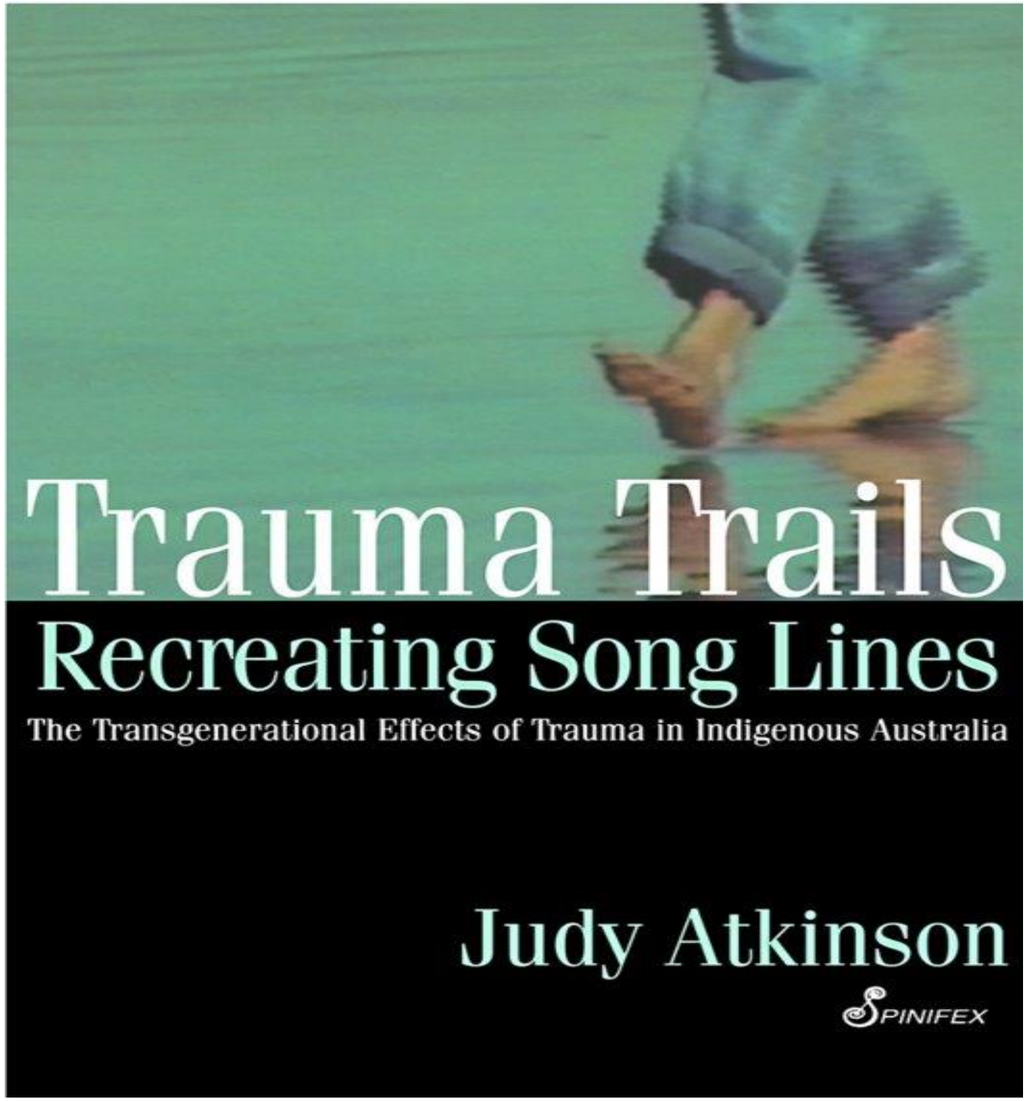
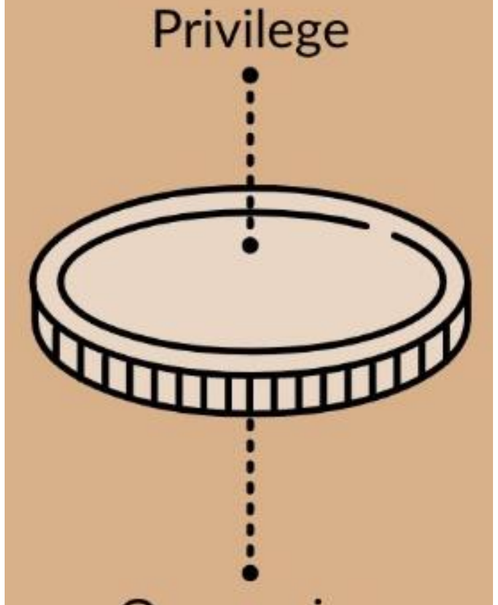


We've been following the 'trauma trails' across Australia (Atkinson, 2002; Atkinson et al., 2014) that have resulted from the trauma of invasion and colonisation.

These trauma trails have had cross-generational consequences and continue to cause profound hurt...which require Indigenous-informed responses intrinsically imbued with belief in possibilities of healing.

Privilege and Oppression
Two sides of the same (systemic) coin?

