Contagious trauma: reframing the spatial mobility of trauma within advocacy work

Abstract

Scholars have theorized that advocates who *listen* to the experiences of traumatized individuals suffer from 'vicarious trauma,' where they become affected by the process of working with trauma sufferers. Yet I argue that trauma is contagious, rather than vicarious: contagious trauma *spreads,* compounding and binding together sometimes unrelated life traumas. This paper focuses on the spread of contagious trauma within advocates who work together with people affected by two sets of policies that compound trauma in Australia's Northern Territory, Aboriginal Australians affected by the 2007 Northern Territory Emergency Response Legislation and asylum seekers affected by Australia's policies of mandatory detention. Using ethnographic data from participant observation and interviews with advocates as well as autoethnographic excerpts from field notes, I argue that advocates experience contagious trauma as the effects of witnessing trauma combine toxically with their own life traumas. Contagious trauma *expands* the destructive effects of traumatic public policy, and simultaneously *shrinks* the capacity of advocacy that contests these policies. Capacity shrinks as advocates construct barriers to keep trauma at bay.

Keywords: trauma, contagious, advocacy, Aboriginal, asylum seeker, Australia, vicarious trauma, proximity

Bullet points:

Contagious trauma: reframing the spatial mobility of trauma within advocacy work

- Trauma is contagious, rather than vicarious, and spatially expansive.
- Contagious trauma compounds often unrelated traumatic associations.
- Contagious trauma relies upon relationships of close engagement or proximity.
- Advocates in Darwin, Australia, experience trauma through their advocacy work.
- In response to contagious trauma, advocates construct barriers and limits.

Words: 8,122

Introduction

"Certainly one challenge of this listening is… the danger—the danger… of the trauma's contagion…" (Caruth, 1995: 10)

The concept of trauma occupies liminal space between the body and mind, individual and collective, event and perception. A trauma represents a physical or psychological wound, but one that is only understood as 'trauma' because of how one experiences it *after the fact.* Trauma is characterized by repeated flashing back to a traumatic episode at unexpected times and places. Through flashbacks, "the experience of the trauma, fixed or frozen in time, refuses to be represented *as* past, but is perpetually reexperienced in a painful, disassociated, traumatic present" (Leys, 2000:2). Continual flashbacks "destablis[e] any production of linearity," constructing new temporalities that are, as Caruth writes, "always connected with another place, another time" (Edkins, 2003: 16; Caruth, 1995: 8-9).

While trauma's disruptive influence on narrative time has focused much attention on trauma's temporalities, its spatiality, the space of 'listening,' as Caruth (1995:10) writes above, the space of 'contagion,' also proves challenging. Scholars have theorized that advocates who listen to the experiences of traumatized individuals suffer from 'vicarious

trauma,' where they become traumatized by the process of working with traumatized others. Yet I argue that trauma is contagious, rather than vicarious: contagious trauma *spreads,* compounding and binding together sometimes unrelated life traumas. This paper focuses on the spread of contagious trauma within advocates who work together with people affected by two sets of policies in Australia's Northern Territory, Aboriginal Australians affected by the 2007 Northern Territory Emergency Response Legislation and asylum seekers affected by Australia's policies of mandatory detention. Advocates experience contagious trauma as the effects of witnessing trauma combine toxically with their own life traumas, *expanding* the destructive effects of policies, and simultaneously *shrinking* the capacity of advocacy that contests these policies.

The paper proceeds by introducing the multiple methods involved in constructing this argument, then details the case for trauma as contagion. Next, I contextualize advocacy projects in Australia, and then explore the expansion of trauma and barriers to advocacy it creates. Finally, I consider the effects of contagious trauma for advocacy projects.

Methods

Ethnographic encounters underpin this project. Between 2010 and 2012, I spent nine months in Australia having conversations about Aboriginal communities facing the consequences of the federal Northern Territory Emergency Response legislation (2007) and asylum seekers grappling with Australia's policies of mandatory detention. I conducted participant observation, 25 semi-structured interviews, and archival research in Darwin, Australia focused on the network of Aboriginal and asylum seeker advocacy organizations.

Interviews with advocates form about half of the evidence for contagion that I incorporate into this paper. The second half of my data is formed by autoethnographic

episodes drawn from notes during the course of field research. Tensions over representation underpin these stories of trauma. Trauma studies as a discipline is thick with survivor testimony, to the point where survivors feel pressured to give voice to unspeakable events again and again (Tamas, 2012). Critics have argued that a focus on subjects as victims offers a simplified reading of their subjectivity that voyeuristically elevates the traumatic story above the complexity and mutability of the subject themselves (Radstone, 2007: 23). Such concerns about portraying traumatized individuals as subjects, combined with the ethical questions of who can claim the 'right' to speak about trauma without appropriation, led me to autoethnography (Luckhurst, 2008). There are risks to telling traumatic stories, there are stories which are not mine to write, and there are stories for which research is not an appropriate method of response. If I wanted to risk telling intimate and traumatic stories of trauma, I determined that I needed to tell my own.

