

Engaging Australian Aboriginal Youth in Mental Health Services.

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Keywords

Cultural competence, cultural consultants, culture-bound syndromes, acculturative stress, acculturation, traditional treatment hierarchy.

.....that children should suffer from want in a world of excess, that is the greatest shame of all....

Sir Bob Geldorf, 2002, 60 minutes interview.

Introduction

Research studies on Aboriginal groups in Australia and internationally continue to illustrate the negative impact of colonisation on their mental health (Australian Institute of Health and Welfare, 2009; Blum, Harmon, Harris, Bergeisen, & Resnick, 1992; Radford, Harris, Brice, Van de Byl, Monten, Matters, Neeson, Bryan, & Hassan, 1991). Despite this, a number of recent articles have argued that Aboriginal people do not access mental health services at a level that is commensurate with this need (Australian Institute of Health and Welfare, 2009; Garvey, 2000; Hunter, 2007; Vicary & Andrews, 2001).

Reasons for this poor access are numerous; however, it is clear that the paucity of culturally derived empirical models of effective practice which can be applied with Aboriginal youth, regardless of their geographical location and tribal affiliation, contributes to the resistance within the field to depart from mainstream practice. The result for Aboriginal youth is that there is a reliance upon individual practitioners to make a determination of how and when to incorporate cultural differences into practice. Culture therefore continues to remain distal rather than proximal to the engagement process (Cuellar & Paniagua, 2000; Vicary & Andrews, 2001).

A primary barrier to the development of evidence based models is the prevailing view within the field that the extent of diversity within the Aboriginal culture makes universal models of best practice impossible to achieve. It will be argued that it is possible to develop universal models that can be applied to Aboriginal people as long as these models require that cultural diversity (via an exploration of individual cultural identity and beliefs) is a primary foundation of all practice. In addition, it is also essential that once established models are tested out with a sufficient sample of the target population, in this case, Aboriginal youth. In doing so, the first section of this paper will focus on providing an overview of the particular barriers and difficulties identified by Aboriginal youth when engaging in mental health services with (predominantly) non-Aboriginal (NA) practitioners in research conducted by Westerman (2003). Strategies aimed at increasing the number of services and practitioners who are both culturally and clinically competent will then be

proposed. The paper will conclude by testing out these strategies with a sample of Aboriginal youth (N=111) to determine a culturally validated engagement model for use with Aboriginal youth across Urban and Rural (remote locations) of Western Australia.

Existing problems in quality service provision

Aboriginal people who come into contact with mental health services are more likely to receive services which are primarily reactive in their nature (Atkinson, Bridge, & Gray, 1999; Memmott, Stacy, Chambers, & Keys, 2000). This often means a range of services including basic counselling, advocacy, support or diversionary activities. Misunderstanding and miscommunication were seen as common hindrances to productive and effective service delivery, resulting in negative experiences for both Aboriginal patients and their carers (Eley, 2006). In combination, this has resulted in a dearth of preventative or therapeutic levels of intervention with Aboriginal youth, despite the obvious need for these. Whilst examples of good practice obviously exist, this has not been provided in a form that has been empirically and culturally validated, therefore not providing opportunities for replication of the efficacy of such models across different Aboriginal groups. This has impacted upon service delivery at the individual clinical level as well as at the broader system levels, the combined effect being that there is a significant amount of inequity in access to mental health services by Aboriginal youth (Social Health Reference Group, 2004; Vicary, 2003).

Problems at the individual practice level include that practitioners often have the desire to be 'culturally appropriate', but are frustrated by the lack of empirically grounded conceptual frameworks that have proven their efficacy with Aboriginal youth. Therefore when Aboriginal youth present to services, successful outcome is mostly measured subjectively and often in the absence of a consistent theoretical framework which can be applied to specific presenting issues. This again makes tracking successful outcome attributable to intervention fraught with difficulty.

At the system level, services struggle with how to embed culturally appropriate practice within mainstream policies and procedures in the absence of empirical evidence regarding what constitutes 'best practice'. It also makes it difficult for organisations to determine whether there is a 'fiscal' value in adopting distinct practices with Aboriginal clients; the end result of which is significant organisational resistance to change (National Aboriginal and Torres Strait Islander Health Council, 2002; Swan & Raphael, 1995).

