

**THE ASSESSMENT OF INDIGENOUS AUSTRALIANS PRESENTING WITH
AFFECTIVE DISORDERS: ADVANCES, CHALLENGES AND FUTURE
DIRECTIONS**

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NAME: PANAGIOTA (PEGGY) GRYPMA
(nee KYRIAKOULAKOS)

ADDRESS: XXX

ID NO: XXX

EMAIL ID: XXX

THESIS SUPERVISOR: Dr Peter Gale

COURSE COORDINATOR Professor Irene Watson

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PANAGIOTA GRYPMA (NEE KYRIAKOULAKOS)

B.A. (Hons Psych), Registered Psychologist.

David Unaipon College of Indigenous Education and Research

University of South Australia

City West Campus

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CANDIDATES DECLARATION

Thesis Title: THE ASSESSMENT OF INDIGENOUS AUSTRALIANS PRESENTING WITH AFFECTIVE DISORDERS: ADVANCES, CHALLENGES AND FUTURE DIRECTIONS

Candidate's name: PANAGIOTA GRYPMA (NEE KYRIAKOULAKOS)

I declare that this thesis is the result of my own research, that it does not incorporate without acknowledgement any material submitted for a degree or diploma in any University and that it does not contain any materials previously published, written or produced by another person except where due reference is made in the text.

Signed _____

Date: _____

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PREFACE

The subjugation and marginalisation of people of Indigenous background has resulted in a failure to recognise Indigenous forms of knowledge construction as enabling legitimate contributions to the theory and practice of Psychology until relatively recently. Similarly, the perceptions and experiences of people of non English speaking backgrounds whose first language is not English have either remained within the category of ‘the other’ or have been subsumed within the category of the ‘white’ positional subject, neither of which allows for a legitimate voice and contribution to knowledge from a unique cultural perspective. Few researchers have consciously and explicitly written from the position of non-Indigenous, but ‘non-White’ perspectives. ‘Non-White’ here is defined as a person who neither identifies as Indigenous nor with the dominant white subject position in so far as ‘White’ is defined as a person of British or Northern European origin. Paradies (2006, pp. 357-8 in Garvey 2007, p. 3) has discussed his refusal to be categorised as either Indigenous or non-Indigenous, and instead: ‘...seeks to create a hybrid space of multiplicity in which to explore his multifaceted indigeneity’. The present author argues that while a person of non-English speaking background cannot pretend to speak to the multiple disadvantages experienced by Indigenous groups, they are nonetheless able to contribute to research from a ‘wide-angle’ lens in so far as they are speaking from a marginalised position as members of minority cultures (Sonn 2005, p 62). The arguments that unfold within this thesis aim to transcend the polarised debates which have constricted discussions between ‘black’ (Indigenous) and ‘white’ (members of the dominant group). As a person of non-English speaking background who has been socialised within the Greek language and culture, the present author therefore responds to the need to create a space for a new dialogue which accommodates the perspectives and insights of non-Indigenous, ‘non-White’ positions.

Hence this thesis has been written with a view to providing a voice and opening a dialogical space for perspectives which are based on the lived experiences and perceptions of members of ‘non-Indigenous, non-White’ cultures, otherwise known as people of diverse cultural and linguistic or non-English speaking backgrounds. These perspectives often become silenced within polarised debates which assume that ‘whiteness’ is a homogenous category under which people of diverse cultural

backgrounds may be subsumed. This results in impoverished uni-dimensional arguments which fail to recognise that: ‘...race intersects with gender and class in complex ways’ (Cuthbert 2008, p. 3). Cuthbert (2008, p. 3) argues that whiteness is not a monolith and that members of the dominant group have varied experiences as a direct reflection of their class and gender as well as their race. This thesis extends Cuthbert’s (2008) argument further by asserting that if language and culture are the mediums through which a person experiences their world, then when a person has been socialised within a language and culture that is substantially different from that of the dominant culture, it follows that they will have developed a sufficiently differentiated worldview from that of the dominant white Australian subject position. Cuthbert (2008, p. 3) has demanded the need for a: ‘...variegated response to, and theorisation of, whiteness’. This thesis acknowledges that people of non-English speaking backgrounds occupy a position which is separate from and outside of the white position on the basis of their continued lived experiences and racialised identities. Giannacopoulos (2007) has commented that the implementation of the ‘White Australia’ policy demonstrates the extent to which people of Southern European backgrounds have been subjected to racial prejudice and were once not considered as desirable or as capable of assimilation as their Northern European counterparts. Giannacopoulos (2007) contends that Southern Europeans, for example, have been denied full acceptance as members of the white dominant group despite changes within bureaucratic systems which have facilitated their integration within mainstream society. On these grounds, Giannacopoulos (2007) has contested the idea that Southern Europeans may be regarded as having remained fully complicit in Indigenous dispossession given the extent to which racial identification continues to remain determined by a person’s physical attributes, name, and the language and culture within which they have been socialised. As a person of Southern European background who has been socialised within a language and culture which is substantially different from that of the dominant culture, the present author consciously embraces a position which explicitly acknowledges that the research contributions contained within this thesis have been shaped and influenced from within this perceptual and experiential basis.

