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PSYCHOLOGICAL SERVICES

Managing Directors Report

March 2017

The teaching of therapy in practically all academic institutions has been mono-cultural. Concepts deeply embedded in modern North American and Western European societies have been presented as the international and intercultural ways of therapy" Waldegrave and Tamasese, 1993

We go a bit broad in the Jilya March edition and focus on Aboriginal mental health, cultural counselling services and programs as a general theme. In terms of attempts to progress the knowledge and evidence base we turn mostly to the starting point to this understanding – that being, to understand how Aboriginal mental health is best understood and defined.

As a psychologist, I have always taken a fairly 'analytical' and 'evidence based approach to my work with clients (probably not a surprise to any of you!). This is the reality of the profession of psychology and I will say that I have never regretted the choice to study this discipline as a result. I say this because over the years, in working with the most complex of issues with Aboriginal clients and communities and particularly when I first graduated, like most young psychologists, I simply struggled – and this was without getting to the 'Aboriginal bit' yet!.

It is an unfortunate truth that when we choose to work in this rewarding and challenging field, we often 'bypass' the 'general' struggle that ALL psychologists go through when they are finding their way. Certainly with me, there was not only external pressure to 'fix it all' but there was an inordinate amount of pressure I would also place on myself to have all of the answers. I see this in so many Aboriginal AND non-Aboriginal psychologists who work in Aboriginal communities.

The passion is so great and the desire for change is so great that often the expectations from self often result in two outcomes – burnout, or worse than that, a belief that 'nothing works' or it is all 'too hard'.

I guess the basis of psychology and the evidence base that it consistently hammered helped during these 'dark times'. I never really understood the concept of the scientist-practitioner model when I was at university.

It just seemed that undergraduate psychology achieved the worst of all outcomes for a practical, country bumpkin like myself – it seemed to churn out miniature Einstein's who could calculate a 2-way ANOVA or a Multiple Regression Analysis as easy as you like. However, put a client in front of them or even more 'outrageously' a client who does not respond to the standardised application of said 'evidence based practice' and even the best 'scientists' would go to water.

This has certainly been my experience. The ability to test out 'what works' is simply not within the concept of 'evidence based practice'. So, with that framework in mind and having spent all of my life, living and working in remote areas in which you either had to find solutions or not be able to help your client, I have been passionate about finding solutions to things that have seemed to have eluded the field for the most part. But, as my Aunty Bigali used to tell me 'Bub, if it was easy, everyone would do it" – quite helpful hey?

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So, I have set upon a journey which has become thankfully easier as the years go by – my hope is that as a result, todays youth (baby psychologists) struggle less than I had to. The less they have to struggle, the greater the chances that their attention does not become diverted from where their focus should be – that is, on being the best psychologists they can be. That is my passion for this generation and I see it occurring already. There is definitely less of a struggle today than when I started my degree a million years ago, as a result of more 'evidence based practice' for our mob, and that is worth talking about.

So, for me, it was obvious that the journey could only be progressed by providing an answer to a primary - how do you make culture scientific??

This then ultimately became the million dollar question and one which seemed to elude most who were working in this field, certainly when I started out and to a large degree, still today. The answer to me was however fairly obvious due in no small part to being trained as a 'scientist' – apply the research methodology that the science has provided us with to the concept of culture. Not so easy when Aboriginal culture is the most secretive culture in the world – I kid you not. Something I only recently discovered (to my embarrassment) when I started to travel into other Indigenous cultures around the world after being invited to international Keynotes in Canada, USA (Nome, Alaska) and New Zealand (three times!). The response to my comments about Aboriginal culture being 'so secretive – we have men's business, women's business and hierarchies in which certain people look after knowledge – and that this knowledge is not available to anyone who does not reach a level of power, or attain a certain 'rite of passage' or hierarchy in a community. It was a revelation to me that other Indigenous cultures did not hold things so secretive, or taboo for others to know about. I have pondered this in a more obvious way since 2003 and more realistically (although without awareness) throughout my career. It struck me that unless we were able to overcome the barrier of making culture 'scientific' then there would be no arguing with best practice as the science would support it.

To me it simply meant that you need to obtain sufficient evidence in a quantitative manner and then replicate that evidence across populations of Aboriginal people to satisfy the science. Simple? Well this has been a focus of IPS for the past two decades and I am pleased to say a focus of many of our Aboriginal leaders in this field. We talk a similar way – often we just choose different paths to arrive at the same outcome.

So, to this issue of Jilya and the starting point of addressing this at a fundamental level. The first of these is to provide a more complete picture of the relevance of culture as a trigger and maintaining factor in mental health symptoms for Aboriginal people. This should begin by firstly understanding the concept and range of culture bound disorders that exist in Aboriginal populations which often 'trick' practitioners into misdiagnosis of mental health complaints (see Feature Article). Clearly, this currently does not occur within normal practice. The use of mainstream definitions of mental health and well-being need to recognise that we do not live in a monocultural world – differences need to be clearly articulated. At the practitioners level it is these issues that continue to confuse mental health diagnosis given the reality that culture bound syndromes often share symptoms in common with mainstream mental illnesses (for example, having a spiritual visit of a deceased loved one is a normal part of grieving, but at what point is the person experiencing hallucinations or delusions that would warrant a diagnosis of psychosis or schizophrenia?).

The Feature Article provides the 'evidence base' for the range of Culture Bound Syndromes in Aboriginal Australians, determined using quantitative research methodology (i.e. applying the 'science to culture'). Surprisingly, this is the first time that these illnesses have been empirically explored in Australia despite the relatively large volume of research on culture bound syndromes that exists in many Indigenous populations for the better part of the last two decades (see Paniagua, 2013 for a review). This is perhaps not surprising given the secretive nature of the culture.

A further challenge which will be explored in future issues of Jilya is also that 'at what point does exploration of cultural factors assist – either at a client or practitioner level, and at what point does it cause 'harm'.

A question that all of us should ponder and one which is not realistically covered in any ethics classes for any of the mental health professions. It is a reality that you can actually do the 'clinically right thing, but the culturally wrong thing'. I believe that as Aboriginal psychologists it is our duty to assist practitioners to figure out the difference. The starting point is the validation of cultural explanations for illness and client distress. A process of cultural formulation (developed by Westerman, 2003) which has been adapted from the DSM-IV guidelines is also be provided in the Feature Article to assist in making sense of cultural difference in a culturally safe way. Obviously, the pre-requisite of cultural competence is a big factor here and one which will be explored throughout every edition of Jilya.

In the next edition whilst we will have a focus on grief and loss, based upon feedback we have received from our members, and just to ensure that we are able to be flexible in our ability to provide you with a practitioner focus, we will also follow a general theme of cultural competence in Aboriginal mental health.

Managing a number of cultural and ethical dilemmas with some case studies will also be a part of this theme of future magazines which I look forward to exploring with you. I will also be exploring this issue in my Webinar.

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