not become violent victimizers as adults, but the development of PTSD in some child victims may be one of the factors that accounts for subsequent violence (Collins & Bailey, 1990, pp. 218–219).

Children who witness violence towards others may be at risk of replicating the violence at a later time if their social environment accepts that type of behaviour (Collins & Bailey, 1990; Windom, 1989; Yehuda et al., 2001; van der Kolk, 2003, 2005). Many young Indigenous men feel alienated and angry because of what they have seen, heard and experienced as children. They have become de-sensitised towards violence, and sometimes this normalisation of violence carries through to their relationships.

Although there have not been specific studies to document these issues in Aboriginal peoples, given the high level of abuse suffered by Aboriginal peoples, it is likely that the same patterns exist (Angus & Woodward, 1995). For example, the concept of cyclic violence has been proposed as a “metaphor for understanding the cultural ways in which the transmission of destructive patterns of self-abuse and violent behaviours occur in Indigenous communities, as well as the inter-generational component” (in National Crime Prevention, 1999, p. 8). Atkinson (2002) discussed this process by suggesting that the:
... mechanisms of oppression that were enacted during these periods (i.e. violence that is physical, structural and psychological) and reactions to repeated traumatic loss and grief (i.e. anger, shame, perpetual grief, substance abuse) can become internalised, and through repetition normalised. In this manner, transfer of elements of the historical trauma and reactions may occur between generations (inter-generational trauma) and across successive generations (trans-generational trauma), until redressed by individual family and community healing (Atkinson, 2002, p. 120).

The normalisation of violence (or inter-generational cycle of violence) was identified by the NSW Aboriginal Child Sexual Assault Taskforce (2006) as a major factor influencing violent behaviours, specifically child sexual assault. Violence was reported to be going on for generations and was thus minimalised, as it had become 'normal' (NSW Aboriginal Child Sexual Assault Taskforce, 2006). One participant in the inquiry stated:

The trauma of child sexual assault makes it very difficult for people to develop healthy relationships … because you’ve got, you know, children being raised like three generations in a row where sexual and family violence has been part of their life … (Transcript 24, NSW Aboriginal Child Sexual Assault Taskforce, 2006, p. 61).

According to Atkinson, the endemic nature of family violence over a number of generations has resulted in a situation where:

Violent behaviours become the norm in families where there have been cumulative intergenerational impacts of trauma on trauma on trauma, expressing themselves in present generations as violence on self and others (Atkinson, 1996, p. 7).

The concept of ‘cyclic violence’ also serves to emphasise ‘the extent to which the aggression and violence are transmitted through social and cultural processes, rather than simply emerging out of the blue’ (National Crime Prevention, 1999, p. 8).

**Violence as both a symptom and cause of trauma**

Figley (1985, 1986) suggested that violent behaviours are both a symptom of PTSD and a symptom of recovery from PTSD. The Aboriginal and Torres Strait Islander women’s task force on violence report acknowledges that trans-generational trauma can be both
a cause and effect of violence (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

The revised third edition of the APA Diagnostic and Statistical Manual indicates that those diagnosed as suffering from PTSD often report higher levels of aggression than in their premorbid state. This aggression may range from mild (e.g. irritability) to severe (e.g. outbursts of anger without provocation). Although a tendency to act violently is not explicitly identified as a criterion for PTSD diagnosis, the clear implication is that those with PTSD may be at greater risk to act violently (Collins & Bailey, 1990, p. 204).

A national survey of Vietnam veterans by Kulka et al. (1987) provided evidence of a relationship between PTSD and violence. Kulka et al. (1997) compared Vietnam-era veterans who did not actually serve in Vietnam with veterans who had served in Vietnam. There was a significant relationship between levels of lifetime PTSD symptoms and hostility scores for male Vietnam veterans, and a direct relationship between PTSD symptoms scores and the violence index for both males and females (Kulka et al., 1997).

Most of the past research on the relationship between violence and PTSD has focused on the relationship of war trauma to subsequent involvement in violence, suggesting that violent behaviour is an ‘associated symptom’ of PTSD (Escobar et al., 1983; Van Putten & Emory, 1973; Wilson & Zigelbaum, 1983; Yager, Laufer & Gallops, 1984). Collins and Bailey (1990) have found evidence to support a relationship between PTSD and violence, suggesting that patients with traumatic stressors, even those that are not combat-related, are potentially violent. Major life stressors, such as injustice and disadvantage, have some role in eliciting angry and violent reactions (Howells, 1998).

Miller (1982) suggested, that due to the injustices and disadvantages caused by oppression, ‘Aborigines have turned their rage in on themselves … The result is the long list of cell suicides, self-injury, homicide, domestic violence, child abuse and neglect’. Miller also argues that ‘this violence, directed towards oneself or displaced onto someone else, had it origins with whites. When the dreamtime disintegrated, when whites broke, possibly forever, the link between the past, present and future, helplessness and desperation became endemic in Aboriginal community life’ (cited in Dudgeon & Mitchell, 1991, p. 34). This contention still appears to be relevant today.
The United States Vietnam Veterans’ Association suggests that the suppression or non-treatment of trauma can result in behaviours that again cause trauma in victims and their families through increased levels of intra-family violence, rape, child abuse and neglect, suicide and other forms of self harm, homicide and increased criminal activity (Figley, 1985).

The subsequent trans-generational effects of historic trauma on Aboriginal children were described by Milroy (2005) to be seen through impacts on attachment relationships with caregivers and on parenting and family functioning, the association with parental physical and mental illnesses, and disconnection and alienation from extended family culture and society. Milroy notes that these effects are exacerbated by chronic exposure to continuing high levels of stress and trauma, which include multiple bereavements and other losses. In addition, these effects are also compounded by secondary traumatisation, where children witness the on-going effects of the original trauma on a parent or family. 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 [Aboriginal and Torres Strait Islander Women’s Taskforce on Violence, 1999] recognised to be both the cause and effect of trans-generational trauma (Ralph et al., 2006, pp. 120–121).

Consequently, people become more and more marginalised as attempts to articulate their pain are dismissed or ignored. These well-recognised symptoms of trauma consist of violence in families and communities (Danieli, 1985; Epstein, 1979; Figley, 1985; Spiegelman, 1986, 1991; van der Kolk, 2003, 2005; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005).

In effect, the untreated trauma behaviours add further to the existing trauma, creating a multi-layered, self-perpetuating cycle of generational violence and dysfunction, which over time can become normalised behaviour. For example, the trauma behaviours have:

… lost their shock value because the community is in continuous mourning. The community becomes so desensitised to violent acts that they are unable to perceive the patterns of violence across families and generations, or the inherent strengths in the community itself that can be mobilised to counter such behaviour (DeBruyn, 1988, p. 58).
The current levels of suicide, sexual abuse, alcoholism and family violence are among the recognised effects of trauma experienced by Australian Aboriginals (Atkinson, 2002; Danieli, 1985; Gordon et al., 2002; Epstein, 1979; Figley, 1985; Manson et al., 1997; Milroy, 2005; Ralph et al., 2006; Spiegelman, 1986, 1991; van der Kolk, 2005). These events are not only the effects of trauma but are also traumatic stressors themselves, capable of creating yet more traumas. Therefore the current traumatic events that we are seeing are significant stressors that can lead to PTSD and act to transmit the violence and abuse through the generations. However, to date there does not appear to have been a comprehensive study into the relationship between Aboriginal violent behaviour and generational PTSD.

**Trauma expressed as anger, violence and criminal behaviour**

Angry forms of violence are caused and triggered, in part, by exposure to negative life experiences, and violent events are more likely to occur when the individual is in a negative affective state (Howells, Day, Byrne & Byrne, 1999; Perry, 2002; van der Kolk, 2005; van der Kolk et al., 2005). Anger translated into violence is almost always a central feature of response to trauma, because it is a core component of the survival response in humans. Anger provides a concentration of attention, thought, brain energy and action in the face of threatening situations. While it has great value for coping with life’s adversities (i.e. by giving increased energy to persist in the face of obstacles), uncontrolled anger can lead to a continued sense of being ‘out of control’ of one’s self, and can result in multiple problems in the family and personal lives of those who suffer from PTSD. Extreme threats can result in PTSD sufferers becoming ‘stuck’ in the anger response, leading to a feeling of being out of control when confronted by otherwise minor obstacles in life. In situations of early childhood abuse, the ability to control emotions has been shown to be affected, leading to extreme bouts of rage and anger (Chemtob, Novaco, Hamada, Gross & Smith, 1997).

Being physically or psychologically abused as a child can sharply increase the risk for later delinquency and violent criminal behaviour (Perry, 2001, 2002; van der Kolk, 2003, 2005; van der Kolk, Perry & Herman, 1991; van der Kolk et al., 2005). The last few decades have produced numerous studies that have shown that many children who have been traumatised (such as by being exposed to family violence) have chronic problems with hyper-arousal, impulse control and unmodulated aggression against self and others (Burgess, Hartman & McCormack, 1987; Cole & Putnam, 1992; Green, 1980; Lewis & Shanok, 1981; Perry, 1994, 2001, 2002; van der Kolk, Perry & Herman, 1991; Schneider-Rosen & Cicchetti, 1984; Steiner, Garcia & Matthews, 1997; van der
Kolk, 1989, 2003, 2005; van der Kolk, Perry & Herman, 1991; van der Kolk et al., 2005), as well as difficulty negotiating relationships with caregivers, peers and subsequent marital partners (Finkelhor, Hotaling, Lewis & Smith, 1989; Schneider-Rosen & Cicchetti, 1984; van der Kolk, 2005).

Developmental trauma sets the stage for unfocused responses to subsequent stress, leading to dramatic increases in the use of medical, correctional, social and mental health services. People with childhood histories of trauma, abuse and neglect make up almost the entire criminal justice population. Physical abuse and neglect are associated with very high rates of arrest for violent offences. In one prospective study of victims of abuse and neglect, almost half were arrested for non traffic related offences by age 32. Seventy-five percent of perpetrators of child sexual abuse reported to have themselves been sexually abused during childhood. These data suggest that most interpersonal trauma on children is perpetuated by victims who grow up to become perpetrators and/or repeat victims of violence. This tendency to repeat represents an integral aspect of the cycle of violence in our society (van der Kolk, 2005, p. 402).

Van der Kolk’s (2005) work reaffirms Alice Miller’s (1983) classic analysis of the origins of the behaviours of extremely violent people, which submitted that extremely violent behaviours come from the interrelated experiences of:

- being profoundly hurt as a child
- being hurt, but in addition being prevented from experiencing or expressing the pain of that hurt
- having no other single human being in whom the person can confide their true feelings
- having a lack of education or knowledge and thereby being unable to intellectualise the abuse
- having no children on whom one can repeat the cycle of abuse (Miller, 1983, p. xi).

Atkinson (2002) also draws on Miller’s (1983) classic works by suggesting that the violence against others and self, the self-medication through substance misuse, and the tension reduction behaviours (Briere, 2002) such as self-mutilation (Briere & Gil, 1998) and suicidality (Zlotnick, Donaldson, Spirito & Pearlstein, 1997) in Aboriginal Australia are expressions of the layers of trauma originating in childhood and now reverberating through the generations:
In colonised societies there have been multiple layers of both acute and overt acts of violence, and chronic and covert conditions of control have been established. These separately are traumatic and oppressive. Collectively, and compounding over generations, the pain may become internalised into abusive and self-abuse behaviours, often within families and discrete communities. The rage is not only turned inwards, but cascades down the generations, growing more complex over time (Atkinson, 2002, p. 82).

Wilson (1988), who worked with Vietnam veterans, and Atkinson (2002) both provided clear evidence to support the notion that violent behaviours resulting from trauma are often linked to what society labels as criminal behaviour. In a study of 1,342 men who were draft eligible during the Vietnam War, Yager et al. (1984) found that violent experiences in Vietnam were associated with later stress symptoms, arrests and convictions. According to Wilson and Zigelbaum (1986), PTSD can be linked to criminal behaviour in two ways, one in which pre-existing PTSD symptoms incidentally lead to criminal behaviour, and the other where the offences committed are directly connected to the specific trauma experienced by the individual.

PTSD survivors have been known to carry out criminal actions in an attempt to re-create the traumatic situation that led to the development of PTSD. The unconscious reliving of a traumatic experience may precipitate criminal behaviour (Wilson & Zigelbaum, 1986, p. 305).

Therefore, it appears that traumatic experiences and violence are connected in a vicious circle, in which experience of violence might promote PTSD, and symptoms of PTSD (like hyper-arousal, the readiness for attack, anger outbursts, and flashbacks triggered by conditions similar to previous traumatic experiences) may in turn contribute to uncontrolled violence and criminal acts (Begic & Jokic-Begic, 2001; Byrne & Riggs, 1996).

PTSD and its symptoms appear to be related to serious expressive violence (operationalised as an arrest or incarceration history for homicide, rape, or aggravated assault). Typically these offences involve expressive violence. It also appears that the PTSD symptom usually precedes the violence (Collins & Bailey, 1990, p. 217).
The memories of trauma and the resultant anxiety, combined with efforts to self-medicate with alcohol and drugs, can lead to an emotional numbness, which in turn may lead to seeking emotional sensation through risk-taking or adrenaline-producing activities. These often include violent behaviours that can be exacerbated by the constant feeling of needing to be on-guard, leading to misinterpretation and over-reaction to situations, and resulting in violent behaviours that are out of proportion to the perceived threat.

Compounding the many violent expressions of unresolved trauma are the problems of alcohol and drug misuse. Goldberg (2006) found that the path from victimisation in childhood to criminal behaviour is facilitated by PTSD and drug and alcohol misuse. For Aboriginal people, and for children growing up in environments where there have been multiple violations, the anger that is experienced as a natural and essential response to violations has no safe outlet. It is stored in the body for expression under duress. This invariably occurs in unstructured and explosive expressions of violence, aided by alcohol as an enabler (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

**The relationship between alcohol and other drugs, violence and trauma**

The suggestion that alcohol can contribute to explosive violent episodes is explained by Atkinson (2002), who suggested that people initially use alcohol as a way of alleviating a number of needs stemming from unhealed trauma. Alcohol is also used by people experiencing chronic communal traumatic stress in an attempt to numb the intensity of their feelings or, conversely, to allow them to feel more intensely. Atkinson (2002) explained that alcohol may not directly cause violence, however using alcohol to either not feel or to feel more intensely has the potential to compound and intensify violent actions through the loss of impulse control and a need to express the trauma stored in the body.

The literature commonly makes an association between alcohol consumption and drug abuse, and family violence and child abuse in Aboriginal communities (Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Gordon et al., 2002; Memmott et al., 2001; Northern Territory Government, 2007).

... The available evidence indicates clear links between alcohol consumption, violence and injury, although the relationship is complex and not necessarily one
of simple causality. Injury patterns are clearly related to the cycle of Community Development Employment Project (CDEP) and Social Security payments with high rates on paydays and the day following, and marked declines when canteens are closed (Fitzgerald, 2001, p. 13).

The Aboriginal and Torres Strait Islander women’s task force on violence report found that the women expressed strong emotions about the role of alcohol in violence and how it influenced all aspects of their lives, regardless of whether they were drinkers or non-drinkers (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

Alcohol-related violence is the most significant feature of serious crime, particularly violent crime, committed by Aboriginal peoples (Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Gordon et al., 2002; Memmott et al., 2001; Northern Territory Government, 2007). However the assertion has been repeatedly made that alcohol does not cause violence (Adams, 1988), but rather compounds and intensifies violent actions (Atkinson, 2002; Hunter, 1990) and provides a socially acceptable excuse for negative behaviour.

... some people argue that there are cultural expectations as to the behaviour of a person under the influence of alcohol and that in some cases aggression is the expected mode of behaviour (Bolger, 1991, p. 45).

Furthermore, discussions about the links between violence and alcohol and other drugs cannot be understood or given meaning, except in relation to the dependent situation of Aboriginal people within the Australian State (Homel, Lincoln & Herd, 1999) and the trans-generational trauma in Indigenous lives (Atkinson, 2002). The use of alcohol and drugs as a way of coping with past traumas of colonisation and dispossession is a point made by many commentators (Atkinson 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Gordon et al., 2002; Milroy, 2005). However, substance abuse is, in turn, creating its own trauma in communities, such that there is now a link between substance abuse, growing violence, and the current dysfunction and despair in Indigenous communities (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

A number of studies indicate that individuals with complex and chronic trauma histories are more likely to use drugs and alcohol (Acierno, Resnick, Kilpatrick, Saunders & Best, 1999; Grilo et al., 1997; Kofoid, Friendman & Peck, 1993; Manson et al., 1997;
McCreary & Sadava, 2000). Kofoed et al. (1993) clarify that whilst suffering from a traumatic disorder such as PTSD does not automatically result in problems with alcohol use, such problems do often occur together and are interrelated. Kofoed et al. (1993) report that up to 75% of survivors of violent trauma report problematic alcohol use, as do 10%–33% of those who survive accidents, illness or disasters. Jacobsen, Southwick and Kosten (2001) report that 60%–80% of Vietnam veterans seeking PTSD treatment have alcohol-use disorders. Furthermore, women who have been exposed to trauma, particularly sexual abuse, show an increased risk of alcohol-use disorders, as do men exposed to sexual abuse.

In order to cope with the intense feelings associated with traumatic experiences, some people self-medicate with alcohol and other drugs as a form of emotional avoidance, in an attempt to anesthetise the negative effects associated with traumatic experiences or subsequent trauma memories. Conversely, drugs and alcohol may be used to act as a mechanism for releasing feelings and enabling ‘... the expression of pent-up feelings of rage or despair without the person or group having to take responsibility for the consequences that may result — that is, the rage that may be expressed as violence (Reser, 1990 in Atkinson, 2002, p. 228).

Aboriginal people’s use of alcohol and other drugs is, in many instances, connected to the traumatisation in violence that has occurred over generations, and the multiple losses within families and communities through removal and through early death from ill-health or risk-taking, suicides and homicides. Those who are flooding with emotions may use alcohol to try to numb the intensity of their feelings; conversely, when they are numb and unable to feel, alcohol can allow them to feel more intensely. The drugs may therefore function to release feelings (Atkinson, 2002, p. 225).

According to the Bringing them home report: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families, alcohol is the self-treatment of choice for many with acute depression and may be used to cope with feelings of fear, guilt, sorrow, agony and horror from previous traumatic experiences, and as a self-medication for unresolved grieving needs (Human Rights and Equal Opportunity Commission, 1997; Atkinson, 2002).

If they hadn’t used alcohol they probably would have committed suicide … You can’t be here to carry that sort of pain and depression. We’re incapable of staying alive with that sort of feeling, and alcohol was a sort of first aid (Michael...
Judith Herman (1992) has pointed to evidence that a chemical reaction occurs in the brain at the time of a traumatic stressor, which helps the victim to survive the event psychologically intact by permitting a degree of dissociation from it. However, traumatised people who cannot spontaneously dissociate attempt to produce similar numbing effects by using alcohol or narcotics.

The sorts of things that can happen with people who are having flashbacks of traumatic events is that it can cause such psychic pain that the person might start to drink heavily or use other psycho-active substances heavily (Dr Jan McKendrick evidence 310 from the Bringing them home report, 1997, Human Rights and Equal Opportunity Commission, 1997, p. 44).

Substance use can serve to alleviate affective numbness in some trauma survivors by inducing transient and predictable pleasurable bodily sensations or emotions. However in turn, this can be related to further victimisation, and thus may result in further (and potentially more complex) post-traumatic symptomatology (Acierno et al., 1999).

Therefore, traumatised people run a high risk of compounding their difficulties by dependence on alcohol or other drugs. The symptoms of PTSD are made worse by alcohol abuse, although the abuse is often undertaken for reasons of avoidance and relief from such symptoms (Jacobsen et al., 2001). Alcohol abuse reduces the ability to concentrate and to be productive, impacts on sleep, reduces the ability to cope with stress and trauma memories, causes emotional numbing and social isolation, and intensifies feelings of anger, irritability, depression and hyper-vigilance (Kofoed et al., 1993).

Memmott et al. argued that the:

Extent of alcohol consumption in a community, and the extent of violence being committed and experienced by members of that community, is a direct reflection of the collective emotional and psychological damage that has been caused to individuals of that community and that collectively may manifest as dysfunctional community syndrome (2001, p. 28).
Therefore, although alcohol may trigger violent episodes, it is a symptom of the underlying issues associated with trauma behaviours, and:

without intervention and without healing and recovery from the long-term effects of the underlying longitudinal causes of violence impacting on Aboriginal people as well as the situational and precipitating factors, cycles of inter-generational violence will continue to be perpetuated and alcohol will continue to be used as a way to avoid dealing with these problems (Memmott et al., 2001, p. 26).

Methodological considerations

After reviewing the literature on the relationship between violence and trauma in Aboriginal Australia, it appears essential to explore trauma symptoms in Australian Aboriginal men who are considered criminally violent, in an attempt to establish if they have been exposed to traumatic stressors and are suffering from psychological symptoms associated with trauma stress. To be beneficial, such an exploration should include the number and nature of traumatic stressors and trauma symptoms, as well as the contextual factors that predispose and/or that may amplify the experience of, and response to, trauma, along with potential patterns of generational trauma and dysfunction. In light of the cultural considerations of the trauma experiences discussed earlier in this chapter, certain methodological considerations (such as ensuring that traumatic stressors and trauma symptoms reflect the specific experiences of Australian Aboriginal peoples) are necessary to develop culturally sensitive, appropriate and meaningful information.

As discussed earlier in this chapter under ‘Defining the concept of trauma’, in the past two decades there has been an increase in interest among psychologists, psychiatrists and psychotherapists in the study of ethnocultural aspects of trauma (Dyregrov, Gupta, Gjestad & Raundalen, 2002; Kirmayer, Lemelson & Barad, 2007; Lee & Lu, 1989; Mollica et al., 1996; Rhoades, 2005; Summerfield, 1991; Wilson, 2004, 2005, 2007) and post-traumatic experiences (Marsella, Friedman, Gerrity & Scurfield, 1997). The conceptualisation that trauma has been conceived as an event (of a short or longer duration) that is outside the range of usual human experience and that would be markedly distressing to anyone suggests that the individual, regardless of their cultural environment, can in some way experience negative psychological consequences when confronted with overwhelming experiences. However, the growing body of evidence arguing that PTSD symptoms may have a hard-wired biological basis suggests that:
there may be a universal biological response to trauma that can be detected in humans from every sort of ethnocultural background. Although the frequency, severity, and phenomenology of such symptoms may be modified by ethnocultural and genetic factors, the weight of research at this time suggests that activation of the biological response system is at least partially responsible for PTSD re-experiencing and arousal symptoms (Marsella et al., 1997, p. 534).

Neurobiological studies specifically document that affect dysregulation, right hemisphere alterations in brain functioning and strong kindling phenomena (see list of definitions and terms on page xiii) are universal in PTSD, regardless of culture (Friedman, 2000; Schore, 2003; Wilson, 2004, 2005; Wilson, Friedman & Lindy, 2001). Wilson (2004, 2005) suggests that there is a ‘trauma archetype’ that represents a universal form of traumatic experience across time, space, culture and history.

However, defining trauma can be problematic when it is discussed from a cultural perspective. This conceptualisation of trauma based on Western biomedical approaches and Western psychoanalysis may be too narrow and restricted for the discussion of trauma and post-traumatic experiences in a cross-cultural dimension. Western biomedical approaches and psychoanalysis do not embody a socialised view of mental health. Most people exposed to the effects of trauma in the non-Western world do not go through traumatising events as a private or individual experience (Summerfield, 1995).

By contrast, in Aboriginal communities traumatising events are generally faced as collective experiences in which the traumatic content of the experience is not attached to the event itself, but to the pain and negative consequences associated with it. Western models generally consider the person as a self-contained unit, an individual completely independent of others (Bracken, Giller & Summerfield, 1995). In this way, many challenges are raised when research on trauma and post-traumatic experiences is conducted with traumatised people from societies where the individual is conceived as part of an extended family that includes the living and the dead, a special group, or communities such as Australian Aboriginal peoples. The traumatic experiences are not strictly confined to their overwhelming impact on the individual psyche. However, collective and individual traumas are not mutually exclusive. For example:

Experiencing socio-political events such as war, genocide or disaster in a cultural, national or community context does not mean that one will not also experience such events as an individual. The fact that trauma may occur on a
There is little doubt a broader conceptualisation of trauma is needed in which traumatic experiences are viewed within both the individual and collective experiences of peoples and communities. Furthermore, the loss or disintegration of cultural beliefs and values should be considered as traumatic experiences as well. However, as discussed earlier in the chapter in the section ‘Defining the trauma concept’, it is not only the PTSD conceptualisation of trauma that appears to be lacking, but also concepts of complex trauma and dysfunctional community syndrome. Historical trauma was suggested as the most appropriate conceptualisation of trauma relevant to Australian Aboriginals but, again, empirical studies of this concept have only been conducted on American First Nation peoples (Whitbeck et al., 2004). Furthermore, as suggested by Whitbeck et al. (2004), the trauma and losses for ‘American Indians’ are not ‘historical’ in the sense they ended with military defeat and occupation of territory, but rather the traumas and ‘losses are ever present, represented by the economic conditions of reservation life, discrimination, and a sense of cultural loss’ (Whitbeck et al., 2004, p. 121). The same situation could apply to Australian Aboriginal peoples, who are not only faced with daily reminders of loss but are also exposed to regular traumatic experiences due to family violence, alcohol and drug misuse, and ‘sorry business’.

Therefore, to avoid defining another Western-derived syndrome or adopting a syndrome specific to a particular population such as HT, which may not include aspects that are particular to the Australian Aboriginal population, it is suggested:

... that a better approach is to retain PTSD as the frame of reference and to use cross-cultural techniques to assess the applicability of this construct to the diverse ethnocultural expressions of post-traumatic distress (Marsella et al., 1997, p. 535).

The cultural validation of traumatic experiences has demonstrated that what can be widely conceived as a traumatic stressor in one culture may not be so in another. Research suggests the characteristics or nature of traumatising events (Herman, Russell & Trocki, 1996; Roth, Wayland & Woolsey, 1990; Wilson, 2007) and their cultural interpretation (Canive & Castillo, 1997), including the context in which they occur, are very important factors in achieving correct diagnosis. Therefore it is important to widen the concept of trauma from the Western viewpoint and adjust it to the cultural
dynamics of Australian Aboriginal peoples by including the following objectives in the investigative procedures of the research:

1. The cultural concept of the person
2. Cultural idioms (i.e. characteristics) of distress, such as fear and anxiety
3. Specificity of the cultural meaning of trauma.

According to Casebeer and Verhoef (1997), Keane, Kaloupek and Weathers (1997), Manson, (1997) and Wilson (2007), these three objectives can be better fulfilled when applying a constellation of methodological approaches — methodologies that provide much more freedom for individuals, families and their communities to express what they have experienced and the level of associated trauma in light of their cultural background and histories.

**The measuring instruments — limitations, challenges and solutions**

Research in non-Western societies raises many challenges when constrained by the singular application of Western etiological categories for diagnosis of mental health or illness in a different cultural environment, such as that pertaining to this study. Although these measuring instruments do indicate some mental health problems across populations, they do not seem adequate for a complete and correct diagnosis, given that they were developed within a Western philosophical framework based on Eurocentric values, assumptions and norms. There are few published ethnocultural studies of PTSD addressing assessment issues, in spite of the fact that cultural sensitivity in assessment procedures may be a major factor in the determination of PTSD rates and clinical features (Kirmayer et al., 2007; Marsella et al., 1997; Wilson, 2007). At present, there are no standardised ethic (universal) measurements of trauma and PTSD (Dana, 2005).

The diagnostic tools utilised to diagnose the impact of the layered trauma resulting from colonisation on the mental health of people are interviews, questionnaires, self-reports, scales and other instruments elaborated for specific populations (e.g. North American or Western Europeans) who have experienced a different range of traumatic experiences (McFarlane & de Girolamo, 1996). These experiences are different because Australian Aboriginal peoples have their own unique cultural background and have suffered, and continue to suffer, the effects of generations of exposure to social, cultural and spiritual disintegration (Queensland Department of Aboriginal and Torres Strait Islander Policy, 2000; Human Rights and Equal Opportunity Commission, 1997).

It is also common to use categorisations of mental distress or behavioural problems based on models that do not have the same meaning across cultures. Victims react to
extreme trauma in accordance with what it means to them. Interpreting these meanings is an activity that is socially, culturally and often politically framed (Dyregrov et al., 2002; Kirmayer et al., 2007; Summerfield, 1995; Wilson, 2004, 2005, 2007). Despite the attempts arising from the advent of trans-cultural psychiatry to respond to the cultural demands of diagnosing and treating mental disorders (Kleinman, 1977; Littlewood, 1990; Murphy, 1969; Weiss et al., 1986), deeper research is required into the relationships between culture, trauma and post-trauma.

Although there is debate over the appropriateness of assessment techniques used to measure traumatic stress disorders in non-Western societies, many researchers and practitioners agree that exposure to traumatic stressors may result in immediate and long-term negative consequences for individuals, families, communities and nations (de Girolamo, 1992; de Girolamo & Orley, 1992; Marsella et al., 1997; Perry, 1986; Perry, 1994, 2001, 2002; van der Kolk, 2005). In fact, most of the research supports the universality of the biologically determined components of the PTSD experience (Friedman, 2000; Friedman & Marsella, 1997; Marsella, Friedman & Spain, 1997; Schore, 2003; van der Kolk & Saporta, 1993; Vasterling & Brewin, 2005; Wilson, 2004, 2005; Wilson et al., 2001) and the diagnosis of PTSD in people from non-Western cultures (Friedman & Marsella, 1997; Manson et al., 1997; Marsella et al., 1997; Wilson, 2004, 2005, 2007).

However, there are significant cross-cultural variations in the experience of PTSD, which is a dysfunction that implicates biological, psychological and social aspects of functioning — all of which are influenced by ethnocultural facts such as cultural conceptions of health and disease, perceptions and definitions of trauma, conceptions of the person, and standards concerning normality and abnormality (Marsella et al., 1997; Wilson, 2004, 2005, 2007). It is therefore imperative when conducting research utilising the constructs embedded within the assessment of traumatic stress, specifically PTSD within an Australian Aboriginal context, that all of the possible cultural biases are considered and Aboriginal perceptions and views are appropriately addressed in order to validate the research.

Nevertheless, PTSD is a clinically meaningful diagnosis across cultures because of the universality of human experience in response to trauma. However, the ethnocultural variations in the perceptual and experiential aspects of responses to trauma require developing methods of enquiry that incorporate these aspects into the PTSD construct. The research must understand both the ethnocultural context in which an event has
occurred and the ethnocultural options through which a strong emotional response to that event might be expressed (Atkinson, 2002).

Although standardised instruments provide some of the best means for comparisons across subgroups within a given population, they possess significant deficiencies when used cross-culturally, especially in light of language differences. Even when the majority of the respondents within a study speak English, the use of standardised instruments remains potentially problematic (Dana, 2005; Manson et al., 1997; Wilson, 2007). Firstly, questions that appear in standardised instruments may be incomprehensible to members of a different ethnocultural group. For example, the interpretation of *feeling as if you were going mad* may be interpreted as a question about anger rather than one's sanity (Manson et al., 1997). Secondly, the unacceptability of questions due to cultural variations may cause some problems and these questions may need to be placed into context. For example, a question asking the respondent *had they ever been injured leaving physical scars* does not take into account the practice of using scarification in the traditional ceremonies of some tribal groups. Thirdly, some questions may prove to be irrelevant in cross-cultural research, such as queries about social support networks that fail to include relatives. Such questions ignore the kin-based relationships within Aboriginal communities. Finally, other questions may either result in incomplete answers or fail to consider local equivalents. For example, questions that attempt to elicit help-seeking behaviour, measured by whether a respondent has told a health care professional about a problem, may ignore local equivalents such as traditional healers, Aboriginal-run programs and Aboriginal health services.

Failure to acknowledge or allow for the potential incomprehensibility, unacceptability, irrelevance and incompleteness of questions in the methodological framework may result in misclassification through false-positive and false-negative responses. The over- or under-reporting of symptoms and syndromes can render diagnostic comparisons with other groups tenuous (Manson et al., 1997). It is imperative to address both the form and content of the measurement instruments to be used in any cross-cultural research in order to avoid such misclassification. Manson et al. (1997) suggest the use of focus groups, in which each of the participants is asked a series of questions pertaining to both the form and content of the measurement instruments, in order to provide direct comment and suggested revisions to validate the cultural component of the research. Focus groups are equivalent to ‘talking circles’ in Aboriginal society, suggesting that participants would be comfortable with this method (Kenny, 2000, 2004). The focus groups need to include people who have experienced similar events, professional or respected leaders who have been involved with the target group,
and professionals familiar with the culture, language and mores of the society (Keane, Kaloupek & Weathers, 1997).

Although PTSD has both culturally bound and universal dimensions and can be diagnosed in people from non-Western cultures, it is clear that diagnostic validity could be improved if greater attention is given to culturally sensitive issues such as the cultural concept of the person, the culture’s idioms of distress reactions and its social construction of reality, particularly with respect to trauma (Marsella et al., 1997; Wilson, 2004, 2005, 2007). It is therefore appropriate to use an instrument that takes these considerations into account.

**Summary**

The literature reveals that Australian Aboriginal peoples have suffered multiple losses and traumatisation from the time of colonisation, and suggests that this has resulted in post-traumatic stress symptoms that are manifested in the high numbers of Aboriginal people compared to non-Aboriginal people being incarcerated, specifically for violent crimes.

The RCIADC was the first major national report to identify possible links between trauma and the over-representation of Australian Aboriginals incarcerated for violent crimes. Subsequently, there has been research conducted into defining the nature of this trauma, drawing on studies of populations such as war veterans and holocaust survivors, and more recently with the indigenous populations of other colonised nations.

What can be seen is that there are particular aspects to the way in which trauma has been inflicted on Australian Aboriginals, specifically men, and how that trauma has led to behaviours that are seen as criminal, feeding a cycle that now crosses generations. This untreated trauma, compounded by continuing governmental policies or removal, incarceration, and lack of culturally specific treatment, has led to endemic violence in all forms within some Aboriginal communities.

Despite all that has been written about the violence and trauma inflicting Australian Aboriginals, the relationship between violence and generational post-traumatic stress needs to be further explored, as to date ‘... insufficient research has been conducted for anyone to speak or write with authority on the issue of contemporary violence within Aboriginal Australia. For this reason, preventative and rehabilitative educational programs cannot be developed to their full potential’ (Atkinson, 1990, p. 24). In fact, there has been no substantial systematic research conducted on Aboriginal males who
have been imprisoned for violent crimes in an attempt to understand the pathology that surrounds that violence. However, for this to occur, a measuring instrument that is applicable to Australian Aboriginal peoples, and that would permit both a quantitative and qualitative measure of the levels of trauma suffered, is required.

In developing such an instrument, the nature of trauma as experienced by Australian Aboriginal peoples must be carefully defined to ensure that cross-cultural aspects of trauma, including language, expression, symptomatology and cultural concepts, are taken into account.
CHAPTER THREE

Methodology – Constructing a cross-cultural, multi-method Indigenist approach

Methodology is important because it frames the questions being asked, determines the set of instruments and methods to be employed and shapes the analyses. Indigenous methodologies are often a mix of existing methodological approaches and indigenous practices (Tuhiwai-Smith, 1999, p. 143).
Chapter Three: Methodology — constructing a cross-cultural, multi-method Indigenist approach

The chequered history of research into Australian Aboriginal peoples by non-Aboriginal people, and the misuse of research outcomes, makes it important to select methodologies that are culturally sensitive, relevant and non-abusive, and which are preferably qualitative in nature (Martin, 2001, 2003, 2007). However, this research incorporates a quantitative component to help overcome the lack of empirical data relating to issues of trauma, particularly generational trauma within Aboriginal Australia. The research methodology has been designed to ensure that the inclusion of a quantitative method has occurred in such a way that cultural integrity has been maintained.

This chapter therefore outlines the foundational basis of an Indigenist research approach, incorporating the principles and functions of *dadirri* (Ungunmerr, 1988 in Stockton, 1995), or deep listening, to guide the research process. Indigenist research, that is research performed and informed by Indigenous Australians that emphasises resistance and political integrity and privileges Indigenous voices by focusing on the individual and communal stories of the research participants as a source of power, is the central philosophy that guides the research process.

The philosophical framework adopted in this research is outlined in relation to the foundational basis, suggesting that the use of a triangulated pragmatic mixed-method approach, using both qualitative and quantitative techniques, is appropriate when conducting cross-cultural studies. Emphasis is also placed on ensuring that cultural integrity is maintained by focusing on ‘Stories’ as the primary validation tool. It is argued that the use of qualitative data, in this case the use of semi-structured interviews, contextualises and validates the quantitative data by improving the cultural specificity of the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ).

This chapter operationalises the primary focus of the research, which is to explore the relationship between Aboriginal male violence and generational post-traumatic stress, by outlining the specific aims, methods and purpose of each research question.

The development of a cross-cultural instrument that measures traumatic stressors and trauma symptoms, as defined by the DSM-III-R for PTSD including cultural idioms of distress reactions relevant to Australian Aboriginal peoples, through a documentary analysis of major reports and focus group discussions is presented, outlining the
methods, procedures and analysis of this process. The procedures for selecting the research participants, including detailed inclusion and exclusion criteria and the ethical and legal clearances that were obtained, are also outlined. Concerns for the safety of the researcher are briefly addressed, followed by a list of the measurement instruments used in the research. A description of the AAVHTQ, the format of the semi-structured narrative interviews following trauma themes and life histories, and the construction of the research participants’ geno-histograms are outlined. The research procedures are detailed, addressing language, literacy and confidentiality issues, followed by the preliminary procedures required to set up the interviews with inmates. The final section of the chapter describes the interview procedure and examines details associated with both the quantitative and qualitative data analysis and presentation.

**Cultural considerations: Foundational basis – an Indigenist approach**

The foundation for this research, by its very nature, must be informed by an Indigenist research philosophy and practice. The research is about Indigenous Australians, and is conducted by an Indigenous Australian, on a subject matter of central importance to Indigenous Australians: incarcerated males, who have committed crimes of violence within their own families and communities. The philosophy, methodology and methods used in the research are therefore paramount.

From within a Western paradigm, the research methodology and method, as outlined in this thesis, encompass a multi-methodological and multi-method pragmatic approach, guided by the Indigenist framework outlined below, which is premised by the work of Indigenous scholars.

As Judy Atkinson, a scholar with Jiman heritage, demonstrates in her book (2002), a number of standpoints must first be acknowledged. Martin Nakata, a Torres Strait Islander man, contextualises the position of Indigenous scholars who, he says, are often engaged in studying texts that have been written about them, which because of the content and context of the text, is not simply an intellectual pursuit but also, ‘an emotional journey that often involves outrage, pain, humiliation, guilt, anxiety and depression’ (1998, p. 2). Researching can also involve an emotional and painful journey. Nakata also delineates Western academic convention, which while imposing itself on Indigenous peoples, has only recently allowed us the academic freedom to negotiate our own intellectual imperatives and critique of our own ways of knowing and being in the world.
Karen Martin, a Noonuccle scholar from the Quandamooka people of south-east Queensland, outlines an Australian Aboriginal research chronology as having the following phases:

- Terra nullius phase: 1770–1900
- Traditionaling phase: 1900–1940
- Assimilationalist phase: 1940–1970
- Early Aboriginal research phase: 1970–1990
- Recent Aboriginal research phase: 1990–2000

Martin, both in the 2001 paper mentioned above and her PhD study on Indigenist research (2007), outlines the ways in which research has previously been used on, and about, Australian Aboriginal peoples to classify, pathologise, subjugate, and dispossess Aboriginal peoples and dismantle our sustaining relationships. She discusses Aboriginal ontologies (assumptions about the nature of reality) and epistemologies (the ways of knowing that reality); standpoints which provide a framework for Indigenist research, a term Martin has taken from the writings of Lester-Irabinna Rigney. Martin describes this framework as having three essential contextual components: Ways of Knowing, Ways of Being, and Ways of Doing (Martin, 2001, pp. 25–26) in the exploration of ontologies and epistemologies.

Lester-Irabinna Rigney (1999), of the Narungga Nation of South Australia, outlines an Indigenist research approach that he says, in the context of cultural safety, should be based on ‘rights, respect and responsibilities’ in research (1999, p. 3). The research conducted in this study has, as a primary principle, cultural safety embedded within its ethics. Rigney further identifies Indigenist research as encompassing three fundamental and interrelated principles (Rigney, 1997). These principles are:

- resistance as the emancipatory imperative
- political integrity
- the privileging of Indigenous voices (Rigney, 1997, p. 12).

In this research, an Indigenist research approach acknowledges the trauma of Australian Aboriginal lives, including the history of attempted physical, cultural and spiritual genocide of Australian Aboriginal peoples, and focuses on the survival and resistance against racist oppression by uncovering and protesting against continuing forms of oppression (Rigney, 1997). This is done through the validation of Stories as
central to the lives of Indigenous peoples.

Moreover, it is research which attempts to support the personal, community, cultural and political struggles of Indigenous Australians to carve out a way of being for ourselves in Australia in which there is healing from the past oppressions and cultural freedom in the future (Rigney, 1997, p. 12).

To truly ensure the political integrity of Indigenist research, Rigney states that Indigenous peoples themselves must undertake the research, thereby providing a social link to the political struggle of the communities (Rigney, 1997). Indigenous Australians can take the research into the heart of the Indigenous struggle and, by doing so, make the researcher responsible to the Indigenous communities and their struggles (Rigney, 1997). The heart of the Indigenous struggle, for this writer, is to document and explicate the Stories that show the pathway from abused to abuser, from victim to perpetrator, and to look beyond the initial impact of wars and colonisations to assess their inter-generational outcomes.

In a research process involving Aboriginal participants, Indigenous voices must be privileged:

"Indigenist research is research which focuses on the lived, historical experiences, ideas, traditions, dreams, interests, aspirations and struggles of Indigenous Australians. It is Indigenous Australians who are the primary subjects of Indigenist research. Indigenist research is research which gives voice to Indigenous people" (Rigney, 1997, p. 13).

Martin (2001) concurred, acknowledging the responsibility Indigenous peoples have to define their own research needs, and to deliver their own research in ways that are meaningful to them, using a research paradigm which is 'liberatory, emancipatory and confirming, and undeniably political' (Martin, 2001, p. 26).

Indigenous Australian peoples have identified qualitative research methods incorporating oral histories (Stories) or narrative-style interviews and focus groups, for example, as preferred methods of data collection, as they promote Indigenous voices in the research process (Winch & Hayward, 1999). In providing a setting for the Stories to be heard, it is important not to deconstruct the narratives too vigorously but let the Stories stand in their own integrity, weaving the research outcomes through, building relatedness between childhood and adulthood — allowing the voices of those informing
the research to be validated. It is essential that Aboriginal peoples themselves contribute to the ongoing dialogue and debate, and actively provide alternative solutions to issues directly affecting them from a culturally informed and knowledgeable position. Collins observes that:

> suppressing the knowledge and viewpoint of any oppressed group makes it easier for the dominant groups to rule because the seeming absence of an independent consciousness in the oppressed can be taken to mean that subordinated groups willingly collaborate in their own victimization (1990, p. 5).

Furthermore, Freire (1972) suggested that it is the knowledge and wisdom of the oppressed that provide the most credible solutions to issues affecting their lives. This is also emphasised in other consciousness-raising approaches, where people are assisted to articulate their own needs and to develop their own strategies of action in order to meet those needs (Chambers, 1993; Fals Borda & Rahman, 1991; Rahman, 1993).

This research provides an avenue to explore and articulate specific issues of concern to Indigenous Australians and is discussed and written by Indigenous peoples for Indigenous peoples, supporting Freire’s (1972) fundamental principle that wisdom comes from below (in reflective discussion), rather than from above.

Judy Atkinson (2002) advocated the use of the principles and functions encompassed in dadirri to provide a framework that ensures Indigenous voices are privileged within the process and that research is conducted in an empowering and meaningful way. Dadirri is an Aboriginal concept referring to a deep contemplative process of listening to one another in reciprocal relationships (Ungunmerr, 1988 in Stockton, 1995).

> While dadirri is a word that belongs to the language of the Ngangikurungkurr people of the Daly River area of the Northern Territory, the activity or practice of dadirri has its equivalence in many other Indigenous groups in Australia. The Gamalarraay [people] have the words winangar (listening) and gurri (deep) so winangargurri has a similar meaning to dadirri. Aboriginal peoples of central Queensland talk of yimbanyiara (listening to elders) which has similar meanings and behavioural responsibilities to dadirri (Atkinson, 2002, p. 97).

Atkinson (2002) suggested that using the principles and functions of dadirri privileges an Aboriginal research approach, encompassing Aboriginal world views, and guides the
process in the Aboriginal community in a way that is both ethical and credible (Atkinson, 2002). According to Atkinson (2002), the principles and functions of dadirri include:

- a knowledge and consideration of community, and the diversity and unique nature that each individual brings to community (In this thesis, community is named as those incarcerated men who, in their diversity, have similar Stories and backgrounds)
- the approval of the research proposal and methods by Aboriginal peoples themselves (The ethics approach validates this principle)
- ways of relating and acting within community — understanding the principles of reciprocity and responsibility (The reciprocity is recognised in our sharing of Stories, and my responsibility to act with fidelity to those stories)
- ensuring that research participants feel safe and that issues of confidentiality are respected (The adherence to cultural safety is also acknowledge by this writer)
- non-intrusive observation, or quietly aware watching
- deep listening and hearing with more than the ears
- listening and observing the self, as well as in relationship to others
- a reflective non-judgmental consideration of what is being seen and heard
- a purposeful plan, based on lessons learnt from listening, with actions informed by learning, wisdom and the informed responsibility that comes with knowledge
- responsibility to act with fidelity in relationship to what has been heard, observed and learnt
- an awareness and connection between the logic of the mind and the feelings of the heart
- acknowledgement that the researcher brings to the research his or her subjective self.

By incorporating the principles and functions of dadirri into the research, the researcher embraces the world views of Aboriginal peoples, and does so with the ethical responsibility and sensitivity necessary to ensure that Indigenous voices are heard and honoured.

Indigenous interests, experiences and knowledge must be at the centre of research methodologies and the construction of knowledge about Indigenous peoples.
Indigenist research is research by Indigenous Australians whose primary informants are Indigenous Australians and whose goals are to serve and inform the Indigenous liberation struggle to be free of oppression and to gain power (Rigney, 1997, p. 14).

This research was conducted by an Indigenous person, and the primary informants were Indigenous Australians, whose voices were heard from within an Indigenist research framework. The privileging of Indigenous voices is further emphasised by the use of qualitative data — the individual Stories of the participants — to complement quantitative data. The individual narratives or Stories of the men participating in this research give meaning and validity to the ‘numbers’ and this emphasis on their words showcases Aboriginal Indigenist methodology, in which the Story is the primary validation tool.

Tuhiwai-Smith (1999) reminds us that whilst Stories are individual, they contribute to a collective, communal Story. The research process, through the deep listening to Stories, may assist the research participants to make sense of their own Stories and to reaffirm their life experiences as distressing, as the process builds relatedness. Karen Martin (2007) uses relatedness theory to explore the philosophy and practice of Indigenist research, defining: ways of knowing; ways of being; ways of doing. Martin discusses these three principles in reference to Story.

Stories are our law. Stories give identity as they connect us and fulfil our sense of belonging. Stories are grounding, defining, comforting and embracing. Stories vary in their purpose and content and so Stories can be political and yet equally healing. They can be shared verbally, physically or visually. Their meanings and messages teach, admonish, tease, celebrate, entertain, provoke and challenge. However, there are protocols to observe with Stories, and one such protocol is that you must only tell a Story, as you know it (Martin, 2007, p. 45).

Cora Weber-Pillwax, a Cree thinker and researcher, explains Cree principles of Stories:

People still tell stories, achimowina and atoyakwina, each with its own protocol, preparation, and purpose. Certain persons tell particular stories at certain times of the year and during certain events or situations. Stories may be for and about teaching, entertainment, praying, personal expression, history, and power. They are to be listened to, remembered, thought about, meditated on. A person’s
word is closely bound up with the story that he or she tells. A person’s word belongs to that person and in some instances can be viewed as being that person, so words – in particular some words in some contexts – are not carelessly spoken (2001a, p. 156).

James Youngblood Henderson maintains that Stories are more than repositories of information and knowledge, and offers:

Not only do stories transmit validated experiences, but they also renew, awaken, and honour life forces (2002, p. 266).

So, as Martin says, Stories have power and give power (2007, p. 46). For the incarcerated men who provided the Stories on which this research is based, and hence from which it derives its power, there is reciprocity. While their contribution is central to this research, in the sharing of their Stories, they will have had the opportunity to reflect on their own lives, and see the relatedness between their early childhood experiences and their adult behaviour. As Martin affirms:

Ways of Knowing are about the past, our ancestry and heritage but equally about our present and future. These are the Stories of our relatedness. Our Stories continue as they incorporate change according to social, political, historical and spatial dimensions of individuals and the group (Martin, 2007, pp. 45–47).

Ways of Being are an extension of our Ways of Knowing, connecting our principal awareness of relatedness to gain a deeper (dadirri) understanding of this relatedness. Through Ways of Being, we learn from our Stories. We therefore have the capacity to begin to make choices and hence reaffirm our Ways of Doing.

By reframing research, political integrity (Rigney, 1997) is achieved when cultural respect and cultural safety (Rigney, 1999), and world view congruence (Gibbs & Memon, 1999), become core to research theory and activity. Youngblood Henderson shares:

As Aboriginal people, we must reclaim our worldviews … to find the path ahead … We must be patient and thorough, because there are no shortcuts in rebuilding ourselves, our families, our relationships, our spiritual ceremonies, and our solidarity (2002, p. 274).
This research focuses on the Stories which relate childhood trauma that may have contributed to the behaviours resulting in the incarceration of Indigenous Australian men for crimes of violence. Hence the philosophical framework which follows rises from the foundation of Indigenist research to provide a pragmatic (practical and realistic) approach to knowledge and validation of the larger, communal Story.

**Philosophical framework**

Keane, Kalupek and Weathers (1997) suggested employing a mixed-method approach in the assessment of trauma-related disorders in a cross-cultural setting by combining, for example, documentary data, focus groups, interviews and psychological tests. Such an approach provides the most reliable information possible and is seen as a necessity, particularly in cross-cultural research (Casebeer & Verhoef, 1997; Keane et al., 1997; Manson, 1997). This approach is particularly important, given the dearth of empirical data available investigating trauma-related disorders, including inter- and trans-generational trauma, in Indigenous Australia that is presented in a way that maintains the integrity of an Indigenist research approach while also providing the much needed empirical data.

To complement this process, triangulation was applied to the research (Olsen, 2004; Reinharz, 1992; Sarantakos, 1993;) to increase the validity of the research, explore and improve knowledge, and deepen and widen the understanding of the research topic. Triangulation is the combination of two or more theories, data sources, methods, or investigators in the one study of a single phenomenon to converge on a single construct (Foster, 1997; Sarantakos, 1993). Apart from the foundational Indigenist approach, this research applied both inter-method triangulation, consisting of two or more methods of different methodological origin and nature, and intra-method triangulation, consisting of two or more techniques of the same method (Sarantakos, 1993). It is argued that the use of a variety of methods and techniques from different methodological origins strengthens the research by obtaining a variety of information on the same issue. It can also increase both the validity and reliability of the research by overcoming the deficiencies of single-method studies (Sarantakos, 1993).

However, there is some debate that multi-method approaches are problematic because the two paradigms (quantitative and qualitative) do not study the same phenomena.

The qualitative paradigm is based on interpretivism (Altheide & Johnson, 1994; Kuzel & Like, 1991; Secker et al., 1995) and constructivism (Guba & Lincoln, 1994), and asserts
that there are multiple realities or multiple truths based on one’s construction of reality. Therefore, reality is socially constructed and constantly changing. There is no access to a reality that is independent of our minds, no eternal referent by which to compare claims of truth (Smith, 1983), and the researcher and the object of study are interactively linked so that findings are mutually created within the context of the situation which shapes the inquiry (Guba & Lincoln, 1994; Denzin & Lincoln, 1994). The emphasis is on process and meaning through studies, using small purposeful samples capable of supplying specific information, rather than a representative sample of the larger group (Reid, 1996).

In contrast, the quantitative paradigm is based on positivism. It asserts that there is only one truth, an objective reality that exists independent of human perception. The researcher and object of study are independent entities and the goal is to measure and analyse relationships between variables, within a value-free framework (Denzin & Lincoln, 1994). Sample sizes are much larger than those used in qualitative research and aim to be representative of the population from which they are derived, particularly when employing statistical methods in order to make inferences about the population based on findings from the samples (Carey, 1993).

Basically, qualitative research emphasises an inductive-subjective-contextual approach, whereas quantitative research emphasises a deductive-objective-generalising approach. Therefore, some have argued that the two methods cannot be combined for cross-validation or triangulation purposes, and can only be combined for complementary purposes (Sale, Lohfeld & Brazil, 2002).

However, this research is not concerned with the simple combination of different kinds of data, but rather the attempt to relate them, so as to counteract the threats to validity in each. It is not expected that each source of data will confirm the other, but rather that each source will contribute an additional meaning so that the sources complement each other. Mixed-methods research is not limited to testing findings against each other; instead, it is about forging an overall or negotiated account of the findings that brings together both components of the conversation or debate. The quantitative and qualitative findings should be mutually illuminating and their interpretation done in a manner that forges connections between them in an integrated manner (Bryman, 2007).

A pragmatic approach has been postulated as a new guiding paradigm in social sciences research combining qualitative and quantitative methods, as a way to redirect our attention to methodological, rather than metaphysical, concerns (Morgan, 2007) and
offers a specific justification for combining qualitative and quantitative methods (Johnson & Onwuegbuzie, 2006). Whereas the quantitative approach to the connection of theory and data relies on deductive methods and the qualitative approach focuses on inductive methods, the pragmatic approach is a version of abductive reasoning that moves back and forth between induction and deduction — first converting observations into theories and then assessing those theories through action (Morgan, 2007). The researcher’s relationship to the research process using the quantitative approach relies heavily on objectivity and with the qualitative approach, subjectivity. However, the pragmatic approach emphasises an inter-subjective approach in which the researcher captures the duality of working back and forth between subjective and objective frames of reference, focusing on processes of communication and shared meaning that are central to any pragmatic approach (Morgan, 2007).

Under a qualitative approach, inferences from data are specific and context-dependent, while, under a quantitative approach, they are universal and generalised. The pragmatic approach seeks to transcend this distinction by rejecting the need to choose between a pair of extremes, instead introducing the concept of transferability. The idea of transferability of research results was borrowed from Lincoln and Guba (1985), who treated the question of whether the things learnt in one context can be applied in another as an ‘empirical’ issue. In other words:

... we cannot simply assume that our methods and our approach to research makes our results either context-bound or generalisable: instead, we need to investigate the factors that affect whether the knowledge we gain can be transferred to other settings (Morgan, 2007, p. 72).

Thus, the focus from a pragmatic approach is on what people can do with the knowledge they produce, and not on abstract arguments about the possibility or impossibility of generalisability.

The pragmatic approach sits comfortably with Indigenist research as the foundation of this inquiry. While qualitative research (the Stories) emphasises the inductive-subjective-situational context, and quantitative research the deductive-objective-generalisation, true objectivity can only be achieved through inter-subjectivity — hearing, knowing and understanding the variations, the nuances, and multiplicity of the Stories, which also have their interconnecting commonality. Inter-subjectivity is achieved through immersion in the Stories — not one Story, but multiple Stories. The researcher, in essence, sits in the centre of the Circle, where Stories are shared and knowledge
emerges in the listening, observing, reflecting, understanding, knowing and acknowledgement of the contribution that each Story makes to the whole body of knowledge. Within Indigenist world views, life is understood as an interactive process within physical, social and spiritual contexts, and research or inquiry into the world around us is approached from a variety of angles, observations and reflections, which are all interconnected processes (Ife, 1995). Within this research, the centre of the Circle, where the researcher sits, provides inter-subjectivity, with an awareness of self, as the listener and the collector of Stories, and others (the Storytellers — the research participants) in their sharing of Stories. Under Western terms of reference, the researcher/listener/collector of data is at the point of triangulation, the Pragmatic, which combines qualitative and quantitative methods, with the interconnection between the qualitative and quantitative providing the Pragmatic centre. Within the research protocols of Judy Atkinson (2002), the receiver of the Stories (the researcher), holds the responsibility of a non-intrusive observation; a deep listening, observing the self as well as others in the circle, a reflective non-judgemental acceptance of what has been heard, with responsibility to record the truth of the Story as it comes from the fidelity and integrity of the Storytellers.

The knowledge and insight gained from using a multi-method approach utilising both qualitative and quantitative methods can provide a framework that is consistent with Aboriginal world views, which are dynamic and holistically informed and directed. The following diagram provides a visual context to the use of Indigenist research philosophy and practice as foundation, information and reflecting the multi-method approach (Figure 1).
Regardless of debate in this area, it is clear that combining qualitative and quantitative research methods in a synergistic fashion provides a richer interpretive framework than is possible by either method alone. It is appropriate in cross-cultural research, especially in indigenous populations that have oral traditions, as it encompasses an Aboriginal world view (Marsella, Friedman, Gerrity & Scurfield, 1997).

Aboriginal communities, political organisations and scholars are insisting that the integrity and validity of research cannot be assured by western methodologies alone. They must be tempered by methodologies that are compatible with Aboriginal methods of investigation and validation (Castellano, 2004, p. 106).

The use of qualitative research methods to enhance the quantitative method is thought to add cultural validity to the research by providing ‘... contextual data to improve the validity and cultural specificity of quantitative survey instruments’ (Baum, 1998, p. 149). In fact, the Cooperative Research Centre for Aboriginal Health suggests that the interface between bio-medical and social science research is ongoing and that the adoption of research approaches that involve a combination of qualitative and...
quantitative methodologies is proposed as a positive way forward in the area of Indigenous health research’ (Henry et al., 2002, p. 5).

Research questions

This study explores the relationship between the violence of male Australian Aboriginals and generational post-traumatic stress. The systematic exploration of this relationship was operationalised by the following four sub-questions and their related aims, methods and purpose:

1. What are the trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples? Key themes derived from a documentary analysis of major seminal reports and focus group discussions with key informants assessed trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples. This information was utilised in the development of the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ), a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples.

2. Has the study population in this particular research been exposed to traumatic and violent events? Semi-structured, in-depth interviews, combined with the application of the AAVHTQ, a cross-cultural instrument developed in the study, determined the nature, level of exposure and frequency of traumatic stressors experienced by the study population.

3. Does the study population in this particular research suffer from symptoms associated with PTSD as defined by the AAVHTQ? The AAVHTQ, a cross-cultural instrument capable of measuring trauma-related symptoms in Australian Aboriginal peoples, was administered to the study population to assess symptoms of PTSD and specific cultural idioms of distress reactions and their potential significance.

4. Are there the patterns of generational trauma and violence (dysfunctional behaviours) amongst the study population in this specific research? The construction of geno-histograms compiled through semi-structured, in-depth interviews explored patterns of generational trauma and dysfunction in the study
population and allowed detection of changes in the rates of traumatic stressors and dysfunctional behaviours across the generations.

**Documentary analysis and focus group discussion research methods**

Research Question 1: What are the trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples?

**Documentary analysis**

Three major reports relevant to understanding Australian Aboriginal experiences of trauma and violence were analysed to address research question one: *What are the trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples?* The aims of the documentary analysis were to identify cultural idioms of stress reactions, specific traumatic stressors for Australian Aboriginals, and trauma and violence themes and Stories from an historical, contemporary and generational perspective. The resultant information formed the basis for the focus group discussions, which in turn informed the development of the AAVHTQ. The three reports considered relevant for this purpose consisted of retrospective primary and secondary documents.

The reports analysed were:

1. *Bringing them home report: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families* (Human Rights and Equal Opportunity Commission, 1997).

This report was considered highly relevant to the study population because it is believed that many Aboriginal peoples in prisons have been affected by the forcible removal of children from their families (RCIADIC, 1991). The report also has national coverage and represents what has been called the ‘second wave’ of historical trauma and grief, resulting from child removal and institutionalisation, and unprecedented government intervention in the intimate workings of Aboriginal families (Haebich, 2000). The report asserts that ‘not one Indigenous family has escaped the effects’ (Bringing them home: A guide to the findings 1997, p. 4) of children being forcibly removed from their families, either directly or indirectly, that these impacts continue to ‘resound through the generations of Indigenous families,’ and that the effects were ‘inherited by their own children in complex and sometimes heightened ways’ (Bringing them home: A guide to the findings 1997, p. 222).