Cultural and Clinical Competence within Service Delivery

The solution to increasing access to mental health services by Aboriginal youth therefore lies in the integration of cultural and clinical competencies at the system and practitioner levels. However, this integration must not be to the detriment of client quality assurance. Clinical competence is often defined as the extent to which certain therapeutic techniques are proven to be effective treatments for certain disorders (National Health Priority Areas, 1998; Raphael, 1992; Spence, 1994). Cultural competence refers to the ability of practitioners to identify, intervene and treat mental health complaints in ways that recognise the central role that culture plays in unwellness (Cross, Bazron, Dennis, & Issacs, 1989; Cuellar & Paniagua, 2000; Dana, 2000; Westerman, 2003). Research demonstrates that services struggle to meet criteria of cultural as well as clinical competence (Dana, 1998; Dana, 2000; National Health and Medical Research Council, 2006). For the NA practitioner, cultural competence is the struggle that is usually of primary concern (Dana, 1998; Dana, 2000; Vicary, 2003). For Aboriginal practitioners, whilst cultural competence cannot simply be assumed, the struggles are more often at the level of clinical competence – which is often determined through the utilisation of mainstream treatments and interventions that often run contrary to the belief systems of Aboriginal people. Importantly, for both NA and Aboriginal practitioners there continue to be very real struggles in understanding Aboriginal mental health within a clinical framework. This deficit in culturally competent services is

one of the major reasons preventing Aboriginal clients accessing services. This is depicted in Figure 1 overpage. Based on this model, it is argued that service providers and agencies either fall to the left (cultural competence) or right (clinical competence). Few individuals or services are able to integrate clinical and cultural elements of service delivery. For example, accurate diagnostic formulation can only occur if practitioners have a clear understanding of the cultural and clinical manifestations of mental illness to be able to determine the most likely cause of client distress (clinical or cultural). This makes working with Aboriginal clients a challenging enterprise for the average clinician.

Increasing Cultural Competence in Services

There is abundant research evidence that the development of guidelines, which aim to increase the cultural competence of clinicians, increases service utilisation and promotes

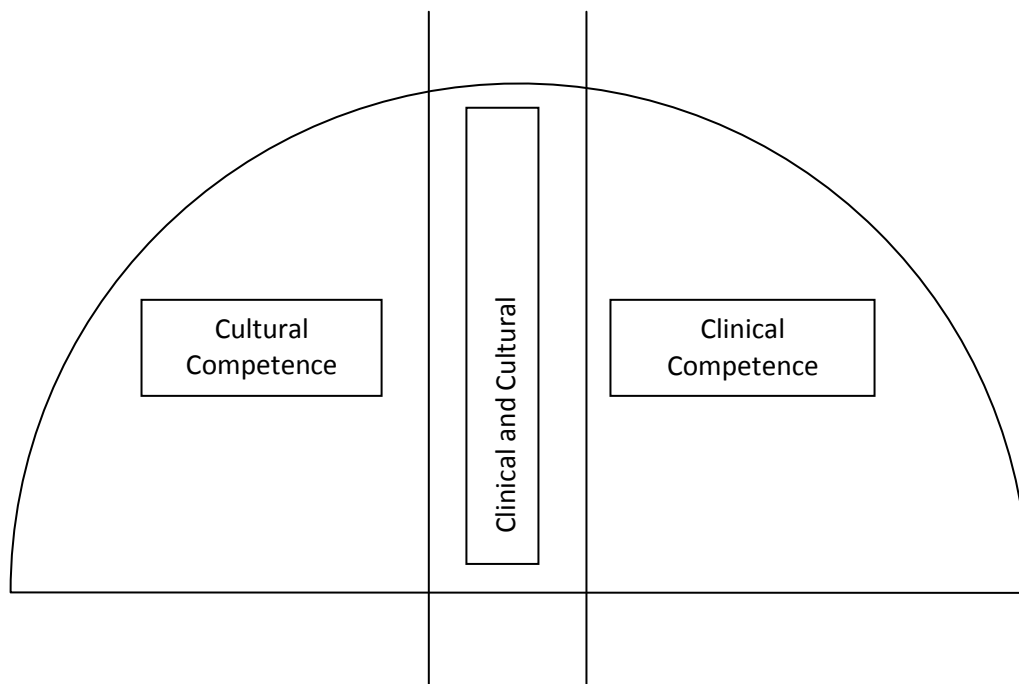


Figure 1: The Dual Struggle in the provision of services to Aboriginal mental health clients (Westerman, 2003)

beneficial outcomes for Aboriginal clients (Casey, 2000; Social Health Reference Group, 2004; Steering Committee for the Review of Commonwealth / State Service Provision, 2003; Vicary & Andrews, 2001; Vicary, 2003). Dana (2000) has defined the components of cultural competence as eleven different counselling competencies. These have been organised under cultural awareness and beliefs, cultural knowledge, and flexibility (Dana, 1998; Dana, 2000). Cross, Bazron, Dennis and Issacs (1989) have also developed a Cultural Competence Continuum for primarily NA practitioners to increase their level of competence in working with minority populations. This continuum has been used to design training programs, and improve the self-awareness of clinicians regarding their strengths and deficits in working with minority populations. Within Australia and internationally, there has however, been very little focus on the development of Aboriginal mental health cultural competencies with the primary focus being on the development of health service delivery frameworks (National Health and Medical Research Council, 2006). The impacts of this are enormous. First, universities are currently unable to train practitioners using practice. Second, uniform models of evidence based culturally competent mental health organisations and systems do not have clear benchmarks against which to identify cultural competence or incompetence within practitioners. Third, existing ethical guidelines and codes of conduct are not able to articulate the management of the numerous cultural dilemmas that present to practitioners as part of standard

