THAT'S JUST THE WAY HE IS": SOME IMPLICATIONS OF ABORIGINAL MENTAL HEALTH BELIEFS

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Abstract

Recent qualitative research conducted in metropolitan Perth and the Kimberley region of Western Australia has highlighted major gaps in service delivery to Aboriginal clientele suffering depression[1] and suicidal ideation (Vicary 2002). Seventy Aboriginal people were interviewed for approximately 100 minutes about their beliefs and attitudes towards mental health, western psychology, western practitioners, and strategies for improving mental health care delivery. Three in four respondents (72%) indicated that they believed that Aboriginal people did not perceive depression as a state that could be addressed via treatment. Instead they perceived it as a characteristic of the individual concerned stating ‘that’s just the way he is”. Subsequently they reported that individuals might not get the assistance they require in overcoming their illness.

[1] The authors references to depression do not conform with Eurocentric perceptions rather it refers to the Aboriginal Australians’ conceptualisation as explained within the main article. The study highlights that participants consistently perceived the course and treatment of depression as following a different aetiology to that of mainstream Australia.

That's Just the Way He is": some implications of Aboriginal mental health beliefs

While there has been an increasing recognition of Aboriginal disadvantage during the last 20 years, and successive government attempts to address these inequities, Aboriginal people are still disadvantaged compared to their NA counterparts. The quality of life, life expectancy and equality of opportunity remain significantly lower for Aboriginal people. A report by the Task Force on Aboriginal Social Justice (Task Force on Aboriginal Social Justice 1994) highlights the fact that on all major measures of socio-economic wellbeing, Aboriginal people continue to suffer enormous disadvantage. Raphael and Swan (Swan and Raphael 1995) noted that Aboriginal people continue to experience greater poverty than NA Australians, have higher rates of unemployment, more inadequate housing, poorer participation and completion in education, poorer access to clean water, waste disposal, and utilities than the white population. Aboriginal people remain over-represented in prisons by a factor of 14 and in police custody by a factor of 26 (Kosky and Goldney 1994).

Another example of the inequality between Aboriginal and NA people can be identified through the practice of removal. For example, in Western Australia, in the 1960's the 'Welfare' or the Police was still systematically removing Aboriginal children from their families. McCotter (1981) in a report prepared by the then Western Australian Department of Community Welfare stated that 57% of all children in care were Aboriginal. Over two thirds of these children were placed with NA families. Dodson (1991) found that 44% of children in substitute care in Western Australia were of Aboriginal descent despite Aboriginal people making up just 2.5% of the population. Dodson concluded that Aboriginal children and their families are still experiencing institutionalisation and that to date no generation of Aboriginal children has been free from the threat of removal by the State. Removal, and the threat of removal, has had a significant impact on the way in which Aboriginal people relate to government agencies and departments, the level of trust developed and the outcomes achieved.

Aboriginal children are often current victims of past policy and practices. Many young Aboriginal people have indicated that some of the factors described previously are now affecting their generation. This generation ultimately will become the Aboriginal leaders of the future and many of these people will have had personal experience of the legacy of recent Aboriginal history. For example, Webber (1980) notes that about 20% of Aboriginal children and youth have diagnosable mental health issues. Further, Kamien (1978) suggests that substantial behaviour problems are apparent in 25%-30% of Aboriginal 5-14 years old. Anxiety, learning delay and attention deficit problems are also likely to be found in this cohort, however, this is yet to be systematically examined with most reports being anecdotal in nature[2]. Although the problems previously discussed are by no means an

[2] The prevalence of mental health disorder in the NA population for 4-11 years is 16% and for 12-16 years 21% (N.H.P.A., 1998).

exhaustive review, they are indicative of the problems some Aboriginal children encounter and how these issues subsequently impact on their potential for learning and forming close relationships.

Additionally, child abuse and neglect also affect Aboriginal children and young people (Ford, 2000). The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has developed a prevention plan to combat the issues. Notably this action plan emphasises the importance of both current and historical issues and strongly argues the case for prevention as opposed to reaction. This plan implements strategies that are grounded in the issues associated with colonisation, Aboriginal child rearing practices, the Stolen Generation, racism, self determination and the contributions of the kinship and Elder roles. Importantly, the programme recognises the requirement of a holistic approach, a synthesis of both Indigenous and western methodologies, to deal with the prevention and treatment of child abuse and neglect amongst Aboriginal children and youth.