This report specifically represents the study population for this research as it is concerned with Aboriginal male offenders in custody.

3. *The Aboriginal and Torres Strait Islander women’s task force on violence report*, (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

The objective of the task force was to identify the factors behind the escalation of violence in Aboriginal and Torres Strait Islander communities in Queensland. Although this report is specific to Queensland, it clearly represents the study population for this research as the literature review draws on national research identifying multiple explanations of violence in Aboriginal communities and the effect violence has on individuals, families and communities. The report also specifically examines the trans-generational effects of trauma as a cause and effect of violence.

The documentary method employed a secondary analysis of the specific reports focusing on the major themes of the research: *PTSD, trauma, generational trauma, violence* and *dysfunctional behaviours*.

**Focus group discussions**

Focus group discussions were held to provide the expert and experiential advice, guidance and knowledge that informed the development of the AAVHTQ, a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples, which was used in this study. This was achieved by discussing the nature of trauma, eliciting examples of specific traumatic stressors and identifying culture-specific symptoms of trauma relevant to Australian Aboriginal peoples. The focus group discussions also addressed any concerns that the focus group participants had with the research.

A major assessment and methodological problem in cross-cultural PTSD research is related to the concept of cross-cultural equivalence. Cross-cultural equivalence means the extent to which phenomena are equal or similar across cultures. Content, linguistic, conceptual, scale and technical, and normative equivalence are all essential for valid cross-cultural assessment and measurement (Keane et al., 1997). To ensure content equivalence, ‘one needs to consider the various ways in which an individual in that
culture might perceive, evaluate, and experience a high-magnitude stressor’ (Keane et al., 1997, p. 187). Keane et al. (1997) suggested the use of focus groups for creating measurement instruments that understand the broad behaviour and psychological effects of particular traumatic stressors.

The focus group participants in this research were required to test for linguistic and semantic equivalence of items in the AAVHTQ, ensuring that grammar, denotative measuring and connotative meanings were similar to the original HTQ. Additionally, the Katherine Regional Language Centre (KRLC) examined the AAVHTQ and provided additional modifications to ensure the linguistic and semantic content of items in the AAVHTQ were appropriate. Determining whether a concept is similar across cultures (for example, the concept of trauma and violence, and more specifically PTSD and its associated symptoms) is referred to as conceptual equivalence. It was also important to consider the measurement construct of the assessment tools (referred to as scale and technical equivalence), to ensure that true/false methods or Likert scaling were appropriate systems for research participants to answer in a way that reflects their experience or view of life (Keane et al., 1997). Normative equivalence, that is, the norms that are the basis for determining abnormality and normality within a culture, was considered within the constructs of the research and was addressed through the focus group discussions.

As suggested by Keane et al., (1997) invitations to participate in Focus group discussions were sent to 18 various key people in the community who had either committed or experienced violence and traumatic stressors and/or who were professionals familiar with the culture, language and mores of Australian Aboriginal society (Appendix A). A detailed research proposal, a proposed agenda for the focus group discussions (Appendix B) and a focus group discussion consent form (Appendix C) with a stamped, self-addressed envelope were included with the invitation.

A total of seven representatives agreed to participate in the focus group discussions. The following is a list of the focus group participants:

- two male participants, one Aboriginal and one non-Aboriginal, from Northern Territory Corrections — Berrimah prison
- one Aboriginal female participant from the Office for Aboriginal and Torres Strait Islander Health (OATSIH)
- one Aboriginal male participant from Cowdy Ward, Royal Darwin Hospital
one female non-Aboriginal participant from Don Dale Centre — Juvenile Detention, Northern Territory Corrective Services
one Aboriginal male participant from the Menzies School of Health
one Aboriginal male participant from the Council for Aboriginal Alcohol Programs Service (CAAPS).

Focus group participants were required to complete a focus group consent form (Appendix C) indicating that they:

- had read and understood the aims, methods and anticipated use of information derived from the focus group discussions
- understood that the focus group discussions would be used as a basis for developing a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples
- understood the results may be reported in medical, psychiatric, psychological and social academic journals
- were free to withdraw their consent at any time during the focus group discussions, at which point their participation would immediately cease and any information obtained from them would not be used if so requested
- voluntarily and freely gave their consent to participate in the focus group discussions.

The first focus group discussion had the following format:

1. Welcome and introductions
2. Signing focus group consent forms and general housekeeping
3. A brief overview of the research including background, PTSD (generational) definition and symptoms, purpose, aims, methods and the desired outcomes and benefits of the research
4. A definition of what is considered a traumatic stressor or event
5. Introduction of the HTQ, plus a list of traumatic stressors and characteristics of distress derived from the documentary analysis
6. An overview of the purpose of the focus group discussions and requirements of the participants.

The second FGD consisted of brainstorming traumatic stressors relevant to Australian Aboriginal peoples that were not in the list derived from the documentary analysis of
major reports. The participants then attempted to prioritise the list of traumatic stressors. The role of the focus groups in developing the first part of the AAVHTQ was to add, delete and/or change the wording of the questions in relation to the list of traumatic stressors, so as to reflect the 17 most common traumatic stressors relevant to Australian Aboriginal peoples.

The third FGD brainstormed symptoms or reactions to distress, trauma and violence that are culturally specific to Australian Aboriginal peoples, and which were not on the list derived from the documentary analysis of major reports. The participants then attempted to prioritise the list of culturally specific symptoms. The role of the focus groups was to add, delete and/or change the wording of the questions in relation to the list of culturally specific symptoms, so as to reflect the 14 most common symptoms relevant to Australian Aboriginal peoples.

The fourth FGD addressed the 16 trauma symptoms relating to the DSM-III-R for PTSD to ensure the linguistics, content and form of the questions were appropriate. The concept of the 16 trauma symptoms relating to the DSM-III-R for PTSD needed to remain, however the wording could be changed into plain English or Aboriginal English and adjusted for cultural sensitivity. The scoring scale technique was also addressed in this FGD, to ensure it was an appropriate means of scaling for Australian Aboriginal peoples.

The fifth FGD involved reviewing the final version of the AAVHTQ and attempting to gain consensus amongst the focus group participants for the AAVHTQ. Additionally, the list of concerns, suggestions and potential solutions to those concerns identified during the course of the focus group discussions was approved by the focus group participants as having been satisfactorily addressed.

To address cross-cultural equivalence within the focus group discussions, content, linguistic, conceptual, scale and technical, and normative equivalence were all appropriately adjusted, as required, to meet the specific cultural context. Cultural idioms of stress reactions and specific examples of traumatic stressors relevant to Australian Aboriginal peoples were addressed in the focus group discussions by listing universal concepts of distress and trauma, then eliciting, categorising, examining and identifying differences and similarities in the concepts. This was achieved by systematically applying a five point check list when addressing items in the AAVHTQ. The following questions were used to address both the content and form of each of the items in the AAVHTQ:
1. What does this question mean to me?
2. Is the intended meaning easily understood?
3. How would I ask this question of someone else?
4. Might I encounter resistance in obtaining an answer to this question?
5. How could I rephrase the question to reduce such resistance?

Focus group participants were instructed to apply the five point check list to the development of traumatic stressors, characteristics of distress and the scoring scale. Focus group participants were also encouraged to identify any concerns or suggestions they had with the research, specifically with the questionnaire, and to think about potential solutions to those concerns. This process occurred throughout the course of the focus group discussions, with approval that the identified concerns, suggestions and potential solutions had been adequately addressed at the final FGD.

The results of the focus group discussions included the merging of the results from the documentary analysis with the linguistic and semantic modifications from the KRLC. These are presented in table form (refer to Chapter Five, Table 11 and 12) in order to get a clear picture of the processes that took place in the development of the final AAVHTQ.

**Qualitative and quantitative research methods**

Research Question 2: Has the study population in this particular research been exposed to traumatic and violent events?

Research Question 3: Does the study population in this particular research suffer from symptoms associated with PTSD, as defined by the AAVHTQ?

Research Question 4: Are there patterns of generational trauma and violence (dysfunctional behaviours) amongst the study population in this specific research?

**Research participants**

**Sample**
A non-random, proportional stratified sampling procedure was applied using quota sampling, in which the researcher set a quota of research participants to be chosen from a specific population group by defining the basis for choice (e.g. age, gender, ethnicity and crime type) and by determining its size. The quota set for this research was 70 Australian Aboriginal men between the ages of 18 and 50 who were currently
incarcerated for a crime defined as violent in nature, i.e. homicide, assault, sexual offences, and theft, robbery and breaking and entering that involved an act of violence against the person, as opposed to a property offence.

**Detailed inclusion criteria for research participants**

- Sentenced inmate
- Male
- Personally identify as Australian Aboriginal
- Aged 18-50
- Incarcerated for a crime of violence (homicide, sexual assault, assault, and theft, robbery and breaking and entering which involved violence against a person)
- Voluntary participant
- Willing to be interviewed by a female
- Would be incarcerated at the time of the interview

**Detailed exclusion criteria for research participants**

- Female
- Non-Aboriginal
- Incarcerated for a crime that is not violent in nature
- Non-voluntary participant
- Not willing to be interviewed by a female
- If there is a possibility that the inmate will be released before the interview date

To increase national representation, ten research participants were chosen from each of seven institutions in six States/Territories across Australia. It was decided to include 20 research participants from the Northern Territory (ten from both Alice Springs and Darwin), due to the large population of Aboriginal peoples in that region. New South Wales corrections declined the request to conduct research in their state, due to resource limitations and methodological issues relating to multi-method approaches and Indigenist validation processes that rely heavily on qualitative material. The study population was therefore reduced to a total of 60 research participants. A list of the prisons visited is provided in Appendix D.

Sarantakos (1993) argued that it is valid to generalise on the basis of a small sample of the total population if the study population is homogenous, as is the case with the current research topic (Aboriginal males who have committed a crime of violence against the person).
To have a truly homogenous population is very difficult. The study population for this specific research can be considered homogenous based on gender, race, age and crime type, even though the strict definition of ‘homogeneous’ refers to the quality of coming from the same origin, or being the same, or having identical attributes (Sarantarkos, 1993). Accepting homogeneity does not suggest there are not differences within the population, particularly between different tribal groups or other non-identified variables, but rather accepts a practical level of ‘sameness’ for the purposes of this research.

Within the qualitative framework, generalisations are based on the typical case studied, which is thought to be representative of a species. What qualitative research claims is that such findings can be interpreted beyond the cases studied and are examples of an ‘exemplar generalisation’ or ‘analytical generalisation’; that is, the sample units can act as typical representatives of a class or group of phenomena. That said, this research does not claim that it will be able to generalise the results to ‘all Australian Aboriginal men’ but rather make ‘exemplar generalisation’ that Australian Aboriginal men aged 18-50, who have been exposed to high levels of trauma and violence throughout their lives and who are currently incarcerated for a crime of violence, may be more vulnerable to developing trauma-related symptoms. Furthermore, as discussed in the section titled philosophical framework, the pragmatic approach utilised in this research focuses on making inferences from data based on what people can do with the knowledge they produce, rather than developing abstract arguments about the possibility or impossibility of generalisability.

**Justification for the selection of an offender population as potential research participants**

The most effective and efficient way to recruit potential research participants for the proposed research was to invite inmates who met the inclusion criteria. This was based on a number of reasons:

- The research was specifically about Australian Aboriginal men who had committed a violent crime; therefore, this made the decision to recruit research participants from correctional institutions the most effective and efficient choice.
- It would have been very difficult to recruit research participants from the wider community who meet the selection criteria, as many people are not willing to identify that they have committed the specific crimes of violence outlined in the inclusion criteria. Theoretically, research participants could have been recruited through the parole system, but the geographical and timing restraints of the
research made this a difficult method of recruiting the required number of research participants.

- Individuals who have committed crimes of violence are often imprisoned for lengthy periods, making the recruitment process outside the correctional system very difficult. This is compounded by geographical difficulties when considering that some Aboriginal men live in remote communities.
- Within the offender population there was an accessible group of Australian Aboriginal males who could be identified as having been convicted of crimes outlined in the inclusion criteria.
- Legal definitions of violent behaviour (crimes of violence such as homicide, assault, sexual assault, and theft, robbery and breaking and entering which involve violence against the person) are consistent for all research participants if selected from within the offender population, whereas in a community setting, what is considered violent and what is not may be open to individual interpretation.
- The ability to standardise and clearly identify research participants who had been convicted of crimes of violence, and who met the research inclusion criteria, could only be achieved through the selection of research participants from within the offender population of a correctional institution.

Ethical and/or legal clearances obtained
The Northern Territory University Human Ethics Committee gave their formal approval to commence the research on 28 February 2001. Ethics approval is valid for one year; thus each year, the ethics approval was updated until the completion of the research project.

Historically, research that has been conducted on Australian Aboriginal peoples has, in some instances, been used for negative political purposes and has contributed to the further oppression of Australian Aboriginal peoples (Atkinson, 1996). For this reason, ethics policies and protocols have been developed to specifically ensure that research meets appropriate standards when dealing with Australian Aboriginal peoples. A number of fundamental principles must be applied, such as gaining the informed consent of individuals and/or communities involved in the research and demonstrating the benefit of the research to the local, as well as broader, Aboriginal and Torres Strait Islander peoples. Acknowledgement of ongoing Australian Aboriginal peoples’ ownership and appropriate use of research results were all addressed within the research methodology, specifically the foundational basis of the research, which encompasses the principles and functions of dadirri (Ungunmerr, 1988 in Stockton, 1995).
Evidence of support and consent for this research by Australian Aboriginal communities and individuals was granted from the following Australian Aboriginal organisations and people:

- Marcia Langton, former Director of the Centre for Indigenous Natural and Cultural Resource Management (CINCRM) (Details held on file in the Higher Education and Research Branch)
- Cooperative Research Centre for Aboriginal Health (CRCAH), Indigenous Fourth Pathway Project, In-kind Project
- State Justice and Correctional Departments Research and Ethics Committees
- seven focus group discussion participants, who included Australian Aboriginal peoples who had experienced and/or committed violence, had been exposed to traumatic stressors or who were professionals familiar with the culture, language and mores of the society
- the Aboriginal male research participants from six prisons in five States/Territories of Australia, who are currently incarcerated for a crime of violence and who gave their informed consent in writing before participating in the research, and again just before their interview commenced.

As stated above, State Justice and Correctional Departments throughout Australia require formal approval for research that is conducted in their prisons, and generally have their own research management committees and ethics boards that are required to approve research. Letters requesting formal approval to conduct this research in specified prisons were sent to State Justice and Correctional Departments CEOs or equivalents throughout Australia (Appendix E). The process of gaining this approval and the specific conditions of approval (which were all met) is outlined in Table 5.
<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Approval granted by</th>
<th>Name/s of correctional institution</th>
<th>Date of approval</th>
<th>Conditional upon:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Territory</td>
<td>Northern Territory Correctional Services, Commissioner</td>
<td>Alice Springs Correctional Centre Benimiah Prison (Darwin)</td>
<td>22 June 2001</td>
<td>ethics standards that apply to such research</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>no identifying codes in relation to the research participants (e.g. names of prisons, names of people or location identifiers) are to be used within the thesis.</td>
</tr>
<tr>
<td></td>
<td>Victoria</td>
<td>Department of Justice, Research Ethics Committee</td>
<td>2 November 2001</td>
<td>advising participants that any reference to non-adjudicated offences should be avoided as they may need to be referred to the appropriate authority. A clause to this effect must be added</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Port Phillip Prison</td>
<td></td>
<td>no identifying codes in relation to the research participants (e.g. names of prisons, names of people or location identifiers) are to be used within the thesis.</td>
</tr>
<tr>
<td>Queensland</td>
<td>Department of Corrective Services, Research Committee</td>
<td>Townsville Correctional Centre</td>
<td>6 June 2001</td>
<td>mutually agreeable arrangements being made with the General Managers of each centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>no identifying codes in relation to the research participants (e.g. names of prisons, names of people or location identifiers) are to be used within the thesis.</td>
</tr>
<tr>
<td></td>
<td>South Australia</td>
<td>Department for Correctional Services, Research Management Committee (RMC)</td>
<td>11 October 2001</td>
<td>the words ‘the views expressed in this report are not necessarily those of the Department for Correctional Services’ should be displayed clearly on this report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yatala Labour Prison</td>
<td></td>
<td>a draft of this report being made available to the RMC prior to its completion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a copy of the final report and a one to two page summary being forwarded to the RMC, as soon as practicable following completion of the study</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>any intended publication of results being approved by the RMC</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>no identifying codes in relation to the research participants (e.g. names of prisons, names of people or location identifiers) are to be used within the thesis.</td>
</tr>
<tr>
<td></td>
<td>Western Australia</td>
<td>Ministry of Justice, Policy and Research Applications Committee and Aboriginal Policy and Services and Health Services Directorates</td>
<td>27 September 2001</td>
<td>providing the Department with a copy of the final PhD thesis, as well as a copy of any subsequent secondary analysis done (including related publications in the researcher’s name), preferably in electronic form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Canning Vale Prison</td>
<td></td>
<td>no identifying codes in relation to the research participants (e.g. names of prisons, names of people or location identifiers) are to be used within the thesis.</td>
</tr>
</tbody>
</table>
**Researcher's emotional and physical safety**

The researcher's emotional and physical safety was considered in the planning stages of this research. The various State/Territory Correctional and Justice Departments throughout Australia have in place protocols for personal safety that the researcher was required to follow for each prison. Additionally, the research supervisor and a network of colleagues in the field were utilised for de-briefing sessions when more intense, specific discussions were necessary.

**Measuring instruments**

The measuring instruments were administered according to the research schedule, (Appendix F) and consisted of semi-structured, in-depth interviews with five parts:

1. Data on demographic characteristics, including age, education, marital status, number of children, usual occupation, crime types, recidivism, traditional language and use of English (part of research schedule)

2. Data on individual stressor events or experiences specific to Australian Aboriginal peoples, producing two total scores (continuous variables): *number of traumatic stressors and level of exposure* (17 items that are Aboriginal specific — first section of AAVHTQ) (Appendix G)

3. Data on trauma symptoms, producing two total scores (continuous variables): *AAVHTQ symptom severity score — composite score* and *DSM-III-R symptom severity score — PTSD total score* (16 items from DSM-III-R and 14 items that are Aboriginal specific — second section of AAVHTQ) (Appendix G)

4. Qualitative, semi-structured, in-depth narrative interview focusing on life histories, trauma themes and violence, and expanding on AAVHTQ and geno-histograms. The qualitative data contextualises, validates and adds more insight to quantitative data and was used to cross-check data in AAVHTQ and geno-histograms (part of research schedule)

5. Geno-histograms developed from semi-structured, in-depth narrative interview, mapping generational trauma and violence in current and older generations. The data produce a *total geno-histogram score and rates of specific traumatic stressors and dysfunctional behaviours* that measure increases or decreases in the events and behaviours from the current to the older generations.

**Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ)**

The AAVHTQ is an adaptation of the Harvard Trauma Questionnaire (HTQ), which is a cross-cultural instrument designed for the assessment of traumatic stressors and traumatic responses in one instrument. Richard Mollica and his colleagues (1992) at the
Indochinese psychiatric clinic at Harvard University developed the questionnaire. The HTQ manual provided guidelines for the adaptation of the questionnaire to other cultures. Both traumatic stressors and trauma symptoms are included in the questionnaire.

In the first section of the AAVHTQ, 17 items describe a range of stressors experienced by Australian Aboriginal peoples. The 17 traumatic stressors listed were derived from a comprehensive documentary analysis, substantiated by focus group discussions with key informants, and were then refined by the KRLC to ensure linguistic and semantic equivalence. For each item, the research participant communicated whether he had (1) not experienced, (2) heard about, (3) witnessed, or (4) personally experienced that stressor. This was communicated to the research participants by asking them if they saw any of these things happening (witnessed), heard noises like this were going on (heard about), or if it happened to them at any time (personally experienced).

A number of traumatic stressors variables were generated from the 17 stressor experiences by counting all the items endorsed, disregarding whether they were heard, witnessed or experienced. Instead of attempting to assess the relative severity of a specific traumatic stressor, this study measured the degree of exposure or level of exposure to events identified in the documentary analysis and focus group discussions as central to the Australian Aboriginal experience. This approach enabled a response scale that was free from preconceptions regarding possible relationships between types of events and symptom severity. It was important to present the participants with response categories that implied a range of exposures, rather than asking direct ‘yes/no’ questions, thereby allowing them to respond to items such as unwanted sex and touching (rape and/or sexual abuse), without revealing more about their experiences than they were inclined to, while not denying them altogether. The level of exposure variable was calculated by counting all positive answers on each of the four categories or response, to produce a total number of events experienced, a total number of events witnessed and a total number of events heard about, as well as those that received no endorsement at all.

The symptom portion of the AAVHTQ consists of 30 items, 16 of which correspond to DSM-III-R criteria for PTSD, and specifies a cluster of symptoms that are associated with overwhelming environmental stress. These symptoms are arranged along three dimensions: re-experiencing traumatic stressors, physiological arousal, and avoidance and numbing. Although the concepts of the 16 DSM-III-R symptoms were not changed, it was necessary to ensure that the wording was pitched at an appropriate level. To
achieve this, the trauma symptoms were refined by the focus group discussions and subsequent review by the KRLC to ensure linguistic and semantic equivalence. The 14 additional trauma symptoms, which tap into other aspects of distress, as it is expressed in Australian Aboriginal culture, were developed through the documentary analysis and focus group discussions, and then similarly refined by the KRLC to ensure linguistic and semantic equivalence. These items were scored on the following four-point scale: (1) not at all, (2) a little bit, (3) a fair bit, and (4) a lot. To ensure clarification to the research participant, each level of the scale was demonstrated by the researcher holding her arms in the shape of a circle. For example, to demonstrate a little bit, the researcher held up her hands in the shape of a small circle, or for a lot, a large circle using her arms.

As the list of 30 items in the symptom portion of the AAVHTQ includes 16 DSM-III-R items, two total scores for each research participant were calculated.

1. AAVHTQ symptom severity score (total score): the sum of the scores for items 1–30 divided by 30
2. DSM-III-R symptom severity score (total PTSD score): the sum of the scores for items 1–16 divided by 16.

Essentially, two continuous variables were created: the AAVHTQ symptom severity score and the DSM-III-R symptom severity score. As per the recommendation from the HTQ manual for the adaptation of the instrument to other cultures, research participants with AAVHTQ symptoms severity scores (total scores) equal to or greater than 2.5 were considered symptomatic for PTSD (Mollica et al., 1996).

It is important to note that the AAVHTQ has not been completely validated by Western standards on Australian Aboriginal peoples and, as such, results need to be interpreted carefully and sensitively. In fact, there is no tool available that has been specifically developed and validated for Australian Aboriginal peoples to measure trauma-related disorders. With this in mind, the HTQ was chosen as the most suitable tool, as it is a cross-cultural instrument that provides guidelines for its adaptation to a specific culture. Through a documentary analysis of major reports and focus group discussions with key informants, the HTQ was adapted into a form considered suitable for Australian Aboriginal peoples. Additionally, the language in the questionnaire was approved by the KRLC as culturally appropriate ‘Aboriginal English’. Under a Western-oriented quantitative framework, validation of the AAVHTQ must be tested against a ‘gold standard’. This becomes ‘catch 22’, as the primary reason for developing the AAVHTQ
is the lack of a current instrument that is culturally sensitive and relevant. Therefore, to measure the AAVHTQ against an existing non-Aboriginal gold standard can not provide an indication of validity. Within an Aboriginal methodology, however, it is the Stories, the qualitative narratives that give credibility and validity to the research. It is the narratives that provide contextual data that improve the validity and cultural specificity of the quantitative questionnaire.

Semi-structured narrative interviews following trauma themes and life histories
Semi-structured narrative interviews were conducted, using primarily open-ended questions to provide a non-directive means of gaining information from the participants about their life experiences, including family histories, and inviting participants to speak freely. The in-depth interviews were audio taped with the permission of the interviewees. This method provided a certain amount of flexibility and non-intrusiveness, whilst also allowing for experiences to be explored in some depth. Questions that centred on the participants’ understanding of violence and experience of violence throughout their lives were addressed using general questions such as:

1. What is your understanding of violence?
2. How many times have you been charged with a violent offence?
3. What were the charges?
4. Can you tell me what you think makes you violent?
5. Has there been much violence in your life?
6. Can you tell me a bit about it?

Questions that centred on the participants’ understanding of trauma and experiences of trauma throughout their lives, including the impact of current events, were addressed using general questions such as:

1. What is your understanding of trauma?
2. Can you tell me about some of the good things and bad things that have happened to you in your life?
3. Have you ever experienced something that is so bad that it would be very upsetting to almost anyone?
4. How many things like that have happened to you?
5. What was the worst thing like that, that happened to you?
6. Do you think about these things a lot when you are by yourself?

Research participants were also encouraged to expand on trauma themes and symptoms identified in the AAVHTQ.
Geno-histograms

Geno-histogram construction has been identified as a particularly helpful method of data collection to elicit patterns of generational trauma and violence (Danieli, 1993). The geno-histograms are a structural diagram of a family’s current (1st generation) and older (2nd and 3rd generation) generational family relationship system. With the help of the researcher, research participants were asked to construct their own current and older generational family trees, specifically focusing on traumatic stressors and dysfunctional behaviours of family members. The current and older generational family tree codes that identified the specific traumatic stressors and dysfunctional behaviours are provided in Appendix H.

Procedure

Non-English languages and literacy issues

Many Australian Aboriginal peoples, particularly from communities, use English as a second (or more) language and educational levels can be very low or non-existent for some. Therefore it was important to consider these issues and incorporate procedures that provided the most comfort and optimal outcomes for the research participants. Translating written material into specific languages was considered; however, there are around 250 distinct Australian Aboriginal languages, including Pidgin English and Kriol languages specific to particular geographic locations. Advice from the KRLC stated that only 5% of the Aboriginal prison population in the top end of the Northern Territory and Western Australia have Kriol literacy. Alice Springs, Tennant Creek and anywhere south of Broome in Western Australia do not support Kriol literacy. Furthermore, only a small percentage of people who speak community languages also have literacy in that language. It was deemed unproductive to provide the written material in Kriol and/or community languages specific to a geographic location.

The optimum method of ensuring that most interviewees understood what was to be discussed was to put everything in plain English or, as suggested by the KRLC, ‘Aboriginal English’, whether spoken or written. This view is supported by Donovan and Spark (1997) in their guidelines for survey research in remote Australian Aboriginal communities, which provide a general recommendation for researchers to use plain English rather than attempting to use dialect.

When speaking English to Aboriginal people not fluent in English, interviewers should treat them in the same way as they would treat any other non-English-speaking persons, that is they should: speak slowly and clearly; avoid using
long words when short words will do (for example, “investigate” versus “find out”); avoid using technical jargon or figures of speech (for example, “clear as mud”, “flat as a tack”; and use concrete rather than abstract nouns (Donovan & Spark, 1997, p. 92).

The KRLC translated all the reading material into plain English or ‘Aboriginal English’ and pitched it at a grade four level. Some general recommendations on conducting the interviews were also provided by the KRLC, including performing comprehension checks during various stages of the interviews (i.e. after explaining the main points for discussion, the research participants were asked to tell the researcher, in their own words, what was to be discussed). Rather than asking ‘Do you understand?’ and having people often answer ‘Yes’, regardless of their comprehension, the researcher would ask ‘Can you tell me in your own words what I am going to talk about?’ The researcher explained she needed to know that she had explained herself properly (as opposed to the research participant failing to understand with the possible implication that they are a bit slow). This elicited fuller responses from the research participant, as required by the research, rather than monosyllabic answers.

Research participants were also offered the option of using an interpreter. It was the responsibility of the designated contact person in each prison to ensure that the information packages provided to inmates were fully understood and that potential research participants clearly understood that interpreters would be available if needed. The first consent form included a section asking the preferred language of the potential research participant and whether they wanted to have an interpreter. Additionally, the researcher was required to discuss potential communication issues prior to commencing the interview, ensuring that these issues were fully addressed by the designated contact person assigned by the prison. At the time of the interview, if the researcher determined that the participant’s first language was not English, she asked what language he used, if he learnt it at school or just at home, and explained that she only spoke English but that an interpreter could be arranged for the interview, which would be postponed to later in the week. If the research participant chose not to have an interpreter, the researcher reminded him that the interview would be conducted in English. The researcher then explained that if something did not make sense, the research participant should question it, and if he wanted to explain something from his own language or culture, then he should do so. Only one research participant requested an interpreter. The services of the Aboriginal Interpreter Services (AIS) were used for this interview.
Confidentiality
Issues of confidentiality were addressed by ensuring that data collected were stored in a secure location and that the tapes were numbered so that they could not be traced to an individual. A professional transcription service was used to transcribe the semi-structured narrative interviews and a confidentiality statement for the transcribers (Appendix I) and instructions on the format for the transcriptions (Appendix J) were agreed to and signed. Once transcription of tapes was complete, the interview tapes were returned to the researcher for safe keeping. A disclaimer was provided with the information sheet, assuring the research participants that all data and tapes would remain confidential and stored in a safe environment. Furthermore, the confidentiality of interview material also covered any disclosure of potentially legally sensitive matter by the research participants and ensured that the researcher would have no legal impediment to discussing prior criminal history or the obligation to report any incidents of potential illegal activity that had not already been reported to the authorities. As requested by the various State and Territory correctional institutions, no identifying codes in relation to the research participants were used within the thesis (e.g. names of prisons, names of people or location identifiers). To meet this requirement and to ensure the confidentiality of the research participants, AAVHTQ scores were used to reference the research participants in the thesis (e.g. research participant, non-PTSD symptomatic with a score of 2.37). All material relating to this research, including the tapes containing the narrative interviews, will be stored in a safe environment for up to five years from the date of submission of the final thesis and then destroyed by means of incineration.

Preliminary procedures
Once approval was provided by the State Justice and Correctional Departments, formal written advice was sent to the designated contact person within the specified prisons, informing them of the research approval. The designated contact person was assigned by the State and Justice and Correctional Departments, at their discretion, based on the suitability of the person to the research purpose (Table 6).
Table 6: Designated contact people in correctional institutions assigned by the State Justice and Correctional Departments

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Correctional Institution</th>
<th>Designated contact person/people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Territory</td>
<td>Alice Springs Correctional Centre</td>
<td>Program Manager</td>
</tr>
<tr>
<td></td>
<td>Berrimah Prison (Darwin)</td>
<td>Manager, Prisoner Rehabilitation</td>
</tr>
<tr>
<td>Victoria</td>
<td>Port Phillip Prison</td>
<td>Manager, Therapeutic Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Koori Liaison Officer</td>
</tr>
<tr>
<td>Queensland</td>
<td>Townsville Correctional Centre</td>
<td>Manager, Offender Development</td>
</tr>
<tr>
<td>South Australia</td>
<td>Yatala Labour Prison</td>
<td>Manager, Intervention</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Canning Vale Prison</td>
<td>Psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prisoner Support Person, Offender Management</td>
</tr>
</tbody>
</table>

Attached to the formal written advice sent to the designated contact person was an instructional package containing a covering letter (Appendix K), research summary sheet (Appendix L) and copies of inmate packages with instructions (Appendix M). The inmate packages consisted of a letter of invitation to inmates to participate in the research (Appendix N), a plain language statement (Appendix O), and a preliminarily first consent form (Appendix P). The KRLC revised all of the items in the inmate package to ensure that the language was pitched at an appropriate level.

It was the role of the contact person in each prison to distribute the inmate packages to Aboriginal inmates who met the research inclusion criteria: i.e. Aboriginal males aged 18–50, currently incarcerated for a crime of homicide, assault, sexual offences, and theft, robbery and breaking and entering that involved violence against the person, and who were not adverse to being interviewed by a female. The research participants were given the opportunity to examine the inmate packages or have the appropriate contact person read it to them, ensuring they understood the details of the project before deciding they were willing to voluntarily participate in the research.

Inmates who decided to participate in the research were required to sign the first consent form, which was collected by the contact person within the prison. Once ten participants were identified from each prison, the first consent forms were either mailed to the researcher or the researcher collected them when she arrived at the prison. Prior to arriving at the prison, the researcher confirmed with the contact person the intended dates and times for the interviews.

**Interview procedure**

In line with the research schedule (Appendix F), the preliminarily stage of each interview began with general introductions and confirmation that the research participant had been given prior opportunity to read through the inmate package or have the information in the package explained to him in a comprehensible way. The researcher discussed
the plain language statement with the research participant to ensure he understood the purpose of the research and his involvement in it. The researcher briefly introduced the structure of the interview research schedule to each participant.

Research participants were also encouraged to question procedures at any time during the interview. Most importantly, because of the political and potentially highly emotive nature of the research, careful consideration was taken in terms of ensuring the welfare of each research participant.

This was necessary because individuals who still suffer from the effects of trauma may be re-traumatised every time something reminds them of the original trauma. Where PTSD is involved, this is true even for those who have made some degree of recovery. Things that remind people of their original trauma can bring back memories of that trauma and may result in severe distress (Dr Jane McKendrick, Victorian Aboriginal Mental Health Network, evidence 310, cited in the Bringing them home report, Human Rights and Equal Opportunity Commission, 1997, p. 17).

To address possible re-traumatisation, a preamble about the emotive nature of the questions and the possibility of touching on subjects that could be emotionally and mentally stressful were discussed before the interview commenced. Additionally, on-site social workers and psychologists were fully briefed on the nature, purpose and goals of the research study before the commencement of interviews, and research participants were reminded that counselling and support was available and encouraged to access these services if they felt they were adversely affected by the interview.

Final confirmation of the research participants’ role in the research was obtained by going through the final consent form (Appendix Q) in detail and ensuring that the research participants acknowledged that:

- they understood the purpose and goals of the research
- they understood the research procedure
- participation was voluntary
- they felt comfortable being interviewed by a female
- they felt comfortable conducting the interview in English and, if not, understood that they could request access to an interpreter
- they clearly understood the nature of the material to be discussed and the potential for it to cause distress
- they could tell as little or as much as they wanted
they understood that the interviews would last approximately two hours
they understood the interview would be audio taped
they understood the interview was completely confidential
they were empowered to stop taking part in the research at any time if they felt uncomfortable and, if they chose to do so, that their data would not be used
the correctional centre psychologists and welfare staff had made a commitment to provide ongoing aftercare counselling if they required it.

Once each research participant acknowledged the above points, he was required to sign the final consent form indicating that both he and the researcher were satisfied that the details of the interview and the research participant’s rights were clearly understood.

The interview then officially commenced and the tape recorder was turned on. The interview started with general background information and then moved on to violence and trauma themes, as previously detailed in the 'semi-structured narrative interviews following trauma themes and life histories' section. When using the ‘Aboriginal way’ of interviewing, the relationship that the researcher and research participant initially develop is a crucial strategy in determining the impact of the interview process on the research participant. Techniques such as making connections (family/place), two-way sharing, yarning and storytelling, humour, talking plain, reading non-verbal communication, non-shaming, being open to scrutiny and focusing on the whole person in their context provide an informal and trusting environment, enabling the research participant to feel safe and relate on an equal level (Lynn, Thorpe, Miles, Cutts, Butcher & Ford, 1998). Using this style of interviewing, the AAVHTQ was then administered, encouraging research participants to expand on trauma and violence themes and symptoms endorsed in the questionnaire.

In the last part of the interview, before the geno-histogram was drawn up, the researcher showed the research participant her own family tree as a model and shared stories of her own life experiences of violence and trauma. The use of self in Aboriginal interview styles takes on a whole new dimension (Lynn et al., 1998). The informal, friendly emphasis in the interactions requires the Aboriginal researcher to engage in far greater self-disclosure, sharing the storytelling in the process of connecting with the person (Lynn et al., 1998). For Aboriginal peoples, information gathering is an exchange process involving an ongoing reciprocal relationship and, specifically for traditional peoples, information exchange was, and is, part of the building of a relationship (Donovan & Spark, 1997; Lynn, et al., 1998). In contrast, most Western researchers engage in minimal self-disclosure and sharing, while at the same time expecting the
participant to share intimate aspects of their lives, although the mutual sharing of life experiences is a principle strongly advocated in feminist and empowerment approaches (Lynn et al., 1998).

Using the geno-histogram as a talking point, discussion then focused on positive childhood memories, plans for the future (including goals within the correctional institution, such as further education or artwork for those who had a life sentence), and again sharing stories in a reciprocal fashion. Finally, the research participants were asked how they felt about the interview, how they were feeling and if they felt the need to follow up the interview with counselling from correctional staff.

**Data analysis**

**Quantitative data (demographic, AAVHTQ and geno-histogram data)**

All of the quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS) software for Windows (version 13.0). Descriptive statistics were processed to present the demographic characteristics of the research participants. Descriptive statistics were also employed to analyse the AAVHTQ data to establish if the study participants were experiencing symptoms associated with PTSD according to both the *DSM-III-R symptom severity score* and the *AAVHTQ symptom severity score*, including exploring the most commonly occurring trauma symptoms. Patterns of cumulative trauma were also examined through the descriptive statistics, establishing the *number of traumatic stressors* and exploring commonly endorsed traumatic stressors across the study population, including identifying the *level of exposure*.

The reliability of the AAVHTQ was assessed for internal consistency using Cronbach’s coefficient alpha. Sensitivity and specificity tests were used to examine criterion validity of the AAVHTQ, while the Pearson product moment correlation was used to assess cross-validation on all four continuous variables: *number of traumatic stressors, level of exposure, DSM-III-R symptom severity score* and *AAVHTQ symptom severity score*.

Research participants were grouped into non-PTSD symptomatic and PTSD symptomatic groupings according to the *AAVHTQ symptom severity score* (≥2.5 is PTSD symptomatic) and, using a between-subjects design, independent group t-tests were conducted on the three remaining continuous variables (*number of traumatic stressors, level of exposure* and *DSM-III-R symptom severity score*) to determine whether the difference between means for the two groups on the three sets of scores was significant.
To test whether any of the specific demographic characteristics, trauma symptoms, or traumatic stressors endorsed by the participants were associated with PTSD, non-parametric crosstabs and chi-squared tests for association were performed. Two-tailed exact chi-squared tests were used with crosstabs when the number in the cells dropped below five. Two-tailed Fisher’s exact tests were used when the expected frequencies were less than five for two or more cells of a 2 x 2 table. For all these analyses, alpha was set at .05.

Rates of traumatic stressors and dysfunctional behaviours across the current and older generations derived from the geno-histogram data were analysed using paired t-tests to determine any changes in the rate of those events and behaviours across the generations and to assess patterns of generational trauma and violence.

**Qualitative data derived from semi-structured narrative interviews**

Verbatim transcriptions of the audio taped semi-structured narrative interviews were provided by a professional transcription service. Conversational fillers, such as ‘um’, ‘er’, ‘mm’ etc., and non-verbals, such as laughter, crying, sighing, long pauses after a question and tones depicting emotions such as anger, were also included in the transcriptions. The transcriptions produced a rich qualitative data set. To ensure emotive tone was not lost in the categorisation and coding of the narratives, a manual thematic analysis was conducted, rather than using a qualitative data analysis program. Conducting a manual analysis required complete immersion in the data and the re-reading of the transcriptions more times than would be required if a computer program was used. The manual thematic analysis involved identifying, analysing and reporting on patterns and themes within the data, and coding and categorising those themes and patterns into a matrix as a guide to include them with the quantitative data in the results. There were five phases to the thematic analysis (adapted from Braun & Clark, 2006, p. 87), as outlined in Table 7.
### Table 7: Phases of thematic analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarising with the data</td>
<td>Transcribing data (done by professional transcriber)</td>
</tr>
<tr>
<td></td>
<td>Reading and re-reading the data, noting down initial ideas</td>
</tr>
<tr>
<td>Generating initial categories, using</td>
<td>Categorising interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code/category</td>
</tr>
<tr>
<td>research schedule and AAVHTQ as a</td>
<td></td>
</tr>
<tr>
<td>guide, and identifying other potential</td>
<td></td>
</tr>
<tr>
<td>categories</td>
<td></td>
</tr>
<tr>
<td>Searching for themes</td>
<td>Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis</td>
</tr>
<tr>
<td>Defining and naming themes</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme</td>
</tr>
<tr>
<td>Incorporating data into results</td>
<td>The final opportunity for analysis. Selection of vivid, compelling extract examples and incorporating extracts of narratives into results</td>
</tr>
</tbody>
</table>

Analysis is not a linear process of simply moving from one phase to the next. Instead, it is more a recursive process, where movement is back and forth through the phases, as needed. It is also a process that develops over time and should not be rushed (Ely, Vinz, Downing & Anzul, 1997). As the research was administered in a semi-structured style, many of the categories and themes arising from the thematic analysis related to items from the research schedule, such as conceptions of trauma and violence, and specific items in the AAVHTQ, including the traumatic stressors and symptoms. Table 8 is a list of categories and sub-categories extracted from the semi-structured narrative interviews, which are refined later in the results section as specific themes.
<table>
<thead>
<tr>
<th>Category</th>
<th>Sub categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison experiences</td>
<td>incarceration of self, family and friends (past and present), identity within the prison environment, institutional violence, institutionalisation, police violence</td>
</tr>
<tr>
<td>Detachment/fragmented and fractured identities</td>
<td>forced separations including removal from family and land, stolen generation and adopted/fostered out (self and family), fragmentation of families causing family and/or community breakdown, crucial role of family connections, not accepted by own community, not belonging to anything and feeling lost (between worlds), institutionalisation</td>
</tr>
<tr>
<td>Acculturation (colonisation) and racism</td>
<td>shamed and being shamed for being Aboriginal (racism), denial of culture—denied traditional and customary practices including traditional languages, institutional violence—bad experiences with government agencies (including police, welfare, housing and education system), lack of knowledge about past, creating a sense of being lost, belonging nowhere (between worlds), significant rejection and identity issues, black = guilty</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>perpetrator sexual assault/rape, victim sexual assault/rape, knowledge of sexual assault/rape happening to others</td>
</tr>
<tr>
<td>Poverty and social support</td>
<td>homelessness, poverty and lack of essential services, low social support, no/low/inappropriate essential services support</td>
</tr>
<tr>
<td>Violence and trauma</td>
<td>perpetrator physical violence, victim physical violence, family violence, themes around inter-generational and trans-generational violence and trauma, violence as both a cause of and symptom of trauma</td>
</tr>
<tr>
<td>Personal understandings of violence and trauma</td>
<td>themes around inter-generational and trans-generational trauma and violence, definitions of trauma and violence, themes around breaking the cycle of trauma and violence</td>
</tr>
<tr>
<td>Traditional justice</td>
<td>dispensing traditional justice involving violence or harm to others, received traditional justice involving violence or harm, ‘gamin’ traditional justice</td>
</tr>
<tr>
<td>Category</td>
<td>Sub categories</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Suicide</td>
<td>► suicide attempt/contemplation</td>
</tr>
<tr>
<td></td>
<td>► suicide of family/friends</td>
</tr>
<tr>
<td>Murder and death</td>
<td>► perpetrator of murder</td>
</tr>
<tr>
<td></td>
<td>► victim of attempted murder</td>
</tr>
<tr>
<td></td>
<td>► murder of family/friends</td>
</tr>
<tr>
<td></td>
<td>► witnessing the murder of a stranger</td>
</tr>
<tr>
<td></td>
<td>► accidental death family/friends</td>
</tr>
<tr>
<td>Family violence/fighting</td>
<td>► normalisation of family violence</td>
</tr>
<tr>
<td></td>
<td>► endemic nature of family violence</td>
</tr>
<tr>
<td></td>
<td>► cyclic nature of family violence</td>
</tr>
<tr>
<td>Grief and loss</td>
<td>► detrimental impact of constant sorry business</td>
</tr>
<tr>
<td></td>
<td>► violence as an expression of grief and loss</td>
</tr>
<tr>
<td>Alcohol and other drugs</td>
<td>► normalisation of drinking patterns</td>
</tr>
<tr>
<td></td>
<td>► alcohol and other drugs as a primary recreational activity</td>
</tr>
<tr>
<td></td>
<td>► self-medication</td>
</tr>
<tr>
<td>Trauma symptoms</td>
<td>► avoidance numbing</td>
</tr>
<tr>
<td></td>
<td>► hyper arousal</td>
</tr>
<tr>
<td></td>
<td>► re-experiencing</td>
</tr>
<tr>
<td>Positive ways forward towards healing</td>
<td>► the power of narrative — the need to tell one’s story</td>
</tr>
<tr>
<td></td>
<td>► reconnection with culture</td>
</tr>
<tr>
<td></td>
<td>► art and music as both positive expression and tool for release</td>
</tr>
<tr>
<td></td>
<td>► removing alcohol</td>
</tr>
<tr>
<td></td>
<td>► increasing employment opportunities</td>
</tr>
<tr>
<td></td>
<td>► honouring tribal laws</td>
</tr>
</tbody>
</table>
The narratives derived from the in-depth interviews were also used to cross check and validate the results of the AAVHTQ and geno-histogram constructions, and changes were made to both of these when the narratives clearly and unambiguously provided more accurate data. Additionally, in order to honour the Aboriginal voices that are part of this research, deconstruction and interpretation of narratives were kept to a minimum and extensive quotes have been provided under the relevant sections in the results to allow the research participants to weave their own stories.

**Summary**

Great care must be taken when conducting research into issues affecting Australian Aboriginal peoples. This is the legacy of decades of research conducted from a Western viewpoint, by non-Aboriginal people, which often had no or little regard for Aboriginal world views, cultural sensitivities or norms, or little intent of serving the best interests of Australian Aboriginal peoples.

This research was conducted by an Australian Aboriginal woman. At its heart is the concept of Indigenist research that takes the Stories of Australian Aboriginal men and uses these Stories to complement, contextualise and validate quantitative data. This multi-method approach to research is considered most appropriate when conducting cross-cultural research and ensures that the voices of those at the centre of the research, in this case the men imprisoned for violent crimes, are heard and that their Stories contextualise and validate the quantitative data.

The collection of quantitative data was conducted through the use of the AAVHTQ. The lack of a valid instrument for measuring trauma in Australian Aboriginal peoples led to the development of the AAVHTQ. This was achieved through a documentary analysis to identify the specific traumatic themes and characteristic of distress that impact on Australian Aboriginal peoples and communities, which was later refined by a series of focus group discussions.

The use of focus group discussions, conducted by a group of people who were respected members of the Australian Aboriginal community, or who had long standing connections with and the support of Australian Aboriginal peoples, ensured the cultural validity of the identified trauma themes and characteristics of distress and translated them into the traumatic stressors and symptoms that were used in the AAVHTQ. The aim of the focus group discussions was to address any and all issues of concern about the research, develop the measuring instrument and to achieve a consensus about the
validity of the ways forward for the research. This is in keeping with the Australian Aboriginal idea of the talking circle, where all concerned may express their views and where all concerns are addressed.

At all stages in the development of the AAVHTQ and the processes that led to the application of the AAVHTQ, as well as the conduct of the semi-structured narrative interviews and the construction of research participants’ geno-histograms, emphasis was placed on ensuring that there were no cultural barriers confronting the research participants, and that there would be no negative influences or impacts on their ability to tell their Stories.

Mutual respect and responsibility on the part of the researcher and the research participant are at the heart of this multi-method, cross-cultural research. The Stories told by the men are the qualitative data that is interwoven with the quantitative data extracted from the AAVHTQ, semi-structured interviews and geno-histograms, in order to contextualise, validate and reflect cultural traditions of oral history. Without this validation, the research would risk relying on measurement instruments that, on their own, do not reflect the cultural norms and expectations of Australian Aboriginal peoples, nominally the opportunity to tell their stories in their own words.
CHAPTER FOUR

Results of the documentary analysis

People subjected to prolonged, repeated trauma develop an insidious progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is “not herself”, the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all (Hermann, 1992, p. 86).
Chapter Four: Results of the documentary analysis

This chapter provides the results of the documentary analysis that was conducted to address research question number one: ‘What are the trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples?’ The three reports selected for the documentary analysis focus on the historical and contemporary experiences of Aboriginal peoples. These publications, which document Aboriginal experiences of trauma and violence, facilitate understanding of these experiences, particularly cultural idioms of stress reactions and specific traumatic stressors relevant to Australian Aboriginal peoples.

The three reports analysed are:

1. Bringing them home report: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families (Human Rights and Equal Opportunity Commission, 1997)
2. Final report of the Royal Commission into Aboriginal deaths in custody (RCIADIC, 1991)
3. Aboriginal and Torres Strait Islander women’s task force on violence report (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

This chapter provides descriptive summaries of the major themes of each report, using extensive quotes to highlight their important findings. These quotes also bring focus to the oral tradition, through the use of Aboriginal voices, thus avoiding an interpretative analysis. The documentary analysis works on the assumption that the stories provided within the three reports are credible.

The traumatic stressors and cultural idioms of stress reactions identified in the three documents are presented in a matrix of results that includes a description of the units of trauma themes, justification for the selection of the trauma themes and the potential issues, such as dysfunctional behaviours that may be associated with the traumatic stressors. Additionally, a matrix outlining the cultural idioms of distress reactions is provided, including the characteristics of distress, the justification of inclusion of the specific characteristic of distress and the PTSD symptom cluster (i.e. avoidance/numbing, arousal and intrusive symptoms) relating to the specific characteristic of distress where relevant.
Descriptive summaries of the analysed reports

Bringing them home report

The Bringing them home report (BTHR) (Human Rights and Equal Opportunity Commission, 1997) is particularly pertinent to this thesis because of its relevance to the study population; many of the Aboriginal people who are in prisons have been affected by the forcible removal of children from their families (Final report on the Royal Commission into Aboriginal deaths in custody, 1991, p. 20). The BTHR has national coverage and suggests that ‘not one Indigenous family has escaped the effects’ of children being forcibly removed from their families, either directly or indirectly (Human Rights and Equal Opportunity Commission, 1997, p. 31).

Indigenous children have been forcibly removed from their families and communities since the very early days of the European occupation of Australia. This process has had significant psychological effects on the individuals involved.

\[
\text{We may go home, but we cannot relive our childhoods. We may reunite with our mothers, fathers, sisters, brothers, aunties, uncles, communities, but we cannot relive the 20, 30, 40 years that we spent without their love and care, and they cannot undo the grief and mourning they felt when we were separated from them. We can go home to ourselves as Aborigina} \]

\[
\text{l, but this does not erase the attacks inflicted on our hearts, minds, bodies and souls, by caretakers who thought their mission was to eliminate us as Aborigina} \]

\[
\text{l} \] (Human Rights and Equal Opportunity Commission, 1997, p. 11).

Nationally, the BTHR estimates that between one in three and one in ten Indigenous children were forcibly removed from their families and communities between 1910 and 1970. Furthermore, the report suggests that the impact of the removal policies does not stop with the children removed but rather that it ‘resounds through the generations’ and ‘is inherited by their own children in complex and sometimes heightened ways’ (Human Rights and Equal Opportunity Commission, 1997, p. 189).

\[
\text{There's things in my life that I haven't dealt with and I've passed them to my children. Gone to pieces. Anxiety attacks. I've passed this on to my kids. I know for a fact if you go and knock at their door they run and hide. I look at my son today who had to be taken away because he was going to commit suicide because he can't handle it; he just can't take any more the anxiety attacks that he and Karen have. I have passed that on to my kids because I haven't dealt} \]

From 1910 to 1970, government policy stated that Aboriginal children could be put into an institution or mission dormitory, or could be fostered or adopted. More than half (56%) of the individuals who told their stories to the National Inquiry had experienced multiple placements following their removal. Many of the children who were removed were discouraged from seeking any family contact and were told they were unwanted, rejected or that their parents were dead, even if this was not true. They were taught to reject and feel contempt for Aborigines and Aboriginality and, therefore, themselves.

Separation and institutionalisation can amount to traumas. Almost invariably they were traumatically carried out with force, lies, regimentation and an absence of comfort and affection. All too often they also involved brutality and abuse. Trauma compounded trauma. No counselling was ever provided. These traumas have impacted particularly in creating high levels of depression and complex PTSD. PTSD has a lot of somatic symptoms, impact on personality, on impulse control, and often leads to ongoing patterns of abuse (Human Rights and Equal Opportunity Commission, 1997, p. 167).

Institutional conditions were very harsh, often with severe punishments for breaking the rules, and the provision of basic necessities such as food, clothes and shelter was insufficient.

There was no food, nothing. We was all huddled up in a room like a little puppy dog on the floor. Sometimes at night we’d cry with hunger. We had to scrounge in the town dump, eating old bread, smashing tomato sauce bottles, licking them. Half of the time the food we got was from the rubbish dump (Human Rights and Equal Opportunity Commission, 1997, p. 137).

Although the promise of a good education was often used as an inducement for parents to give their children to the authorities, the BTHR states that the education provided was generally no more than preparation for menial labour (Human Rights and Equal Opportunity Commission, 1997). When children were sent out to work, they were not entitled to receive their wages and, even though the money was supposed to be held in trust, many never saw any of what they had earned.
Excessive physical punishments were common, with many of the witnesses reporting they were physically assaulted and brutally punished in their various placements, particularly in foster or adoptive families.

Almost a quarter (23.4%) of witnesses to the Inquiry who were fostered or adopted reported being assaulted there. One in six children who were institutionalised reported physical assault and punishments (Human Rights and Equal Opportunity Commission, 1997, p. 14).

One in five people who were fostered, and one in ten people who were institutionalised, reported that they were sexually abused while in care. One in ten witnesses also reported that they were sexually abused in a work placement.

There was tampering with the boys … the people who would come in to work with the children, they would grab the boys’ penises, play around with them and kiss them and things like this. These were the things that were done … It was seen to be the white man’s way of lookin’ after you. It never happened with an Aboriginal (Human Rights and Equal Opportunity Commission, 1997, p. 140).

The National Inquiry found that authorities failed to care for and protect removed children from such abuses.

The removal policies and the conditions endured by those removed have had a profound effect on many people, and this effect is being passed down from generation to generation. As the BTHR highlights:

It is difficult to capture the complexity of the effects for each person. For the majority of witnesses to the Inquiry, the effects have been multiple, continuing and profoundly disabling. The trauma of separation and attempts at “assimilation” have damaged their self-esteem and well-being, and impaired their parenting and relationships. In turn their children suffer. There is a cycle of damage people find difficult to escape unaided (Human Rights and Equal Opportunity Commission, 1997, p. 153).

These inter-generational effects result from several key factors. Firstly, the BTHR recognises the importance of a primary caregiver to a child’s social development, and notes that the loss of the primary carer in infancy can lead to:
➢ insecurity and lack of self-esteem, feelings of worthlessness
➢ depression and suicide
➢ delinquency and violence, sometimes leading to imprisonment
➢ alcohol and drug misuse

It has been argued that early loss of a mother or prolonged separation from her before age 11 is conducive to subsequent depression, choice of an inappropriate partner, and difficulties in parenting the next generation. Anti-social activity, violence, depression and suicide have also been suggested as likely results of the severe disruption of affectional bonds (Human Rights and Equal Opportunity Commission, 1997, p. 156).

Secondly, psychiatrist Professor Ernest Hunter told the Inquiry that the high rate of self-harm, including suicide and family violence, among many young men in Indigenous communities is related to the inappropriate construction of male identity in Indigenous families. This inappropriate construction often arises because male role models are absent due to removal or incarceration, or because the role of males who are present has been undermined by the removal policies (Human Rights and Equal Opportunity Commission, 1997, p. 193).

Related to this is a third inter-generational effect of the removal policies: that of undermined parenting skills. The Inquiry found that those people who had been brought up in institutions, or who had passed through different foster families, had not learnt adequate parenting skills.

Separation of people from families interrupts the flow of knowledge and understanding with respect of stages of child development and culturally appropriate models of parenting and household management (Human Rights and Equal Opportunity Commission, 1997, p. 192).

Some of these people find it very difficult to show love to their own children, as they did not receive it themselves.

Another thing we find hard is giving our children love. Because we never had it. So we don't know how to tell our kids that we love them. All we do is protect
them. I can’t event cuddle my kids’ cause I never ever got cuddled. The only
time was when I was getting raped and that’s not what you’d call a cuddle, is it?

The Inquiry found that as parents, many ‘stolen generations’ children have ‘problem’
children of their own, who are at risk of being removed on the grounds of neglect or
abuse, or because they become offenders (Human Rights and Equal Opportunity
Commission, 1997, p. 191). The fear that their children will be taken away may explain
the reluctance of some Aboriginal peoples to use mainstream services or to discipline
their children.

Finally, the loss of heritage experienced by many of the children who were forcibly
removed left many with no sense of identity or belonging. Furthermore, the family
members and communities that were left behind to grieve the loss of removed family
members suffered immensely and, in turn, this affected the health and morale of many
Indigenous communities.

Indigenous men and women generally lost their purpose in their families and
communities. Individual response to this loss could result in drinking binges,
hospitalisation following accidents or assaults, or behaviour which leads to
incarceration or premature death (Human Rights and Equal Opportunity

According to the report, the fear of having children removed meant some people exiled
themselves from their communities and hid their Aboriginal identity in an attempt to
protect their children (Human Rights and Equal Opportunity Commission, 1997). The
legacy of the child removal policies continues to haunt individuals, families and
communities and is evident in the cyclic nature and inter- and trans-generational waves
that are expressed in the high levels of violence and abuse in Indigenous Australian
communities.

The truth is the past is very much with us today, in the continuing devastation of
the lives of Indigenous Australians (Human Rights and Equal Opportunity

Final report of the Royal Commission into Aboriginal deaths in custody
This national report (1991) is relevant to this thesis as it addresses Aboriginal male
offenders in custody.
Between October 1987 and November 1990, the Royal Commission into Aboriginal deaths in custody (RCIADIC, 1991) investigated the deaths of ninety-nine Aboriginal persons in police and prison custody. These deaths occurred during the period of nine years and five months that was covered by the Letters Patent of the Royal Commission. The final report covers the circumstances surrounding each individual death and, more importantly, examines the lives of each of those who died and the way in which their lives were inextricably connected to their deaths. The principal and immediate explanation for these deaths in custody is identified as the disproportionate rate at which Aboriginal peoples are arrested and imprisoned in Australia. However, the RCIADIC (1991) also recognises that the underlying issues, and the extent to which these contribute to the disadvantaged position of Aboriginal peoples, are crucial to understanding the complex factors leading to high rates of arrest and imprisonment.

It was apparent in every case examined by the Royal Commission that the Aboriginality of those who died played a significant and in most cases dominant role in their being in custody and dying in custody. Aboriginal people have a unique history of being ordered, controlled and monitored by the state. Examination of the lives of those who died documented through government files revealed a familiar pattern of state intervention into and control over their lives. Much of this intervention and control was exercised through the criminal justice system. Although there were exceptions, the vast majority of the deceased had come into contact with the criminal justice system at an early age, and had repeated contact with it throughout their lives (RCIADIC, 1991, p. 4).

The high number of Aboriginal peoples in custody is one aspect of the continuing legacy of the history of control. The Royal Commission found that ‘… Aboriginal people were more likely to have died in police custody rather than in prisons, whereas non-Aboriginal people who died were more likely to have died in prisons. Approximately two-thirds of the Aboriginal deaths were in police custody’ (RCIADIC, 1991, p. 12).

The reasons Aboriginal peoples are disproportionately placed in custody provides a background to the social, cultural, historical and legal factors underlying their contact with the criminal justice system. For example, the RCIADIC found that a much higher proportion of Aboriginal peoples (57%), as opposed to non-Aboriginal peoples (27%), were placed in custody due to public intoxication (1991, p. 14). In all, 64% of all the offences for which Aboriginal peoples were arrested were attributable to drunkenness, together with other ‘good order’ offences (many of which would have been alcohol-related), compared to only 32% for non-Aboriginal peoples (RCIADIC, 1991, p. 14).
Twice as many Aboriginals than non-Aboriginals were sentenced to prison for defaulting on fines (39.5% versus 19.7%), suggesting many of the prison sentences experienced by Aboriginal peoples are avoidable (RCIADIC, 1991, p.14).

The RCIADIC (1991) found that Aboriginal peoples are taken into custody and held in police cells at a rate of twenty-seven times that of non-Aboriginal peoples, and that Aboriginal peoples are more likely to spend longer periods in police custody. Specifically, Aboriginal peoples who are held for the offence of public drunkenness spend, on average, twice as long in police cells as non-Aboriginal peoples and, in general, the rate of imprisonment of Aboriginal adults is fifteen times higher than that for non-Aboriginal adults.

