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On the relationship between shame and problems with alcohol through the narratives of Aboriginal women

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ABSTRACT

In Australia many Aboriginal women have a lifelong experience of trauma which has been identified as a significant risk factor for the development of alcohol and other drug (AOD) problems. Although it is acknowledged that problem AOD use and associated harms is an issue for many Aboriginal women, significant dimensions of the issue remain largely unaddressed. It has been widely reported that there are multiple barriers to addressing issues of problem AOD use amongst Aboriginal Australians including fear, lack of services, and gaps in our knowledge of culturally safe therapeutic practices. For Aboriginal women, whose voices have been historically silenced, these gaps are even wider. Informed by the stories of Aboriginal women who have experienced a problem with alcohol, as well as Aboriginal counsellors and community workers who have worked with them, this article presents a conceptual framework. The aim of this framework is to contribute to greater knowledge and more culturally sensitive practices in the provision of services for Aboriginal women experiencing alcohol and other drug (AOD) related harm. Based on ethnographic fieldwork, and using narrative-inquiry methods, this article examines the development and maintenance of alcohol problems as experienced by Aboriginal women. In particular a broader and more nuanced understanding of the impact of gendered racism, and the role of the self-conscious emotion of shame is made.

Key words: Aboriginal women, racism, shame, narrative, alcohol.

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INTRODUCTION

The relationship between the high rates of harm related to the use of alcohol and other drugs (AOD) and the complex historical traumas experienced by Indigenous peoples subjected to settler-colonisation (Wolfe, 2006) has been widely documented (Brave Heart, 2004; Gray & Wilkes, 2010; Human Rights and Equal Opportunity Commission, 2008; Lawson Te-Aho, 2013). The National Indigenous Drug and Alcohol Committee (NIDAC) reported in 2010 that in Australia over 60 per cent of Aboriginal people consume alcohol at harmful levels despite it having been found that it is far more common for Aboriginal Australians than non-Aboriginal Australians to abstain from alcohol (Brady, 2005, 2008, 2012). Although one in seven clients of mainstream AOD services is Aboriginal, it has been found that often these services do not necessarily provide the most appropriate therapeutic responses to Aboriginal people and many fail to address the concerns that Aboriginal people have expressed about working with non-Aboriginal AOD workers (Bacon, 2013; Bennett, 2013). Further it has been reported that non-Aboriginal workers often have difficulty in listening to an Aboriginal person's story (Vickery& Westerman, 2004).

As a woman with Maori ancestry I believe this is an area worthy of investigation. The material for this article has been drawn from my doctoral research study*: 'Looking at Our own History Book': Exploring the Relationship Between Shame and Problems with Alcohol Through the Stories of Aboriginal Women'.* It aimed to create an in-depth understanding of the relationship between shame and alcohol problems as experienced by Aboriginal women. Based on ethnographic fieldwork, in-depth interviews with Aboriginal AOD counsellors, community workers, service users and conversations with cultural informants, the study contributes to our understanding of the role of shame in the development and maintenance of alcohol problems as experienced by some Aboriginal women and contributes to a better appreciation of the potential for narrative and storied approaches to therapy (Brady, 2012; Waldegrave, 2012; White, 2000; White & Epston, 1990; Wingard & Lester, 2001).

The research did not claim to represent the situation of all Aboriginal and Torres Strait Islander women in Australia. There are many differences in culture, lived experience and in points of view among Aboriginal Australians and Torres Strait Islanders. Rather the study was conducted in Victoria with participants who described themselves as Aboriginal people, and some as Yorta Yorta. As recommended in the Australian Indigenous HealthInfoNet Guidelines for Aboriginal and Torres Strait Islander Terminology (Australian Indigenous HealthInfoNet, 2017), when referring to research participants, the term 'Aboriginal' was preferred to the term 'Indigenous'.