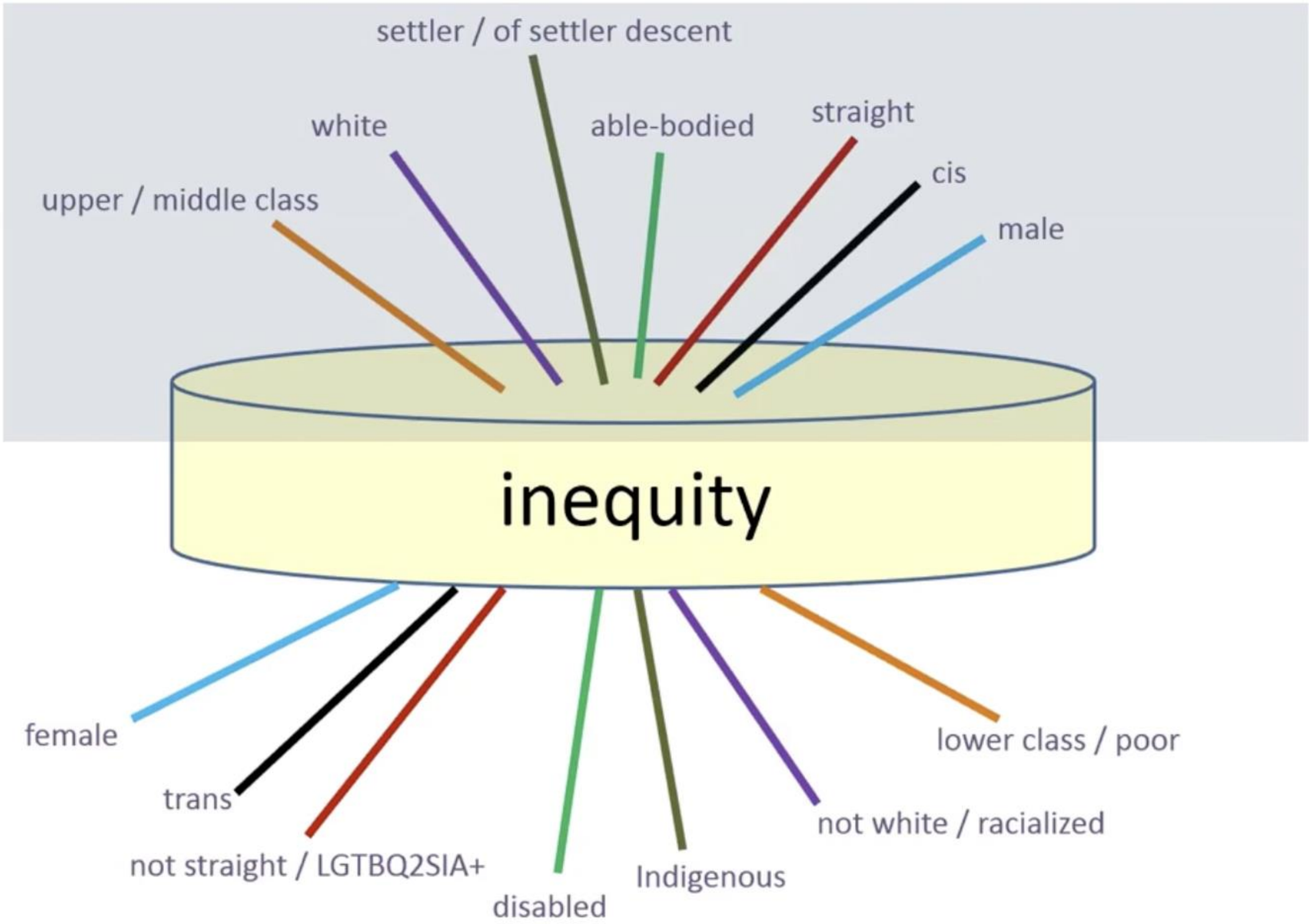
The coin: System of Inequality
The social structure that produces and maintains inequality. Includes settler-colonialism, racism, sexism, cisgenderism, ableism, classism.



Top of the coin: Privilege
You have advantages others do not. You did not earn it. You have it because of who you happen to be.

Bottom of the coin: Oppression
You have disadvantages others do not. You did not earn it. You have it because of who you happen to be.

Dr Cammi Murrup-Stewart


settler / of settler descent
white
able-bodied
straight
cis
male
upper / middle class
inequity
female
trans
not straight / LGTBQ2SIA+
disabled
Indigenous
not white / racialized
lower class / poor

Allyship

- Being a genuine ally involves a significant amount of self-reflection, education, and active listening.
- It requires allies to recognise that they often enter this space from a position of power and privilege - privileges that have been gained through unjust systems that marginalise the very groups they aim to support.
- It is not enough to simply show up in solidarity and speak out against these unjust systems.
- Allies must also take action to dismantle these systems and clearly distinguish themselves from those who oppose these groups.
- Allies need to change their own behaviours and remain mindful not to perpetuate the systems of oppression that they seek to challenge.

allyship is...

an active, consistent, and arduous practice of unlearning and re-evaluating

in which a person of privilege seeks to operate in solidarity with a marginalized group of people

~~save, fix or help~~

- The Anti-Oppression Network

A Reorientation:

I see & understand my own role in upholding systems of oppression and dis/advantage that create dominant voices and coloniality

I work to de-centre my voice and that of privileged others and centre those of Indigenous Australians

I learn from the expertise of, and work in solidarity with, Indigenous Australians

This includes working to help build insight and mobilise action amongst people in positions of privilege

I mobilise in collective action under the leadership of folks on the bottom of the coin to dismantle systems of inequality

Even though there is growing understanding of social conditions affecting health and mental health challenges, they continue to ignore:

“…existing Indigenous perspectives on colonial causes of mental distress … [and labelled] them as ‘other’, ‘alternative’, or ‘lacking in rigour and validity’. This biased view has invalidated centuries of Indigenous wisdom and healing practices, reducing them to footnotes in the dominant narrative of healthcare and causing irreparable harm to the mental health of Indigenous Peoples.”

(Murrup-Stewart & Wills, 2024, para. 6).

Mind, Body, Heart & Spirit

Jonathan Ferrier, a Mississauga, Anishinaabe (Ojibwe) scientist and a biology professor, says:

> ***Indigenous people are very scientific— it's just that our science includes the heart.***

Burrage et al. (2022) explain:

“

To decolonise itself as a discipline and better serve Indigenous communities, the field of psychology must open up to understandings of trauma, loss, and healing that decentralise the individual.

Does psychology, does neuropsychology, offer healing?