These disproportionate arrest and imprisonment rates may be a reflection of Australia’s past failure to fully understand the culture and social structure of Indigenous communities. According to the RCIADIC it is:

the legacy of Australia’s history [that] helps to explain the deep sense of injustice felt by Aboriginal people, their disadvantaged status today and their current attitudes towards non-Aboriginal people and society. It is one of the most important underlying issues that assist in the understanding of the disproportionate detention rates of Aboriginal people (1991, p. 16).

Until the 1970s, Aboriginal peoples were portrayed in schools as a ‘doomed and primitive race who were not part of Australian society’ (RCIADIC, 1991, p. 16). They had no property rights, on the basis that the land was terra nullius. As the colonies expanded, violence towards Aboriginal peoples increased as Aboriginal groups resisted attempts to dispose them of their lands. This set the tone for law and order very early on and provides some insight into Australian Aboriginals’ long held mistrust of the police, who were the main enforcers of these laws.

Historically, Aboriginal experience of the criminal justice system has been one of discrimination and repression. That historical experience remains very much the perception of the criminal justice system today held by many Aboriginal people (RCIADIC, 1991, p. 17).

The lasting legacy of assimilation policies, involving the abandonment of traditional cultural ways and language, the dislocation of families and kin networks, and the imposition of social controls, has had a profoundly damaging effect on Aboriginal
peoples. The RCIADIC states that “while prisons may be seen as the most extreme form of institutionalisation, their structure and motives were part of a cultural continuum of discipline and socialization” (1991, p. 18). It is this continuum that has eroded individuals, families and communities and left a legacy of trauma and destruction in its wake.

In line with the findings from the BTHR (Human Rights and Equal Opportunity Commission, 1997), the RCIADIC (1991) found that the removal of Aboriginal children from their families, and their subsequent placement into institutions, has had a profoundly detrimental impact on the lives of those involved.

The contemporary experience of Aboriginality is closely related to the sense of self-esteem. Poor self-esteem reflected in emotional and behavioural factors that are linked to excessive drinking and offending is very much a product of non-Aboriginal institutional and individual efforts to deny Aboriginal culture and heritage to Aboriginal children. It is clear that the earlier programs of separation of families, forced relocation and institutionalisation are a significant underlying issue (RCIADIC, 1991, p. 20).

The RCIADIC (1991) found that almost half of those who died in custody had been removed from their parents.

The RCIADIC (1991) also reports that the status and responsibilities of Aboriginal men, particularly the transition of young men into adults, has been eroded by the intrusion of Western society into Aboriginal culture.

In the absence of identifiable cultural mechanisms for this transition, alternative means of achieving status may be developed. These may sometimes be at odds with the laws created by non-Aboriginal society. This is sometimes manifest in drinking, offending and violence … it is often the combination of drinking and violence which leads young Aboriginal men into custody (RCIADIC, 1991, p. 21).

The RCIADIC (1991) recognises that prison has become a ‘rite of passage’ for some men, representing a status system developed to replace more traditional and healthy ways of being initiated into manhood. Additionally, cases presented to the RCIADIC (1991) clearly demonstrate that many of those who died in custody began their cycle of incarceration in the juvenile justice system.
The history of disruption, intervention and institutionalisation to which Aboriginal and Torres Strait Islander families and children have been subject has left many of those families confronting severe difficulties in securing the adequate care and control of their children. Although there are many positively culturally-based social controls operating, it is apparent that many Aboriginal families are in crisis (RCIADIC, 1991, p. 27).

The RCIADIC (1991) also concludes that the issue of Aboriginality, particularly positive images, is central to Aboriginal peoples regaining their self-esteem. Negative stereotypes in the general community and media representations have traditionally focused on alcohol misuse, violence and interaction with police, and these themes continue today. The report indicates that police culture also reinforces these stereotypes, highlighting a number of racist and derogatory comments discovered in police records, which suggest these attitudes are at the very least tolerated by supervisory officers.

The RCIADIC (1991) reports widespread disaffection with education services available to Australian Aboriginal peoples. The reasons for this disaffection include a lack of access, inappropriate curricula, which often conflicts with Indigenous values, and the impact of community issues, such as high levels of violence and peer group pressure that increases absenteeism. The imposed obligation of education for young people has also led to confrontations with welfare agencies and the juvenile justice system. The RCIADIC (1991) also states that poor education leads to a lack of options for meaningful employment and reduces access to resources that help shape lives and communities.

The RCIADIC states that ‘the links between unemployment, low economic status and imprisonment are well established’ (1991, p. 11). The lack of employment opportunities can be linked to the lack of educational opportunities, despite the cultural adjustments made by many Australian Aboriginal peoples in an effort to maximise their employability. The resultant high level of unemployment in communities represents a high financial burden on those Australian Aboriginal people who are employed; ‘By every measure of economic status, Aboriginal people appear to be significantly disadvantaged’ (RCIADIC, 1991, p. 11).

The RCIADIC (1991) found that alcohol and other drugs play a significant role in offending behaviour. However, it is important to emphasise that the patterns of alcohol and other drug misuse cannot be considered in an historical void, particularly since use
is a well documented symptom of trauma behaviour (Kofoed, et al., 1993; Manson, et al., 1997).

The RCIADIC (1991) also states that a lack of housing, infrastructure and land impacts in a number of ways on the lives of those who die in custody.

Not only were a high proportion of those who died homeless, but many were removed from their families as children as a result of family living conditions. The inadequacies of housing and infrastructure available to Aboriginal people today are a reflection of the failure of governments in the past to address these needs (RCIADIC, 1991, p.33).

Spiritual links to land are particularly important to Aboriginal peoples and the systematic process of dispossession from lands over many generations has created layers of unresolved trauma and grief and has contributed to a lack of belonging (RCIADIC, 1991, p. 34). This has a profound effect on an individual’s ability to resolve the trauma and grief, and can even compound their effects.

The Commission has identified that rather than there being a single direct cause of Aboriginal deaths in custody, Aboriginal people continue to suffer a compounding range of social disadvantages that contribute to their vulnerability to incarceration, and to their poor psychological and physical health. Lack of access to land is the most fundamental element of the social disadvantages identified [by the] Commission as contributing to deaths in custody (RCIADIC, 1991, p. 34).

The policy of self-determination has not failed, as some would claim, it hasn’t been tried yet according to Mick Dodson (2006) and Pat Dodson (2002). Self-determination as a concept in its true form, is still a relevant and essential goal to combating the disempowered position of some Aboriginal peoples.

The gaining by Aboriginal people of effective control over the decision-making process affecting themselves, and gaining the power to make the ultimate decisions wherever possible, is a key underlying issue concerned by the Commission. It is, along with access to land, the issue which connected with all others. One of the deepest legacies of history for Aboriginal people, and one which has contributed to deaths in custody, is the control to which their lives have, and in many cases still are, subject by people who neither share their
In summary, the overall levels of disadvantage that Aboriginal peoples experience is manifested in the phenomena of Aboriginal over-representation in custody and high levels of Aboriginal deaths in custody, which in turn contribute to the compounding, cumulative cycle of trauma that continues to fuel this disadvantaged position.

**Aboriginal and Torres Strait Islander women’s task force on violence report**

Although not a national report, the *Aboriginal and Torres Strait Islander women’s task force on violence report* (WTFV) (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000) is relevant to the study population for this thesis as it draws on national research identifying the multiple explanations of violence in Aboriginal communities and the effect that this has on individuals, families and communities. It also considers the concept of inter- and trans-generational trauma as a legitimate cycle.

The WTFV was formed in response to levels of violence reaching a crisis point in some Indigenous communities.

> All we want is for the violence to stop. We don’t want our men to go to jail. But by the same token we as a community have to try to address the issue of alcohol, drugs and violence (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000 p. 289).

The WTFV reports that the impact of history has had a devastating effect on the levels of violence experienced in contemporary Indigenous communities (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000). While dispossession, cultural fragmentation, marginalisation, high unemployment, poor health, low educational attainment and poverty have become endemic elements in Indigenous lives and are commonly correlated with high levels of violence, the WTFV suggests that a more rigorous investigation is needed (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

The WTFV acknowledges that such violence is not new and that numerous attempts have been made to rectify the situation (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000). However, it suggests that ‘… people who could have made a difference have failed to intervene to stop innocent women and children from being bashed, raped, mutilated and murdered and exposed to
forms of violence that have been allowed to escalate to a level that is now a national disgrace’ (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 9). The taskforce found that government representatives have failed in their attempts to deliver meaningful support, despite numerous government reports and pleas of assistance from Indigenous women’s groups. By exposing the severity of the violence through the voices of the people experiencing it, the WTFV hopes to identify solutions derived from a knowledge base incorporating the reality of the cyclic generational dysfunction that is fuelled by compounding trauma experiences (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

The WTFV reports that all forms of physical, psychological, cultural and structural violence are being perpetrated on Indigenous peoples (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000). Throughout the consultations, colonisation and dispossession were repeatedly identified as central factors to the levels of alcohol and drug misuse, violence and dysfunction reported in some Indigenous communities. The erosion of cultural and spiritual identity, and the dismantling of families and communities, has had a profound effect on the ability of individuals, families and communities to maintain relationships, obligations and social order and control. Although the WTFV acknowledges that some Indigenous people have been able to escape the past, others have not and the consequences of the past haunt them in the present.

Appalling acts of physical brutality and sexual violence are being perpetrated within some families and across communities to a degree previously unknown in Indigenous life. Sadly, many of the victims are women and children, young and older people who now in many cases are living in a constant state of desperation and despair (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000 p. 11).

The WTFV found that it is men who generally inflict most of the violence, but also highlight that there is a clear recognition from Aboriginal women that their men are also experiencing grief and trauma; thus any efforts to break the cycle of violence must incorporate a collective approach in order to reunite families (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

The research conducted by the WTFV also reveals that there are few relevant services available for people in critical situations, as well as very few counselling services
capable of dealing with trauma and grief on a meaningful level (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000).

*Although many Indigenous people carry unresolved trauma and grief from both historical and contemporary experiences, there are inadequate counselling services available in a majority of communities. This situation not only compounds the stress experienced by individuals but also exacerbates the likelihood of violence because of the limited services available to assist people with their alcohol or substance addictions or to deal with their unresolved traumas. The atmosphere in many communities is now one of continuing fear from which there is currently no escape* (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 11).

This continuing fear experienced by some individuals is very real and warranted, given the levels of violence reached in some communities. The cumulative trauma experienced in such circumstances is a compounding factor and stimulus for further community dysfunction.

*Violence is now overt; murders, bashings and rapes, including sexual violence against children, have reached epidemic proportions with both Indigenous and non-Indigenous people being perpetrators. Youth suicides over the past decade have increased to an alarming level. Aboriginal people, both young and old, are continually going through “sorry business”, with death becoming an all too frequent presence in their lives. By any level we must all admit that something has gone desperately wrong and that urgent intervention is now required* (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 12).

The historical and continuing losses experienced by Aboriginal families provide some explanation of the causes of, and factors contributing to, the levels of violence and potential trauma-induced disorders evident in the present. Essentially, the ‘historical situations can also set in place repeated and cumulative traumatic impacts that compound the trauma across generations’ (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 47). The WTFV identifies PTSD and trans-generational trauma as both causes and effects of contemporary violence and abuse witnessed in some Indigenous communities (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000). This is compounded by substandard and overcrowded housing, poor health, poor education
and welfare dependency, creating feelings of hopelessness and anger, sometimes expressed as rage, violence on self and others, and criminal activities.

The extent of violence is demonstrated by the rapidly mounting incarceration rates. It is also reflected in the statistical data on interpersonal violence, homicides, rapes and suicides. Anecdotal evidence was given that sexual abuse of young males is increasing, and remains largely unreported, because of the hidden nature of male to male sexual attacks and the shame that is often expressed by the victim (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 13).

Although the WTFV acknowledges that not all Indigenous families face such circumstances, it suggests that those who do appear to be trapped in a cyclic vortex where ‘deviance and atrocities have become accepted as normal behaviour and as such, form an integral part of the children’s socialisation’ (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 13). However, it also states that, as ‘normal’ as this behaviour had appeared to become, ‘it is important to remember that human reactions and behaviour in response to trauma [such as violence] are the natural reactions of normal people to abnormal situations, and that abnormal situations may, overtime, appear to become the norm when inappropriate responses are made to human needs’ (Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000, p. 24).

**Trauma themes, characteristics and cultural idioms of stress reactions**

The three reports analysed for this thesis consistently identify common traumatic stressors, highlighting a number of trauma themes and potential characteristics of distress relevant to Indigenous Australian peoples. These trauma themes are presented in Table 9, along with justifications for their selection and some of the potential issues specifically identified as being associated with each theme.
<table>
<thead>
<tr>
<th>Units of trauma themes</th>
<th>Justification for selection</th>
<th>Potential issues</th>
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</thead>
</table>
| Children being forcibly removed from their families (separation policies) | Bringing them home report (Human Rights and Equal Opportunity Commission, 1997) identifies that ‘not one Indigenous family has escaped the effects’ of this event. BTHR estimates between 1 in 3 and 1 in 10 children being removed. Identified in Royal Commission into Aboriginal deaths in custody (RCIADIC, 1991) as the most profound legacy of assimilation policies. RCIADIC (1991) found that half those who died in custody had been removed from their parents. | ➢ Loss and grief  
➢ Loss of childhood  
➢ Loss of cultural identity  
➢ Loss of spiritual identity  
➢ Poor self-esteem  
➢ Poor well-being  
➢ Impaired relationships  
➢ Impaired parenting skills  
➢ Inability to show love to own children  
➢ Lack of trust in authorities because of fear own children will be removed  
➢ Cycle of damage that affects their children (inter-generational effects)  
➢ High levels of violence  
➢ High levels of abuse  
➢ High levels of alcohol and drug use  
➢ High levels of offending  
➢ Suicide  
➢ Impacts of removal policies do not end with those removed, but resound through the generations (inter-generational trauma)  
➢ Inter-generational mental health issues (e.g. anxiety attacks) |
| Loss of primary carer in infancy                            | Specifically identified in BTHR.                                                                                                                                                                                                                                                   | ➢ Insecurity  
➢ Loss of self-esteem  
➢ Feelings of worthlessness  
➢ Depression  
➢ Suicide  
➢ Delinquency and violence leading to imprisonment  
➢ Alcohol and drug misuse  
➢ Lack of trust  
➢ Lack of intimacy                                                                                                                                  |
<table>
<thead>
<tr>
<th>Units of trauma themes</th>
<th>Justification for selection</th>
<th>Potential issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of mother or prolonged separation before age 11</td>
<td>Specifically identified in BTHR.</td>
<td>- Depression&lt;br&gt; - Choice of inappropriate partner&lt;br&gt; - Parenting difficulties&lt;br&gt; - Anti-social behaviour&lt;br&gt; - Violence&lt;br&gt; - Self harm</td>
</tr>
<tr>
<td>Inappropriate male role model constructs</td>
<td>Evidence to BTHR stated that male role models are inappropriate either due to absence or undermining of male role models as a result of removal policies.&lt;br&gt; RCIADIC (1991) identifies intrusion of non-Aboriginal laws and institutions as a primary reason for the loss of appropriate male role models.&lt;br&gt; RCIADIC (1991) identifies imprisonment of young men as a right of passage.</td>
<td>- High rates of:&lt;br&gt;  - Self harm&lt;br&gt;  - Suicide&lt;br&gt;  - Family violence&lt;br&gt;  - Alcohol misuse&lt;br&gt;  - Offending&lt;br&gt;  - Incarceration</td>
</tr>
<tr>
<td>Life in institutions (missions)</td>
<td>Evidence to BTHR stated such institutional life was characterised by force, lies, regimentation, brutality, abuse and absence of comfort and affection.&lt;br&gt; RCIADIC (1991) identifies flow on effects to own children.</td>
<td>- High levels of mental health issues such as depression and complex PTSD.&lt;br&gt;  - Lack of impulse control leading to patterns of ongoing abuse.&lt;br&gt;  - Personality disorders&lt;br&gt;  - Poor parenting skills</td>
</tr>
<tr>
<td>Lack of necessities such as food, shelter and clothing and adequate health services</td>
<td>Evidence to BTHR stated that children would cry at night with hunger and that they would scrounge rubbish dumps for food.&lt;br&gt; RCIADIC (1991) identifies lack of housing as a common theme amongst those who had died in custody.&lt;br&gt; Aboriginal and Torres Strait Islander women's task force on violence (WTFV) identifies overcrowding and a lack of adequate housing as contributing to issues confronting Aboriginal communities.</td>
<td>- Rage&lt;br&gt;  - Violence&lt;br&gt;  - Hopelessness&lt;br&gt;  - Anger&lt;br&gt;  - Lack of impulse control leading to patterns of ongoing abuse.</td>
</tr>
<tr>
<td>Children taught to reject and feel contempt for Aboriginal culture and heritage/Loss of culture</td>
<td>Reported in BTHR as a common occurrence for those adopted/fostered out or institutionalised.&lt;br&gt; WTFV identifies cultural fragmentation as endemic through Aboriginal communities.</td>
<td>- Self contempt&lt;br&gt;  - High risk alcohol use&lt;br&gt;  - Offending&lt;br&gt;  - Loss of identity&lt;br&gt;  - No sense of belonging</td>
</tr>
<tr>
<td>Lack of good education</td>
<td>Commonly reported to BTHR that education was generally no more than preparation for menial labour.&lt;br&gt; RCIADIC (1991) identifies lack of education could be linked to several issues and needed further consideration.&lt;br&gt; WTFV identifies a lack of good education as endemic in Aboriginal communities.</td>
<td>- Low self-esteem&lt;br&gt;  - Poverty&lt;br&gt;  - Imprisonment&lt;br&gt;  - Self-destructive behaviours&lt;br&gt;  - Hopelessness&lt;br&gt;  - Criminal behaviour</td>
</tr>
<tr>
<td>Poverty</td>
<td>Commonly reported to BTHR.&lt;br&gt; RCIADIC (1991) identifies poverty as linked to several issues and needing further consideration.&lt;br&gt; WTFV identifies poverty as endemic in Aboriginal communities.</td>
<td>- Low self-esteem&lt;br&gt;  - Self-destructive behaviours&lt;br&gt;  - Imprisonment</td>
</tr>
<tr>
<td>Units of trauma themes</td>
<td>Justification for selection</td>
<td>Potential issues</td>
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<td>--------------------------------</td>
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</table>
| Physical abuse (violence)      | Almost a quarter of witnesses to BTHR reported being physically abused while fostered or adopted out. WTFV identifies ‘appalling acts of physical brutality … being perpetrated … to a degree previously unknown in Indigenous life’, and the common goal of women to stop the violence inflicting communities. | ▶️ Cycles of violence  
▶️ Sense of fear in communities  
▶️ Imprisonment |
| Sexual abuse                   | BTHR found that 1 in 5 of those fostered and 1 in 10 institutionalised were sexually abused. WTFV identifies ‘appalling acts of sexual violence … being perpetrated … to a degree previously unknown in Indigenous life’. WTFV identifies specifically the anecdotal evidence of increasing male to male sexual violence and the unreported nature of this abuse. | ▶️ Lack of trust in authorities (Seen as the ‘white man’s way of looking after you’).  
▶️ Impaired parenting  
▶️ Poor self-esteem  
▶️ Poor well-being  
▶️ Impaired relationships  
▶️ Cycle of damage that affects their children (inter-generational effects)  
▶️ Shame |
| Lack of adequate or relevant counselling or support services | WTFV recognises the need for a collective approach to reunite families, and identifies the lack of services able to deal with people in critical situations, or deal with trauma and grief on a level that is meaningful. | ▶️ Compounded stress  
▶️ Increased violence due to inability to deal with alcohol and substance dependency  
▶️ Fear in communities |
| Assimilation policies          | Guide to findings of BTHR identifies this as a major negative impact on the ongoing well-being of Aboriginal peoples and culture. RCIADIC (1991) identifies the legacy of these policies as widespread and ongoing. | ▶️ Poor self-esteem  
▶️ Poor well-being  
▶️ Impaired relationships  
▶️ Cycle of damage that affects their children (inter-generational effects)  
▶️ Abandonment/loss of traditional ways and language  
▶️ Dislocation of families and kin networks  
▶️ Loss of traditional social controls  
▶️ Legacy of trauma |
| Loss of children due to removal policies | The BTHR specifically identifies the impact on individuals and wider community from the after effects on those parents whose children were removed. | ▶️ Grief  
▶️ Episodic high risk alcohol use  
▶️ Accidents and assaults leading to hospitalisation  
▶️ Behaviour leading to incarceration  
▶️ Behaviour leading to premature death  
▶️ Wider impact on health and well-being of community |
<table>
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<tr>
<th>Units of trauma themes</th>
<th>Justification for selection</th>
<th>Potential issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early contact/repeated contact with criminal justice system</td>
<td>RCIADIC (1991) identifies this as a common factor amongst those who died in custody.</td>
<td>- Suicide</td>
</tr>
</tbody>
</table>
| High levels of incarceration in watch houses | RCIADIC (1991) reports high rates of incarceration in watch houses for Aboriginal peoples compared to non-Aboriginal people, including longer times spent in watch house. | - Sense of injustice  
- Negative attitudes towards non-Aboriginal peoples and society |
| Concept of terra nullius | RCIADIC (1991) identifies the concept of terra nullius as the basis for dispossession of Aboriginal lands and the incarceration or use of violence towards Aboriginal peoples. | - Lack of trust towards police and authorities  
- Dispossession – loss of connection to land – loss of sense of belonging  
- Lack of property rights  
- High rate of incarceration  
- Violence from authorities  
- Violence towards others as resistance to dispossession  
- Discrimination  
- Repression |
| Incarceration | Identified in BTHR as a common outcome for those removed and abused, who in turn abused alcohol and drugs. Often also an outcome for parents who grieved for removed children.  
Central theme of RCIADIC (1991), including link to juvenile offending and repeat offending, as well as self harm and suicide. | - Suicide  
- Self-harm  
- Loss of male role models to community, developing cyclic patterns of anti-social behaviour and further imprisonment  
- Loss of traditional initiation passages replaced by prison as a rite of passage  
- Breakdown of family and community  
- Loss of social order and control  
- Relationship breakdowns |
| Negative stereotyping of Aboriginal peoples in the media | RCIADIC (1991) identifies the need to show positive images of Aboriginal peoples in order to assist those most disadvantaged with regaining their self-esteem. | - Shame  
- Feelings of worthlessness and hopelessness  
- Poor self-esteem |
| Racism | RCIADIC (1991) reports a police culture of racism through entries in police records.  
WTFV identifies the physical, psychological, cultural and structural violence being perpetrated on Aboriginal peoples. | - Loss of culture  
- Loss of identity  
- Loss of spirituality  
- Breakdown of family and community  
- Loss of social order and control  
- Relationship breakdowns |
<table>
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<tr>
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<th>Potential issues</th>
</tr>
</thead>
</table>
| Dispossession of land                        | RCIADIC (1991) identifies dispossession of land as a systematic process over many generations. Also states that a 'lack of access to land is the most fundamental element of the social disadvantages ...' WTFV identifies dispossession as central to the problems impacting on Aboriginal communities. | ➢ Loss of spirituality  
➢ Grief  
➢ Lack of belonging  
➢ Inability to resolve trauma and grief  
➢ Compounding effects of trauma  
➢ Violence  
➢ Alcohol and drug misuse |
| Loss of control over own life                | RCIADIC (1991) identifies the control over Aboriginal lives by governments and institutions as central to the disadvantages that have led to deaths in custody. WTFV identifies the repeated failures of government policies and inadequate and inappropriate solutions to problems impacting on Aboriginal communities. | ➢ Suicide  
➢ Violence  
➢ Alcohol and drug misuse  
➢ Increased chance of being murdered due to breakdown in social controls |
| Alcohol and drug abuse                       | WTFV reports alcohol and drug misuse as endemic in Aboriginal communities and central to the cycle of violence. | ➢ Violence |
| Sorry Business                               | WTFV identifies that for Aboriginal peoples, sorry business has become an almost continuous process. | ➢ Loss and grief  
➢ Mental Illness  
➢ Alcohol and drug misuse  
➢ Imprisonment |
| PTSD and trans-generational trauma           | WTFV identifies PTSD and trans-generational trauma as both a cause and effect of contemporary violence and abuse. | ➢ Violence  
➢ Sexual assault/rape |

Table 10 identifies the specific cultural idioms of distress reactions identified as significant in the three reports, along with justification for their inclusion. This includes identifying those characteristics of distress that concur with the 16 DSM-III-R symptoms in the original HTQ that must be included in the final AAVHTQ (refer to Chapter Five, Table 12). Other specific cultural idioms of distress reactions not currently included in the 16 DSM-III-R HTQ symptoms are also listed, including a justification for their inclusion and the potential symptom cluster in terms of PTSD.
Table 10: Characteristics of distress - trauma symptoms

<table>
<thead>
<tr>
<th>Characteristics of distress</th>
<th>Justification for inclusion</th>
<th>Symptom cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger/rage</td>
<td>WTFV reports anger is a common reaction to overcrowding, poor housing, poor health and poor education.</td>
<td>Arousal</td>
</tr>
<tr>
<td>Self contempt/Low self-esteem</td>
<td>BTHR reports this is a common outcome for those institutionalised and taught to feel contempt for, and to reject, their Aboriginality. BTHR highlights this in particular for those removed as infants. RCIADIC (1991) reports poor self-esteem and related behaviours are the outcome of non-Aboriginal institutional efforts to deny culture and heritage to Aboriginal children. RCIADIC (1991) identifies the constant negative stereotyping of Aboriginal peoples in media as contributing to poor self-esteem.</td>
<td>Avoidance/numbing, Depressive</td>
</tr>
<tr>
<td>Isolation from society</td>
<td>BTHR reports reluctance of those removed to use mainstream services due to fear of having their own children removed. RCIADIC (1991) identifies the sense of injustice felt by Aboriginal peoples as a result of the teachings of mainstream education, the concept of terra nullius and the higher rates of incarceration for Aboriginal peoples compared to non-Aboriginal peoples as building a sense of isolation from non-Aboriginal society.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Grief and mourning</td>
<td>BTHR identifies these as ongoing symptoms resulting from removal policies, both for those removed and those whose children were removed. WTFV views the lack of adequate and relevant counselling and support services as fundamental in fuelling the ongoing cycle of trauma, grief and mourning.</td>
<td>Avoidance/numbing, Depressive</td>
</tr>
<tr>
<td>No sense of identity or belonging</td>
<td>BTHR views this as the result of the denial of heritage forced upon children who were removed. BTHR also reports many who, out of fear of having children removed, exiled themselves from their communities. RCIADIC (1991) identifies breakdown of kin systems, social controls and loss of heritage as a result of assimilation policies as contributing to Aboriginal peoples lacking a sense of belonging. RCIADIC (1991) reports that dispossession of land is a fundamental social disadvantage for Aboriginal peoples and central to loss of spirituality and identity. WTFV views the erosion of culture and identity as a form of violence inflicted by the dominant culture and considers it an ongoing issue.</td>
<td>Avoidance/numbing, Depressive</td>
</tr>
</tbody>
</table>
### Characteristics of distress

<table>
<thead>
<tr>
<th>Symptom cluster</th>
<th>Justification for inclusion</th>
</tr>
</thead>
</table>
| Violence including physical and sexual violence. | BTHR reports higher levels of violence amongst those removed and those left behind.  
The Australian Association of Infant Mental Health (AAIMH) in the BTHR argues that violent behaviours are more likely amongst those removed as children.  
RCIADIC (1991) views high rates of violence as a manifestation of the destruction of Aboriginal culture by non-Aboriginal laws.  
WTFV identifies violence as endemic in Aboriginal communities, to the point that it is accepted as normal behaviour. |
| Impulsive behaviour | Prof B. Raphael reported to BTHR that a lack of impulse control is a common somatic symptom of PTSD. |
| Anxiety | Reported by a witness to BTHR, who also reported that she had passed her anxiety on to her children. |
| Substance misuse | BTHR identifies this as a common behaviour for those removed, particularly those removed as infants.  
RCIADIC (1991) considers high rates of substance abuse as the outcome of removal policies and ongoing assimilation policies.  
WTFV reports high rates of alcohol and drug abuse amongst dysfunctional Aboriginal communities. |
| Poor health | BTHR reports that some who were institutionalised were given inadequate food and shelter, resulting in ongoing health issues.  
BTHR reports that the grief and loss amongst those in communities whose children had been removed often led to poor health. |
| Depression | The AAIMH argues that depression is a likely outcome for those removed as children.  
BTHR reports high levels of depression amongst those removed and/or institutionalised. |
<p>| Homelessness | RCIADIC (1991) reports that many who died in custody were homeless. |
| Shame | WTFV reports anecdotal evidence of increasing rates of male to male sexual violence, in turn leading to increased levels of shame amongst those men sexually abused. |
| Problems establishing relationships | BTHR identifies this as common amongst those removed. |</p>
<table>
<thead>
<tr>
<th>Characteristics of distress</th>
<th>Justification for inclusion</th>
<th>Symptom cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems maintaining relationships</td>
<td>BTHR identifies this as common amongst those removed. The AAIMH suggests that the choice of an inappropriate partner is a likely outcome for those removed as children. WTFV argues that structural violence inflicted by the dominant culture is one of the causes leading to breakdown of relationships.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Poor/impaired parenting skills (e.g. unable to show love to own children)</td>
<td>BTHR reported that poor parenting skills are a legacy of those who were removed at a young age. The AAIMH argues that those removed as children are more likely to have difficulty in parenting the subsequent generation.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Suicide</td>
<td>BTHR reports that suicide can be the result of removal from parents as an infant. The AAIMH argues that suicide rates are higher for those removed as children. RCIADIC (1991) identifies high rates of suicide amongst Aboriginal men who were removed and who were in frequent contact with the criminal justice system from a young age.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Self harm (e.g. mutilations)</td>
<td>Prof E. Hunter reported to BTHR his belief that high rates of self harm among young Indigenous men were the result of their removal.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Loss of trust and intimacy</td>
<td>BTHR identifies this as common for those removed, particularly those removed as infants.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Fear</td>
<td>WTFV reports that high rates of physical and sexual violence have led to communities living in a constant state of fear.</td>
<td>Arousal</td>
</tr>
<tr>
<td>Despair</td>
<td>WTFV reports that many victims of physical and sexual violence are living in despair.</td>
<td>Avoidance/numbing</td>
</tr>
<tr>
<td>Desperation</td>
<td>WTFV reports that many victims of physical and sexual violence are living in desperation.</td>
<td>Avoidance/numbing</td>
</tr>
</tbody>
</table>

Avoidance/numbing: This symptom cluster involves withdrawal from emotional and interpersonal experiences, characterized by a sense of detachment and emotional numbness.

Arousal: This symptom cluster involves heightened awareness and emotional responsiveness, characterized by increased emotional reactivity and sensitivity to stimuli.
Summary

All three reports identified colonisation and dispossession and the resultant institutionalisation, combined with ongoing discrimination and racism, both at the social and structural levels, as key stressors, or traumatic stressors, in Aboriginal people’s lives. The process of being driven from home and land, having families and tribal communities broken up and the forced separation of children from parents appears to have resulted in profound losses of self, family, community and culture. The reports found that such losses were manifested in specific characteristics of distress (cultural idioms of stress reactions), including the overrepresentation of Aboriginal peoples in the criminal justice system, alcohol and drug misuse, rage and anger directed at the self and others (resulting in violence to self and others), emotional issues, shame for being Aboriginal, low self-esteem, poor mental and physical health, and social and community dysfunction that resulted in some Aboriginal communities being gripped in fear, despair and desperation.

The lack of recognition and meaningful support to deal with these traumatic stressors and the resultant idioms of distress leave Australian Aboriginal peoples with unresolved and ongoing trauma and grief, which passes down through the generations. This appears to be contributing to the compounding, cumulative cycle of trauma that continues to fuel the disadvantaged position of Australian Aboriginal peoples in wider society.

The key traumatic stressors and specific characteristics of distress (cultural idioms of stress reactions) identified in this chapter provide the basis for the focus group discussions used in the development of the AAVHTQ.
CHAPTER FIVE

Focus group discussion results – cultural validation

Aboriginal communities, political organizations and scholars are insisting that the integrity and validity of research cannot be assured by western methodologies alone. They must be tempered by methodologies that are compatible with Aboriginal methods of investigation and validation (Castellano, 2004, p. 106).
Chapter Five: Focus group discussion results

This chapter provides the results of the focus group discussions that were held to address research question number one: What are the trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples? The focus group discussions consisted of five, four-hour sessions over a period of five weeks. A total of seven representatives who had experienced violence and traumatic stressors themselves and/or were professionals familiar with the culture, language and mores of Aboriginal society agreed to participate in the focus group discussions. The following is a list of the focus group participants:

- two male participants, one Aboriginal and one non-Aboriginal, from Northern Territory Corrections — Berrimah prison
- one Aboriginal female participant from the Office for Aboriginal and Torres Strait Islander Health (OATSIH)
- one Aboriginal male participant from Cowdy Ward, Royal Darwin Hospital
- one female non-Aboriginal participant from Don Dale Centre — Juvenile Detention, Northern Territory Corrective Services
- one Aboriginal male participant from the Menzies School of Health
- one Aboriginal male participant from the Council for Aboriginal Alcohol Programs Service (CAAPS).

The focus group discussions provided expert and experiential advice, guidance and knowledge that informed the development of the AAVHTQ, a cross-cultural instrument capable of measuring traumatic stressors and trauma symptoms, as defined by the DSM-III-R for PTSD including cultural idioms of distress reactions relevant to Australian Aboriginal peoples, and addressed any concerns that focus group participants had with the research.

The results of the focus group discussions included the merging of the results from the documentary analysis with the linguistic and semantic modifications from the KRLC. These are presented in table form (Tables 11 and 12) to provide a clear picture of the processes that took place in the development of the final AAVHTQ items.

As discussed in Chapter Four, the KRLC provided input into the linguistic and semantic content of the items in the AAVHTQ to ensure the language presented was appropriate and pitched at a level that would be comprehensible to the Aboriginal participants.
interviewed across Australia. The modifications made to the AAVHTQ by KRLC are classed as Aboriginal English; however they were designed to also suit Kriol speakers who feel confident using English. KRLC highlighted that questions phrased with the verb in the negative can be confusing to some Aboriginal people and are therefore best avoided. For example ‘not having anywhere to go for help’ would be better phrased as ‘having nowhere to go for help’.

The instructions in the preamble of the AAVHTQ, which was read to each research participant, were also modified by KRLC to reflect Aboriginal English. The words in brackets indicate the changes made by KRLC: ‘I would like to ask you questions about your past history and present symptoms (how you are feeling today). However, you may find some questions unsettling (But, might be some of these questions might make you upset). If so, please feel free not to answer (if this happens, don’t worry about answering, we can keep going onto the next question or leave it all together). The answer to the questions will be kept confidential (No-one will find out your answers here – when I put them in a report I can’t use your name).’

**Traumatic stressors**

The research included four categories of traumatic stressors, with a question asking participants to ‘Please indicate whether you have experienced, witnessed, or heard about any of the following events’. KRLC suggested that words like ‘indicate’ are not known and ‘experience’ can cause some confusion. Although the categories experienced, witnessed, heard and not were retained for reporting purposes, the questions about exposure to specific traumatic stressors were modified to ‘Can you tell me if you ever saw any of these things happening or if you heard noises like this was going on or if it happened to you anytime?’

Seventeen traumatic stressor items are provided in the final AAVHTQ (refer to Table 11). These represent the top 17 traumatic stressors identified by the focus group participants as being particularly relevant to Australian Aboriginal peoples. The focus group participants developed the 17 traumatic stressors by extracting themes from the documentary analysis that they thought were particularly relevant, and then refined them and added additional items that were not identified in the documentary analysis. Table 11 also provides a justification for inclusion and modifications of the specific traumatic stressors, indicating where the traumatic stressor was extracted from and outlining the suggestions made by the focus group participants to improve the linguistic and semantic content. Additionally, to ensure appropriate linguistic and semantic content of the traumatic stressors, the KRLC modifications are provided in the final column and are
**bolded** if a change has been made to the final focus group suggestions. The *KRLC modification* column represents the final AAVHTQ item.
<table>
<thead>
<tr>
<th>Item number</th>
<th>Traumatic stressor</th>
<th>Justification for inclusion and modifications</th>
<th>Focus group modifications</th>
<th>KRLC modification (bolded if change has been made) and FINAL AAVHTQ ITEM</th>
</tr>
</thead>
</table>
| 1           | Children being forcibly removed from their families (separation policies)  
Loss of primary carer in infancy  
Loss of mother or prolonged separation before age 11  
Loss of children due to removal policies | Consistently identified in all three reports in the documentary analysis (DA) as a significant stressor. Focus group discussions (FGD) confirmed significance and agreed this is a top 17 stressor. FGD felt the need to refine the traumatic stressors into an overall concept that included adoption, fostering, stolen generation and removal into institutions, highlighting the fragmentation of families. | Adopted or fostered out | Adopted or fostered out |
| 2           | Sorry business | Identified in WTFV in DA as a significant stressor and confirmed as a top 17 stressor by FGD. FGD felt it needed to be more specific in identifying the trauma associated with sorry business in terms of the associated cumulative grief and loss. | Frequent natural or unnatural deaths of family or friends | A lot of deaths of family or friends in one year |
| 3           | Murder of family member or friend | Identified specifically by FGD as a top 17 stressor because rural and remote community members are exposed to high levels of homicides of people well-known to them | No change | Murder of family member or friend |
| 4           | Physical abuse (violence) | Consistently identified in all three reports in the DA, and by FGD, as significant. FGD also revealed that family violence/fighting includes child abuse, which is not seen as separate by the community. FGD felt wording needed to change to reflect this cultural interpretation. | Family violence/fighting | Family violence/fighting |
| 5           | Lack adequate health services  
Lack of adequate or relevant counselling or support services | Identified in all three reports in DA as a common theme and significant stressor. FGD identified it as a top 17 stressor but clarified that it was also an access issue (i.e. no/low/inappropriate essential services support). It also covered the whole person (i.e. emotional, mental, physical and spiritual). FGD also identified this as a social support issue (i.e. low social support). | Emotional, mental, physical or spiritual health problems without access to appropriate services or people | Emotional, mental, physical or spiritual health problems and nobody who can help you sort it out |
| 6           | Sexual abuse | Identified in DA in the BTHR and WTFV as significant and supported by FGD as a top 17 stressor. FGD argued the wording needed to be more specific to reflect the levels of abuse (i.e. rape vs. sexual abuses, which are seen as different in communities). | Rape and/or sexual abuse (unwanted sex or touching) | Unwanted sex or touching (rape and/or sexual abuse) |
| 7           | Inappropriate male role model constructs  
Life in institutions (missions) | All three reports in the DA identified the dismantling of families and communities in various ways. The FGD agreed absentee fathers led to confusion with appropriate male role models, that forced placement in missions contributed to unhealthy communities and that the continuing breakdown of families and communities acted as a specific traumatic stressor understood by most Indigenous peoples. | Family and/or community breakdown | Family and/or community breakdown |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Incarceration</td>
<td>High levels of incarceration in watch houses</td>
<td>Made to live/sit down a long way from your family</td>
<td>Made to live/sit down a long way from your family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identified in RCIADIC (1991) as a significant stressor, due to the forced separation from family and community. FGD agreed that being incarcerated is a significant stressor with numerous reasons for it being stressful. FGD felt a need to clarify one of the issues not covered in other traumatic stressors thus far, specifically to highlight forced separation from family and community (other than removal policies) as a traumatic stressor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Colonisation</td>
<td>Dispossession of land Loss of control over own life Concept of terra nullius Assimilation policies Children taught to reject and feel contempt for Aboriginal culture and heritage/loss of culture</td>
<td>Being forced to accept non-Aboriginal culture and language and losing own cultural rights, language, identity, land and connection to land</td>
<td>Being forced to accept whitefella way and talk English. Losing some or all of your traditional language or ceremony</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All three reports in the DA identified these traumatic stressors as significant in contributing towards a loss of identity and a legacy of trauma. FGD agreed these stressors needed to be included in the top 17 stressors as general concepts of colonisation and of losing culture.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Not respected by own community</td>
<td>FGD identified alienation within community and recognised that acts of excessive alcohol use, violence and imprisonment were a rite of passage for young men. All lead to fear, significant rejection and lack of respect by their own community, resulting in identity issues.</td>
<td>Not respected by own community</td>
<td>Not accepted by own community</td>
</tr>
<tr>
<td>11</td>
<td>Murder of stranger or strangers</td>
<td>Identified specifically by FGD as a top 17 stressor and as separate from the murder of family or friend</td>
<td>No change</td>
<td>Murder of stranger or strangers</td>
</tr>
<tr>
<td>12</td>
<td>Racism</td>
<td>Negative stereotyping of Aboriginal people in the media</td>
<td>Shared for being Aboriginal and experiencing racism</td>
<td>Shamed for being Aboriginal and people being racist towards you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All three reports in DA identified issues associated with racism perpetuated by institutions as a significant ongoing traumatic stressor. FGD agreed it was a top 17 stressor; however words like ‘negative stereotyping’ needed to be adjusted to reflect cultural understandings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Not belonging to anything</td>
<td>Specifically identified by FGD as a cultural stressor that is particularly relevant and common among Australian Indigenous peoples, who often feel in-between worlds (i.e. not belonging in the Indigenous world or the non-Indigenous world, creating feelings of detachment and fragmented, fractured identities).</td>
<td>Not belonging to anything</td>
<td>Not belonging to anything and feeling lost</td>
</tr>
<tr>
<td>14</td>
<td>Lack of necessities such as food, shelter and clothing Lack of good education Poverty</td>
<td>Identified in all three reports in DA as significant stressors and by FGD as a top 17 stressor. FGD felt the wording needed to be more specific and simplified, highlighting homelessness, poverty and a lack of essential services.</td>
<td>Basic needs not being met</td>
<td>Being hungry or not have a proper house to live in or not have a proper school or clinic to go to</td>
</tr>
<tr>
<td>Item number</td>
<td>Traumatic stressor</td>
<td>Justification for inclusion and modifications</td>
<td>Focus group modifications</td>
<td>KRLC modification (bolded if change has been made) and FINAL AAVHTQ ITEM</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>Institutional violence Early contact/repeated contact with criminal justice system</td>
<td>Identified in all three reports in DA as contributing to a cycle of institutionalisation. Specifically identified by FGD as a top 17 stressor that needed to be refined into something tangible by isolating institutions responsible for institutional violence, such as police (legal), welfare and housing departments.</td>
<td>Bad experiences with the legal welfare and housing systems</td>
<td>Bad things happened to you with the police, welfare-mob and housing commission</td>
</tr>
<tr>
<td>16</td>
<td>Alcohol and drug misuse</td>
<td>WTFV identified this as endemic and central to the cycle of violence. FGD agreed that it is a top 17 stressor but felt that the wording needed to be more specific to reflect the traumatic experiences specifically associated with being intoxicated or being around people that are intoxicated.</td>
<td>Bad experiences from taking drugs and/or alcohol or bad experiences from being with other people who have been taking them</td>
<td>Bad things happened to you from taking drugs and/or alcohol or bad things happened to you from being with other people who have been taking them</td>
</tr>
<tr>
<td>17</td>
<td>Any other stressors not identified in DA or FGD</td>
<td>The focus group participants suggested including an open-ended question in the traumatic stressors section. This would ensure that a comprehensive list of traumatic stressors was provided and would identify other potential traumatic stressors that may have been missed in the documentary analysis and FGD.</td>
<td>Any other situation that was so frightening to you that you felt your life was in danger</td>
<td>Specify:</td>
</tr>
</tbody>
</table>
**AAVHTQ trauma symptoms**

The preamble to the trauma symptoms section of the AAVHTQ also required minor modifications by KRLC. The words in brackets indicate the changes made by KRLC: ‘The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please listen to or read each one carefully and decide how much the symptoms bothered you in the past week (this week just past)’.

A total of 30 trauma symptoms are provided in the final AAVHTQ (refer to Table 12) which represents a combination of PTSD symptoms as defined in the DSM-III-R including cultural idioms of distress reactions relevant to Australian Aboriginal peoples. Items 1–16 represent the symptoms relating to PTSD as defined by the DSM-III-R, which remained in concept, but which had their wording changed into Aboriginal English and were adjusted for cultural sensitivity. The remaining items (items 17–30) represent cultural idioms of stress reactions relevant to Australian Aboriginal peoples, which were extracted from the documentary analysis results and refined, with additional items added by the focus group participants. Table 12 also provides a justification for inclusion and modifications of the trauma symptoms, indicating where the trauma symptoms were extracted from and why modifications were needed. The focus group modification column represents the specific modifications made by the focus group participants to improve the linguistic and semantic content. Additionally, to ensure appropriate linguistic and semantic content of the trauma symptoms, the KRLC modifications are provided in the final column and are bolded if a change has been made to the final focus group suggestions. The KRLC modification column represents the final AAVHTQ item.
<table>
<thead>
<tr>
<th>Item number</th>
<th>Trauma symptoms</th>
<th>Justification for inclusion and modifications</th>
<th>Focus group modifications</th>
<th>KRLC modification (bolded if change has been made) and final AAVHTQ item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recurrent thoughts or memories of the most hurtful or terrifying events</td>
<td>DSM-III-R required item. Also identified in WTFV and by focus group participants as relevant. FGD agreed that the word ‘recurrent’ was not transferable and could be simplified by describing it as ‘coming up over and over again’.</td>
<td>Thoughts or memories of the most hurtful or terrifying events coming up over and over again</td>
<td>Thoughts or memories of the most hurtful or terrifying events coming up over and over again</td>
</tr>
<tr>
<td>2</td>
<td>Feeling as though the event is happening again</td>
<td>DSM-III-R required item. FGD have seen the word ‘flashbacks’ used for this symptom before and felt that it would provide a better understanding if it was included</td>
<td>Flashbacks – feeling as though the event is happening again</td>
<td>Flashbacks – feeling as though the event is happening again</td>
</tr>
<tr>
<td>3</td>
<td>Recurrent nightmares</td>
<td>DSM-III-R required item. FGD felt that the word ‘recurrent’ was not transferable and that a more specific explanation was required, such as ‘over and over’.</td>
<td>Having the same bad dreams over and over again</td>
<td>Having the same bad dreams over and over again</td>
</tr>
<tr>
<td>4</td>
<td>Feeling detached or withdrawn from people</td>
<td>DSM-III-R required item. DA also reported feelings of isolation from society by BTHR and RCADIC (1991), suggesting that Indigenous people felt withdrawn from the mainstream community. FGD agreed that words like ‘detached’ or ‘withdrawn’ would be difficult to interpret and needed to be more specific.</td>
<td>Feeling alone and staying away from people</td>
<td>Feeling alone and staying away from people</td>
</tr>
<tr>
<td>5</td>
<td>Unable to feel emotions</td>
<td>DSM-III-R required item. FGD agreed that the word ‘unable’ was not transferable and that a more definitive word was necessary, such as ‘can’t’, which is easily understood by most Indigenous peoples, including more traditional peoples.</td>
<td>Can’t feel emotions</td>
<td>Can’t feel emotions</td>
</tr>
<tr>
<td>6</td>
<td>Feeling jumpy or easily startled</td>
<td>DSM-III-R required item. FGD felt that ‘feeling jumpy’ may be taken literally (i.e. wanting to jump) and words like ‘startle’ may not be transferable. The symptom needed to be simplified by stating the actual feeling (i.e. nervousness). Furthermore, fear and anxiety were also identified by BTHR in the DA as significant characteristics of distress, and the FGD felt that ‘nervous’ covered these symptoms of distress too.</td>
<td>Feeling nervous</td>
<td>Feeling nervous</td>
</tr>
<tr>
<td>Item number</td>
<td>Trauma symptoms</td>
<td>Justification for inclusion and modifications</td>
<td>Focus group modifications</td>
<td>KRLC modification (bolded if change has been made) and final AAVHTQ item</td>
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<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Difficulty concentrating</td>
<td>DSM-III-R required item. FGD felt the need to simplify this symptom, suggesting that the word 'can’t' is preferable, as it is easily understood.</td>
<td>Can’t think straight</td>
<td>Can’t think straight</td>
</tr>
<tr>
<td>8</td>
<td>Trouble sleeping</td>
<td>DSM-III-R required item.</td>
<td>No change</td>
<td>Trouble sleeping</td>
</tr>
<tr>
<td>9</td>
<td>Feeling on guard</td>
<td>DSM-III-R required item.</td>
<td>No change</td>
<td>Feeling on guard/keeping a look out for trouble</td>
</tr>
<tr>
<td>10</td>
<td>Feeling irritable or having outbursts of anger</td>
<td>DSM-III-R required item. Also identified in DA as anger/rage. High rates of self harm (e.g. mutilations) were also identified in WTOV in DA as a result of removals. FGD felt words like 'irritable' and 'outbursts' would not be understood and that the word 'angry' translated into irritable and 'taking it out on others' was an indication of an outburst.</td>
<td>Feeling angry all the time and taking it out on others or yourself</td>
<td>Feeling angry all the time and taking it out on others or yourself</td>
</tr>
<tr>
<td>11</td>
<td>Avoiding activities that remind you of the traumatic or hurtful event</td>
<td>DSM-III-R required item. FGD felt the word 'avoiding' could cause confusion and could be simplified by saying 'not doing things' and that the word 'traumatic' could be simplified by replacing it with 'bad'.</td>
<td>Not doing things that remind you of the hurtful or bad experiences</td>
<td>Trying to keep away from things that remind you of the hurtful or bad things that happened to you</td>
</tr>
<tr>
<td>12</td>
<td>Inability to remember parts of the most traumatic or hurtful events</td>
<td>DSM-III-R required item. FGD agreed that words like 'inability' could be simplified to 'not being able' and 'traumatic' could be changed to 'bad'.</td>
<td>Not being able to remember some of the most hurtful or bad experiences</td>
<td>Not being able to remember some of the most hurtful or bad things that happened to you</td>
</tr>
<tr>
<td>13</td>
<td>Less interest in daily activities</td>
<td>DSM-III-R required item. FGD agreed that 'less interest' and 'daily activities' were not terms that were widely used and could be replaced by something more simple and directive.</td>
<td>Not caring about everyday things</td>
<td>Not caring about everyday things. List:</td>
</tr>
<tr>
<td>14</td>
<td>Feeling as if you don't have a future</td>
<td>DSM-III-R required item. FGD agreed that the concept and feeling of 'hopelessness' is widely understood and should be included. 'Future' should also be distinguished between a 'good future' or 'no future at all' to ensure there is no confusion.</td>
<td>Feeling as if you don't have a good future or any future at all (hopelessness)</td>
<td>Feeling as if you don't have a good future or any future at all (hopelessness)</td>
</tr>
<tr>
<td>Item number</td>
<td>Trauma symptoms</td>
<td>Justification for inclusion and modifications</td>
<td>Focus group modifications</td>
<td>KRLC modification (bolded if change has been made) and final AAVHTQ item</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>Avoiding thoughts or feelings associated with the traumatic or hurtful events</td>
<td>DSM-III-R required item. The FGD agreed that the words ‘avoiding’, ‘associated’ and ‘traumatic’ were problematic and needed simplifying.</td>
<td>Trying not to think or feel about anything to do with the bad or hurtful experiences</td>
<td>Trying not to think or feel about anything to do with the bad or hurtful things that have happened to you</td>
</tr>
<tr>
<td>16</td>
<td>Sudden emotional or physical reaction when reminded of the most hurtful or traumatic stressors</td>
<td>DSM-III-R required item. FGD agreed that the word ‘sudden’ would not be understood and could easily be replaced with ‘quickly’. Also suggested that again ‘traumatic’ could be replaced with ‘bad’ and ‘events’ is not understood and would need simplifying.</td>
<td>Quickly losing it when you are reminded of the most hurtful or bad experiences</td>
<td>Going mad or crying when you are reminded of the most hurtful or bad things that have happened to you</td>
</tr>
<tr>
<td>17</td>
<td>Despair/Desperation/Depression</td>
<td>Identified in BTHR and WTFV in DA as common characteristic of distress of victims of physical and sexual violence, and a likely outcome for those removed or institutionalised. FGD agreed that these characteristics of distress are particularly relevant in Indigenous communities, but that the translation was related to feelings of isolation and feeling like you are the only one that is feeling this way.</td>
<td>Feeling that people do not understand what happened and that you are the only one who has suffered these events</td>
<td>Feeling that people do not understand what happened and that you are the only one who has suffered these things</td>
</tr>
<tr>
<td>18</td>
<td>Feeling guilty</td>
<td>Specifically identified in FGD as a common characteristic of distress that is particularly relevant to Aboriginal peoples.</td>
<td>Feeling guilty</td>
<td>Feeling guilty</td>
</tr>
<tr>
<td>19</td>
<td>Self-contempt/self-esteem/Shame</td>
<td>Identified in all three reports in DA as common outcomes of institutionalisation and negative stereotyping of Aboriginal people in the media. Cultural idiom of distress identified by FGD. FGD identified ‘shame’ as the cultural equivalent to self-contempt and a low self-esteem.</td>
<td>Feeling shame</td>
<td>Feeling shame</td>
</tr>
<tr>
<td>20</td>
<td>Grief and mourning/Obsessing about a bad experience</td>
<td>DA of BTHR and WTFV revealed that these symptoms were common for those removed or who had children removed. The FGD agreed that people tend to spend excessive time thinking about why things have happened when they are in a state of grief, and so decided to change the wording to reflect this.</td>
<td>Spending time thinking about why these events happened</td>
<td>Spending time thinking about why these things happened</td>
</tr>
<tr>
<td>21</td>
<td>Feeling as if you were going crazy</td>
<td>FGD identified specific cultural characteristic of distress as particularly relevant to Indigenous Australians.</td>
<td>No change</td>
<td>Feeling as if you were going crazy</td>
</tr>
</tbody>
</table>

KRLC: Keleti Regional Language Centre.
AVHHTQ: Australian Aboriginal and Torres Strait Islander Health Humanitarian Taskforce.
<table>
<thead>
<tr>
<th>Item number</th>
<th>Trauma symptoms</th>
<th>Justification for inclusion and modifications</th>
<th>Focus group modifications</th>
<th>KRLC modification (bolded if change has been made) and final AAVHTQ item</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Feeling that you have no one to rely on</td>
<td>FGD identified feelings associated with not being able to rely on people as a common symptom of distress for Indigenous Australians.</td>
<td>No change</td>
<td>Feeling that you have no one who will look after/out for you</td>
</tr>
<tr>
<td>23</td>
<td>Disassociation</td>
<td>The FGD identified feelings of disassociating as a common cultural idiom of distress, but felt it needed to be worded carefully in a descriptive statement to be fully understood.</td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing</td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing</td>
</tr>
<tr>
<td>24</td>
<td>Loss of trust and intimacy</td>
<td>Identified in BTHR as common for those removed, particularly those removed as infants. FGD agreed that this was a significant cultural idiom of distress, but felt the wording needed to be simplified and made into a statement.</td>
<td>Feeling someone you trusted betrayed you</td>
<td>Feeling someone you trusted did something to betray you</td>
</tr>
<tr>
<td>25</td>
<td>No sense of identity or belonging</td>
<td>Identified in all three reports in DA as a significant characteristic of distress related to the breakdown of families and culture, resulting in feelings of worthlessness. FGD agreed that this was a significant cultural characteristic of distress and that &quot;feeling worthless&quot; captures the issue.</td>
<td>Feeling worthless</td>
<td>Feeling worthless</td>
</tr>
<tr>
<td>26</td>
<td>Violence (including physical and sexual violence); Impulsive behaviour</td>
<td>Violence and impulsive behaviour was identified in all three reports in the DA as a significant characteristic of distress. Violence is seen as a symptom of and recovery from trauma. FGD agreed that violence was the usual expression of impulsive behaviour and was particularly relevant as a cultural idiom of distress, but felt that the wording needed to reflect what the person was doing.</td>
<td>Becoming violent to self or others</td>
<td>Becoming violent to self or others</td>
</tr>
<tr>
<td>27</td>
<td>Alcohol and drug misuse</td>
<td>Identified in all three reports in the DA as both a cause of distress and a symptom of distress, particularly for those people removed from their families as infants. It is primarily used for avoidance or numbing effects. FGD agreed that the wording needed to reflect this and that the word ‘abuse’ was not appropriate.</td>
<td>Taking drugs and/or alcohol all the time to help you forget</td>
<td>Taking drugs and/or alcohol all the time to help you forget the bad things that happened to you</td>
</tr>
<tr>
<td>Item number</td>
<td>Trauma symptoms</td>
<td>Justification for inclusion and modifications</td>
<td>Focus group modifications</td>
<td>KRLC modification (bolded if change has been made) and final AAVHTQ item</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>Problems establishing relationships (feeling unloved or unable to give love), Poor/impaired parenting skills (e.g. unable to show love to own children)</td>
<td>Both the BTHR and WTFV in the DA identified these as common problems amongst those removed and suggested that poor parenting skills were a legacy of removal at a young age. FGD agreed these issues were significant cultural characteristics of distress, particularly relevant in populations where removal policies were prevalent. FGD felt that the characteristics needed to be merged into one statement.</td>
<td>Problems establishing and maintaining relationships (feeling unloved or unable to give love)</td>
<td>Problems establishing and maintaining relationships (feeling unloved or unable to give love)</td>
</tr>
<tr>
<td>29</td>
<td>Suicide</td>
<td>Identified in BTHR and RCIADIC (1991) as a significant characteristic of distress, with high rates amongst those men who had been removed and who had frequent contact with the criminal justice system from a young age. FGD agreed this was a particularly important sign of distress and needed to be identified as suicidal thoughts.</td>
<td>Suicidal thoughts</td>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>30</td>
<td>Have you ever felt that the event didn't happen to you or that you don't feel bad about it (denial)?</td>
<td>FGD identified denial as a common cultural characteristic of distress, which was possibly a survival technique.</td>
<td>No change</td>
<td>Have you ever felt that these things didn't happen to you or that you don't feel bad about it (denial)?</td>
</tr>
</tbody>
</table>
**Scoring**

A discussion with the focus group participants examined the scoring scale technique to ensure it would be readily understood and culturally appropriate. The focus group participants decided not to attempt to assess the relative severity of events, given their view that traumatic stressors experienced by Australian Aboriginals were catastrophic. Instead, they decided it was preferable to measure the degree of exposure to stressors already identified as central to Australian Aboriginal experiences. This would create a response scale that was free of preconceptions regarding possible relationships between types of events and symptom severity. Instead of asking direct ‘yes/no’ questions, a range of categories were developed to reflect degree of exposure, therefore allowing research participants to respond to items such as ‘rape’ without revealing more about their experiences than they wanted, whilst not denying the event altogether. Additionally, focus group participants stated that calculating the number of traumatic stressors endorsed was a particularly important score, capable of depicting the cumulative and compounding levels of trauma experienced in Aboriginal communities.

The trauma symptoms were scored on a four-point scale as follows: (1) *not at all*, (2) *a little*, (3) *quite a bit*, and (4) *extremely*. Two types of variables could be generated by this scale: a continuous measure of experienced symptom severity, formed by averaging responses on each symptom scale over participants (range: 30–120); and a categorical measure of symptoms (i.e. the presence or absence of symptoms). The focus group participants agreed that information regarding symptom severity is especially important in studying such highly traumatised populations as Australian Aboriginals. It is possible that when the level of exposure to trauma is so high, it is precisely the severity of symptoms, and not their presence or absence, which can identify individuals who meet the DSM-III-R criteria for PTSD or those who have a profound functional disability. The KRLC suggested that words like ‘quite’ and ‘extremely’ intended for use in this scale were not well-known and could cause confusion. Consequently, the wording of the four-point scale was modified to: (1) *not at all*, (2) *a little bit*, (3) *a fair bit*, and (4) *a lot*. KRLC suggested that in addition to just reading out the scale to the research participants, the researcher should visually display each of the various levels in the scale. For example, ‘a little bit’ would be visually displayed by the researcher holding up her hands in the shape of a small circle, while ‘a fair bit’ would be a bigger circle and ‘a lot’ would be a large circle using the arms.
Specific concerns and suggestions provided by focus group participants

A discussion was held with the focus group participants about any concerns regarding the research project and potential solutions. Participants were encouraged to provide more detail about concerns and suggestions, to provide possible solutions and to continue to raise concerns as an ongoing process throughout the course of the focus group discussions. Some of the concerns raised were as follows:

1. Is it appropriate to have non-Aboriginal peoples participating in the focus group discussions?

There were two non-Aboriginal peoples in the focus group discussions. They had many years of experience working in the Aboriginal community and were well respected by community members, including some of the other Aboriginal focus group participants. The focus group agreed that it was appropriate for these two people to be in the focus group discussions because they brought a wealth of experience and knowledge that would be very useful in developing the AAVHTQ.