Writing my own stories poses its own problems, from the ethical issues in representing the traumatized self (Tamas, 2009: 17), to the oversimplification of painful stories for consumption (Bondi, 2014). Implicit in the decision to focus on the contagious *spread* of trauma is a politics of equivalency: Does a focus on advocates obscure the marginalized people whose pain is at the heart of advocates' stories? Yet the decision to focus on trauma as contagion explicitly pushes back against such lines of questioning, drawing both on critiques of scholars' voyeuristic focus on finding the most painful stories (see e.g. Radstone, 2007) *and also* a demand for the acknowledgement of trauma's expansive capacity. That policies that compound trauma cause *more* pain is not an admission that they cause equivalent pain, or that they cause comparable pain, but demands the understanding that *more* pain is in itself a call to action. The choice to tell advocates' stories and my own stories also draws on other geographers' work using one's

own experience in order to reflect on geopolitical processes and embrace a sense of shared humanity by recognizing a bit of others in one's self (Bondi, 2014; Robinson 2011; Valentine, 1998).

Throughout this piece, the autoethnographic flashbacks disrupt the narrative, allowing multiple traumas to compound, intensify. Writing trauma in this way is itself a method of analysis. I weave together stories unexpectedly, exploring trauma's mobility, interconnectedness, and how it binds unrelated aspects of pain, suffering, and memory together. As Luckhurst (2008: 3) writes, trauma is "worryingly transmissible," and the disruptive intimacy of the autoethnographic moments helps to refocus the reader on the fundamental temporal destabilization at the heart of what trauma means, and moves a step towards representing that instability within a written narrative.

Trauma as contagion

I have 20 minutes before the next bus arrives. We are outside the busiest shopping mall in the Northern Territory and I sit on a bench outside, breathing in the air, humid and stale with the smells of body odor and cigarette smoke. I read, trying my best to shut out the chaos around me. Bus riders here are like bus riders where I grew up, the mentally ill, the poor, but also because we are in Darwin, they are the tourists, the drunk, the homeless, all of us smelling like mildew and sweat, with tinges of the sweet smells of cheap alcohol and vomit. I am mentally preparing for another trip to the detention center, trying to center my mind and body to absorb the rage and despair I feel once inside. Shouting begins, from a group of Aboriginal men and one woman. They are drunk, sloppy, waving hands. I peer above the line of my book, watching. The men evidently think the woman has taken their money, but don't seem to know what to do. One shouts, "I'm no woman-basher!" Mall security comes over, a

white man in a cheap uniform, and asks the woman to empty her pockets. She does. There is nothing. The men are not satisfied, gesture at the woman's chest and erupt into angry discussion, none of it in English. Their gestures finally become legible to the security man: they believe she has put the money under her shirt. She stands back, rips up her shirt and bra. An explosion: her lighter falls to the ground, sparks, burns. Bits of paper and trash rain out over the sidewalk. Her breasts hang down, exposed, narrow, mimicking the folds of her stomach as they buckle over a mid-stomach scar: two bags of flesh on each side, naked. There is no money anywhere. I dream that night of scarred flesh, the raised scars on the Sri Lankan refugee's arm in the Melbourne detention center, the folds of the Aboriginal woman's skin hanging down over her waistband, scars, scars, everywhere.

Whereas some theorists believe that trauma memories are firmly embedded and immobile (van der Kolk & van der Hart, 1995:163), others have begun exploring the spread of trauma through space. Trauma acts as a social glue, connecting victims of different events through similar stories (Degloma, 2009: 114), and alternately as a social disruption, fraying whole communities through damage to social fibers (Erikson, 1995: 190). For me, dreams of scars brought together the brief glimpse into the alcohol abuse and 'woman-bashing,' the everyday manifestations of the ongoing trauma of colonial dispossession for Aboriginal residents of the Northern Territory, with the intensely traumatic experience of witnessing self-harm in Australian detention centers. The separate stories of trauma compounded, intensified, and, as later excerpts from fieldnotes will demonstrate, expanded to incorporate past incidents of personal trauma as well.

Trauma's movement through space works in a variety of ways. Witnesses become traumatized by hearing or seeing the traumatic event, whereas those who work or live with traumatized people may experience "secondary traumatization" through their proximity

(Degloma, 2009: 109). Advocacy is one key route of transmission: Degloma (2009: 110), for example, explores how "trauma carrier groups" such as advocacy organizations or mental health associations lead trauma to "be transmitted like a social pathogen." Clinicians have used several terms to identify the spread of trauma through space, including vicarious trauma. 'Vicarious trauma' is defined as the "painful and disruptive psychological effects of trauma-based work" (Barrington & Shakespeare-Finch, 2013: 90). Craig and Sprang (2010: 320-21) note that vicarious trauma is extremely common in clinical settings and cite studies where between 27 and 100 percent of those caregivers surveyed suffered mental health consequences from working with traumatized people.