THE ASSESSMENT OF INDIGENOUS AUSTRALIANS PRESENTING WITH AFFECTIVE DISORDERS: ADVANCES, CHALLENGES AND FUTURE DIRECTIONS

ABSTRACT

There are a number of social determinants which place Indigenous people at high risk of developing psychological disorders such as depression and anxiety. Socio-economic disadvantage, substandard housing, loss of identity, and a lack of employment and educational opportunities are among the well-known factors that are contributing to the health inequalities experienced by Indigenous people today, many of which can be argued to be associated with the long-term consequences of colonisation. Research examining the nature and extent of psychological injury within Indigenous populations has been hampered by a lack of culturally validated methodologies upon which effective assessment procedures and interventions may be developed. Tracy Westerman (2002, 2003, 2004), an Indigenous Psychologist, has proposed a rigorous and extensive application of Clinical Psychological theory, adapted to accommodate cultural factors in the understanding of Indigenous mental health. Indigenous academic Judy Atkinson (2002, 2007) and other researchers also provide insights into the complexities of Indigenous mental health from the perspective of disciplines such as Anthropology, Sociology and Indigenous epistemologies. Mainstream approaches within Psychology and Psychiatry have based the assessment and diagnosis of psychological disorders on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association) which is assumed to have universal validity and applicability. Although Westerman (2002) proposes a more extended application of Clinical Psychological theory and practice that takes Indigenous culture into account, this thesis explores the extent to which Westerman's (2002, 2003, 2004) theorisation remains embedded within Western frameworks for understanding Indigenous mental health. It is suggested that a critical analysis of the conceptual and theoretical foundations of Clinical Psychological theory and practice is required in order to facilitate the development of a model for a cross-cultural approach to psychological assessment and therapy with Indigenous Australians. A flexible model of psychological practice is proposed, incorporating critical cross-cultural perspectives in the assessment of Indigenous clients with affective disorders.

Keywords: Indigenous Australians, Psychology, cross-cultural assessment, depression, anxiety, postpsychiatry.

CHAPTER 1:

Introduction

This study aims to examine the challenges and specific considerations in the identification and assessment of Indigenous clients presenting with depressed moods and anxiety states, generically referred to as ‘affective’ or psychological disorders. Given evidence of the rising incidence of mental health disorders within the Indigenous community, there is an established and urgent need to identify and assess how these disorders are manifested within Indigenous Australian cultures in order that more effective interventions may be developed (Esler, Johnson & Thomas, 2007; Hunter, 2003; Kowal, Gunthorpe & Bailie, 2007). Studies such as those conducted by Westerman (2002, 2003, 2004), Vicary & Westerman (2004), and Petchovsky et al (2004) examining the phenomenology and aetiology of depression and anxiety within Indigenous Australian populations have been sporadic. Consequently, there are few published examples of effective screening instruments and culturally valid methods and approaches to enable the identification and assessment of psychopathology within the Indigenous community (Mitchell, 2006; Kowal, Gunthorpe & Bailie, 2007). Research examining the prevalence of mental health disorders within Indigenous populations has been hampered by conflicting definitions of mental health, and the limitations of dominant methodologies and approaches in conducting research (Westerman 2002, p.2). Without such research, Indigenous Psychologist Tracy Westerman (2002, p. 2) warns that ‘culture-bound disorders’, culture specific symptoms and/ or risk factors that are unique to the development of psychological disorders within Indigenous populations may remain undetected or misdiagnosed. Additionally, access and equity to culturally appropriate mental health services is likely to be compromised (Westerman 2002, p.2). Esler, Johnston & Thomas (2007, p.259) also state that the lack of culturally validated assessment tools does not permit an adequate response to the current policy demand for appropriate screening instruments in order to conduct epidemiological studies within Indigenous populations. This in turn means that there is a dearth of culturally validated therapeutic interventions that have been developed in response to the urgent need for adequate mental health services within the Indigenous community.

