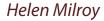# 21

Understanding the Lives of Aboriginal Children and Families

Helen Milroy

OVERVIEW

Two case studies representing the lives of young people in an urban and rural context, respectively, are presented in this chapter with the intention of engaging the reader in the life course of young people in Aboriginal families affected by loss, grief and other traumatic life episodes. The resilience of these young people is highlighted, along with cultural and familial trajectories as a guide to consider the most appropriate pathways for action. This chapter aims to provide mental health practitioners, teachers, social workers and other community service providers with a deeper understanding of the clinical and cultural complexities that need to be taken into account when working with children and young people. These case studies also highlight the need for practitioners and policy-makers to address the many social determinants that influence Aboriginal children and young people's health, education and social and emotional wellbeing outcomes. The case studies resonate with many of the chapters in the book, which often describe in statistical and theoretical terms the key issues impacting on young people's lives.

INTRODUCTION

Understanding child and youth mental health can be challenging especially when considering the cultural context, historical legacy, and social determinants as they apply to child development. As with the adult population, there is ongoing concern regarding appropriate assessment and diagnosis as well as effective interventions for children in regard to mental health concerns.

The general approach to understanding child mental health problems comes from both developmental and child psychiatry perspectives. To work effectively with children, it is important to understand developmental milestones and how development impacts on language and cognition, behaviour, emotional regulation and relationships. In addition, it is important to understand how the child develops their sense of self and identity, how they see the world and develop coping strategies and life skills, and how they are able to adapt across the life span.

All of these issues can be affected by a number of risk and protective factors that are well known and include genetic predisposition, family history, life stress events and experiences, as well as personal attributes such as gender, perceived intelligence, appearance and temperament. Many of these life stressors are discussed in Chapter 6 (Zubrick and colleagues) and Chapter 17 (Atkinson and colleagues). A report produced by the previous Department of Health and Ageing (DoHA) on '*promotion, prevention and early intervention for mental health: a monograph*' provides an important and comprehensive overview for understanding the various individual, family, community and cultural factors relevant to mental health, with an emphasis

on successful negotiation of developmental transition points across the lifespan.[1] Hence, the understanding of child and youth mental health is vital to understanding mental health and illness in general, as many adult chronic health problems and mental health disorders have their antecedents in childhood.

ADOPTING A PUBLIC HEALTH APPROACH

The DoHA report outlines the importance of adopting a public health approach to 'protect, support and sustain the emotional and social wellbeing of the population by promoting the factors that enhance mental health.'[1(p30)] Ideally this approach is implemented across the whole spectrum of health, starting when people are well, and aims to optimise mental health and wellbeing in individuals, families and communities. The concept of the 'promotion of emotional and social wellbeing' is generally preferred by Aboriginal people as it is compatible with holistic concepts of mental health held by Aboriginal peoples. The report emphasises the importance of improving the social, physical and economic environments that affect mental health and wellbeing and strengthening the capacity of communities as well as individuals.

When applying these principles of promotion and early intervention across diverse cultural groups, there are additional complexities to consider. The report acknowledges the significant level of risk operating in many Aboriginal and Torres Strait Islander communities and the difficulties for programs to be effective when faced with social disadvantage, racism and discrimination and a lack of basic health and mental health service.[1] Hence, when considering the issues relevant for Aboriginal and Torres Strait Islander children, the additional and often unrelenting burden of loss and grief as well as trauma complicate how mental health problems are perceived, assessed and managed.

In addition, how a child responds to adversity will be affected by their cultural beliefs, family system and community capacity, all of which can be under considerable stress. These adversities can be counterbalanced through resilience and strengths of both the individual and communities. Teasing out and identifying the differences between a mental health disorder and the overwhelming nature of disadvantage and transgenerational trauma and loss can be difficult, especially in children. However, as Hunter observes, it is:

> disarmingly easy and dangerous to minimise or deny mental health disorders within the cross-cultural context, and clinicians need to retain their clinical vigilance whilst not pathologising culture in order to provide effective interventions for mental health problems.[2(p8)]

One of the common problems encountered in child mental health services is developing an understanding of what drives behaviour and how behaviour is labelled. This is particularly important in younger children where language may be limited. Malchiodi (2008) notes that 'children relive their traumas not only in their minds but also through their actions.'[3(p16)] In order to work effectively with Aboriginal and Torres Strait Islander children, understanding cultural behaviours and child rearing practices as well as individual responses to trauma is vital to avoid misdiagnosing and mislabelling, and to developing effective interventions.