Asymmetrical relations of power characterize vicarious trauma: the trauma of the detained asylum seeker entangles unevenly with the night terrors of the white Australian advocate, reflecting their different access to mobility, legal representation, citizenship rights, and belonging within Australia. Calgaro (2015) argues that vicarious trauma represents an emotionally entangled set of processes deeply connected to the power asymmetries of qualitative research as well. The causal framework taken from the clinical study of trauma in the 1980s and 1990s is rightly criticized for assuming that trauma refers to singular events with causes, recoveries with treatment, and this framework takes on especially problematic connotations as applied to vicarious trauma because of the incommensurability of the perceived 'events' in question (Till, 2012).

At the heart of my argument, however, is a distinction in how trauma moves. According to theories of vicarious trauma, working in close proximity leads the practitioner to take on the trauma of another, to feel the painful experience of the traumatized by imagining what it would be like to be in their shoes. Close engagement, emotional and perhaps spatial proximity to the traumatized person, leads the practitioner to engage with

the *same catastrophic happening* that so disrupted the traumatized person's life. The traumatized person's story, affect, or behavior so affects the practitioner that they take on this same trauma.

Contagion, however, is something different. Contagion is a process not of acting through another, but *spreading* and *expanding.* I argue here that close engagement with policies that result in trauma through care, empathy, and spatial or emotional proximity *spreads* trauma, expanding trauma both in terms of binding unrelated traumas together and widening the circle of people affected by these damaging policies. Close engagement with the traumatized individuals does not necessarily result in the taking on of *their* feelings, but forms connections to other and often unrelated traumas in other times and spaces, just as for me, the memories of the asylum seeker's self-harm compounded the trauma associated with witnessing the dispute at the bus station. Contagion is similar to what Drozdzewski and Dominey-Howes (2015) call the "assemblage of traumatic experiences" that connect various forms of traumatic encounters and engagement over time. Rather than 'taking on' a traumatized person's trauma, contagious trauma is a process of connecting several and often unrelated traumas, a process whereby trauma adheres, spreads, and expands. My accelerated heartbeat as I listen to your traumatic story, the weight of my despair, my memories of being trapped, all of these become fused through the *contagion* of trauma, a process that amplifies the devastation associated with policies that compound trauma.

Contextualizing advocacy projects in Australia

The other night I had a nightmare where my ex-husband was chasing me around the bed, arm outstretched and bitterly angry, trying to hit me. I used to have violent, angry dreams often. There was such a stretch of angry dreams during the time I visited Ahmad at the

detention center in Darwin. By the time I was escorted onto the military base, x-rayed, and buzzed through the double set of secure doors, I was already struggling to balance my own frustration and anxiety with how casually violence, terror, death and despair would creep into the conversation, like when Ahmad told me that members of his ethic group in Afghanistan don't tell you to 'have fun' when you travel, they tell you: 'don't get killed.' Or when we discussed the construction of the new detention center 40 miles from town, and his first concern was the distance between the facility and the nearest police. We both knew that people needed the police because they strung themselves up in the stairwells, swallowed glass, or cut their veins. He later told me he didn't want to open his heart to me because I might get too upset. That strategy didn't work. I didn't have another way to deal with his emotions other than lean into them. I became fatigued. December 27th, I wrote: "I wish sometimes he would go to Tasmania because coming here exhausts me." Two months later, I wrote, "I am tired of detention, of signing in, of rage and depression and stories… Enough. I am exhausted." But the anger settled in my pores at night, toxically combined with the violence surrounding my divorce and the deaths of friends, replayed again and again as I slept.

Ahmad's stories of everyday violence inside the detention center reflected the violence of detention policies more broadly and their dehumanizing political effects, but my dreams literally brought the threat of violence into my home. My dreams connected the trauma of deaths, divorce, and intimate violence with the structural violence of Ahmad's detention, and how I witnessed that violence playing out in his everyday life. The trauma of detention spread to my dreams in contagious fashion, compounding the violence of enclosure with other traumas in other times and places.

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Part of the reason why trauma can become so contagious is because of its embeddedness within particular times and spaces; for example, as cultural geographers (e.g. Till, 2012) attest, social wounds can be grounded in the built environment. By 2011, Darwin, Australia had become a significant site in the geographies of enclosure that produced widespread and contagious trauma. Mandatory detention of asylum seekers, a policy developed in the 1990s, entered Australian public imaginations in 2001 with the *Migration Act*, which excised Australian coastal and island territories from the country for purposes of migration, and constructed a highly politicized regime of interdiction and indefinite detention for asylum seekers. By 2011, Darwin, the capital of Australia's Northern Territory, has also become its 'Capital of Detention,' housing more asylum seekers in detention at three different sites than any other place in the country (Coddington, 2014).

Meanwhile, in 2007, allegations of Aboriginal child sexual assault in Northern Territory communities prompted a federal 'Intervention' in the Territory through the Northern Territory Emergency Response (NTER) legislation. NTER included 'law and order' measures, financial controls over Aboriginal Australians, and renewed forms of federal control over Aboriginal lands. To apply the NTER directly to Aboriginal communities, the legislation lifted the protections of the *Racial Discrimination Act 1975* (Senate Standing Committee on Legal and Constitutional Affairs, 2007). Darwin, as the capital of the Northern Territory, became both the epicenter of NTER implementation and also the most visible site of the consequences of the legislation (Coddington, 2014).