2. Some men, particularly in the Top End, will not open up to a female interviewer, especially when discussing the possible stresses associated with male initiation.

This is a valid point and one that was considered in the methodology. One criterion for voluntary participation in the research was feeling comfortable with a female interviewer. The focus group participants agreed that this should not be an issue as long as the men were aware that the interviewer would be female and that they had the choice not to participate if they found this problematic. The focus group participants suggested wearing respectful clothing as an appropriate strategy.

3. The results of the research may be used to justify Aboriginal male violence.

A disclaimer in the introduction of this thesis, under the title 'potential abuses or misapplication of the results of the research', address this potential issue and suggests that if the results are used to justify Aboriginal male violence, it will be a total misapplication of the intended purpose of the research.

4. It is important that the research participants are offered the appropriate support services following interviews to prevent re-traumatising participants.
It was a requirement of the State/Territory Correctional Institutions to offer counselling to all research participants.

5. The focus group participants suggested that it was important to avoid extensive interpretation of participants’ Stories/narratives, which they felt was prevalent in Western approaches to qualitative research. The preference was for the narratives to be woven through the results. In other words, they wanted to let the men tell their Stories in their own way.

The use of extensive quotes, which have not been extensively deconstructed or interpreted, was addressed in the methodology. It was agreed that this method was respectful and honoured an Indigenous approach to research that emphasises, among other things, the oral tradition.

6. The focus group suggested that the inclusion of a basic question asking participants for their conceptions of trauma and violence would contribute to the specificity of the cultural meaning of trauma and would validate the research participants’ understanding of the concepts.

Research participants’ conceptions of trauma and violence were incorporated into the research schedule questions and are presented in the results.

**Summary**

The focus group discussions provided a cultural validation of the research, representing a talking circle in which all concerns, suggestions and views could be aired and solutions found through consensus. The personal and professional experiences of the individual members in the focus group discussions were fundamental in extracting significant traumatic stressors and specific cultural idioms of stress reactions from the documentary analysis and further refining and introducing new items into the final 17 traumatic stressors and 30 trauma symptoms that became part of the AAVHTQ.

There were four main themes that influenced the focus group participants’ refinement and selection of the final 17 traumatic stressors in the AAVHTQ. The most prevalent theme related to issues of *violence* and included violence associated with the deaths of family and friends, murder of family, friends and strangers, family violence, sexual violence, institutional violence and the violence that is imposed on oneself through drug and alcohol misuse or being exposed to others who abuse drugs and alcohol. The second most prevalent theme related to issues of *loss and grief*, which also
encompassed issues associated with deaths of family and friends (including murder), fragmentation of families through adoption, family and community breakdown, rejection by one’s community, having a sense of not belonging, and being forced to sit down a long way from home and family. The third theme centred on issues of **racism and colonisation**, such as being forced to accept the whitefella way, and loss of language and culture. The fourth theme concerned issues relating to a **lack of support**, such as having emotional, mental, physical and spiritual health problems with no one being there to help, and being hungry all the time, or not having a proper house, medical clinic or school to go to. The focus group added an open-ended question that permitted the research participants to include in their narratives any other traumatic stressors where they felt their lives were threatened, and which had not been identified through the documentary analysis or focus group discussions. This was to ensure that the research participants’ narratives added to the data, and that the AAVHTQ, interviews and geno-histograms did not provide artificial barriers to the collection of such data.

Of the 30 trauma symptoms identified, the first 16 represent the required DSM-III-R PTSD core questions and were only modified to ensure research participants’ comprehension. The final 14 were those symptoms identified as specific to Australian Aboriginal peoples. The focus group members utilised the information from the documentary analysis and refined it into 14 significant cultural idioms of stress reactions that were not captured in the DSM-III-R items. The nature of the cultural idioms of stress reactions identified by the focus group participants centred around trust issues, isolation, suppressed memories, obsessive thoughts about traumatic stressors (with an associated sense of isolation), guilt, shame, relationship difficulties, disassociation, general feelings of worthlessness, self-medication through drugs and alcohol, aggression and emotional turmoil connected to the traumatic stressor, and suicidal ideation.

The scoring system for traumatic stressors within the AAVHTQ was modified from the scoring system of the HTQ, as the focus group participants believed that Australian Aboriginal peoples’ experience of trauma was catastrophic. Instead, it was decided to measure the degree of exposure, permitting responses free of preconceptions regarding possible relationships between events and symptom severity. The focus group participants also determined that it was important to include within the AAVHTQ the ability to count events and symptoms to permit a depiction of cumulative and compounding levels of trauma. To allow a measure of symptom severity, focus group participants believed that it was imperative to allow for a range of responses. This is
particularly important when studying such highly traumatised populations as Australian Aboriginal peoples.

In examining the research as a whole, the focus group participants questioned the appropriateness of the researcher’s gender for interviewing Aboriginal men, particularly across the Top End, and raised concern about the possible use of the research to justify ongoing violence by Australian Aboriginal men. The group identified the need for counselling support to be offered to those interviewed in the event that they were re-traumatised by the telling of their Stories, as well as the need to avoid extensive interpretation of the Stories. It was also suggested that, in telling their Stories, the men be encouraged to explain their personal understanding of violence and trauma. In all cases these issues were dealt with, and solutions were found, through discussion and agreement reached by consensus.

All traumatic stressors, trauma symptoms and the terms used for the scoring of the AAVHTQ, as well as those elements of the AAVHTQ that were read to, or read by, the research participants, were vetted and adjusted by the KRLC. This was done to ensure that the tone and level of language was appropriate, in order to maximise the research participants’ understanding.

The final version of the AAVHTQ, that provides a comprehensive list of traumatic stressors and trauma-related symptoms relevant to Australian Aboriginal peoples, was developed by merging the results of the documentary analysis with the linguistic and semantic modifications from the KRLC and the additional contributions of the focus group participants. This final version of the AAVHTQ was the primary instrument used in the interviews with the Aboriginal men from various prisons, the results of which are presented in Chapter Six.
Because like well you’re the black sheep of the family now, before it was my mum, before that was my uncle, before that it was my grandfather. Now I believe that why it’s happening like that is because it’s passed on from one people to the next. I think something that trauma is; I think it’s something that so bad that happened to you that you can’t get on with your life because it’s holding you back. And if people don’t give you those chances to learn from your mistakes then you’re just going to be stuck in that way. And it’s hard to get out of it when you feel traumatised, basically by that because you’re caught in that circle of all that turmoil and all that trouble, that you’ve lived in your life. Because what ever it is you’ve got to do with your life, and I think my life is to teach my children to stop that cycle from happening, because it’s been happening for so long. It’s got to stop somewhere and now that I’ve been [sorry] and I’ve learnt so much I think I can go back to my children and say hey, I love yours very dearly and I just don’t want this to happen to you (Research participant, PTSD symptomatic with a score of 2.57).
Chapter Six: Quantitative and qualitative research results

The following chapter provides the quantitative and qualitative results derived from the semi-structured in-depth interviews described in Chapter Five. The quantitative and qualitative data explore the relationship between Australian Aboriginal male violence and generational post-traumatic stress by establishing whether the Aboriginal men committed for a violent offence who took part in this research have been exposed to traumatic stressor’s, whether they suffer from symptoms associated with PTSD (as defined by the DSM-III-R including specific cultural idioms of distress reactions relevant to Australia Aboriginal peoples), and whether there are patterns of generational trauma and violence in their families. This was achieved by administering the AAVHTQ and by collecting individual ‘Stories’ relating to the traumatic stressors and cultural idioms of distress reactions from the research participants, including exploring traumatic stressors and dysfunctional behaviours between the current and older generations. A total of 60 men were interviewed for this study, however two of the research participants had missing data to such an extent that it was decided not to include them in the results. The remaining 58 research participants had no missing data.

Although some preliminarily quantitative reliability and validity statistics are provided in this chapter, it is important to note that the purpose of the study was not a comprehensive ‘Western’ (i.e. quantitative) validation of the AAVHTQ and therefore the results should take this into consideration. Rather, emphasis was placed on using the qualitative data — the individual Stories of the participants — as a validation against the AAVHTQ. For example, the narratives derived from the in-depth interviews were used to cross check the results of the AAVHTQ and geno-histogram constructions and changes were made to both these when the narratives clearly and unambiguously provided more accurate data. There were a number of interviews (n = 18) in which the research participants contradicted themselves, providing responses that were different in the semi-structured narrative interview and general discussion, when they were encouraged to simply tell their stories, compared to their responses when the formal AAVHTQ was conducted. When amending the AAVHTQ responses, the context and clarity of the contradictory information was considered and the amendment was only made when the contradictory information was clear and unambiguous. The freedom of expression that the semi-structured narrative interviews encouraged, which allowed the research participants to simply tell their Story and share their feelings, was considered to elicit more comprehensive responses.
Additionally, as a result of re-reading the interview transcripts, the researcher modified the geno-histogram coding based on research participants’ comments during the semi-structured qualitative and AAVHTQ interviews. In 20 cases research participants revealed details of events that had happened to them and members of their family, which were subsequently omitted during the geno-histogram construction. These additions were only made where the reference was clear about what had occurred and which people were involved. It is the individual narratives, the testimonies from the men who participated in this research, that add qualitative insight into the quantitative statistical results, thus bringing enhanced meaning. It is this emphasis on the Stories that highlights narrative as the primary validation tool.

The qualitative data were extracted using a manual thematic analysis. As the research was administered in a semi-structured style, many of the categories and themes arising from the thematic analysis related to items from the research schedule, such as conceptions of trauma and violence, and specific items in the AAVHTQ, including the traumatic stressors and symptoms of distress. Therefore, the qualitative data are presented alongside the findings of the AAVHTQ in order to contextualise and validate the quantitative data and to provide alternative explanations where necessary. In order to honour the Aboriginal voices that are part of this research, deconstruction and interpretation of narratives was kept to a minimum, and extensive quotes are provided to allow the research participants to weave their own stories individually and collectively. All of the qualitative data throughout this research includes the AAVHTQ score, indicating whether the participant was PTSD symptomatic or non-PTSD symptomatic (≥2.50 represents symptomatic for PTSD according to AAVHTQ).

Quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS) software for Windows (version 13.0). Descriptive statistics and scatter plots were examined for grouped and ungrouped data to test for normality, linearity and homoscedasticity for four variables: number of traumatic stressors, level of exposure, DSM-III-R symptom severity score and AAVHTQ symptom severity score. Normality and homogeneity of variance assumptions were not violated for these four variables. No outliers were identified in either the ungrouped or grouped data.

This chapter also presents descriptive statistics to provide an overview of the demographic characteristics of the research participants, as well as to explore the AAVHTQ data to establish if members of the study population were experiencing symptoms associated with PTSD and to identify the most commonly occurring symptoms. Descriptive statistics are also provided in terms of determining patterns of
cumulative trauma, establishing the number of traumatic stressors and exploring commonly endorsed traumatic stressors across the study population, including identifying the level of exposure. This chapter also explores potential associations between PTSD symptomatology and specific demographic characteristics, PTSD status and traumatic stressors. Additionally, the qualitative data are explored to provide a deeper understanding of endorsed traumatic stressors by presenting themes associated with the endemic nature and normalisation of family violence, grief and loss, and alcohol and drug misuse, as well as the profound effects of experiencing the murder of family, friends or strangers, institutional violence, fractured families and souls, acculturation (colonisation) and racism, from the perspective of the research participants.

The rates of traumatic stressors and dysfunctional behaviours across the current and older generations of the research participants, as derived from the geno-histogram data, are presented, exploring both the changes to the rate of those events and behaviours across the generations and the potential patterns of generational trauma and violence.

Finally, qualitative themes extracted from the individual stories of the research participants in terms of positive ways forward are addressed, including discussions about breaking the cycle of trauma and dysfunction for the next generation.

**Participant demographic characteristics**

The total study population of this research consisted of 58 Aboriginal males who had been imprisoned for violent crimes, including homicide; sexual assault; assault; and theft, robbery and breaking and entering involving violence against the person. The geographic distribution of the participants was: ten from Queensland, 20 from the Northern Territory, eight from Victoria and ten from South Australia.

Table 13 presents the demographic characteristics of the research participants. The ages of the participants ranged from 19 to 50 years, with an average age of 30.6 years ($SD = 8.27$). The participants received an average of 9.1 years ($SD = 1.87$) of education. A large proportion of the participants (70.6%) had never been in a permanent relationship or were divorced/separated or widowed, and only 17 (29.3%) were currently married or in a de facto relationship. The average number of children that participants had was 2.3 ($SD = 2.1$). There was a range of ‘usual occupations’, with 11 participants (19.0%) listing no usual occupation and the remainder spread fairly evenly across a range of occupations.
As many participants had multiple convictions on different violent crimes, the crime types were ranked in order of seriousness with homicide first; sex offences second; assault third; and finally, theft, robbery and breaking and entering involving violence against the person. The most common crime type was assault, representing 22 (37.9%) of the participants, and the least common was theft, robbery and breaking and entering involving violence, representing six (10.3%) of the participants.

Recidivism rates were only included for a repeat offence meeting the violence criteria, and which ended in a conviction and jail sentence. Therefore, a participant with a recidivism rate of 1 is currently serving a second sentence for their second violent offence. For purposes of classification the researcher set the rate of 1–2 as a low recidivism rate; 3–4 a moderate recidivism rate; and 5+ sentences served a high recidivist rate. The average recidivist rate was 4.8 (SD = 3.4), with recidivism rates ranging from a minimum of one repeat offence to a maximum of 13 repeated offences.

Less than half — 24 (41.4%) — of the participants still spoke their traditional language and the remaining 34 (58.6%) did not speak their traditional language at all. The majority (86.2%) of participants felt ‘very comfortable’ speaking English.
Table 13: Number and percentage of participant demographics and characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total frequency ((n = 58))</th>
<th>Percentage of sample ((n = 58))</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-27</td>
<td>25</td>
<td>43.1</td>
</tr>
<tr>
<td>28-37</td>
<td>19</td>
<td>32.8</td>
</tr>
<tr>
<td>38-50</td>
<td>14</td>
<td>24.1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Primary school (1-6)</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>High school (7-10)</td>
<td>45</td>
<td>77.6</td>
</tr>
<tr>
<td>High school (11-12)</td>
<td>10</td>
<td>17.2</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>28</td>
<td>48.3</td>
</tr>
<tr>
<td>Married/Defacto</td>
<td>17</td>
<td>29.3</td>
</tr>
<tr>
<td>Divorced/separated/widower</td>
<td>13</td>
<td>22.4</td>
</tr>
<tr>
<td><strong>No. of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>16</td>
<td>27.6</td>
</tr>
<tr>
<td>1-4</td>
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<td>5-8</td>
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<td>13.8</td>
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<tr>
<td><strong>Usual occupation</strong></td>
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<td></td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>19.0</td>
</tr>
<tr>
<td>Labourer(^\text{a})</td>
<td>11</td>
<td>19.0</td>
</tr>
<tr>
<td>CDEP(^\text{a})</td>
<td>7</td>
<td>12.1</td>
</tr>
<tr>
<td>Trades</td>
<td>8</td>
<td>13.8</td>
</tr>
<tr>
<td>Human services</td>
<td>8</td>
<td>13.8</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>22.4</td>
</tr>
<tr>
<td><strong>Crime types(^\text{b})</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td>15</td>
<td>25.9</td>
</tr>
<tr>
<td>Sex offences</td>
<td>15</td>
<td>25.9</td>
</tr>
<tr>
<td>Assault</td>
<td>22</td>
<td>37.9</td>
</tr>
<tr>
<td>Theft, robbery &amp; breaking and entering all involving violence against the person</td>
<td>6</td>
<td>10.3</td>
</tr>
<tr>
<td><strong>Recidivism(^\text{c})</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 (low)</td>
<td>18</td>
<td>31.0</td>
</tr>
<tr>
<td>3-4 (moderate)</td>
<td>19</td>
<td>32.8</td>
</tr>
<tr>
<td>5+ (high)</td>
<td>21</td>
<td>36.2</td>
</tr>
<tr>
<td><strong>Traditional language used</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>58.6</td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>41.4</td>
</tr>
<tr>
<td><strong>Comfortable speaking English</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat</td>
<td>3</td>
<td>5.2</td>
</tr>
<tr>
<td>Fairly comfortable</td>
<td>5</td>
<td>8.6</td>
</tr>
<tr>
<td>Very comfortable</td>
<td>50</td>
<td>86.2</td>
</tr>
</tbody>
</table>

\(^{a}\) CDEP is the acronym for 'Community Development Employment Projects', which are a voluntary, paid alternative to unemployment benefits for Indigenous Australians, based on community enterprises.

\(^{b}\) Ranked by most serious crime, as many participants have multiple convictions on different violent crimes. Rank is in order of most serious crime as follows: homicide; sex offence; assault; and theft, robbery and breaking and entering, all involving violence against the person.

\(^{c}\) Recidivism rates are only included for a repeat offence that fits the violence criteria, and which ended in a conviction and jail sentence. Therefore a participant with a recidivism rate of 1 is currently serving a sentence for their second offence. 5+ sentences served is considered a high recidivist rate.

Qualitative validation of understandings of trauma and violence

As suggested in the focus group discussions, the research participants were asked to describe their personal understanding of trauma and violence, to ensure that the researcher and participants shared a common understanding. A small selection of the qualitative responses is provided below as typical illustrations of the research participants’ understanding of trauma.

Something bad happens and I put it inside me and I push it down, then something else bad happens and I put it inside me and I push it down, then all of
a sudden I’ve got so much pushed down that it just explodes. And that’s what trauma is, bad experiences and you keep putting it inside you and you’re pushing it down, pushing it down and there’s no really good programs that help you sort of take it out, take it out, so you’re free of it all. Well I used to use violence to get rid of it. Trauma is to me, something that never leaves you. It’s inside, it’s internal and it won’t, it will never leave (Research participant, non-PTSD symptomatic with a score of 2.37; however was PTSD symptomatic, 2.60, according to DSM-III-R score).

It’s things that you, well me, things that I think about, bad things, that have happened to me in the past that still affect me today (Research participant, PTSD symptomatic with a score of 3.30).

I guess the side effects left after something bad has happened. I will let you know about one thing that happened. I had an auntie and she had a few kids back in Queensland and her fiancé actually murdered and raped the kids and everything like that. And got three life sentences for it. That sort of left a bit of a mark in my mind to say well what’s the world coming to when you’ve got fellas who go and do things like that? (Research participant, PTSD symptomatic with a score of 2.50).

Something comes across and pulls the pins out and kind of like bang (Research participant, PTSD symptomatic with a score of 2.67).

The outcomes of an experience, really bad experiences the type that really stay with you for life (Research participant, PTSD symptomatic with a score of 3.30).

Something that has psychological scarring (Research participant, PTSD symptomatic with a score of 3.00).

All of the research participants seemed to have a clear understanding of the concept of trauma, with some participants succinctly summing it up and others providing a deeper level of understanding. A small selection of the qualitative responses is provided below as illustrations of the research participants’ understanding of violence:

Violence is your emotions, when you don’t get your own way. Well I think back to my girlfriend, where like she had that domestic violence order against me and a lot of the time it was arguing over what people don’t do, where the money was
going to be spent and it involved drugs and it involved alcohol. And when I was
on those things, and after the fact that maybe we decided no we don’t want
these things and then when we’ve finally got it I said I didn’t really want any of it,
and eventuated into an argument and then I hit her. You know and then I’d go
and have a drink with her, she was the first relationship and I hit her and she
said I freaked out, I thought her family were going to come down and kill me.
And year 11; like what brought all that to a stop was something else that I didn’t
talk about, that happened like with my sister and her boyfriend living with them
two, and the domestic violence. She was my sister so I had to take her side and
obviously what he was doing was wrong as well. You know but he knew that, he
didn’t need to, the way he was hitting her but I could see what she was doing,
making him angry and getting him to that point. And she’s let him in the house.
And I said well what the fuck and we got into the biggest punch on, and I got my
head kicked there. I was just so rapt and I had to crawl out the door but bobbers
came along; I mean we were fighting for a good 10 to 15 minutes; we were
punching on, up against the walls. Because he was there and he was saying
you want to hit [female name] hey, and he was getting into me because I hit her.
Yeah. And then another time I’ve got an actual scar where my mother flogged
me with the belt, with the buckle. And it was going to get to the point where I
actually had to get out because it was causing so much anger amongst
everybody in the house and I was just very, very violent, very angry young man,
that’s what violence is (Research participant, PTSD symptomatic with a score of
2.57).

Violence is emotion (Research participant, PTSD symptomatic with a score of
2.60).

Violence is, to me it’s attacking someone, putting fear into somebody (Research
participant, PTSD symptomatic with a score of 2.53).

If violence is for example, like natural is to fight, you have to fight. To me
violence is raw, how can I put it. Violence, it’s instant and it’s raw. Yeah in a
sense but when I talk about that raw, it’s the intelligence it ain’t there. Do you
know what I mean, it ain’t thinking, you speak to a child on the bottom, it’s raw
and you can speak to a child at other levels and it can understand, it can
decipher information (Research participant, PTSD symptomatic with a score of
3.17).
Violence is sadness then anger (Research participant, PTSD symptomatic with a score of 3.23).

To me violence would be fighting. Say going to a pub, getting drunk and then coming home and just realising that you’re either depressed or something, and you know you’re not happy with the way your life is and you beat the shit out of your missus. But I think me being here in protective custody and then; see this fella is in for having sex with a 14 year old. And I mean to me that’s violence, because that’s; I mean he was a school teacher and I mean he’s abusing his power (Research participant, non-PTSD symptomatic with a score of 2.20).

I would describe violence as probably a form of protecting yourself, or it could be in many ways. The upper hand, like using it to overpower someone. Or if you want something. Or it could be violence through family or whatever. It could have, what do they call it, ah domestic [violence] (Research participant, non-PTSD symptomatic with a score of 1.90).

Violence is people with rage (Research participant, PTSD symptomatic with a score of 2.67).

Violence it’s an action where; action where people get hurt, mentally or physically (Research participant, PTSD symptomatic with a score of 3.57).

I would say; when you torture people and stuff, not just physically but mentally and spiritually, stuff like that, sexual stuff that’s violence too (Research participant, non-PTSD symptomatic with a score of 2.20).

All of the research participants appeared to have a clear understanding of violence, with some participants demonstrating that they understood violence to be not just physical but also psychological and spiritual.

**Reliability and validity of the AAVHTQ**

Reliability of the AAVHTQ was assessed by the method of internal consistency. Cronbach’s coefficient alpha, a measure of the degree to which items on a questionnaire are inter-correlated, was found to be high for both the trauma-related symptoms on the DSM-III-R criteria (α = .82) and the trauma-related symptoms for the AAVHTQ (α = .90).
The criterion validity of the AAVHTQ was assessed by measuring the degree to which the AAVHTQ correctly classified participants as either PTSD symptomatic \((n = 34)\) (known as the sensitivity of a screening instrument) or non-PTSD symptomatic \((n = 24)\) (known as the specificity of a screening instrument). Participants who were either PTSD symptomatic or non-PTSD symptomatic were generated according to the DSM-III-R criteria listed in the AAVHTQ (items 1–16). Based on calculation of scores on the trauma-related symptoms in part IV of the AAVHTQ (section III.B.), participants were grouped into a PTSD group and non-PTSD group using the clinical cut-off score. Comparisons with the DSM-III-R PTSD symptomatic yielded a cut-off score of 75 (or a mean score of 2.50), which was selected to maximise classification accuracy. Using scores of greater than 75 on the 30 symptom items to determine participants who were PTSD symptomatic, the resulting sensitivity of the AAVHTQ for the presence of PTSD was .97 and the specificity was .79. These findings indicated that 82.4% of participants who were PTSD symptomatic and 98.5% of participants who were not PTSD symptomatic in this 58-participant sample were correctly classified by the AAVHTQ when compared against the DSM-III-R criteria. The significance of the fourteen Aboriginal-specific items (items 17–30) in detecting PTSD was demonstrated by the finding that their inclusion with the sixteen DSM-III-R items substantially improved the accuracy of the scale.

Cross-validation was achieved for the AAVHTQ using a Pearson product-moment correlation. Scores on the trauma symptoms in the AAVHTQ were positively correlated with scores on the total number of traumatic stressors endorsed \((r = .418, p < .001)\) and the level of exposure, which is the total number of traumatic stressors endorsed as experienced \((r = .433, p < .001)\); that is, higher event scores were associated with higher symptom scores for the AAVHTQ. Scores on the trauma symptoms in the DSM-III-R criteria listed on the AAVHTQ (items 1–16) were also positively correlated with scores on the total number of traumatic stressors endorsed \((r = .332, p < .011)\) and the level of exposure (total number of traumatic stressors endorsed as experienced) \((r = .357, p < .006)\); that is, higher event scores were associated with higher symptom scores for the DSM-III-R. The AAVHTQ score and DSM-III-R scores were also positively correlated \((r = .945, p < .000)\), with higher AAVHTQ symptom severity scores being associated with higher DSM-III-R symptom severity scores. Finally, the total number of traumatic stressors endorsed and the level of exposure (total number of traumatic stressors endorsed as experienced) were also positively correlated \((r = .977, p < .000)\), with higher total traumatic stressors endorsed being associated with higher traumatic stressors endorsed as experienced.
Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) descriptive

Participants’ responses to the AAVHTQ were examined to determine the number of participants that reported experiencing a traumatic stressor during their lifetime. Table 14 presents the descriptive statistics for the number of traumatic stressors and level of exposure. Among the 58 participants who completed the AAVHTQ, the number of traumatic stressors (the total number of traumatic stressors endorsed as experienced, witnessed or heard) was very high, with an average of 10.41 (SD = 2.87) out of a possible 16 events. None of the research participants endorsed less than four total events and the maximum number endorsed was 16.

The numbers of events endorsed in both the heard about and witnessed categories were negligible, and so were made redundant in terms of establishing the level of exposure. The majority of the traumatic stressors endorsed were in the experienced category. Therefore, the primary level of exposure for all events endorsed was experienced. The average number of events experienced was very high at 10.05 (SD = 2.82), indicating that the most common level of exposure in this research sample was experienced. This suggests that the majority of the participants had been exposed to high levels of cumulative trauma, which they had personally experienced, as opposed to witnessed or heard about.

Table 14: Descriptive statistics for total number of traumatic stressors and level of exposure (n = 58)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of traumatic stressors*</th>
<th>Level of exposure*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>10.41</td>
<td>10.05</td>
</tr>
<tr>
<td>Median</td>
<td>11.00</td>
<td>11.00</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>2.87</td>
<td>2.82</td>
</tr>
<tr>
<td>Minimum</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Maximum</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Skewness</td>
<td>-0.48</td>
<td>-0.44</td>
</tr>
<tr>
<td>Kurtosis</td>
<td>-0.18</td>
<td>-0.35</td>
</tr>
</tbody>
</table>

*Number of traumatic stressors = sum of all items endorsed including heard, witnessed and experienced.

*Level of exposure = sum of all traumatic stressors endorsed as experienced.

Table 15 presents the number and percentage of participants endorsing each traumatic stressor. The traumatic stressors most commonly endorsed by participants were a lot of deaths of family and/or friends in a one year period (loss and grief/sorry business) (89.7%), being exposed to family violence and fighting (87.9%), having traumatic experiences from taking drugs or alcohol themselves or being around people who are taking them (89.7%), and other events not identified in the check list that the participants felt were so frightening that they believed that their life was in danger (84.5%).
qualitative data in fact revealed that there were no extra traumatic stressors identified that were not already on the check list; instead, the question relating to any other event not identified simply allowed the participants to elaborate on one or more of the traumatic stressors that they had already endorsed. The traumatic stressor least commonly endorsed by participants was being hungry and not having a proper house to live in or not having a proper school or clinic to go to (low formal and informal social support) (36.2%).

Table 15: Number and percentage of participants endorsing each traumatic stressor

<table>
<thead>
<tr>
<th>Item #</th>
<th>Traumatic stressors</th>
<th>Total number of events endorsed (n=58)</th>
<th>Percentage of sample (n=58)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adopted or fostered out</td>
<td>27</td>
<td>46.6</td>
</tr>
<tr>
<td>2</td>
<td>A lot of deaths of family or friends in a one year period</td>
<td>52</td>
<td>89.7</td>
</tr>
<tr>
<td>3</td>
<td>Murder of family or friend</td>
<td>31</td>
<td>53.4</td>
</tr>
<tr>
<td>4</td>
<td>Family violence/terror</td>
<td>51</td>
<td>87.9</td>
</tr>
<tr>
<td>5</td>
<td>No support for emotional, mental, physical or spiritual health problems</td>
<td>42</td>
<td>72.4</td>
</tr>
<tr>
<td>6</td>
<td>Unwanted sex or touching (rape and/or sexual abuse)</td>
<td>22</td>
<td>37.9</td>
</tr>
<tr>
<td>7</td>
<td>Family and/or community breakdown</td>
<td>45</td>
<td>77.6</td>
</tr>
<tr>
<td>8</td>
<td>Made to live/sit down a long way from your family</td>
<td>45</td>
<td>77.6</td>
</tr>
<tr>
<td>9</td>
<td>Being forced to accept whitefella way and talk English i.e. losing some or all of your traditional language and ceremony</td>
<td>35</td>
<td>60.3</td>
</tr>
<tr>
<td>10</td>
<td>Not accepted by own community</td>
<td>33</td>
<td>56.9</td>
</tr>
<tr>
<td>11</td>
<td>Murder of stranger or strangers</td>
<td>26</td>
<td>44.8</td>
</tr>
<tr>
<td>12</td>
<td>Shamed for being Aboriginal and people being racist towards you</td>
<td>41</td>
<td>70.7</td>
</tr>
<tr>
<td>13</td>
<td>Not belonging to anything and feeling lost</td>
<td>38</td>
<td>65.5</td>
</tr>
<tr>
<td>14</td>
<td>Being hungry and not having a proper house or clinic to go to</td>
<td>21</td>
<td>36.2</td>
</tr>
<tr>
<td>15</td>
<td>Bad experiences with police, welfare mob and housing commission</td>
<td>42</td>
<td>72.4</td>
</tr>
<tr>
<td>16</td>
<td>Bad things happened to you from taking drugs and/or alcohol or bad things happened to you from being with other people who have been taking them</td>
<td>52</td>
<td>89.7</td>
</tr>
<tr>
<td>17</td>
<td>Any other time that was so frightening to you that you felt your life was in danger</td>
<td>49</td>
<td>84.5</td>
</tr>
</tbody>
</table>

Over half of the research participants — 58.6% (n = 34) — had PTSD scores in the clinical range (≥2.50 represents symptomatic for PTSD according to AAVHTQ), while 41.4% (n = 24) were non-PTSD symptomatic. Table 16 presents the descriptive statistics for the DSM-III-R symptom severity score and the AAVHTQ symptom severity score. The mean AAVHTQ symptom severity score was 2.55 (≥2.50 represents symptomatic for PTSD according to AAVHTQ and DSM-III-R), the median was 2.57 and the standard deviation was 0.62. The DSM-III-R symptom severity score, derived from the trauma-related symptoms in part IV of the AAVHTQ (section III.B. items 1–16), showed a similar mean score of 2.57, a median of 2.50 and a standard deviation of 0.64. Again, the average score was above the PTSD symptomatic clinical cut-off of 2.50.
Table 16: Descriptive statistics for DSM-III-R symptom severity score and AAVHTQ symptom severity score (n = 58)

<table>
<thead>
<tr>
<th>Variable</th>
<th>DSM-III-R symptom severity score</th>
<th>AAVHTQ symptom severity score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.57</td>
<td>2.55</td>
</tr>
<tr>
<td>Median</td>
<td>2.50</td>
<td>2.57</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>0.64</td>
<td>0.62</td>
</tr>
<tr>
<td>Minimum</td>
<td>1.10</td>
<td>1.43</td>
</tr>
<tr>
<td>Maximum</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Skewness</td>
<td>-0.03</td>
<td>0.12</td>
</tr>
<tr>
<td>Kurtosis</td>
<td>-0.56</td>
<td>-0.76</td>
</tr>
</tbody>
</table>

(2.5 represents symptomatic for PTSD according to AAVHTQ)

* DSM-III-R symptom severity score = sum of items 1–16 divided by 16

* AAVHTQ symptom severity score = sum of items 1–30 divided by 30

Table 17 presents the number and percentage of participants endorsing each of the PTSD symptoms as listed in the AAVHTQ. The symptoms most commonly endorsed by the participants were becoming violent to self or others (87.9%) and feeling like someone did something to betray you (86.2%). The symptom least commonly endorsed by participants was feeling as if you are going crazy (41.4%).

Table 17: Number and percentage of participants endorsing each PTSD symptom as listed in the AAVHTQ

<table>
<thead>
<tr>
<th>Item #</th>
<th>AAVHTQ PTSD symptoms</th>
<th>Total number of symptoms endorsed (n=58)</th>
<th>Percentage of sample (n=58)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intrusive memories</td>
<td>48</td>
<td>82.8</td>
</tr>
<tr>
<td>2</td>
<td>Flashbacks</td>
<td>37</td>
<td>63.8</td>
</tr>
<tr>
<td>3</td>
<td>Nightmares</td>
<td>26</td>
<td>44.8</td>
</tr>
<tr>
<td>4</td>
<td>Feeling alone and staying away from people</td>
<td>49</td>
<td>84.5</td>
</tr>
<tr>
<td>5</td>
<td>Can’t feel emotions</td>
<td>38</td>
<td>65.5</td>
</tr>
<tr>
<td>6</td>
<td>Feeling nervous</td>
<td>37</td>
<td>63.8</td>
</tr>
<tr>
<td>7</td>
<td>Can’t think straight</td>
<td>45</td>
<td>77.6</td>
</tr>
<tr>
<td>8</td>
<td>Trouble sleeping</td>
<td>41</td>
<td>70.7</td>
</tr>
<tr>
<td>9</td>
<td>Feeling on guard/keeping a look out for trouble</td>
<td>40</td>
<td>69.0</td>
</tr>
<tr>
<td>10</td>
<td>Feeling angry all the time and taking it out on others or yourself</td>
<td>41</td>
<td>70.7</td>
</tr>
<tr>
<td>11</td>
<td>Trying not to think or feel about anything to do with the bad or hurtful things that happened to you</td>
<td>45</td>
<td>77.6</td>
</tr>
<tr>
<td>12</td>
<td>Not being able to remember some of the most hurtful or bad things that happened to you</td>
<td>49</td>
<td>84.5</td>
</tr>
<tr>
<td>13</td>
<td>Not caring about everyday things</td>
<td>35</td>
<td>60.3</td>
</tr>
<tr>
<td>14</td>
<td>Feeling as if you don’t have a good future or any future at all</td>
<td>34</td>
<td>58.6</td>
</tr>
<tr>
<td>15</td>
<td>Trying not to think or feel about anything to do with the bad or hurtful things that happened to you</td>
<td>40</td>
<td>69.0</td>
</tr>
<tr>
<td>16</td>
<td>Going mad or crying when you are reminded of the most hurtful or bad things that happened to you</td>
<td>41</td>
<td>70.7</td>
</tr>
<tr>
<td>17</td>
<td>Feeling that people do not understand what has happened and that you are the only one who has suffered these things</td>
<td>46</td>
<td>79.3</td>
</tr>
<tr>
<td>18</td>
<td>Feeling guilty</td>
<td>43</td>
<td>74.1</td>
</tr>
<tr>
<td>19</td>
<td>Feeling shame</td>
<td>43</td>
<td>74.1</td>
</tr>
<tr>
<td>20</td>
<td>Spending time thinking about why these things happened</td>
<td>46</td>
<td>82.8</td>
</tr>
<tr>
<td>21</td>
<td>Feeling as if you were going crazy</td>
<td>24</td>
<td>41.4</td>
</tr>
<tr>
<td>22</td>
<td>Feeling that you have no one who will look after/out for you</td>
<td>29</td>
<td>50.0</td>
</tr>
<tr>
<td>23</td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing</td>
<td>33</td>
<td>56.9</td>
</tr>
<tr>
<td>24</td>
<td>Feeling someone you trusted did something to betray you</td>
<td>50</td>
<td>86.2</td>
</tr>
<tr>
<td>25</td>
<td>Feeling worthless</td>
<td>36</td>
<td>62.1</td>
</tr>
<tr>
<td>26</td>
<td>Becoming violent to sell or others</td>
<td>51</td>
<td>87.9</td>
</tr>
<tr>
<td>27</td>
<td>Taking drugs and/or alcohol all the time to help you forget the bad things that happened to you</td>
<td>42</td>
<td>72.4</td>
</tr>
<tr>
<td>28</td>
<td>Problems making and keeping relationships (feeling unloved or unable to give love)</td>
<td>43</td>
<td>74.1</td>
</tr>
<tr>
<td>29</td>
<td>Suicidal thoughts</td>
<td>30</td>
<td>51.7</td>
</tr>
<tr>
<td>30</td>
<td>Have you ever felt that the event didn’t happen to you or that you don’t feel bad about it</td>
<td>26</td>
<td>44.8</td>
</tr>
</tbody>
</table>
**Traumatic stressors and level of exposure and variance between PTSD symptomatic and non-PTSD symptomatic participants**

Using a between-subjects design, independent sample t-tests were performed to compare the means of the three sets of scores relating to PTSD symptomatic and non-PTSD symptomatic outcomes. The three continuous variables: *number of traumatic stressors* (the total number of events endorsed including witnessed, heard and/or experienced); *level of exposure* (the total number of traumatic stressors endorsed as experienced, on the AAVHTQ); and *DSM-III-R symptom severity score* (derived from the trauma-related symptoms in part IV of the AAVHTQ, section III.B. items 1–16), were used as the dependent variables and PTSD (PTSD symptomatic group or non-PTSD symptomatic group according to the AAVHTQ) was used as the factor (grouping variable). For these analyses, alpha was set at .05. The results of the t-tests show that the mean for the PTSD symptomatic participants is significantly higher than that of the non-PTSD symptomatic participants for each of the three continuous variables: *number of traumatic stressors*, *level of exposure* and *DSM-III-R symptom severity score* (Table 18). In simple terms, those participants who were PTSD symptomatic, according to the AAVHTQ, had been exposed to a significantly higher number of both traumatic stressors in general and traumatic stressors specifically experienced, and had significantly higher DSM-III-R scores compared to the non-PTSD symptomatic group.

Table 18: Independent t-tests between PTSD symptomatic and non-PTSD symptomatic — Mean differences in AAVHTQ scores representing total number of traumatic stressors, level of exposure and DSM-III-R by PTSD symptomatic and non-PTSD symptomatic groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>PTSD symptomatic (n = 34)</th>
<th>Non-PTSD symptomatic (n = 24)</th>
<th>Difference between PTSD + and - PTSD - and + t (df = 1,56)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of traumatic stressors</td>
<td>11.32 2.75</td>
<td>9.13 2.56</td>
<td>-3.09 .003</td>
<td></td>
</tr>
<tr>
<td>Level of exposure</td>
<td>10.88 2.71</td>
<td>8.88 2.59</td>
<td>-2.83 .006</td>
<td></td>
</tr>
<tr>
<td>DSM-III-R symptom severity score</td>
<td>2.97 0.64</td>
<td>1.99 0.37</td>
<td>-8.93 .000</td>
<td></td>
</tr>
</tbody>
</table>

Given the statistically significantly higher means for the PTSD symptomatic group compared to the non-PTSD symptomatic group for each of the three continuous variables, it was deemed appropriate to utilise a PTSD symptomatic versus non-symptomatic dichotomy in further data analysis. Differences between the two groups will be examined in the following sections in terms of: demographic characteristics; the nature, level of exposure and frequency of specific traumatic stressors; the frequency and level of severity of symptoms endorsed by the participants; and generational trauma and dysfunction derived from the participants’ current and older generational histograms. The qualitative data derived from the semi-structured interviews will be
utilised throughout the results to highlight specific themes and to provide a richer, more meaningful interpretation and oral validation of the results.

**Demographic and participant characteristics in relation to PTSD symptomatic and non-PTSD symptomatic scores**

To test whether any of the specific demographic characteristics of the participants were associated with PTSD symptomatology, non-parametric crosstabs and chi-squared tests for association were performed. Two-tailed exact chi-squares were used with crosstabs when the number in the cells dropped below five. Two-tailed Fisher’s exact tests were used when the expected frequencies were less than five for two or more cells of a 2 x 2 table. For these analyses, alpha was set at .05. The variable of age was originally run as a continuous variable; however no significant relationships were found between age and PTSD symptomatic and non-PTSD symptomatic and therefore age categories were used to present the descriptive data.

Table 19 presents the demographic data and specific characteristic data of the participants and their relationship with PTSD. All of the demographic data and participant characteristics were independent of being PTSD symptomatic or non-PTSD symptomatic; that is, no significant relationships were found between these variables and being PTSD symptomatic.
### Table 19: Number and percentage of participant demographics and characteristics and relationship with PTSD symptomatology (n = 58)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (n = 58)</th>
<th>PTSD symptomatic group (n = 34)</th>
<th>Non-PTSD symptomatic group (n = 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19–27</td>
<td>25</td>
<td>43.1</td>
<td>14</td>
</tr>
<tr>
<td>28–37</td>
<td>19</td>
<td>32.8</td>
<td>12</td>
</tr>
<tr>
<td>38–50</td>
<td>14</td>
<td>24.1</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1.7</td>
<td>0</td>
</tr>
<tr>
<td>Primary school (1–6)</td>
<td>2</td>
<td>3.4</td>
<td>1</td>
</tr>
<tr>
<td>High school (7–10)</td>
<td>45</td>
<td>77.6</td>
<td>27</td>
</tr>
<tr>
<td>High school (11–12)</td>
<td>10</td>
<td>17.2</td>
<td>6</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>28</td>
<td>48.3</td>
<td>14</td>
</tr>
<tr>
<td>Married/de facto</td>
<td>17</td>
<td>29.3</td>
<td>10</td>
</tr>
<tr>
<td>Divorced/separated/widower</td>
<td>13</td>
<td>22.4</td>
<td>10</td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>16</td>
<td>27.6</td>
<td>8</td>
</tr>
<tr>
<td>1–4</td>
<td>34</td>
<td>58.6</td>
<td>21</td>
</tr>
<tr>
<td>5–8</td>
<td>8</td>
<td>13.8</td>
<td>5</td>
</tr>
<tr>
<td>Usual occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>19.0</td>
<td>6</td>
</tr>
<tr>
<td>Labourer</td>
<td>11</td>
<td>19.0</td>
<td>7</td>
</tr>
<tr>
<td>CDEP†</td>
<td>7</td>
<td>12.1</td>
<td>4</td>
</tr>
<tr>
<td>Trades</td>
<td>6</td>
<td>13.8</td>
<td>5</td>
</tr>
<tr>
<td>Human services</td>
<td>8</td>
<td>13.8</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>22.4</td>
<td>9</td>
</tr>
<tr>
<td>Crime types</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td>15</td>
<td>25.9</td>
<td>12</td>
</tr>
<tr>
<td>Sex offences</td>
<td>15</td>
<td>25.9</td>
<td>10</td>
</tr>
<tr>
<td>Assault</td>
<td>22</td>
<td>37.9</td>
<td>9</td>
</tr>
<tr>
<td>Theft, robbery &amp; breaking and all involving violence against the person</td>
<td>6</td>
<td>10.3</td>
<td>3</td>
</tr>
<tr>
<td>Recidivism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–2 (low)</td>
<td>18</td>
<td>31.0</td>
<td>10</td>
</tr>
<tr>
<td>3–4 (moderate)</td>
<td>19</td>
<td>32.8</td>
<td>10</td>
</tr>
<tr>
<td>5+ (high)</td>
<td>21</td>
<td>36.2</td>
<td>14</td>
</tr>
<tr>
<td>Traditional language used</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>58.6</td>
<td>21</td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>41.4</td>
<td>13</td>
</tr>
<tr>
<td>Comfortable speaking English</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat</td>
<td>3</td>
<td>5.2</td>
<td>1</td>
</tr>
<tr>
<td>Fairly comfortable</td>
<td>5</td>
<td>8.6</td>
<td>2</td>
</tr>
<tr>
<td>Very comfortable</td>
<td>50</td>
<td>86.2</td>
<td>31</td>
</tr>
</tbody>
</table>

* CDEP is the acronym for ‘Community Development Employment Projects’ which are a voluntary, paid alternative to unemployment benefits for Indigenous Australians, based on community enterprises.
* Ranked by most serious crime, as many participants have multiple convictions on different violent crimes. Rank is in order of most serious crime as follows: homicide; sex offences; assault; and theft, robbery and breaking and entering, all involving violence against the person.
* Recidivism rates are only included for a repeat offence that fits the violence criteria, and which ended in a conviction and jail sentence. Therefore a participant with a recidivism rate of 1 is currently serving a sentence for their second offence. 5+ sentences served is considered a high recidivist rate.

## Traumatic stressors in relation to PTSD symptomatology

This section elaborates on the results of the independent sample t-tests comparing the PTSD symptomatic and non-PTSD symptomatic group means for the number of traumatic stressors and level of exposure (refer to Table 18). The relative odds ratio was also calculated for the number of traumatic stressors. Additionally, to test whether any of the specific traumatic stressors endorsed by the participants were associated with PTSD symptomatology, non-parametric crosstabs and chi-squared tests for association were performed. Two-tailed exact chi-squares were used with crosstabs when the...
number in the cells dropped below five. Two-tailed Fisher’s exact tests were used when the expected frequencies were less than five for two or more cells of a 2 x 2 table. For these analyses, alpha was set at .05.

The PTSD symptomatic group reported exposure to, on average, 2.19 more traumatic stressors than the non–PTSD symptomatic group (\((M = 11.32, SD = 2.75)\), \(t(1,56) = -3.09, p < .01\)), suggesting that the greater number of traumatic stressors endorsed, or the more cumulative the amount of traumatic exposure, the more likely it was that the participants would be PTSD symptomatic. The same relationship was found when looking at the level of exposure, specifically the number of events endorsed as experienced as opposed to witnessed or heard (\((M = 10.88, SD = 2.71)\), \(t(1,56) = -2.83, p < .01\)). The traumas endorsed by the participants appeared to have a high level of exposure (i.e. experienced) and were both cumulative and compounding.

There was a strong relationship between traumatic experiences and symptom scores. For example, rates of PTSD varied from 48.3% among the 29 participants reporting 11 or fewer traumatic stressors, to 69.0% among the 29 participants who reported more than 11 traumatic stressors. The relative odds ratio of being PTSD symptomatic was 2.2 in the group who reported the greater number of traumatic stressors. Once again, this data suggests that post-traumatic stress symptoms appear to be more specifically associated with the cumulative amount of traumatic stressors.

The number and percentage of participants in each the PTSD symptomatic and non-PTSD symptomatic group who reported each traumatic stressor is presented in Table 20. The table presents the total number of traumatic stressors, that is the number and percentage of traumatic stressors for all endorsed categories (witnessed, heard and experienced), therefore ensuring that all endorsements of traumatic stressors are accounted for. The positive and negative predictive power of each traumatic stressor is also provided. Positive predictive power was defined as the probability of PTSD being present when a specific traumatic stressor is present. This probability was calculated by dividing the number of PTSD symptomatic participants (according to the AAVHTQ symptom severity score) reporting each traumatic stressor by the total number of participants reporting the same traumatic stressor. Negative predictive power was defined as the probability of not meeting criteria for PTSD when a traumatic stressor is absent. This probability was calculated by dividing the number of non-PTSD symptomatic participants (according to the AAVHTQ symptom severity score) that did not report each traumatic stressor by the total number of participants that did not report that event. A representation of those participants that endorsed no for a traumatic
stressor and who were not PTSD symptomatic can be extracted from the negative predictive power.
Table 20: Number and percentage of participants reporting each traumatic stressor and the positive and negative predictive power of each traumatic stressor by PTSD symptomatic and non-symptomatic

<table>
<thead>
<tr>
<th>Item #</th>
<th>Traumatic stressors</th>
<th>Total number and percentage of traumatic stressors (n = 58)</th>
<th>PTSD group number and percentage (n = 34)</th>
<th>Non-PTSD group number and percentage (n = 24)</th>
<th>$\chi^2$ (df = 1)</th>
<th>$p$</th>
<th>Positive predictive power</th>
<th>$\alpha$ set at .05 for all analyses. ns = non-significant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adopted or fostered out</td>
<td>27 (46.6)</td>
<td>16 (47.1)</td>
<td>11 (45.8)</td>
<td>0.01</td>
<td>ns</td>
<td>.59</td>
<td>.56</td>
</tr>
<tr>
<td>2</td>
<td>A lot of deaths of family or friends in one year period</td>
<td>52 (89.7)</td>
<td>30 (88.2)</td>
<td>22 (91.7)</td>
<td>0.18</td>
<td>ns</td>
<td>.57</td>
<td>.33</td>
</tr>
<tr>
<td>3</td>
<td>Murder of family or friend</td>
<td>31 (53.4)</td>
<td>18 (52.9)</td>
<td>13 (54.2)</td>
<td>0.01</td>
<td>ns</td>
<td>.58</td>
<td>.40</td>
</tr>
<tr>
<td>4</td>
<td>Family violence/fighting</td>
<td>51 (87.9)</td>
<td>30 (88.2)</td>
<td>21 (87.5)</td>
<td>0.001</td>
<td>ns</td>
<td>.56</td>
<td>.42</td>
</tr>
<tr>
<td>5</td>
<td>No support for emotional, mental, physical or spiritual health problems</td>
<td>42 (72.4)</td>
<td>28 (82.4)</td>
<td>14 (58.3)</td>
<td>4.06</td>
<td>.044</td>
<td>.66</td>
<td>.62</td>
</tr>
<tr>
<td>6</td>
<td>Unwanted sex or touching (rape and/or sexual abuse)</td>
<td>22 (37.9)</td>
<td>19 (55.9)</td>
<td>3 (12.5)</td>
<td>11.25</td>
<td>.001</td>
<td>.86</td>
<td>.58</td>
</tr>
<tr>
<td>7</td>
<td>Family and/or community breakdown</td>
<td>45 (77.6)</td>
<td>25 (76.5)</td>
<td>19 (79.2)</td>
<td>0.06</td>
<td>ns</td>
<td>.57</td>
<td>.38</td>
</tr>
<tr>
<td>8</td>
<td>Made to live/sit down a long way from your family</td>
<td>45 (77.6)</td>
<td>29 (85.3)</td>
<td>16 (66.7)</td>
<td>2.81</td>
<td>ns</td>
<td>.64</td>
<td>.61</td>
</tr>
<tr>
<td>9</td>
<td>Being forced to accept whitefella way and talk English (i.e. losing some or all of your traditional language and ceremony)</td>
<td>35 (60.3)</td>
<td>20 (58.8)</td>
<td>15 (62.5)</td>
<td>0.08</td>
<td>ns</td>
<td>.57</td>
<td>.39</td>
</tr>
<tr>
<td>10</td>
<td>Not accepted by own community</td>
<td>33 (56.9)</td>
<td>23 (67.6)</td>
<td>10 (41.6)</td>
<td>3.87</td>
<td>.049</td>
<td>.69</td>
<td>.41</td>
</tr>
<tr>
<td>11</td>
<td>Murder of stranger or strangers</td>
<td>26 (44.8)</td>
<td>17 (50.0)</td>
<td>9 (37.5)</td>
<td>0.89</td>
<td>ns</td>
<td>.65</td>
<td>.46</td>
</tr>
<tr>
<td>12</td>
<td>Shamed for being Aboriginal and people being racist towards you</td>
<td>41 (70.7)</td>
<td>26 (76.5)</td>
<td>15 (62.5)</td>
<td>1.33</td>
<td>ns</td>
<td>.63</td>
<td>.52</td>
</tr>
<tr>
<td>13</td>
<td>Not belonging to anything and feeling lost</td>
<td>38 (65.5)</td>
<td>26 (76.5)</td>
<td>12 (50.0)</td>
<td>4.36</td>
<td>.037</td>
<td>.68</td>
<td>.60</td>
</tr>
<tr>
<td>14</td>
<td>Being hungry and not having a proper house to live in or not having a proper school or clinic to go to</td>
<td>21 (36.2)</td>
<td>18 (52.9)</td>
<td>3 (12.5)</td>
<td>9.96</td>
<td>.002</td>
<td>.85</td>
<td>.56</td>
</tr>
<tr>
<td>15</td>
<td>Bad experiences with police, welfare mob and housing commission</td>
<td>42 (72.4)</td>
<td>27 (79.4)</td>
<td>15 (62.5)</td>
<td>2.01</td>
<td>ns</td>
<td>.64</td>
<td>.56</td>
</tr>
<tr>
<td>16</td>
<td>Bad things happened to you from taking drugs and/or alcohol or bad things happened to you from being with other people who have been taking them</td>
<td>52 (89.7)</td>
<td>31 (91.2)</td>
<td>21 (87.5)</td>
<td>0.21</td>
<td>ns</td>
<td>.59</td>
<td>.50</td>
</tr>
<tr>
<td>17</td>
<td>Any other time that was so frightening to you that you felt your life was in danger</td>
<td>49 (84.5)</td>
<td>30 (88.2)</td>
<td>19 (79.2)</td>
<td>0.68</td>
<td>ns</td>
<td>.61</td>
<td>.55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of traumatic stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>M(SD)</td>
</tr>
<tr>
<td>10.41(2.87)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.05(2.62)</td>
</tr>
</tbody>
</table>

Probability of the presence of PTSD when the event is present.
Probability of the absence of PTSD when the event is absent.
Exact tests are used with crosstabs when the number in cells drop below 5. 2 tailed exact $\chi^2$ and p value is used in these cases. Fisher’s exact test were used in 2 x 2 tables.
PTSD symptomatic participants were significantly more likely than non-PTSD symptomatic participants to report having no support for emotional, mental, physical or spiritual health problems (low formal and informal social support), unwanted sex and touching (rape and/or sexual abuse), not being accepted by their own community (personal and social identity issues), not belonging to anything and feeling lost (personal and social identity issues) and being hungry and not having a proper house to live in or school or clinic to go to (low formal and informal social support).

Many of the participants elaborated on the traumatic stressors they endorsed in the AAVHTQ. Qualitative accounts of the participants’ experiences are provided in this section, in conjunction with the quantitative results, to bring focus to the individual stories and to provide additional information to assist in the interpretation of the results.

Rape and/or sexual abuse
PTSD symptom severity, or a positive PTSD symptomatic outcome, was significantly related to exposure to unwanted sex or touching (rape and/or sexual abuse) \( (\chi^2 (1, n = 58) = 11.25, p < .001) \), with a positive predictive power of .86. In other words, the higher the reported level of exposure to sexual abuse was, the greater the chance was of participants being PTSD symptomatic. The strength of this relationship may be even greater, as under-reporting due to shame and guilt is often a factor in cases of sexual abuse and rape:

> And when they abuse their child, like it’s hard for the community to say, it’s a big shame job you know. And so it’s in the law, you know, you can’t say, they have to hide it. They can’t say anything. There’s a lot of, lot of, lot of child abused and raped. Back in my community but no one’s saying it (Research participant, PTSD symptomatic with a score of 2.57).

A number of PTSD symptomatic participants elaborated on the nature and severity of their experiences, and highlighted the generational trauma resulting from them. They found expression and release for their own abuse by abusing others:

> When I was three, yeah about three or four, I was molested by a [female] family friend. When I was five, I had to perform some sexual acts on a [male] neighbour. In the same year [1985] I had to give someone a blow job. I was, well probably seven or six. I started being stupid with all of the girls that would come around and that, you know. That was just a regular thing you know, it wasn’t on and off sort of thing, it was like every opportunity that I got I would be stupid with these girls. When I was about seven years old, eight or seven, my
father molested me in bed. Well he raped me actually, that went on for a night. [Actual penetration?] Yep. That went on for a night. That left a big stabbing hole in my heart actually. But I don’t know. I suppose being ignored was the worst part about it I suppose. I did try to tell people but not straight out. You know only because I was afraid to. When I went to the mission I got gang raped by these two [family name], [male name] and [male name]. They caught me on my own in the bush while we were all walking back from the front gate. [I was] about nine I think. At the same time up there you know, I molested a young boy up there, out at the mission and attempted to molest a young girl that was there also. [He] was about six I think. She was about eight or nine, I don’t know. I was in the sort of like idiotic state where I was about nine or ten, 11 maybe even and we were boyfriend and girlfriend sort of thing, which is stupid I suppose. Apart from my own sexual abuse by my father, a few weeks after that, he told me to go around the corner and grab one of my cousins. Remember them cousins I told you about who moved to [city]. One was a female and she, I don’t know she was like a can short, and I went around and grabbed her. And he told me to grab her and tell her that mum wanted to see her over here. So we went over there and as soon as we walked in the house my fucking father was standing up there in the dark, and he just slapped me in the ears and said to me sit down there and don’t move. For about three or four hours I could hear this girl just fucking screaming her head off in the room, I want to go home. That was all she repeated for about 3 hours. But I don’t know. I groomed this young girl into walking with me for some money. And I yanked with her and just walked with her to an isolated spot in the middle of the scrub, up in [town] and I just raped her. [And can you remember what she was doing while you were doing that, was she crying or fighting you?] No she passed out [quietly spoken] (Research participant, PTSD symptomatic with a score of 3.00).

You know what makes me violent it’s my past. I have been abused physically and mental health. Physically and sexually. Started from about kindy, and that was not a good experience. Was molested in all the foster homes and two of my mother’s friends that’s why I’m violent that’s why I done this stuff [rape] (Research participant, PTSD symptomatic with a score of 3.57).

And you know like; I suppose the biggest part in my life was the sexual abuse. You know that happened from not long after the old man grabbed me, a friend of the family and I put up with it till the age of 14, when I said no enough’s enough. It started about 4 or 5 years old. Now, like with my crime now, [rape] like when I
see these programs mob and they say hang on, you talk about empathy. Now let’s put on your shoes, putting yourself in the shoes of the victim and I said hang on, woo, pull up, I was a victim. So I’ve seen both sides of the fence and I can comment to you as a victim and as a perpetrator of the crime (Research participant, PTSD symptomatic with a score of 3.37).

Yeah it was a family relation, like a distant relation and that made things worse then. I would have been about 12 and the other kids they would have been about 9 or something like that. The guy mucking around with us he’s about fuck; in his 30’s. Nah but the thing is not right. Like I was only a kid, but, like a kid doesn’t; like at the age of say seven, eight, a kid knows what he’s doing, you know what I mean. And I knew what had to be done. And yeah I walked up and sneaked over him with an iron bar. But it made him stop, you know what I mean. What made it more difficult was like in our family sort of we take; and even now I don’t like my family to know because the people I talked to, they said well you should have told someone. Then as I grew older then they sort of realised the family, what do you call it, you know link together, our family is together, you know stick together. But when I started talking to one of the counsellors in Darwin well I felt good you know I don’t mind telling somebody else but not my family. Because if I tell my family, that’s my family. If they ever found out you know there’s going to be a problem. And I don’t want them to start up aye (Research participant, PTSD symptomatic with a score of 2.57).

Other examples of the nature and severity of sexual abuse and rape provided by a number of PTSD symptomatic participants highlight that exposure to this type of assault may not be confined to Aboriginal families and communities, but may also occur in foster homes and within the wider community in general:

Happened to me [sexual abuse] but I think that was normal when you were taken away and put somewhere that didn’t care for you. Especially like a lot of the ones that got adopted out and that, moved around. Yeah it happened to a lot of my cousins (Research participant, PTSD symptomatic with a score of 3.47).