Healing at a community level

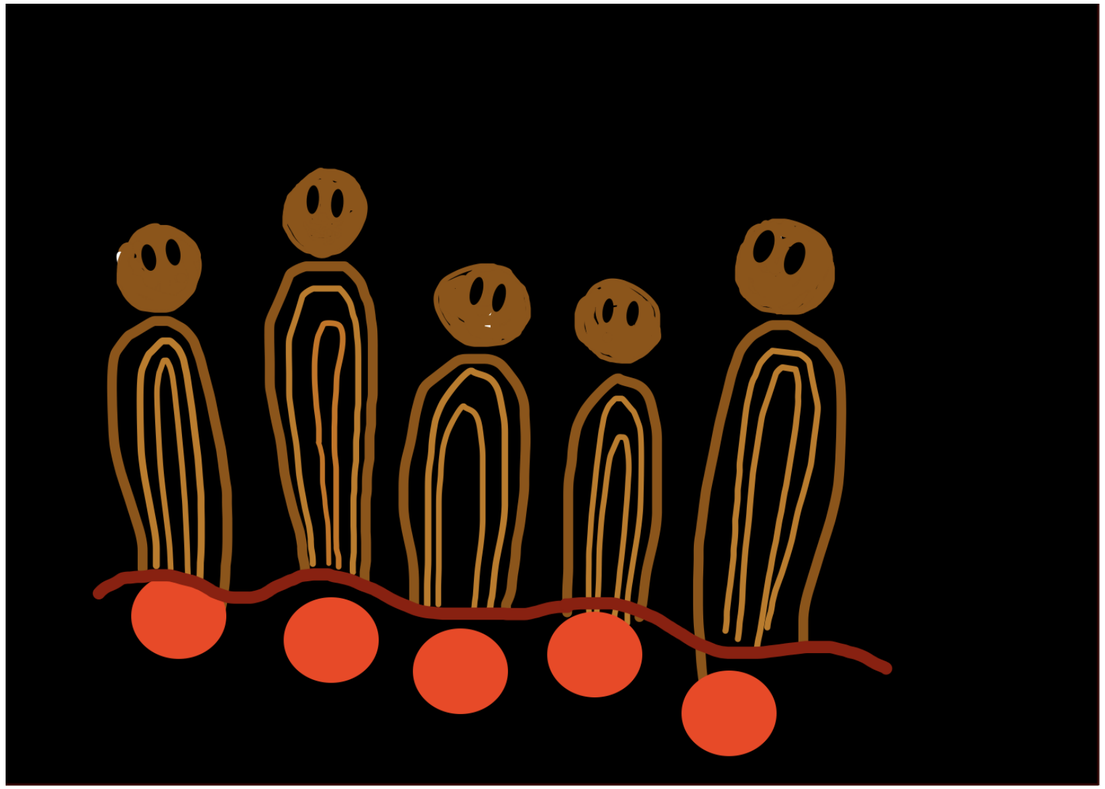
Three major themes experienced across generations of Aboriginal and Torres Strait Islander peoples and into the present:

- the extreme sense of powerlessness and loss of control.
- the profound sense of loss, grief and disconnection; and
- the overwhelming sense of trauma and helplessness.

Three pathways to recovery:

- self-determination and community governance.
- reconnection and community life; and
- restoration and community resilience (Milroy et al., 2014).

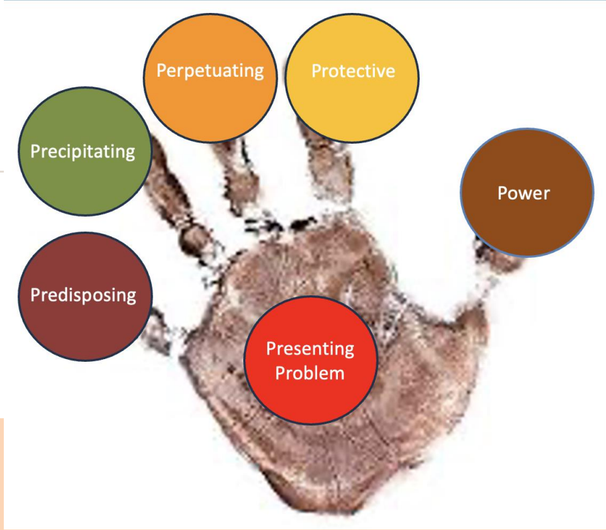
Lunch



THE MODEL

Introducing 6Ps x 8 Domains

5 Ps + 7 SEWB domains + two additions



- **6th P: Power (& privilege)**

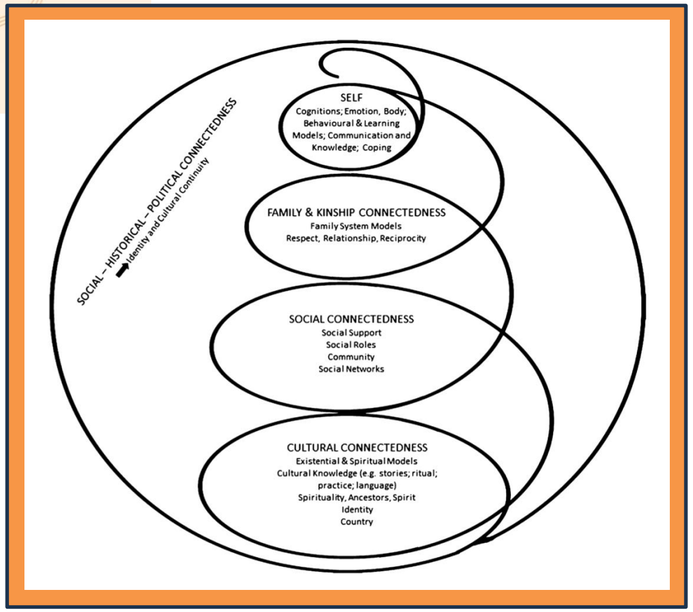
  The Power Threat Meaning Framework + the coin model of privilege

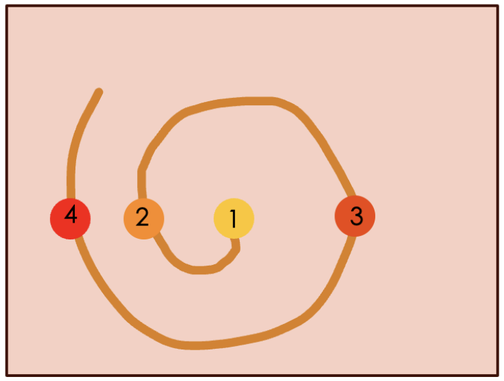
- **8th Domain — Lived Experience Context**

  Kilcullen & Day, SEWB & Understandings of Selfhood: Temporal, historical & socio-political determinants of connection

