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Understanding the Australian Aboriginal experience of collective, historical and intergenerational trauma

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Abstract

This article provides a summary of the evolving definition of trauma, including different forms of trauma and its impact on the health, behaviours and well-being of individuals and communities. Specifically, it discusses collective, historical and intergenerational trauma and the value of these concepts in understanding the health and social challenges we see within colonized Indigenous communities, particularly within Australian Aboriginal communities. The article argues that the current approach to addressing challenges within Australian Indigenous communities will have limited impact unless accompanied by a significant focus on understanding and addressing the level of trauma that permeates these communities. Programmes and initiatives that focus on reducing the rates of certain variables, such as rates of infant mortality, rates of incarceration or rates of school completion, are very important but are only treating symptoms unless the underlying trauma is addressed. Due to the ongoing devastation caused by many years of forced child removal, this is especially important for health, legal and welfare practitioners within the child protection system and the social work field if we are to break the cycles of family and cultural disruption.

Keywords

Aboriginal Australians, child protection, collective, historical, intergenerational, trauma

This article seeks to demonstrate that collective, historical and intergenerational trauma is strongly evident within Australian Aboriginal communities, and child protection, health, legal and welfare practice within these communities should be informed by trauma frameworks. It commences with a review of the research literature that defines trauma and studies its impact, then examines the relevance of this literature to Australian Aboriginal communities. The word Indigenous is used respectfully and interchangeably with the terms Aboriginal or Aboriginal and Torres Strait Islander in this article. All terms are used to acknowledge, describe and honour the original inhabitants and traditional owners of Australia and their descendants.

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The evolution of the definition of trauma

The study of trauma is a relatively new field, although the human experience of and exposure to trauma are clearly not recent phenomena. The harm experienced by victims of trauma, prior to the last century, was met with little understanding or support, despite how debilitating the effects of exposure to trauma had been for many (Van der Kolk et al., 1994). It was not until the 20th century that such effects were documented and given names such as Shell Shock, Battle Fatigue, Accident Neurosis and Post-Rape Syndrome (Talbott, 1997). In 1952, the American Psychiatric Association (APA) published the first *Diagnostic and Statistical Manual of Mental Disorders* and included a diagnostic category labelled Gross Stress Reactions (APA, 1952). In 1968, the release of the second edition of the *Diagnostic and Statistical Manual* (DSM-II) altered this category to Transient Situational Disturbances, a term predominantly used to describe the symptoms of war veterans (Everly, 1995; Meichenbaum, 1994).

One of the most devastating and well-documented community-based, trauma-related events of the 20th century was the Holocaust in World War II (Herman, 1992; Wilson et al., 1988). The experiences of Holocaust survivors and their ongoing impact on health and well-being were not formally recognized and understood as trauma or trauma effects until two decades after the war had ended. Increased understanding, and benefits from psychological treatments that developed in response to the clinical APA definition of trauma, have primarily been of assistance to the descendants of the victims as well as to ageing survivors (Kellermann, 2001).

Vietnam veterans are another prominent group who have, in more recent times, received acknowledgement of the trauma they experienced during their military service and, for many, the resultant post-traumatic stress disorder (Herman, 1992; Scurfield, 1993). Once again, acknowledgement of trauma came slowly. Many veterans dealing with the aftermath of combat service had to deal with community hostility for their role in the Vietnam War. This occurred as the media coverage at the end of the Vietnam War brought distressing and graphic images of the horror of war and the faces of victims. These pictures influenced public perceptions and raised questions about the necessity and morality of the war, with blame frequently directed towards the returning soldiers. As a result, not only did Vietnam veterans suffer from the effects of post-traumatic stress syndrome because of their battle experiences, but their trauma was exacerbated by public vilification. The experiences of these veterans became an area of significant study (Andreasen, 2010; Hillman, 2002; Van der Kolk et al., 1996), leading to advances in thinking about and defining trauma and its impact.

It was not until 1980 that trauma was officially recognized in the field of Psychiatry, with its entry as a diagnostic entity in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn [DSM-III]; APA, 1980). A revision of the DSM-III in 1987 stated that trauma is 'an event that is outside the range of usual human experience' that would 'evoke symptoms of distress in almost everyone' (APA, 1987: 236). By the mid-1990s the APA had made a distinction between common stressors such as bereavement, chronic illness, job loss and marital breakdown as one level of trauma, and traumatic experiences marked by intense fear, terror and helplessness. Along with this definition, specific trauma events and/or experiences were noted, such as combat service, rape and natural disasters (Herman, 1992; Hillman, 2002; Van der Kolk et al., 1994, 1996; Wilson et al., 1988).