SHAME

SHAME AND ENGENDERED RACISM

Since the arrival of the first Europeans in Australia, Aboriginal woman have been described in highly disparaging terms and suffered from the imposition of deficit discourses particularly in relation to racial identity and gender (Conor, 2016; Huggins & Huggins, 1994; Johnson, 2015a). Many women experience a flawed sense of self, which negatively affects identity. (Brown,2012). For Aboriginal women, this negative self-image may be compounded by poverty, injustice, racism and gender stereotyping (Brady, 2005; Conor, 2016; Huggins & Huggins, 1994; HREOC, 1997, 2008; Tracey, Robins & Tangney, 2007). Alongside their stories of injustice and oppression (Denborough, 2011; Waldegrave, 2012) many of the Aboriginal women with whom I have worked, and those who contributed to this study, talked about experiencing the self-conscious emotion of shame, (Goffman, 1963). This appeared to be strongly related to prevailing discourses of indigenous deficit, that is, the

stories these women had been told about themselves by others (Brown, 2012; Drahm-Butler, 2015; Huggins & Huggins, 1994; Towney, 2005).

Shame has been described as the 'intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging' (Brown, 2012, p. 5). Further, Brown (2012) argues that shame often precedes problems with alcohol, and that it is maintained by problem alcohol use and becomes even greater when a person's health, self-care and behaviour are adversely affected by alcohol. Shame has been described by Tangney (1998) as an ugly feeling that negatively affects interpersonal behaviour. It has been described as not only harmful to wellbeing (Maxmen, 2007) but as a significant risk factor in the development and maintenance of AOD problems (Potter-Efron, 2002), and as being prevalent among women with alcohol problems (Wiechelt, 1999). Brown (2012) has found that shame cannot survive exposure to empathy and argues that when feelings of shame are shared with someone who is capable of listening without judgement, shame can dissipate, whereas in the presence of silence and secrecy, shameful feelings become more powerful.

It has also been found that shame is of concern to many Aboriginal people, and that this experience of shame has its genesis in their experiences of ongoing trauma and the racialised deficit narratives that continue to support the social, cultural and economic interests of white Australia (Adams, 2014; Johnson, 2015a; Towney, 2005). However, the literature in this field is quite limited, and there have been calls for further research on the topics of shame, alcohol, gender that can arise from experiences of racism and prejudice (Dearing, Stuewig & Tangney, 2005).

SHAME AS A SELF-CONSCIOUS EMOTION

Shame is a powerful emotion. It can be debilitating and destructive. Usually it arises not through our own actions but through a concern that others may think badly of us (Tangney, 1998). A socially constructed emotion linked to experiences of oppression, shame negatively affects the construction of social identity (Maxmen, 2007; Wingard & Major, 2015; Tafjel & Turner, 1979). It is also seen as a significant risk factor in the development and maintenance of alcohol problems (Brown, 2012; Fossum & Mason,1986; Potter-Efron, 2002).

NARRATIVE APPROACHES TO COMMUNITY WORK AND COUNSELLING

Narrative approaches to community work and counselling, arose from work by Michael White in partnership with Aunty Barbara Wingard, Jane Lester and Aboriginal community workers (Denborough, 2011). It positions the problems experienced by people and communities in a social, political and historical context. Narrative approaches to therapy are commonly used by Aboriginal community workers and counsellors. This study examined the use of narrative practices in relation to their potential to address the alcohol problems that some Aboriginal women experience and to support the development of a more positive self-account (Bacon, 2013; Johnson, 2015b). By many accounts, deficit narratives are familiar, not only to Aboriginal Australians, but to many fourth world[1] populations, including the Maori people of Aotearoa/New Zealand and the First Nations peoples of North America.

[1] Colonised indigenous populations and ethnic and religious minorities who have been subjected to political and economic oppression may be referred to as 'fourth world populations' (Manuel & Posluns, 1974). The term is also sometimes used to refer to those from the poorest countries in the world.

Such narratives have been found to be profoundly destructive to individuals and communities (Bennett, 2013; Drahm-Butler, 2015).

No study could claim to represent the situation of all First Nation women in Australia. Nevertheless, as a case-study of five Aboriginal women's accounts of their experiences with alcohol, shame and healing, and the accounts of their Aboriginal community workers/AOD counsellors in Melbourne and the Victorian regional city of Shepparton, this study provides a closely textured account of how we *make ourselves* through the narratives we create from our lived experience (McKenzie, 2010).and how this needs to be the basis for responding to alcohol and other drug problems as experienced by Aboriginal women.