mental health practice. To provide just one sobering example of this need, existing ethical guidelines (Australian Psychological Society, 1996) refer to mainstream standards of informed *clinical* consent but do not provide guidelines regarding the need to negotiate informed *cultural* consent to ensure that the disclosure and potential use of culturally sacrosanct information is negotiated with Aboriginal clients as part of standard practice. This can result in the reality that Aboriginal clients can 'give up' information to practitioners which is useful within a mainstream context, but results in significant distress for the client culturally.

Westerman (2003) has extensively explored the concept of Aboriginal mental health cultural competencies for use with services and practitioners which may provide a useful foundation for future practice and research validation. It is becoming increasingly evident that until cultural competence is able to be defined and certainly measured in the same manner as clinical competence, the reality of insisting upon 'minimum standards' of practice will not be realised within the Indigenous mental health field. Cultural competence will then unfortunately continue to exist as the 'poor cousin' to clinical competence.

Engaging Aboriginal Youth in Mental Health Services

Research indicates that not only are Aboriginal youth less likely than their NA counterparts to engage in mental health services, they are also likely to engage at a more chronic level, and do so for shorter periods of time (McKendrick, Cutter, Mackenzie, & Chui, 1992; Vicary & Andrews, 2001). A number of research papers have attempted to provide explanations for this (Dudgeon, 2000; Garvey, 2000; McKendrick, Thorpe, Cutter, Austin, Roberts, Duke, & Chiu, 1990). Primarily the basis of these explanations has been the 'cultural inappropriateness' of existing services, or the failure of mental health services and clinicians to embrace Aboriginal conceptualisations of health and well-being (Dudgeon, 2000). However, as already discussed, there have been few attempts to define or fully operationalise the basis of cultural inappropriateness, or provide methods by which clinicians are able to adapt their practice appropriately. The range of problems that have been identified within this study as impacting on the engagement of Aboriginal youth in mental health services will now be described at the practitioner and system levels of service delivery. This will be followed by the provision of solutions to each issue based on study findings.

The use of culturally inappropriate methods of engaging youth in mental health services

NA clinicians often find it difficult to engage with Aboriginal people at a level that 'makes sense'. Problems are often related to clinicians having a lack of cultural knowledge, understanding of local customs, language and norms. These problems were narrowed down by Westerman (2003) to two constructs; (A) the cultural appropriateness of the processes used by practitioners when engaging Aboriginal youth client relationship. and, (B) qualities intrinsic to the practitioner –

A. The cultural inappropriateness of the processes used by practitioners when engaging with Aboriginal youth

1. Appropriateness of Introductions and Establishing Rapport

In establishing rapport with Aboriginal youth it is paramount that an immediate and personal connection is made between therapist and client. The best method of achieving an immediate therapist-client connection is through a discussion about genealogy. Aboriginal people have a strong spiritual connection to ancestry, which is based on the belief that in the beginning our ancestors were all connected to each other (Reid & Trompf, 1991; Tonkinson, 1976). The basis for this approach is that if you have knowledge of relations or ancestors that are known to each other, a connection is immediately made. This requires that therapists have a comfort with the need to self-disclose regarding their own family connections and background. Unless this is done, Aboriginal

people will not be able to 'place' the therapist and therefore relate at a therapeutic level (Seru, 1994; Sheldon, 2001). To facilitate this capacity to connect at a greater level, practitioners should also have an understanding of different language and family groups, tribal boundaries and skin groups within the region in which they work.

2. Assessing Aboriginal youth outside of cultural context

There are many examples of misdiagnosis, under-diagnosis and over-diagnosis occurring with Aboriginal youth as a direct result of being assessed outside of their community, or preferred cultural context (Hunter, 1988; Westerman, 2003). Hunter (1988) for example noted that Aboriginal people assessed in foreign and sterile environments would present as significantly more distressed than usual. This means that practitioners must ensure that the assessments they have conducted 'match' how Aboriginal people are viewed within their culture. This has two elements. First, it must be ascertained if presenting symptoms are evident across both mainstream and cultural contexts. Second, it is important to establish whether identified symptoms impair the individual within both of these environments. A number of authors have discussed the need to triangulate data sources in order to ensure the accuracy of the diagnosis of mental ill health in Aboriginal youth (Drew, 2002; Kearins, 1981). It is essential that some form of collateral information is gathered in order to provide additional evidence to support any assessment particularly when clinicians are from a different cultural background to their client.

