Abstract

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Re-Storying: Conceptualizing and contextualizing problem alcohol and other drug use amongst Australian Aboriginal women

Australian Aboriginal people have experienced significant trauma as a result of settler-colonisation (Wolfe, 2006). Such historical trauma has been clearly identified as a significant risk factor in the development of alcohol and other drug (AOD) problems (Human Rights and Equal Opportunity Commission, 1997, 2008; Wilson, Grey, Stearne & Saggers, 2010).

Although it has been reported that problem AOD use and associated harms are an issue for many Aboriginal women, many problems go unaddressed due to complex barriers which may include fear, gaps in culturally safe practices and a lack of appropriate services (Brady, 2005, NADA, 2015).

This paper describes some culturally safe responses to working with Australian Aboriginal women who are seeking support for problems with substance use. Specifically, this paper recognizes the need for mainstream AOD services to consider

the use of narrative based therapies when providing a therapeutic response to Australian Aboriginal women who are experiencing AOD problems.

This presentation will provide an opportunity for audience members to identify elements of narrative approaches that they may find useful in their own practice.

Re-Storying: Conceptualizing and contextualizing problem alcohol and other drug use amongst Australian Aboriginal women

In presenting a case for culturally safe therapeutic practices I will be drawing on my doctoral research and the literature review from my thesis:

Healing in the Yarn: Exploring culturally acceptable responses to Australian Aboriginal women who have experience of feelings of shame and are seeking counselling for problems with alcohol.

The Problem

The relationship of complex historical and trans generational traumas (Atkinson, 2008; Denham,2008) suffered by First Nation peoples who have experienced settler - colonisation (Wolfe, 2006) to high rates rates of alcohol and other drug (AOD) related harm has been widely documented (Brave Heart, 2004; Gray & Wilkes, 2010; Human Rights and Equal Opportunity Commission, (HREOC), 1997,2008). The National Indigenous Drug and Alcohol Committee, (NIDAC), (2010) has reported that harmful substance use is widespread and that over 60% of Aboriginal Australians drink alcohol in such a manner that causes both short term and long term harms. Furthermore, AOD use has been found to be a major factor in high mortality and imprisonment rates, family violence and in 75 per cent of homicides (Wilson, Gray, Stearne & Saggers, 2010; Chikritzhs et al., 2007). Such harms occur despite research indicating that more Aboriginal Australians than non-Aboriginal Australians abstain from alcohol (Brady, 2010; Department of Health and Ageing, 2010).

Reported differences in the prevalence of AOD related harm between Aboriginal and non-Aboriginal people, and Aboriginal women specifically, has been attributed to many factors, including those related to genocide, historical and trans-

generational trauma, ongoing racism and discrimination (Brave Heart, 2004; Catto & Thompson, 2008; NIDAC, 2010; Tatz, 1999).

The Context

It has been established (Foley, 1997; Tatz,1999, 2001; Wolfe, 2006) that in Australia, for many years following colonisation, it was assumed that Aboriginal people would either die out or assimilate. White skin was seen as a signifier of racial superiority (Tatz; 1999; Towney,2005) and vigorous efforts were directed at eradicating Aboriginality. Many Aboriginal children, particularly those with lighter skin, were forcibly removed from their families and placed on Missions and many Aboriginal women were subjected to forced marriages aimed at "breeding out the colour "(McGregor, 2002).

The ongoing oppression, and the hardships experienced by Aboriginal women have been described as creating such severe conditions of sustained stress (HREOC, 1997; Ranzijn, McConnachie & Nolan, 2009; Wanganeen, 2010) that the impacts on individuals have been reported as similar to those usually associated with post-traumatic stress disorder (PTSD) (Atkinson, 2008).

In addition, the deficit narratives constructed around Aboriginal Identity have contributed to the development of a range of problems, including those associated with alcohol and other drug use (Cloud Ramirez & Hammack, 2014; Towney, 2005). Such deficit narratives are familiar to many First Nations peoples throughout the colonised world (Fanon, 1961). To cite just one example, Bishop & Glynn (1999) have reported that the Maori people of Aotearoa / New Zealand have for many decades received powerful messages that they do not measure up, as the only criteria of worth and success are those which are associated with the cultural standards of the white colonisers (Smith, 1999).

In addition to the more overt practices of colonial oppression, such as the 2007-2012 Northern Territory Intervention, described by Professor Triggs, President of the Human Rights Commission, as in breach of the basic principles of public international law (Human Rights Commission President Gillian Triggs criticises NT Intervention in remote Aboriginal communities, 2015), social control of Aboriginal people has continued.