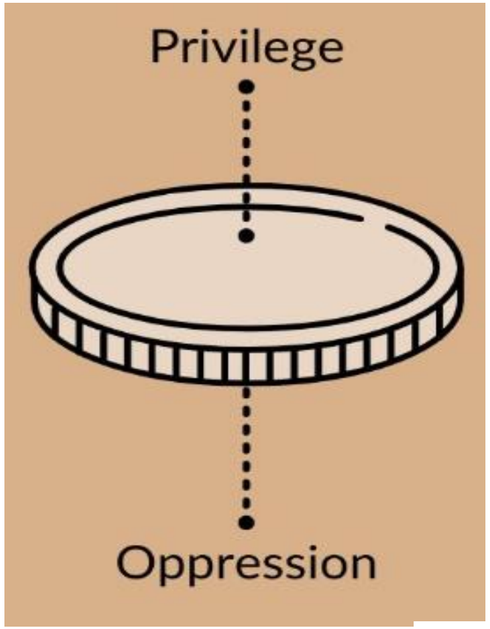
A matrix for decolonised, culturally informed and culturally responsive formulation.

6 Ps x 8 Domains

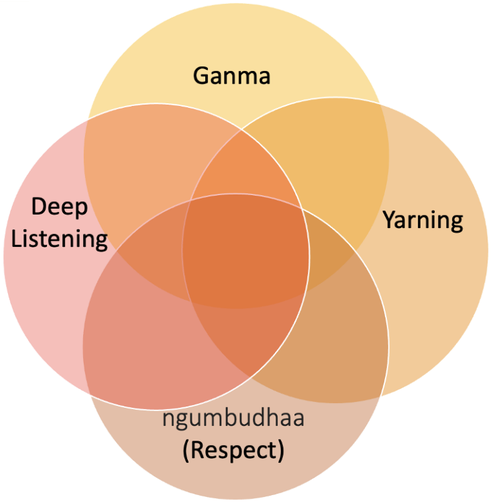




1. Presenting Problem
2. Precipitating & perpetuating factors
3. Predisposing & protective factors
4. Power & lived experience context – once trust is established

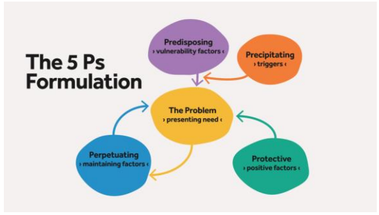


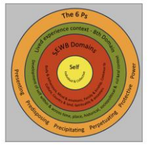
Relational Selfhood



A FAMILIAR TOOL

The 5Ps: a familiar starting point





Presenting	Predisposing	Protective	Precipitating	Perpetuating
The problem as it shows up now	Risk factors	Resources and strengths	What triggered it	What maintains it

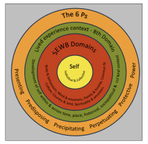
- Weerasekera (1996), built on Engel's biopsychosocial model (1977)
- Dominates Australian psychological practice; offers structure, clarity, iterative case formulation

- The “5 Ps” is a very widely used formulation tool taught & used in psychology across Australia.

- It aims to understand an individual’s *presenting problem/s* in terms of the *predisposing, protective, precipitating* and *perpetuating* factors that surround it.

- The formulation ostensibly includes important socioeconomic and historical factors.

- However, there is usually much more focus on the personal psychology of the individual rather than their social milieu, even though the inequitable division of power, determined by social, economic and political processes, is a central cause of health inequalities worldwide



A FAMILIAR TOOL

Where the 5Ps falls short

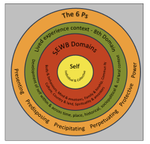
In practice, it is much more "biopsycho" than biopsychosocial. It does not account for:

- Spiritual injury
- Loss of Country
- Cultural suppression
- Colonisation & coloniality
- Intergenerational trauma
- Systemic violence & racism
- Who has voice
- Power Inequity & resource disparity

Used uncritically in colonised environments, the 5Ps risk misattributing systemic harm to individual deficit & pathology.

6th P = Power

Ongoing interrogation of power and power relations is essential to decolonisation, cultural responsiveness and cultural safety – if we only offer deeply individualised treatment for overt psychopathologies, we enact yet more violence by failing to address social ecologies perpetuating injury and trauma, and in fact adhering to limited biomedical formulations.



6TH P — POWER

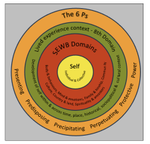
The Power Threat Meaning Framework

Distress as a response to psychosocial history and social injustice, not disorder

- **What has happened to you?** — POWER
- **How did it affect you?** — THREAT
- **What sense did you make of it?** — MEANING
- **What did you have to do to survive?** — THREAT RESPONSE

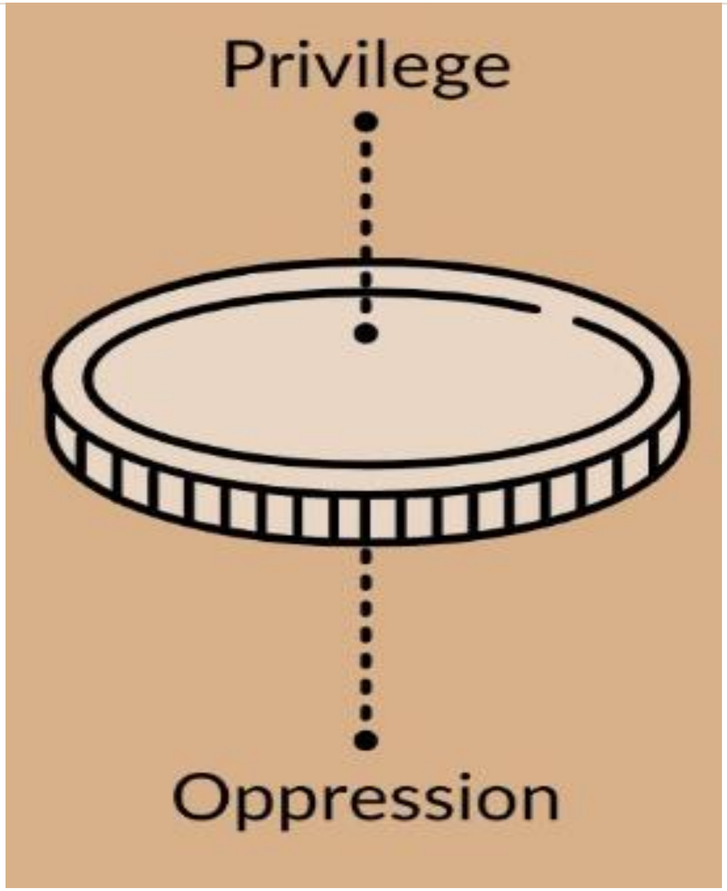
Two more questions draw out strengths: “What are your strengths?” and “What is your story?”