As policies of enclosure took root in Darwin, so too did advocacy projects for Aboriginal and asylum seeker justice, building on community legacies of advocacy for marginalized groups. As I describe below, advocates' close engagement with people

traumatized by policies of enclosure produced opportunities for the contagious spread of trauma.

Contagion through proximity

There is yelling in the street outside. I am awake, startled from another intense dream. I hear the night traffic, the bottles smashing on the pavement, the loud voices speaking other languages I do not know. Probably most of the night traffic is quiet, just some of the many activities in this divided place I cannot see, or know, or understand. We live in parallel worlds, but take the same bus. One of my first nights in Darwin I attend the launch of a book containing Aboriginal experiences of the Northern Territory Emergency Response legislation, and I begin to put names to places I had only seen through the windows of the bus, where the grass grows long and the roads turn to dirt and mud. I don't understand, at first, that there are Aboriginal land claim areas in the middle of Darwin itself, that these remnants are the last holdouts of land struggles begun in the 1970s, that these homes with busted out windows looking out like toothless mouths towards the highway, that these are the hard-fought claims to country. At the book launch, we are invited by the speaker to come to Bagot Community, "the little dark place… [where] there's no lights at night." It's true, I realize: Bagot has no streetlights. Bagot's homes are open to the elements; from the street I see mattresses on floors, TV's flickering, small children on beat up bikes in the driveways. "Have a look," she tells me, "we are right here in Darwin yet we are treated like little children." Later, I attend meetings in Bagot. I walk through the streets, edged by tall grass, stared at by children, their bikes stopped. I think it's the walking, not the whiteness, that is the strange part, but it's hard to know. I am less than a mile from home. I could be thousands of miles from home. It is hard to ignore the divisions in this city. On the bus to Bagot I pass the bare

ground where the Retta Dixon Children's Home once stood, where 'half-caste' children were imprisoned and educated. The woman at the book launch explains that living in Bagot, "We are still prisoners of our own country… They will always find a way to keep us captive." Indeed, there is an empty guard post where the community meets the highway. I pass by, anxious to head towards the light. Later, that night, my sleep is restless. I wake often to the sounds of the night traffic.

The night traffic within the divided city reminded me of historical legacies of colonial policies of enclosure, battles for access to country, and continued poverty and inequality that combine to produce stark racial divisions in Darwin. Witnessing how traumas compounded in the built landscape, how Bagot becomes the forgotten "little dark place" was also a process of grappling with my own capacity to engage with community tensions and processes of marginalization. I next turn to the story of a mental health professional whose experience also demonstrates the paradoxical engagement at the heart of contagious trauma, the proximity necessary to care that is also the space of potential contagion. The mental health professional's experience demonstrates how trauma's contagious spread compounds its effects on the body, and suggests that this expansion of trauma is dependent on proximity.

Now employed at a community-based trauma therapy center in Darwin, the mental health professional had also worked on Christmas Island (Australia) as part of a detention center mental-health team. On Christmas Island, the mental health team "didn't count" when crises occurred, and the management contractor "trashed" the island, leaving a divided community in its wake. Trauma counselors saw eight patients daily, yet patients were only referred to therapy after 18 months of steadily worsening mental health. She describes how guards waited within eyesight of patients, limiting their ability to receive

private counseling. Her hands clench, imprinting the tensions of the workplace and her memories on her body. The mental health issues of the people she worked with have combined with irresponsible management and tense surveillance to intensify her stress.

Yet as bad as Christmas Island was, Darwin is worse. She refers to the Northern Immigration Detention Center (NIDC) in Darwin as "hell on a stick." Asylum seekers detained there are on drugs, delusional, in need of psychiatric hospitalization. It is "hard enough to be a refugee," but asylum seekers are then further traumatized in detention and are "not healthy people anymore," unable to function in mainstream community life after release. Torture and trauma make physical changes to brain function, she says, and what detention centers do was "manufacture mental illness." Exposure to self-harm was common, "not a new story." Her rising anxiety and embodied stress demonstrates the bodily cost of compounded trauma over time, contagious trauma that expands as it draws together experiences in different spaces and times.

For the mental health professional, reckoning with the traumas of asylum seekers is made more difficult by the constant hostility from the wider community. She cites ignorance and stigma within the general public as well as the "very negative" coverage of asylum seekers in the media as conditions that exacerbate the stress and difficulty of her work. "We are a really scared little country," she says. "What we are missing is that if the Australian government does this [mandatory detention] to refugees, it could do it to anybody. We are not safe." The explicit connections she draws between different types of traumatic experiences—witnessing the lack of care for traumatized people within the detention system, undergoing intense surveillance in the workplace, observing incidents of self harm, and facing community hostility—underscore how trauma expands over time. The spread of

traumatic associations binds together these somewhat unrelated events, widening the impact of policies like mandatory detention.