Furthermore, it has been reported (Sonn, 2004) that through abnormalising difference western psychology and its practices has the potential to produce new forms of social control (Bowers, 2008).

Australian Aboriginal Women

According to the literature, although many Aboriginal women are affected by alcohol and other drug (AOD) related harms, little research has been conducted in this field (Brady,1990,2014; Gray, Stearne, Wilson &Doyle, 2010). There is also a gap in knowledge in relation to Aboriginal women (and men) in urban or 'settled' areas as most of the research to date has been undertaken in remote communities already known to experience a high prevalence of AOD related problems (Brady, 1990, 2014; NIDAC, 2014).

The lack of research about AOD use among women from diverse cultural backgrounds and Aboriginal women specifically has resulted in a corresponding gap in services for Aboriginal women (Gray, Stearne, Wilson & Doyle, 2010; National Drug and Alcohol Research Centre, 2013; Rankine, Gregory, Tonks & Evans, 2013).

Research has found that women and girls who have experienced traumatic events are more likely to develop the type of problems and to report a greater degree of severity of symptoms commonly associated with PTSD (Milicevic, 2010) and it has been established that amongst many women who experience AOD problems that

the initial function of AOD use was as a form of self-medication, in other words, an attempt to numb themselves in order to avoid emotional pain (Briggs & Pepperell, 2009).

Many Aboriginal women in Australia, have been removed from their families and have grown up not knowing where they belong. Such experiences of dislocation profoundly shape a woman's sense of identity and have been found to bear a relationship to problems with AOD use, shame and parenting (HREOC, 1997, 2008; NIDAC, 2010; Zubrick et al., 2012).

Most, if not all of the informants in this study report high levels of historical and generational trauma (Denham, 2008; Wanganeen, 2010) as well as feelings of shame about their Aboriginality which pre-dated the heavy alcohol use. These feelings were reported to be exacerbated over time as the alcohol use increased.

Nearly every Aboriginal woman interviewed in this study has experienced traumatic childhood events such as being removed from their families. Some have spoken of hiding in the bushes when the welfare officers came, separation from siblings, unstable foster homes and of running away, living on the streets and finding alcohol, in particular, to be effective as a pain killer.

Research informs us that women experiencing AOD problems, particularly Aboriginal women, are reluctant to engage with agencies (Briggs & Pepperell, 2009). One reason cited by many informants is a fear that their children will be removed, or of coming into contact with the Police or Welfare agencies (Brady, 2010). Many Aboriginal women have experienced being taken away from their mothers by social workers or other welfare practitioners. Another barrier to seeking help is the experience of shame, a self- conscious emotion, which has been linked to AOD problems (Briggs & Pepperell, 2009; Potter-Effron, 2002). Other concerns cited

include a lack of gender specific services and a lack of culturally appropriate services (Gray, Stearne, Wilson & Doyle, 2010; Walker & Sonn, 2010). As a consequence, many Aboriginal women do not receive help for AOD problems until the emergence of very serious health issues (Brady, 2005; Ware, 2013).

In mapping the history of colonisation in Australia from an Indigenous woman's perspective, Atkinson (2002) provides a unique line of evidence which supports the idea that unacknowledged or unresolved trauma in previous generations remains a present issue for many women. The study of Atkinson's own family over six generations makes the point powerfully that such trauma can be linked to a range of harms, including substance use, violence and mental health issues. This echoes a statement made by Sigmund Freud over a century ago. Writing on the power of unexpressed emotion, Freud said that such feelings do not die or disappear, but will eventually emerge, often in quite destructive ways. It has been reported that Australian Aboriginal women have been particularly vulnerable in terms of internalising deficit discourse.

One notable problem with the widespread application of AOD therapy modalities designed by non Aboriginal practitioners (McKelvie & Cameron, 2010) is that they may tend to focus on changing behaviour in relation to substance use and may not adequately address underpinning issues such as trans generational and historical trauma and the social context in which the problem has arisen. In addition, Covington (2008) reports that in providing AOD treatment, gender is an important consideration, arguing that AOD treatment has developed over time as a single focused intervention in order to address problems as experienced by men. Research suggests that treatment for women's AOD problems may be ineffective unless it takes into account the gender specific factors such as the high level of trauma, abuse and

violence experienced by many women (Briggs & Pepperell, 2009; Covington, 2008). As it has been established that such experiences increase a woman's likelihood of experiencing both negative self-conscious emotions such as shame and AOD problems (Brown,2004, 2012; (Dearing, Stuewig & Tangney, 2005; Potter-Effron, 2002) it is important that AOD treatment for women addresses issues of power, gender and oppression. (Covington, 2008; Prilleltensky, 2003, 2008, Winslade & Smith, 1997).