Johnstone et al., 2018; Division of Clinical Psychology, 2013



6TH P — POWER

The coin model of privilege



two faces, one coin

- Health inequities cannot be individualised — reduced to genetics, biology or behaviour
- Privilege and oppression are equally unearned, structurally reinforced positions
- Intersecting forces: sexism, racism, ableism, settler colonialism, classism
- Shifts focus from individual deficit to embedded institutional inequity

Nixon, 2019

Power Threat Meaning Framework (PTMF)

- 'What has happened to you?' (How is Power operating in your life?)
- 'How did it affect you?' (What kind of Threats does this pose?)
- 'What sense did you make of it?' (What is the Meaning of these situations and experiences to you?)
- 'What did you have to do to survive?' (What kinds of Threat Response are you using?).

Plus:

- 'What are your strengths?' (What access to Power resources do you have?)
- 'What is your story?' (How does all this fit together?)

(Johnstone et al., 2018)

REFRAME

Reframing the clinical question

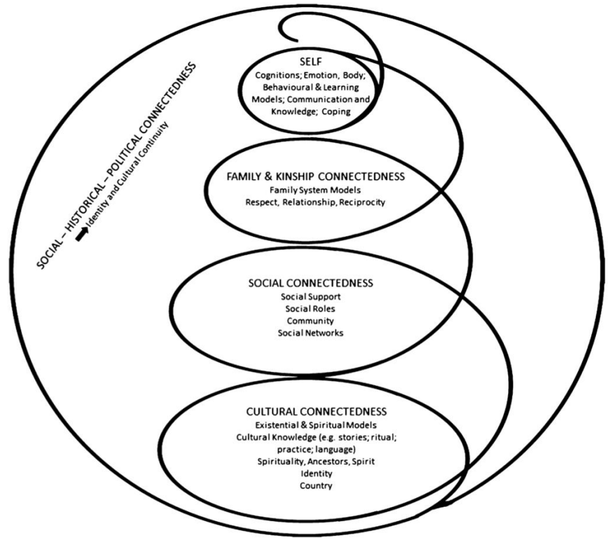
“What is wrong with this person?”

“What has happened to them?”

- The client becomes the knowledge holder, not the case subject
- Honours narrative sovereignty, cultural authority, self-expertise & community voice

8TH DOMAIN

Lived Experience Context

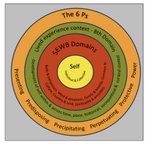


- Adds the determinants of SEWB directly into the formulation
- Maps a profile of strong or unbalanced connection across all the seven domains
- Draws on Kilcullen & Day's culturally informed case conceptualisation (2018)
- Informed by Bronfenbrenner & Morris's bioecological model: Process, Person, Context, Time

WHY IT MATTERS

"It is only by reaching an accurate understanding of the context in which problems (and strengths) arise" that a culturally informed formulation can be developed.

Kilcullen & Day, 2018, p. 282



ABORIGINAL & TORRES STRAIT ISLANDER SELFHOOD

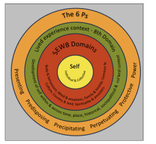
Selfhood: autonomy held within relationalism

"A reflective self is a communal self: a self that understands how communal acts affect those around them, both human and non-human, over time."

Graham, 2023, p. 3

Individual autonomy held within relationalism

- Settler colonialism, genocide & ethnocide severed essential ties: decimated the source of Being for Aboriginal and Torres Strait Islander peoples
- Disconnection from Country is disconnection from self
- This severing continues to shape distress across every SEWB domain