3. Aboriginal beliefs regarding mental ill health

It is generally accepted that Aboriginal culture is holistically based (Australian Bureau of Statistics, 1997; Clarke & Fewquandie, 1996; Zubrick, 2005). In definitional terms, this means that concepts of mental ill health for Aboriginal people will always need to take into account the entirety of one's experiences, including physical, mental, emotional, spiritual and obviously, cultural states of being. It is also becoming increasingly evident that symptoms are not just symptoms but a manifestation of a different cultural reality. Westerman (2003) for example, found that Aboriginal clients presenting with similar conditions could manifest this distress physically, spiritually, culturally or mentally. In more practical terms, this means that Aboriginal people tend not to operate within a mind / body dichotomy (Slattery, 1994) and will therefore present with a sense of *being unwell within themselves* or feeling that *things are not quite right*. Practitioners must therefore resist commenting upon discrete symptoms or emotional labels which are framed within a mainstream set of diagnostic criteria associated with specific disorders (Roe, 2000). Making statements of a broad sense of unwellness such as things "not looking right" or "not too good in self" are more effective strategies for initial engagement in the concept of mental unwellness. This is in obvious contrast to westernised views of mental health in which people are more likely to ascribe feeling unwell to a specific symptom (e.g., being sad, anxious and so forth).

The Aboriginal belief system is such that bad luck, ill health, negative life circumstances are always attributed to *external forces or reasons* (Reid & Trompf, 1991). Mental health is no exception to this and it is for this reason that many mental health problems do not necessarily come to the attention of mental health practitioners. In effect, when ill health occurs, individuals will most likely attribute this to some external wrongdoing which is most likely to be culturally based. For example, "doing something wrong culturally", or "being paid back" for wrongdoing are common attributions made to mental health conditions (Sheldon, 2001; Vicary & Andrews, 2001). This reflects the intertwining of spirituality and particularly relationships with family, land and culture (Slattery, 1994).

4. The inappropriate use of cultural consultants

Whilst there is now strong evidence to support the utilisation of cultural consultants to ensure engagement and service uptake, it is the lack of guidelines around the application of this model which often impacts on its effectiveness (Vicary, 2003; Waldegrave & Tamese, 1993).

The use of cultural consultants should become standard practice throughout mental health services working with Aboriginal youth. In fact, Vicary (2003) found that ninety two percent of Aboriginal people in his study stated they would not see a NA practitioner unless another Aboriginal person (cultural consultant) had vouched for them. 'Vouching' means that members of the Aboriginal community would convey positive or negative information about the therapist to potential clients. However, practitioners often engaged cultural consultants in ways that were culturally inappropriate. These factors include; (a) engaging the wrong level of cultural consultant for the presenting problem. This is particularly relevant for Aboriginal culture which is hierarchical in its nature. This means that particular individuals hold different levels of power within communities and therefore the ability to resolve certain culturally-related transgressions; (b) engaging a cultural consultant of the opposite gender to the client and failing to determine whether gender differences need to be addressed, particularly if the counsellor is the opposite gender to the (Aboriginal) client. Given that gender is a sub-culture within Aboriginal culture any gender differences need to be minimised through the engagement of a cultural consultant who is of the same gender to the client. In instances in which you have an Aboriginal male client who has been through traditional lore, it is also essential that any male cultural consultant utilised, has also been through lore; (c) engaging a cultural consultant who had an avoidance relationship with the client; (d) engaging a cultural consultant from a different tribal or language group to the client and who did not have an understanding of each other's culture, and; (e) engaging a cultural consultant who was feuding with the client's family. Added to these concerns is the fact that Aboriginal people who were approached to be cultural consultants would not necessarily volunteer information of a cultural nature that precluded them from being engaged as cultural consultants due to issues of 'shame'. Solutions to the effective engagement of cultural consultants include; (i) that practitioners must ask the question "Is there any cultural reason why you can't be involved?" (ii) That practitioners were culturally knowledgeable and competent; (iii) that the client nominated the cultural consultant, and (iv) the community validated this choice or 'vouched' for the person as appropriate.