We went to [city] and I remember [my] parents giving me money and they said the shops just down the road there. All I was worried about was chips and chocolate and cool drinks. I come out of the shop and I walked around the corner to walk back home, then I got picked up by these white people, about four. Four white blokes and I didn’t know where I was going. Then the next thing
I knew I was in this place and I could hear them talking and I thought there was a woman there too, but there was no woman, it was all blokes. They told me to sit down and I was sitting down, and they put this tape on, this video tape. They said watch the tape. That was it and I seen that, then they started on me, the whole lot of them. We were sitting around drinking, but we was drinking metho one; methylated spirits one and coke mix. Drinking that. I ended up flaking out and everybody else all left. And I looked around; they all took off. Then I sat there, I had my smokes and I still had my money on me and everything. I walked to this pub, sat down and bought myself a drink then there was about 8 blokes. I was the only black fella there, sitting down. They asked me if I wanted to come with them to a party. I was more than tipsy and then; I couldn’t stand up properly see, and I couldn’t answer them because I was well over half drunk. I wasn’t paralytic or anything. Then I went too; so they chucked me in the car with them and we went to this place, then they carried me into this room, into the bedroom. And I was drunk. I was too buggered to get up you know. But them mob, they wasn’t drunk because they were heroin freaks too, you know. And they give me this shot of heroin. Well like I was on the nod, like I was sleeping and couldn’t wake up or anything, you know. And the first thing I knew was; I know I had clothes on, I had my clothes on. Plus I didn’t wake up till two days after that. I didn’t know what happened at the time because I was knocked right out. And when I was waking up they all come in at once. They had me tied down, my legs and arms spread right out. They put this pillow under my stomach. I hated them at first. I figured it was more than eight. I don’t have much (pause) there must have been over 16. And while they were doing that to me they kept putting heroin into me, you know. I couldn’t move, nothing. I just felt like I wanted to get rid of myself. The day they left I felt disgusted, I just stuck the cold water on, I just sat in the shower washing myself right out. But they locked the doors, they locked the front door, windows, everything. I couldn’t get out of the place. They kept on bringing drink back, heroin and stuff. The first bottle of beer they gave me I smashed across a blokes face, stabbed him in the neck, stabbed all the other blokes as well. And I took off. I was walking around [town] for 18 months, [State]. I didn’t know what to do or where to go after all that had happened. That’s why I don’t trust anybody now; I don’t trust nobody except myself

(Research participant, PTSD symptomatic with a score of 4.00).

From reading this participant’s story, it becomes evident that his ability to trust others was greatly diminished by his traumatic experiences.
Low formal and informal social support

PTSD symptom severity, or a positive PTSD symptomatic outcome, was also significantly related to participants reporting that they felt they had no support for emotional, mental, physical or spiritual health problems (low formal and informal social support) \( (\chi^2 (1, n = 58) = 4.06, p < .05) \), with a positive predictive power of .66. For some of the participants, the most traumatic stressor was the lack of access to relevant, sensitive and appropriate services to provide the support they required, or being able to trust the people sufficiently to use such services if they were available. For other participants, the issue was not having any support through their social networks, families and communities or not trusting the support that was available. For some participants, the trauma was a combination of both social and service support, combined with trust issues. The feelings of helplessness and hopelessness that can develop when an individual’s emotional, mental, physical and spiritual health issues are not addressed are highlighted in the following participant’s narrative:

“I served seven years, from ‘86 to ‘93, I was let out into society. There was no programs or nothing in here that would help me cope and nothing out there, they didn’t tell me where to go for help and I lost my way, I couldn’t handle it. I mean my head was a mess, there were so many distractions and that. Trying to look for work was hard. They ask you have you ever been in jail then they would say ‘What for?’ I would say sexual assault. Oh yeah we got no more work, it just so happens that we had somebody in mind, you know. Well like I said, you know, life goes on. It doesn’t stand still, it doesn’t say look mate sorry we dealt you the wrong hand; you’ve got to come back and get another one, yeah. It doesn’t, it goes on but hey it would be nice if someone helped me out, help me make some sense of this stuff in my head, you know I know it’s not right but hey it just gets worse when you’re left to your self to sort it out, nobody to talk to makes me sick, sick in the head and sick in the body makes me really scared too you know because I always end up back in here, make sure I do, so I can feel a bit safe and a bit supported, it’s not real good but it’s better than nothing though (Research participant, PTSD symptomatic with a score of 3.37).

This participant highlights the lack of emotional, mental and physical support available to him when he was released from prison. The desperation he felt appeared to result in the commission of further crimes in order to return to the prison to obtain some support, regardless of its limited capacity. Another participant articulates the perceived lack of emotional, mental, physical and spiritual support from his peers, family and community:
You know like I went from this family to that family, to that family, to that family, you know what I mean. Made me feel fucking lost. I didn't know who to trust, I didn't know who, you know, who to trust, who am I? Like um; (pause) I've experienced my whole family turning on me, all my friends too and the community, and where do you go when that happens? (Research participant, PTSD symptomatic with a score of 2.57).

The following participant describes the lack of support from his social support networks, including family, friends and community, and at the professional level, plus his inability to trust anyone to provide that support even if it was available:

*Feels like um, since I've grown up now its like well I'm on my own. No one’s going to care about me and I've just got to care about myself and do my own thing now. Because I notice when you're little everyone cares and a lot of love’s shown but when you grow up older, its like you’re on your own. Yeah well when family don’t care it makes it hard you know when you need someone to help you and I've tried to get help with the health service to help me make some sense of all this crap in my head but they’re no good too and I don’t trust those fellas. You've got to try and survive yourself. Yeah like we lived in [town] see and everything’s just changed now. Like you know, because we had a lot of friends in [town] when we was young and there's no one like wanting to go out no more so no one to talk to it makes me feel real bad inside you know in here [points at his chest] (Research participant, non-PTSD symptomatic with a score of 2.03).*

PTSD symptom severity, or a positive PTSD symptomatic outcome, was also significantly related to participants feeling like their basic needs were not being met, identified by factors such as being hungry and not having a proper house to live in or not having a proper school or clinic to go to (low formal and informal social support) ($\chi^2 (1, n = 58) = 9.96, p < .05$), with a positive predictive power of .85. Being homeless, poor and not having access to essential services, or choosing not to utilise essential services because they are not culturally sensitive, were identified by participants as particularly traumatic. The following narrative provides an insight into the fear associated with having to survive extreme poverty and the subsequent effect it had on the individual’s sense of self:

*Yeah living rough you know sleeping out cause you don’t have a house to live in that was tough. Never slept real well when I was living like that was too scared, scared that someone might take you in the night, flog your gear, not that I had*
much but it was enough to keep me alive. I can still remember how hungry I used to get, felt like your gut was going to explode. I tried to get some help but there’s not many blackfella places, you know somewhere you can go to get help that understands or stuff and the whitefella ones I always felt shamed when I would go into those places begging for food you know not much pride in that (Research participant, PTSD symptomatic with a score of 3.17).

Personal and social identity issues

PTSD symptom severity, or a positive PTSD symptomatic outcome, was also significantly related to participants reporting they felt a lack of acceptance by their own community (personal and social identity issues) ($\chi^2 (1, n = 58) = 3.87, p < .05$), with a positive predictive power of .69. Participants had a much greater chance of being PTSD symptomatic if they felt unaccepted by their own community. The importance of being accepted by one’s own community in terms of a person’s sense of self is clearly articulated by the following PTSD symptomatic participants:

You feel useless and that sort of thing because you trusted these people [community] and they go and sort of stab you in the back. It’s little things like that you know. Like no matter what you try to do is good, it’s still not good for them [community]. And like whatever I try to do up home, whatever I do it’s not right and I don’t know why. Yeah they [community] get the police on me. They stare me up, they want to crack on me, they charge me. I just started and they hit you and if you return the favour they go and get them fellas in blue. They say he’s been in jail, he’s a trouble maker, that’s what they brand you by and this place here reflects on that. You know they don’t give you a second go. And I get offended when they say you’re a mongrel, I just feel no good. Yeah and just keep getting put down all the time, that sort of thing you know. That’s really hurtful and I get no support you know, lack of support. Put one more dog, I had nine dogs; seven dogs all dead. Seven dead, two alive. Yeah they’re my family now. Yeah because when I come out [of prison] I’m comfortable around dogs you know they [community] don’t want me. Because if I can’t be a father to my kids I might as well be something to my dogs. That’s how I always put it (Research participant, PTSD symptomatic with a score of 3.30).

Yeah my community will have nothing to do with me, reckon because I have done some bad things but the community is a mess, I’m a mess, everything is messed up. They don’t accept me any more; my community, but they wouldn’t say that out loud. But I know they don’t, oh yeah. It makes me feel like I’ve always been an outsider. I’ve always been on the outside of everything,
everything on the outside. If they won’t have me who will, belonging to community, community accepting you makes everything make sense. I am a man without a home without community without country, man without country or community has no heart, that was what I was learnt, heart is country and community. I mean Bulanders [white man] don’t want me don’t understand me, I don’t understand them, my community doesn’t want me so what’s the point? (Research participant, PTSD symptomatic with a score of 3.00).

This participant also endorsed suicidal thoughts in the symptoms section of the AAVHTQ. This highlights the high level of trauma Aboriginal peoples experience when they feel they are not being accepted by one's own community, justifying its inclusion in the AAVHTQ traumatic stressors check list as a culturally specific traumatic stressor.

PTSD symptom severity, or a positive PTSD symptomatic outcome, was also significantly related to participants feeling like they don’t belong to anything and feeling lost (personal and social identity issues) \( (\chi^2 (1, n = 58) = 4.36, p < .05) \), with a positive predictive power of .68. This differed from not being accepted by one’s own community in that some men clearly were accepted by their own community but appeared to suffer from identity issues. They felt they did not belong to anything, resulting in them feeling lost and detached from their communities, families and society in general, regardless of whether their families and communities embraced them. Some of the participants that had been removed from their families when they were young felt they did not belong in either the Aboriginal or non-Aboriginal worlds, and this appeared to create feelings of detachment. Detachment is both a symptom of PTSD and a traumatic experience itself, as highlighted in the following participants’ stories:

See like, you know; well I didn’t grow up with my real brothers and sisters. I grew up wild, myself. As I was saying I grew up wild, I grew up myself. So I don’t have much to do with my family or community. That really hurt not having my family to look after me, give me support. Yeah it did. It did bother me. It felt like I was all alone. You know I had none of my people left. I was reconnected with my family through Link-Up and they were real good the whole family yeah and the whole community there where they lived they all looked after me but it didn’t feel right I mean I didn’t know them it felt weird. I don’t reckon I belong anywhere there I still don’t belong and I still feel I am alone and have none of my people left (Research participant, PTSD symptomatic with a score of 4.00).
I don’t feel connected to my culture and language no. Well I’ve always felt that way. I’ve never been connected anywhere, either with my family, my immediate family or um, my mother and them, the family that are down that side because I’ve always considered myself a loner after all the abuse and that, yeah. The only person that I was really close to was my youngest brother but he died in Christmas 93, a car accident killed him. Apart from [brothers name] there wasn’t, you know, like with [brothers name], he looked up to me and I had to be there for him so I had no one really felt really lost (Research participant, PTSD symptomatic with a score of 3.37).

Well yeah of course, naturally I feel like I don’t belong and feel lost because when I’m with a group of my own you know with my brothers and sitting down and their mates, and I’m the odd one out because I’m not talking broken English sort of thing you know I’m well spoken because I was brought up in foster homes, they [his family] accept me and all but I don’t feel like I belong (Research participant, non-PTSD symptomatic with a score of 1.47).

I use to be quite angry, when I was younger, yes. But the thing of being a brown is you’re in the middle. A black and a white make brown, it’s not like paint. A lot of these mob don’t realise that so either way, the white haven’t been educated enough too or they know that the browns are theirs; the black didn’t want the browns around with pride. So in a sense I don’t really give a jack, do you know what I mean? I don’t belong anywhere and nobody wants me anywhere (Research participant, PTSD symptomatic with a score of 3.47).

**Endemic nature and normalisation of family violence, grief and loss, and alcohol and drug misuse as both a symptom of and cause of distress**

While domestic violence for non-Indigenous peoples refers to assault by a spouse or partner, the term *family violence* or *family fighting* is used by Australian Aboriginals to describe violence within the larger group of relatives. It also includes child abuse. PTSD symptomatology was not significantly associated with any of the traumatic stressors most commonly endorsed by the participants: *a lot of deaths of family and/or friends in a one year period* (loss and grief/sorry business) (89.7%), *being exposed to family violence and fighting* (87.8%), and *having bad experiences from taking drugs or alcohol themselves or being around people who are taking them* (89.7%). However, the fact that a majority of participants reported these events suggests the need for further exploration through an examination of the qualitative data.
A majority (87.9%) of the participants reported being exposed to family violence. Some participants’ accounts of family violence highlight its endemic nature, the traumatising effects and the normalisation of this event:

*I mean seeing your mum get bashed all the time, it goes straight into the mind. It all adds up but mainly I’ve seen a lot of fights when I was little. Big community fights. Big family fights. Over the years I used to be hit around, people used to get into me, flog me you know. I was flogged a lot of the time, all of the time and see it all of the time, it feels normal to me. Well they was doing me a favour, you know making me tough on the inside and made me harder, stubborn oddly enough* (Research participant, PTSD symptomatic with a score of 3.30).

*I grew up and there were gangs, little gangs from the Shanghai’s. We had Shanghai’s, the gangs with the East Side, the Gaffes and us and it was little wars. All over little things. All over practically nothing. And in between all that would be all your fights and in between that you’d have your own disputes and brawls inside the institution with different people. Well you’d get belted with the hose, you’d get belted with the stick, with the cane and you become accustomed to that. If you say that’s violence, you become accustomed to it* (Research participant, PTSD symptomatic with a score of 3.17).

*And that’s what I mean, like all these things next to my name [geno-histogram codes]. I always thought it was just part of life, you know, the floggings and that were just part of growing* (Research participant, PTSD symptomatic with a score of 3.37).

It is also important to acknowledge that family violence encompasses more than domestic violence (i.e. spouse on spouse), also including the extended family and child abuse. The sexual abuse experienced by the following participant was so severe that the damage to his rectum resulted in him requiring a colostomy bag:

*You know what makes me violent, it’s my past. I have been abused physically and mental health. Physically and sexually, from about kindy age, real young yeah. Having three; well my mother used to, you know bash us all the time when she was drunk and everything else; bash, bash. Yeah really big flogging. It was more than floggings. A busted eye, a broken nose, busted lips, choked, kicked, thrown out a window. Mum did this to me, mm yeah mum and it was the fellas she brought home that use to do the other stuff, you know the sex stuff,
that's why I wear this bag here (Research participant, PTSD symptomatic with a score of 3.57).

My oldest brother used to get into a few arguments with my mother and brother, my oldest brother that's living with him now. My grandfather and my father used to tie him in a chicken cage with a pole in the middle and a rope around his neck, like a fucking dog. Oh mate they’re sick. Sick cunts I reckon (Research participant, PTSD symptomatic with a score of 2.53).

Another qualitative account from a participant highlights the normalisation of alcohol and drug use within the family and community environment, which has become part of ‘identity’ and the need to ‘belong’:

Well; see when I was a kid right, I was raised; and I was raised in a big family right. My mum and that used to drink all the time and she used to bring, you know parkies home and that, and like, you know fucking hell she’d come home and drink and that. When I’d come home they’d turn around and ah, like they’ll have a charge and that; and they’ll drink and that and then they’d just all turn on each other. But that’s what everybody does, everybody I know anyway, its just normal. I do too because I like the feeling of them, the drink and the drugs they make me feel like everybody else (Research participant, PTSD symptomatic with a score of 2.57).

A majority of the participants saw alcohol and other drug misuse as both a symptom of violence and distress and as a primary cause of the violence and distress. A number of participants brought focus to the violence that is enabled through alcohol:

I started drinking and then I was violent then myself. I use to just fight most of them in my family, that’s all. I never use to fight other people, just my family members. When I use to be drunk, I always use to fight. Yeah sometimes just walk around schools and smash glass when I’m drunk. Then when my mum comes and tells me I then turn around and punch her. Yeah. The same as my old man. Because they never use to drink, there was no alcohol but since the white man came, they brought everything, you know like drink. Yeah. I don’t really think too much about the bad thing. You know otherwise, just through the drinking that’s all, I use to get bad things. You know do bad things just drinking but when I’m without drink I’m alright (Research participant, PTSD symptomatic with a score of 3.07).
You know what makes you violent, I’ll tell you, you drink too much you know, you drink cause it hurts. You drink the first time in the morning (Research participant, non-PTSD symptomatic with a score of 1.47).

You get a lot of blokes do violent things through alcohol, that’s the main problem (Research participant, PTSD symptomatic with a score of 2.50).

What triggers off my violence is like we sit around and drink beer and it always gets out of control but we need to drink hey to help us forget some of the shit (Research participant, non-PTSD symptomatic with a score of 2.40).

Yeah I was drinking and then [when he committed the crime he is currently incarcerated for] I was drunk at the time actually. I belted my then girlfriend. It was just basically through alcohol and jealousy that caused my attitude to change you know, sort of thing and become violent. Yeah well I don’t know what I can give for the answer to that. It was maybe just my stupidity of myself taking up the grog again. I mean I could talk all my seven years prior. You could say the welfare, but like the child welfare. Like both [of us] once were into drinking and we had the first boy and we both were pretty heavily into the drinking sort of thing. We nearly had him taken off us cause we were so violent I mean the grog would make us like that (Research participant, non-PTSD symptomatic with a score of 1.47).

I was smoking dope and I was still only 16 years old, yeah. A 16 year old woman I just smashed her, hurt the face and grabbed her by the hand and knocked her down but one thing, I was smoking and dope, dope and petrol, sniffing petrol. And also cockroach spray yeah and it made me go crazy violent (Research participant, PTSD symptomatic with a score of 3.33).

There would be a process where in the morning they would walk to town. Because of the citizen riots and laws and stuff, you couldn’t go in the pub, so they knew legally they couldn’t get alcohol. So the alternative to it was getting cordial and Metho. Now the methylated spirits brewed to kill more people. I found about four of my aunties and uncles. My mother sent me down the track to go and find them and I found them dead. I still haven’t come to terms with finding them dead because I went back and my mother, she thought why, you
I know a lot of people on drugs, I mean I'm talking heaps of people use, abuse, anything. I've seen them all. But the only one that I really see that's make people violent, if anything, are the people that drink. Not really the drugs so much, it's mainly the alcohol. Yeah they get really violent when they drink, yeah the alcohol, they end up being fuck wits (Research participant, non-PTSD symptomatic with a score of 1.80).

And because I was too drunk I couldn't control my temper. So I picked up the spears and it was pretty dark. There was one nephew. I think my cousin's brother was there too, there was about four of them trying to stop me. Yeah I was just, I went off my head and darts was swinging all over the place. The next thing I know was that my sister was down. And I looked. I was in the toilet then. I was exhausted and then my wife sang out to me. She told me come here [respondents name] she went. I walked over there and she pointed at my sister and try and wake her up. And I looked. I was seeing blood then. I started to panic then and I told [female name] don't panic there. I was there and I tried, that was my only sister. Trying to wake her up, talk to her and I was crying too. I started running out from there because they was taking too long. I run over to my uncle's place and I was crying, singing out to help me, saying I need people to help me. By the time help arrived it was too late and you know I did it but it felt like someone else. When the pictures come in my head it's someone else (Research participant, PTSD symptomatic with a score of 3.23).

I remember when like my old man used to take us fishing, camping. But we really wasn't fishing, he was teaching us how to fight but he use to beat the shit out of us. Like my old man was a boxer and I don't know what to do about it because I know what I'm capable of. If I end up getting back on that, on the grog and that, that worries me. And the speed and heroin because when I’m on that stuff I black out. Plus I get all hyped up. I black out too and then I don’t know what will happen after that. Bad stuff happens when I’m on that shit like these scars here (points to scars). My brothers and me we were all drinking and then one brother he goes listen here you little black cunt and bang, bang. He stabbed me five times. And then that’s all I remember. Sometimes like when I used to be like real into the drugs and the alcohol, you know some person would tell me this about my woman and I’d go and do that (click of the finger) to her.
But it’s hard miss you now to not go back on the stuff because it helps me block out bad thoughts but (laughs) I suppose it’s making new bad ones (Research participant, PTSD symptomatic with a score of 2.60).

Alcohol and other drugs were also identified by some of the participants as not only violence enablers but also as catalysts to committing crime, as they gave the participants feelings of power and invincibility that translated into criminal activity:

Oh my crimes range to unlawful use of motor vehicles to break and enters. And for this year now it was armed robbery, and this is the worst that I’ve had to deal with. I mean the worst that I committed. It’s basically through the power you get in the head from drug and alcohol abuse you know you feel invincible (Research participant, PTSD symptomatic with a score of 2.50).

Numerous deaths of family and/or community members (grief and loss/sorry business) also appeared to be a common experience of the research participants (89.7%). The qualitative data suggested that the deaths of loved ones happen so often that there is little opportunity to grieve, and for some people there is no time to feel happy because they are in a constant state of cumulative grief. The normalisation of this event through multiple deaths can also lead to the numbing of feelings:

Lots of deaths yeah lots of deaths, lots of sorry business. I reckon there have been about 16 funerals this year, but that’s pretty normal, lots of brothers in here, yeah they go through the same thing. It always makes me sad, sometimes really sad, but it happens so often that you kind of get use to it (Research participant, non-PTSD symptomatic with a score of 2.37).

My auntie died, hang on [male name] he died because they had a lot to do with my life. They looked after me when I was a kid. I miss them because you know, I can remember them doing good things for me, you know. Yeah a lot of family gone now but not much time to grieve sort of like one funeral so close to the next and to the next then to the next one you know what I mean? Yeah always feeling sorry and no time to feel happy (Research participant, PTSD symptomatic with a score of 3.07).

Yeah, we were all young and just about five elders there and we had an accident and my best friend died in front of me. Yeah, he died right there in front of me. I was a part of the accident too because I got caught on my ankle and my leg. I
came to hospital and then when I grew up and I wasn’t feeling happy because my friend died in front of me yeah not happy too many deaths already just another one but that one made me not happy (Research participant, PTSD symptomatic with a score of 3.07).

Shit yeah fucking burying someone every other week but the one that stands out yeah is I think about Mum dying and all this and that. I see her in the coffin and people kissing the coffin and all that sort of stuff. I think of that. And I went home and give her some money, give her about $500 or something. I went to sleep and the next minute there’s a phone call, there were people down the pub looking for me and I went out. I ended up going out. She said don’t come home if you get too pissed or all this shit and that. So I never come home and the next day she was dead. So that sort of hit me pretty hard (Research participant, PTSD symptomatic with a score of 2.93).

**Murder of family, friends or strangers**

PTSD symptomatology was not significantly related to witnessing the murder of a family member, friend or strangers; however 26 (44.8%) of the participants reported witnessing the murder of a stranger and 17 of these were PTSD symptomatic. The murder of a family member or close friend was reported by 31 (53.4%) participants, with 18 of these being PTSD symptomatic. A number of the participants shared their stories about witnessing the murder of a family member, friend or stranger, and the specific effects this had on their lives:

*When I was six my old man shot my mum, yeah fucking shot my mum, bang in the head. They had been blueing all night. He made me clean her brains off the floor. When I raped that girl I felt like all my pain was going into her, when she screamed that was me screaming, I know it sounds fucked up but that’s what it felt like. I looked at my hands after, the blood on my hands and the shit, it was all slimy, I thought I was cleaning up my mum’s brains again, it felt the same* (Research participant, PTSD symptomatic with a score of 3.17).

*Older brother, yeah, he’s passed away now. He got murdered too. I saw that one. That was 1991. I always think about that, him (pause) always can’t get it out of my head* (Research participant, PTSD symptomatic with a score of 2.53).

*When my nephew killed my, stabbed my uncle. He stabbed my uncle four times in the neck. They had an argument when they, after they were drinking alcohol. Not good to see that kind of thing it plays with your mind. Yeah I reckon that put*
me on a bad track. The first time I got into trouble was I burnt an old house down next to a church. I don’t know something inside me made me do it. Ah you know, because when I see my family get hurt you know and none of my family are doing anything about it. And then I’m the worst one out of the lot. I was crazier than all of my people. That’s worse. Because one white bloke, one Aboriginal bloke, my dad would have been about 71, 72 before he passed away. They tried to mob my dad. I told them, I said you lay a finger on my dad you two are dead men walking. They thought I was joking around. I said don’t move. I shot the two of them with my father’s gun and one of them blokes, he’s from here, and he’s from [town]. But I told him don’t, never hit my father. And they were the blokes, they were both my brother-in-laws, they were living with my two older sisters; they’ve got kids from my older sisters. They shouldn’t do that, hit their father-in-law like that there, not in front of me anyway (Research participant, PTSD symptomatic with a score of 4.00).

But that’s me, I talk to myself. You know it’s hard for me to say because I don’t know what’s wrong with me. I know there’s something wrong with me but I don’t know. My violence, most of my violence has been through things that have happened to my family. I’ve seen two of my brothers get done in drunk fights, had their brains bashed out. You know the way I react from a couple of years ago. You know something happened to my sister and a couple of years later, you know she got messed with and they killed her. That sticks with you (Research participant, PTSD symptomatic with a score of 3.30).

And until I turned about, oh shit, it would have been about eight, nine, and a couple of my mates were in a bit of trouble. They got into a couple of fights and I knew how to fight because of being in foster homes and other bigger kids picking on me because I wasn’t the same colour as them, or I wasn’t the same as them, or I just didn’t want to do anything with them. So I used to get bashed a fair bit. And I learnt to stick up for myself. And I went to a party, this was when I was about nine, nine and a half, just turning ten. I went to a party with a couple of mates and one of my mates got stabbed and they put him under [died]. I got them back in the end, I waited then one day I turned around, because being in a gang I don’t want to let my mates down, I stabbed three blokes. One of them I put in hospital for six months, the other one went six feet under, I don’t know what happened to the other bloke. So yeah, yeah when I saw my mate get stabbed it started something in me that’s why I’m here now (Research participant, non-PTSD symptomatic with a score of 2.07).
And this bloke’s just walked straight into the caravan and just grabbed this thirty-eight and just said fucking boom man, and just blew his head clean off. And down in [town] here, you know I’ve witnessed blokes getting shot down there. Bloody another bloke got disembowelled down there one night, it was a pretty wild camp back, a long time ago and it makes you hard to that sort of going ons and easier to do it to others, mmm yeah much easier (Research participant, non-PTSD symptomatic with a score of 1.97).

Institutional violence and fractured families and souls

The enforcement of institutionalisation in the form of forced separations from families and communities through adoptions, foster care, children’s homes and imprisonment, including juvenile detention centres, appeared to be profoundly traumatic for the research participants and was reported as having long term detrimental effects on individuals, families and communities. Although not statistically significant in relation to PTSD symptomatology, 45 (77.6%) of the participants endorsed family and community breakdown as a primary traumatic stressor, and 26 of these participants were PTSD symptomatic. Family and community breakdown were viewed as both processes and outcomes of institutionalisation:

This “family and community breakdown” one, this one here yeah well you know they break up the families don’t they stick us in here [prison], they take our kids away and put them with people that don’t know our culture so they never know who they are. And some of them people they hurt us, they hurt our kids then those kids come back one day but they are not the same, never the same, they all mucked up and are angry and then they hurt their families, you with me? Then those kids are taken away because their mums and dads are fucked up, you see this family and community breakdown one it’s what they do [process] and it’s what happens because of it [outcome] (Research participant, PTSD symptomatic with a score of 3.17).

PTSD symptomatology was not significantly related to being adopted or fostered out (fragmentation of families), which included being placed in a children’s home, although 27 (46.6%) participants reported such enforced separations and 16 of these were PTSD symptomatic. Although not statistically significant in relation to being PTSD symptomatic, 45 (77.6%) of the participants reported being made to live or sit down a long way from your families (forced separation) — which was enforced through police custody and imprisonment, including juvenile detention centres — as highly traumatic. Of these, 29 were PTSD symptomatic. Having bad (traumatic) experiences with the
police, welfare mob and housing commission (institutional violence) was reported by 42 (72.4%) of research participants, of whom 27 were PTSD symptomatic. However, no significant relationship was detected between this event and being PTSD symptomatic. Experiences with institutional bodies were primarily through police or custodial contact and welfare. The latter was particularly related to removal from one's family and the subsequent traumatic experiences within those placements. None of the research participants reported experiencing any negative experiences with housing authorities. Many participants reported experiencing emotional, physical (including sexual), spiritual and mental violence in custodial and welfare placements. This trauma was further compounded by the dysfunctional behaviours that emerged from the processes and outcomes of institutionalisation, which is clearly articulated in the following qualitative accounts of welfare placements:

When I was younger because I moved from my mum's house to the foster care because it was pretty violent; because my mum's boyfriend was bashing her and bashing us around. I didn't just stay in one foster care. I went into like, about six or seven. Some were ok, some wasn't - got mucked around with sexually and stuff and sometimes pretty violent. I just guess I wasn't their only child (Research participant, PTSD symptomatic with a score of 2.70).

Well when I was small I was taken away from my parents by welfare. A place in [town] and that's where most of my violence started. Before that it wasn't like that you know. I mean I was made do things that I didn't want to do. Like go to church, go to school and ah, sex (pause) if I didn't do those things then I was belted but I mean none of that stuff made any sense to me and they were trying to make me lose my culture but that is who I was (Research participant, non-PTSD symptomatic with a score of 2.07).

And them fellas [welfare mob] don't know what it's like to be taken away from your parents. Yeah. It's like I think sometimes I'm a dick head for getting myself locked up again, you know, because I'd rather be out there you know. See like I said before the human service fellas fucked everything up for me (Research participant, PTSD symptomatic with a score of 2.60).

I still think about this society and how it's made up. How they deal with me. I mean I know it's my responsibility to accept things and I do. But I feel very dirty about the society and how they perceive me to be and how they've handled me all through the years. You know like when I was ten the best thing they could do
was put me in a home. And I remember this was very traumatic and I never forget about it. And when you’re that little, this little boy he’s screaming for his mummy because outside it’s raining. And ah, that was very traumatic and I’ve always looked at them police; and I look at them and I think to myself as a man looking back and I think well you know if that’s the best that you could do to show that little boy; and you know I remember them coming around to the schools and saying to all the girls and boys how such nice people we are. Oh but they come to you, the minute they put me in there, many times, they come to you and hurt you. To me when I look back on that I consider that in my mind and in my heart that that’s a form of child abuse in itself. I just feel that way. And I am little bit dirty with them over it because when they do that they unbalanced me (Research participant, non-PTSD symptomatic with a score of 2.10).

Yep, I got taken away from my home when I was 11. They threw me in a mission. Um; when I went to the mission I got gang raped by these 2 [family name], [male name] and [male name]. Um; they caught me on my own in the bush while we were all walking back from the front gate. I was about nine I think. At the same time up there you know, I molested a young boy up there, out at the mission and attempted to molest a young girl that was there also. He was about six I think. She was about eight or nine; I don’t know (Research participant, PTSD symptomatic with a score of 3.00).

You see I’ve got taken off my mum by family services for a few years. I spent a few years in different foster care with different parents and that was not real good. Yeah being molested three times. Three different people. One of my foster parents. The male foster parent yeah he did it continually. Yeah. I wasn’t with them for long (Research participant, PTSD symptomatic with a score of 3.57).

See that’s what I mean, I lost a lot of my culture and that um; by being taken off mum (Research participant, PTSD symptomatic with a score of 3.37).

The foster homes treated you pretty shocking. Yeah that’s why I had to learn how to fight and that. It’s pretty shocking (Research participant, non-PTSD symptomatic with a score of 2.07).
Especially like a lot of the ones that got adopted out and that, moved around. Yeah it happened [sexual abuse] to a lot of my cousins (Research participant, PTSD symptomatic with a score of 3.47).

Well you already know about human services, they make me mad and when I’m mad I get violent you see, you know for what they’re doing to my family now. You know for taking our daughter away (Research participant, PTSD symptomatic with a score of 2.60).

Ah; ooh; the only hurtful thing was being taken away from my mum and that. Ah custody and that one time yeah. For four years I’ve got to live with my grandmother and grandfather. Yeah so they put me with my grandparents. Yeah and I never seen my mother for four years. That really hurt me, yeah (Research participant, non-PTSD symptomatic with a score of 2.10).

And then they take me out of my family, off my brothers and my mum and dad. They take me away from them people where I was always happy. And me in the boys homes and all the different arts in the schools they’ve got me, you know a real good time and stuff. The next minute you do your 21 days or whatever, and then you’re released back to home again and then you’re back to that impoverished background. So they show the world to me and then they put me back into the situation, sort of really unbalanced. And it really unbalanced my life; you know what I’m saying to you? (Research participant, non-PTSD symptomatic with a score of 2.10).

The level of violence against, and witnessed by, the research participants in custodial care was very disturbing. Many of the research participants shared their stories of being ‘roughed up’ by police or prison officers, and viewed these events as ‘common knowledge’ and an expected outcome of going into custodial care:

These days its just common knowledge that if you go to prison or you go to the police lock up you’re going to get belted (Research participant, non-PTSD symptomatic with a score of 2.07).

And when I went to [State] jail I’d seen two people get knifed, as soon as I walked in I was only 17 year old kid. How they can make a 17 ½ year old boy see that? I’d seen that walking in there and it fucks with you for the rest of your life. But violence, I’d seen violence here and there. It was never anything
personal. I didn’t mean to be personal to anybody but the thing is they’ve [police] been bashing me up all my life and they’ve been bashing my family up and all the rest of it. I swear to you. And then they want to um; and then because I’ve bashed one of them up they give me all this time (Research participant, non-PTSD symptomatic with a score of 2.10).

Well they [police] did bash me once. I broke into this place in [town] and I didn’t know there was a car stolen that was sitting across the road. And the police come and caught me in the shop. They were trying to get me to say that was my car as well, like parked across the road so I could just go in. But it wasn’t. I had nothing to do with it and they took me in the bushes and bashed me. But I still didn’t give in because I didn’t steal it. I got caught like with chasing. Like after get caught you know they just drag you out of the car and they just belt you, and handcuff you and drop the boots in. And get back to the police station and they do the same thing over and over. You know they try to say that you’ve done this and you’ve done that, and put more charges on you and what not. Yeah the guys [police] sort of back there again; where they sort of put a gun to my head and saying we’re going to take you out to the bush and kill you, and that type of stuff you know (Research participant, PTSD symptomatic with a score of 2.70).

Oh well I’ve got scars on the back of me shoulders from police handcuffs and I’ve got a bit of skin off the palm of the hands and pushed on the bitumen with the handcuffs behind me back. It never changed one bit, from then till today (Research participant, non-PTSD symptomatic with a score of 1.47).

Oh I just got bashed up by the cops one time and that, yeah. I got put in hospital a couple of times by them. Sort of like got me when I was; with this spray, pepper spray and all that in my eyes and all that so I couldn’t see and just flogged me around the cells and that, yeah (Research participant, non-PTSD symptomatic with a score of 2.10).

It was what, two senior officers and four puppets and they stabbed me in the shoulders with the keys and that there. I’ve copped a lot of hidings from the coppers (Research participant, PTSD symptomatic with a score of 2.57).

I still don’t know who I am to this day really. Yeah, it’s a bit hard for me to explain why, yeah. Well them police had me, lying on my face. You know hog
tied arms behind my back. Um, and when they got me to the police station they took me out to the yard and a couple of the coppers come in and they; because I was bleeding and that, they stopped and that. They put gloves and that on and they come in and I got flogged a bit. I know who they were, yeah, but that’s a different story. Um, and they give me a good hiding and after they finished with me they just threw me in the holding cell. I don’t know whether it was a rubber cell, I think it was. And as you go down, you go down stairs and there’s holding cells down there. They took me down there. I’m not too sure but I think it was because there was no cameras and that. They give me a hiding down there and that’s when they took me back up and I asked to speak to an Aboriginal liaison officer. Um didn’t get one of course. Went into court and I had a couple of black eyes and that and blood all over my face and that. They wanted me to have a shower and that before I went to court and I didn’t, I didn’t want to. I wanted the judge to see, you know. Because if they can get away with that, what else are they going to do that they can get away with? (Research participant, PTSD symptomatic with a score of 3.30).

Oh yeah but as soon as they start being racist or something, I just get up and smack them straight on the mouth, you know what I mean. Oh I’ve had screws you know flog me now. I’ve had a copper snap my legs and that, that was on the outside, backwards and that; they snapped my leg in three places. They had me in the police station for about three and a half days and didn’t tell no one. I was in the jack shop and had me lying down on the chairs so I couldn’t move, you know what I mean, I wasuffed to the chair and he’s saying fucking um; just tell us, they’re your own stick ups and we’ll stop flogging you. I said I don’t know what you’re talking about, do you know what I mean? And they just flogged me and broke my legs, and then chucked me on the side of the road and let me go, and I’ve never been charged with it. But yeah you get hidings all the time in the police station and you get used to that (Research participant, non-PTSD symptomatic with a score of 1.77).

I won’t be able to work when I get out this time because the screws broke my arm here. I’ve got no control over this arm. I can do that [demonstrating movement] but I’ve got no strength in it, I wouldn’t be able to lift a chain saw or wouldn’t be able to split wood you know like that. He broke my arm and one broke my arm, a couple of blokes broke my arm in the hospital, in the ward. I was in the ward crook and I had a blue with this inmate and his heavies come in
then and done the heavy (Research participant, PTSD symptomatic with a score of 2.93).

Oh yeah. If you assault any of these officers, you cop it down the back by about 10 of them. While you’re handcuffed, on your own; no matter how loud you scream, nobody is going to hear you. But there’s no such thing as a good officer. Honest to God, there isn’t anything as a good officer. There’s a few that maybe you could. Yeah they come here, you know from home, outside and um; if they’ve got problems they will bring it to work and distribute it amongst prisoners as ever they wish. There’s a bloke down the back right, that’s been down there for three years, four years. He doesn’t want to get out because he believes that whole institution is totally up the shit. I agree with him. Probably. He’s just withered away man. He’s isn’t the man that he used to be anymore. Um. When I seen him last time, he had big broad shoulders, big arms, big legs, he was huge. When I seen him about a month ago, maybe two months ago, he was as skinny as a rake. I’ve done nothing but do prison time even since I was 13. You know I haven’t had a life, so what good is it me coming to you, doing nothing but jail. Jail, jail, jail, jail (Research participant, PTSD symptomatic with a score of 3.00).

And there are some police that you know don’t, just look the other way sort of thing. But if you’re doing something serious or that, then they can’t look the other way, they’ll just; but I’ve got some police that you know, have given me a hell of a hiding and put guns to my head and all that, you know (Research participant, non-PTSD symptomatic with a score of 1.90).

As far as I’m concerned they treated me like that little black boy that cleans shoes because that’s where they fucking had me, in this little shed out the back cleaning fucking shoes. You know what I mean. And then when I come inside they’d treat me like shit, you know what I mean. The police officers oh yeah, yeah fucking oath. Yeah one got sacked. I got backed by about 30 of them though, but one got sacked. 30 on one. Yeah, me and myself (laugh), yeah they all wanted a kick. Yeah they used me as a ball, fucking oath, yeah kicked the shit right out of me. To tell you the truth I didn’t even know what to fear from. Because I don’t really; I mean I don’t remember it, I remember it, I remember being pinned to the ground, getting my head slammed into the road. But you don’t feel pain after a while that’s what I’m saying. After the 4th hit I think I relaxed, I think I was out, I was out. Um, but yeah, they kept on going. It wasn’t
a matter of he’s limp, he’s knocked out. Yeah they kept on going. Then they took me back to the police station and bashed the shit out of me again, and I don’t even remember that one (Research participant, non-PTSD symptomatic with a score of 1.80).

People that have got power over you; and the police, they’ve got power you see. Once you’re in their custody you’re finished (Research participant, PTSD symptomatic with a score of 3.23).

Some of the men were reluctant to expand on their negative experiences within custodial care, fearing that their disclosures may have repercussions:

Yeah there has been a time in my life that I have been real scared lots of times but I don’t want to say. Nah look, because like; yeah fucking, I’ve experience that with the police force before. Fucking, yeah; oh just fucking listen here you little black fucking rat. Who the fuck do you think you are coming up to our country town doing shit like this? Fucking take you out the bush and bury you, you little shit. You know shit like that. This is; sorry I’m not really talking much right because I just feel a bit wary about talking about fucking police. You know what I mean, like, alright I’m just worried about myself, you know what I mean. And if this can come back on me, you know what I’m saying (Research participant, PTSD symptomatic with a score of 2.57).

A number of the participants identified mental and emotional violence within custodial care:

Ah; well sometimes (pause); sometimes when you’re in situations like this here [prison] and you’re closed in. Like there’s a lot of mind games go on, do you know what I mean? Or you think you’re hearing voices but you’re not, its just mind games. You get like a lot of people, you know someone; like if you leave the door open in the morning they can come in and tell you to hang yourself and all that. Yeah but I don’t know. Like even the officers, they play mind games, like over in [name of division] and all that they tell you to hurt yourself you know just go and hang yourself we don’t care type stuff (Research participant, PTSD symptomatic with a score of 3.47).

I was in intensive care here for a week and then I was taken down the [hospital], have the operation. They done an angiogram through the groin and I spent a
month in prison. Yeah. And half the time you never get out of your cell anyway because you're locked down. While you were in there you just go mad. That's it. If they put you in isolation, [name of division], you go down there, you have your TV, stereo, you can have your buyers, everything. Here nothing, that 42 days I sat down there with nothing, absolutely nothing. I served three and a half months down there and that changed me yeah (Research participant, PTSD symptomatic with a score of 3.37).

What really give me the shits was these um, um our friend was dead and how he was treated. They treated him with disrespect I believe, after he was dead. They dragged him out of the cell, cracked his head on the floor, tried to resuscitate him in front of everybody and then locked everybody up you know which was pretty sad. But in the position that he was found in by the first person that found him, that's exactly how I saw him about 45 minutes earlier. I didn't think he was dead, I thought he was asleep (Research participant, PTSD symptomatic with a score of 3.00).

The officers are trying to get blacks and whites to have a war in here. Well when we; once we ask for something, we ask for something and we don't get, and when the white people ask, they get. Its just like we don't get a fair chance of anything but if it's a white prisoner he'll get what he wants (Research participant, non-PTSD symptomatic with a score of 2.17).

Ah; well on Friday I was supposed to go to my sister's funeral right. And I was supposed to go to it. It was starting at two o'clock that was when the big funeral was going to start. The wing officer that we're allocated because we're all allocated a wing officer; I tried to explain to him that if they came and picked me up at two o'clock I would not make it to the funeral because that's when it starts, and he just did not want to listen to what I had to say. So I went and said it loudly so that everybody heard and I just aimed it at him, and um, he rang up to recovery, which is the police here, they'll come and take you away. And he actually rang them up and they came down to the unit, and as soon as they handcuffed me the officer who I tried to explain things to, he just came up and got in my face you know. He was like fuck, make you miss this now, you're nothing but a racist mate you know, you're the lower scum of the earth you know, so why the hell should I do anything for you. I don't really give a fuck about your sister; I hope you don't go to her funeral, fuck you. That's what he said to me. He didn't really give a fuck. But I've been called a lot worse names.
than that you know and had a lot more bad things said to me. So it just rolled off my back anyway and I got taken down to [location], this was on Friday morning. The funeral was going to be at two o’clock, the viewing at one o’clock. It was going to start at one. So I went down the back and the assistance superintendent rocked up about five minutes later asking what am I doing here. So I explained to him, knowing all too well that things would be getting done and he went and made a phone call, come back and said right you’re out of here in 20 minutes. You know at 11 o’clock they’ll be here. So shower, shave and whatever, when you come back to here you won’t be coming back down here, you’ll be going back to your block, so just behave yourself. And everything went smoothly after that. It was just that the officer of that morning, I don’t know he’s very insensitive I believe. Now if I was another prisoner, you know like somebody not so institutionalised as myself, anything could have happened. You know I could have probably assaulted him and ended up getting bashed down the back (Research participant, PTSD symptomatic with a score of 3.00).

Institutionalisation appears to have become normalised for some participants, in that they seemed to have difficulty contemplating life outside prison and were unable to adjust to life once they left custody, particularly if there were no programs to assist with reintegration into society:

Because to me a lot of prisoners, even though they might seem like good blokes and what not, but I tend to sort of want to be on my own and not have anything to do with anybody. You know don’t get into the politics side with the prisoners. Um yeah. Because it was such a long time that I spent inside, no re-socialisation type of stuff on the farm and what not, I sort of fell into a depression state two weeks after being out. I wanted to sort of come back and I just locked myself in a room where I had the TV set up like in a cell. I didn’t move out of the house for about two months. Made myself my own little prison. Yeah and just hide myself away and then I ended up getting onto the amphetamines and that sort of took a lot of the pressure off. I got out and about and meet people (Research participant, PTSD symptomatic with a score of 3.10).

One of the big things with me I suppose, um, like being in here you get a prison mentality and in here your word is your honour. And um, a lot of the time; see people on the outside don’t know that sort of thing and when you talk to them, um, because I’ve done so long in here. I’ve served 14 years and the thing is, is that when you get out of places like this you have [had] everything catered to
your every needs so its real hard to adjust (Research participant, PTSD symptomatic with a score of 3.37).

I believe and I can feel this, that I’ve become institutionalised. Um, I actually like this place because it’s a comfort zone for me. I feel really, really comfortable here. Um, but even though I do miss other things like home, mum, you know kangaroo meat and damper um, at the moment I’m actually doing what needs to be done and through that comes being institutionalised (Research participant, PTSD symptomatic with a score of 3.00).

I don’t care about being in prison. It doesn’t really worry me. Yeah of course it’s boring in here but it doesn’t really worry me being in here. It is kind of like a family, we look after each other. One big community better than back home not as much violence yeah one big community it is. Down here it’s different but up home the prison’s a lot better (Research participant, PTSD symptomatic with a score of 2.70).

I wanna stay in here, yeah I feel like I won’t be accepted by society outside (Research participant, non-PTSD symptomatic with a score of 1.80).

Yeah I think back now and I look back, and I think yeah I felt safer then. Yeah I feel safer in here. Being incarcerated, yeah. When I look back and I think back now. That’s why when I first got locked up this is alright; it’s a lot safer in here than the other bullshit I used to put up with on the outside. Do you know what I mean? (Research participant, PTSD symptomatic with a score of 2.53).

Acculturation (colonisation) and racism
A large number of participants — 41(70.7%) — reported feeling traumatised from feeling shamed for being Aboriginal and experiencing racism, with 26 of these being PTSD symptomatic. This was not statistically significant in terms of being PTSD symptomatic. Similarly, 35 participants (60.3%) reported that being forced to accept ‘whitefella way’ and to speak English (acculturation/colonisation) were particularly traumatic because of the potential loss of some or all of their traditional language and ceremony. Of these, 20 were PTSD symptomatic, although again there was no statistically significant relationship between this traumatic stressor and PTSD symptomatology. A number of participants brought focus to the potentially debilitating effects of racism and acculturation/colonisation, such as the loss of culture:
And this is really where it makes you very angry, knowing that you can’t have any of your culture because of what they’ve actually done. They’ve moved people from tribes, they’ve moved them off their tribe or their place and put them in the missions and that’s what happened to my grandparents. I grew up with a little bit of knowing that when I was in primary school because I was getting caught and being racist towards, against, you know people saying you boong. I’ve been harassed and punched around by police, yeah a couple of times. Just being black you’re guilty. And all their … history. And every one of us, every Aboriginal that’s in jail, every man has got the same story to tell about what’s happened to their people. In every facet that you can think of. Yeah. It just seems because of my Aboriginality it’s so hard to walk into a bloody interview and you think well is that person going to hire me, because you know I’ve got to work really hard to prove to him that I am capable of doing this job or whatever it is. Due to the fact that I’m black it makes it extra hard, I’ve got to … even more. Yeah. That’s the worst thing about it, that’s what I think because what happened to our people, what happened to our culture, what’s happened to our land. That’s the worst part. People come to you and I don’t even know where I come from (Research participant, PTSD symptomatic with a score of 2.57).

When there wasn’t alcohol it was similar life, everybody was free, things were normal before. Then alcohol came into this country (Research participant, PTSD symptomatic with a score of 3.50).

And I used to sit in the camp sites where they had fire going, where they used to sit and talk and always blame it on you know, the assimilation policy. And you know I used to go to school and I used to have these little ambitions of my own where kids used to say you can’t do that. You know and teachers used to say you boongs, you’re not going to be nothing, you’re not going to make it in the world (Research participant, non-PTSD symptomatic with a score of 2.37).

There was one teacher at this catholic school we had to go to, didn’t like us, there was five Aboriginals in the whole school and they told us that we weren’t allowed to sit together in class, that we were no good. Yeah. And even the principal called us up and asked us to find new friends to hang around with at lunch time. And it was mine, I paid for it. They’ve [the police] stolen three watches of mine, engraved. What do I do, what I want to make a complaint? Of course. Like I don’t know, I can’t, don’t bed with white woman. I just can’t, they’re different. They’re a lot different. They’re not so loyal. They don’t
understand. And they’re a part of everything that I hate. Which is the white way and what they’ve done. My grandfather was alive for 75 or whatever years he was and I mean nothing changed. They just got better at doing it. Nothing changed. It still hasn’t changed and he died an unhappy man. He was happy for us, happy with us, he loved us, he loved his family but he was still unhappy. Getting chained to trees and flogged and shit. You know. Yeah that’s right. They even wrote a book on how to breed us out, a recipe book for breeding out the blackness of our skin but its not about the blackness of our skin, it’s in your heart and in your blood. You see my father kept me away; he kept me and my sister away from mum’s family. Because they’re white (Research participant, PTSD symptomatic with a score of 3.70).

Yeah being forced to accept whitefella way I believe, you know this is why we got this whole, this whole Aboriginal race fucked up for. I can’t ah; you know I just; I’ve lived. They’ve taken everything from us and want us to go. They don’t want to accept anything we’re going to do. You may have said it’s good your traditional way but when we try to keep our traditions in our way and keep our language, you as a German missionaries come in and can’t speak; you know you’re not allowed to speak your own language, you have to speak. This is all on documentaries and everything, you know even though they’ve got it all down in black and white and everything, in traditional time they never did that (Research participant, PTSD symptomatic with a score of 3.07).

The way the [town] to me was the white people are just pure prejudice but I’ve grown fond of a lot of people there. Some people who I’ve worked with I can call close, almost family although they’re white. They’ve been very good. It was just the law itself that I’ve got no liking for because of the way things have been put upon me, instead of further investigation. There’s a lot of other Murris in here who have similar cases, similar problems but different charges. Yet it all comes down to discrimination, to black man’s rights (Research participant, non-PTSD symptomatic with a score of 1.47).

Um; oh; well I mean I realise that ah, a lot of our traditions are being forgotten about and I realise that yeah, we lived off the land, right. We didn’t have to pay taxes or worry about paying for our food, you know we’d just go out and hunt for it. And you know these days if you don’t work out there. I mean you can’t survive on the dole because it’s not enough money and well it’s hard to get work
when you’re a blackfella (Research participant, PTSD symptomatic with a score of 2.50).

White fella way um, they forced us to smoke, um, smoke, drinking, stealing (Research participant, PTSD symptomatic with a score of 3.33).

**AAVHTQ PTSD symptoms in relation to PTSD symptomatic or non-PTSD symptomatic**

To test whether any of the specific PTSD symptoms endorsed by the participants in the AAVHTQ were associated with PTSD symptomatic or non-PTSD symptomatic, non-parametric crosstabs and chi-squared tests for association were performed. Exact chi-squared tests were used when counts per cell fell below five. Fisher’s exact tests were used in 2 x 2 tables. For these analyses, alpha was set at .05.

Table 21 presents the number and percentage of participants who reported each symptom in terms of PTSD symptom status. Participants who were PTSD symptomatic reported the majority of the AAVHTQ PTSD symptoms significantly more often than non-PTSD symptomatic participants ((M = 2.97, SD = 0.39), t (1, 56) = -10.78, p < .001).

Table 21 also presents the positive and negative predictive power of each symptom. Positive predictive power was defined as the probability of PTSD being present when a specific PTSD symptom is present. This probability was calculated by dividing the number of PTSD symptomatic participants (those with an AAVHTQ score ≥2.50) who reported each PTSD symptom by the total number of participants reporting that PTSD symptom. Negative predictive power was defined as the probability of not meeting criteria for PTSD when a specific PTSD symptom is absent. This probability was calculated by dividing the number of non-symptomatic PTSD participants (those with an AAVHTQ score <2.50) that did not report each PTSD symptom by the total number of participants not reporting that symptom. A representation of those participants that endorsed no for a particular symptom and who were non-PTSD symptomatic can be extracted from the negative predictive power. The symptoms with the strongest positive predictive power were: feeling like you were going crazy (.87); feeling like you have no one to look after/out for you (.83); feeling worthless (.83); flashbacks (.78); feeling like the event didn’t happen to you and that you don’t feel bad about it (denial) (.77); trying not to think or feel about anything to do with the bad or hurtful things that have happened to you (.75); not caring about everyday things (.74); can’t feel emotion, feeling like you are split into two people and one of you is watching what the other is doing, suicidal thoughts and going mad and crying when you are reminded of the most hurtful
or bad things that happened to you (all .73); feeling guilty, feeling shame and problems making and keeping relationships (feeling unloved and unable to give love) (all .72); and taking drugs and/or alcohol all the time to help you forget the bad things that happened to you (.71).

Only six symptoms were not significantly related to being PTSD symptomatic according to the AAVHTQ: nightmares, trouble sleeping, trying to keep away from things that reminded you of the hurtful or bad things that happened, not being able to remember some of the most hurtful or bad things that happened to you, feeling like someone you trusted did something to betray you and becoming violent to self or others. The apparent reason that no significant relationship was extracted from these symptoms was that they are normalised across both the PTSD symptomatic and non-PTSD symptomatic groups (i.e. a majority of the entire study population experienced these symptoms). The sole exception to this was nightmares, which was not highly endorsed across the entire study population. Of the six symptoms above, three were the most commonly endorsed symptoms by a majority of participants; becoming violent to self or others and feeling like someone did something to betray you, both endorsed by 51 (87.9%) participants, and not being able to remember some of the most hurtful or bad things that happened to you — endorsed by 49 (84.5%) participants. Trying to keep away from things that remind you of the most hurtful or bad things that have happened to you — 45 (77.6%) participants — and trouble sleeping — 41 (70.7%) participants — were also frequently reported. Therefore, violent behaviours, trust issues, suppressed memories, avoidance behaviours and sleep issues were the symptoms most likely to be endorsed by the participants, regardless of whether they were PTSD symptomatic or not.
Table 21: Number and percentage of participants endorsing each AAVHTQ PTSD symptom and the positive and negative predictive power of each symptom by PTSD symptomatic or non-PTSD symptomatic

<table>
<thead>
<tr>
<th>Item #</th>
<th>AAVHTQ PTSD symptoms</th>
<th>Total number and percentage of symptoms n = 58</th>
<th>PTSD group number and percentage n = 34</th>
<th>Non-PTSD group number and percentage n = 24</th>
<th>χ² (df = 1)</th>
<th>p</th>
<th>Positive predictive power</th>
<th>Negative predictive power</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intrusive memories</td>
<td>48 (82.8)</td>
<td>32 (94.1)</td>
<td>16 (66.7)</td>
<td>7.43</td>
<td>0.01</td>
<td>0.67</td>
<td>0.90</td>
</tr>
<tr>
<td>2</td>
<td>Flashbacks</td>
<td>37 (63.8)</td>
<td>29 (85.3)</td>
<td>8 (33.3)</td>
<td>16.45</td>
<td>0.00</td>
<td>0.78</td>
<td>0.76</td>
</tr>
<tr>
<td>3</td>
<td>Nightmares</td>
<td>26 (44.8)</td>
<td>18 (52.9)</td>
<td>8 (33.3)</td>
<td>2.19</td>
<td>ns</td>
<td>0.69</td>
<td>0.50</td>
</tr>
<tr>
<td>4</td>
<td>Feeling alone and staying away from people</td>
<td>49 (84.5)</td>
<td>33 (97.1)</td>
<td>16 (66.7)</td>
<td>9.91</td>
<td>0.002</td>
<td>0.67</td>
<td>0.88</td>
</tr>
<tr>
<td>5</td>
<td>Can’t feel emotions</td>
<td>38 (65.5)</td>
<td>28 (82.4)</td>
<td>10 (41.7)</td>
<td>10.31</td>
<td>0.001</td>
<td>0.73</td>
<td>0.70</td>
</tr>
<tr>
<td>6</td>
<td>Feeling nervous</td>
<td>37 (63.8)</td>
<td>26 (76.5)</td>
<td>11 (45.8)</td>
<td>5.72</td>
<td>0.017</td>
<td>0.70</td>
<td>0.62</td>
</tr>
<tr>
<td>7</td>
<td>Can’t think straight</td>
<td>45 (77.6)</td>
<td>30 (88.2)</td>
<td>15 (62.5)</td>
<td>5.36</td>
<td>0.021</td>
<td>0.66</td>
<td>0.69</td>
</tr>
<tr>
<td>8</td>
<td>Trouble sleeping</td>
<td>41 (70.7)</td>
<td>26 (76.5)</td>
<td>15 (62.5)</td>
<td>1.33</td>
<td>ns</td>
<td>0.63</td>
<td>0.53</td>
</tr>
<tr>
<td>9</td>
<td>Feeling on guard/keeping a look out for trouble</td>
<td>40 (69.0)</td>
<td>28 (82.4)</td>
<td>12 (50.0)</td>
<td>6.88</td>
<td>0.009</td>
<td>0.70</td>
<td>0.56</td>
</tr>
<tr>
<td>10</td>
<td>Feeling angry all the time and taking it out on others or yourself</td>
<td>41 (70.7)</td>
<td>28 (82.4)</td>
<td>13 (54.2)</td>
<td>5.40</td>
<td>0.02</td>
<td>0.68</td>
<td>0.64</td>
</tr>
<tr>
<td>11</td>
<td>Trying to keep away from things that remind you of the hurtful or bad things happened to you</td>
<td>45 (77.6)</td>
<td>27 (79.4)</td>
<td>18 (75.0)</td>
<td>0.16</td>
<td>ns</td>
<td>0.60</td>
<td>0.46</td>
</tr>
<tr>
<td>12</td>
<td>Not being able to remember some of the most hurtful or bad things that happened to you</td>
<td>49 (84.5)</td>
<td>30 (88.2)</td>
<td>19 (79.2)</td>
<td>0.09</td>
<td>ns</td>
<td>0.61</td>
<td>0.55</td>
</tr>
<tr>
<td>13</td>
<td>Not caring about everyday things</td>
<td>35 (60.3)</td>
<td>26 (76.5)</td>
<td>9 (37.5)</td>
<td>8.93</td>
<td>0.003</td>
<td>0.76</td>
<td>0.65</td>
</tr>
<tr>
<td>14</td>
<td>Feeling as if you don’t have a good future or any future at all</td>
<td>34 (58.6)</td>
<td>24 (70.6)</td>
<td>10 (41.7)</td>
<td>4.85</td>
<td>0.028</td>
<td>0.70</td>
<td>0.58</td>
</tr>
<tr>
<td>15</td>
<td>Trying not to think or feel about anything to do with the bad or hurtful things that have happened to you</td>
<td>40 (69.0)</td>
<td>30 (88.2)</td>
<td>10 (41.7)</td>
<td>14.26</td>
<td>0.000</td>
<td>0.75</td>
<td>0.78</td>
</tr>
<tr>
<td>16</td>
<td>Going mad or crying when you are reminded of the most hurtful or bad things that happened to you</td>
<td>41 (70.7)</td>
<td>30 (88.2)</td>
<td>11 (45.8)</td>
<td>12.21</td>
<td>0.000</td>
<td>0.73</td>
<td>0.76</td>
</tr>
<tr>
<td>17</td>
<td>Feeling that people do not understand what has happened and that you are the only one who has suffered these things</td>
<td>46 (79.3)</td>
<td>32 (94.1)</td>
<td>14 (58.3)</td>
<td>10.98</td>
<td>0.001</td>
<td>0.69</td>
<td>0.83</td>
</tr>
<tr>
<td>18</td>
<td>Feeling guilty</td>
<td>43 (74.1)</td>
<td>31 (91.2)</td>
<td>12 (50.0)</td>
<td>12.44</td>
<td>0.000</td>
<td>0.72</td>
<td>0.90</td>
</tr>
<tr>
<td>19</td>
<td>Feeling shame</td>
<td>43 (74.1)</td>
<td>31 (91.2)</td>
<td>12 (50.0)</td>
<td>12.44</td>
<td>0.000</td>
<td>0.72</td>
<td>0.90</td>
</tr>
<tr>
<td>20</td>
<td>Spending time thinking about why things happened</td>
<td>48 (82.8)</td>
<td>32 (94.1)</td>
<td>16 (66.7)</td>
<td>7.43</td>
<td>0.011</td>
<td>0.66</td>
<td>0.80</td>
</tr>
<tr>
<td>21</td>
<td>Feeling as if you were going crazy</td>
<td>24 (41.4)</td>
<td>21 (61.8)</td>
<td>3 (12.5)</td>
<td>14.08</td>
<td>0.00</td>
<td>0.87</td>
<td>0.62</td>
</tr>
<tr>
<td>22</td>
<td>Feeling that you have no one who will look after/out for you</td>
<td>29 (50.0)</td>
<td>24 (70.6)</td>
<td>5 (20.8)</td>
<td>13.93</td>
<td>0.000</td>
<td>0.83</td>
<td>0.65</td>
</tr>
<tr>
<td>23</td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing</td>
<td>30 (56.9)</td>
<td>24 (70.6)</td>
<td>6 (25.0)</td>
<td>6.28</td>
<td>0.012</td>
<td>0.73</td>
<td>0.60</td>
</tr>
<tr>
<td>24</td>
<td>Feeling someone you trusted did something to betray you</td>
<td>50 (86.2)</td>
<td>31 (91.2)</td>
<td>19 (79.2)</td>
<td>1.71</td>
<td>ns</td>
<td>0.62</td>
<td>0.62</td>
</tr>
<tr>
<td>25</td>
<td>Feeling worthless</td>
<td>36 (62.1)</td>
<td>30 (88.2)</td>
<td>6 (25.0)</td>
<td>23.90</td>
<td>0.000</td>
<td>0.83</td>
<td>0.82</td>
</tr>
<tr>
<td>26</td>
<td>Becoming violent to self or others</td>
<td>51 (87.9)</td>
<td>30 (88.2)</td>
<td>21 (87.5)</td>
<td>0.01</td>
<td>ns</td>
<td>0.59</td>
<td>0.43</td>
</tr>
<tr>
<td>27</td>
<td>Taking drugs and/or alcohol all the time to help you forget the bad things that happened to you</td>
<td>42 (72.4)</td>
<td>30 (88.2)</td>
<td>12 (50.0)</td>
<td>10.30</td>
<td>0.001</td>
<td>0.71</td>
<td>0.75</td>
</tr>
<tr>
<td>28</td>
<td>Problems making and keeping relationships (feeling unloved or unable to give love)</td>
<td>43 (74.1)</td>
<td>31 (91.2)</td>
<td>12 (50.0)</td>
<td>12.44</td>
<td>0.000</td>
<td>0.72</td>
<td>0.90</td>
</tr>
<tr>
<td>29</td>
<td>Suicidal thoughts</td>
<td>30 (51.7)</td>
<td>22 (64.7)</td>
<td>8 (33.3)</td>
<td>5.55</td>
<td>0.019</td>
<td>0.73</td>
<td>0.57</td>
</tr>
<tr>
<td>30</td>
<td>Have you ever felt that these things didn’t happen to you or that you don’t feel bad about it (denial)?</td>
<td>26 (44.8)</td>
<td>20 (58.8)</td>
<td>6 (25.0)</td>
<td>6.51</td>
<td>0.011</td>
<td>0.77</td>
<td>0.56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M (SD)</th>
<th>M (SD)</th>
<th>M (SD)</th>
<th>t (df = 1)</th>
<th>p</th>
<th>AAVHTQ symptom severity score</th>
<th>DSM-II-R symptom severity score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.55</td>
<td>0.62</td>
<td>2.97</td>
<td>0.39</td>
<td>1.94</td>
<td>0.023</td>
<td>2.97 (0.44)</td>
</tr>
<tr>
<td>2.57</td>
<td>0.84</td>
<td>2.97</td>
<td>0.44</td>
<td>1.98</td>
<td>0.023</td>
<td>2.97 (0.37)</td>
</tr>
</tbody>
</table>

° Probability of the presence of PTSD when the symptom is present.  
° Probability of the absence of PTSD when the symptom is absent.  