FACTORS INFLUENCING MENTAL HEALTH

Although there is a paucity of data on specific child mental health conditions for Aboriginal and Torres Strait Islander children and youth, there is evidence of:

- greater risk for emotional and behavioural difficulties;
- greater exposure to risk factors and stressful life events;
- higher rates of suicide;

- higher rates of hospital admissions for mental health problems;

- higher rates of incarceration; and

- higher numbers of removal of children under child protection compared with the general population.[4, 5]

Added to this is the increased risk for:

- developmental disability;

- low birth weight;

- physical health problems; and

- poorer educational outcomes,

suggesting the need to consider a comprehensive approach when considering mental health disorders in Aboriginal and Torres Strait Islander children and young people.[6-8]

ILLUSTRATING THE COMPLEXITIES AND ISSUES

The following constructed case studies illustrate some of the complexities and issues as well as the potential interventions to consider when working with Aboriginal and Torres Strait Islander children and youth.

Case Study   **Marla**

Marla is a ten year-old Aboriginal girl living with her family in a three bedroom state housing town-house in a large city. She has two brothers aged six years and six months respectively. In the last 12 months, she has suffered the loss of her maternal grandmother aged 54 years through chronic illness, her father aged 30 years from an acute myocardial infarction and a male cousin aged 16 years from suicide. Three years ago, her sister died from sudden infant death syndrome aged 13 months.

Marla has lost all interest in attending school and has been spending most of her time at home helping her mother with the baby. Previously, she had been described as a pleasant student and achieved average grades, with good physical health and normal developmental milestones.

Marla's mother is concerned about her school refusal, and admits her school attendance has also been patchy over recent years. She is concerned about the school reporting the family to child welfare services and reluctantly accepted the referral to child and adolescent mental health services for assessment.

Marla's family is supported by an extensive family kinship system with several aunties and paternal grandparents and there are often additional relatives staying in the home.

Marla presents as shy and stays close to her mother often fussing over the baby. She says very little in the interview but admits she enjoys staying home to look after her brother. She denies most symptoms presented to her but has trouble sleeping and usually ends up in her mother's bed at night. She displays little emotion but brightens up when interacting with her baby brother. She appears disinterested in the toys in the room, makes very little eye contact and refuses to stay without her mother present in the room.

Diagnosis, Management and Prognosis for Marla

There are a number of contributing factors to consider in this story prior to understanding Marla. The magnitude of grief and loss for this family is enormous and when the full history unfolds, there is an even greater level of complexity. Marla's maternal grandmother was part of the Stolen Generations and had subsequently suffered the loss of her own children at times under child protection, including Marla's mother.

This generational impact was a common outcome reported in the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, as a consequence of removal as children.[9] The grandmother had significant mental and physical health problems throughout her life and Marla's mother had provided most of her care until her death. Over generations, the family had experienced many good events but also many bad experiences with health and mental health services, child and family welfare and education systems and were wary of services in general.

Marla is a remarkably resilient child and a very capable carer for the family. At the age of ten, she has experienced far too much for her young years and is hardened to the realities of life. The fear of losing more family members through death or removal is very real and makes school attendance seem insignificant. The cultural obligation to care for family was taught from a young age and this is clearly one of Marla's strengths, even if this obligation is at the expense of her own childhood and impacts on her school attendance.