In some cases there are similarities in the frequency of mental and behavioural problems experienced by Aboriginal children and youth compared to those experienced by their NA peers (Hunter 1993). Hunter notes that while there may be a similar frequency between the two populations, Aboriginal children and youth are often disadvantaged in that they are not able to access appropriate services. Further, Hunter highlights that some behaviours and mental illness (e.g., depression and anxiety) may be reactions to racism, dispossession, disadvantage and perceived oppression. Substance abuse further complicates this picture of Aboriginal behavioural and mental health problems (Brady, 1991). Brady argues that psychosocial health problems, historical and current issues, early parenthood, poor environment, interpersonal and family violence, inter-generational substance abuse, abuse and neglect and poor physical health all contribute to, and exacerbate, negative outcomes for Aboriginal young people.

Past policy continues to affect subsequent generations of Aboriginal people. This is perhaps best exemplified by victims of the Stolen Generation. Effects upon victims and families of the Stolen Generation are both profound and ongoing. Children who were removed, and families who had members taken, continue to feel deeply affected by the experience and demonstrate a wide range of psychological symptomology as a result of this practice (Aboriginal Legal Service 1995). Psychological reactions include inconsolable grief and loss, post-traumatic stress disorders, low self esteem, powerlessness, anger, depression, anxiety, suicide and self harm, alienation from cultural and kinship ties and personality and adjustment disorders; poor parenting skills, disrupted attachment, poor relationship skills, lack of cultural identity, substance abuse, violence and guilt (ALS, 1995; Swan & Raphael, 1995).

There is also a range of social and cultural problems experienced by victims of the Stolen Generation. These factors have subsequently caused further disadvantage to those who were removed from their families (ALS, 1995). Some of these social and cultural

consequences include lack of quality education (at missions and reserves), identity confusion and inability to fit into the NA or Aboriginal communities, abuse and neglect experienced while in care, lack of access to cultural information and heritage, involvement in the criminal justice and welfare systems, and poor parenting role models (Swan & Raphael, 1995).

Aboriginal Australians continue to have a higher rate of suicide when compared to NA Australians. Western Australian data indicate that the number of recorded suicide deaths for Indigenous young people is disproportionate to those of NA (Hillman, Silburn et al. 2000). The suicide rate within Aboriginal communities is currently twice that of other Australians. The rate of suicide in Aboriginal communities is continuing to rise.

Aboriginal deaths continue to exceed those of NA people at all ages (Swan & Raphael, 1995). Communicable and preventable disease contributes to higher levels of hospitalisation and death amongst the Aboriginal population compared to the NA. The authors delineate the growing trend and impact of chronic diseases such as diabetes, kidney disorders, cardiovascular disorders and respiratory illness upon the Aboriginal population. These factors contribute to traumatic and untimely death, which in turn, perpetuates cycles of trauma and grief that are often associated with the effects of early negative policies and current problems. Further, the effects of discrimination and racism create levels of uncertainty, low self-esteem and distress among the Aboriginal population.

The historical losses and separations experienced by Aboriginal families are compounded by adverse health conditions, high rates of early and untimely death, substance abuse, suicide and self harm, mental health problems and family separation through incarceration or welfare intervention (e.g., child protection agencies). The Royal Commission into Aboriginal Deaths in Custody (1991) and the Burdekin Report (Burdekin 1993) have focussed attention on the range of mental health issues that arise from, or are associated with, the previously described adverse circumstances (Raphael & Swan, 1995). As Raphael and Swan point out, to further understand Aboriginal mental health their conceptualisations of such issues must be explored.