Exact tests are used with crosstabs when the number in cells drops below 5. 2 tailed exact chi squares and p value is used in these cases. Fisher’s exact tests were used in 2 x 2 tables.  α set at .05 for all analyses.  
ns = non-significant.
Many participants elaborated on some of their traumatic symptoms, and this information added qualitative insight into the quantitative statistical results, enhancing the meaning of the numbers. The narratives are broken into the three sub-categories of PTSD symptoms: re-experiencing, avoidance/numbing and arousal.

**Re-experiencing symptoms**

Those participants who endorsed both intrusive memories ($\chi^2 (1, n = 58) = 7.43, p < .05$) and flashbacks ($\chi^2 (1, n = 58) = 16.45, p < .001$) were significantly more likely to be PTSD symptomatic. A number of the participants elaborated on these specific symptoms:

*It’s just when I’m in my cell of a night time and that, that things really flood into my mind. Well you know, that’s when you have time to dwell on things and that’s when things start coming to you. Yeah, like when I was sexually abused the smell of going to the toilet. You know, that a number two isn’t it? I always take a smoke with me so no smell or nothing, you know it doesn’t remind me of anything. It can’t be helped. Like I said it’s all in the subconscious. It comes when it wants. Ah you might be sitting in your cell having a smoke and then at exactly that same time something; like it might be somebody walking past a window and you think hey, Christ that brought back that, you know (Research participant, PTSD symptomatic with a score of 3.37).*

*I worked alright, I started drinking. Started getting violent when I started drinking. I would fear for my life that’s was when I drank too much and I get the horrors, you know, thinking of something. Seeing things and thinking about heart stopped, and thinking about death (Research participant, PTSD symptomatic with a score of 2.80).*

*I think about it a lot all the time. Every night before I go to sleep and it just doesn’t matter what I do I can’t get rid of the thoughts (Research participant, PTSD symptomatic with a score of 3.23).*

*Yeah I always think about it. You know even when I’m not drinking, or I’m just lying in bed, sitting around anywhere. You know just might crash up, you know (Research participant, PTSD symptomatic with a score of 2.93).*

*Yeah when I’m by myself. When I have no one to talk to. You know my memory goes pow, goes back (Research participant, PTSD symptomatic with a score of 3.53).*
A majority of the participants — 43 (74.1%) — reported feeling guilt and shame about violence they had inflicted on others, and there was a significant relationship between these feelings and classification as PTSD symptomatic ($\chi^2 (1, n = 58) = 12.44, p < .001$). The shame and guilt for some was so intense that they could not elaborate on those specific feelings. However, one participant summed up his own feelings about how he felt after killing a woman:

Well when I stabbed the woman, feel real guilty, real guilty lots of shame, after that I slashed up and just here and cut my throat. Trying to hang myself on my belt and all this shit (Research participant, PTSD symptomatic with a score of 2.93).

Those participants endorsing the symptoms of going mad or crying when you are reminded of the most hurtful or bad things that happened to you ($\chi^2 (1, n = 58) = 12.21, p < .001$) and spending time thinking about why these things happened ($\chi^2 (1, n = 58) = 7.43, p < .05$) were significantly more likely to be PTSD symptomatic. One of the research participants identified these two symptoms as particularly relevant to thoughts he had about his sexual abuse:

All the crap I have been telling you it's just real hard to make sense of it and the sexual abuse that's the worst one hey. Yeah. So that's one thing that really stays with me yeah I think about it a lot and that one about going mad and crying yeah that's how I go when I think about it (Research participant, PTSD symptomatic with a score of 2.57).

Although the symptom of nightmares was not significantly related to being PTSD symptomatic, over half of those who endorsed this symptom — 18 — were PTSD symptomatic and only eight were non-PTSD symptomatic. Excerpts from some of the research participants’ narratives provide insight into this specific symptom:

Oh it's been what; it's been 13 years say since I killed him and I've probably had about 100 dreams about him, you know real bad ones (Research participant, PTSD symptomatic with a score of 3.10).

Yes well I guess I've got that because I just keep on the mothers; well mum, she was having an affair with this fella and I got a bit scared of him when I was younger. Because he tried to molest me. I have bad dreams about it now and
then like it’s happening again oh really all the time actually (Research participant, PTSD symptomatic with a score of 2.70).

The male foster parent molested me. Yeah. Continually, yeah. Yeah. I wasn’t with them for long. You know it always amazes me the welfare mob bloody send people to people like that. I still think about it. I have bad dreams always, always have (Research participant, PTSD symptomatic with a score of 3.57).

Yeah well it’s the same, it’s like I’m dreaming you know and I have this thing when I can’t help out, having the same bad dream over and over a lot (Research participant, PTSD symptomatic with a score of 2.57).

Avoidance numbing symptoms
Being PTSD symptomatic was significantly related to feeling alone and staying away from people (avoidance) ($\chi^2 (1, n = 58) = 9.91, p < .01$) and can’t feel emotions (numbing) ($\chi^2 (1, n = 58) = 10.31, p < .001$). Some participants elaborated on these avoidance behaviours:

Yeah I like being alone yeah and try to stay away from people, yeah, a lot of that (Research participant, PTSD symptomatic with a score of 3.07).

I did understand, I see my mum and dad they had this argument, no not over me. What ever they had argument about. I had my own things to worry about. Yeah, I used to go out. As soon as the argument started I’d go fishing or something, go play with friends. I used to do that in those days. A couple of times, when growing up in my community, didn’t have much violence. I see a lot of violence but never from me. It never happened in front of me. You know, I used to choose my own way to get out from the trap but I stay away, stay away from everyone these days so I got trapped after all (Research participant, non-PTSD symptomatic with a score of 1.43).

Oh; a few years ago, just like drinking up town and that, and fight. Yeah sometimes because I was drunk but sometimes I just think it is; I don’t know I’m one of those blokes that don’t know how to express my feelings. I cant feel anything and all that, like show my feelings (Research participant, PTSD symptomatic with a score of 3.47).

I don’t feel emotion just numb I don’t feel anything, I am like that, yeah a lot (Research participant, PTSD symptomatic with a score of 3.07).
Those participants who endorsed trying not to think or feel about anything to do with the bad or hurtful things that have happened to you were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 14.26, p < .001$). A number of the participants described the avoidance of thoughts or ‘burying thoughts’ as a basic survival instinct, which was sometimes necessary to avoid a volatile response:

**Because then she’d turn around and she’ll make me bring up a lot of things. And I don’t want to bring up things, what’s already buried I don’t want to think about that stuff just bury it, if I don’t bury it then it’s hard to go on** (Research participant, PTSD symptomatic with a score of 2.57).

**Well I don’t like sharing my problems with the inmates. And I don’t like sharing their’s so I like to go and keep it to myself. Oh yeah I had an accident, I fought with my brother. I had a fight with my brother, I killed him, I had a big operation on my stomach because my side was really damaged and every time I take my shirt off I look at myself in the mirror I see this big scar on my stomach. So to keep going to survive you know what I’m saying, I don’t like looking at that scar so I try not to take my shirt off much** (Research participant, PTSD symptomatic with a score of 2.67).

**Because when I blocked it out and I don’t want to sort of go back there you know. They asked me if I wanted to talk about it and I said no. I don’t want to go back there because you know, not in the situation like here in prison you know because I’ll get angry. Then when I go back I might get (fingers flicking) I might upset the officers or what ever you know** (Research participant, PTSD symptomatic with a score of 2.57).

**See my mother told my brothers and sisters never drink with me, never bring the past up, and when they bring the past up I let them have it. When they give me the shits I’ll smash or something then, you know, they get me riled up too much, you know. They never ever, they’re not supposed to bring the past up when I drink. Because if they bring it up I’ll bash them. You know what you’ve done wrong, no matter if you’re old, senile or what. You know there’s reflections in your; there’s picture in your life that you always flicker up you know, you know always come up in your thoughts, your dreams or whatever of what you’ve done wrong or parts of your life. I don’t think anybody should say that’s not true, because I believe it’s true, I believe we all have that, you know. Yeah I think**
about it because there’s certain people who were in our life and grew up with us, and see my mother, she left me in the house with them. She took the 3 younger ones and left me in the house (Research participant, PTSD symptomatic with a score of 3.07).

Denial symptoms such as have you ever felt that the event didn’t happen to you or that you don’t feel bad about it were significantly related to being PTSD symptomatic ($\chi^2 (1, n = 58) = 6.51, p < .05$). None of the participants chose to discuss this symptom. Those participants who endorsed the symptom feeling that you have no one who will look after/out for you were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 13.93, p < .001$). One of the participants highlighted the intense pain he felt with this symptom, identifying it as the only hurtful thing he has to deal with:

I suppose the only hurtful thing is; I look back on my family now because I don’t sort of know them and I don’t get much support from them. To me they just feel like total strangers and I worry about that you see like there is no one to look out for me, you know like you said look after me make me feel wanted (Research participant, PTSD symptomatic with a score of 3.10).

Those participants who endorsed the symptom feeling as if you are split into two people and one of you is watching what the other is doing (dissociation) were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 6.28, p < .05$). A couple of the participants described their experience of dissociation and one reported finding peace in his ability to remove himself from the pain located in his body:

Ooh, that’s a good question isn’t it? Feeling like you’re split into two people yeah and one is watching the other. I haven’t really thought about that but sometimes, yeah like there’s a good and bad side of me and I don’t know which I’m looking at (Research participant, PTSD symptomatic with a score of 3.30).

Yeah it’s just that I carry so much pain in here (points at chest) that I just can’t breathe sometimes and I think sometimes I kind of go out of myself so you know I can see myself sitting there, it’s like it’s just too hard to be in my own body yeah and it feels peaceful to be removed yeah pretend it’s not me just for a while yeah peaceful (Research participant, PTSD symptomatic with a score of 3.10).

Both feeling worthless ($\chi^2 (1, n = 58) = 23.90, p < .001$) and feeling that people do not understand what has happened and that you are the only one who has suffered these
things ($\chi^2 (1, n = 58) = 10.98, p < .001$) were significantly related to being PTSD symptomatic. Qualitative information was only provided for feeling worthless. The following research participant’s feelings of worthlessness were so intense that he felt he would have been better off not being born at all:

You know what the worst thing that has happened to me it’s being born. I didn’t ask for this life, I was born into it. I don’t show it on the outside though, how can I say it, I’ve adapted in ways to not show my weaknesses. Ah; that’s like, I don’t know what I was put on this place for. But it’s not me. It is in a way but that’s; like spiritual and it’s like only they’re here to guide me to get where I’ve got to be. Like I haven’t; seen these scientists because they categorise it, I know their little ways and they … Yeah for me that was because I didn’t really understand my culture until I come up this way and I didn’t have one, yeah (Research participant, PTSD symptomatic with a score of 3.57).

Almost three quarters of the participants — 43 (74.1%) — reported they experienced problems making and keeping relationships (feeling unloved or unable to give love) and this was significantly related to being PTSD symptomatic ($\chi^2 (1, n = 58) = 12.44, p < .001$). Of the 31 participants who endorsed this symptom and who were also PTSD symptomatic, a number shared their stories about their inability to love and to give love, providing insight into the experiences of this symptom:

I grew up with my mother and my step father, my dad was never there. All I ever wanted was his love because every time, when I grew up with my life there at [town], when everything went bad in my life all I ever wished for was him. I just want my dad. And I grew up like that thinking I want my dad, and I know my son’s going to be going through the same bloody thing which is hurting me because I know he’s going to be saying where’s my dad but my dad he was never there so I never felt his love makes it real hard to give love to my son because of that (Research participant, PTSD symptomatic with a score of 2.57).

Well you know how you get a boil. For a long time, you know you just sit there and you watch it fester. And then one day you just get sick of it, you knock the head off and squeeze it out and it’s gone. See, but don’t get me wrong, it’s not all gone. I still feel for that piece of shit out there and he will meet his match. You know like, even the smell of going to the toilet now upsets me. Um. I can’t sleep in the same bed as my wife or any of the girlfriends or whatever. But emotionally that stays with you forever. But I would say in respect of the bearing
it has had on my life, like I've never been able to hold a relationship I suppose (Research participant, PTSD symptomatic with a score of 3.37).

I don’t know what to do with love, you know how to show it and I have never showed it to her. She is a good woman. Especially when she gets close so close trying to get close. And there’s a wall that I’ve built up. But I don’t know if I can do that, take the wall down because I don’t want to get hurt. I’ve been hurt too much times. I hurt real badly and it not going to happen again. I try to better myself. So that this is the end now. Say something and wonder what to say. I start realising that my behaviour; behaviours and why me. I’m not going to get by. I’m just going to keep on going around the same track (Research participant, PTSD symptomatic with a score of 3.57).

The symptom not caring about everyday things was significantly related to being PTSD symptomatic ($\chi^2 (1, n = 58) = 8.93, p < .01$), and was endorsed by 35 (60.3%) of the participants, 26 of whom were PTSD symptomatic. None of the participants elaborated on this symptom. A significant relationship was found between feeling as if you don’t have a good future or any future at all and being PTSD symptomatic ($\chi^2 (1, n = 58) = 4.85, p < .05$) and 24 of the 34 (58.6%) participants endorsing this symptom were PTSD symptomatic. The following participant highlights the hopelessness he felt about his future, which was so bad that he found it difficult just waking up every day:

The future well I don’t think I have much of one, I think about that yeah a lot. Sometimes I just get tired of waking up everyday. I was thinking the other night when I was little and with my dad up here, I always wanted to be like him. Well some might say that I am like him yeah. I used to say I’m going to be in jail with him and all that (Research participant, PTSD symptomatic with a score of 3.47).

Those participants who reported suicidal ideation were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 5.55, p < .05$) than those that did not report such thoughts. A number of the participants shared stories of suicidal ideation and one participant discussed the preventative effect of a sibling’s suicide:

And I said to him look mate I don’t want to fucking live anymore, I don’t care, fuck it. He [father] said what, you don’t want to live mate, you don’t want people to; he was just going on and on like that. And he’s just bashing me with his left hand while he’s driving the car and I just, just sort of arguing I said look I don’t want to live anymore and he said well here, fucking deal with it and he give me
the gun and he said you kill yourself, I didn’t do it, well obviously I am here today
but it was real close (Research participant, PTSD symptomatic with a score of
2.53).

I did it the third time. I just tried to OD myself, properly (Research participant,
PTSD symptomatic with a score of 2.60).

But one time my daughter was taken away from me and I was sitting at the back
[of the hotel] talking to my brother-in-laws and for no reason at all I got up and
the next minute I was in the hospital. All my brothers-in-laws found me hanging
in a tree. I tried to kill myself yeah, at that time, yeah and sometimes think about
it now (Research participant, non-PTSD symptomatic with a score of 2.07).

Yeah I think of suicide all the time, just this week seriously, I have, I have before.
I've really got to; I've been down the bottom I think a lot of times where you
know, I've thought fuck. Yeah I've had enough, I've had enough. You know I
don’t want to do this no more. I don’t want to play this game no more, Yep.
Yeah. Well then I'll pull myself up then I'll say weather the storm. Yep my kids
and what problems I'm going to leave behind if I do that. Yeah. I've had a lot of
people; I know a lot of people that have committed suicide (Research
participant, PTSD symptomatic with a score of 2.53).

Yeah I think of suicide that comes into my head every night but I try to block it
out (Research participant, PTSD symptomatic with a score of 3.47).

Well I can’t remember a day that I haven’t thought about suicide. You know just
to get out of this place. What stops me for doing it? (Laugh) Um; yeah like I did
just then, I laugh at myself sometimes. But sometimes it’s just; I can’t explain, it’s
just an easy way to get out of life when you’re in this sort of life. Um, you know
most of the time I do think about it, yeah (Research participant, PTSD
symptomatic with a score of 3.30).

In suicidal ways; being raped three times fucks with you. Hurt myself twice, I
jumped off a building, I took pills. Obviously it didn’t work someone found me.
You know the stuff that goes through your head before you do it just that I sick of
it that’s it. I’m sick of it. But I was happy, feeling happy to do it to get out. And
the second time it didn’t happen. That’s like I survived, like I’m here now. That’s
like bad thing, bad thing, bad thing and then I tried to get on the right track (Research participant, PTSD symptomatic with a score of 3.57).

Yeah I had to cut him down. With the hose, he’d hung himself with the hose. We couldn’t do nothing about it, he was just hanging there. He was on the bend with the roof, up the bottom of the house, underneath the house, it was very bent under the house and he was hanging there by the hose, and his knees were about five or six centimetres from the ground. So he had his knees crossed up, legs crossed up under him, so he could stop. He could actually stand up, so he just strangled himself. He didn’t even break his neck. I’ve actually gone and thought about suicide like, but the only thing that stops me is seeing … , that I can get out. And that stops me from actually going through with it because I know all the pain and all the horror that it causes the family. I’m married and everything, it’s just like wow and I couldn’t cry (Research participant, PTSD symptomatic with a score of 2.57).

The symptom taking drugs and/or alcohol all the time to help you forget the bad things that happened to you is relevant in both the arousal cluster and avoidance and numbing cluster, and participants endorsing this symptom were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 10.30, p < .001$). The following participants’ stories bring focus to the avoidance/numbing aspects of this particular symptom:

A few years ago, just like drinking up town and that, and fight and that. Drinking to feel. But sometimes I just think it is; I don’t know I’m one of those blokes that don’t know how to express my feelings and all that, like show my feelings. You could say I’ve seen a lot of it [violence], like uncles and dad and all that fighting. Yeah; not like ah; oh how can I say that. I’ve just been brought up around a lot of; drank alcohol and drugs and all that and I suppose violence come with it. Yeah freaking out, like once I stayed up for two weeks, never had no sleep for two weeks (Research participant, PTSD symptomatic with a score of 3.47).

And I had a counsellor but he wasn’t always there. So I just started drinking and using again. To try and take problems away and plus once you get back into that habit of using, you just don’t give a fuck about yourself. And you don’t care about other people either. And all I was worrying about was my habit, you know, and where I’m going to get money from (Research participant, PTSD symptomatic with a score of 2.60).
Coz family being drunks and all that. My mum, she passed away. When I was 18 she passed away. Yeah. After when she went I just lost control of my life. I wanted to go drinking and smoking a lot. I drank and smoked all the time cause it made me feel better, all the pain and that, it took it away, yeah. My missus ended up drinking because she was seeing me and I was drinking too much. Yeah. I was; because I was smoking a lot I was getting paranoid and all that (Research participant, PTSD symptomatic with a score of 3.23).

Sometimes it was over the top because my dad was a drinker and he’d actually just go too far. I smoked, I spent a lot on gunga when I was in [town], I grew up with it. I started at 11 years old smoking that stuff. I just got up and left the house and why I ended up leaving her completely is because when I left her and I went to my mate’s place and got drunk, got stoned, and I actually popped a couple of pills this time, I was just ooh, all over the joint, I just didn’t know where I was. Ok well I guess I’m not too clear on because I think, sometimes I do go into a state of mind where I just think oh I don’t really want to handle this at the moment. I just want to go into my shell and be alone. And I find being alone is great. Yeah. I actually got into a lot of trouble, a lot of fights when I’ve been drinking and it’s been very horrific. Like you said you do it to pull down the blinds, oh shit yeah, yeah definitely (Research participant, PTSD symptomatic with a score of 2.57).

Because before I tried not to think about it and of course everyday I was thinking about it. It was always with me you know and like the only time that I didn’t think about it was when I was drunk, that’s the only time I was happy then. Yeah I had to be drunk all the time (Research participant, PTSD symptomatic with a score of 2.57).

So that’s what I did. I sort of; I was on the heroin as well, on the sly sort of thing. Try and get rid of the pain sort of thing (Research participant, non-PTSD symptomatic with a score of 1.90).

Yes I take marijuana; all the time every day. I guess me and my brother do it because it relaxes us from what we’ve been through (Research participant, PTSD symptomatic with a score of 2.70).

Only when I was doped. That’s like, that’s my way of dealing with it. Because when I’m stoned I’m not there. Well see I’ve got big stereo head phones and
I've got a big stereo. And when I crank it up, it's just me in my room, you know. Yeah it just; for one day I'm not in the jail, I'm not in his power, I'm not in these mob's power, I forget about my abuse and that. Um, I used alcohol to block it out. You know I abused alcohol real bad and I even had the suicide attempts and all that (Research participant, PTSD symptomatic with a score of 3.37).

While not being able to remember some of the most hurtful or bad things that happened to you was the third most commonly endorsed symptom — endorsed by 49 (84.5%) participants —, it was not significantly related to being PTSD symptomatic and participants did not provide any additional comments about this particular symptom. Similarly, the fourth most common symptom, trying to keep away from things that remind you of the hurtful or bad things that happened to you, which was reported by 45 (77.6%) participants, was not significantly related to being PTSD symptomatic, and no participants elaborated on this symptom.

Arousal symptoms
Those participants who endorsed feeling angry all the time and taking it out on yourself or others were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 5.40$, $p < .05$). This symptom is similar to the symptom of becoming violent to self or others but, as participants highlight in the narratives below, it is more about the anger and the physiological violence that flows from that anger:

And then we moved, we were living together again for a while and then like I got too angry, I was just too angry again. She said you’re too angry again, you get so upset about something and you go off, I can’t deal with that, I can’t handle all this pain that you’re going through and I said I can’t handle this pain and then she would cop it nah but mainly through words (Research participant, PTSD symptomatic with a score of 2.57).

Well the last psychologist I spoke to, he came from outside and he thought I was angry with him but I wasn’t. I was angry with the problem and I kept on telling him that but he went and changed the statement around but yeah it cause I take it out on people when I am feeling that way (Research participant, PTSD symptomatic with a score of 4.00).

What gets me wild, contradictory people. Arrogant people. Just people that talk down to you in general and people not keeping their word. Other blokes in there always trying to stand over you take things. I’ve got six brothers, older brothers and, if I got up off my chair and went into the kitchen to grab a drink of water and
I come back, one of my brothers in my chair, hey that's my chair, get out. Nah, (click of fingers) into it. And like from there; when we used to do wrong, the old man used to give us a flogging, but, we knew what it was for. You know, like stealing cars and stuff like that. As a juvenile I stole a few cars. And you know, he'd give us a flogging but it wasn't out of the ordinary. Like all my brothers went through the same thing, nephew and nieces and all that. But emotionally that stays with you forever. You know, the physical side of it, you heal in a couple of days but the emotional side I reckon that's what triggers me to do some of the violent things I'm in here for (Research participant, PTSD symptomatic with a score of 3.37).

That's just how I am a couple of times it was just to let anger out so I didn't hurt anyone else. I'd take it out on myself. That's what I would do for my girl friend at the time, or brothers, sisters, things like that. And all I can remember is seeing my stepbrother flogging my stepfather. It was a piece of steel, it was big, it was probably a metre high by an ice cream container round. And it was a hollow tube. It had all my stepfathers' maps and stuff like that, of gold mines or whatever. Um, and all I can remember is the last of it was my brother actually flogging my stepfather while my stepfather was knocked out. And I got charged with an assault on one of the officers. Um, in the end it was dropped because I'm not too sure whether it was the drugs, coming off the drugs or whether it was just me. I was normal, I went and had a blood test done and the next minute I just snapped, I went off, started throwing chairs around, I was smacking one of the screws in the mouth. I'm not too sure but (Research participant, PTSD symptomatic with a score of 3.30).

Well; I don't know what makes me do the violence stuff. I learnt a lot of things back, I've seen and I can't find a way like to express myself, yeah, like get rid of anger, you know talk about things and that. But yeah; then some little thing like my ex or my cousins or something will say to me and then I'll just go off or something. But some of it was drug related too. I was just getting violent sometimes because I never had no money for drugs and all of that. Oh they were like fighting but it wasn't; it was drunk fighting not really (Research participant, PTSD symptomatic with a score of 3.47).

Those participants who endorsed the symptom feeling nervous were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 5.72, p < .05$). A similar symptom, feeling on guard and keeping a look out for trouble (hyper-vigilance), also showed a
significant relationship with being PTSD symptomatic ($\chi^2 (1, n = 58) = 6.88, p < .01$).

Not surprisingly, a number of the participants highlighted that being in prison equated to constantly feeling nervous and demanded hyper-vigilance. Some of the participants also described these symptoms as a result of their upbringing or previous traumatic experiences and stated that this was ‘how they had been all their lives’:

I have to keep on guard and keep a look out for trouble yeah of course that’s how you live in prison but I am like that on the outside too (Research participant, PTSD symptomatic with a score of 2.70).

It’s all out there, out in the open. And like I said I’m a bit too forward sometimes and people don’t like it, and that’s when they start looking for fights, you know. And that’s why I say you’ve got to keep on your guard in here. That always plays on my mind. Every time I go to my room at night time. Every time it gets dark, every time I hear a noise, bang, I’m awake. I’ve sat there with loaded shotguns under my chin. And all because of this fucking thing; oh sorry, excuse the language. And like for the years that I’ve suffered and then the abuse that I put my victims through. Yeah after doing five and a half years, I got out, released in 99 and I didn’t go to my family because I know I wouldn’t have last long. But my first night out I was real nervous I heard a truck going in the distance and I’d just wake up automatically and I’ll be sitting up all night scared shitless. I thought I would settle down you know sometime but it still feels that way all the time (Research participant, PTSD symptomatic with a score of 3.37).

Yeah definitely got to keep a look out for trouble and stuff and on guard a lot especially in here, especially for me, for a bloke who’s doing a long time, you know we’ve got to look out for these things (Research participant, PTSD symptomatic with a score of 3.10).

I want to be in the cell by myself because I know it’s safe for me. There’s this other bloke, he’s in there but he’s from up North too, he an Aboriginal bloke. Still I don’t trust him, that’s why I keep watch (Research participant, PTSD symptomatic with a score of 4.00).

And my abuse. I couldn’t stop thinking about it and that led me my drinking and then with what happened in here that sort of made it worse. I couldn’t sleep if I was sober because I was scared, or if I did sleep it would be during the day. During the night, when everyone’s asleep. Like because during the day
everyone was awake, I knew like my family or whoever, they were watching me and like at night when no one’s awake, they’re all asleep I’d have to stay awake because I was scared. Not scared, I guess just because of this you know. Because I didn’t know that anyone could; I’ve only heard and seen something like this happen to someone but when it happened to me, that someone actually hit me and got violent with me with something that sort of shook me up a bit (Research participant, PTSD symptomatic with a score of 2.57).

You know you go up the road, to go to the shop and then all of a sudden you get this sort of weird feeling and look, people looking at you. You know you say what have I done wrong now you know so you got to keep a look out yeah and feel on guard you just don’t trust anyone is my motto (Research participant, PTSD symptomatic with a score of 3.30).

Sometimes I picture myself walking down the street and people seeing me. Oh there’s [respondent’s name] now, that so and so, done this and that. And they’re talking like this. Yeah that’s what worries me so yeah I keep on guard all the time (Research participant, PTSD symptomatic with a score of 3.23).

Being on guard well that’s the way I’ve been all my life, you have to be when you are grown up like I was with all the violence around (Research participant, PTSD symptomatic with a score of 2.93).

Those participants who endorsed the symptom can’t think straight were significantly more likely to be PTSD symptomatic ($\chi^2 (1, n = 58) = 5.36, p < .001$). However, no additional comments were provided by the participants for this symptom.

Participants who were PTSD symptomatic were significantly more likely to endorse the symptom feeling as if you were going crazy than those who were not PTSD symptomatic ($\chi^2 (1, n = 58) = 14.08, p < .001$). One of the participants shared his perspective on feeling crazy, believing that he was fulfilling his grandmother’s prophecy:

Going crazy I am crazy I feel like that all the time. Yeah because my grandma told my mum, she had a dream and I wasn’t born, I was inside my mother’s tummy. My grandmother told my mum its different, you’re going to have a little boy and he’s going to be mad. She said to my mum she had a dream about this. Mum didn’t believe. But she believes now. I didn’t know at that time. Oh when I get angry, I just get angry, I can’t control myself. Mm and I just got scars, that
was from my mum the other day. I started to kick into my sister there. I don’t know what, she just got crazy and I hit my sister for no reason. I was cheeky too; I hit my sisters and a friend in the bush. My mum was waiting for me. As soon as I came back, I opened the door she threw a pot, I don’t know. Just fights. I thought it was fun. Yeah I enjoy fighting it’s the only thing I am good at (Research participant, PTSD symptomatic with a score of 3.53).

The symptom taking drugs and/or alcohol all the time to help you forget the bad things that happened to you was significantly related to being PTSD symptomatic ($\chi^2 (1, n = 58) = 10.30, p < .001$). This symptom belongs in the arousal cluster as well as the avoidance/numbing cluster because it was reported to be a mechanism to elevate feelings of power, as described by the participants below:

Nah every time I drink and that, like I get real angry at people, you know what I mean I get violent. Yeah and the same as on them, on their pills, when I pop tablets and that, like it just makes me want to attack people, you know what I mean. Like you know what I mean; I just think, you know what I mean; oh they’re talking about me, things like that and when I’m drinking I feel stronger you know what I mean like I can take on anyone (Research participant, non-PTSD symptomatic with a score of 1.77).

Yeah I thought that [drugs and alcohol] was helping me a lot but it didn’t. It turned out now it didn’t, it just made you worse. Nah and I thought all the time I was on it [drugs and alcohol], I just thought it going to fucking relieve the stress you know calm me down but it didn’t it made me more angry and real violent real fucking violent I wanted to bash everyone and the thing is when you are like that you’re invincible so yeah it feels good at the time (Research participant, PTSD symptomatic with a score of 3.30).

Not surprisingly in a study population that has been imprisoned for violent crimes, a majority — 51 (87.9%) — of research participants endorsed becoming violent to self or others. Thirty of these participants were PTSD symptomatic. However, there was no significant relationship between this symptom and being PTSD symptomatic, possibly because of its high prevalence across the study population. A number of the participants described this symptom as a symptom of, and release from, their traumatic experiences:
Well actually I was doing alright when I was in [city] and then the only reason why I got back here was because my mother sent for me, because I’m the one in the family that does the punching. If anything goes wrong, you send for me and I’ll come down and I’ll sort you out, that’s what I do. My elder brother, he talks. I don’t talk, if you don’t listen to what I say I’ll punch you, you know. I’ve got to ask her [mother] about all the things she doesn’t answer for but only when I’m stoned, drug or sober. I’ve got to ask about all the things that have happened to me but she doesn’t answer it. I got flogged severely, as I said, and the only thing my mother ever hit me with was an iron bar. I mean as I said to these fellas there; they say, they might meet paedophiles, or you know and they’ll want me to do something to them or something like that. I said well I really don’t care about them but if they hurt my kid I’ll come down there and I’ll put a knife through their throat. You know I’ve always thought; I always have this dream, I have this dream of I’d like to see someone die but I’d like to shoot him and wait till all the blood come out and put my finger in there and fiddle around and see. I’d think cut someone’s throat and see all the blood come out and put my finger in there and feel what it’s like. I’d like to see someone hang themselves. And be there to pull him off the rope to see what he looks like. You know what I mean, they’re silly things but I’ve always been fascinated. I want to see what someone’s like dead, I’d like to shoot someone (Research participant, PTSD symptomatic with a score of 3.07).

Something bad happens and I put it inside me and I push it down, then something else bad happens and I put it inside me and I push it down, then all of a sudden I’ve got so much pushed down that it just explodes. And that’s what trauma is, bad experiences and you keep putting it inside you and you’re pushing it down, pushing it down and there’s no really good programs that help you sort of take it out, take it out, so you’re free of it all. Well I used to use violence to get rid of it. Trauma is to me, something that never leaves you. It’s inside, it’s internal and it won’t, it will never leave (Research participant, non-PTSD symptomatic with a score of 2.37; however was PTSD symptomatic, 2.6, according to DSM-III-R score).

I use violence as an alcohol. What makes me spark off, what clicks and makes me do it is adrenaline. As soon as I’m in a thing where I read somebody’s body, the body language. I attack on body language. You know stand like a soldier style and demand. And I’m there willing to bring them down as quick as possible. The body language is the thing that makes me attack. Yeah, before they even
The second highest endorsed symptom, which was endorsed by 50 (86.2%) participants, was feeling someone you trusted did something to betray you, with 31 of those endorsing it being PTSD symptomatic. However, there was no significant relationship between the symptom and being PTSD symptomatic and none of the participants elaborated on this symptom.

The symptom trouble sleeping was endorsed by 41 (70.7%) of the participants, 26 of whom were PTSD symptomatic. Again, no significant relationship was detected between this symptom and PTSD status. A couple of participants highlighted their previous abuse as a primary obstacle to restful sleep and indicated that they use alcohol to induce sleep:

That's why I can't sleep well. That's why when I lay back it comes back in my head all the time (Research participant, PTSD symptomatic with a score of 4.00).

I have trouble sleeping on the outside. Because after this here I wouldn't sleep and even for my injuries, my abusive wife, the only time I could really sleep was if I was drunk. So I got drunk all the time, yeah like a big cycle, yeah I had to be drunk all the time to sleep (Research participant, PTSD symptomatic with a score of 2.57).

**Generational trauma and dysfunction**

To establish if there was any change in the number of traumatic stressors and dysfunctional behaviours in the participants’ current and older generational family trees, participants were asked about the number of people in their own (1st) generation and the number of traumatic stressors experienced and dysfunctional behaviours displayed by specific family members in that generation. The same process was repeated with the 2nd and 3rd generation family members. Participants had limited knowledge of 3rd generational family members, so the 2nd and 3rd generational data were combined. Therefore, the term ‘current generation’ refers to the participant’s own (1st) generation, and the term ‘older generations’ to the (2nd and 3rd) generations of their parents and grandparents.
To establish if there was a significant difference in the rate of traumatic stressors and dysfunctional behaviours between the current and older generations, a within-subjects design using a repeated measures t-test (also referred to as the dependent-samples or paired t-test) was utilised, with an alpha of .05.

A geno-histogram score was calculated for the current and older generations in order to determine changes in the rate of traumatic stressors and dysfunctional behaviours between generations for a particular participant. The individual participant’s geno-histogram score consisted of the summation of all the generational trauma and dysfunction for each family member in the current generation, divided by the number of family members in that generation. The same process was repeated for the older generations. Of the PTSD symptomatic participants, 32 (94.1%) showed an increase in the rate of traumatic stressors and dysfunctional behaviours from the older to the current generation. Only two (5.9%) showed a decrease. Of the non-PTSD symptomatic participants, 21 (87.5%) showed an increase in the rate of traumatic stressors and dysfunctional behaviours from the older to the current generation, and three (12.5%) showed a decrease.

The mean rate and standard deviation of traumatic stressors and dysfunctional behaviours for the current generation were .18 and .09 respectively, while for the older generation, they were .09 and .06. The mean rate of traumatic stressors and dysfunctional behaviours for each participant was significantly higher in the current generation than the older generation ((M = 0.09, SD = 0.09), t (57) = 7.72, p < .01). The higher levels of traumatic stressors and dysfunctional behaviours in the current generation lend support for increased generational trauma and dysfunction in this sample.

A rate was calculated to establish which specific trauma and dysfunctional behaviours had changed from one generation to the next. This rate was calculated for each participant in the respective generation, for each trauma and dysfunctional behaviour. In other words, the number of each of the specific traumatic stressors and dysfunctional behaviours was divided by the number of current generation relatives, with the same being done for the older generations. A paired t-test was performed on the two rates for each participant.

Table 22 shows that there were significant differences in the mean rates of all traumatic stressors and dysfunctional behaviours between the current and older generations, with the exception of deceased by unnatural causes and stolen generation.
<table>
<thead>
<tr>
<th>Geno-histogram traumatic stressors and dysfunctional behaviours</th>
<th>Current generation</th>
<th>Older generations</th>
<th>Paired difference between current and older generations</th>
<th>t (df = 57)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deceased by natural causes</td>
<td>0.02</td>
<td>0.06</td>
<td>0.22</td>
<td>0.14</td>
<td>-0.19</td>
</tr>
<tr>
<td>Deceased by unnatural causes</td>
<td>0.05</td>
<td>0.08</td>
<td>0.05</td>
<td>0.05</td>
<td>-0.00</td>
</tr>
<tr>
<td>Deceased by unknown causes</td>
<td>0.00</td>
<td>0.00</td>
<td>0.08</td>
<td>0.13</td>
<td>-0.08</td>
</tr>
<tr>
<td>Have been incarcerated</td>
<td>0.27</td>
<td>0.18</td>
<td>0.07</td>
<td>0.11</td>
<td>0.20</td>
</tr>
<tr>
<td>Currently incarcerated</td>
<td>0.17</td>
<td>0.10</td>
<td>0.01</td>
<td>0.02</td>
<td>0.16</td>
</tr>
<tr>
<td>Stolen generation*</td>
<td>0.11</td>
<td>0.20</td>
<td>0.07</td>
<td>0.14</td>
<td>0.04</td>
</tr>
<tr>
<td>Perpetrator sexual assault/rape</td>
<td>0.05</td>
<td>0.08</td>
<td>0.02</td>
<td>0.04</td>
<td>0.02</td>
</tr>
<tr>
<td>Victim sexual assault/rape</td>
<td>0.09</td>
<td>0.15</td>
<td>0.03</td>
<td>0.08</td>
<td>0.06</td>
</tr>
<tr>
<td>Perpetrator physical violence</td>
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<td>0.20</td>
<td>0.12</td>
<td>0.18</td>
<td>0.14</td>
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<tr>
<td>Victim physical violence</td>
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<td>0.27</td>
<td>0.13</td>
<td>0.19</td>
<td>0.24</td>
</tr>
<tr>
<td>Suicide</td>
<td>0.13</td>
<td>0.13</td>
<td>0.01</td>
<td>0.02</td>
<td>0.12</td>
</tr>
<tr>
<td>Alcohol misuse</td>
<td>0.31</td>
<td>0.24</td>
<td>0.20</td>
<td>0.21</td>
<td>0.10</td>
</tr>
<tr>
<td>Drug misuse</td>
<td>0.29</td>
<td>0.25</td>
<td>0.10</td>
<td>0.18</td>
<td>0.19</td>
</tr>
</tbody>
</table>

*Stolen generation includes all child removals under the previous ‘stolen generation’ policies and current child welfare removal policies.

There was a significant decrease in the mean rate of deceased by natural causes from the older generations to the current generation (\(M = -0.19, SD = 0.15\), \(t = (57) = -10.01, p < .001\)). There was also a significant decrease in deceased by unknown causes from the older generations to the current generation, due to the limited knowledge of the causes of death in the older generations (\(M = 0.08, SD = 0.13\), \(t = (57) = -0.049, p < .001\)).

However, these events were the only ones to decrease across the generations. Table 22 indicates that the mean rate of all other traumatic stressors and dysfunctional behaviours increased significantly from the older generations to the current generation. In other words, the mean rates of family members who have been or are incarcerated, are a perpetrator or victim of sexual assault/rape and physical violence, have committed suicide, and misused drugs and alcohol are significantly higher in the current generation than in the older generations.

Incarceration could be described as both a traumatic stressor and the outcome of dysfunctional behaviours resulting from previous traumatic experiences. There are significantly more family members in the current generation who have been incarcerated (\(M = 0.20, SD = 0.19\), \(t = (57) = 8.03, p < .001\)), or who are currently incarcerated (\(M = 0.16, SD = 0.10\), \(t = (57) = 12.40, p < .001\)), compared to the older generations. The following participant highlights the generational component of incarceration:
I mean places like this can control your feelings. I mean you've been in prison and that, and here there's no help, I know that, there's no help at all because I've been in prison. I've got my ex who's going to prison tomorrow, she's taking my son with her and he's only eight months old. Yeah until he's one she can take him in and then I've got to go and collect him. So it's going to be then. Well I hope to be out on Friday. But there, he still stays there until he turns one because he's on the breast at the moment. And then I've got my 14 year old daughter, she's going to court next week. So she may end up in prison too and she's been giving me a hard time since I've been in here. Bloody whole family will be in prison soon looks like we are taking after my dad and grandfather after all (laughs) (Research participant, non-PTSD symptomatic with a score of 2.07).

The mean rates of family members identified as either perpetrators of sexual assault/rape ($M = 0.02$, $SD = 0.08$), $t = (57) = 2.21$, $p < .05$) and/or victims of sexual assault/rape ($M = 0.06$, $SD = 0.16$), $t = (57) = 3.02$, $p < .01$) were significantly higher in the current generation than in the older generations. That is, there are significantly more family members in the current generation who have either been a perpetrator and/or a victim of sexual assault or rape than in the previous generations. The following participant reported more prevalent sexual abuse in the current generation and provided insight into his experience as both a victim and perpetrator of sexual abuse:

And I obviously got told about all the sexual abuse in my family as well and there was lots of it but not so much with my grandparents and stuff but my parents and lots of my brothers and sisters here you see (pointing at geno-histogram). So I grew up really fast and left home at 15. Because there's a lot of things in my life that are sort of sexual in nature because I was abused when I was experimenting as a child with sexuality. The worst thing is when I started doing it to somebody else, when I did it to my little cousin and that was the worst thing. And due to the fact that that happened, my family; it's happened then my family have divided. So maybe through all their anger and all that from their own stuff on to me (Research participant, PTSD symptomatic with a score of 2.57).

The mean rate of family members identified as either perpetrators of physical violence ($M = 0.14$, $SD = 0.22$), $t = (57) = 5.06$, $p < .001$) and/or victims of physical violence ($M = 0.24$, $SD = 0.27$), $t = (57) = 6.84$, $p < .01$) was significantly higher in the current generation than in the older generations. That is, there are significantly more family members in the current generation who have been a perpetrator and/or a victim of
physical violence than in the older generations. A number of participants elaborated on generational violence and one suggested that ‘if you grow up with it you become it’:

Yeah I was told I'm on a report. A psychiatrist determined that I am never to be released, stay in prison for ever was their determination because of violence. But they never did any kind of research or homework to find out the real cause. A lot of it was violence inflicted through family feuding which they didn’t look at you see if you grow up with it you become it (Research participant, non-PTSD symptomatic with a score of 2.37).

I believe my violence stemmed from upbringing. I came through in the 60s, in the depression where kids where taken away, the assimilation policy of welfare that failed and its disruption to the whole network of family units was destroyed, and all the families turned to alcohol and violence (Research participant, non-PTSD symptomatic with a score of 2.20).

I stayed with my sister in [city] and that’s when I learnt about the cycle of domestic violence, with her my sister because her boyfriend was bashing her. You see my father use to bash us he was bashing me and then I ended up not living there anymore. But also my father bashed my mother, so there’s a big cycle there (Research participant, PTSD symptomatic with a score of 2.57).

Yeah, yeah. I've got a bit of a fucking temper but that's about it. What riles me up, oh it depends; if I’m on drugs or alcohol, you know it don’t take much then. Yeah well mum, mum was the main actor in the house, she used to flog dad all the time, kick the cunt out of him. Yeah. Chasing around with knives and shit. Oh it’s not really normal but mum’s dad use to carry on like that but it just spun me out a bit I suppose. I got used to it after a while and now I am a bit like that myself, maybe my parents gift to me [laughs] (Research participant, non-PTSD symptomatic with a score of 1.73).

I would have been about nine when my father left and my mother had a defacto relationship. And he would just, he’d be alright but as soon as he had a drink or something he’d just start swinging for no reason. I just can’t understand the man. And you know my mother would like he’d go off at me and my mother would usually get in the way and that, and I’m only nine years old and you know I don’t know what's going on. Yeah I went through about ten years of that, till I turned 19, 18 and then I just didn’t take it no more. I went and got myself a gun
and I put it to his head, and I said you just leave now or else I'll be forced to do something I don't want to do. I did it though that's what I'm in here for but my kids saw that so I suppose they will be messed up now, but you know I just couldn't take it anymore (Research participant, non-PTSD symptomatic with a score of 1.90).

I'm violent probably cause seeing a lot of it when I was a kid, when I was growing up so I suppose my kids will be the same watching me and all (Research participant, PTSD symptomatic with a score of 3.30).

Yeah the only stuff that sticks in my head is when I look at memories of dad, my father bashing my mum and all that. They're the only things, yeah the things that make me do the stuff I do now (Research participant, non-PTSD symptomatic with a score of 2.10).

I hit him with a brick. Well we was on both, we were on both sides of the family, it was one mob. And I know something went wrong and I started getting angry. Yeah always fighting. I see a fight every, every single payday, every Friday you know. Like nearly killed her. Yeah always fighting that's all I saw so I am still fighting today (Research participant, non-PTSD symptomatic with a score of 2.47).

Violence, yeah if I spoke to you from when I started to where I finished we'd be here a month. I've used more violence and seen more and experienced past you just wouldn't be able to add it all up. Well in a family of 100 or more, and being one that was youngest, I was leading people who should have been leading me. I was leading my uncles and aunties so that's how much their reliance was on me in violence. Where other family members used verbal and drink to use as a conflict, I used machetes, axes, irons, things all hand held and I hit people, their skulls and arms and everything you know. I became so bad with violence I started to initial my name on them. We'd be down the river somewhere, we'd hear the [commotion] and we'd run back and that's being three or four years old, that's where it all started. We were witnesses to 20 odd fights a day. And see I used to; violence was a norm to me and in the end I used; what stopped me from using violence ever again was when nephews and nieces wrote letters to me, while I've been in jail saying they wanted to be like me when they grew up (Research participant, non-PTSD symptomatic with a score of 2.37).
Ah it’s probably; it’s probably one of the hardest questions you’ll probably ask me. I can’t really say; you can’t really say what violence is because it can just; with me violence happens out of the blue most of the time. But that's me, I talk to myself. You know it’s hard for me to say because I don’t know what’s wrong with me. I know there’s something wrong with me but I don’t know. My violence, most of my violence has been through things that have happened to my family. You know the way I react from a couple of years ago. You know something happened to my sister and a couple of years later I’ll wait. Then I’ll see someone and then I’ll sort it out. Yeah. Anything to do with my family. Yeah, Um; heaps of things, I’ve been shot at, I’ve been bashed with numerous of things (Research participant, PTSD symptomatic with a score of 3.30).

Dad use to fight us, dad use to hit, still does. Stabbed me in the leg once. But everything I’ve copped, I must have deserved it. Because he’s my father. They brought ya into the world and they can take you out of the world that’s what I teach my kids (Research participant, PTSD symptomatic with a score of 2.70).

My father, he used to bash my mother. Yeah big time floggings. Yeah. I was in the room crying. And I was scared too. I don’t know what to do, shut the door. All the time when I was being grown up. Yeah. And every time I heard my mother cry, like I’d cry for my mum too sometimes. Go back home and then when my father come back drunk and would start arguing again. Yeah. And I’d hold my mum but my dad grabbed me and just threw me, threw me in the room, yeah. Kept on arguing, fighting. Really scared when I was being grown and still really scared but I have become the thing to be scared of (Research participant, non-PTSD symptomatic with a score of 2.40).

Violence yeah, well sometimes it can be like, maybe you want to show off. Other times it could be stuff that’s been on your mind and that, and all it takes is just one small trigger of some sort to send you over the edge. (Sigh) well um, ever since I could walk probably, um, I copped a hiding you know like a weekly thing. Um it turned into almost a daily thing for about 11 years or so. Um, it was all directed at me for things that I did wrong or for things that I didn’t do, or for things that I said, all that sort of stuff. Whenever my father raised his voice I would cower at the thought of being bashed which normally would come next. Big floggings, yeah; my father he isn’t a small man and he’s like really, really big in stature as well. Um I don’t know, I guess being a small person and having somebody stand over you is kind of frightening. Yeah. So he [father] just
carried me from there and punched it out of me from there, through the lounge room, through the kitchen, slung me up against the wall in the shower room, cracked my ribs, ended up breaking them and flogged me that much that when I woke up, I woke up covered in my own shit. That’s how bad he flogged me that day you know. Apart from that day, all the rest of them just seemed like you know not much. My aunties tell me that my father had a pretty hard time growing up too so maybe that’s where he gets it from which makes sense because that’s where I definitely get it from (Research participant, PTSD symptomatic with a score of 3.00).

What makes me real violent; well I had a background when I was younger. I used to see my mum get bashed up by my old man (Research participant, non-PTSD symptomatic with a score of 2.17).

Well I’m a black sheep. I don’t talk to no one. I don’t mix with my family. So yeah. Say like in here because they go why do you go to jail all the time, and it’s because of them assholes [family]. Because that’s why I started thieving and all of that, mainly because of them, especially the old girl. Seeing her get bashed all the time, that’s why I started thieving and move her from town to town, away from [my] father (Research participant, PTSD symptomatic with a score of 2.57).

Oh it’s just violence and that with my mother and like. I just picked it up and that from my mother. You know every time. Yeah I just got used to it and that; yeah I just picked it up and all that (Research participant, non-PTSD symptomatic with a score of 2.10).

Yeah he [father] he hurt me pretty bad when I was young and I blame him for where I am now. But the thing I hate about it is he’s [interviewee’s father] so quiet, he won’t talk about it. He won’t talk about things or say sorry, or I’ve done this because of that. You know he won’t explain himself or anything, it’s just like he tries to pretend nothing has happened. I don’t know. Apparently he used to get treated like shit too. With all the whip and all that sort of stuff (Research participant, PTSD symptomatic with a score of 2.53).

The mean rate of family members identified as having committed suicide ($M = 0.12, \ SD = 0.13$), $t = (57) = 7.00, p < .001$ was significantly higher in the current generation than in the older generations. That is, there are significantly more family members in the current generation who have committed suicide, compared to the older generations. A
couple of the participants talked about their experiences of family suicide and their own self harm:

My uncle hung himself, saw that, because he was away from his little kids, that's all. Just that mother wouldn't let him look after that first daughter. There has been a lot of hangings, yeah. Lots in my family and community. My grandfather hung himself when he was in lock up. It's the thoughts in your head, that's why my uncle did it just for his thoughts to stop them. I have those thoughts too a lot and think if I did it would stop the thoughts and I could rest and I know a lot of brothers feel the same (Research participant, PTSD symptomatic with a score of 3.53).

Yeah and see my brother, he hung himself in [prison name] well this year too. But you see my dad did too. That was pretty hard you know, for me. Because I was in prison as well you know. And I was just not long talking with him on the phone and that there was a big rush you know. It took a bit of time to get over that you know and I tried to hang myself to get away from the thoughts (Research participant, non-PTSD symptomatic with a score of 2.07).

The mean rate of family members identified as misusing either alcohol ((M = 0.10, SD = 0.28), t = (57) = 2.80, p < .01) and/or other drugs ((M = 0.19, SD = 0.29), t = (57) = 4.95, p < .001) was significantly higher in the current generation than in the older generations. That is, there were significantly more family members in the current generation who appeared to have misused drugs and/or alcohol, compared to the older generations. The following participants discuss substance use across the generations:

Plenty of alcohol makes you violent, and we were put in a boy’s kind of home, a Salvation Army home. Mum was a bit of an alcoholic, my father was an alcoholic, abusive and stuffing up before I was even born. So apparently when she was pregnant with me. Yeah a lot, apparently when I was a baby too. You know like take us kids and take us out in the bush and dump us there. My mother would be wondering where we was and stuff like that; you know just to get at my mother. Oh yeah, I can remember getting hammers chuck at me and stuff like that, rocks. My brother getting knocked out cold for something that I did because he couldn’t catch me. So I ran off. Yeah that’s why my brothers are all alcoholics you know. He nearly died from alcoholism but he ended up turning his life around when he was about 36. I don’t know mid 30’s. Well when my brother died, my oldest brother stopped drinking. I can’t say for all of them
but a lot of the ones I knew there was alcoholism and diabetes. The three aunties that I know anyway died from diabetes and alcoholism, you know drink and if I wasn’t in here I would be the same. But you know it’s the drugs and stuff that are worse these days, the old fellas didn’t get into that stuff just the alcohol (Research participant, PTSD symptomatic with a score of 2.53).

But in a way, like I didn’t really care. Like I didn’t like my mum. It was just things about her. Like she used to hit my brother, hit me a lot and like I didn’t do nothing wrong. And then my mum used to come and attack me because she was you know, drinking and that. So drink plays on her mind a bit, so she used to come around and give me and my brother a bit of a flogging and now we both drink because she fucked us up so bad (Research participant, non-PTSD symptomatic with a score of 2.07).

It is important to note that although there was not a significant increase in the mean rate of family members identified as stolen generation in the current generation, there was nevertheless an increase from the older generations ((\(M = 0.04, SD = 0.23\), \(t = (57) = 1.45, p < .151\)). A number of participants brought focus to the institutional control and effects of child removal across the generations:

See a lot of them died by abusing the alcohol, thinking that would wipe the memories of their being stolen, being taken away but all it did was get their kids taken away cause they were too drunk to look after them yeah there is a cycle there for sure (Research participant, non-PTSD symptomatic with a score of 2.37).

Here I think you’ll find in the Aboriginal community that’s what happens to a lot of black people, grandmothers, grandparents and sometimes people think that the mums and dads are not responsible. But its not that it’s the grandparents, they want to take them. There’s a lot, it’s very common and people don’t understand that (Research participant, PTSD symptomatic with a score of 2.57).

See the great grandfather is from here (points at geno-histogram). Then my grandfather, from his son married a woman from [town name], they had 13 children. Those 13 children were all institutionalised, are you with me? My mother was institutionalised from [town name] and they met while in the institution, in the bungalow here. Fucking with my family like that you know putting them all away from each other, that’s violence, that’s the sort of violence
that going to fuck anyone up. Can I just say something before we go? This institution, being institutionalised it sort of hardens, do you know what I mean. It’s very hard to explain. You harden; we had a death in here, so a lot of people were upset. To me I find life and death go hand in hand. Do you know what I mean? If I’m dying I would tell my kids don’t dribble on, enjoy your life because this is part of life. But that’s a fact about this institutionalisation is growing up with no love so you can’t give it to other people because you don’t know what it is and how, to you know express it (Research participant, PTSD symptomatic with a score of 3.17).

Positive ways forward from the perspective of the research participants

Some of the research participants identified various techniques and strategies they felt would be beneficial in terms of dealing with the pain resulting from traumatic experiences. They identified the power of narrative, which gives people the opportunity to talk and make sense of their own stories, grounding the self through reconnection with culture. They also embraced art and music as forms of expression and as tools to release and make sense of their stories. Incorporating strategies that remove alcohol as the primary social tool or recreational activity, increasing employment opportunities, and honouring tribal laws, as part of an overall solution combined with mainstream laws, were also identified by some of the participants as necessary processes to gain some control in individuals, families, communities and Aboriginal peoples’ lives in general. Some of the research participants also discussed children and the cycle of trauma, believing that the process of generational trauma and dysfunctional behaviours impacts on successive generations and that it is up to this generation to break the cycle.

The power of narrative

For many of the participants, a major tool in the healing process was having permission to talk and, more importantly, having someone that truly listens to their stories and empathises as they disclose their pain. Some of the men felt that they had never had the opportunity to unpack themselves, to peel back the layers through story, through narrative, in a process of legitimising their experiences; not to justify their own abusive behaviours, but to find meaning behind why they have ended up feeling angry, being violent and committing crimes. Those participants who had been given the opportunity to talk without judgement found it to be profoundly healing. The power of narrative is described by the following participants:

I mean I never got up to talk at AA, but I did one time. And that’s when I got out on bail last year. I was talking about what I did to my family and how I hurt them
and that and then I said, after all the things what I said. I said I wish they were here now so I could tell them how much I love them and how sorry I am. And um; I ended up crying after it, you know. And what made me feel good was when it was finished everyone just come up and patted me on the back and made me feel better, and I said yeah, I needed that I needed to be heard (Research participant, PTSD symptomatic with a score of 2.60).

See like I've went through that experience with my brother hanging himself. Within myself, you know. I cried and I cried, and I cried, you know and that thought was there you know. You've just got to get to somebody who you really know, close, to keep you going through you know you need someone to talk to who will really listen but there is no one in here that's like that but you really need that (Research participant, non-PTSD symptomatic with a score of 2.07).

And I was in speaking to one of the education people, trying to arrange better programs and things like that. Well it would be just someone to talk to and that, because none of the programs here like do nothing like that. Well like these fellas that can't read and write, that's good for them if they do that, talk hey that would be better for them. And like we'll have to get into drug and alcohol talk too. But most of them don't want to do anger management or nothing like that they just need to talk (Research participant, PTSD symptomatic with a score of 2.57).

But I try not to think about what's happened to me [sexual abuse], but I think about my little sister you know. Men [sexual abuse] happened to her. I've spoke to people before about it. This is why I can talk about it now. I spoke to a psych while I was in prison in [state] because I couldn't, it was eating me up. It [sexual abuse] happened to me too. I was 11 and I don't know, probably when I was younger too, I don't know. How do you think it made me feel, it made me feel sick mate, scared, shaken. But I think bringing it out to mum and dad, and just talking about it, and just talking it with my sister has made it heal a bit you know (Research participant, PTSD symptomatic with a score of 2.70).

Well you know that's the problem you know no one is listening, no one wants to listen, I mean you are listening to me now but nobody has asked me like this before (crying) ask me and then really listened. It helps, do you know what I mean? Yeah it helps to talk, I haven't told anyone before about what happened to me with the you know [rape] and it kind of like, like lets me, what's the word,
release some of this shit that sits in me it’s not a secret any more, that helps I reckon (Research participant, PTSD symptomatic with a score of 3.17).