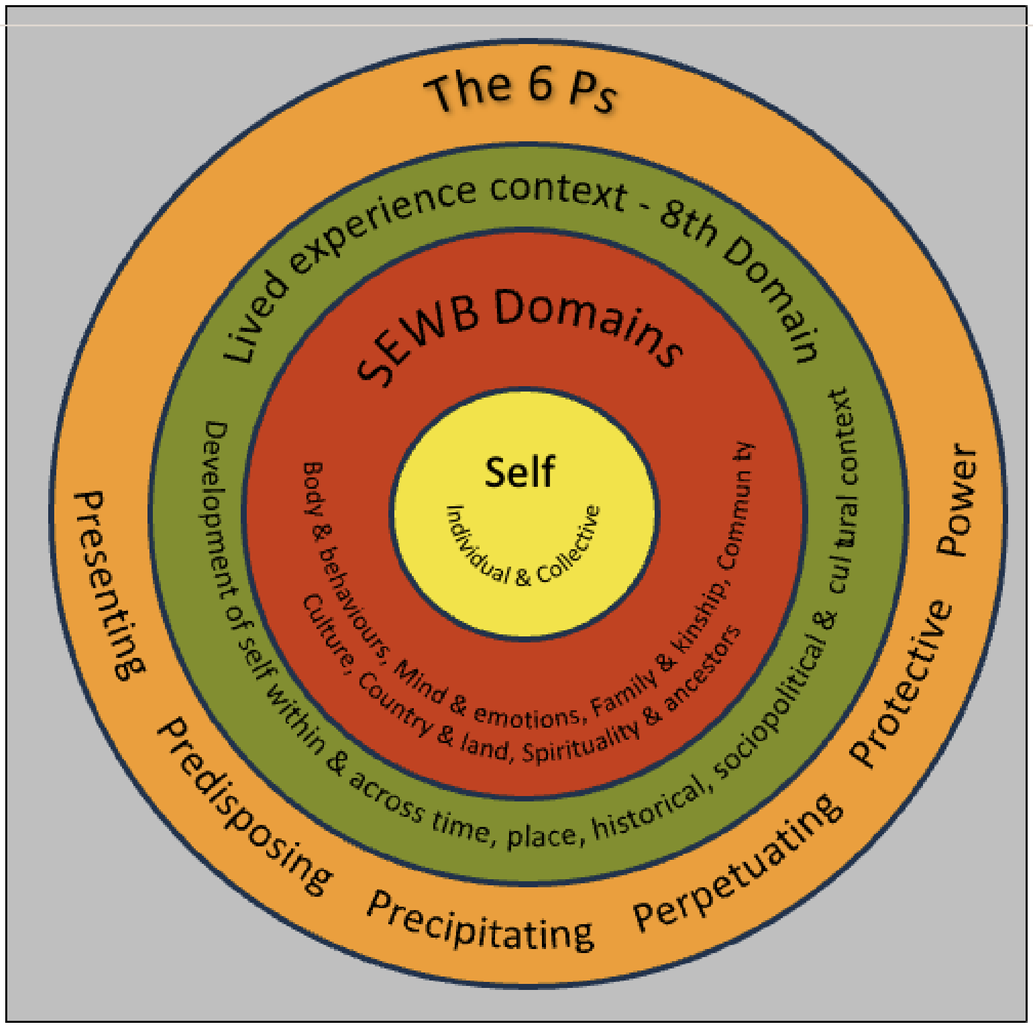
8TH DOMAIN

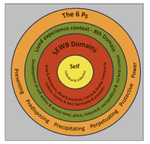
What the 8th domain asks: Lived Experience Context

Temporal	When did disruptions of connection occur?
Historical	What was happening in society at the time?
Developmental	How did selfhood develop over (that particular) time?
Socio-political	What policies, events and structural factors were at play?
Intergenerational	What was transmitted, lost, retained or survived across generations?

Just as self is both individual & relational, 1:1 therapy holds selfhood within networks of belonging & dis/connection

Individual autonomy held within relationalism





THE MODEL

The 6Ps x 8 Domains matrix

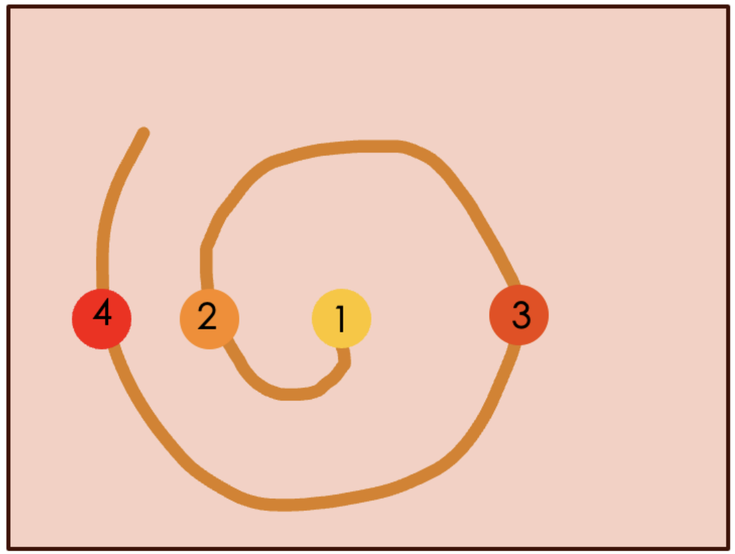
Illustrative structure — a living formulation tool, not a checklist

	Country	Culture	Spirit.	Social	Family	Body	Mind	Lived Exp.
Presenting	Disrupted connection to Country							
Predisposing								
Protective		Cultural renewal, mentors						
Precipitating								
Perpetuating								
Power					Removal & incarceration disrupt kinship			

THERAPEUTIC APPLICATION

The crucible metaphor

Kuyken et al., 2008



1

Unfolds over time

Reliability and validity improve when formulation builds iteratively; not linear but iterative

2

Collaborative empiricism

The client (and family/community) holds essential expertise about their own context & meaning-making

3

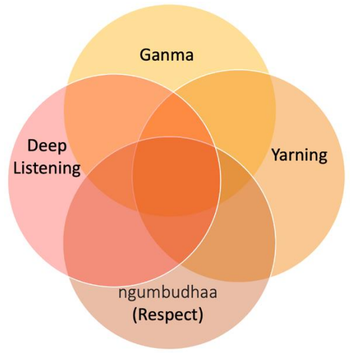
Strengths woven throughout

Client strengths provide both symptom relief & long-term resilience

Premature inquiry into colonial violence, before relationship is established, risks re-traumatisation.

RELATIONAL FOUNDATIONS

Deep listening



Dadirri

NGAN'GIKURRUNGGURR, DALY RIVER

Inner, deep listening and quiet, still awareness; a way of life, not a technique

Wangii

DHURGA, YUIN NATION

Being respectful and open to knowledge, & in turn is given more knowledge; walking with one foot in the spirit world

Winanga-li

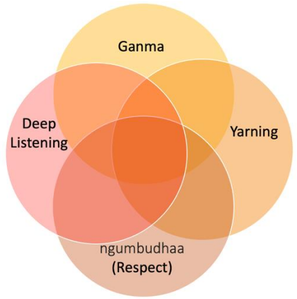
KAMILAROI

“I sit with you and understand you” - suspending answers to hold meaning jointly

Shifts therapist from leadership to custodianship of the co-created relational space.

RELATIONAL FOUNDATIONS

Respect: ngumbudhaa & Yindyamarra



ngumbudhaa

DHURGA

To like, to love, to respect

Yindyamarra

WIRADYURI

Respect, gentleness, honour; to do things slowly

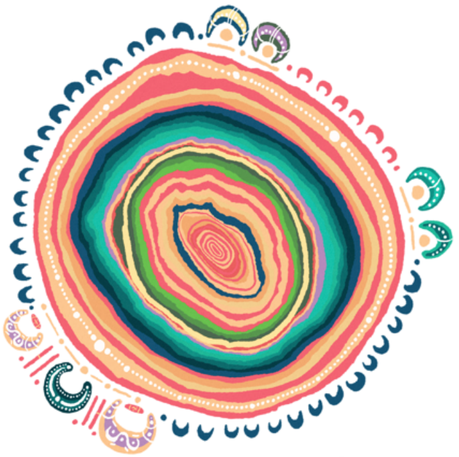
Grant & Rudder, 2010, p. 485

Recognises the interconnectedness of all living things: without Country & each other, we do not exist.