5. Putting people on the 'spot' for a direct answer

One of the greatest mistakes made by NA practitioners in particular is the expectation that Aboriginal youth will respond to questions posed with a direct answer. Communication styles within Aboriginal communities are such that hierarchies of decision-making power exist. This means that decisions often take time to be reached, and that there are also certain people within communities who hold the 'power' for certain types of decisions. Additionally, research supports the notion that putting Aboriginal people on the spot for a direct answer to a direct question, particularly of a personal nature will result in 'shame' to them (Tamisari, 2003). Malin (1997) argues that Aboriginal young people considered that it was 'less shame' to get an answer incorrect, than to continue to have the 'spotlight' on themselves. Questions which are more narrative and open-ended are consistently seen as the most effective approaches as they provide a practical context to the clients presenting issue and also ensure that the client will respond with a story (Harris, 1977; Kearins, 1976; Malin, 1997).

(B) Qualities intrinsic to the practitioner – client relationship

1. Cultural disparity between client and practitioner

A major contributor to the lack of engagement of Aboriginal youth in mental health services has been identified as the extent of cultural differences between client and practitioner (Dudgeon, Grogan, Collard, & Pickett, 1993; Eley, 2006; Kearins, 1981). The cultural compatibility hypothesis argues that the engagement of Indigenous and minority population clients is enhanced when ethnic barriers are minimised (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). This means that the greater the extent of cultural difference between client and practitioner, the less the likelihood of effective engagement (and accurate assessment). The cultural consultant model already discussed is a

particularly vital model in ensuring that the extent of these differences between client and practitioner are minimised.

2. Gender Differences between client and practitioner

As already discussed, gender is a subculture in Aboriginal culture. Aboriginal people are generally raised to relate closely to people of the same gender (Davidson, 1988; Harris, 1977; Kearins, 1976, 1981). This means that boys and girls are often separated from each other at an early age and encouraged to interact closely with those of the same gender. As a result, it can be inappropriate for mental health practitioners to work with Aboriginal youth of the opposite gender. On occasions when this does occur, it is not unusual for Aboriginal youth being labelled as “non-communicative”, “difficult to engage”, or that the practitioner was “unable to establish rapport”. This is often the result of the “shame” felt by youth to engage in intimate discussions with people of the opposite gender.

The gender and cultural differences between practitioner and youth could also be exacerbated by discussing private issues, such as commenting on the quality of family relationships, discussing intimate relationships, and most particularly, topics which included any questions of a sexual nature. Discussions of private matters such as these rarely occur between Aboriginal people of the opposite gender. Matters of a sexual nature were considered by participants to be the height of ‘shame’. Participants noted examples of instances where such discussion had occurred and that this had resulted in a number of behavioural presentations, which were misinterpreted by NA practitioners. Examples included young women who would bow their heads, not make eye contact, and even cry when questioned by NA males regarding sexual issues. A few participants had noted that this had resulted in labels such as depression, as well as anxiety.

The use of cultural consultants who are of the same gender as the client was considered to be an appropriate solution to this problem in instances where assessments had to be conducted by practitioners of the opposite sex to the Aboriginal client. In addition, the use of culturally appropriate counselling strategies would also increase the likelihood that assessments would be more culturally valid.

(C) Some solutions

1. The Use of Culturally Appropriate Counselling Techniques

Some authors have discussed the use of culturally appropriate techniques and strategies for non-Aboriginal practitioners to use in working with Aboriginal people and communities (Slattery, 1994; Vicary, 2003). Some of these writers have noted that Aboriginal culture and conceptualisations of mental health differ markedly from western beliefs (Dudgeon et al., 1993; Hunter, 2007; Seru, 1994; Sykes, 1978) and have suggested an array of generic, culturally appropriate methodologies to assist workers in the field. There exists a limited base of specialist therapeutic interventions, which are steeped in conceptual, evidence-based treatment models (Vicary & Andrews, 2001; Vicary, 2003). Roe (2000), has described a culturally derived model of intervention. According to Roe, Ngarlu is located in the stomach, which is the centre for emotions and well being. Ngarlu has been weakened by colonisation; through the processes of dispossession and disempowerment of Aboriginal people. Roe believes that Ngarlu was what kept people strong and healthy as well as providing a strong sense of self. According to Roe Ngarlu is “more than an intuitive or gut feeling; an Aboriginal person can will themselves to die when Ngarlu has been broken or weakened and is very sorrowful” (p.395).

Vicary (2003), a NA clinical psychologist, has also developed a model of therapeutic intervention for NA practitioners to work more effectively with Aboriginal clients. He focuses on ten distinct stages of intervention, the first four being concerned with effective engagement or therapeutic alliance

between the NA practitioner and Aboriginal client. These stages are linked primarily to having attained a high level of cultural awareness through researching local Aboriginal culture, customs, taboos, and language. Vicary also considers that understanding and appreciating the historical context of Aboriginal people is an essential component of this process. Finally, Vicary considers ongoing cultural supervision is essential for NA practitioners to attain cultural competence.