The mental health professional and her colleagues, I learn from interviews, suffer high stress levels, burnout, nightmares, and insomnia. Trauma also "rippled out" throughout the immigration detention system, several interviews confirm. Health staff disappear. Interpreters require trauma therapy. One of the mental-health professional's department managers "broke down like a baby." Staff members suffer from similar symptoms: night terrors, burnout, stress, and high levels of drug and alcohol use, yet their symptoms are erased at a system-wide level. Their trauma is framed as an individual medical or overwork issue. "[The] immigration [department] knows [about the trauma] at an individual level," the mental-health professional said. "We are human beings, we know humanity here in Darwin." Yet it is precisely the individualized nature of the trauma as it is perceived by the immigration department—this person's overwork, that person's burnout—that camouflages the impact of *contagious* trauma, trauma assembled from a constellation of personal and structural trauma circulating through the immigration detention system. Contagious trauma itself becomes individualized to the point of invisibility, leaving staff to construct their own methods of self-protection.

One way to interpret the lodging of trauma in the body through the experiences the mental health professional describes is that the embodied symptoms highlight the importance of *proximity* to contagious trauma. It was only through close engagement with the deep community divisions in Darwin, for example, that I began to feel the contagion of trauma related to what I had experienced in other times and places. Similarly, it was only through close engagement with asylum seekers' mental health that the mental health professional began to make connections between the stress of the workplace, the hostility

of the community, and the 'humanity' she draws on more broadly to emphasize the collective nature of traumatic impact in her work. For trauma to move as contagion, it requires a degree of proximity, sometimes physical, but always emotional, to the traumatic events witnessed. Is it possible that the very feelings of care that the mental health worker employs to engage with asylum seekers are therefore also the mechanism through which contagious trauma expands? I return to this question in the conclusion.

I argue that trauma's *expansion* is at the heart of its power: that in its constant movement it intertwines with different forms of pain and suffering. Trauma is *always already* more than one thing, and it is through this movement that traumas become entangled, compounded, and take on what Caruth (1995) calls their 'unassimilated nature.' But, as the mental health professional's case suggests, and my own experience indicates, a degree of emotional entanglement, if not other forms of proximity, is crucial to the spread of trauma. We are implicated in each other's stories, each other's traumas.

Barriers to advocacy

When transcribing field notes and interviews about detention became a daily task, I started taking Ambien to sleep. I needed to black out my dreams. This regime worked for a time, until it gave me an ulcer. Now as I write about trauma, I revisit those once silenced dreams, the pieces running through my 3:00 am brain in stop motion. The uncontrollably shaking legs. Stop. The hand tremors. Stop. The scars that were not there at the last visit. Stop. The triple fences, the sound of the buzzer of the gates, the x-ray wand, the knock of the guard on the window. Stop. The tropical rainstorm pouring down. Stop. The relief and guilt of release, of pulling my things from the locker and walking unescorted out the front door, past the pacing bodies at the fenceline, past the military guardpost, to the freedom and anonymity of

the highway. Stop. My memories of asylum seekers in detention in Darwin mix and become intertwined in my sleep with other detention centers in other places, in Perth, on Christmas Island, in Melbourne, in Sydney. I transpose x-ray machines and waiting areas, each equally banal and transitory, each filled with the bustle of incomprehensible bureaucracy, of my temporary helplessness, stripped of passport, wallet, and phone. I have the sense every time that the only thing I wield in these moments is a heart more vulnerable, skin less calloused, that the only thing I have to offer is my ability to absorb this pain, and relive it. I have half a bottle of Ambien on my nightstand, but I can't take it. Sometimes I look at it and wish I could, every night. I do not have the energy to wake up from these freeze-framed images forever.

Thus far, I have argued that trauma can become contagious, spreading and binding unrelated traumatic associations together, and that contagious trauma is made possible by close engagement or proximity to the traumatized. My longing for medication to block the associations made possible by contagious trauma represents the consequences of the trauma's expansion: the need for barriers. Advocates exposed to contagious trauma construct what I refer to as geographies of self-protection: barriers to the spread of trauma and limits to their close engagement, geographies that shut down possibilities for further advocacy. I refer to these strategies as 'geographies' precisely because advocates deliberately employ *spatial* tactics such as building barriers or increasing distance to deal with contagious trauma, tactics that operate in the physical space of Darwin and its surroundings as well as the mental 'spaces' representing advocates' openness to intimacy and connection. In the following section I explore the construction of geographies of self-protection in response to the contagion of trauma within two advocacy groups in Darwin.

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I met often with the Darwin Aboriginal Rights Coalition (D-ARC), which became reenergized around the Northern Territory Intervention legislation of 2007. D-ARC works together with indigenous leaders and other advocacy groups throughout Australia that advocate against the measures of the Intervention legislation as well as for indigenous rights more broadly. D-ARC hosts public events promoting awareness of indigenous rights; works with local Aboriginal community leaders to represent local voices at public meetings and hearings; and builds public awareness of indigenous issues through protests, commemorations, concerts, and films.

At the D-ARC meetings, I often saw members of another advocacy group I joined, the Darwin Asylum Seeker Support and Advocacy Network (DASSAN). DASSAN was established in 2009 as both a support group for asylum seekers and a group that promotes "fearless advocacy" without being formally affiliated with government or non-governmental service providers.[1] DASSAN members visit people in detention in the Darwin area; write letters; meet with nongovernmental organizations, service providers, politicians, and media representatives; and organize public events to raise awareness of asylum seeker issues (Coddington, fieldnotes, January 21, 2012).