The fourth edition of the *Diagnostic and Statistical Manual* (DSM-IV) described a traumatized person as one who 'experienced, witnessed or was confronted with an event or events that involved actual threatened death or serious injury, or a threat to the physical integrity of the self or others' (APA, 1994: 427). Typical symptoms cited included sleeping disorders, difficulty in concentrating, and avoidance of situations that evoked the initial traumatic event. A key feature of this definition

was the emerging concept that understanding the impact of trauma may assist in the recovery process (Herman, 1992). This definition made it clear that trauma with significant ongoing impact in the life of an individual can result from a range of experiences, including war and torture but also natural disaster, being kidnapped, rape, child sexual or physical assault, physical assault, terrorism, transport crashes and finding the body of someone who has committed suicide or been murdered (Herman, 1992; Raphael, 1986; Wilson et al., 1988).

A pioneer in the work of traumatology is psychiatrist and researcher Judith Herman (1992), whose initial work related to survivors of incest has since expanded the notion of trauma so that it takes account of one-off short-lived traumatic events as well as prolonged and repeated trauma events (Herman, 1992). More specific trauma writing addressed domestic violence and all forms of child abuse as Herman (1992) applied a trauma framework to ongoing violence and abuse in intimate/family relationships and to differentiate these ongoing traumatic experiences from natural disasters, and war, because the former types of trauma involve a unique feature of betrayal in key developmental and interpersonal relationships by parents and/or partners. Herman (1992) noted that even when the apparent harm or threat had gone, or the event was long over, traumatized people would re-experience the traumatic event(s) as if it were continually recurring in the present, with disrupted and repeated intrusion of traumatic stimuli causing interruptions to the individual's ordinary day-to-day life.

Defining post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) develops after a person has been exposed to an extremely traumatic event that they reacted to with intense anxiety, helplessness or horror and vivid flashbacks of certain situations (Raphael, 1986: 80). The DSM-IV describes three clusters of post-traumatic symptoms: intrusive symptoms, avoidance symptoms and physical arousal (APA, 1994). The fifth edition of the DSM (2013) added an additional cluster that captures negative alterations in cognition and mood such as dissociated amnesia, or distorted self-blame and blame of others for a traumatic event. The DSM-5 (APA, 2013) has been criticized because of the number of PTSD symptoms listed and the emphasis on the heterogeneity of symptom expression. It has been described as taking a 'polythetic approach' to classification, which is not clinically useful because it does not define core and secondary symptoms (Young et al., 2014). Nonetheless, it is important to acknowledge the many different expressions of trauma and its comorbidities.

Brown et al. (2001) found that 92 percent of people with a principle diagnosis of PTSD experienced a comorbid disorder. Galatzer-Levy et al. (2013) found three main patterns of PTSD comorbidity: (1) 62 percent of people with PTSD have a moderate probability of a comorbid depressive episode; (2) 24 percent are depressed and anxious, which is associated with suicidal ideation and mood disorders; and (3) 14 percent develop substance dependency in addition to depression and anxiety and the associated suicidal ideation and mood disorders. The third pattern is more common for males, and the second pattern is more strongly associated with females (Müller et al., 2014). According to Wilson and Sigman (2000: 58), traumatic stressors and their consequences to human life are profound in terms of the depth of impact for 'psychic integration, ego states and spiritual wellbeing'.

Trauma, health and inequity

Health and well-being are interrelated, and often influenced by an individual's community, home and institutions. The health outcomes at the interface of these interactions in an individual's life are more commonly known as 'social determinants of health'. The World Health Organization (2018) defines social determinants of health as 'the conditions in which people are born, grow, live, work

and age and the systems put in place to deal with illness' (Blas, 2011: 189). These conditions are not just responsible for shaping our lives, but ultimately impact on our health and well-being. Professor Michael Marmot (2016), international expert on epidemiology and public health, emphasizes the importance of addressing the 'causes of the causes', that is, the contributing behaviours and circumstances that result in poor health outcomes. Many of the factors that contribute to the burden of disease for Indigenous Australians have a social basis as the origin rather than a specific physical disease (Marmot, 2016). Disproportionality and disparity exist between the health and the well-being of Indigenous people and non-Indigenous people because of the direct social determinants that are associated with 'colonization, marginalization, intergenerational trauma and the lack of government conscience to redress the continuing effects of health inequities' (Griffiths et al., 2016).