The reality is that cultural differences exist. Child-rearing practices within Aboriginal culture are different to those within Anglo-Australian culture, and impact upon the cognitive, emotional and spiritual development of a person from birth. Importantly, it affects how people view the world, how they find solutions to problems, and the skills they need to develop in order to survive within a culture. However, these differences are rarely incorporated into counselling and therapeutic practice. The reason is that cultural differences are often viewed as deficits as opposed to strengths. Research (Harris, 1977; Kearins, 1981; Malin, 1997) has indicated that there is an expectation Aboriginal people would have the following identified cultural strengths; (a) spatial-visual skills; (b) visual memory; (c) practical competence, and; (d) observation skills. As such, the use of guided imagery; cognitive disputational techniques, which are mediated visually, are possible examples of this type of approach. This presupposes that therapists are able to demonstrate some flexibility, and ingenuity in the application of 'mainstream techniques' in a way that fits the 'worldview' of Aboriginal people. Recognition and incorporation of these strengths into assessment, but importantly in the adaptation and delivery of therapies has been discussed by (Westerman & Vicary, 2004). For service providers, specific information which pertains to culturally competent counselling strategies with Aboriginal people should remain a focus of ongoing research. The specific cultural factors which impact on client presentation (e.g., Aboriginal belief system; offending cultural taboos) has been discussed fairly extensively at an anecdotal level, the need is now for empirical research to validate these components.

2. Incorporation of Clients Cultural Beliefs in standard practice

Research with Australian-Aboriginals' indicates that there exist extreme differences between tribal groups. Within and cross group differences have been attributed within the research to the impacts of acculturation. Acculturation refers to the extent to an individual integrates new cultural patterns into his or her original cultural patterns (Cuellar, 2000). It is the process of acquiring a second culture whilst also retaining the beliefs, practices and knowledge of your culture of origin. For Aboriginal people this means moving from living within a traditional environment into mainstream Australian culture and the impact that this has on your prevailing belief system. Given that the acculturation process has strong links to the development of mental ill health (Berry & Kim, 1988), it is essential that practitioners are able to engage with Aboriginal youth about the relevance and influence of their cultural identity and beliefs in the manifestation, interpretation and maintenance of disorder. This must occur at the initial stages of engagement. There is however, reluctance on behalf of practitioners to explore prevailing belief systems of Indigenous clients. This is due mostly to the lack of guidance regarding how this is most effectively done, and particularly, what aspects of the belief system are more important determinants of resilience, risk and maintenance of disorder than others. The international literature has already developed a fairly sound research base demonstrating the relevance of acculturation in accounting for rates of mental ill health (Cuellar, 2000). In a similar fashion, Westerman (2003) has developed an interview protocol for practitioners to explore the prevailing cultural beliefs of Aboriginal youth called the Acculturation Scale for Aboriginal Australian Youth (ASAA-Y: Westerman, 2003). Known as the "Sense of Culture Yarn", the ASAA-Y has a number of important objectives. First, it places a significant onus on practitioners to explore any cultural meaning that is ascribed to illness as standard practice with Aboriginal youth. This means that practitioners are not left to erroneously assume or guess the importance of prevailing cultural beliefs with individual Aboriginal clients. This also creates a sense of normalcy around the discussion of cultural beliefs within itself requires that clinicians develop a degree of comfort and competence with this type of cultural engagement. In many ways, the use of cultural consultants then becomes absolutely vital to the engagement process when practitioners do not

have this capacity. Finally, clinicians often struggle to understand the most important aspects of cultural belief systems. The ASAA-Y provides guidance and direction to assist clinicians to explore this very complex set of beliefs and has been demonstrated as an effective method of engaging Aboriginal youth in services as described in the engagement model provided in this paper.

3. Cultural supervision

All clinicians working with Aboriginal clients should have access to ongoing cultural supervision. Cultural supervision is a formal relationship between members of the same culture or different cultures for the purpose of ensuring that the supervisee is practicing according to the values, beliefs, protocols and practices of that particular culture. Cultural supervision focuses on cultural accountability and cultural development and does not replace clinical professional supervision. This process is formalised and based upon particular cultural competencies. Additionally, clinicians are required to conduct regular self-assessment regarding their particular competencies in specific learning areas. This is overseen by a senior clinician in a co-operative relationship with a cultural teacher of some standing within the local community (Casey, 2000; Westerman, 2003).

4. Developing information regarding culture specific mental health problems – culture-bound syndromes

A study by Westerman (2003) resulted in the validation of a range of disorders, which exist uniquely within the Aboriginal community. These illnesses termed ‘culture-bound disorders’ (American Psychiatric Association, 1994) often mimic mental health disorders, however, the triggers and maintaining factors lie within the cultural beliefs of the client, and therefore resolution often needs to occur at the cultural level. Whilst there is a fairly extensive volume of research on the existence of culture-bound syndromes within Indigenous cultures around the world, this research represented the first attempt to validate the existence of these disorders for Aboriginal Australians. It is essential that practitioners have sound knowledge of culture-bound illnesses within Aboriginal populations to ensure that they are able to engage in discussions about the different manifestations of unwellness with Aboriginal youth.