Through meetings of D-ARC and DASSAN, I began to learn about the collective means through which trauma expanded within spaces of advocacy. The following descriptions are from fieldnotes collected during participant observation at meetings and group events, as well as personal conversations with individual members about the group (all quotations and observations from Coddington, fieldnotes, November 15, 2011-March 1, 2012). Trauma moves through both groups, and while both groups deal with the stress and trauma of advocacy work differently, they each construct barriers to trauma's mobility.

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During my participation with DASSAN, the stress, burnout, and the traumatic associations experienced while with working with asylum seekers was a constant topic of discussion. Several members echoed the comments of one person, who told me it was "hard to keep up motivation." Pursuing diverse individual projects was a strategy to allow the few extremely active members to work around their areas of stress and burnout, as opposed to conducting more centralized, collective work. For example, debates I witnessed at the strategic planning meeting for 2012 centered on issues of stress and burnout, and different members grappled with how to restructure the organization yet were unable to reach conclusions as to how to make permanent change. There was tension in the group as DASSAN struggled with "trying to be everything," as several people summarized the situation, and they cited exhaustion, fatigue, and burnout as consequences of their advocacy work. The consequences of working with traumatized people were explicit topics of conversation throughout: members especially worried about the effects of visiting traumatized asylum seekers in detention for new advocates (Coddington, fieldnotes, January 21, 2012).

Concern for visitors about the trauma of closely engaging with traumatized asylum seekers was a reflection of advocates' own experiences with the spread of trauma. An older advocate working on asylum issues, for example, says, "we've had a decade of horror. Horror gets old." He believes the general public is tired of hearing about the suffering of people in detention, and their trauma—he refers specifically to their suicide attempts—has become "normalized." But his exhaustion is also personal; at the same time he told me that he "can't be sending first time visitors to failed security clearance people [who have been in detention upwards of 12 months], because visitors are unable to cope with their trauma." He has become numb to this type of suffering, though; it has become routine (Coddington,

fieldnotes, January 27, 2012). Numbness closes off emotional connection with detainees, serving as an only partially effective barrier to trauma's exhausting repercussions.

Over time, the collective experiences of advocates began to sediment. Another advocate, a similar story: he no longer makes individual visits to asylum seekers in detention. He has become "overloaded" and says his visits made him "lose the big picture." Really, he asked, "does an untrained person visiting do any good?" (Coddington, fieldnotes, January 27, 2012) While driving together to an event, a third advocate made a similar confession. She stopped making personal visits to detention centers as well: "Something had to give." (Coddington, fieldnotes, January 2, 2012). Here, the decision to stop visiting *distances* these advocates from further trauma. In each case, individual and often 'overwhelming' attempts to cope with asylum seekers' trauma led advocates to decide to curtail their engagement, and limit their advocacy. While it is impossible to know exactly how to attribute the stress, burnout, and exhaustion advocates felt, the explicit connections these advocates made between their own decreasing stamina, the traumatic experiences of asylum seekers, and the horror of detention policies demonstrates how they perceive these events to be interconnected. Advocates' *perception* that they were affected by the trauma of the visits meant that they felt the need to impose limits to their advocacy.

In DASSAN's case, members also attempted to grapple with the spread of trauma through intervening in the organizational structure of the advocacy group itself. In both private conversations and wider group settings, such as the strategic planning meeting, members circled repeatedly around institutional change that would transform the nature of the work for the most active members: finding funding sources, restructuring the 'chain of command,' creating new committee chairs, or limiting the organization's mission. Trauma leads to *individuals'* curtailing forms of advocacy, but the effects of trauma on these groups

also changed their *collective* perspective on advocacy work, accelerating the spread of trauma through the organization. Meetings I attended became occasions for consciously limiting the work of the organization, building barriers to preserve the strength of group efforts. For example, during a conference call with southern advocacy groups, the DASSAN members repeatedly stressed their preference to commit to organizing one event within a multi-day convergence (to be located in Darwin). "We're the detention capital of Australia but we can only do so much," one member said. Another member agreed: "We can't do much more" (Coddington, fieldnotes, December 3, 2011).

While DASSAN members often located the source of their stress within the framework of the organization itself, the embodiment of stress and trauma within the D-ARC membership manifested itself quite differently. Transience and widely differing agendas characterized D-ARC meetings; rarely did more than two or three of the same people attend two meetings in a row, and every meeting provided a new platform for whatever occurred to the membership of the day, encompassing a range of topics from legislative hearings to fire safety. Members privately expressed frustration to me at the difficulty of constructing collective projects from these fragmented pieces. Many of the members who attended most regularly had long-term experience—and, often, disillusionment—with non-governmental organizations that worked with Aboriginal communities and were often loath to organize collectively with other local groups.