MATRIX

6 Ps & 8 domains	1. Country & land	2. Culture & heritage	3. Spirituality & ancestors	4. Social & community	5. Family & kinship	6. Body & Behaviours	7. Mind & emotions	8.Lived Experience Context
Description of Domain	Connection to land & Country is closely tied to spirituality & belonging & underpins identity. Feeling connected to country evokes a positive sense of wellbeing & soothes our spirit. Living in rhythm with Country keeps us strong.	Having relationship with aspects of one's heritage & personal, family & community stories. A connection to culture provides a sense of continuity with the past & shared wisdoms can provide direction & meaning.	Worldviews grounded in relationships with spirituality - story, ritual, ceremony dances & connection to person, L& & place. Spirituality provides a sense of purpose & meaning. Guidance from ancestors & respect for generational knowledge cultivates transgenerational strength.	Mutual obligations & responsibilities guide ethics & behaviours. Individual autonomy is held within reciprocity. Inclusivity & cohesion are grounded in interpersonal interaction. Cultural revitalisation can keep communities strong.	Kinships systems provide multiple carers & attachment figures, including Country. Gender & age roles are delineated & Elders are respected.	All elements of a person's life that is linked to their physical body - including the normal biological markers that reflect the physical health of a person. Includes the importance of optimal functioning of body, mind, heart & spirit. Felt or somatic sense of trauma & grief.	Emphasising staying strong & the importance of overall experiences & wellbeing. Encompasses mental, cognitive, emotional & psychological dimensions of human experience, as well as fundamental human needs – i.e., perceived safety & security, a sense of belonging, sense of control & mastery, self-esteem, meaning making, values & motivation	Every lived experience/life story is locational, specific, & valid at the personal, family & community levels. The broader socio-historical-political context & experiences of racism & trauma contribute to strengths, disruptions & ill-health.
Presenting Problem								
Predisposing (Risk Factors)								
Precipitating (more recent events)								
Perpetuating (maintaining)								
Protective								
Power (& privilege)								

How to Use the 6Ps x 8 domains:



- Start with deep heart listening
- Ask “What’s happening for you right now?” (presenting)
- Explore lived history (predisposing)
- Explore recent triggers (precipitating)
- Explore relational cycles, disconnections & socioecological challenges (perpetuating)
- Identify strengths, family, culture, Country (protective)
- Ask “Where do you feel unheard, judged, silenced, blocked or disadvantaged?”(power & perspective)
- Map onto SEWB
  - Which domains show connection?
  - Which show disruption?
  - How does the lived experience of the 8th domain provide context?
- Plan relational & cultural reconnection strategies as well as intrapsychic as needed
- Consider needed advocacy or case management to address inequities or lack of access to resources
- Walk-with & co-create

Remember the :

- *HOW*
- *WHAT*
- *WHY*

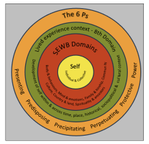
of all diagnoses and assessments - to inform and lead to increased connections & hopeful healing pathways.

Exercise – case conceptualisation

Develop a culturally informed and culturally responsive assessment based on the 6Ps x 8 domains case conceptualisation/formulation which includes the seven SEWB domains of connection & the 8th domain of social-historical-political lived experience, plus a 6th P of Power.

Culturally-informed case conceptualisation template

Domains of Connection & Experiences	Country & Land	Culture & Heritage	Spirituality & Ancestors	Social & Community	Family and kinship	Body & Behaviours	Mind & Emotions	Lived Experiences
Presenting problem(s)								
Predisposing (risk factors)								
Precipitating (triggers)								
Perpetuating (maintaining)								
Protective (resources, strengths)								
Power (access to power & resources & temporal context)								



FOR YOUR PRACTICE

Clinical take-aways

1 **Ask what happened, not just what's wrong**

Reframe the presenting question around power, history and context

2 **Let formulation unfold collaboratively over time**

Don't rush to power or lived-experience questions before trust is built

3 **Treat connection as co-equal with risk**

Strengths and belonging carry as much clinical weight as risk factors

4 **Build practice on relational foundations**

Deep listening, yarning, ganma and respect

Case Study: Louise

Louise was referred for neuropsychological assessment following her most recent hospital admission, after which treating staff documented disorientation to time and place, difficulty following simple instructions, and word-finding difficulties that persisted beyond the expected period of acute intoxication. The referral asks whether her presentation reflects an evolving alcohol-related brain injury, the cumulative effect of repeated head trauma, a manifestation of chronic PTSD and depression, or an interaction of these, and what supports she needs to live safely and as independently as possible.

Background

- Louise is a 53-year-old Aboriginal woman from South Australia. She was previously a long-term permanent employee of the criminal justice system for over 25 years, working in different locations and roles. Her final position in the criminal justice system was as an instructor in a criminal justice academy, lecturing to recruits. Louise was raised by her mother (non-Aboriginal) and estranged from her Aboriginal father most of her life as a child. No family history of neurological or psychiatric illness is known on her mother's side. Family history on her father's side is largely unknown to Louise.
- She has one brother aged 37 and 3 adult children (2 sons aged 24 and 20, and 1 daughter aged 30). She also has 5 grandchildren and spent over 10 years of her life raising her children as a single mother.
- Louise's father Barry contacted her after he was diagnosed as terminally ill. His last wish was to have his children hear and record his story.
- Louise and her brother met with Barry and heard his story of being forcibly removed from his Aboriginal mother at the age of two. He was separated from his siblings, told his mother abandoned him and had since died, and suffered horrific physical, sexual and emotional abuse in the series of institutions in which he was placed. He had been incarcerated many times since the age of 15.
- Both siblings were deeply distressed hearing his story, and Louise wrote Barry's story for him in a notebook. Some 12 months later, her father Barry passed away.
- Louise's brother was deeply impacted by their father's story. Seven months after his father's death, he died by suicide. This had a profound impact on Louise, which triggered a reliance on alcohol. She was eventually drinking at least 2 bottles of wine plus spirits every day, along with increasing hospitalisations from alcohol-related falls and other injuries. Over the following two years, her alcohol use progressively escalated. Hospital records from three separate admissions note that Louise presented as acutely confused, with an unsteady gait and slurred speech; on one occasion, staff documented a query of Wernicke's encephalopathy and administered intravenous thiamine, though no follow-up cognitive review was arranged after discharge. She sustained at least two head injuries during falls serious enough to warrant CT imaging; one scan showed a small subdural collection managed conservatively, again with no follow-up neuroimaging or cognitive review arranged