Reclaiming culture
The following participants identified Aboriginal traditional life (culture) as a source of strength and power, and as a mechanism for grounding themselves, helping them to claim and own their identity, and providing a positive focus and direction once they are released from prison:

But I feel strong. I always feel strong. I will tell you where I get my power from. Well I used to visit a cave when I was growing up. My grandfather used to take me and show me. My dad, I used to go hunt with my dad, he used to use; you know granite with the painting on the walls. We used to sit there for hours and he used to explain to me. That’s the strongest part, like I have to my father and my grandfather and so I want to do more of that, that would help. When I get out I am going to do more of that cause it you know grounds you and gives you back yourself which gets lost in the whitefella world (Research participant, non-PTSD symptomatic with a score of 1.43).

Because when I go back I want to hunt that’s what I want to do like in them old days. Make changes; stop running around in the circle. That’s what I want to do that’s how I will get back on track (Research participant, PTSD symptomatic with a score of 3.53).

Well sometimes now I look at the world and the way it’s going on. And you know they built these kinds of places and all that [prisons]. Me, I feel like that I sort of want to go back in the bush and become strong in here (points at chest then head) and just live as a traditional person (Research participant, PTSD symptomatic with a score of 3.10).

Art and music
A number of the participants found both art and music to be particularly healing. Art through painting was viewed by some as an opportunity to release their stories onto canvas in much the same way that narrative was found to be beneficial. Art also gave the men an opportunity to relax and meditate on their stories and to release some of the pain that they felt was ‘eating them up’. Music, whether it was listening to it or creating it, was another form of expression that allowed the participants to feel and release their stories:
It’s every time I come to jail and then back in [state] we didn’t have to pay for our canvas or paints or anything like that, it was given to us and it was heaps convenient. And I mean I stayed out of trouble while I was in jail because of that and got to know myself better through that and I was making a fair bit of money through sales. I mean I sold two paintings to an officer and they went overseas, each for $1,500 he bought them for. Yeah so I was quite pleased when that happened that made me feel real good about myself. And then I’ve sold heaps like during my time here. Well yeah jail that is, that was at the remand centre back in [state]. Then I went out to [name of jail] and then I started you know buying my own paints and canvas. So that’s it basically what I really want to do when I get out and that’s how I spend my time in jail. You know it keeps me occupied and out of trouble and that and I can paint my pain, do you know what I mean cause that really helps my head settle, the pain kind of goes through the paint brush onto the canvas and then it’s not mine anymore, that probably sounds fucked up but it works for me

(Research participant, PTSD symptomatic with a score of 2.50).

I’ve been doing a lot of paintings about things. I try to do a lot of paintings about the wrongs that they’ve done to our people since they’ve been over here you know and the wrongs that have happened to me, yeah and that I’ve done on other fellas. At the moment I’m working on one painting. I wrote the story and all that and it’s in safe and I’m going to do a painting to that story, that story’s about me you see. A lot of people reckon that all the paintings are racist, they call it racist. Yeah that’s what the art teachers said, but I am just painting the truth, you know my truth so if that’s racist then so be it

(Research participant, PTSD symptomatic with a score of 4.00).

Yeah. I wish there was more guitars and that, because you know when I get stressed I like listening to music or playing the guitar, you know, writing my own stuff, I’ve got a few songs now I written, ones about my life. Or I draw and that works the same as music it helps me to heal I think

(Research participant, PTSD symptomatic with a score of 2.60).

Employment opportunities
Lack of access to employment opportunities was highlighted by some participants as a contributing factor to alcohol misuse. It also negatively impacts on self-esteem and acts as a barrier to integrating into society. Employment was seen as providing a sense of purpose and structure in people’s lives.
Unemployment. The main thing, that’s why when I came in here I said you can have all those courses, you can have all of that but once your employer’s gone, your self-esteem and everything goes, if you can’t provide for your family, and boredom sets in and you start drinking, and that’s to do with communities. If you’ve got nothing, what else are you going to do? So employment to me covers everything because your days are structured. Do you know what I mean? (Research participant, PTSD symptomatic with a score of 3.47).

If I’ll go to school and they try to teach me about health, I’m in high school and they’re trying to tell me what to eat. How can I do that when my mother’s an alcoholic and food is limited? They do not understand that, they’re not reaching through and grabbing us by the throat and saying wait a minute, let’s go here and grab the whole lot. The same with employment or safer communities. Ah, I don’t know how you put this. I was an alcoholic because my whole day was consumed with it. Yet I drank prior to that, and yet I didn’t drink during the day, I went to work, do you know what I mean, there was structure, I had a purpose (Research participant, PTSD symptomatic with a score of 3.17).

Alcohol
A number of participants felt that alcohol education and/or alcohol restrictions, and re-valuating the methadone program would go a long way towards helping to reduce the impact of alcohol and other drugs on individuals and communities:

The thing is trying to learn people how to drink properly. You know how to drink. Even now, you just sit down and think about my people, when they start drinking from Monday maybe till Sunday, you know they just do everything round in a circle, the same things over and over. Well this is what I’m going to do now, when I get out. I’m going to get my people not to drink too much you know. Not to tell them hey you’ve got to stop drinking, I’m not going to tell them like that but I’ll try to encourage them to drink less and try to be with their kids more (Research participant, PTSD symptomatic with a score of 2.50).

You know personally I think the methadone program is a lead up for when you get out. You know to keep you on drugs. I mean when you come to jail it’s about supposedly rehabilitation. I mean how can you rehabilitate yourself when you’re substituting one drug for another? (Research participant, PTSD symptomatic with a score of 2.50).
I'm going to start new back on the island, yeah a long way from the pub, a long way from all my brothers. You know all this temptation in town. Yeah. But that was back then. But now, they grab them; kids aren't interested in ceremony now because elder people are going one by one (Research participant, PTSD symptomatic with a score of 3.10).

I've seen a lot of fellas smoking that and they tell me hey come, you want this one. I just tell them no you can smoke it. That thing, it can put you in, it can put you back in jail, the same thing. I tell them that. People just fighting from the start, protecting from; a canteen was put up people been fighting, fighting. Teenagers stealing truck, stealing truck from staff; that's the problem miss, out there. Yeah I think it would get better, yeah if they took the drink out hey. Got the town and every community, they've been asked for canteen so they can go and drink there but it would be better if they took the drink out miss (Research participant, non-PTSD symptomatic with a score of 2.47).

**Traditional justice and whitefella’s law**

When discussing mechanisms or tools that would assist individual participants, families and communities to move forward, a number of participants chose to discuss traditional justice and felt that it either collided with or was suppressed by white man’s laws, particularly when tribal law business is carried out. A number of the participants stated they were punished by both justice systems; one described this as ‘double jeopardy’ and described white man’s law as a ‘sad law’, as it breaks up families and communities.

*But in my community eye contact is terrible. You know people can get killed for that intrusion. We come in here and do our time. Well I assure you we broke the law, people broke a law. Balander [White] law. Yeah. But in the back of my head I have to think that we’re still going to face our law too. Tribal law is better. The tribal law is the mother of this land and you know it’s the brain. What ever you do, you know break the tribal law or if you commit a crime in a white man’s society and they have to say he broke two law you know double jeopardy. You’ve got to do your punishment here in this place and go back and get payback out there. And you still face it because you broke tribal law too, payback, it’s sort of life. You know, I know because I keep saying that and the people didn’t come in here to payback. If you don’t get that person they come for them in the spirit, the preacher way. Get them in a high spiritual way to kill the people in here. That works, they can make the people unhappy. That’s what I think when people have been going. Yeah. They can go hang themselves, or maybe this person can be mentally ill. You commit a crime; he broke the law of*
his own people. So let him be dealt with by his own people (Research participant, PTSD symptomatic with a score of 3.37).

Even though you do payback, you still got to do your time. And your kids are there beside you, your kids and your wife. All that depends if the family want to stay, we'll split them up or they can come and stay. We have no problem as long as some of them; um, not like restraining order, get restraining order it gets more worse. That's the only splitting people up. Balander law it's sad law, that law is no good. But I said to them you can split us up here, but according to our law, really we're happy, we can't split. Yeah they don't understand much, they need more; to recognise more about Aboriginal laws yeah traditional law, put somewhere in between, like white court and black court. He's here doing life just for nothing. Not even one night for he didn't touch, he told me all the stories. He told me all about it. And I said I see the witch doctor out there, a witch doctor. He said they can see, they can give some sort of spear campaign and reveal false blue eyes, put the eye and it can reflect it on, on the past. He can see right back in the past. He can see what, so he can see whole story. He can see the figures that have been around there. He can see the person who was there. And he can just go back and tell them. He's not guilty; he will find that person and draw his face. Balanda law it can't do that so use tribal law too (Research participant, PTSD symptomatic with a score of 3.37).

Well it happened there, like in traditional way. You know they curse people; they put black magic on them you know. Well I had those sorts of things happening to me. And I come to Darwin and I was out of control. And I assault and raped. So they charged me for rape. But it wasn't my fault because it was business. What my father did before, broke the law. So I had to pay for it. Because when my niece is in trouble. Like she's not supposed to go with this boy. Like in our way, like breaking the law probably or to a wrong skin. Yeah well all my nieces, sometimes my nephews go with wrong skins and I have to be there because I was older than they are. Yeah fix it up, fix it up. To fix it up well you've got to be in this meeting with this 12th tribe and try to sort it out, because; like I follow my father's footprint, he's sort of um; he uses this um, spiritual powers, you know. That can settle down people who want to fight. Sort of soften them. I have those power too. Like; sometimes I use it sometimes, you know, I don't want to use it. It's too much for me now to say stop here, stop this. There's the 12th tribe there and there's a lot of swearing and sort of, I'm scared of spears. Women they're just victims, not perpetrators. Yeah victims but they don't tell us, they
keep it secret. Like they’ll make a brother-in-law come here, what did you do? But you know, custom like; sisters, we don’t call them names, we don’t go near them. We don’t look at them (Research participant, PTSD symptomatic with a score of 2.57).

All I’m doing is just waiting for; the separate law has got to be reduced in parliament and once that law has been reduced then I’m going to appeal. Yeah because my act was actually in Aboriginal way. Law business yeah. Yeah. I couldn’t appeal. Yeah. A couple of years back because the CLP only had one law and it’s European law, that’s all (Research participant, non-PTSD symptomatic with a score of 1.83).

Payback is payback, they get you. You pay for what you did. I’ve heard all the news. When my brothers and cousins, and cousins brothers, all them are waiting on me when I get out. It’s going to be payback (Research participant, PTSD symptomatic with a score of 3.23).

It can still carry on. They won’t forget, they can get payback, revenge. Yeah I’d rather stay here. Because what I did to my own family. But I talk to them on the phone. I ring up my family and tell them what’s going on and they tell me, oh you can’t come home. I tell them no I’m not coming home. Probably go to another community (Research participant, non-PTSD symptomatic with a score of 2.47).

First arrived because true black fellas, you know the way they payback and all that, you know they can get you by pointing the bone and all that. Yeah, that’s what I was scared of. That’s why I said, I’d be happy to go back and get speared in the legs instead of doing 20 years in here because at least it heals you know. Yeah and you go back there and it only happens one day, you know then you move on. 20 years in here make me real sick so you can’t move on (Research participant, PTSD symptomatic with a score of 3.10).

Yeah. Well he’s [the man who murdered the interviewee’s brother] still alive but he’s; my mum seen him the other week, she’s seen him twice already but he’s killing himself because he know what he’s done is bad I suppose. And he knows that one day it’s going to come back to him I suppose. Because he’s only not hurt my family, he’s hurt a lot of other people’s families. So he’s killing himself on heroin and that I suppose. And I just sort of think oh well because my mum’s; you know can you imagine my mum seeing him and stuff like that. I tell her don’t
worry about him, you might as well say he's finished already I suppose, you know dead. Ah things take care of themselves I suppose, karma you call it but it's our law taking care of it through the spirits (Research participant, PTSD symptomatic with a score of 2.53).

**Children and the cycle of trauma**

Many of the participants discussed processes of generational trauma and dysfunctional behaviours, and the cycle that impacts on each successive generation. Children were considered to be ‘born innocent’ and participants believed that it was the environment that was the cause of children's dysfunctional behaviours. Many of the participants expressed a clear desire or obligation to break the dysfunctional cycle and to provide a safer, more harmonious life for the next generation.

Because like well you're the black sheep of the family now, before it was my mum, before that was my uncle, before that it was my grandfather. Now I believe that why it's happening like that is because it's passed on from one people to the next. I think something that trauma is; I think it's something that so bad that happened to you that you can't get on with your life because it's holding you back. And if people don't give you those chances to learn from your mistakes then you're just going to be stuck in that way. And it's hard to get out of it when you feel traumatised, basically by that because you're caught in that circle of all that turmoil and all that trouble, that you've lived in your life. Because what ever it is you've got to do with your life, and I think my life is to teach my children to stop that cycle from happening, because it's been happening for so long. It's got to stop somewhere and now that I've been [sorry] and I've learnt so much I think I can go back to my children and say hey, I love yours very dearly and I just don't want this to happen to you (Research participant, PTSD symptomatic with a score of 2.57).

I'm trying to teach him, even though I go bad. I say boy when someone hits you, you hit them back. You know when they go and hit you for nothing. If you're in the wrong you take your hit, you accept hit but if he hits you more than two times you punch him back. You accept he wrong or get hit once, twice, but if he keeps on hitting you well you chuck away the response with him, you take the guilt for him and you defend yourself now. I like everything political, but I think political issues will always bring in to the violence. I get very sentimental when I think of my kids because I don't want anything to happen. When I think of what's been done to me in my life. I don't want to repeat it; I don't want my kids to go through that. I don't want my kids getting hit. I hit my kids for things that they're naughty
for you know. I’m not going to hit him because he won’t go to the shop. I don’t want, especially my son. I don’t want him to ever live in the life I led. I want to break that cycle, especially for him (Research participant, PTSD symptomatic with a score of 3.07).

Because I get close to them and I’m trying to fucking make up a family where I didn’t have a good life, I try to make it. Yeah well all children are born innocent. That’s right. They grow up to be the way they are and it’s up to us to give them the life we didn’t have, a safe and peaceful place to grow up that would help (Research participant, PTSD symptomatic with a score of 2.70).

And then you try to deal with things and you find it very hard to deal with it and you end up in places like this. To calm you down and to make you think to change to another lifestyle. I tell younger prisoners than me and I talk to them. I say most of us are all fathers, does anyone ever need us more than this place is our kids. By me being in this place its not making my life any better, it’s more like it’s taking my life away from me because at the moment it’s dead time I tell them that it’s time to start thinking about our kids and help them not to end up where we have ended up, yeah break that cycle it’s the least we can do (Research participant, non-PTSD symptomatic with a score of 2.17).

Summary

The reliability and validity statistics for the AAVHTQ revealed a high level of internal consistency and criterion validity. Cross-validation of all four continuous variables (number of traumatic stressors, level of exposure, DSM-III-R symptom severity score and AAVHTQ symptom severity score) showed that they were all positively correlated. By cross checking and validating the quantitative data in the AAVHTQ against the qualitative data, the stories used throughout the research proved to be helpful in ensuring that the results of the AAVHTQ reflected the reality of the participants’ lives. The presentation of the stories alongside the findings of the AAVHTQ complements the quantitative data by providing a basis for interpreting the statistics, which ultimately validates the data by contextualising the numbers.

Over half (58.6%) of the study population were PTSD symptomatic according to the AAVHTQ, with the average scores being above the clinical cut-off of 2.50 for both the AAVHTQ symptom severity score (2.55) and the DSM-III-R symptom severity score (2.57). The most commonly occurring symptoms, endorsed by over 80% of participants, were associated with violent behaviours, trust issues, isolation, suppressed memories,
intrusive memories and obsessive thoughts about traumatic stressors. Other commonly identified symptoms, endorsed by more than 70% of the study population, were associated with a sense of isolation related to experiences of traumatic stressors, confusion, avoidance, guilt, shame, relationship difficulties, self-medication through drugs and alcohol, sleep problems, aggression and emotional turmoil connected to the traumatic stressor. Research participants who suffered from symptoms associated with precarious mental health (feeling like you were going crazy), low self-esteem (feeling worthless) and social isolation (feeling like you will have no one who will look after/out for you) were significantly more likely to be PTSD symptomatic.

The number of traumatic stressors that each member of the study population experienced was very high, ranging from 4 to 16, with an average of 10.41 traumatic stressors, suggesting there are patterns of cumulative trauma across the study population. The most commonly reported traumatic stressors, endorsed by over 80% of the participants, were associated with constant ‘sorry business’, family violence, and drug and alcohol issues. Other commonly identified traumatic stressors, which were endorsed by more than 70% of the study population, were associated with low social support, family and community breakdown, forced separations, racism and institutional violence. The most common level of exposure to the traumatic stressors endorsed was ‘experienced’. The majority of the participants were exposed to alarming levels of cumulative trauma, which they had personally experienced as opposed to witnessed or heard about.

The traumatic stressors that were significantly related to being PTSD symptomatic were no support for emotional, mental, physical or spiritual health problems (low formal and informal social support), unwanted sex and touching (rape and/or sexual abuse), not being accepted by their own community (personal and social identity issues), not belonging to anything and feeling lost (personal and social identity issues), and being hungry and not having a proper house to live in or school or clinic to go to (low formal and informal social support). The more traumatic stressors endorsed, or the more cumulative the amount of traumatic exposure, the more likely the participants in this research were to be PTSD symptomatic.

The qualitative data highlighted the endemic nature and normalisation of family violence, grief and loss, and alcohol and drug misuse as both a symptom and cause of distress, even though the quantitative data suggested that these events were not related to being PTSD symptomatic. Similarly, the murder of family, friends or strangers, institutional
violence, fractured families and souls, acculturation (colonisation) and racism were highlighted as significant issues in the qualitative data.

Significant increases of generational trauma and violence were also established in the research participants’ current and older generational histograms. The rates of traumatic stressors and dysfunctional behaviours in the current generation were significantly higher on most items than in the older generations, lending support to the notion of increased generational trauma and dysfunction for this specific study population.

Positive ways forward from the perspective of the research participants were identified, revealing various techniques and strategies that the research participants felt would be beneficial in terms of dealing with the pain resulting from their experiences. The power of narrative, grounding the self through reconnection with culture, embracing art and music, addressing alcohol and drug misuse as the primary social tool or recreational activity, increasing employment opportunities, and honouring tribal laws, as part of an overall solution combined with mainstream laws, provided some positive focus and potential strategies for moving forward. The recognition of cycles of generational trauma and dysfunction by some of the research participants encouraged them to suggest that it is up to this generation to break the cycle for the next generation.
CHAPTER SEVEN

Discussion and concluding remarks

Something bad happens and I put it inside me and I push it down, then something else bad happens and I put it inside me and I push it down, then all of a sudden I've got so much pushed down that it just explodes. And that's what trauma is, bad experiences and you keep putting it inside you and you're pushing it down, pushing it down and there's no really good programs that help you sort of take it out, take it out, so you're free of it all. Well I used to use violence to get rid of it. Trauma is to me, something that never leaves you. It's inside, it's internal and it won't, it will never leave (Research participant, non-PTSD symptomatic with a score of 2.37; however was PTSD symptomatic, 2.60, according to DSM-III-R score).
Chapter Seven: Discussion and concluding remarks

This study of 58 Aboriginal males incarcerated for a crime of violence explores the relationship between Aboriginal male violent offending and generational PTSD, from both a qualitative and a quantitative perspective. This study has also developed and field-tested a psychometric measure, the AAVHTQ, which attempts to capture the specific traumatic stressors and trauma symptoms, defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions relevant to Australian Aboriginal peoples.

The research participants in this study were predominately young men, who had, on average, 2.3 children, had experienced difficulties maintaining a relationship, had a limited education, were in low paying jobs or were unemployed prior to incarceration, had prior convictions (with an average recidivist rate of 4.8), and had histories of victimisation.

This chapter discusses a number of key findings that emerged from the four research questions, including a number of suggestions from the research participants in terms of potential ways forward that may help to break the cycle of trauma, violence and dysfunction. First, there appears to be a number of traumatic stressors and cultural idioms of stress reactions that may be potentially specific to Australian Aboriginal peoples. Second, the AAVHTQ, when employed in conjunction with the qualitative method, appears to be both a reliable and valid measure to capture the specific traumatic stressors and PTSD symptoms as defined by the DSM-III-R including specific cultural idioms of distress reactions relevant to Australian Aboriginal peoples and to determine PTSD prevalence in this group. With further testing and refinement, the AAVHTQ could be developed into a standardised measure of trauma and its impact on individual psychological and relationship functioning for Australian Aboriginal peoples. The limited sample size and need for quantitative validation needs to be taken into account; however, the qualitative data obtained in this study enhanced the accuracy of the AAVHTQ and therefore supported the validity of this instrument. Third, emphasising qualitative methods appeared to provide a richer data set and elicit more comprehensive responses from the research participants. This was achieved through the use of ‘Stories’ as a culturally appropriate method of gathering data, and as a validation technique and mechanism to contextualise the quantitative data and cross-check the results of the AAVHTQ and geno-histograms.
Fourth, the majority of the research participants were exposed to a significantly high number of traumatic stressors, and the more traumatic stressors they endorsed or the more cumulative the amount of traumatic exposure they experienced, the greater their likelihood of being PTSD symptomatic. These findings lend support for patterns of cumulative and potentially compounding trauma across the study population. Fifth, research participants who were PTSD symptomatic were significantly more likely than non-PTSD symptomatic participants to have reported traumatic stressors associated with low formal and informal social support, personal and social identity issues, and sexual abuse.

Sixth, although not significant in terms of PTSD symptomatology, the qualitative (in terms of the nature and intensity) and quantitative data (in terms of the frequency), highlighted the endemic nature and normalisation of family violence, grief and loss, and alcohol and drug misuse as both a symptom and cause of distress. Traumatic stressors relating to witnessing murder, institutional violence, fractured families, acculturation (colonisation) and racism were also reported to be major traumatic stressors by the majority of the research participants.

Seventh, over half (58.6%) of the study population were found to be PTSD symptomatic, with the most commonly occurring symptoms experienced by the research participants relating to violent behaviour, trust issues, isolation, suppressed memories, intrusive memories and obsessive thoughts about the traumatic stressors. Eighth, research participants who were PTSD symptomatic reported the majority of the AAVHTQ PTSD symptoms significantly more often than non-PTSD symptomatic participants. The symptoms with the strongest positive predictive power were precarious mental health; social isolation and lack of social support; low self-esteem; flashbacks; denial; avoidance; uninterested in everyday matters; dissociation; suicidal ideation; emotional pain and distress; guilt; shame; drug and alcohol misuse; and feeling unloved and unable to give love.

Ninth, there were significant increases in traumatic stressors and dysfunction behaviours for the majority of the research participants between current and older generations, lending support to the theory of the inter-generational transmission of trauma, violence and dysfunction in this study population.

The thematic analysis of the qualitative data revealed that the Aboriginal men in this study appeared to show insight into the origins of their own behaviours, and a desire and willingness to break the cycle for the next generation. The research participants
provided a number of suggestions, from their perspective, in terms of potential ways forward: first, the power of narrative to help them make sense of their lives; second, reclaiming culture as a source of strength and power and as a mechanism for grounding themselves and claiming both their personal and social identity; third, the use of art and music as therapeutic tools; fourth, increasing access to employment opportunities to provide both a sense of purpose and structure in peoples’ lives, therefore increasing self-esteem and relieving boredom, which can contribute to alcohol misuse; fifth, providing alcohol education and applying alcohol restrictions in communities; sixth, incorporating traditional justice into legal systems; and, finally, breaking the dysfunctional cycle in their own children’s lives through education and by dealing with their own trauma, therefore providing safer and more harmonious environments for the next generation.

This chapter also discusses both the limitations and strengths of the study, suggesting that although the results of this study must be considered in light of the limitations, the cross-cultural, multi-methodological, multi-method, Indigenist approach, which focused on the research participants’ stories to contextualise, cross-check and validate the quantitative data, is considered a major strength of the research. Acknowledging that the violent behaviour of some Aboriginal men may be both a cause and an effect of a history of widespread generational trauma is discussed in relation to the potentially important implications of these findings in terms of providing targeted assessment and treatment for Aboriginal males who have been convicted of violent offences and providing a well-validated measure that would be useful in assessing the success of such interventions.

Finally, a number of suggestions for potential future research are presented. These relate to:

- continuing to refine, develop and validate the AAVHTQ into a standardised instrument that is administered in conjunction with qualitative methods
- exploring concepts of risk and resilience as they relate to PTSD symptomatology
- exploring the qualitative data in this study in more detail in a future paper
- empirically testing the effectiveness of narrative style therapies and the creative arts for traumatic distress in Aboriginal violent offenders
- exploring the relevance of a culturally-specific construct for the trauma response within Australian Aboriginal peoples.
Cultural idioms of stress reactions and traumatic stressors, and the reliability and validity of the AAVHTQ — a quantitative and qualitative approach

The first research question asked what are the trauma symptoms, as defined by the DSM-III-R for PTSD including specific cultural idioms of distress reactions and traumatic stressors relevant to Australian Aboriginal peoples. This was designed to facilitate the development of a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples. The development of the cross-cultural instrument was achieved by exploring key themes derived from a documentary analysis of major reports, and through focus group discussions with key informants assessing specific cultural idioms of stress reactions and traumatic stressors relevant to Australian Aboriginal peoples. The results of this question informed the development of the AAVHTQ.

The results of the documentary analysis and focus group discussions suggest that there are a number of traumatic stressors and traumatic symptoms that are potentially specific to Australian Aboriginal peoples. The results of the study also indicate that the AAVHTQ, when used in conjunction with qualitative methods, appears to be both a reliable and valid instrument for assessing PTSD prevalence in this group and also for capturing the specific traumatic stressors and cultural idioms of stress reactions relevant to Australian Aboriginal peoples. Additionally, the emphasis on the qualitative data to contextualise, cross-check and validate items in the AAVHTQ appeared to be a useful and culturally appropriate method to provide a richer data set than reliance on quantitative data alone and elicited more comprehensive responses from research participants. However, the results should be interpreted cautiously due to the limited sample size and the need for further quantitative validation of the AAVHTQ.

The development of the AAVHTQ through the documentary analysis and focus group discussions, including linguistic and semantic modifications from the KRLC, elicited a number of traumatic stressors and characteristics of distress that could be specific to Australian Aboriginal peoples, and potentially to all indigenous peoples who have been colonised. Acculturation (colonisation), dispossession, institutionalisation, discrimination and racism both at the social and structural levels, were all identified as key traumatic stressors in the documentary analysis and focus group discussions were argued to contribute to an array of complex social issues that compounded these stressors. Other common traumatic stressors identified in the documentary analysis and focus group discussions that appeared to be particularly relevant to Australian Aboriginal peoples were:
- witnessing violence associated with the deaths of family and friends and strangers
- family violence
- sexual violence
- institutional violence
- violence that is imposed on oneself through drug and alcohol misuse or being exposed to others who abuse drugs and alcohol
- loss and grief
- fragmentation of families through forced removals
- family and community breakdown
- rejection by one’s community
- having a sense of not belonging
- being forced to sit down a long way from home and family
- a lack of support, such as having emotional, mental, physical and spiritual health problems with no one being there to help
- being hungry all the time, or not having a proper house, medical clinic or school to go to.

Although some of these stressors may also be relevant to the non-Aboriginal population, as a collection of stressors, they appear to be specific to the Australian Aboriginal population’s historical and contemporary experience. Therefore, it is suggested that themes around these stressors must be included in an instrument that purports to assess traumatic distress in Australian Aboriginal peoples.

Many of the traumatic stressors identified in the documentary analysis and focus group discussions appeared to be associated with specific characteristics of distress, including alcohol and drug misuse, rage and anger directed at the self and others (resulting in violence to self and others), emotional issues, shame for being Aboriginal, low self-esteem, poor mental and physical health, and social and community dysfunction. The nature of the cultural idioms of stress reactions identified in the documentary analysis and focus group discussions centred around trust issues, isolation, suppressed memories, obsessive thoughts about traumatic stressors (with an associated sense of isolation), guilt, shame, relationship difficulties, disassociation, general feelings of worthlessness, self-medication through drugs and alcohol, aggression, suicidal ideation, and emotional turmoil connected to the traumatic stressors.

By adapting the Harvard Trauma Questionnaire through inclusion of the traumatic stressors and cultural idioms of stress reactions identified in the documentary analysis and focus group discussions, a psychometric measure for PTSD, the AAVHTQ was
developed. The results revealed good internal consistency and criterion validity, including good cross-validation of all four continuous variables: number of traumatic stressors, level of exposure, DSM-III-R symptom severity score and AAVHTQ symptom severity score. However, the AAVHTQ does not attempt to establish the validity of the construct of PTSD in other cultures or to definitively identify a culture-specific construct for the trauma response within this cultural group. It does however suggest that there are traumatic stressors and symptoms of distress that may be specific to Australian Aboriginal peoples. With that in mind, it is important to highlight that although the AAVHTQ incorporates 14 Australian Aboriginal specific items (items 17–30), the DSM-III-R portion of the AAVHTQ is based on the Western perspective of trauma-related illness and it is therefore bound by the concept of PTSD as defined by the DSM-III-R criteria (i.e. items 1–16 in Part IV). Only when a culture-specific construct can be identified, will it be possible to modify the DSM-III-R symptom items and develop a questionnaire that is truly culture-specific.

It was argued in the methodology that it is the individual narratives from the men who participated in this research that give meaning and validity to the ‘numbers’, and it is this emphasis on the ‘Stories’ that showcases Aboriginal methodology in which the ‘Story’ is the primary validation tool. With this in mind, the quantitative data and analyses were used in conjunction with the men’s stories in order to validate numeric results. For example, the narratives derived from the in-depth interviews were used to cross-check the results of the AAVHTQ and changes were made to these when the narratives clearly and unambiguously provided more accurate data. Eighteen AAVHTQ results were amended using this cross-checking method. Of the 18 AAVHTQ results that were changed, four of the PTSD symptomatic findings were changed from negative to positive. The freedom of expression encouraged by the semi-structured narrative interview method allowed the research participants to simply tell their ‘Story’ and share their feelings, and therefore elicited more comprehensive responses. It appears that the qualitative data enhanced the accuracy of the AAVHTQ and therefore contributed to the reliability and validity of this instrument.

Additionally, the suggestion by the focus group to add an open-ended question that permitted the research participants to include in their narratives any other traumatic stressors where they felt their lives were threatened, and which had not been identified through the documentary analysis or focus group discussions, proved to be an efficient way of establishing if the traumatic stressor check list was comprehensive. The purpose of including an open-ended question in the traumatic stressors section of the AAVHTQ was to avoid limiting participants to the traumatic stressors provided in the check list,
therefore opening up the discussion for the possibility of other events that are considered traumatic within this population. The qualitative data revealed that there were no extra traumatic stressors identified that were not already on the check list, but rather that the question relating to ‘any other event not identified’ allowed the participants to elaborate on one or more of the traumatic stressors that they had already endorsed. This would suggest that the AAVHTQ, when used in conjunction with qualitative data, is a comprehensive list of traumatic stressors relating to the research participants in this particular study and, with further work and field testing, could be a useful traumatic check list relevant to the broader Australian Aboriginal community.

Although this research has not completely validated the AAVHTQ by Western empirical methods, and will need further research to do so, the fact that the average DSM-III-R symptom severity score is 2.57 (≥2.5 represents symptomatic for PTSD according to DSM-III-R criteria) and the average AAVHTQ symptom severity score is 2.55 (≥2.5 represents symptomatic for PTSD according to AAVHTQ) would suggest that the extra cultural idioms of stress reactions represented as the 14 Australian Aboriginal-specific items (items 17–30) did not inflate or decrease the frequency of PTSD symptomatic participants. Additionally, the significantly higher mean for the PTSD symptomatic group compared to the non-PTSD symptomatic group suggests that the more traumatic stressors participants were exposed to, and the higher the level of exposure (i.e. the more events specifically ‘experienced’), the more likely a participant was to be assigned PTSD symptomatic in both the DSM-III-R and AAVHTQ total score categories. This result would be expected if the measurement instrument was valid.

It must be kept in mind that the purpose of the study was not a comprehensive quantitative validation of the AAVHTQ, and therefore the results should take this into consideration. Rather, emphasis was placed on using the qualitative data, the individual stories of the participants, as a validation against the AAVHTQ. Therefore, these quantitative design limitations must be taken into account, and further testing of the AAVHTQ will ultimately be required to quantitatively validate the measure. However, as a preliminary explorative study, this research provides a comprehensive framework for refining the trauma concept by identifying traumatic stressors and cultural idioms of stress reactions that appear to be specific to this study population and potentially, with further research, to Australian Aboriginal peoples in general.
The nature and prevalence of traumatic stressors relevant to the study population

The second research question asked if the study population in this particular research had been exposed to traumatic and violent events. This was achieved through conducting semi-structured, in-depth interviews, in conjunction with administration of the AAVHTQ to determine the nature, level of exposure and frequency of traumatic stressors experienced by the study population. Potential differences between the nature, level of exposure and frequency of traumatic stressors in PTSD symptomatic and non-PTSD symptomatic research participants were also explored. Qualitative data were utilised to determine themes, to contextualise the quantitative data and to enable a deeper understanding of these stressor events.

The results revealed that the majority of the research participants reported they had been exposed to a significantly high number of traumatic and violent events that they had specifically ‘experienced’, as opposed to ‘heard about’ or ‘witnessed’, and the more traumatic stressors they endorsed or the more cumulative the amount of traumatic exposure, the greater their likelihood of being PTSD symptomatic. Traumatic stressors involving low formal and informal social support, personal and social identity issues and sexual abuse were found to be significantly associated with being PTSD symptomatic. However, although not significant in terms of being PTSD symptomatic, both the qualitative (in terms of nature and intensity) and quantitative data (in terms of frequency) highlighted the endemic nature and normalisation of family violence, grief and loss, and alcohol and drug misuse, which could be both a cause and an effect of trauma. Similarly, traumatic stressors such as witnessing murder, institutional violence, fractured families, acculturation (colonisation) and racism were reported by the majority of the research participants and were highlighted as major traumatic stressors through the analysis of the qualitative data.

The mean number of traumatic stressors experienced by the study population was very high (10.41, ranging from 4–16), suggesting patterns of cumulative trauma across the study population. The most common level of exposure to the traumatic stressors endorsed was ‘experienced’. The PTSD symptomatic group reported exposure (on average) to 2.19 more traumatic stressors than the non-PTSD symptomatic group, suggesting that the more traumatic stressors endorsed, or the more cumulative the amount of traumatic exposure, the greater the likelihood that participants were PTSD symptomatic. The same relationship was found with the level of exposure, specifically those events endorsed as ‘experienced’ as opposed to ‘witnessed’ or ‘heard about’. The traumas endorsed by the participants appeared to have a high level of exposure and
were both cumulative and compounding. This is consistent with previous research identified in the literature review, which indicates that Aboriginal families are confronted with cumulative and potentially compounding major life stressors at four times the rate of non-Aboriginal families (Zubrick, et al., 2005).

**Traumatic stressors related to PTSD symptomatology**

The results of the research revealed that five of the traumatic stressors endorsed by the research participants were found to be significantly associated with PTSD symptomatology. Participants who were PTSD symptomatic were significantly more likely than non-PTSD symptomatic participants to report:

- no support for emotional, mental, physical or spiritual health issues (low formal and informal social support)
- lack of acceptance by their own communities (personal and social identity issues)
- not belonging to anything and feeling lost (personal and social identity issues)
- being hungry and not having a proper house to live in or school or clinic to go to (low formal and informal social support)
- unwanted sex and touching (rape and/or sexual abuse).

Unwanted sex and touching (rape and/or sexual abuse) during childhood was significantly related to being PTSD symptomatic. Nineteen of the 22 participants who reported this traumatic stressor were PTSD symptomatic according to the AAVHTQ, with a positive predictive power of .86. This is consistent with published literature indicating the most commonly experienced effect of sexual abuse is PTSD (Domínguez, Nelke & Perry, 2001). Participants' reports of the nature and severity of the sexual abuse highlighted the cumulative and compounding experiences endured throughout their lives. Abuse often commenced in early childhood and as the victim matured the abuse was often re-enacted on extended family and others bringing focus to the inter-family generational component of this abuse. The qualitative data also highlighted that participants did not have the necessary social support to effectively deal with this abuse. Sexual assault has been associated with relatively low levels of social support; specifically a reduced likelihood of being married, and an increased likelihood of experiencing poor relationship structure (low frequency of network contacts) and relationship function (low emotional support from friends, family and spouse) (Golding, Wilsnack & Cooper, 2002).

Themes relating to low formal and informal social support and personal and social identity were relevant for the remaining four traumatic stressors that showed a significant relationship with being PTSD symptomatic. The lack of appropriate formal
support, such as appropriate counselling to deal with participants’ alcohol and drug misuse and their unresolved traumas, was highlighted in the qualitative data as an impediment to moving forward, and in some cases led to the commission of further crimes in order to return to prison to obtain support. For example, one participant stated: ‘when you’re left to yourself to sort it out, nobody to talk to makes me sick, sick in the head and sick in the body’. Consequently he committed a crime so that he could return to prison to ‘feel a bit safe and a bit supported, it’s not real good but it’s better than nothing though’. This is consistent with the findings from the Aboriginal and Torres Strait Islander women’s task force on violence report (Queensland Department of Aboriginal and Torres Strait Islander Policy, 2000), that reported the limited services available to assist people to deal with these issues compounded the stress and potentially exacerbated the likelihood of violence.

A lack of personal and social identity was also a significant stressor that was associated with loss of culture, family and community through separations. Some participants reported they felt like they were ‘between worlds’ (i.e. they didn’t identify or feel they belonged in either the Aboriginal or non-Aboriginal world) and that they had no sense of personal or social identity. For example, one participant who was reconnected with his family through the Link Up program described how he didn’t really know his family members and felt he didn’t belong anywhere: ‘I still feel I am alone and have none of my people left’. Another participant described the anger associated with feelings of not belonging, stating that ‘when you are brown and not black you are in the middle and you don’t belong anywhere and nobody want you anywhere’. Similar effects were reported by men that had been banished from their communities because of dysfunctional behaviours, with one participant describing the impact as being on the outside of everything: ‘if they won’t have me who will, belonging to community, community accepting you makes everything make sense. I am a man without a home without community without country, man without country or community has no heart that was what I was learnt, heart is country and community’. The literature also identifies lack of functional social support and personal and social identity as factors facilitating vulnerability for developing PTSD and contributing to increasing PTSD symptomatology (National Centre for PTSD, 2007). The perceived lack of formal and informal social support and personal and social identity reported by the participants, represented by the endorsed traumatic stressors and increased PTSD symptomatology in this study population, appear to be important issues that require further consideration.

These findings also relate to the classic work of Alice Miller (1983), as discussed in the literature review. Miller (1983) suggested that dysfunctional and violent behaviours can...
stem from the inter-related experiences of a number of variables, including not having a single person to confide in, or, in other words, not having the social support networks available to help make sense of traumatic experiences. Furthermore, a secure sense of self derived through personal identity, and particularly social identity, provide a basis for group members to receive the benefits of social support. It is possible that the existence of effective social support may contribute to increasing personal and social identity, and therefore potentially reduce the likelihood of traumatic experiences developing into an enduring mental illness such as PTSD. It is important to consider that because some Aboriginal families and communities are in a constant state of crisis and dysfunction, due to issues associated with constant sorry business, family violence, and drug and alcohol misuse, their personal and social identity, specifically cultural identity, is eroded and therefore as individuals, families and communities, they may be unable to provide formal or informal social support to other members of the family and community. This can be due to poorly resourced communities and compounded by family and community breakdown, including forced separations, racism and institutional violence, which render the capacity to provide cohesive social support and to develop or maintain a strong personal and social identity very difficult.

**Traumatic stressors unrelated to PTSD symptomatology**

Interestingly, PTSD symptomatology was not significantly associated with any of the traumatic stressors most commonly endorsed by over 80% of the research participants, such as constant sorry business, family violence, and drug and alcohol misuse. All of these events were viewed by some of the research participants as both a symptom and a cause of distress and, in some cases, as a catalyst to violent behaviours. The qualitative data suggested a degree of normalisation of these particular events, as well as the endemic nature of violence in the participants’ families and communities and the debilitating effects of being in a constant state of cumulative grief.

Consistent with the research presented in the literature review, participants reported alcohol as a violence enabler and used it to either numb the intensity of their feelings associated with their trauma resulting from constant sorry business and family violence and/or to feel more intensely, which can compound and intensify violent behaviours (Atkinson, 2002). Alcohol misuse was also reported to be part of identity and was undertaken in some cases to fulfil the need to belong. For example, one research participant explained ‘that’s what everybody does, everybody I know anyway, it’s just normal. I do too because I like the feeling of them, the drink and the drugs they make me feel like everybody else’. The theory that alcohol may have become a distorted expression of identity, culture and group solidarity and, in some cases, a pre-condition of group membership, was discussed in the *Violence in Indigenous communities report* by
Memmott et al. (2001). However, the qualitative results also revealed that alcohol consumption was also due to the lack of meaningful activities in the community, such as employment or traditional activities. The need for meaningful activities and to feel part of a social group that contributes to an individual’s personal and social identity has been a major theme throughout the results.

Similarly, other traumatic stressors endorsed by the majority of the study population associated with fragmented families, forced separations and institutional violence were not statistically significant in terms of being PTSD symptomatic, but were clearly major life stressors that had a profound impact on the lives they affected. For example, one participant described the effects of family and community breakdown as both a process and outcome of forced separations and institutionalisation: ‘you see those kids are taken away because their mums and dads are fucked up, you see this family and community breakdown one it’s what they do [process] and it’s what happens because of it [outcome].’ Institutional violence in terms of the violence that can be inflicted on some of the men in institutional settings, such as custodial care, was also identified by some of the research participants to be particularly traumatic, with one research participant suggesting ‘that it is common knowledge that if you go to prison or you go to the police lock up you’re going to get belted’. However, as frightening as it was for some of the participants, for others institutionalisation had become so normal that it had become part of their personal and social identity, with some men ‘fearing life on the outside’ suggesting that it had become ‘kind of like a family, we look after each other. One big community’ and that prison had become a ‘comfort zone’.

Traumatic stressors associated with acculturation (colonisation) and racism were also not statistically significant in terms of PTSD symptomatology, but were endorsed by the majority of the research participants and were identified as major traumatic stressors in the qualitative results. For example, being forced to accept ‘whitefella way’ and talk English (i.e. losing some or all of your traditional language and ceremony) (acculturation/colonisation) was identified by some of the research participants as the reason why some families and communities are in such a dysfunctional state. Once again, themes relating to issues associated with personal and social identity appear to be relevant. Similarly, experiencing racism had profound effects, contributing to feelings of worthlessness and ‘not belonging’ and creating feelings of intense shame. The issue of shame or ‘being shamed’ is a concept that is particularly relevant to people who have experienced racism. According to Wong and Cook (1992), shame is reported to be a strong factor in the PTSD symptom cluster. Wong and Cook note that the affect, shame and the construct, self-esteem, are highly correlated factors and that each on its own is
correlated to measurements of the construct, depression. In an earlier paper, Cook (1989) reported that shame is one of the most basic and central of human affects. He suggested that shame may be the central affect, of which negative self-esteem is a resultant manifestation. In other words, shame may be the affect behind the construct. The resultant effects of racism and their contribution to shame, and therefore potential PTSD symptomatology, have important implications for intervention strategies with Aboriginal peoples in terms of addressing negative self-esteem.

The majority of the participants reported witnessing the murder of a family member or close friend, but, surprisingly, it was not significantly associated with PTSD symptomatology. It may be that the endemic nature of violence in some families and communities has minimised the impact of this traumatic experience and lessened its impact on PTSD symptomatology. This event may have become normalised and people may have become numbed to its effect. It is also possible that violence is so endemic and normalised in some families and communities, it has become rational, accepted and even expected behaviour that has become part of an individual’s social identity (i.e. they need to belong to a group and therefore participate in the common activities of that group, such as violence). This is consistent with the literature, indicating a growing acceptance of violence as a normal social and cultural aspect of life in many contemporary Australian Aboriginal communities is a compounding issue (Memmott et al., 2001). Nevertheless, the qualitative results highlighted the profound effect that violence has had on some of the participants. This is illustrated in the case of the young man who had witnessed his mother being shot in the head with a shotgun and who was then forced to clean her brains off the floor. This, in turn, resulted in him acting out on the feelings associated with this trauma by raping a girl and imagining her screams and blood to be that of the original trauma.

The lack of a significant relationship between the traumatic stressors discussed above and being PTSD symptomatic may be due to the normalisation of these particular events. It is possible that the very high prevalence of these traumatic stressors across the PTSD symptomatic and non-PTSD symptomatic groups masked any potential differences. This does not mean that these traumatic stressors do not have the potential to elicit PTSD symptoms, but rather that they appear to be so endemic across both the PTSD symptomatic group and non-PTSD symptomatic group that there may be other variables that, when combined with these events, make a person more vulnerable to, or more resilient against, becoming PTSD symptomatic. Furthermore, the fact that all the participants were imprisoned for a violent crime, and the majority had suffered from these traumatic stressors, suggests that there could be a link between the participants’
violent behaviours and alcohol and drug misuse, family violence and grief, and loss/sorry business, witnessing murder, institutional violence, fractured families, acculturation (colonisation) and racism, regardless of whether they are PTSD symptomatic or not. It may be that the PTSD construct may be inadequate to identify the psychological outcomes of these particular traumatic stressors. What is consistent in both the quantitative (in terms of the frequency of endorsements) and qualitative (in terms of nature and intensity) results, however, is that a lack of formal and informal social support, or a perceived lack of social support, along with personal and social identity issues compounded by families and communities in a constant state of crisis and dysfunction due to the nature of the traumatic stressors reported, is an important theme that runs across both the significant and non-significant results.

**The nature and prevalence of traumatic symptoms relevant to the study population**

The third research question asked if the study population were suffering from symptoms associated with PTSD, as defined by the AAVHTQ. This was established by administering the AAVHTQ to assess symptoms of PTSD and other cultural idioms of distress reactions and their prevalence. Potential differences between the prevalence of traumatic symptoms in PTSD symptomatic and non-PTSD symptomatic groups were also explored. Qualitative data were utilised to contextualise the quantitative results, provide a deeper understanding of the symptoms and to explore potential themes from the traumatic symptoms. It was established that over half (58.6%) of the study population were PTSD symptomatic according to the AAVHTQ. The most commonly occurring symptoms were also identified, including specific symptoms that were more likely to be associated with being PTSD symptomatic.

Over half (58.6%) of the study population was PTSD symptomatic according to the AAVHTQ, with the average score above the clinical cut-off of 2.5 (the AAVHTQ symptom severity score was 2.55 and the DSM-III-R symptom severity score was 2.57). Not surprisingly in a study population that has been imprisoned for violent crimes, the most commonly endorsed symptom was becoming violent to self or others (51 respondents, or 87.9%), followed closely by feeling someone you trusted did something to betray you (50 respondents, or 86.2%). Both of the most common symptoms were also two of the 14 culturally specific items in the AAVHTQ. Symptoms associated with isolation, suppressed memories, intrusive memories and obsessive thoughts about traumatic stressors were also endorsed by over 80% of the study population. Other commonly identified symptoms endorsed by more than 70% of the study population were a sense of isolation in their experiences associated with the traumatic stressor,
confusion, avoidance, guilt, shame, relationship difficulties, self-medication through
drugs and alcohol, sleep problems, aggression, and emotional turmoil connected to the
traumatic stressor.

As would be expected, the research participants who were PTSD symptomatic reported
the majority of the AAVHTQ PTSD symptoms significantly more often than non-PTSD
symptomatic participants. The symptoms with the strongest positive predictive power in
order of significance were precarious mental health (feeling like you were going crazy),
social isolation and lack of social support (feeling like you will have no one who will look
after/out for you), low self-esteem (feeling worthless), flashbacks, denial, avoidance,
uninterested in everyday matters, dissociation, suicidal ideation, emotional pain and
distress, emotional numbing, guilt, shame, substance use, and relationship difficulties
(feeling unloved and unable to give love). The top three AAVHTQ PTSD symptoms with
the strongest positive predictive power (i.e. significantly related to being PTSD
symptomatic) were also three of the 14 culturally specific items in the AAVHTQ. It would
appear that participants who suffered from symptoms associated with precarious mental
health, social isolation and low self-esteem were more likely to be PTSD symptomatic.

All of the re-experiencing symptoms appeared to be significantly related to being PTSD
symptomatic, with the exception of nightmares, which was a DSM-III-R item. All of the
avoidance and numbing symptoms also appeared to be significantly related to being
PTSD symptomatic, apart from not being able to remember some of the most hurtful or
bad things that happened to you, and trying to keep away from things that remind you of
the hurtful or bad things that happen to you (avoidance), even though they were the third
and fourth, respectively, most commonly endorsed symptoms. Both these symptoms
were also DSM-III-R items. Similarly, the majority of the arousal symptoms appeared to
be significantly related to being PTSD symptomatic, apart from becoming violent to self
or others, feeling someone you trusted did something to betray you (two of the 14
culturally specific items in the AAVHTQ) and trouble sleeping (DSM-III-R item).
Interestingly, the symptoms becoming violent to self or others and feeling someone you
trusted did something to betray you were not significantly related to PTSD status, even
though they were the two most highly endorsed symptoms, as discussed earlier on in
this section and were both two of the 14 culturally specific items in the AAVHTQ. It may
be possible that these two symptoms are so prevalent across both the PTSD and non-
PTSD symptomatic groups that any potential differences are masked. Nevertheless, the
qualitative data highlighted both these symptoms as major issues for the majority of the
research participants. For example, becoming violent to self or others was reported by a
number of research participants as both a symptom of, and release from, their traumatic
experiences, suggesting violence was used as a mechanism to release anger and trauma, and to re-enact their own trauma or dissociate from it in much the same way that people use alcohol to dissociate.

On the other hand, the symptom of feeling angry all the time and taking it out on yourself or others (a DSM-III-R item) was significantly related to being PTSD symptomatic. Anger is a significant activator and an important risk factor for violence (Novaco, Ramm & Black, 2000) and ‘an inevitable consequence of anger arousal’ (Day et al., 2006, p. 526). It would appear that the anger felt by participants is finding release in acts of violence, as reported by a majority of participants in this study. In other words, anger is the symptom and violence the consequence. This may suggest that anger is a cultural idiom of distress and violence is a mechanism for release. According to the Australian PTSD Guidelines, cultural-bound expressions of distress are often interpreted by non-Indigenous people as anger (Australian Centre for Posttraumatic Mental Health, 2007). However as Day et al. suggest, ‘to experience anger as violence or to experience violence as a necessary release of angry emotion alerts us to the need for intervention that helps clients distinguish between awareness and expression’ (2006, pp. 525–526).

Further, it could be possible that the significant symptom of anger could be enabled by alcohol and drugs misuse, as highlighted by a number of the participants. Also, the qualitative data revealed that the misuse of alcohol and drugs was used as a mechanism for pulling down the blinds (i.e. avoidance and numbing), as well for increasing feelings of power (i.e. arousal that can sometimes result in violent behaviours).

Losing the ability to trust anyone was also contextualised through the qualitative data as a major issue. It seems that losing the ability to trust can then result in a diminished ability to seek out people and services that can provide essential support, and thereby contribute to creating difficulties establishing or maintaining relationships. This cycle may then compound the existing trauma and trust issues by contributing to the person feeling unsupported and isolated. This highlights the issue of perceived lack of social support discussed earlier. It appears that without the appropriate support to deal with the many trauma symptoms, trauma-based behaviours and issues (such as uncontrolled anger leading to violence, relationship difficulties, shame and self-medication through alcohol and drugs) may continue unabated and feed the cycle of trauma.

**Patterns of generational trauma, violence and dysfunction**

The final research question asked if there were patterns of generational trauma and violence amongst the study population in this specific research. This was achieved
through the construction of current and older generational geno-histograms, which were compiled through semi-structured, in-depth interviews to establish if there were changes in the rates of traumatic stressors and dysfunctional behaviours across the generations. Similar to the AAVHTQ, the emphasis on the qualitative data to contextualise, cross-check and validate the final construction of the histogram resulted in 20 geno-histograms being amended.

The results indicate that the rates of traumatic stressors and dysfunctional behaviours in the current generation were significantly higher on the majority of items compared to the older generations, lending support for the inter-generational transmission of trauma and violence. The mean rate of family members that had been or were currently incarcerated, were a perpetrator or victim of sexual assault/rape and physical violence, who had committed suicide, or who had misused drugs and alcohol were all significantly higher in the current generation than in the older generations.

However, there was a significant decrease in the mean rate of family members that were deceased by natural causes and deceased by unknown causes from the older generations to the current generation, and a non-significant decrease in family members deceased by unnatural causes. As the average life expectancy for Indigenous Australians is 17 years less and death rates are likely to be four times higher than non-Indigenous Australians (Australians Indigenous Health InfoNet, 2007), it is not surprising that the older generations showed a higher mean for natural, unknown and unnatural deaths than the younger generation.

There were also no significant differences found in the mean rate of family members who were removed from their families and identified as stolen generations. The non-significant change in the rate of removal could be explained by the significant policy changes regarding the removal of Aboriginal children from their families, which have attempted to reduce Aboriginal children being displaced, or, at the very least, have attempted to place them with an Aboriginal family. It is important to note however, that although there was not a significant change in the mean rate of family members identified as stolen generations, it was still an increase from the older generations.

Nevertheless, the majority of traumatic stressors and dysfunctional behaviours showed a significant increase from the older generations to the younger generation. This is consistent with the research discussed in the literature review, which suggests that suppression or non-treatment of trauma can result in behaviours that, in turn, cause trauma in victims and their families through increased levels of criminal activity, violence.
against self and others, and self-medication through drugs and alcohol (Figley, 1985). This contributes to those behaviours becoming embedded in the culture, and therefore becoming normalised and transmitted across the generations (Atkinson, 2002; Duran & Duran, 1995; Milroy, 2005, Ralph et al., 2006). The qualitative data contextualised these findings by highlighting childhoods exposed to family violence and sexual abuse fuelled by alcohol and drug misuse, and compounded by unresolved loss and grief and the disruption to whole networks of family units through government policies. The victim-perpetrator cycle was eloquently summed up by one research participant, who suggested that if you ‘grow up with it you become it’.

The significant increases from the older generations to the current generation in the majority of traumatic stressors and dysfunctional behaviours may suggest that the ‘flow down’ of traumatic stressors and dysfunctional behaviours across the generations for those specific items can result in those events and behaviours being repeated at an increased rate, due to normalisation through learnt patterns of behaviour and symptomatic trauma responses. It may also suggest that this ‘flow down’ rate may continue to increase across successive generations without effective intervention.

Potential ways forward from the perspectives of the research participants — breaking the cycle

Thematic analysis of qualitative data adds rich insight into the nature, meaning and consequences of the traumatic experiences of the study population and the devastating impacts on their families and communities. The qualitative results of this study revealed that the research participants appeared to show insight into the origins of their own behaviours and a desire and willingness to ‘break the cycle’ for the next generation. The research participants suggested a variety of techniques and strategies they felt would be beneficial in terms of dealing with their own pain resulting from traumatic experiences as potential ways forward that could contribute to breaking the cycle.

First, narrative was identified by the majority of the research participants as a powerful process that was necessary to help the men make sense of their own lived traumas. For some of the men, the research interview was the first opportunity to talk about some of the traumatic experiences that they had endured throughout their lives, and specifically the anger attached to those experiences. The men consistently referred to the need to be heard and to be able to talk, but most importantly to have someone who truly listens to them in a non-judgemental way. Narrative is a very powerful tool that has the potential to begin to address some of the traumatic stressors and therefore the symptoms that are associated with traumatic distress, by giving the person the
opportunity to legitimise their experiences and find meaning behind why they have ended up feeling angry, and then translated this anger into violence and potential criminal activity. Telling one’s story may provide an opportunity to gain a deeper understanding of one’s experiences and oneself. In fact, the opportunity to talk without judgement was described to be a profoundly healing experience by many of the participants.

The concept of narrative and the benefits of ‘telling your story’ are not new. For example, Narrative Exposure Therapy, or as it was first called, Testimony Therapy, is a well-known psychotherapy for people with PTSD. It encourages them to tell their detailed life history chronologically to someone who writes it down, reads it back to them, helps them integrate fragmented traumatic memories into a coherent narrative, and returns it to them at the end as a written testimony (Kornfeld & Weinstein, 1983). Narrative exposure is thought to help individuals understand their experiences and themselves by organising and remembering events in a coherent fashion, while integrating thoughts and feelings. Similarly, Narrative Exposure Therapy works on the premise that each of us has stories that we tell ourselves, which combine our values, expectations, hopes and fears, and much of our self-perception. Encouraging the telling and adaptive retelling of the story of trauma has been shown to be particularly healing (Norman, 2000). In fact, narrative therapy was identified some time ago as a culturally sensitive and appropriate therapy for Australian Aboriginal peoples (Aboriginal Health Council of Australia, 1995). The power of narrative or the opportunity to tell one’s story in a safe environment, without judgement or prejudice, is supported and discussed in detail by Atkinson (2002) as a healing tool for traumatic distress, based on the premise that if you don’t know where you have been, then you don’t know where you are going (Atkinson, 2002). It is therefore suggested that rehabilitative programs for violent offenders with a history of trauma consider incorporating narrative as an essential component.

Second, the research participants highlighted the importance of reclaiming culture as a source of strength and power, and as a mechanism for grounding oneself and reclaiming one’s own identity. Many of the research participants believed that focusing on culture may help to alleviate feelings of ‘being between worlds’; as one research participant described, ‘it grounds you and gives you back yourself which gets lost in the whitefella world’. Traumatic stressors associated with a lack of personal and social identity were found to be significantly related to PTSD symptomatology, and therefore cultural identity as a source of strength is an important consideration. Furthermore, culture has the potential to provide a positive focus and direction, particularly once the
men are released from prison. Many of the men suffer from anger, negative self-esteem, feelings of worthlessness and shame as a result of experiencing racism and other traumatic experiences. One of the traumatic stressors that was endorsed by over two-thirds of the research participants was related to being shamed for being Aboriginal and people being racist towards them. Disrespectful treatment and perceptions of injustice are commonly implicated in angry and aggressive behaviour (Bettencourt & Miller, 1996). As discussed in the literature review, the pervasive loss of culture that has occurred since colonisation, and the racism and discrimination that have been part of that process, has created layers of anger and eroded some people’s identity (Day et al., 2006). For example, Novaco et al. (2000, p. 292) suggest that anger is ‘deeply entrenched in identity and that there is a need to empower people by fortifying their self-worth’. The process of reclaiming one’s culture may assist in contextualising the anger and contribute to developing a positive personal and social identity and to reducing negative self-esteem, therefore reducing the affective state of shame.

Third, the research participants identified the use of art and music as therapeutic tools. In much the same way that narrative provides a mechanism to release stories, art and music are other tools to ‘tell the tale’. For example, one research participant who was trying to make sense of the ‘wrongs that they’ve done to our people’ was able to articulate this through painting. Another research participant described both art (painting) and music (playing music on the guitar and writing songs) as processes of healing, while another described how painting helps clear his mind by visualising his pain going through the paint brush onto the canvas and then releasing it. Some people are so traumatised that they are unable to verbalise their feelings, so art and music allow the ‘Story’ to be told in a way that provides another level of expression and self-exploration. Art and music also have the potential to link into the cultural dimensions of a person’s identity. As Atkinson suggests, the creative arts have the potential to provide people with the tools to understand the essence of who they are in an articulation of both their cultural and spiritual being (2002, p. 202). The use of art and music as therapeutic tools in addressing traumatic experiences are well-documented in the literature, which suggests that there is a healing process that comes from creating through art or music, including dance, by allowing people to participate deeply, effectively and safely, because art speaks of the inner needs and experiences and cuts across cultures (Atkinson & Atkinson, 1999). Although there is currently no controlled evidence on creative therapies, it is worth considering their use as a therapeutic tool for Aboriginal men who have experienced trauma, as it clearly provided benefits for a number of research participants in this study in terms of helping them release their stories and re-connect with their culture.
Fourth, the research participants highlighted a need to increase access to employment opportunities to provide both a sense of purpose and structure in people’s lives, therefore increasing self-esteem and relieving the boredom that can contribute to alcohol misuse. Some of the research participants identified that the lack of purpose and structure that results from a lack of employment makes it hard to integrate into society, affects self-esteem, and is a contributing factor to alcohol misuse through boredom, which can then increase violence in the community. The link between violence and high unemployment, and the need to increase employment opportunities as part of the process of empowering people financially, physically, mentally and spiritually, is consistently referred to in the literature (Aboriginal Women’s Task Force on Violence, 2000; Al-Yaman et al., 2006). Powerlessness creates many problems for Indigenous peoples, and therefore self-empowerment has to be a priority. Increasing access to employment has the opportunity to address a number of structural issues, including giving people a sense of purpose and structure in their lives and increasing their self-esteem, which may assist them in dealing with their traumatic experiences and help them to re-integrate into society.