As the extended family are all suffering from the same levels of grief and trauma, there is likely to be significant health and mental health issues, and the eldest children may carry the burden of care for sick and suffering adults. Due to the shortened life expectancy, high burden of disease and the altered population age structure, there are fewer Elders in the community to buffer families and support children, and fewer adults healthy enough to provide care for sick relatives or earn sufficient income for families contributing to overcrowding and social disadvantage.[6] The stark realities of this diminished capacity for Aboriginal families and communities is outlined in Chapter 7 (Parker and Milroy) and Chapter 18 (Parker and colleagues).

Addressing Trauma and Loss

To really understand Marla, there must be an understanding of the generational history and the present reality of family and community burden as well as the resilience and strengths that allow a young girl like Marla to cope with life. As noted in the *Closing The Gap* clearinghouse resource sheet on social and emotional wellbeing, those programs that 'operate in isolation from, or do not address the legacy of, past trauma, past and current racism and issues such as poverty and homelessness' are unlikely to be effective.[10(p2)]

There is a pervasive sense of sadness but it is unlikely to represent as an isolated depressive episode. There is also a level of transgenerational trauma and fear that contributes to the need for Marla to stay home and be close to her mother as well as cultural practices and obligations to care for her brothers that may not represent an anxiety disorder. The withdrawal and avoidance behaviour following the repeated grief and loss are predictable reactions—but do they need clinical or interdisciplinary intervention?

Strategies for Working with Marla and her Family

The school refusal can be understood as a reaction to overwhelming stress but may also be seen in light of Marla's perception of the lack of usefulness of school in her current situation, especially if the education she is receiving does not affirm her cultural identity or alienates her from her family. For both teachers and practitioners who are involved with Marla, there will be diagnostic uncertainty, yet the need for a holistic approach to assist Marla is obvious given the present scenario. There is a tension between labelling for the purposes of treatment and medicalising historical, cultural and social factors that is disempowering. Finding the balance between a strengths-based approach whilst treating mental illness is challenging. But what is clear is that Marla is suffering and at risk if she is unable to resolve the grief and loss and continue to reach her potential.

It would be important for Marla's family to feel they have been understood across the generations of burden they carry and the strength of survival they have shown. Marla's mother may seem dismissive of Marla's lack of school attendance but, in the context of their family

life, this is a low priority and not due to neglect. Supporting Marla's mother may be the key to alleviating the burden on Marla and allowing Marla the freedom to play and experience her childhood as a child should. For teachers, school counsellors and social workers involved with Marla, working to support Marla and her family may be achieved through good engagement practices such as cultural vouching, obtaining the assistance of Aboriginal Education Workers, Aboriginal mental health workers or Elders from the community.

Supporting Cultural Connections

Engaging Marla in a narrative approach may help her to understand the historical burden she carries, provide the opportunity for an empathetic response by the clinician to her present predicament, promote her strengths and create a new story for her future. Dowling and Vetere (2005) describe 'narrative approaches as inviting self-disclosure in the form of story-telling' thereby allowing the child to explore their own life with the clinician.[11(p19)] Narrative approaches allow the child and therapist to reflect on what has happened over time, including over generations, from both the difficulties and strengths perspectives, in order to develop a cohesive sense of self.[12] There is also a goodness of fit, with cultural norms using storytelling to convey important lessons in life. Marla will be better able to assist her family if she is re-engaged with school and achieves a good education.

Incorporating cultural concepts and beliefs around ancestry, spirituality and cultural connections can support the grief process and affirm cultural identity. As Aboriginal and Torres Strait Islander children often grow up in a family system that supports early autonomy and self-reliance,[13] Marla may well bounce back quite quickly with the right support and respond well to learning new strategies. This will promote resilience when facing adversity in the future. Marla may well benefit from having a strong therapeutic relationship outside the family system where she can be free from her burdens and feel supported.