The generational sorrows and trauma experienced by indigenous people have been clearly linked to the development of AOD addictions (Mate, 2008; Brave Heart, 2004). Given that narratives and storytelling are important to Aboriginal cultures, and that telling stories is an essential way through which indigenous knowledges are shared (Bacon, 2007, 2013; Hume, 2002; Wingard & Lester, 2001), the methodologies chosen are considered by Indigenous researchers to be culturally appropriate to use when conducting research in Indigenous communities who have experienced settler-colonisation (Lawson Te-Aho, 2013; Smith, 2012; Vickery & Westerman, 2004). Following Ong (1982), who proposes that cultures and languages that are traditionally based on orality and storytelling possess different qualities of thought and expression to those that have become substantially literary, this study concentrated on listening to the narratives of the research participants, and attempted to understand and report on the meaning of their lived experiences.

AOD TREATMENT DISCOURSE

Language is structured into the discourses through which society is organised and it is in the interests of powerful groups in society that some discourses are privileged over others (Burr, 1995; Lilja, 2013). Generally, AOD discourse is largely modernist in tone, and is dominated by the language associated with the medical and allied health professions. Smith and Winslade (1997) observe that medical metaphors are used widely in the AOD field. The use of words such as 'recovery', 'treatment', 'assessment' and 'diagnosis' and the use of a disease model within the AOD sector locate the field firmly within a twentieth century scientific discourse. Thus, despite being a meaningful and appropriate therapeutic response for many people, mainstream approaches to AOD counselling may not be appropriate for all clients. If cultural and social factors are not considered, the counselling provided may be inconsistent with an individual's own worldview, priorities and values, and also potentially damaging to the individual's cultural and social identity (Brijnath et al., 2011; Corey, 2013; Holdstock, 2000; Sue & Sue, 2012; Walker, Schultz & Sonn, 2014).

According to NADA (2016), the use of mainstream AOD treatment models are neither appropriate nor effective when used with women who have experienced trauma. Mate (2008) has established that when addressing AOD problems experienced by colonised indigenous populations, for lasting positive change to occur, it is necessary to explore the effect of issues such as trauma and the self-conscious emotion of shame. In addition, Tamasese and Waldegrave (2005) state that for therapeutic responses to indigenous people and to women, specifically, to be just, they must arise from deeply engaged ethical

considerations that include cultural and gender accountability (Australian Human Rights Commission, 2010).

GETTING CONNECTED

The study followed the lead provided by Aboriginal researchers and was initiated through contact with members of the Aboriginal community members with whom the author was acquainted. As found by Vickery and Westerman (2004), in order to be accepted into Aboriginal or Torres Strait Islander communities, non-Aboriginal Australian researchers need to be 'vouched for' by an Aboriginal person known to and trusted by the community. An Aboriginal friend, who at the time was working at Rumbalara (Aboriginal Community Controlled Health Service at Maroopna), vouched for me to members of the Rumbalara Board and the Chief Executive Officer (CEO). Once I had received permission to contact members of staff to establish if they or any of their clients would be willing to participate in the study, the research began. An email was sent out to all AOD and family services staff, containing a description of the study and other information for potential research participants from the two targeted groups:

1. (Group A) Aboriginal women who had experience of an alcohol problem
   (Amber, Pearl, Jade, Ruby and Dorrie – not their real names)
2. (Group B) the counsellors/community workers working with the women
   (Uncle Lance James, Aunty Suzanne Nelson, Sharon Jones, Bianca, Kristy, Amber and Trish).

Nearly all of the Aboriginal community workers/counsellors who took part in this research asked me to use their real names. The five women who had experienced a problem with alcohol were not identified by their real names and some identifying details were removed in order to protect their privacy. 'Pearl', 'Violet' and 'Ruby' were introduced to me through one of the senior Aboriginal AOD counsellors at Rumbalara's AOD service Guawa Place in Shepparton. 'Dorrie' and 'Jade' were introduced to me through an Aboriginal community worker and AOD counsellor in Melbourne. Each of these five women had experience of narrative approaches to community work and counselling (Bacon, 2013; Drahm-Butler, 2015; Johnson, 2015b;Wingard & Lester, 2001; White, 2004; Wingard & Major, 2015).

FINDINGS: WHAT WAS UNCOVERED THROUGH THIS STUDY

The study participants, both the Aboriginal community workers/counsellors and the women with whom they had worked reported three significant dimensions to shame:

- Firstly, there was shame associated with identifying as an Aboriginal Australian woman in Australia.
- Secondly, there was the shame associated with the Stolen Generations and especially shame associated with having your own children removed.
- Finally, there was a dimension associated with being a 'black woman and drunk'.