Identity, career and the precipitating incident

- Louise has a fair complexion, and her Aboriginal identity is not cosmetically apparent, while her brother was much darker. Her identity was questioned throughout her life.
- Louise had progressed up the organisational hierarchy to a top-level educator of criminal justice staff. After the death of her father and brother she approached her supervisor about telling her story to new graduates as part of their training.
- Her supervisor, an Aboriginal man joked that no one would believe she was Aboriginal.
- Louise's alcohol use increased in frequency and intensity; she self-medicated with alcohol and marijuana daily and this impacted on her work performance. Around this time, her GP also documented Louise's reports of worsening memory ('losing my train of thought mid-sentence'), missed appointments, and difficulty concentrating; these were attributed to her PTSD and depressive symptoms, and no cognitive screening was conducted.
- After 6 months, Louise was medically discharged from her job with a diagnosis of post-traumatic stress disorder. Her medical discharge consisted of a generous monetary compensation payment and therefore she did not return to work in any capacity.

Current presentation

- Louise's substance abuse further worsened significantly, and she became estranged from her children and grandchildren. She made 2 suicide attempts and had multiple admissions to hospital emergency departments, including admissions to treat alcohol-related injuries and accidents in public. Her alcohol consumption significantly escalated.
- Louise advises that her family won't respond to her calls for help. Louise has not been engaged with any drug and alcohol treatment service, mental health case management, or GP for the past eight months. She was last prescribed sertraline and diazepam (as required) for her PTSD approximately a year ago; it is unclear whether she is still taking either, in what quantities, or whether any interaction with her current alcohol intake has been reviewed.

Case Conceptualisation

6Ps \ SEWB Domains	Country & Land	Culture & Heritage	Spirituality & Ancestors	Social & Community	Family & Kinship	Body & Behaviours	Mind & Emotions	Lived Experiences
Presenting Problem(s)	Disconnection from Country; unclear which Country/mob, severed connections	Grew up separated from her Aboriginal heritage; limited cultural knowledge or practice	No current spiritual or ancestral practice yet named	Increasing isolation reported alongside drinking	Profound grief following her father's death and her brother's suicide, estrangement from grand/children	Excessive alcohol consumption daily; recurrent alcohol-related falls and hospitalisations	Depressive and trauma symptoms; disorientation; difficulty following simple instructions, anomia	Presentation cannot be understood outside Stolen Generations context, trauma, lateral violence, racism
Predisposing (risk factors)	Intergenerational severance from Country through her father's removal at age 2	Raised by non-Aboriginal mother; Aboriginal father absent for most of her life	Removal broke intergenerational transmission of spiritual/ancestral knowledge. Early estrangement from father	Family history of institutionalisation and disconnection from Aboriginal community networks. Lateral violence	Fractured family structure; estranged from her father as a child.	No heavy alcohol use reported prior to these losses	Identity shaped by absence and disconnection; unprocessed intergenerational trauma	Louise reports her father had excessive use of alcohol; long-term disconnection from father & heritage
Precipitating (triggers)	Hearing her father's story reactivated grief for Country she never knew	Barry's disclosure of his Stolen Generations story, made on his deathbed. Brother's resultant suicide.	Learning father's story and history of disconnection from ancestry	Loss of her brother – the one person who shared this grief – to suicide	Shared trauma of hearing Barry's story with her brother; his death by suicide 7 months later	Escalation of drinking following her brother's death.	Hearing a detailed account of her father's abuse; sudden loss of her brother	Unresolved grief, vicarious traumatisation, death of father & brother, estrangement from family
Perpetuating (maintaining)	No current pathway back to Country identified	Cultural knowledge gap unaddressed; no cultural support yet engaged	Grief for ancestors, father & brother; no ceremony or cultural healing engaged	Reduced social contact; loss of job-based community; hospitalisations may further isolate her	Loss of the one sibling who shared this grief; unresolved mourning; loss of contact with grand/children	Alcohol as primary coping strategy; injury cycle increasing health risk	No grief or trauma-informed support in place; belief she has "no one to depend on"	Intergenerational impact of forced removal continues through the family
Protective (strengths)	Emerging curiosity /willingness to learn about Country through her father's story	Deep motivation to honour her father's story. Long successful career.	The notebook functions as an act of ancestral honouring	Previously had wide network of friends & community	Relationship with her father in his final months; role as keeper of his story	Able to access medical care when injured	Insight that she is "drinking to cope" – capacity to name her own experience	Recording her father's story contributes to truth-telling and resists erasure
Power (access & context)	Colonial removal policy stripped access to Country; reclaiming it sits largely outside Louise's control	Denied heritage; no contact with culture	Loss of sacred sense of being or any spiritual dimensions of existence. Loss of ancestry, including physical remains.	Experience of lateral violence from manager. Feels not white enough to be blak, not blak enough to be white.	Removal policy directly targeted kinship structures; Louise is now the living link to that history	Standardised risk/addiction tools may pathologise her drinking without recognising it as a grief response	A Western diagnosis of "alcohol use disorder" risks obscuring the grief and trauma driving it	Any formulation treating Louise's drinking as individual pathology, outside this history, is incomplete and potentially harmful

Check-out question

What is one key takeaway from this training that you will apply to your practice when working with Indigenous Australians & others – and how do you plan to integrate it into your approach?

AIPA
AUSTRALIAN INDIGENOUS PSYCHOLOGISTS ASSOCIATION

Thank you

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AIPA Stream

Brief Survey