5. Incorporating culturally appropriate treatment options within interventions

There is a need to acknowledge existing frameworks of healing within Aboriginal communities and in particular those pertaining to the resolution of culture-bound disorders. This should be conducted via the following methods;

1. Offering Aboriginal clients the option of traditional methods of healing as a primary treatment,
2. Recognising and respecting the traditional processes that exist for Aboriginal people to resolve mental health problems. This has been referred to by Vicary (2003) as the “Traditional Hierarchy of Treatment for Aboriginal Clients”, which will be explained further in the next section,
3. Facilitating traditional methods of healing through engaging with appropriate cultural healers and cultural consultants (at an appropriate level).

Recent research indicates that a primary barrier to engagement in mental health services for Aboriginal people lies in the failure of services to acknowledge and to also be able to work within traditional methods of resolving mental health problems (Garvey, 2008; Vicary, 2003; Westerman & Vicary, 2004) as already discussed.

6. The hierarchical structure of Aboriginal problem resolution: implications for treatment and intervention

The anthropological examination of the Aboriginal culture has led to the depiction of the Aboriginal culture as hierarchical (Tonkinson, 1976; Vicary & Andrews, 2001). Aboriginal research also consistently discusses the hierarchical processes that exist in most daily activities from problem resolution, to food distribution and division of labour. In line with this, Vicary (2001) and Westerman (2004) have argued that there exists a hierarchy of treatments that are specific to Aboriginal people. Vicary (2001) conducted research in both the Kimberley as well as Perth and found that this process was just as relevant for urban Aboriginal people as it was for more remote Aboriginal people. It has also been demonstrated that Aboriginal people will explore cultural explanations prior to any other interpretations of mental ill health (Vicary & Andrews, 2001; Vicary, 2003). It is therefore vital for practitioners to have a good conceptual understanding of the traditional hierarchy of treatment interventions (see Vicary, 2003).

7. Operating outreach

A number of papers (Dudgeon et al., 1993; Vicary & Andrews, 2001) have highlighted the need for mainstream services to operate an outreach capacity where possible, based upon the expression of this need by the Aboriginal community. Additionally, Vicary (2003) argues that Aboriginal people are more likely to engage with practitioners who are highly visible in communities as this provides the opportunity for Aboriginal people to determine the appropriateness of the practitioner through being able to see and judge them. This often occurs through a spiritual dimension – that is, a sense of the person's strength and goodness of spirit is often the basis under which engagement will occur (Roe, 2000). This occurs for three major reasons. First, it is partly the result of the stigma that Aboriginal people will often feel when accessing a mental health service. As Aboriginal culture tends to externally attribute causality, this can often mean that if someone becomes unwell, it is because they have done something wrong (culturally). The stigma for unwellness is therefore arguably greater for Aboriginal people. Second, it matches the strong sense of spirituality that Aboriginal people have within themselves and are able to see in others. Finally, it is also attributed to the comfort of a familiar location as well as the fact that foreign and sterile settings (such as offices) are known to impact on the behavioural presentation of Aboriginal clients (Hunter, 1989; Vicary, 2003; Westerman, 2003).

8. Referral Processes of Services

Contact between Aboriginal people and mental health services most often occurs in an indirect manner (Vicary, 2003). Additionally, research indicates that Aboriginal clients are less likely to present to services with direct complaints of social, emotional or mental health problems (Westerman, 2004). Referrals to mental health services are predominately received by a significant family or community member, otherwise referred to as traditional referrals. This is consistent with traditional healing models in which access to healers (Maban) occurs via a family member or appropriates other approaching the healer on behalf of the individual who is unwell. Further research into this vexing problem is needed to enable services to develop appropriate guidelines around this referral process.

9. Evaluation of cultural competencies within service delivery

For services to ensure ongoing and effective changes in the extent of cultural competence, they must ultimately aim to have minimal standards of cultural competence that must be attained by all staff who work directly with Aboriginal youth. Having clearly defined and measurable Aboriginal mental health cultural competencies (Westerman, 2003) as already discussed is one potential method of setting much needed benchmarks of effective practice within the field. Ensuring that practitioners have ongoing access to cultural supervision to increase cultural competence is also

necessary (see Vicary, 2003 for a review). Finally, services must also be able to use a range of cultural consultants in their service which reflect the complexity of the presenting problem and validate the central role that culture can often play in treatment.