The impact of structural inequalities and interpersonal and institutional discrimination can have adverse effects on educational outcomes, securing employment, economic advancement and access to housing, and is 'aetiologically important in the causation of illness' for Indigenous Australians (Awofeso, 2011: 4). The recent Inquiry into Intergenerational Welfare Dependence, conducted by the Australian House of Representatives Select Committee on Intergenerational Welfare Dependence (2019), found that institutional discrimination was identified as a significant factor in reducing the 'likelihood of Aboriginal people accessing essential services in areas such as the health system as well as the media, education, welfare and criminal justice systems and in the provision of public housing' (p. 14). The report, titled *Living on the Edge*, also drew attention to the 'disproportionately high level of disadvantage and prevalence of intergenerational trauma faced by Aboriginal children and families' (House of Representatives Select Committee on Intergenerational Welfare Dependence, 2019: 34).

Research supports that trauma has not only a psychological impact but also a significant impact on the physical well-being of the individual. There are a number of recent, comprehensive studies that clearly demonstrate an association between trauma and impaired health (Felitti and Anda, 2009; Schnurr et al., 2014; Tran et al., 2015). For instance, Scott et al. (2013) conducted a cross-national study in 14 countries, with a total participant group of 38,051 adults and found significant associations between experiences of a traumatic life event and 9 of the 11 physical conditions they asked about: arthritis, back and neck pain, headaches, heart disease, high blood pressure, asthma, diabetes, peptic ulcer, chronic lung disease. The risk of physical ill health increased with the number of traumatic events experienced by an individual. These associations remained significant regardless of whether or not the individual had experienced PTSD following their trauma event(s), contradicting earlier research that argued that it was the bio-behavioural effects of psychological distress in the form of PTSD that led to poor health outcomes (Banyard et al., 2009). It seems that experiencing trauma, regardless of its impact on subsequent mental health, leads to increased risk of poor health outcomes. Another interesting aspect of the study was that trauma was not associated with cancer or stroke, again challenging earlier assumptions that stress led to cancer (Scott et al., 2013). There is a need for further research to better understand the pathways or mechanisms through which trauma interferes with the health of the body. It is likely that there are behavioural pathways (e.g. trauma leads to an increase in behaviours that increase health risks, such as smoking or drinking to excess), as well as abnormalities in cortisol response, cardiovascular arousal and neurocognitive structure and function (Scott et al., 2013).

Childhood trauma, behaviour and development

It is well documented that childhood trauma, including abuse and neglect, increases the risk of substance abuse, depression, anxiety and other emotional and behavioural difficulties in young people, interfering with their development of adjustment and self-regulatory capacities (Goldman et al., 2016; Grasso et al., 2013; Saunders and Adams, 2014). Recent research has investigated

neural pathways that might explain the link between trauma and depression as well as other stress-related disorders. For example, Suzuki et al. (2014) found that limbic hyperactivity was a bio-marker of early life stress and trauma in children.

Witnessing intimate family violence is a relatively recently acknowledged form of trauma (Carter and Myers, 2007; Laing and Humphries, 2013; Stanley and Goddard, 2002). Evidence suggests that children exposed to intra-familial violence display trauma-related behaviours that parallel the trauma behaviours of children living in war-torn countries (Herman, 1992). Insana et al. (2014) found that two-thirds of children who had been exposed to intimate partner violence within their families experienced sleep problems, most commonly nightmares, and those with sleep problems also demonstrated poor adaptive functioning. The authors point out that childhood sleep disorders are an early risk indicator for emotional and behavioural difficulties, as well as adult anxiety disorders, and are a symptom of PTSD. Insana et al. (2014) argue that sleep disturbances mediate the relationships between exposure to family violence and neural responses to emotionally salient information, leading to poor psychological outcomes. Their logic is as follows: children exposed to family violence have heightened amygdala activation and child maltreatment is associated with smaller medial prefrontal cortex volumes (McCrory et al., 2010). The amygdala and the medial prefrontal cortex are part of the neural circuit that processes emotionally salient information and formulates behavioural responses, and both are highly sensitive to sleep loss; therefore, early sleep disturbances lead to neurological changes that impact on development and behaviour (McCrory et al., 2010).

Importantly, maternal psychopathology was strongly associated with child outcomes in the study described above (Insana et al., 2014). Children who demonstrated resilience were more likely to have mothers with good mental health. This finding mirrors those from other studies, such as an Israeli study that found that maternal mental health mediated the negative impact of war trauma on infant sensorimotor and language development (Punamaki et al., 2018). In any discussion of the impact of trauma, particularly in relation to children, it is important to acknowledge the factors that are protective and support the building of resilience. Maternal emotional well-being is key, as can be education settings (Goldman et al., 2016) and cultural/community connections (Brave Heart et al., 2011).