Importantly, for First Nation people healing also involves developing a positive account of cultural identity (Ramirez & Hammack, 2014).

The Failure

It has been reported that Australian mainstream AOD services have not only largely failed to address the needs of Aboriginal people (Gray& Wilkes, 2010; Wilson, Stearne, Gray & Saggers, 2010) but have, at times, demonstrated values and practices that are not supportive of an individual's sense of cultural identity (Curtis & Harrison, 2001; McKenzie, 1997).

Until recent times, little consideration has been given to how First Nation people see things and how this differs from the worldview and experiences of the white middle class, those whose standards are used to measure an individual's healthy mental state (Bishop & Glynn, 1999; Carvajal &Young, 2008; Fox & Prilleltensky, 1997; Prilleltensky, 2008; Sue & Sue, 2012). According to Lawson Te-Aho (2013) Western psychological discourse is not only culture bound but can be profoundly damaging to indigenous populations who have experienced settler - colonisation. Through positioning the problem within any individual, the historical conditions that contribute to the emergence of AOD problems amongst some Aboriginal women

(HREOC, 1997) can be overlooked and furthermore, individuals may experience further feelings of deficit (Prilleltensky, 2008).

In order to conceptualise and contextualise the problems that we see amongst First Nation populations today, we must remember that until 1967 Aboriginal people were classified, in Australia, as fauna and flora. An Aboriginal counsellor whom I recently interviewed said:

'I was 11 years old (in 1967) when I found out that I was now a person. Before that…well, I didn't have any leaves or branches, so I thought that I must be an animal. We were all animals to white people'.

Culturally Safety

In order to provide culturally safe responses to AOD problems experienced by Aboriginal people, researchers and practitioners need to position themselves in partnership with Indigenous Australians and adopt appropriate methodologies in both research and practice (NIDAC, 2010; Lawson Te-Aho,2013; Smith, 2012).

This would involve consulting with Aboriginal researchers and practitioners (Department of Health and Ageing, 2007) and understanding both the cultural importance of storytelling to Aboriginal people (Bacon, 2007) and the need to use a trauma informed lens when addressing problems that have arisen amongst Aboriginal Australians in the context of loss, grief and colonial history (Atkinson, 2008: McKelvie & Cameron, 2010; Wanganeen, 2010).

Narrative Therapy

One aspect of my current research is to look at the value of storytelling and narrative approaches to therapy, which can be best understood as emerging from the work of social constructionists (Denborough, 2011) who developed ideas that challenged notions about truth, objectivity and individual knowledge, and emphasised

the importance of language as a medium through which local truths could be constructed (Gergen, 2001; Hansen, 2006).

White and Epston's narrative therapy is critically engaged with the language of representation (Besley, 2002) and can be understood as sitting within a broader movement within the social sciences, philosophy and the humanities, described as the linguistic turn (Rorty, 1967). Narrative approaches are distinguished through their engagement with the cultural work of placing personal problems back into the realm of culture and history.

Following the 1987-1991 Royal Commission into Aboriginal Deaths in Custody Tim Agius invited Michael White and other counsellors from the Dulwich Centre to provide support for families and friends affected by the death of a loved one whilst in police custody.

Agius was certain that the emergent narrative approach would prove appropriate, although, as he later recalled (Agius, 2008), Michael White, as a non Aboriginal Australian, had misgivings as to his own suitability for this task.

Aboriginal families at Camp Coorong shared their stories, their yarns of loss, grief and survival and the Dulwich counsellors listened and responded. Stories of great courage, resilience and strength emerged. The manner in which the stories were told, and the ways in which they were received and responded to were described by Australian Aboriginal counsellors as making the tellers feel stronger (Wingard & Lester, 2001). This was the beginning of many partnerships between non-Aboriginal and Aboriginal workers, which continues to have a profound effect on the ways in which narrative approaches to counselling and community work are constituted and enacted (Agius, 2008; Hegarty, Smith & Hammersley, 2010; Man-Kwong, 2004; Ncube, 2006; Towney, 2006).

Narrative approaches, which are theoretically and philosophically underpinned by constructionist ideas (Gergen, 1983: Gergen & Gergen, 1984), excavate wide fields of knowledge in order to explore how various therapeutic practices position individuals and their problems. Counselling based on constructionist ideas position problems experienced by people as occurring within a social, cultural and political context and draw from an understanding that each individual produces meaning from the narratives available to them (Drewery & Winslade, 1997).