It was clear from the stories that the self-reported experience of shame was implicated as a precipitating factor in the establishment and maintenance of heavy-drinking practices among the women, which resulted in alcohol becoming a significant problem (Dearing, Stuewig & Tangney, 2005; Fossum & Mason, 1986; Potter-Efron, 2002). For Pearl, Ruby, Violet and Dorrie, high levels of shame were primarily linked with their racial and gendered identity—what it was to be an Aboriginal woman in Australia.

> *I hit the Moselle because I wanted to kill my pain and just hurt myself so much that I just went and got myself drunk because I felt worthless … I felt shame because I was worrying about what people out there would think I was … You're a drunk! You're an alcoholic. That's where the shame comes back into it. Makes it worse again. (Pearl)*

Trish, one of the Aboriginal AOD community workers, spoke about racism as creating conditions under which Aboriginal women felt less than human:

> *When I was born, we weren't even considered to be human. Flora and fauna. Australia was founded on racism. We know that. The system still has systemic racism. Absolutely. And we know that our whole communities have been silenced over the years from the laws that were there. You weren't allowed to teach language. You weren't allowed to teach dance. And if you then get caught, you'd be locked up, and we know that the prison system has an over-representation of all of us. We know that the hospital systems have an over-representation. We know that drugs and alcohol is really our way of running away from the pain and shame … With feeling bad about our identity … It [the drug and alcohol use] may deaden the pain for a short time, but we're carrying it all the time. So often we don't feel as though we're worth anything.*
>
> *Racism in Australia is rife. So, until you sort out society and sort out that, we're going to have to learn ways around that shame. You can see it in our children, trying to wash their skin colour off sometimes, because they get affected by racism in the schools, still. We have to learn to stand tall for who we are…So, yes, there is shame out there, but if you can get that woman to see, to walk past that shame and realise that the experience of shame, of being who you are, an Aboriginal woman, is no shame … then you get somewhere. (Trish)*

One of the other Aboriginal community workers referred to trans generational trauma and ongoing racism:

> *Feeling worthless…*
>
> *All that kind of stuff is why our black women drink. And that's what you were perceived as growing up as a child, worthless. You know white mainstream society as well, the amount of racism that you had to put up with too. So, it's not only just that trauma, but it's racist attitudes that people not thinking they're worthy enough to achieve anything. So, you lose all that dignity, and pride, and self-esteem and confidence as a human being. When you constantly have crap put on you. And these poor women, they've got to deal with that. (Sharon Jones)*

THE USE OF ALCOHOL TO RELIEVE FEELINGS OF SHAME, PAIN AND LOSS

All of the women described using alcohol to seek relief from shame and other painful feelings and related how, over time, the alcohol use became a problem. The women were aware that this created a vicious cycle where, as the alcohol use increased, so too did the emotional pain, shame and experiences of various types of loss (Dearing Stuewig & Tangney, 2005; Fossum & Mason, 1986; Potter-Efron, 2002).

The narratives of both groups shed light on the relationship between socially constructed shame and alcohol problems as experienced by some Aboriginal women, and the types of therapeutic approaches that might be helpful. They also highlight what it means to live in contemporary Australia as an Aboriginal woman.

In addition to describing the effects of shame and its dimensions on Aboriginal women experiencing problems with alcohol, the community workers and counsellors talked about how shame creates challenges in the development of a positive social identity (Johnson, 2015a). They described how the social identity of Aboriginal women has been constructed around a social discourse that, in the words of Uncle Lance James, positions Aboriginal women at the bottom of the social ladder (Tamasese & Waldegrave, 2005). They identified that, for many of their clients, such subjugation has engendered and reinforced a sense of shame that penetrates to the core of their gendered racial identities (Huggins & Huggins, 1994).

RESPONDING TO 'ALCOHOL PROBLEMS' AS EXPERIENCED BY ABORIGINAL WOMEN

It is clear from the testimony of the women, and that of their Aboriginal community workers/counsellors who participated in this research that focusing on the symptoms only and using non-narrative therapeutic practices not only misses the point of what the problem is, but perpetuates and exacerbates the problem—a point poignantly made by Aboriginal woman Maria Edwards in an interview with *Sunday Age* reporter Justin McManus (2018) on the tenth anniversary of Kevin Rudd's apology to the Stolen Generations:

> *Children are being taken because the parents are not being offered help, just like my mother. They don't receive help to restore relationships, or they are simply sent to rehab where, in many cases, they come out worse.*

The stories highlighted that usually the decision to change occurred at a time when the costs of maintaining the alcohol use outweighed any perceived benefit (Prochaska, DiClemente & Norcross, 1992). Such costs came in the form of further loss related to health and wellbeing, human dignity and valued relationships.