Aboriginal Conceptualisations of Mental Health Practice

There is a disparity between the Aboriginal and NA conceptions of mental health. Sykes (1978) stated that professionals, in particular doctors, working with Aboriginal families should be educated about Aboriginal history and Aboriginal communities. She cautioned however, against professionals who learn a little about Aboriginal society and then use this knowledge to make decisions on the peoples’ behalf and push along their own agendas. The need to recognise this difference has long been stated by indigenous people. There have been numerous attempts to define indigenous mental health (IMH) concepts; however, the common theme has consistently been that IMH needs to consider the holistic nature of health and well-being. Reflecting this view most adequately was a position paper

on Aboriginal Mental Health at the National Aboriginal Community Controlled Health Organisation (National Aboriginal Community Controlled Health Organisation 1993) which stated that:

> "For Aboriginals, mental health must be considered in the wider context of health and well-being. This requires that health be approached in the social emotional context and that social emotional health and psychiatric disorders encompass oppression, racialism, environment, economical factors, stress, trauma, grief, cultural genocide, psychological processes and ill health." (Cited in Swan & Raphael, 1995, p. 1).

Whilst definitions of indigenous mental health have generally advocated for the incorporation of mind, body, spirituality, environmental and spiritual constructs, this position paper also argues for the inclusion of socio-historical-political factors implicated in the development of disorder amongst indigenous groups. This must include the impact of colonialism; trauma, loss, and grief; separation of families and children; the taking away of land; and the loss of culture and identity; plus the impact of social inequity, stigma and racism (Swan and Raphael 1995). Current definitions have also failed to include the extent to which these factors have impaired the functioning of the individual being assessed. The issue of truly defining indigenous mental ill health therefore requires not just understanding the potential origin of such problems, but also how to assess the extent to which these specific factors are important and their implications for the individual.

In concordance with the above, treatment options must also reflect this difference in perception. Hence, there needs to be acknowledgement of the existing frameworks of healing within Aboriginal communities and in particular those pertaining to the resolution of mental health disorders. This must occur in such a way that there is opportunity within the assessment process to explore the extent to which the particular mental health issue is symptomatic of the individual's underlying cultural and/or spiritual issues. Often, it is the case that mental health problems will manifest themselves spiritually and culturally and therefore can often only be resolved in this manner.

For instance, serious sickness, including mental health is often attributed to *external forces or reasons (Reid and Trompf 1991; Westerman 1997).* In effect, when ill health occurs, individuals will most likely attribute this to some external wrongdoing that is most likely to be culturally based. For example, "doing something wrong culturally" whether this be through some form of cultural transgression or not being able to achieve cultural resolution of incidents, will often result in the individual experiencing symptoms that are consistent with mental ill health (Westerman 2000; Sheldon 2001; Vicary and Andrews 2001). This reflects the intertwining of spirituality and particularly relationships with family, land and culture (Slattery 1994).

Additional to this is the debate within the literature regarding the extent to which mainstream diagnostic criteria has relevance or consistency across different cultural groups

and most particular Indigenous peoples (Allen 1998). The conceptual view of depression and suicidal behaviours within Aboriginal people in Western Australia was explored by Westerman (2003) who noted that there were a number of features that did not conform to mainstream diagnostic criteria found in the DSM-IV. Obviously this study requires replication within other Indigenous groups in Australia. However, it is important that information of this type is implemented within current practice to ensure that where there exists a difference in symptom presentation or causality, this can be identified and addressed by services. It has also provides an important evidence base for the notion that differences may exist in the phenomenology of all mental disorders with Aboriginal people.

Current Study – Method

Prior to the conducting the study approximately 18 months was spent canvassing the Aboriginal community, both in the Perth metropolitan and Kimberley regions, as to the relevance and potential use of the study. Feedback from these consultations was instrumental in the design of the methodology and included the development of an Aboriginal steering group, use of cultural consultants and cultural validation processes. A critical part of the research centred on the steering group who provided advice and guidance on all aspects of the study as well as 'vouching' for the researchers.

This group was formed by a process suggested by Aboriginal people consulted in the scoping phase. An Elder who held a senior position in government was approached and agreed to be the chair of the steering committee. Five other people were recruited because of their experience and knowledge of the communities. This phase was very significant for the implementation of the research as it involved the Aboriginal community in a way that was acceptable to them. It also allowed for cultural validation of the methods and outcomes. The implementation of the Aboriginal community derived methodology generated a significant degree of interest and resulted in Aboriginal people from across the state of Western Australia asking to be included in the study.