Case Study ⟩ Brandon

Brandon is a 14 year-old Aboriginal adolescent from a small remote community. He had been acting strangely for some time but more recently had become aggressive towards his family. Brandon had been using marijuana quite heavily over recent months, had disturbed sleep and often walked around the house at night. He was seen talking to himself, sometimes shouting abuse and isolating himself in his room. He had threatened to kill everyone if they didn't leave him alone. He was taken to the health centre and subsequently evacuated under the Mental Health Act to an authorised mental health adolescent inpatient unit for assessment for psychosis.

On admission to the ward, he was quiet and guarded, mostly staring at the floor. He ignored most questions but at times would look around the room suspiciously and stated on several occasions he wanted to go home. At times Brandon would pace around the room clenching his fists and banging his head on the wall. He was given some sedation and over the next few days appeared to settle. He admitted to hearing several voices, one was his deceased grandfather calling his name and the others he didn't recognise but they said bad things about him and his family. He was worried he was going to be punished at night when he was asleep but couldn't say what he had done wrong. These symptoms had been getting worse over a six-month period and he had used the marijuana to try and 'chill out' but it appeared to make things worse. He had thought about hanging himself but had not acted on these thoughts.

Diagnosis, Management and Prognosis for Brandon

Brandon has a combination of both cultural and psychotic phenomena and it is important to understand how cultural beliefs and experiences can influence symptom formation and meaning. Hearing his grandfather's voice may be an expected culturally acceptable spiritual experience depending on how this experience is understood by his family and cultural belief

system. Hearing and seeing ancestors may be a comfort in times of sadness or illness but may be alarming when present during everyday life.

The unknown voices, however, are more likely to be psychotic in nature as they are derogatory, threatening, unfamiliar and distressing and could be secondary to the marijuana use. Delusional beliefs similarly need to be understood in the context of culture. If there is any doubt, engaging an Aboriginal mental health worker, Elder, traditional healer or family member may assist in differentiating what is a cultural norm in regard to symptoms and changes in behaviour.

In regard to the wrong doing, if indeed Brandon has transgressed traditional law, his fear of retribution may be real and cause significant anxiety and agitation. He may not be able to speak about the incident outside of his cultural group and this may require a cultural solution. If so, this issue may not resolve until Brandon returns to his community and even then there may be concern for his safety. It would be useful if an Aboriginal health worker was able to speak to Elders within the community regarding Brandon's treatment and intervention regime.

Brandon had a traumatic developmental history with exposure to alcohol in-utero, low birth weight with delayed language and learning difficulties. He was exposed to domestic violence over several years and was sexually abused by an uncle at age seven years. As Brandon struggled at school, he misbehaved and was repeatedly suspended for disruptive behaviour. He mostly wandered around the community with a small group of boys often getting into trouble for vandalism.

Brandon and his three younger sisters had been placed with his maternal grandmother six years ago due to the violence at home. He had been using alcohol and marijuana regularly from the age of twelve years, often threatening violence if he was not given money for drugs. Brandon's family had also suffered the loss of many relatives during his life. Brandon's father was in jail for drug related offences and his mother lived in a nearby community. Brandon's grandmother struggled to contain his behaviour and was scared of him returning home due to his aggression. Refer to Chapter 20 (Hayes, D'Antoine and Carter) for a more comprehensive examination of a typical life cycle of children living in a community affected by harmful substance use and an example of positive community response to promote social and emotion wellbeing, and develop community-led prevention and early intervention strategies.

Although the diagnosis may be relatively easy to make as a first episode psychosis, the management and prognosis for Brandon are much more challenging. There are many underlying issues and the potential for other untreated conditions or comorbidities that will make treating a psychosis more difficult. Brandon had never received any developmental or psychological support despite a clear history of developmental disability and significant exposure to trauma. Instead, his behaviour early on was seen as disruptive and was treated with disciplinary measures at school.

Many boys often act out aggressively in response to trauma and distress and, given the problems with language development, Brandon probably had difficulty in expressing frustration and strong emotion. As noted by Webb 'all people experience stress, their culture determines whether and in what manner they acknowledge this distress.'[14(p14)] As well, both internalising and externalising behaviours are common, as reactions to traumatic stress and may include violence, sexualised behaviours and dissociation, making their conduct at school difficult to understand and manage.[15] See Chapter 22 (Walker and colleagues) for a more extensive discussion of behavioural and emotional problems in young people.