To seek help despite the shame associated with identifying alcohol as a personal problem required great courage and can rightly be seen as an act of resistance. What emerged from the stories is that seeking support for her alcohol problem represents an act of resistance by the woman to the dominant discourses of what it is to be an Aboriginal woman in Australia. Despite some of the women describing the experience of seeking help for an alcohol problem as a potentially shaming experience, each had done so when they felt that they were ready to change their relationship to alcohol. What also emerged from the stories is the critical role played by the Aboriginal counsellors and community workers in enabling the women to experience their acts of seeking help as resistance against the prevailing social, historical and political landscapes.

> *I've lost too much through drinking … The loss continued, and it just got worse and worse, and what actually made me stop me was the fear of losing my son … when he left, that's when I thought, 'No, I can't. I've lost too much'. … It was like, 'I don't want to live like that anymore, and I don't want to keep hiding things with alcohol'. So, I stopped doing it. (Ruby)*

DISCUSSION

The research findings demonstrate the value of AOD practitioners embracing the use of narrative and storied approaches in working with Australian Aboriginal women seeking help for alcohol problems, to 'treat' the immediate alcohol problem, and to address the underlying issue of endemic low self-esteem that gives rise to and perpetuates the problems. All of the women spoke about the importance of being able to tell their story and feeling heard.

For some of the women, part of the construction of a more positive self-account involved naming the injustice, and having that injustice witnessed and affirmed. In particular, the incorporation of themes related to justice-seeking within some of the narrative practices used at two Aboriginal Community Controlled Agencies, Guawa Place at Rumbalara in Maroopna and Winja Ulupna in Melbourne, were experienced as very helpful. Pearl spoke of the impact of justice-seeking on how she felt about herself. Having her story taken seriously, , and being supported to seek justice in relation to a particular series of events had affected her self-esteem in a positive manner (Waldegrave, 2012; White & Epston, 1990).

Uncle Lance James put this very succinctly:

> *The women's stories must be listened to, again and again if necessary. The injustices must be witnessed. The Aboriginal woman is not the problem; transgenerational trauma and racism are the real problems here, so separate the alcohol problem from the person. You can help to heal shame through listening, naming the injustices and showing her compassion.*

A number of recommendations from the research were made. Firstly, it was recommended that mainstream AOD services, as part of their reconciliation action plans offer storied and narrative therapeutic responses (individual and group) to Aboriginal women. Such approaches are culturally safe and support the emergence of a positive self-account through locating problem alcohol (or other drug) use within a social, historical and political context. To do this, AOD counsellors and community workers will need to be trained, wherever possible, by Aboriginal practitioners, in narrative approaches.

The second recommendation was that clinical practices provided to Aboriginal women should be carried out in consultation with Aboriginal community-controlled agencies.

In the third recommendation, mainstream AOD agencies could develop services that reflect a sound understanding of how problems with AOD may be differently constituted according to gender and adopt trauma-informed practices when working with women (NADA, 2016).

It was also recommended that mainstream AOD services increase their numbers of Aboriginal staff in all areas of service delivery and make this a matter of priority through the adoption of affirmative action in recruitment policies that reflect the urgent need for more Aboriginal counsellors and community workers in this field.

The final recommendation concerned the need for the Australian Government to demonstrate its commitment to 'closing the gap' in life expectancy between Aboriginal and non-Aboriginal Australians by providing secure, ongoing funding to Aboriginal community-controlled AOD services to provide gender-specific counselling services as well as long-term, culturally appropriate residential services to accommodate Aboriginal women and their children.

DIRECTIONS FOR FUTURE RESEARCH

In future research a larger study to better understand the prevalence of the self-conscious emotion of shame among Aboriginal women who have sought support for alcohol or any other drug problem could be undertaken. Further there is more to learn about the efficacy of narrative approaches to counselling and community work for Aboriginal women who experience problems with AOD use. Such research would help us understand how addressing injustices plays a role in supporting the emergence of a more positive self-account for Aboriginal women;

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