An unmistakable embodiment of the trauma, stress and discomfort related to advocating for Aboriginal issues was the racial makeup of the group: despite meetings being held within the community room of one local Aboriginal community and despite the personal connections between members of the group and local Aboriginal leaders, the meetings at the time I attended were entirely white. Historically, the group included both

Aboriginal and non-Aboriginal Australians, but due to burnout, exhaustion, and family responsibilities, D-ARC's Aboriginal allies did not attend meetings during the time of my field research. The contrast between the blackness of the neighborhood and the whiteness of the meeting table offered a stark display of the toll of advocacy work; as one member explained, "The [local Aboriginal] community is exhausted. The five women who have all their shit together get pulled in every direction, they have to keep their families running, they get exhausted. Also, no one listens. Why bother?" (Coddington, fieldnotes, January 26, 2012)

For the five women the advocate described, their absence was directly attributed to a combination of traumatic experiences bound together. On the one hand, community members struggled to navigate daily life amidst a spectrum of types of trauma. Aboriginal residents of Darwin, particularly in the impoverished community of Bagot where D-ARC met, were simultaneously dealing with repercussions from intergenerational trauma, including child removal policies, state violence and discrimination; intergenerational poverty and dispossession; antagonism from the wider Australian community; political invisibility; community and domestic violence; and widespread issues with mental health and addiction (Trudgen, 2000). Bound together with the everyday traumas of life under the continued legacies of colonization were the unfamiliar cultural aspects of white Australian advocacy work and its lack of impact: as the advocate noted, "no one listens. Why bother?" The trauma associated with daily life combines with the stress and exhaustion of advocating in a vacuum, and Aboriginal community leaders construct geographies of self-protection by simply not showing up.

The contagion of trauma affected white Australia advocates as well. As multiple white advocates relate, non-Aboriginal Darwin residents shy away from Aboriginal

advocacy. The long-term nature of the problems and the trauma is "too full on," a long-time advocate who works closely with the Aboriginal community tells me (Coddington, fieldnotes, February 21, 2012). In another example, a different advocate deeply committed to Aboriginal justice who works for an Aboriginal advocacy organization becomes ill from the stress of hearing about Aboriginal women's sexual trauma and eventually has to find other work (Coddington, fieldnotes, January 14, 2012). In contrast to DASSAN, where contagious trauma combining witnessing, exhaustion, and burnout were embodied through constant conversation, at D-ARC, these same issues brought about by the difficulties of cross-racial advocacy and the stress and trauma of Aboriginal community lives were instead characterized by absence. The whiteness of meetings communicated both the stress of making cross-racial advocacy happen, and the trauma and burnout of Aboriginal leaders. White advocates struggled to balance refusal to be, as one advocate said, another white person doing nothing, with questions about, "what is the role of the white activist?" (Coddington, fieldnotes, January 26, 2012) Absence became one method of circumscribing the contagious nature of trauma associated with Aboriginal advocacy work.

In each case, advocates enacted barriers to advocacy efforts. Both DASSAN and D-ARC turned inward in response to the contagious trauma associated with advocacy. Both groups then engaged in self-protective mechanisms to limit their exposure to stress and burnout, refusing additional projects or limiting collaboration as a result. The strategies of these groups echo the choices made by the mental health professional and her colleagues. For her, the contagious trauma binding together the effects of working with traumatized people, stress and burnout cause her colleagues to leave, quit, or become hardened to the suffering they witness. Their humanity becomes obscured, and thus these experiences are often made invisible. Similarly, the individual choices advocates make—to avoid the 'full on'

nature of Aboriginal issues, to question or leave their work—likewise constrain the types of advocacy they choose to engage in. Each of these little decisions becomes part of a larger story of faltering energy, affecting the success of advocacy efforts at the community level. Contagious trauma expands, widening the circle of those affected by policies that compound trauma; in response, advocates limit their work.

Implications of contagious trauma

In this paper, I have made a case for understanding the mobility of trauma as contagion. Contagious trauma is a process not of 'taking on' another's trauma, like vicarious trauma, but rather a compounding of trauma, an expansive process that binds the trauma of witnessing with the often unrelated life traumas of the advocate themselves, the stress of work or the hostility of friends and neighbors, the deaths of friends or other buried memories. Contagious trauma occurs in a space of proximity. Paradoxically, close emotional or physical engagement both allows advocates to care, or to empathize with traumatized individuals, and provides the space in which traumas can compound. In response to the compounding of trauma, advocates protect themselves, constructing barriers or limits to the advocacy work that allows trauma to expand. These geographies of self-protection limit advocacy efforts, constraining the type of advocacy that can occur as a result of traumatic public policies. In effect, contagious trauma thus both expands the reach of policies that compound trauma and shrinks the capacity of advocates to contest these policies.

My experience reflected the shrinking capacity of advocacy as I, too, chose to limit my advocacy efforts in response to the expansion of contagious trauma. I was exhausted, and something had to give. Of course, I also knew I was leaving Darwin and would eventually not have to manufacture my own distance from the advocacy efforts. Time and

many thousands of miles did it for me. Yet the trauma of the advocacy work that I absorbed stays with me, revisiting my dreams. Limited advocacy does not automatically mean worse advocacy, but one cannot automatically assume it makes for better advocacy either. In cases where advocates place their strongest selves in positions to advocate for justice, perhaps their efforts will be stronger as well. Yet contagious trauma exhausts people; it creates more limits, more constraints, and requires more energy to overcome, and these barriers translate into different kinds of advocacy efforts.