The outcome of the consultation was a qualitative study conducted (2000, 2001, 2002) both in the Kimberley and metropolitan Perth regions of Western Australia. In total 70 informants, 35 from each geographical region were interviewed (see Table 1). Participants were Aboriginal community members who were approached to take part in the study by the cultural consultants, Steering Group or the researchers. Some were employed in mental health, education and welfare service delivery to the Aboriginal community, while others were part time employed or looking for work. The interviews were conducted by the researchers with a 'cultural consultant', who helped in culturally validating the interpretation of the data. The interviews were transcribed, the transcription validated by members of the Steering Group and the text thematically analysed.

Table 1. Location of study participants by geographical location, gender and age.

Location	Age	Gender		Frequency	Total
		Male	Female		
Kimberley	20 – 30 years	4	4	8	
	31 – 40 years	1	9	10	
	41 - 50 years	4	8	12	
	50 > years	2	3	5	35
Perth	20 – 30 years	4	8	12	
	31 – 40 years	9	4	13	
	41 – 50 years	1	4	5	
	50 > years	2	3	5	35

Eight focus groups were conducted after the initial results were obtained so that the original informants could culturally validate the data and subsequent interpretations. All of the research process was monitored and reviewed by an Aboriginal steering group and cultural consultants. Both groups ensured that practice and procedures implemented by the Non-Aboriginal researcher were culturally appropriate, sensitive and relevant. The findings of the study were then sent to all of the study participants for their information and advice prior to publication.

Current Study – Findings and Discussion

Study participants indicated that cultural interpretations were made about an illness when someone became unwell. Indeed, Westerman (2003) noted there were a number of culture-bound illnesses that exist in Aboriginal people in Western Australia that often conform to DSM-IV criteria but have a different cause and therefore require a more appropriate and varied treatment regime. She discussed a number of illnesses validated within the Aboriginal culture, but particular to this study is an illness termed as *longing for, crying for or being sick for country,* which seemed to follow the same symptom base as clinical depression. However, the cause is the individuals removal from their country, place of dreaming, or spirit for extended periods of time. The resolution was complex and involved a number of interventions that are beyond the scope of this paper but are discussed extensively by Westerman (2000) and combine traditional treatment with westernised forms of psychotherapy.

This study also supported the view that when someone was suffering from some form of mental illness, treatment is therefore dependent upon the cultural explanation given to the illness. The study found that there were a variety of traditional treatments available to mentally ill Aboriginals. Similar to the western mental health model, these treatments are

hierarchical, with more intensive and intrusive treatments being provided to the most seriously ill. Such treatments may be sought via traditional avenues to deal with this issue (e.g. bush doctor or Elders). If traditional methods were not successful the individual might then be taken to western health services.

Study participants stated that depression in Aboriginal communities often went unnoticed and subsequently the traditional methods of interpretation and healing were not activated. In their view, mental illness moved from characterlogical to pathological when the illness became visible (e.g., crying in public regularly, high-risk behaviour) or resulted in behavioural aberrations (e.g., suicidal behaviour). Participants argued that once the illness was recognised individuals received mental health services, however this was typically when their illness had become acute. When an individual was engaging in suicidal behaviour a cultural interpretation of this behaviour was also made and culturally appropriate treatments sought.

For example, some study participants described depression as a disturbance in a person's wellness. Their notion of wellness is holistic and ecological and incorporates a broad range of personal and environmental factors. These participants indicated that weaknesses in wellness pre-disposed a person to illness (depressive or other illnesses). Onset of illness would further reduce wellness and may allow malevolent spirits to influence a person to take a certain course of action. People interviewed as part of the study highlighted the differences between the western treatment of depression (e.g., medication, counselling, hospitalisation) and indigenous treatments (methods to build resilience against the spirits and to increase wellness). They believed that a blend of the western and indigenous models of mental health intervention would offer a more successful way of intervening with depressed Aboriginal clients (e.g., strategies to assist depressed individuals in developing resilience against the harmful spirits).

A blend of traditional and western systems of mental health intervention may also increase Aboriginal people's comfort and willingness to seek help from mental health services. Respondents remarked that at present, many Aboriginal people were fearful of western mental health and practitioners. This concern is largely derived from experiences of family or community members who have had contact with western mental health treatments. A number of these people have been institutionalised away from their country and family. When these individuals returned home they were often not the same person their family remembered. Even when treatment has occurred in a community setting the use of medication often results in an inability of the individual to fulfil their roles in the family and community.