Historical trauma and post-colonial trauma

Emergent within the trauma literature over the past two decades has been the notion of historical trauma. This term, which was first used to understand trauma among Holocaust survivors, became useful to capture the experience of American Indian/Native Alaska communities (Evans-Campbell, 2008), who had endured a history of 'community massacres, genocidal policies, pandemics from the introduction of new diseases, forced relocation, forced removal of children [through] Indian boarding school policies, and prohibition of spiritual and cultural practices' (Evans-Campbell, 2008: 316). Halloran (2004) uses the term 'cultural trauma' to describe the interruption of cultural knowledge and practices in order to undermine the worth of a people. Davoine and Gaudilliere (2004) describe the impact of cultural genocide, geographic displacement or forced removal as a 'dehistoricization of experience' (p. 47). They use the term 'frozen trauma' to explain how past trauma can remain present. Central to this understanding, they argue, is the need of individuals and groups to have their experiences acknowledged, 'naming the unnameable' experience of their trauma.

Colonial atrocities such as forced relocation, slavery, destruction of culture, and child removals and family loss suffered by the American Indian/Native Alaska communities, Canada's First Nations people, South African and New Zealand Indigenous populations (Hoosain, 2018; Paradies, 2016; Roy, 2014) are, in many ways, parallel to the experiences of another people colonized by the

British: the Australian Indigenous people. Aboriginal and Torres Strait Islander people also survived despite genocide, introduced diseases, forced removal from their lands and the prohibition of spiritual and cultural practices, and endured the forced removal of their children. The forcible separation of Aboriginal of Torres Strait Islander children over a number of generations until 1969 (known as the 'Stolen Generations') is, arguably, the practice that has left the most traumatic legacy, which continues to have a profound impact on Aboriginal people today (Grace et al., 2016).

Professor Helen Milroy (2018), an Indigenous psychiatrist specializing in child and adolescent psychiatry, offers a comprehensive description about the multi-layered effects of intergenerational trauma on Indigenous Australians by explaining that

> the transgenerational effects of trauma occur via a variety of mechanisms including the impact of attachment relationships with care givers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from the 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 effects of the original trauma which a parent or care giver has experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality. (p. 11)

Halloran (2004) described the forced removal and assimilation of children as the 'most crucial assault' on Aboriginal Australians. Cunneen and Libesman (2000) use the term 'postcolonial trauma' and the 'application of genocide' to describe the effects of the forced separation of Aboriginal children (p. 113). They argue that assimilation practices, including the separation of Aboriginal children from their families and communities, constituted a deprivation of liberty, breach of guardianship duties, abuse of power, denial of parental rights and a violation of human rights, as children were imprisoned in orphanages; subjected to physical, sexual and emotional abuse; subjected to punishment; subjected to hunger and fear; subjected to harm and exploitation; and were told that their parents were dead (Cunneen and Libesman, 2000).

Forced separation and assimilation have meant that significant numbers of Aboriginal people experienced the destruction of the family unit, the dislocation from home and community to unfamiliar places with unfamiliar people, because as children they were denied what is now considered to be a fundamental and universal human right: the right to 'grow up in a family environment, in an atmosphere of happiness, love and understanding' (Office of the United Nations High Commissioner for Human Rights, 1989). The consequences of these human rights abuse violations are evident within Aboriginal communities, which experience high documented rates of self-harm, drug and alcohol use, violence, unresolved grief, mental illness, depression, transience, homelessness, marginalization, discrimination, feelings of insecurity and hopelessness (Atkinson, 2002; Menzies and McNamara, 2008; Raphael et al., 1998) and 'a sense of helplessness in the face of conditions over which they feel they have no control' (Kosiak, 2018: 125).

Separation and assimilation as collective and intergenerational trauma

Despite growing national and international literature describing collective, historical and intergenerational trauma, there is very little research that positions assimilation and separation for Aboriginal Australians as trauma (Atkinson, 2013; Cunneen and Libesman, 2000; Dillon, 2009; Fan, 2007; Kennedy, 2001; Stevens and Bushell, 2000). The dominant discourse within policy and practice

contexts in Australia centres on the notion that there is widespread failure on the part of Aboriginal communities to thrive. This article argues that the challenges evident within Aboriginal communities today do not reflect failure on the part of Aboriginal people, but equate to overwhelming evidence of trauma symptoms at individual and collective levels.