The implications of contagious trauma are provocative as well as destructive. Trauma theorists such as Caruth (1995) and Edkins (2003) explore the disruptive potential of trauma time, theorizing the challenge of flashbacks and their reappearance in different places and times for linear, narrativized understandings of time. Trauma forces time to be comprehended differently, pushing for ways of exploring time that circle back, leap forward, and blur past, present, and future. Contagious trauma offers a similar challenge for understandings of movement through space. Rather than a chronological narrative, with a beginning, middle, and end, whereby trauma 'X' moves through victim 'Y' and ends by lodging also within advocate 'Z,' contagious trauma offers an understanding of movement through space that circles back on itself as well, concentrating and expanding. In a theory of contagious trauma, trauma 'X' that happens to 'Y' and is witnessed by advocate 'Z' becomes compounded by Z's life events, widening the circles of impact, such that trauma 'X' expands over space, spreading, building, and transforming as it does so. The narrative of contagious trauma becomes even more unstable if we imagine trauma 'X' to represent its own constellation of traumatic happenings and associated life events. The process through which contagious trauma moves and builds over space and time provides an accompaniment to the disruptive potential of trauma time. Furthermore, the writing style incorporating my

remembered nightmares is, in part, also the beginning of a conversation of how to write a narrative of a movement through space without an easily identifiable beginning and end, as well as a demonstration of trauma's destabilizing effect on narrative time.

While the argument for contagious trauma has straightforward and practical implications for advocacy projects that engage with traumatized people and events, it also offers potential for theories of trauma and geography. Contagious trauma builds on work such as Till (2012), Willis (2009) and Perera (2010) that explore the importance of space for the workings of trauma. Yet rather than focus on the mobility of trauma within the macrospaces of global geopolitics (Perera 2010) or the built environment (Till 2012) or even the everyday landscapes of grief and healing (Willis 2009), this analysis offers an exploration of the everyday effects of trauma's movement through space on the scale of individuals and small groups. Close scrutiny of the everyday movement of emotion-laden processes such as traumatic association could add to debates in emotional geography in particular about the mobility of fear, pain, and anxiety across space (Drozdzewski and Dominey-Howes 2015; Saville 2008; Pain 2009).

Contagious trauma also responds to debates in geography around the idea of 'contagion' itself. Geographers have taken up the idea of affective contagion, as developed by Thrift (2008), to describe flows of feelings and affective energies between people and things. For Thrift, contagion represents a passive process, where undifferentiated bodies unconsciously (or semi-consciously) transmit and receive knowledge. Contagious trauma is, by contrast, a very active process, where embodied differences that underpin the creation of traumatic public policies are central to the landscape in which trauma moves. Contagious trauma builds on the individual experiences of traumatized people and advocates, as well as the particular bond they form as they work together, and through that relationship trauma

gains capacity to expand, widening the impact of traumatic public policies and limiting advocacy.

The spread of contagious trauma simultaneously strengthens the case for advocacy against policies that compound trauma, such as those affecting asylum seekers and Aboriginal communities in the Northern Territory, yet complicates the case for doing advocacy through 'care' work relying on proximity, work that generates connection but facilitates the transmission of trauma. As Lawson (2007: 5) writes, neoliberal political strategies individualize social responsibility, pushing the burden of caring and advocating for the dispossessed towards individuals and communities and depoliticizing this work in the process. She (2007: 5) argues instead for "care ethics," a framework emphasizing the "relational, spatially expansive, and public" nature of the work of caring for others. Perhaps an ethics of care focused on advocacy and trauma would accept the role of boundaries, as Cuomo and Massaro (2015: 103) write, as playing "an important ethical role in keeping both researchers and participants emotionally and physically safe," and allow advocates to care for themselves in the long term as well as the traumatized people on whose behalf they work. It may also be the case that advocates need to be prepared to accept the contagion of trauma as part of the privilege of intimately caring for others, that to do advocacy will come at personal cost, and that there can very well be a lifespan to intimate advocacy work.

Yet it may also be the case that advocating in the context of contagious trauma cannot be reconciled with an ethics of care. Perhaps the spread of trauma is, simply, bad. Indeed, as Coates (2015: 1) writes, sometimes hopeful perspectives obscure the terrible repercussions of damaging politics: "I think that a writer wedded to 'hope' is ultimately divorced from 'truth'… I have to be open to things falling apart. Indeed, much of our history is the story of things just not working out." The spread of trauma and the limits it imposes

on advocacy allow for the expansion of political strategies antithetical to an ethics of care: trauma's contagion is part of the fallout.

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[1] Service providers who are directly contracted to work with asylum seekers in detention facilities in Australia are often contractually prevented from speaking publicly about asylum seeker issues by the Department of Immigration and Citizenship.