The constant disruptions in Brandon's development may have left him with poor communication and social skills, low self-esteem, poor sense of mastery and little hope for the future. At his age, he may be too shamed to admit he has problems reading and writing and may try to cover his deficits by being aggressive, oppositional or defiant. Trying to assess cognitive function at this age is complicated and there are few validated assessment tools for Aboriginal and Torres Strait Islander adolescents available. However, some assessment of the

level of intellectual functioning may be useful in regards to services and supports. As well, when assessing formal thought disorder (given that disorganised speech, is one of the central signs of schizophrenia.),[16] one must consider the presence of his language difficulties, English as a second language and Aboriginal forms of English as expressions.

Brandon has no strong male role models in his family and may struggle to know how to form a strong male identity and role in the family and community, especially if Brandon is no longer able to return to the care of his grandmother due to his behaviour. His trauma and grief issues may be difficult to address due to his limited cognitive capacity or psychological mindedness. His current trajectory may see him on a path towards juvenile justice, further harmful drug use and chronic illness. In this case, it is even more important to find his strengths, build his life skills and give him a sense of achievement and restore a sense of purpose and hope. Gender issues may impact on his engagement with female clinicians and he may benefit from a male mentor or strong men's group.

Treating the psychosis effectively will also help to alleviate distress and assist Brandon in managing his behaviour and sleep disturbance. Good communication and education about his condition, while not making him feel ashamed, is important for engagement in ongoing treatment. Open and positive communication between Brandon, the health team, service providers and the community, and education and awareness about Brandon's condition in a manner that does not make him feel ashamed, is important for engagement in his ongoing treatment. Dealing with the substance use must incorporate an understanding of the underlying developmental disruptions and traumatic exposures to be effective.

Using Culturally Appropriate Resources

Use of culturally appropriate resource material with strong visual elements such as those produced by the Australian Integrated Mental Health Initiative (AIMhi) in the Northern Territory and Queensland may assist in understanding Brandon's current position and the '*Stay strong*' plans may be useful in empowering him Brandon to identify what works for him and how to get further help.[17, 18] The *Strong Spirit Strong Mind* materials developed through the Western Australian Drug and Alcohol Office have also proved effective in supporting young people to deal with harmful substance use—see Chapter 26 (Casey) and Chapter 8 (Wilkes and colleagues) for further discussion on addressing harmful substance use in culturally affirming ways. Engaging Brandon back into education through practical programs that support life skills development and mastery will assist in improving his self-esteem.

Although Brandon's best support is likely to come from his grandmother, her health and wellbeing as well as the safety of his sisters requires consideration. Monitoring and follow up in remote communities can be difficult, especially if services only visit monthly and there is little opportunity to develop strong relationships. The longer Brandon stays in hospital, the more likely he will become homesick, especially if his family were unable to come to the city to support him. The choice between returning home and maximising his recovery in the city is a difficult one to make, especially if relapse is a likely possibility. It is critical in such cases to adopt an interdisciplinary approach that will enable and support a continuity of care plan for Brandon.

CONCLUSION

These case studies illustrate some of the historical, cultural, spiritual, social, psychological and political complexities involved in identifying, assessing and managing significant mental health issues in Aboriginal and Torres Strait Islander children and young people. Although the presenting problems may seem simple at first, the full breadth and depth of the issues may only be revealed over time and with the development of trust and good engagement. The possibilities for recovery, however, are also enhanced due to the resilience and resourcefulness of children, the richness of culture and the potential that resides in their development.

REFLECTIVE EXERCISES

1. How would you consider the transgenerational impact of grief and trauma on child development today?

2. How does considering the issues through a trauma informed and cultural lens influence the approach to assessment and management of children with mental health problems?

3. How does your service promote strong cultural identity?

4. What options for cultural therapies are there for inclusion in management?

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PART 5