Terms such as 'collective trauma' and 'cultural bereavement' extend beyond the individual to apply to a shared community response. The experience of collective trauma can be shaped by the group's own past history, strengths and resilience. The notion of collective trauma offers an understanding of how trauma experiences of separation continue to impact on Aboriginal people as a group. According to Erikson (1994), the impact of collective trauma is a 'blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community' (p. 233), which effectively renders the group powerless and deprived of the communal scaffolding, structures and systems to navigate traumatic situations. In Eisenbruch's (1991) work with refugees he uses the term 'cultural bereavement' to describe the experience of the 'uprooted person or group resulting from loss of social structures, cultural values and self-identity' triggering an ongoing sense of guilt for 'abandoning culture and homeland' (p. 674). Erikson and Eisenbruch, respectively, explain collective trauma and cultural bereavement in the context of an entire cultural group and how they are experienced.

Atkinson (2002) and Ratnavale (2007), in examining collective and intergenerational trauma within Aboriginal Australia, propose that the trauma origins stem from the ongoing colonizing practices of social marginalization, incarceration and racism in all its forms and the re-traumatization associated with family violence, sexual abuse, self-harming and substance misuse. The symptomology of trauma is prevalent in many Aboriginal communities; it is a shared trauma, a collective trauma (Menzies and McNamara, 2008). Former Australian Human Rights Commissioner Sir Ronald Wilson, in the 'Bringing Them Home' DVD (Human Rights and Equal Opportunity Commission, 1997), states that 'there is not one Aboriginal family or community in Australia today that has not been scarred by the separation policy, if not in this generation then in former generations'. Typical symptoms for collective and intergenerational trauma include deep mistrust of self and others, including family; fear and anticipation of betrayal; shame and humiliation; losing traditional values; desecrating land and institutions; violence against women; self-directed violence, suicide and risk-taking behaviour; substance abuse; unremitting grief; intergenerational conflict-role diffusion; sexual abuse; other boundary violations; dependency–hostile or pathological; a conspiracy of silence and an overall attitude of secrecy (Atkinson, 2002; Evans-Campbell, 2008; Krieg, 2009; Tilbury, 2009).

Socio-economic disadvantage and burden of disease for stolen generations

A new report released in 2018, titled 'Aboriginal and Torres Strait Islander Stolen Generations and descendants. Numbers, demographic characteristics and selected outcomes', explores in more detail the experiences of the Stolen Generations. The report was commissioned by The Healing Foundation, as part of the Action Plan for Healing funded by the Department of the Prime Minister and Cabinet and authored by staff from the Australian Institute of Health and Welfare's (AIHW, 2018) Indigenous and Maternal Health Group. Key findings in the study note that

> Stolen Generations aged 50 and over are more likely to be worse off than other Indigenous Australians of the same age on a range of health and socioeconomic outcomes and their descendants were also consistently more likely to have experienced adverse outcomes over a broad range of health, socioeconomic and cultural indicators, compared with a reference group of Indigenous people aged 18

> and over who reported neither being removed themselves from their own families, nor having any relatives removed. (AIHW, 2018: viii)

The data examined a number of significant health and well-being measures and found that members of the Stolen Generations were

> 3.3 times as likely to have been incarcerated in the last five years, 1.8 times as likely to have government payments as their main income source, 1.7 times as likely to have experienced violence in the previous 12 months, 1.7 times as likely not to be the owner of a home, 1.7 times as likely to have poor self-assessed health and 1.6 times as likely to have experienced homelessness in the last 10 years when compared to other Indigenous Australians. (AIHW, 2018: vii)

Comparisons between Indigenous surviving members of the Stolen Generations and non-Indigenous Australians were even more telling about the health disadvantages and health inequities experienced by those Indigenous adults who, as children, were stolen from their families. The data compared the health and well-being outcomes of non-Indigenous Australians to the members of the Stolen Generations, who were

> 4.5 times as likely to have had heart disease, 3.9 times as likely to have had a stroke, 3.3 times as likely to have experienced homelessness (lifetime), 3.0 times as likely to have kidney disease and 2.6 times as likely to have poor self-assessed health. (AIHW, 2018: 83)

Petchkovsky et al. (2004) studied a cohort of nine Australian Aboriginal people who had been removed from their families between 1914 and the late 1960s, as part of the government separation and assimilation policy. Findings revealed that all participants had experienced a 'chronic, traumatic impact on psychological ontogenesis from the point of separation'. Furthermore, all study participants met the diagnostic criteria for 'complex post-traumatic stress disorder', 'depressive state' consistent with chronic childhood trauma impacting on 'development of self', and they could trace lifelong 'chronic depressed moods' back to the time of separation (Petchkovsky et al., 2004: 4–9). Like so many other members of the Stolen Generations (Human Rights and Equal Opportunity Commission, 1997), these research participants had experienced ongoing violence, abuse and neglect in various institutions and adoptive and foster families.