Fear of the western mental health system has resulted in Aboriginal families/communities trying to cope alone with a mentally ill loved one or delaying western treatment. This avoidance of western mental health providers is further compounded by the stigma and shame attached to mental illness in the Aboriginal community, making it less likely an individual or family will seek treatment for depression or other commonly seen mental illnesses (i.e., anxiety related disorders). In such situations, when the mentally ill

individual finally does come into contact with the western mental health system the family's/community's fears are often realised as they often need to be hospitalized and/or medicated.

Of interest is that the participants in this study included people from metropolitan Perth and from remote and rural areas of the Kimberley. The responses of both groups were very similar and indicated that cultural beliefs about mental illness were comparable despite differences in socio/political, environmental and cultural factors affecting the lives of the people living more than 2000 kilometers apart. This is not to suggest homogeneity between the two cohorts. Each of the regional groups also had their own idiosyncratic beliefs and attitudes about mental illness. However, the meta themes of depression, culture, spirituality, concept of wellness, indigenous treatment and concern about contact with the western mental health system were similar.

The interviewees in this study recommended that more effort be spent in educating Aboriginal people about mental illness and overcoming the stigma of seeking assistance for such issues. This is particularly the case with depression, which often goes unrecognised and untreated and subsequently may be one of the factors contributing to the high incidence of Aboriginal suicide in Australia. Participants felt that western and indigenous psychology must work in harmony to provide the most efficacious treatment while simultaneously building resilience in Aboriginal individuals, families and communities.

According to participants, many Aboriginal people believe that mental health problems are a major concern for their communities. However, they are concerned that western models of treatment will not account for the Aboriginal world-view and cultural beliefs about mental illness. To overcome these concerns and to ensure cultural relevance, appropriateness and accountability, Aboriginal communities and groups should be encouraged and assisted to design culturally appropriate mental health services in partnership with non-Aboriginal practitioners. Such services may ultimately be a blend of indigenous and western psychologies delivered by Aboriginal and non-Aboriginal practitioners, with variants in management and delivery options reflecting the local context.

Non-Aboriginal professionals working with Aboriginal individuals and families should be aware of the dissonance that exists between indigenous and western psychology. Recent qualitative research conducted in Western Australia (metropolitan Peth and the Kimberley) has demonstrated that Aboriginal conceptualisations of mental health are very different from the generally eurocentric mainstream version. Lack of awareness by western practitioners of these differences may have a negative and culturally insensitive impact upon Aboriginal clientele. Respondents in the study quite clearly articulated their preference for clinical services provided by Aboriginal professionals, however they acknowledged that this was not always possible due to the small numbers of such professionals. Many of the respondents believed western service delivery to Aboriginal people could be improved with the widespread use of Aboriginal cultural consultants as co-therapists.

Many of the respondents in the study maintained that western therapy was often ineffectual with Aboriginal clientele, particularly those individuals suffering from depressive

illnesses. Western style therapy itself was not seen as problematic, rather the process applied by some western therapists when undertaking the therapy with Aboriginal clientele was considered culturally inappropriate. Some of the process issues considered inappropriate by study respondents included:

(1) Referral issues (e.g. the requirement of some counsellors for a written or self referral, non acceptance of "third person" referral),
(2) Environmental considerations (e.g., undertaking therapy in an office setting, not being flexible with time, not listening to the client's suggestions about comfortable therapy settings),
(3) Non-Aboriginal therapists undertaking therapy without consulting with Aboriginal colleagues (e.g., making fundamental mistakes such as visiting a client's home and expecting to come inside, assuming homogeneity of Aboriginal people).
(4) Cultural consultants or Aboriginal therapists not being included or considered as part of the therapeutic process.
(5) Therapeutic process and intervention not transparent or explained to the Aboriginal client so that they might be aware of the direction and intended outcomes of the intervention.
(6) Client not empowered to provide input into what therapeutic option might be the best fit for them (see Point 4).
(7) Maintenance of the professional and personal dichotomy. Aboriginal participants noted that they preferred to have one relationship with a non-Aboriginal practitioner rather than having it divided into the professional and personal realms.
(8) Poor knowledge and understanding of Aboriginality was considered a barrier to intervention by all study participants

A few respondents argued that some Aboriginal people preferred to undertake therapy with non-Aboriginals. They felt that concerns about confidentiality led many to seek mainstream services. Aboriginal mental health services are sometimes avoided; as clients are concerned their private business may become common knowledge throughout the Aboriginal community. Therefore these clients may choose a service outside of the Aboriginal community and a non-Aboriginal practitioner to provide the service.