As with other critical approaches to psychology (Fox & Prilleltensky, 1997), narrative approaches aim to address specific problems, which are "externalised" and to formulate responses based on collaborative, ongoing conversations (White, 1997). Counsellors using narrative approaches to therapy (White & Epston, 1990) work with the client to examine the dominant narrative and excavate other less-privileged narratives that may not be as obvious (Weegman, 2010). Through this process, the dominant story may be revised, and alternate stories may emerge. Personal accounts are often multi-layered and contradictory and so uncovering diverse aspects of a person's experience can expose hidden strengths. For example, a person who has an *alcoholic story* as a dominant narrative (Winslade & Smith, 1997) may start to recognise many aspects of their lived experience in which the alcohol problem was not so dominant (McKenzie, 1997; Polkinghorne, 2004; Weegman, 2010).

Through such investigations, narrative therapy aims to interrogate dominant stories, listen for subjugated narratives, privilege individual insights and work with metaphor in order to construct a more positive self -account. It is, after all, through story telling (Bacon, 2007) that humans create meaning from experience (White & Epston, 1990).

It has been widely reported that narrative approaches appear to be a respectful way of working with individuals seeking to journey away from harmful use of alcohol or other drugs. (Cherubin, 2005; Hegarty, Smith & Hammersley, 2010: Moxley-Haegart, 2009: Winslade & Smith, 1997).

Substance use problems possess lived, discursive and cultural aspects, each of which exerts power beyond the "literal" dimensions of the problem. Therefore, the role of language, and the potential of language to reconstruct a positive sense of self in client's addiction narratives must not be overlooked, for it is only through engaging in reflexive processes such as therapeutic conversations that new discourses may be produced. Whilst there are other professional processes that focus on the biological and chemical facets of substance use, therapeutic conversations, or counselling can legitimately address the discursive space in which the relationships between AOD use and the individual and formed and maintained (Weegman, 2010, Smith & Winslade, 1997).

Migration

For individuals affected by serious and long-term harmful AOD use to change harmful consumption patterns, a significant change to personal priorities, aspirations and pre-occupations may be needed, which concomitantly affect one's sense of identity (Smith & Winslade, 1997) .The degree to and manner in which the individual's sense of identity is affected depends on the type of language used when discussing the substance use and whether space is made for seeing other parts of the individual's identity.

This is particularly of relevance when discussing the position of women.

Words used to negatively label an individual (for example, as a female alcoholic) can be counter productive as such language powerfully impacts on the way

a woman sees herself, or may be seen by others. Self-narratives, that is, the stories we tell ourselves about our "selves", are essential to our sense of who we are. When problem stories are told in such a way that may invite a person to feel inadequate it can be counter productive as it may make change even more difficult.

Narrative practices, which can include one to one therapeutic conversation, have also been developed for group and community work, using local knowledge. In recent times they have been adopted and adapted for use in a range of cultural and political contexts including Colombia, Rwanda and Gaza where Indigenous peoples face war, poverty and political oppression. Akinyela (2002) describes narrative approaches as providing pathways towards the de-colonisation of people's lives (Denborough, 2011; Man-Kwong, 2004; Moxley- Haegart, 2009; Ncube, 2006; Omaar, 2007). Through engaging with discourse around how language is used, narrative approaches to therapy offer a possibility of psychopolitical validation (Prilleltensky, 2003). Additionally, the privileging of stories, as well as the use of metaphor has particular resonance for Aboriginal women (Bacon, 2007).

Through the exploration of alternative stories, a woman's alcohol problem story may be re-presented in a manner that challenges the culture of consumption, de-constructs addiction and supports a migration towards a more positive self-account or preferred identity (Freedman & Combs, 1996; White, 1997).

Many Aboriginal women that I have spoken to, who have left alcohol behind, say that such strength comes from a positive self- account and a sense of connectedness – to family and friends, and to the land. They also speak about a need to re-story a sense of self - based on a positive account of their gender and cultural identity. In order to do that the dominant story of Aboriginal deficit needs to be

contextualised and contested (Cherubin, 2005; Hegarty et al., 2010; Towney, 2005; West, 2003).

Wingard and Lester (2001) wrote a book called “Telling stories in ways that make us stronger”. They identified narrative approaches as a safe form of therapy through which it is possible to tell stories in ways make us women stronger. This is critical for Aboriginal women, as healing can only occur when their stories of injustice are acknowledged and the dominant narratives constructed to serve colonial settler interests, are challenged (Friere, 1970; Wolfe, 2006).

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