10. Engagement Model for Aboriginal Youth

Information provided in this paper has been used to develop a Model of Engagement for Aboriginal youth in Western Australia. It has so far been tested with 111 Aboriginal youth across Urban (N=48) and Rural/Remote (N=63) locations, resulting in effective engagement with 108 of the sample (see Westerman, 2003). Extrapolation of these themes occurred in a manner that aimed to provide clinicians with an engagement process that could be used sequentially, however, it is by no means prescriptive, and some steps may not be seen as relevant to the process, or need to occur in a different order. The final engagement model involves eleven steps.

Step One: Consider the location of therapy – this must be natural and incidental and preferably within the clients own home or community to reduce the potential for bias associated with being assessed outside of cultural context. Ask client to select location.

Step Two: Sit or stand ‘side by side’ with clients, looking down at the ground in front of you and ‘checking in’ with your client occasionally. This addresses any cultural concerns regarding level of eye contact (assess relative to non-verbal cues regarding comfort with this). It also aims to reduce anxiety Aboriginal youth may experience about being ‘put on the spot’ or highlighted to provide a direct answer to a direct question.

Step Three: Notice and acknowledge any non-verbal expression of illness or discomfort. This is best expressed via Aboriginal views of mental health and well being instead of in illness terms (that is, the disease model is not appropriate). Comment is made on general sense of “not being well within themselves”, or “not looking too good” in themselves (as opposed to looking depressed, anxious or sad).

Step Four: Introduce self ‘Aboriginal way’. This means contextualise yourself in relation to your land / country as well as cultural background or origin. Ask the youth to contextualise themselves in relation to their land and country. Ask questions such as “Who are your mob / people?”; “Who are your tribal group or people?”, and “Where is your country?”

Step Five: Make a statement about any cultural or gender differences between yourself and youth by making comment on this difference and invite youth to make comment on whether this is an issue or how they feel about this.

Step Six: If these differences are seen as an issue, ask client to nominate cultural consultant (aims to minimise extent of cultural bias in assessment process). Engagement of cultural consultant must occur with regard to the cultural appropriateness of the person. Assess whether there are cultural factors operating for the cultural consultant. Ask the question: “Is there any cultural reason why you can’t be involved with this client?” including:

- a) Men’s versus women’s business.
- b) Avoidance relationships.
- c) Different tribal grouping.
- d) Community infighting.
- e)

Step Seven: Negotiate limits to confidentiality. That is, that things will remain private, however if the client states that they will harm themselves or someone else you will have to breach that confidentiality. This will occur in negotiation with the client. The focus is on the absolute

transparency of practice. This means you have to discuss (a) who you will tell through prior negotiation with your client, and (b) exactly what will be told – that is, “Only the information regarding your risk to self and others”. This addresses issues of trust that is often a concern for Aboriginal youth.

Step Eight: Discuss or negotiate issues regarding possible payback¹ or retribution with community or family of youth, particularly in the case of ‘at risk’ suicidal youth. This needs to occur prior to your involvement with the youth and may also need to occur on behalf of the cultural consultant if necessary to ensure their involvement particularly with ‘at risk’ Aboriginal youth.

Step Nine: Engage at the cultural level with client. Discussion should occur around the belief system of client and the extent to which this impacts on assessment and therapeutic process using the Acculturation Scale for Aboriginal Australians – Youth (ASAA-Y: Westerman, 2003).

Step Ten: If client has strong connection with their Aboriginal belief system, offer the option of resolving the problem through traditional or westernised methods of therapy (or both). However, the practitioner must have the cultural competence to be able to facilitate this process through engagement with an appropriate cultural consultant to determine whether the community deems this to be appropriate.

Step Eleven: Assess level (or hierarchy) of intervention that has already occurred within the community.

11. Summary and Recommendations

In order to increase the current levels of access by Aboriginal youth to mental health services, changes must occur at the practitioner and system levels of service delivery. The focus of this change should be to embed elements of cultural and clinical competence within all aspects of practice. This firstly requires that the predictors of culturally competent mental health practice be more clearly defined through ongoing validation of these constructs. This has often proved elusive, not the least because there is a lack of direction from within the research regarding at which point along the engagement process culture needs to be taken into account. This paper has aimed to provide some validation of the central role of culture in engagement of Aboriginal youth in mental health services by articulating the core features of effective engagement techniques with this population. In terms of future directions, it is obviously important that this model is validated across different Aboriginal groups and particularly amongst NA practitioners in order to determine its clinical (and cultural) utility with this population. It is also vital that key organisations that have a role in the development of practice guidelines such as the Australian Psychological Society and the more recently developed Australian Indigenous Psychologists Association (AIPA) go beyond a broad framework of cultural practice and continue to contribute to empirical and culturally sound, practice oriented research.

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