Study participants felt that they would be more inclined to seek counselling and therapy provided by non-Aboriginals if they had some fundamental skills and knowledge. Respondents identified a non-racist attitude and a sound knowledge of Aboriginality as being two of the core components required by non-Aboriginal therapists. They also delineated the need for gender specific confidential expert services. Further they argued that counseling should provide honest non-judgmental practical guidance and advice to Aboriginal clients (this is consistent with traditional counseling practices) and be flexible enough to incorporate new ideas and suggestions (e.g., location and time of the session). Participants also preferred a non-Aboriginal therapist who was interested in developing a total relationship with them (not based on the traditional professional Vs personal domains).

They also suggested that a narrative ("yarning about my problem") way of working would be more appropriate when working with Aboriginal people. Many participants stated that they felt that it was rude when counsellors interrupted to summarize or ask questions without first listening to the whole story. Most Aboriginal people who seek counselling want to tell their story and get it over with. According to study participants, Aboriginal clients want to have a practical solution provided for their problem. They often do not want to return for more counseling. This frequently means that western counseling only becomes a viable option when there is a crisis and traditional means of problem solving have proved ineffective.

Ninety two percent of study respondents stated they would not see a non-Aboriginal practitioner unless another Aboriginal person had vouched them for them. 'Vouching' means that members of the Aboriginal community would convey positive or negative information about the therapist to potential clients. Potential clients might then view the non-Aboriginal practitioner in a more favorable light (depending on the information provided) knowing that an individual(s) with a good reputation and significant standing within the Aboriginal community had made the recommendation.

The vouching process follows methods Aboriginal people often employ to gather information about unknown non-Aboriginal people. Generally, Aboriginal people seek out other Aboriginal people who have had contact with the non-Aboriginal individual and ask their impressions of him or her. Aboriginal people often go to great lengths to gain this information (e.g., long distance telephone calls, asking relatives in other regions to consult on their behalf, visiting other towns). If the persona consulted provides a positive recommendation, the potential client is likely to be more receptive to working with the non-Aboriginal worker. However, if the response is negative then the client, family and sometimes and the entire community will be hesitant to engage with the practitioner.

The Aboriginal people interviewed as part of this study acknowledged that there was a lot of information for the non-Aboriginal practitioner to accommodate in order to work effectively with Aboriginal individuals, families and communities. They recognised that the majority of non-Aboriginal practitioners would require some guidance to develop the skills and knowledge necessary to develop a strong therapeutic alliance with Aboriginal clients. They suggested that initially non-Aboriginal counselors develop their skills and knowledge through talking to and networking with Aboriginal people. The relationships gained from such consultation are invaluable in dispelling myths and stereotypes and are often critical when the vouching process is applied.

Further, the study cohort recommended that the non-Aboriginal practitioner attend "A Ways of Working Workshop" or a Culture Camp to further develop their understanding of Aboriginality. Interviewees also maintained that non-Aboriginal practitioners use a cultural consultant or Aboriginal co-workers when working with Aboriginal clients (the need for which *may* diminish once a sound therapeutic alliance has been formed). They also suggested that the non-Aboriginal practitioner develop an Aboriginal supervision group who could

provide input into the therapeutic process and culturally validate the therapists work with Aboriginal clientele.

Finally, the study participants stated that non-Aboriginal therapists who were cognizant of the issues confronting Aboriginal people, who were willing to listen and learn, who were willing to apply a blend of western and indigenous psychologies using Aboriginal advisors were more likely to be successful in their work with indigenous clients. The agenda of the non-Aboriginal therapist is also important to success in developing a strong therapeutic alliance. As one participant articulated, a European therapist *who has good "lian" (a good heart/spirit) is in the box seat to start working well with us. Everything else develops from this*.

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