De Maio et al. (2005) found that approximately 12 percent of Western Australian Aboriginal children aged 4–17 years had carers who had been forcibly separated from their families. These carers were more likely to have gambling or alcohol problems, more likely to have contact with mental health services, less likely to have family or social support and more likely to have been arrested or charged by police. Their children were more than twice as likely to suffer clinically significant emotional and behavioural difficulties, and used drugs and alcohol at a rate twice as high as Aboriginal children whose carers had not been forcibly removed. This research takes a measure of intergenerational trauma and makes it clear that government child removal policies were a dismal failure. They were put in place guided by the belief that they would either eradicate the Aboriginal population or at the very least transform Aboriginal people into a version of 'white' that was acceptable to the dominant Anglo-Australian population (Human Rights and Equal Opportunity Commission, 1997). Instead, Aboriginal communities survived, but not without the effects of trauma for those who were removed, and for their children to follow.

Conclusion

It is clear, in reviewing the 'causes of the causes' (Marmot, 2016) and symptoms of trauma presented in this article, that current challenges observed within Australian Aboriginal communities are best understood through a trauma lens. Investment in high quality, culturally appropriate, evidence-informed strategies and equitable access to human services and public infrastructure is an important start. In addition to these approaches, there needs to be more research to assess alternative practices across all human service providers working with Indigenous people. For example, high-quality early childhood education services are key, as are programmes addressing substance dependence and improved social housing strategies. However, treatment of the symptoms will never be truly effective in the absence of understanding and addressing the underlying trauma. A symptom-specific approach often throws the responsibility for change back to individuals and vulnerable communities, but

> changing the marginal position of Aboriginal and Torres Strait Islander peoples is not only the job of Aboriginal and Torres Strait Islander peoples but for all Australians. We need the same opportunity without being made the same. We will need an approach that strengthens culture. (Arabena et al., 2016)

An acknowledgement of injustice and intolerance needs to be a fundamental component in the relationship between Indigenous and non-Indigenous Australians for the ongoing recovery of the members of the Stolen Generations, their families and their communities.

A trauma-informed approach requires that there is, first of all, sincere reflection on the part of those who are responsible for the trauma, including governments and those who operate within and represent government systems, on how actions past and present have caused harm, and second, commitment to work in legitimate partnership with Aboriginal people to begin to make amends and shift the trajectories that lead to poor economic, educational, health, housing and social outcomes. Within the child protection system, for example, 36.1 percent of Aboriginal child removals are because of 'neglect' (Australian Institute of Health and Welfare, 2017: 28). More research and changes to child protection policy and practice are needed in order to determine whether the troubling levels of child removal would improve if instead of seeing this 'neglect' as failure on the part of the parents, it was seen as reflecting the lack of opportunity for the development of parenting skills, as well as cultural differences, in what is understood to be good parenting practice. If a trauma lens was applied, would child protection professionals seek out avenues of family support and agency partnering before moving so quickly to child removal?

The research literature examining the nature and impact of trauma at the individual level and at the level of whole communities has grown rapidly over the past two decades. This growing understanding has provided a new framework for thinking about the disadvantage and social challenges present within some communities, such as colonized Indigenous communities that not only experienced historical displacement and genocide but have endured ongoing racism, intensive government intervention, and disconnection from culture through attempts at forced assimilation. There is a gap in the literature as trauma frameworks within the Australian context are yet to permeate the systematic practice of child protection, health, legal and welfare professionals and social work practitioners in their interactions with Aboriginal and Torres Strait Islander people. Further research is recommended to ascertain practitioners' understanding of trauma as a result of forced separation and assimilation, and how to utilize trauma literature and implement trauma-informed principles when working with Indigenous people. There is also a need to develop a research agenda for theoretically informed trauma and recovery healing services for the Stolen Generations and other Indigenous Australians. This article argues that practice approaches guided by trauma theory are imperative in order to address the challenges that exist within colonized Indigenous communities.

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