Fifth, the research participants suggested providing alcohol education and applying alcohol restrictions in communities. A number of the participants felt that more education was required to help people ‘learn to drink properly’ or that it would be better ‘if they took the drink out’ and that alcohol in particular was responsible for the fighting and criminal activity within some families and communities. These views are consistent with the research discussed in the literature review, which commonly draws an association between violence, including child sexual abuse, in Indigenous communities and alcohol and drug misuse (Atkinson, 2002; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Fitzgerald, 2001; Gordon et al., 2002; Memmott et al., 2001; Northern Territory Government, 2007).

Sixth, the research participants suggested incorporating traditional justice into legal systems. When discussing mechanisms or tools that may assist in the process of moving forward, a number of the research participants chose to discuss issues associated with traditional justice. Some of the participants felt that the Western legal systems, described as ‘whitefella law’, placed them in a position of double jeopardy, and also contributed to breaking up families and communities. Instead, they felt that ‘tribal law is better ... the tribal law is the mother of this land and you know it’s the brain’. Some of the men felt that tribal law was not respected and that if ‘law business’ was carried out in the ‘Aboriginal way’, such as through paybacks, then a second punishment
was inflicted through the implementation of ‘whitefella law’. A number of participants felt that tribal law was more effective than ‘whitefella law’, suggesting that they would rather be speared in the legs, as the physical wounds heal and allow you to move on, whereas 20 years in prison ‘makes me real sick so you can’t move on’. The honouring of ‘tribal law’ could be treated by the government as integral to attempts to develop and maintain functional, self-determining Aboriginal people and communities.

Seventh, the research participants placed great importance on breaking the dysfunctional cycle in their own children’s lives by providing safer and more harmonious environments for the next generation. There appeared to be a clear understanding of the process of generational trauma and dysfunction, with many of the participants suggesting that it was the environment that was the cause of children’s dysfunctional behaviours, which then translated into adolescent and adult dysfunction. There was a clear desire by the majority of research participants to provide a safer, more harmonious environment for the younger generation to help break the cycle. Some participants thought that education is the answer to the generational cycle of trauma and dysfunction that leads to imprisonment, and that it is up to this generation to teach the young that there is an alternative path.

‘… And if people don’t give you those chances to learn from your mistakes then you’re just going to be stuck in that way. And it’s hard to get out of it when you feel traumatised, basically by that because you’re caught in that circle of all that turmoil and all that trouble, that you’ve lived in your life. Because what ever it is you’ve got to do with your life, and I think my life is to teach my children to stop that cycle from happening, because its been happening for so long. It’s got to stop somewhere and now that I’ve been sorry and I’ve learnt so much I think I can go back to my children and say hey, I love yous very dearly and I just don’t want this to happen to you’.

However, the men reported that they need to be given the chance to make this possible by first dealing with their own trauma. The issue of formal social support in the form of appropriate services that help individuals deal with their own trauma appears once again to be a theme that has emerged from the results of this study.

**Limitations and strengths of the study**

There are several limitations to this study, other than the method by which the AAVHTQ was validated. First, the statistical power to detect significant differences was reduced through data being derived from a small sample group of 58 Aboriginal men from
various prisons who agreed to participate in the study. Aboriginal peoples represent a
diverse group, and therefore this research does not claim to be representative of the
experiences of all Aboriginal offenders. It is acknowledged that generalising from a
sample of this size must be done with caution, but the consistency of the participants’
experiences and views expressed in the qualitative data is compelling. Furthermore, the
main findings are supported by other research.

Second, all of the information provided by the research participants in terms of the
demographic details, AAVHTQ, and geno-histogram data were self-reported. Thus, the
data provided were subject to over- or under-reporting. However, it is suggested that
under-reporting is more likely; this issue will be discussed later in this chapter.
Response biases are a possible limitation, as the participants may have responded to
the assessment items with fake or exaggerated answers. Therefore, it is possible that
the participants appeared more (or less) psychologically distressed than they actually
were. The stressors associated with being incarcerated may have contributed to the
elevated response for PTSD symptom severity and the level of psychological distress.

Third, the retrospective design of the study is a possible limitation, and questions can be
raised about the validity of the information obtained on traumatic life events and the
generational data on the participants’ older and current generation family members. The
results could be biased by mood or motivational factors, or by limited recall, with some
researchers claiming that depressed and suicidal patients (two possible outcomes of
PTSD) experience more difficulties in reporting specific information about life events that
occurred in the past compared to control groups (Evans, Williams, O’Loughlin &
Howells, 1992; Williams & Dritschel, 1988). Conversely, on the basis of a review on the
influence of psychopathology on memory, Brewin, Andrews and Gotlib (1993) concluded
that claims concerning the general unreliability of retrospective reports are exaggerated
and that there is little reason to link psychiatric pathology with less reliable or less valid
recall of life experiences. Thus, there is reason to believe that the subjectively
experienced differences in exposure to traumatic life experiences reflect objective
differences in exposure. It is also important to highlight that the research participants
were able to provide a high level of detail relating to their older and current generation
family members, despite some of the participants being removed from their families.
They may have felt that they didn’t ‘know’ certain people in their families, but they were
able to provide the details that the geno-histograms required. In fact, the detail in the
older generations was as complete as in the younger generations.
A fourth limitation may be related to the potential under-reporting of traumatic stressors, specifically rape and sexual abuse. The shame and guilt associated with rape and sexual abuse may have resulted in the research participants being reluctant to discuss this issue, and therefore the true extent and the strength of the relationship of this stressor to being PTSD symptomatic is likely to be underestimated. The reluctance to report rape and sexual abuse is consistent with the finding from the recent report *Little Children are Sacred*, which reported that the shame, secrecy and embarrassment surrounding rape and sexual abuse, combined with the fear and mistrust of police and the criminal justice system in general, language and communication issues, and obligations under the kinship system, made it very difficult for individuals to disclose (Northern Territory Government, 2007). Additionally, survivors of sexual abuse often feel shame and guilt, and have been found to be less trusting of others and therefore less likely to talk openly (Finkelhor & Browne, 1986). As discussed in the literature review, issues of trust can be associated with PTSD symptomatology and are particularly prevalent in peoples that have experienced developmental trauma (Herman, 1992; Ralph et al., 2006). Therefore research participants who may be suffering from traumatic disorders may have found it difficult to share their stories, which again could contribute to an under-reporting of results.

A fifth limitation to this study may be related to the researcher being a woman. Some men, particularly in the Top End, will not open up to a female interviewer, especially when discussing the possible stressors associated with male initiation. Although this issue was a topic in focus group discussions and was addressed in the methodology by ensuring that the criteria for voluntary participation included feeling comfortable with a female interviewer, it still needs to be flagged as a potential limitation.

Similarly, although all attempts were made to ensure that any language barriers were reduced by incorporating specific procedures in the research methods and offering interpreters, a sixth limitation to this study may be related to language issues. It appeared that the greater the language difficulties, the lower the AAVHTQ score. Although at times the researcher was able to work around this issue to extract answers, there were times when it was clear that the research participant either did not understand the question or simply did not know how to answer. This issue suggests that it could be possible that PTSD prevalence rates could be underestimated due to language barriers.

Finally, as this research used a multi-method approach incorporating both qualitative and quantitative data, a purely qualitative approach was not possible.
Attempts have been made to ensure that the qualitative and quantitative data have been integrated successfully, there is inevitably some compromise to the level of detail that would normally be pursued with qualitative analysis. Therefore the qualitative data were not explored in the detail it deserved and, as such, a more detailed qualitative exploration of some of the major themes emerging from the narratives, in an attempt to make connections and elicit more overarching themes, would have provided more of an integration of the content.

Despite the limitations of this study, it is important to highlight the major strengths of this research, which lie in the cross-cultural, multi-methodological, multi-method, Indigenist approach. This approach influenced the way the data was gathered and how it was presented, validated and finally interpreted. The focus on the qualitative data was considered to provide cultural credibility to the research design. The deconstruction and interpretation of the qualitative data was kept to a minimum and it was presented alongside the quantitative data in an attempt to provide a richer, more meaningful interpretation and oral validation of the results. Essentially, this process ensured that the individual ‘Stories’ provided by the research participants were honoured, but also that the collective ‘Stories’ of the men were presented in a cohesive fashion. As discussed previously, using the qualitative data to contextualise, cross-check and validate the quantitative data proved to be an essential method in ensuring that the data in the AAVHTQ and geno-histograms was a true reflection of what the research participants were sharing. Another strength of this study is that because the research participants were incarcerated, they were not under the influence of substances (as far as the researcher was aware) and they were not experiencing withdrawal symptoms, which have the potential to mirror PTSD symptoms and thus potentially inflate PTSD severity estimates.

Potential directions for future research

A number of suggestions are presented in terms of potential directions for future research. First, it would be beneficial to continue to refine, develop and validate the AAVHTQ into a standardised instrument for Australian Aboriginal peoples and to formalise the need to administer this instrument alongside narrative interviews. It may be necessary in future research to lower the cut-off score to capture the true extent of PTSD symptomatology in this group. The clinical cut-off score for PTSD symptomatic in the AAVHTQ was set conservatively at ≥2.5, in an attempt to avoid overestimating trauma and its impact on individual psychological and relationship functioning in this group. Research participants were then grouped into PTSD and non-PTSD symptomatic. Although the AAVHTQ detected that over half (58.6%) of the study...
population were PTSD symptomatic, it was evident that the non-PTSD group, although below the clinical cut-off, were also exposed to a high level of traumatic stressors (average of 9.23 traumatic stressors in the non-PTSD symptomatic group). This may suggest that the effects of trauma are not readily detected by the AAVHTQ due to the high cut-off score, or it may simply mean that this subset of males is highly resilient in terms of negative impact. Exploring risk and resilience as it relates to PTSD symptomatology in this study population would be an effective way to address this issue.

Second, the qualitative and quantitative results revealed that the concepts of social support and personal and social identity, and their relationship to PTSD, are important to consider when attempting to conceptualise trauma-based disorders and identify effective interventions in Aboriginal communities. It may be possible that those men who had stronger support networks (both formal and informal) and a stronger sense of self, both personal and social, had a higher self-esteem (less shame) and were therefore more resilient to PTSD symptomatology. It would therefore be interesting to specifically explore the concept of resilience as it relates to social support or perceived social support, personal and social identity, self-esteem (shame) and PTSD symptomatology in this particular study population.

Third, exploration that specifically looks at shame as an effect of racism, and its contribution to negative self-esteem and PTSD symptomatology, is another potential issue that requires further exploration in this study population. Fourth, it would be interesting to specifically explore the qualitative data in this research in a future paper that provides a more detailed qualitative exploration of some of the major themes emerging from the narratives, in an attempt to make connections and elicit more overarching themes. Fifth, empirical research into the effectiveness of narrative style therapies, the creative arts as a therapeutic tool to express and release trauma stories, and the effectiveness of reclaiming culture to help contextualise anger and increase self-esteem could provide further evidence of the effectiveness of these intervention strategies for Aboriginal violent offenders.

Finally, as discussed in the literature review, there is much debate surrounding the applicability of the PTSD construct cross-culturally, recognising that it is bound by the concept of PTSD as defined by the DSM-III-R criteria. Therefore, further empirical research that explores the relevance of a culture-specific construct for the trauma response within Australian Aboriginal peoples, which may include aspects of historical and complex trauma theory, is necessary.
Potential implications of the research findings

There are a number of important implications of the key findings of this research. The over-representation of Aboriginal men in the criminal justice system, particularly for crimes of violence, is one of the most significant issues facing contemporary Australian society. Understanding the nature of Aboriginal men’s violent behaviour by locating it within the historical and personal context of cultural destruction, grief, loss and trauma is an important process for developing intervention strategies and programs that address their specific needs. With further refinement and validation, the AAVHTQ, used in conjunction with qualitative methods, has the potential to measure trauma and trauma-related symptoms that are specific to Australian Aboriginal peoples. This may be of benefit to a wide range of people and organisations throughout Australia who are interested in determining the prevalence and severity of traumatic disorders specific to Australian Aboriginal peoples. Acknowledging the relationship between Aboriginal male violence and generational post-traumatic stress could have specific implications for policy development, such as a theoretical framework for operationalising and implementing appropriate programs and strategies in the area of family violence in Aboriginal communities in general.

The individual problems seen in Indigenous Australians — alcohol and other drug abuse, depression, suicide — and the social problems seen in Indigenous families and communities — family violence, child abuse, sexual assaults — are best understood as the well-known consequences of traumatic experiences. It is time to acknowledge the psychological evidence and respond to these peoples’ traumatic histories compassionately, and with the understanding that they are still causing an impact today (Australian Psychological Society, 30 May 2007).

More specifically, intervention strategies and programs that are developed within the prison system for Aboriginal violent offenders will be able to draw upon the research findings to more accurately address matters associated with Aboriginal male violence and generational post-traumatic stress. This will enable targeted assessment and treatment for Aboriginal males who have been convicted for violent offences as well as providing a well-validated measure that would be useful in assessing the success of such interventions from an informed, culturally appropriate, holistic perspective that incorporates the past and present.

Potential abuses or misapplications of the results of the research

If the results of this research are used to pathologise people without providing them with the specific services they require, it will be a misapplication of the intended purpose of
the research. The legal profession could also use the results of this research to excuse violent behaviours, particularly in family violence situations. For example, the violence and oppression of Aboriginal men has sometimes been used as a justification to silence Aboriginal women’s voices in relation to family violence in a gender-free public debate on race. The intent of this research is to establish if a relationship exists between violence and generational post-traumatic stress and, if so, to develop an ethical response in the form of appropriate policies, strategies and programs that meet the specific needs of violent offenders, rather than to provide an excuse for violence.

Concluding remarks

There is no doubt that the Aboriginal men incarcerated for crimes of violence in this study have been exposed to high levels of cumulative trauma. PTSD appears to be a legitimate diagnosis for this group; however, there are aspects that appear to be specific to Australian Aboriginal peoples. These include issues associated with the historical and personal context of culturally bound expressions of distress interpreted as anger (which are finding release in violent behaviour), community and family destruction, grief and loss resulting in high levels of family violence, and drug and alcohol misuse. These are all compounded by personal and social identity issues associated with a lack of meaningful activities, such as employment and traditional activities, and a lack of formal and informal social support. It would therefore be reasonable to suggest that the cultural construct of trauma, as it is experienced by Australian Aboriginal peoples, requires further clarification. The use of the AAVHTQ, in conjunction with qualitative methods, appears to be a useful tool to explore traumatic stressors and cultural idioms of distress in this population, and with further refinement and quantitative validation, it may be a useful tool to measure traumatic distress in the wider Australian Aboriginal population.

From the results of this research, it appears possible to state that the violence that we are witnessing in some Aboriginal families and communities, including the high rates of incarceration of Aboriginal men for violent crimes, could be both a cause and an effect of a specific traumatic disorder, relevant to colonised indigenous populations. This disorder has its origins in colonisation, is amplified by post-colonial government policies, and is reverberating through the generations. It is therefore possible that the ‘flow-down’ of traumatic stressors and dysfunctional behaviours across generations will result in those behaviours being repeated at increased rates, and that they will continue to increase across successive generations without effective intervention. It is encouraging, however, that many of the men in this study appeared to show insight into the origins of their own behaviour and a desire and willingness to ‘break the cycle’ for the next generation by suggesting narrative, the creative arts, employment, alcohol restrictions,
honouring traditional legal systems and breaking the dysfunctional cycle in their own children’s lives through education and by dealing with their own trauma as positive ways of moving forward.

The research concludes that the Australian Aboriginal men incarcerated for crimes of violence in this study were exposed to significantly high levels of traumatic stressors that were cumulative, and therefore potentially compounding, with over half (58.6%) of the study population found to be PTSD symptomatic according to the AAVHTQ. Research participants who had endorsed traumatic stressors associated with low formal and informal social support and/or a lack of personal and social identity, and who had been sexually abused and/or suffered from symptoms associated with precarious mental health, low self-esteem and social isolation were significantly more likely to be PTSD symptomatic and appeared to resort to violence to release their trauma. Furthermore, the majority of the men in this study showed patterns of generational trauma and dysfunction in their current and older generational family trees, lending support to the theory of inter-generational transmission of trauma and violence, and suggesting that without appropriate intervention, the trauma and violence is likely to increase across succeeding generations. It is important to note, however, that the results of this research should be interpreted in light of the study’s limitations. The key findings however have important implications for the development of targeted assessment and treatment for Aboriginal males who have been convicted of violent offences and providing a well-validated measure that would be useful in assessing the success of such intervention strategies, as well as for potentially addressing issues of violence across Aboriginal families and communities throughout Australia.
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Dear «NAME2»

RE: Invitation to participate in focus group discussions for a PhD Research study titled ‘The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress’

I would like to invite you or one of your staff members to participate in a series of focus group discussions as part of the preliminary research for my PhD research project. I am a PhD research student studying with the Northern Territory University in Darwin and am currently undertaking a three year research project which began at the beginning of 2000 and is planned for completion by the end of 2006. Formal ethics approval for this research was granted on the 28 February 2001 by the Northern Territory University Human Ethics Committee.

The focus group discussions will consist of between six and 12 people, to include Aboriginal peoples who have either committed or experienced violence and traumatic stressors and professionals familiar with the culture, language and mores of Aboriginal society. It will be necessary to conduct five, four hour sessions over a period of five weeks to complete the necessary tasks. A tentative date for the first focus group discussion is Monday the 14th May 2001 starting at 1.00pm and finishing at 5.00pm.
Subsequent dates will be set one week apart and finalised once notification of who is willing to participate is received and confirmed.

The primary purpose of the PhD research project is an explanatory one, which aims to investigate and explain the relationship between violence and generational post-traumatic stress in the context of Aboriginal males who have been convicted for violent crimes. A secondary purpose, which will be developed in the preliminary stages through the focus group discussions, and used for the primary purpose, is the development of a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples.

The major purpose of the focus group discussions is to develop the cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples by discussing the nature of trauma, elicit examples of particular traumatic stressors and identify culture-specific symptoms of trauma that are relevant to Australian Aboriginal peoples and to give advice on the worth of the research.

Please find enclosed for your perusal a detailed copy of the final research proposal as submitted to the Northern Territory University and approved by the research committee on 27 October 2000 including the proposed agenda for the focus group discussions and a focus group consent form.

If you would like to participate in the focus group discussions please fill in the enclosed consent form and mail it back to me in the enclosed stamped self addressed envelope. Alternatively if you know someone who would be suitable to participate and would like to be involved in the focus group discussions please do not hesitate to pass this information on to them.

Please feel free to contact me on (08) 8942 1970, mobile 0417 866506 or e-mail cdryan@bigpond.net.au or my supervisor, Dr Sharon McCallum, Northern Territory University on (07) 4789 1044, mobile 0418 736 890 or e-mail smcallum@bigpond.com if you require further information or have any concerns.

Thank you for taking the time to read this information and I look forward to hearing from you in the near future.

Yours sincerely
Caroline Atkinson
PhD Student
Faculty of Law, Business and Arts
Discipline: Social and Community Psychology
Northern Territory University

Encl. Detailed research proposal
   Proposed agenda for focus group discussions
   Focus group discussion consent form
   Stamped self addressed envelope
Appendix B: Proposed agenda for focus group discussions

First focus group discussion
Date:  Mon 21-5-01   Time:  1.00 to 5.00pm    Address: NTU Room 39.1.37.

- Introductions
- Housekeeping (toilets, tea and coffee, change of room for last session, questions, more information, keeping informed, research concerns and possible change to days of groups)
- Background to research and methodology (qualitative and quantitative)
- Overview of research aims, methods, purpose and desired outcomes/benefits (OH)
- Overview of the purpose of the focus group discussion
- Handout Harvard Trauma Questionnaire (HTQ)
- Discuss the first 17 stressor events listed in the current HTQ which was developed for Cambodian, Lao and Vietnamese peoples.
- Handout list of traumatic stressors relevant to Australian Aboriginal peoples derived from a literature review and documentary analysis of major reports.
- Explain the focus group’s role in adding, deleting or changing the structure of questions in relation to the list of traumatic stressors.
- Go through the 16 trauma symptoms relating to the DSM-III-R and explain these will not change however the form of the questions can be adjusted to ensure cross-cultural equivalence.
- Go through the 14 culture-specific symptoms which were developed for Cambodian, Lao and Vietnamese peoples and explain that these questions will need to be developed to include culture-specific symptoms for Australian Aboriginal peoples.
- Discuss the need to review the scoring scale technique to ensure cross-cultural equivalence.
- Outline agenda for the remainder of first meeting, second, third and fourth.
- Questions?
- Brainstorm traumatic stressors relevant to Australian Aboriginal peoples which are not on list derived from the literature review and documentary analysis of major reports and current HTQ.
- Prioritise traumatic stressors from 1 to 17 from brainstorming activity, list derived from literature review and documentary analysis of major reports and HTQ.
Discuss and develop wording for each of the 17 stressor events ensuring that the linguistic, content and form of the questions are appropriate.

Apply 1 to 5 check list for each question:

1. What does this question mean to me?
2. Is the intended meaning easily understood?
3. How would I ask this question of someone else?
4. Might I encounter resistance in obtaining an answer to this question?
5. How could I rephrase the question to reduce such resistance?

Review and approve traumatic stressors from 1 to 17.

Second focus group discussion
Date: Mon 28-5-01 Time: 1.00 to 5.00pm Address: NTU Room 39.1.37.

Brainstorm culture-specific symptoms of reactions to distress, trauma and violence specific to Australian Aboriginal peoples which are not on list derived from the literature review and documentary analysis of major reports and current HTQ.

Prioritise culture-specific symptoms of reactions to distress, trauma and violence specific to Australian Aboriginal peoples from 1 to 14 from brainstorming activity, list derived from literature review and documentary analysis of major reports and HTQ.

Discuss and develop wording for each of the 14 culture-specific symptoms ensuring that the linguistic, content and form of the questions are appropriate.

Apply 1 to 5 check list for each question:

1. What does this question mean to me?
2. Is the intended meaning easily understood?
3. How would I ask this question of someone else?
4. Might I encounter resistance in obtaining an answer to this question?
5. How could I rephrase the question to reduce such resistance?

Review and approve culture-specific symptoms from 1 to 14.
Third focus group discussion
Date: Mon 4-6-01    Time: 1.00 to 5.00pm    Address: NTU Room 39.1.37.

- Discuss and develop wording for each of the 16 trauma symptoms relating to the DSM-III-R ensuring that the linguistic, content and form of the questions are appropriate.
- Apply 1 to 5 check list for each question:
  1. What does this question mean to me?
  2. Is the intended meaning easily understood?
  3. How would I ask this question of someone else?
  4. Might I encounter resistance in obtaining an answer to this question?
  5. How could I rephrase the question to reduce such resistance?

- Discuss, and adjust if necessary, the scoring scale technique to ensure that it is an appropriate means of scaling for Aboriginal peoples.
- Review and approve trauma symptoms relating to the DSM-III-R from 1 to 16 and scoring scale technique.

Fourth focus group discussion
Date: Tue 12-6-01    Time: 1.00 to 5.00pm    Address: NTU Room 39.1.38

(note change of room)

- Review final version of HTQ and gain focus group approval.
- Address project concerns and gain approval.
- Keeping informed.
Appendix C: Focus group consent form

Focus group consent form

(Please sign and hand back to me at the first focus group meeting)

I, ................................................................. of .................................................................

........................................................................................................................................

Hereby consent to participate in focus group discussions to be facilitated by Caroline (Carlie) Lisbeth Atkinson for the purpose of:

Providing preliminary research data for a PhD research study being conducted through the Northern Territory University which aims to investigate and explain the relationship between violence and generational post-traumatic stress in the context of Aboriginal males who have been convicted for violent crimes.

The purpose of the focus group discussions is to provide expert and experiential advice, guidance and knowledge which will contribute towards the development a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples and to address any concerns people may have about the research.

I acknowledge:

1. That I have read and understood the aims, methods, and anticipated use of information derived from the focus group discussion detailed in the Detailed research proposal.
2. That I voluntarily and freely give my consent to my participation in the focus group discussions.

3. I understand that focus group discussions will be used as a basis for developing a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples and results may be reported in medical, psychiatric, psychological, social and academic journals.

4. That the focus groups will be audio taped.

5. That I have no objection to my name being referred to in the final thesis.

6. That I am free to withdraw my consent at any time during the focus group discussion, at which point my participation in the group will immediately cease and any information obtained from me will not be used if so requested.

Signature ......................................................... Date .................................
## Appendix D: List of correctional institutions visited

<table>
<thead>
<tr>
<th>Townsville Correctional Centre</th>
<th>Darwin/Berrimah Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dwyer Street</td>
<td>Tivandale Road</td>
</tr>
<tr>
<td>STUART QLD 4810</td>
<td>BERRIMAH NT 0828</td>
</tr>
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<table>
<thead>
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<th>Alice Springs Correctional Centre</th>
<th>Perth: Canning Vale Prison</th>
</tr>
</thead>
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<td>ALICE SPRINGS NT 0870</td>
<td>Nicholson Road</td>
</tr>
<tr>
<td>PH: 08 8951 8911</td>
<td>CANNING VALE WA 6155</td>
</tr>
<tr>
<td></td>
<td>PH: 08 9366 6333</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Melbourne: Port Phillip Prison</th>
<th>Adelaide: Yatala Labour Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cnr Doherty &amp; Palmers Road</td>
<td>Peter Brown Drive</td>
</tr>
<tr>
<td>LAVERTON VIC 3028</td>
<td>NORTHFIELD SA 5085</td>
</tr>
<tr>
<td>PH: 03 9419 5078</td>
<td>PH: 08 8262 2421</td>
</tr>
</tbody>
</table>
Appendix E: Letter to State Correctional/Justice Departments requesting approval to conduct research in specific prison

DATE
ADDRESS

Dear TITLE

RE: Approval for PhD research project titled ‘The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress’

I would like to apply for formal approval from the STATE CORRECTIONAL/JUSTICE DEPARTMENT to conduct individual interviews with NUMBER male Aboriginal inmates who have been convicted for a crime of violence such as homicide, assault and sexual offences in the PRISON NAME between the dates of DATE and DATE.

Each confidential individual interview would last approximately two hours and consist of a semi-structured in-depth narrative interview focusing on life histories, trauma themes and violence; construction of genograms which map generational trauma and violence; and completing a cross-cultural questionnaire designed to measure trauma and trauma-related symptoms in Australian Aboriginal peoples which will be developed in the preliminary stages of the research through focus group discussions with key informants.

The interviews will contribute to the primary data of the PhD research project which is being conducted through the Northern Territory University under the Faculty of Law, Business and Arts. The PhD candidature commenced at the beginning of 2000 and is planned for completion by the end of 2002. Formal ethics approval for this research was granted on the 28 March 2001 by the Northern Territory University Ethics Committee. I plan to begin data collection mid 2001 and as such will need formal approval before commencement. I have been granted an Australian Postgraduate Scholarship Award to assist me with my living expenses while conducting my research and am also applying for additional funding from various bodies throughout Australia to assist with the necessary resources required for the project.
The suggested procedures for conducting interviews with NUMBER Aboriginal male inmates in the PRISON NAME if approval is granted are:

1. Formal advice and approval from Aboriginal Representatives within the STATE CORRECTIONAL/JUSTICE DEPARTMENT is sought.
2. The STATE CORRECTIONAL/JUSTICE DEPARTMENT send formal written approval to myself listing the required processes that will need to take place to meet with the STATE CORRECTIONAL/JUSTICE DEPARTMENT guidelines and identifying the appropriate contact person within the specified prison/s.
3. The STATE CORRECTIONAL/JUSTICE DEPARTMENT sends formal written advice to the appropriate contact person within the specified prison/s informing them of the research approval, including intended dates of interviews and to expect a full information package from myself in the near future.
4. I send out an information package to the appropriate contact person, as identified by your STATE CORRECTIONAL/JUSTICE DEPARTMENT within the specified prison/s, including a covering letter of introduction listing intended dates and times of interviews and a copy of the detailed research proposal and NUMBER inmate packages including covering letters inviting participation in the research on a voluntary basis, plain language statements listing research details and First Consent Forms.
5. Appropriate contact person within the specified prison/s recruits specified number of Aboriginal inmates who meet the research criteria i.e. Aboriginal males aged between 18-50 who are currently incarcerated for homicide, assault and sexual offences and distributes inmate packages to interested participants.
6. Aboriginal inmates either read packages or have the appropriate contact person in the prison read it to them ensuring they understand the details of the research before deciding they are willing to participate in research. If so they sign the First Consent Form and pass back to appropriate contact person within the specified prison/s.
7. Once all First Consent Forms are returned and specified quota reached for specified prison appropriate contact person mails them to me.
8. I confirm directly with appropriate person within the specified prison/s the intended dates for interviews twice before arriving at the specified prison/s.
9. Interviewee signs a final consent form on the day of the interview after they and myself are satisfied they understand the details of the interview.
10. Start interviews in specified prison/s.
The primary purpose of the research is an explanatory one, which aims to investigate and explain the relationship between violence and generational post-traumatic stress in the context of Aboriginal males who have been convicted for violent crimes. A secondary purpose, which will be developed in the preliminary stages of the research and used for the primary purpose, is the development of a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms in Australian Aboriginal peoples.

If a clear relationship is established between Aboriginal violent behaviours and generational post-traumatic stress it should have specific implications for policy development such as providing a theoretical framework for operationalising and implementing appropriate programs and strategies in the area of family violence in Aboriginal communities in general. More specifically, intervention strategies and programs which are developed within the prison system for Aboriginal violent offenders will be able to draw upon the research findings to more accurately reflect issues associated with Aboriginal male violence and generational post-traumatic stress which will provide a positive move towards addressing the issue from an informed, culturally appropriate, holistic perspective which incorporates the reality of the past and present.

Please find enclosed for your perusal a detailed copy of the final research proposal submitted to the Northern Territory University and approved by the research committee on 27 October 2000 and inmate package.

Please feel free to contact me on (08) 8942 1970, mobile 0417 866506 or e-mail cdryan@bigpond.net.au or my supervisor, Dr Sharon McCallum, Northern Territory University on (07) 4789 1044, mobile 0418 736 890 or e-mail smccallum@bigpond.com if you require further information or have any concerns.

I look forward to your formal approval and advice on the appropriate processes which will need to take place to ensure that the research is conducted in a way that meets with the STATE CORRECTIONAL/JUSTICE DEPARTMENT guidelines.

Yours sincerely

Caroline Atkinson
PhD Student
Faculty of Law, Business and Arts
Discipline: Social and Community Psychology
Northern Territory University

Encl. Detailed research proposal
Inmate package (Covering letter, Plain language statement and First consent form)
Appendix F: Interview schedule

Name/code ______________________________________________

Introduction

Introduction of Principal Researcher.

Has the research participant received the initial letter of invitation, PLS and Consent form and had the opportunity to read the information or had it explained to them? Did you understand what it was all about?

Explain the details about the research (go through Plain language statement).

Discuss what we will be doing today (i.e. background information, HTQ, discussions on violence and trauma themes and mapping a 3 generational family tree).

Check that research participant fully understands research. (i.e. are you clear why I am here and what we will be doing and why I will be asking these questions? If not contextualise the research by telling my own story).

Any questions (remind research participants that they are allowed to ask any questions about what is going on throughout the interview).

Explain and sign Final consent form.

Interview start/turn on tape recorder – start time: ________________

Background information

Date of birth: __________________ Place of birth: __________________

Mother’s country: ________________  Father’s country: ________________

Where will you be living when you are not in prison? ____________________
Language

What languages do you speak? ____________________________________________

What language do you feel most comfortable with? _____________________________

How comfortable do you feel speaking in English?

Not at all    Somewhat    Fairly comfortable    Very comfortable

Marital status

Are you married?

Never married    Married    Defacto relationship    Separated/Divorced/Widower

Children

Do you have any children? If yes how many boys/girls and what are their ages?

______________________________________________________________________

Educational level

What grade level did you complete? _________________________________________

Usual occupation _______________________________________________________

Mental illnesses

Have you ever been diagnosed with a mental illness? (e.g. PTSD, trauma disorder, depression etc.)

YES/NO

What are the diagnoses? _________________________________________________
Recidivism

How many times have you been to prison? ________________________________

What were the charges? ________________________________________________

______________________________________________________________________

Violence themes

➢ What is your understanding of violence?
➢ How many times have you been charged with a violent offence? __________
➢ What were the charges? ______________________________________________
➢ Can you tell me what you think makes you violent?
➢ Has there been much violence in your life?
➢ Can you tell me a bit about it?

Trauma themes

➢ What is your understanding of trauma?
➢ Can you tell me about some of the good things and bad things that have happened to you in your life?
➢ Have you ever experienced something that is so bad that it would be very upsetting to almost anyone?
➢ How many things like that have happened to you?
➢ What was the worst thing like that that happened to you?
➢ Do think about these things a lot when you are by yourself?

Administer Australian Aboriginal Version of the Harvard Trauma Questionnaire (this indicates that the person is symptomatic of PTSD — IT IS NOT A DIAGNOSIS)

Discuss answers to AAVHTQ in detail expanding on trauma and violence themes

Discuss similar themes within interview participant’s family and construct genogram (Show example genogram and insert large square on genogram).

Counselling and follow up.
Would you like to see the write up of the interview before I use it? YES/NO

Finish time: ________________________
Appendix G: Australian Aboriginal Version of the Harvard Trauma Questionnaire

Instructions

I would like to ask you questions about your past history and how you are feeling today. But, might be some of these questions might make you upset. If this happens, don’t worry about answering, we can keep going onto the next question or leave it all together. No one will find out your answers here – when I put them in a report I can’t use your name.

Part I: Traumatic stressors

Can you tell me if you ever saw any of these things happening or if you heard noises like this was going on or if it happened to you any time and that you believed that you or someone else could be killed or seriously harmed and/or you experienced feelings of intense helplessness, fear or horror when it happened?

<table>
<thead>
<tr>
<th></th>
<th>Experienced</th>
<th>Witnessed</th>
<th>Heard</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>W</td>
<td>H</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Adopted or fostered out.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>A lot of deaths of family or friends in one year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Murder of family or friend.</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Family violence/fighting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Emotional, mental, physical or spiritual health problems and nobody who can help you sort it out.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Unwanted sex or touching? (Rape and/or sexual abuse).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Family and/or community breakdown.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>Made to live/sit down a long way from your family.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Being forced to accept whitefella way and talk</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>English. Losing some or all of your traditional language and ceremony.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Not accepted by own community.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Murder of stranger or strangers.</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>Shamed for being Aboriginal and people being racist towards you.</td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>Not belonging to anything and feeling lost.</td>
<td></td>
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<tr>
<td>14</td>
<td>Being hungry or not having a proper house to live in or not having a proper school or clinic to go to.</td>
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<tr>
<td>15</td>
<td>Bad things happened to you with the police, welfare mob and housing commission.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>16</td>
<td>Bad things happened to you from taking drugs and/or alcohol or bad things happened to you from being with other people who have been taking them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Any other time that was so frightening to you that you felt your life was in danger.</td>
<td>Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Part II: Personal description**

Can you tell me about the most hurtful or terrifying events that have happened to you in your own community and/or family, if any. (Please tell me where and when these events happened.)

Can you tell me about the most hurtful or terrifying events that have happened to you outside your community and/or family, if any. (Please tell me when and where these events happened.)
Part III: Head injury

Did any of these things happen to you?        Yes  No  Date

Drowning
Suffocation
Beating/hitting or punching to the head

Did you lose consciousness (blank out/black out/drop)?        Yes  No  Date

If yes, for how long?

Part IV: Trauma symptoms

The following are symptoms that people sometimes have after having hurtful or terrifying things happen to them in their lives. Please read each one carefully and decide how much the symptoms bothered you this week just past.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(1) Not at all</th>
<th>(2) A little bit</th>
<th>(3) A fair bit</th>
<th>(4) A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thoughts or memories of the most hurtful or terrifying things coming up over and over again.</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Flashbacks — feeling as though the event is happening again.</td>
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<td></td>
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<tr>
<td>3</td>
<td>Having the same bad dreams over and over again.</td>
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<tr>
<td>4</td>
<td>Feeling alone and staying away from people.</td>
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<tr>
<td>5</td>
<td>Can’t feel emotions.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>Feeling nervous.</td>
<td></td>
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<tr>
<td>7</td>
<td>Can’t think straight.</td>
<td></td>
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<tr>
<td>8</td>
<td>Trouble sleeping</td>
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<td>9</td>
<td>Feeling on guard/keeping a look out</td>
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<tr>
<td>10</td>
<td>Feeling angry all the time and taking it out on others or yourself.</td>
<td></td>
<td></td>
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<tr>
<td>11</td>
<td>Trying to keep away from things that remind you of the hurtful or bad things that happened to you.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Not being able to remember some of the most hurtful or bad things that happened to you.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>Not caring about everyday things.</td>
<td></td>
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<tr>
<td>14</td>
<td>Feeling as if you don’t have a good future or any future at all (Hopelessness?).</td>
<td></td>
<td></td>
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<tr>
<td>15</td>
<td>Trying not to think or feel about anything to do with the bad or hurtful things that have happened to you.</td>
<td></td>
<td></td>
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<tr>
<td>16</td>
<td>Going mad or crying when you are reminded of the most hurtful or bad things that happened to you.</td>
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<tr>
<td>17</td>
<td>Feeling that people do not understand what happened and that you are the only one who has suffered these things.</td>
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<td></td>
<td></td>
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<tr>
<td>18</td>
<td>Feeling guilty.</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>19</td>
<td>Feeling shame.</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td>Spending time thinking about why these things happened.</td>
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<tr>
<td>21</td>
<td>Feeling as if you were going crazy.</td>
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<tr>
<td>22</td>
<td>Feeling that you have no one who will look after/out for you.</td>
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<tr>
<td>23</td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing.</td>
<td></td>
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<tr>
<td>24</td>
<td>Feeling someone you trusted did something to betray you.</td>
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<tr>
<td>25</td>
<td>Feeling worthless.</td>
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<tr>
<td>26</td>
<td>Becoming violent to self or others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Taking drugs and/or alcohol all the time to help you forget the bad things that happened to you.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Problems making and keeping relationships (Feeling unloved or unable to give love?).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Suicidal thoughts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Have you ever felt that these things didn’t happen to you or that you don’t feel bad about it (Denial)?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Scoring

Responses are summed and divided by the number of answered items to generate the following scores:

**Traumatic stressors**

Total number of events

\[= \text{Sum of all items for which response differs from 'NO'}\]

Total events experienced

\[= \text{Sum of all items with positive response to 'EXPERIENCED'}\]

**Trauma symptoms**

**DSM-III – R Score**

\[= \frac{\text{Items 1-16}}{16}\]

**Total Score**

\[= \frac{\text{Items 1-30}}{30}\]

Individuals with total scores \(\geq 2.5\) are considered symptomatic for PTSD

---

**Australian Aboriginal Version of AAVHTQ**

(Developed by Caroline Atkinson with the assistance of focus group participants)

Part of a PhD Research Project by Caroline Atkinson, NTU © 2001

Original HTQ developed by

**INDOCHINESE PSYCHIATRY CLINIC**

**DEPARTMENT OF PSYCHIATRY**

**ST. ELIZABETH’S HOSPITAL**

AND

**THE HARVARD PROGRAM IN REFUGEE TRAUMA**

**DEPARTMENT OF HEALTH POLICY AND MANAGEMENT**

**HARVARD SCHOOL OF PUBLIC HEALTH**

PARTIALLY FUNDED BY LOTUS DEVELOPMENT CORPORATIONS

© 1991 Richard F. Mollica, M.D.
## Appendix H: Current and older generational family tree codes

<table>
<thead>
<tr>
<th>Variable</th>
<th>Shortforms for drawing up tree with inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>□</td>
</tr>
<tr>
<td>Female</td>
<td>O</td>
</tr>
<tr>
<td>Paternal</td>
<td>Use blue highlighter</td>
</tr>
<tr>
<td>Maternal</td>
<td>Use pink highlighter</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>/</td>
</tr>
<tr>
<td>Marriage</td>
<td>_</td>
</tr>
<tr>
<td>Offspring</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>X</td>
</tr>
<tr>
<td>Child in utero</td>
<td>Δ</td>
</tr>
<tr>
<td>Abortion (A), Miscarriage (M) and Stillbirth (S)</td>
<td>Δ(a), (m), (s)</td>
</tr>
<tr>
<td>Age/DOB</td>
<td>#</td>
</tr>
<tr>
<td>Deceased by natural causes</td>
<td>DNC – BH</td>
</tr>
<tr>
<td></td>
<td>- OA</td>
</tr>
<tr>
<td>Deceased by unnatural causes</td>
<td>DUC – M</td>
</tr>
<tr>
<td></td>
<td>- A</td>
</tr>
<tr>
<td>Have been incarcerated</td>
<td>HBI</td>
</tr>
<tr>
<td>Currently incarcerated</td>
<td>CI</td>
</tr>
<tr>
<td>Condition</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Stolen generation</td>
<td>SG</td>
</tr>
<tr>
<td>Mental illness</td>
<td>MI</td>
</tr>
<tr>
<td>Perpetrator sexual assault/rape</td>
<td>PSA/R</td>
</tr>
<tr>
<td>Victim sexual assault/rape</td>
<td>VSA/R</td>
</tr>
<tr>
<td>Victim physical violence</td>
<td>VPV</td>
</tr>
<tr>
<td>Perpetrator physical violence</td>
<td>PPV</td>
</tr>
<tr>
<td>Suicide</td>
<td>SA</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>AA</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>DA</td>
</tr>
</tbody>
</table>
Appendix I: Confidentiality statement for transcribers

As a transcriber of audio taped interviews derived from a PhD Research Project conducted by Ms Caroline Lisbeth Atkinson you have access to confidential material obtained from research participants. In concordance with the ethical guidelines of this project it is required that you sign this confidentiality statement which includes all material related to the research project titled ‘The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress’ in which you act as a transcriber.

I, ........................................................................................................ of ......................................................

..............................................................................................................................................................................................

Agree to the following:

General

➢ I understand that the material I am transcribing is confidential.

➢ The material transcribed will be discussed with no one.

➢ The identity of research participants will not be divulged.

➢ I understand that the contents of the interviews could be potentially distressing and as such have agreed to talk to the researcher before, during and after transcription begins.

Transcription procedure

➢ Transcription will be conducted in such a way that the confidentiality of the material is maintained.

➢ I will ensure that audio-recordings cannot be overhead.

➢ I will maintain strict security of the audio tapes and printed typed transcripts by ensuring that all material is locked in a secure area when I am away from my work.
station. This includes shredding any printed drafts of the transcripts and not storing the material on the hard drive but rather on floppy with one backup.

- I will ensure that I will not make personal use of, reproduce, divulge or allow anyone to listen to the audio tapes or read the transcripts, or part of the transcripts, other than the researcher Caroline Lisbeth Atkinson.

- All materials relating to transcription will be returned to the researcher.

Signed ……………………………………………………… Date ……………………………

Print name: ……………………………………………………………………………………………

Researcher: ……………………………………………………………………………………………

Project title: The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress

Copies to go to: CRCATH (Terry Dunbar), Caroline Atkinson (researcher) and Transcription Organization
Appendix J: Specific format for transcription

➢ Number/letter code on tape to be typed in the top right-hand corner of every page of the transcript.

➢ All pages to be numbered.

➢ All transcriptions begin on side (a) of the first tape and progress to side (b) and side (a) then (b) of the second tape if applicable.

➢ Please type research participants text in normal print and researchers text in Italics.

➢ Transcription must be verbatim (word for word) including stutters, conversation fillers such as um, er, mm etc.

➢ Please also include non-verbals if they stand out such as laughter, crying, sighing, long pause after a question, long silences, anger etc.

➢ All references to specific names must be replaced with a non-descript identifier which includes gender and relationship to research participant and placed in brackets i.e. (female/male friend), (male/female officer), (male/female police officer), (sister), (brother), (uncle), (auntie), (mother), (father), (stepfather), (cousin), (sister/brother cousin) etc.

IMPORTANT NOTE: Please be aware that some of the material contained in the interviews may be quite distressing. If at any stage you feel you need to de-brief or you have any concerns about the content of the interviews please do not hesitate to contact me. Furthermore, some of the interviews were conducted with unavoidable background noise and hopefully this will not affect transcription, however if you have any queries at all please do not hesitate to contact me on:
Caroline (Carlie) Atkinson  
608/16 Moore Street  
Canberra City  ACT  2600

(H): 02 6247 9949  
(M): 0417 866506  
(E-Mail): cdryan@bigpond.net.au
Appendix K: Covering letter to contact person in each prison

DATE
PRISON CONTACT PERSON

Dear NAME

Re: Research to be conducted at the [prison name] from date to date titled ‘The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress’

I have been informed by NAME, STATE CORRECTIONAL/JUSTICE DEPARTMENT, that approval to conduct the research project titled ‘The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress’ has been granted. The STATE CORRECTIONAL/JUSTICE DEPARTMENT will have already contacted the Superintendent of PRISON NAME and yourself about the details of this research and your involvement in it.

Overall, the research project intends to interview a total of 70 Aboriginal men from 7 different correctional institutions in 6 different states/territories throughout Australia. I will be interviewing NUMBER male Aboriginal inmates at the NAME OF PRISON over a period of a week, DATE to DATE, who have been convicted for a crime of violence such as homicide, assault and sexual offences and theft, robbery and breaking and entering which involved violence against the person (See Research summary sheet for selection criteria of research participants at Attachment 1).

Each confidential individual interview would last approximately two hours and consist of a semi-structured in-depth interview focusing on life histories, trauma themes and violence; construction of genograms which map generational trauma and violence; and completing a cross-cultural questionnaire designed to measure trauma and trauma-related symptoms in Australian Aboriginal peoples, which has been developed through focus group discussions with key informants.
The interviews will contribute to the primary data of my PhD research project which is being conducted through the Northern Territory University under the Faculty of Law, Business and Arts. The PhD candidature commenced at the beginning of 2000 and is planned for completion by the end of 2002. Formal ethics approval for this research was granted on the 28 February 2001 by the Northern Territory University Ethics Committee (Attachment 2).

The primary purpose of the research is an explanatory one, which aims to investigate and explain the relationship between violence and generational post-traumatic stress in the context of Aboriginal males who have been convicted for violent crimes. A secondary purpose, which has been developed in the preliminary stages of the research and will be used for the primary purpose, was the development of a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms specifically in Australian Aboriginal peoples.

The development of a cross-cultural instrument capable of measuring traumatic stressors and trauma-related symptoms specifically in Australian Aboriginal peoples had not previously been developed and will thus contribute enormously to a wide range of people and organisations throughout Australia who are interested in determining the prevalence and severity of traumatic disorders.

Additionally, if a clear relationship is established between Aboriginal violent behaviours and generational post-traumatic stress, it should have specific implications for policy development such as providing a theoretical framework for operationalising and implementing appropriate programs and strategies in the area of family violence in Aboriginal communities in general. More specifically, intervention strategies and programs which are developed within the prison system for Aboriginal violent offenders will be able to draw upon the research findings to more accurately reflect issues associated with Aboriginal male violence and generational post-traumatic stress, which will provide a positive move towards addressing the issue from an informed, culturally appropriate, holistic perspective which incorporates the reality of the past and present.

The suggested procedure, subject to your approval, for ensuring the smooth running of this research project is:

- NAME OF PRISON assigns a suitable contact person for me to liaise with throughout the process of the research and informs me of whom that will be.
Suitable contact person, as assigned by the NAME OF PRISON, distributes inmate packages (see Attachment 3 — all written in plain English) to suitable research participants who meet the selection criteria (as listed in Research summary sheet at Attachment 1).

Inmates either read the information in the inmate packages themselves or the assigned contact person at the NAME OF PRISON reads it to them ensuring that the inmates understand the nature of the research and their role in it. This could be done in a group forum to save time.

Once inmates have decided they would like to participate in the research they sign the ‘First consent form’ (part of inmate packages at Attachment 3) and pass it back to the assigned contact person in the Darwin Correctional Centre.

Once assigned contact person in the NAME OF PRISON gets NUMBER signed ‘First consent forms’ they post them back to me (see contact details on Research summary sheet at Attachment 1).

For further information about the research project please find enclosed for your perusal a copy of the final research proposal submitted to the Northern Territory University and approved by the research committee on 27 October 2000 (Attachment 4). Also enclosed are the inmate packages which include an instruction sheet, letter of invitation inviting inmates to participate in the research, a plain language statement and the first consent form which the inmates will need to sign and pass back to the assigned contact person in the prison who will then forward them on to me (Attachment 3).

Please feel free to contact me on (h) (08) 8942 1970, (w) (08) 8946 6748, mobile 0417 866506 or e-mail cdyr@bigpond.net.au or my supervisor, Dr Sharon McCallum, Northern Territory University on (07) 4789 1044, mobile 0418 736 890 or e-mail smccullum@bigpond.com if you require further information or have any concerns.

I look forward to working with you in the near future and receiving NUMBER ‘First consent forms’ from Aboriginal male inmates who are willing to participate in the research.

Yours sincerely

Caroline Atkinson
PhD Candidate, Faculty of Law, Business and Arts
Discipline: Social and Community Psychology
Northern Territory University

Encl.   Attachment 1: Research summary sheet.
Attachment 2: Northern Territory University Human Ethics Committee approval to conduct research
Attachment 3: Inmate packages (Instruction sheet, Letter of invitation to inmates, Plain language statement and First consent form) x 40
Attachment 4: Detailed research proposal
Appendix L: Research summary sheet

Project title:

‘The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress’

Chief investigator or supervisor

Name: Caroline (Carlie) Lisbeth Atkinson (Chief Investigator)

Position: PhD Candidate at the Northern Territory University

Address: Casuarina Campus
          Faculty of Law, Business and Arts
          Northern Territory University
          DARWIN NT 0909

Contact details: PH: (08) 8946 6748, mobile (0417) 866506

E-mail: cdryan@bigpond.net.au
<table>
<thead>
<tr>
<th>Commencement date of research at the name of prison:</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion date of research at the name of prison:</td>
<td>DATE</td>
</tr>
<tr>
<td>Total number of research participants required:</td>
<td>10</td>
</tr>
<tr>
<td>Daily interview schedule:</td>
<td></td>
</tr>
<tr>
<td>First interview to start at 10.30am and finish at 12.30pm.</td>
<td></td>
</tr>
<tr>
<td>Second interview to start at 2.00pm and finish at 4.00pm.</td>
<td></td>
</tr>
<tr>
<td>Two interviews will be conducted each day for 5 days totalling 10.</td>
<td></td>
</tr>
</tbody>
</table>
Selection criteria for research participants

- Sentenced inmate
- Male
- Personally identify as Australian Aboriginal
- Aged between 18 and 50
- Currently incarcerated for a crime of violence (homicide, sexual assault, assault and theft, robbery and breaking and entering which involved violence against the person)
- Voluntary participant
- Willing to be interviewed by a female

Method:

Confidential two hour one-to-one interviews – audio taped

Special requirements:

- Contact person at the PRISON to ensure that a security clearance and approval from the STATE CORRECTIONAL/JUSTICE DEPARTMENT to use the audio-taping device is provided at the front gate.
- A private interview room that is available for the duration of the research (DATE – DATE).
- Commitment by NAME OF PRISON Psychologists and welfare staff to provide ongoing aftercare counselling if requested or required by the research participant.
- Personal safety (as instructed by the NAME OF PRISON staff).
- Due to the nature of the interview material it is imperative that the privacy and confidentiality of the research participants is honoured.
Appendix M: Inmate packages —- instructions

Attachment 3

Contents:
- Letter of invitation to inmates
- Plain language statement
- First consent form

- I have included 40 copies of the inmate packages for distribution. If you require more copies of the inmate packages please let me know.

- Please insert the name of the assigned contact person within the NAME OF PRISON in the ‘Letter of invitation to inmates’ on the underlined areas in the letters.

- Distribute packages to all male Aboriginal inmates that meet the selection criteria (see Research summary sheet at Attachment 1)

- These packages can either be read by the inmates themselves or read to them by the assigned contact person at the NAME OF PRISON. Prior to commencement of the interviews I will double check to ensure that each inmate has a full understanding of the nature of the research and their role in it.

- Once an inmate has decided to participate in the research please ensure that they sign the ‘First consent form’ and pass it back to the assigned contact person at the NAME OR PRISON.

- Once 10 men have volunteered to participate in the research and have signed their ‘First consent form’ and passed it back to the assigned contact person in the NAME OF PRISON the 10 ‘First consent forms’ need to be posted back to myself (see contact details on the Research summary sheet at Attachment 1).
Appendix N: Letter of invitation to inmates

Dear Sir

Re: Invite to participate in research project which looks at the relationship between violence and trauma

I would like to invite you to talk to me for my university research study. I want to talk to Aboriginal men aged from 18 to 50 who have been put in jail because of violent crimes like murder, assault and sexual assault.

I am an Aboriginal woman studying at the Northern Territory University in Darwin doing a three year PhD research study. I want to have a look at and try to explain how some people can be violent because they have grown up with people being violent in their own families and how horrible things that happen to us in our life can make us feel sad, scared, shamed and angry and do bad things. I want to find out if the violence, horrible experiences and bad feelings that have happened to you are passed on to your families and friends making them feel bad too. I want to measure all the horrible things that have happened to you and how that makes you feel bad so we can understand and help people who feel like that. I want to help stop violence in Aboriginal families and communities where bad things happen to children, and then to their children and so on.

I would like to talk to you about the bad things that have happened to you in your life and the things you might of done because you were feeling bad. I would also like to hear about the bad things that have happened in your family so we can look at the whole picture. I will ask questions to see how many bad things have happened to you and how that has made you feel. The talk would go for about two hours and I will keep it very secret.

You do not have to take part in this study. Because you are Aboriginal it would help me a lot to show the Aboriginal side of these things and how they affect Aboriginal families and communities so we can help other people who have had the same things happen to them.

If you want to help me and be in the research study, please read or get assigned contact person INSERT NAME OF ASSIGNED CONTACT PERSON in the NAME OR PRISON...
to explain the ‘Plain language statement’ to you which tells you more about the research. If after that you still want to be part of the research study, please read and sign the ‘First consent form’ and give it to the assigned contact person in the NAME OR PRISON INSERT NAME OF ASSIGNED CONTACT PERSON.

Thank you for reading this letter, I appreciate it a lot. Maybe I’ll see you at the NAME OR PRISON between the DATE and DATE. If you have agreed to participate in the research I will let you know the day and time that I will be seeing you as soon as I can.

Yours sincerely

Caroline Atkinson
PhD Student
Faculty of Law, Business and Arts
Discipline: Social and Community Psychology
Northern Territory University

Encl. Plain language statement
First consent form
Appendix O: Plain language statement

Research project: The Violence Continuum: Australian Aboriginal male violence and generational post-traumatic stress

Researcher: Caroline Lisbeth Atkinson
PhD Postgraduate Research Student
Faculty of Law, Business and Arts
Northern Territory University
DARWIN NT 0800

Purpose of the study: I want to have a look at and try to explain how some people can be violent because they have grown up with people being violent in their own families and how horrible things that happen to us in our life can make us feel sad, scared, shamed and angry and do bad things. I want to find out if the violence, horrible experiences and bad feelings that have happened to you are passed on to your families and friends making them feel bad too. I want to measure all the horrible things that have happened to you and how that makes you feel bad so we can understand and help people who feel like that.

Benefits of the study: I want to show how bad experiences and violence is hurting children, and then their children's children and so on. If people can know more about why their relations are being violent then it will be easier for them to help them, and like that we can try to stop the violence problems in Aboriginal communities.

What you would do? If you want to talk to me for this study, then I would talk to you at the prison for about two hours. I would like to listen to your life story, to hear about
your parents, family and community. I would like you to talk about the horrible things that have happened to you in your life and bad things you have done to others and how this has made you feel. Together we would look at your family and see how many horrible things have happened to them too.

**Risks:**

Talking about the bad things you have done and the horrible things that have happened to you and your family may upset you. The Social Workers and Psychologist in the prison will be nearby to talk to you if you want to. I can't tell the Social Workers or Psychologists anything you told me, but I will if you want me to. You can stop the talk any time you want and you don't have to give a reason. As I am a female you might feel uncomfortable talking to a woman — please do not participate in the interview if this is how you feel.

**Secrecy:**

I will record everything you tell me on a tape, so that I can write down your exact words. This tape will be locked up so no-one except me can get to it. Everything you tell me would be kept very secret. I will not put your name on the tape, and when I write about your story I will not use your name but refer to you by a code number.

**Do you have to take part:**

It's up to you if you want to do this. I would be very happy if you do take part because I think I will help a lot of people who have had the same things happen to them. Please remember that even if you say yes now, you can say no later.

**Results of the study:**

When the two hour talk is finished I will need some time to put it on paper and then you can read it if
you want. If you don’t like what I have put down then I can change the words before it is published.

**Who to contact:**

If you have any more questions you can contact me, the researcher, Caroline Lisbeth Atkinson at the Northern Territory University on ph: (08) 8946 6748, mobile 0417 866506 or email cdryan@bigpond.net.au or you could talk to my supervisor, Dr Sharon McCallum, Northern Territory University on (07) 47891044, mobile 0418 736 890 or e-mail smccallum@bigpond.com.

If you think something is wrong with what I am doing, you can contact the Executive Officer of the Northern Territory University Human Ethics Committee on 08 8946 7064 — and don’t have to talk to me or my supervisor.
Appendix P: First consent form

First consent form

(to be filled in and signed by research participant and sent back to researcher by assigned contact person within the NAME OR PRISON)

I,...........................................................................................................................................................................

...........................................................................................................................................................................

Agree to take part in a human research study to be done by Caroline Lisbeth Atkinson and I understand that the reason for doing the research is:

to have a look at and try to explain how some people can be violent because they have grown up with people being violent in their own families and how horrible things that happen to us in our life can make us feel sad, scared, shamed and angry and do bad things. She wants to find out if the violence, horrible experiences and bad feelings that have happened to us are passed on to our families and friends making them feel bad too. She also wants to measure all the horrible things that have happened to us and how that makes us feel bad. Then she will publish her study in a book so that people can understand and help people who feel like that.

I acknowledge:

➢ That I understand the plain language statement which tells me what the study is trying to do, how it will be done, how long it will take, how it might help people, that it is being done by a woman and what risks there are for me.

➢ That I have decided I want to take part in this study myself, and that nobody has forced me into doing it.
➢ That what I say will be used for the research study, and might be part of study books and journals.

➢ I understand that what I say in the two hour talk will be recorded on tape and used for the research but my name will be kept completely secret unless I say it is okay to use it.

➢ That I can stop taking part in the research study at any time. If I want to stop, then Caroline can’t use my story.

Interviews will be conducted in plain English. If you would like to have a language interpreter at the interview please tick the box below and let me know your language group.

☐ Yes I would like a interpreter present at the interview.

Preferred language group ________________________________________

Signature ……………………………………………………… Date …………………………
Appendix Q: Final consent form

Final consent form
(to be signed on the day of interview before it starts)

I,…………………………………………….of………………………………..………………….

……………………………………………………………………………………………………..

Agree to take part in a human research study to be done by *Caroline Lisbeth Atkinson* and I understand that the reason for doing the research is:

to have a look at and try to explain how some people can be violent because they have grown up with people being violent in their own families and how horrible things that happen to us in our life can make us feel sad, scared, shamed and angry and do bad things. She wants to find out if the violence, horrible experiences and bad feelings that have happened to us are passed on to our families and friends making them feel bad too. She also wants to measure all the horrible things that have happened to us and how that makes us feel bad. Then she will publish her study in a book so that people can understand and help people who feel like that.

I acknowledge:

- That I understand the plain language statement which tells me what the study is trying to do, how it will be done, how long it will take, how it might help people, that it is being done by a women and what risks there are for me.

- That I have decided I want to take part in this study myself, and that nobody has forced me into doing it.

- That what I say will be used for the research study, and might be part of study books and journals.
➢ I understand that what I say in the two hour talk will be recorded on tape and used for the research but my name will be kept completely secret unless I say it is okay to use it.

➢ That I can stop taking part in the research study at any time. If I want to stop, then Caroline can't use my story.

Signature …………………………………………………… Date ……………………………