Within the Australian context, cutting-edge research led by Indigenous Psychologists and Psychologists contributing to cross-cultural research have forged a path toward a greater understanding of the importance of the cultural dimensions of mental health in the theory and practice of Psychology (Dudgeon, 2000; Garvey, 2000, 2007, 2008; Westerman, 2002, 2003, 2004). Research conducted by Tracy Westerman (2002, 2003, 2004) and Judy Atkinson (2002, 2007) for example, although adopting divergent methodological approaches to the study of Indigenous experiences of psychological distress, have independently emphasized the importance of acknowledging the centrality of culture in the understanding of psychopathology within Indigenous populations. Interdisciplinary perspectives have in turn elucidated the contested nature of ‘mental disorder’ and mental health theory and practice. These perspectives are examined within a climate of increasing disaffection among Indigenous and non-Indigenous clinicians and mental health service users with the appropriateness of dominant methodologies and standards in mainstream mental health service delivery. For Indigenous people, the dissonance between an understanding of what constitutes mental wellbeing and the dominant conceptualisations of mental health has resulted in the development of community services which have embraced Indigenous concepts of ‘social and emotional wellbeing’ (Brown, 2007; Garvey, 2008). At a broader level, it has led to a critical analysis of the ethical, philosophical, and epistemological foundations upon which the disciplines of Psychology and Psychiatry are based (Bracken & Thomas 2005, pp. 3-5). This thesis examines new paradigms emerging from the post-modernist movement in Psychiatry that may offer the potential to develop an integrated conceptual framework from which to interpret what have traditionally been construed as ‘mental illnesses or disorders’ (Bentall 2006, p. 220). The wider implications for the development of culturally inclusive frameworks and alternative models of health service delivery for the management of psychological disorders as they are manifested within Indigenous populations are discussed.

Chapter two begins with an examination of the most recent contributions of Indigenous Psychologist, Tracy Westerman (2002, 2003, 2004, 2007), in the understanding of the cultural manifestations of affective disorders within Indigenous Australian populations. This will be reviewed within an international context to

enable a comparative analysis of the psycho-social impact of colonisation on Indigenous cultures in other parts of the world.

In chapter three, research conducted by Atkinson (2002, 2007), Bell (1991), Sutton (2001, 2009) and Brady (1995, 1997) is discussed from the perspective of disciplines grounded in interpretative methodologies such as Anthropology and Sociology, facilitating a rich and nuanced understanding of the influence of culture on Indigenous experiences of distress.

Chapter four reviews the impact of Psychology as a Western scientific discipline on the study of Indigenous people and how its underlying value assumptions have been instrumental in promulgating racial stereotypes which were later used to justify institutional forms of racism, as reflected in the subsequent development of removal policies.

Chapter five establishes the foreground for an exploration of how competing paradigms in the assessment of psychopathology may offer multiple perspectives that can extend our insights into symptom manifestation among Indigenous populations.

In chapters six and seven, new ways of conceptualising mental health are discussed within the context of a critical cross cultural framework, and this forms the basis for the development of a model for working with Indigenous people presenting with mental health issues. This model is discussed in detail in chapter seven and is based on a narrative approach to therapy which endorses a critical cross cultural Psychology framework as the basis of its theoretical foundation.

CHAPTER 2:

Psychological perspectives on Indigenous mental health.

The contributions of Westerman's research to the understanding of psychopathology within Indigenous Australian populations.

Tracy Westerman's (2002, 2003, 2004, 2007) research has been recognised as being at the forefront of advances in the understanding of the unique aspects of Indigenous mental health in Australia. Westerman's (2002, 2003, 2004, 2007) research represents a pinnacle in the effort to reconcile conventional methodological approaches within Clinical Psychology to the study of Indigenous mental health and Indigenous approaches toward the management of mental health and well-being. The impetus for this research has been driven by indications of the rising prevalence of mental health disorders amongst Indigenous populations and an awareness of the limitations of mainstream psychological approaches in providing responsive treatment. Westerman (2002, p. 2) has emphasized that a failure to account for the mediating presence of cultural factors in Indigenous mental health may result in errors or biases in the assessment process, whereby presenting difficulties are either overlooked or misdiagnosed. Westerman's (2007) central argument is that cultural factors play a: '...primary rather than a distal role in determining mental health outcome for Aboriginal Australians' (Westerman 2007, Keynote Address). Accordingly, Westerman (2002, 2003, 2004, 2007) has made notable contributions in three main areas:

- i. Extended research to progress an understanding of the cultural manifestations of depression and suicidal behaviour amongst Indigenous people;
- ii. The development of culturally appropriate approaches and methodologies to identify and assess mental health disorders;
- iii. Identification of the need for culturally validated models of intervention that have demonstrated efficacy across a number of sectors within the Indigenous community.

These are discussed below in further detail.

The cultural manifestations of depression within Indigenous Australian populations.

The first stage of research conducted by Vicary and Westerman (2004, pp. 5-6) explored the phenomenology and aetiology of depression amongst Indigenous people of Western Australia. Vicary and Westerman (2004, pp. 5-6) interviewed a total of 70 Indigenous community members from both the Kimberly and metropolitan Perth regions of Western Australia about their views on Western mental health concepts and service delivery. Despite the diversity of the groups interviewed, Vicary and Westerman (2004, pp. 5-6) found some common themes that emerged with respect to the interviewees' concepts of depression and the influence of culture and spirituality on mental health. For example, 'depression' was understood as synonymous with a 'longing for, crying for, or being sick for country' (Vicary & Westerman 2004, p. 5). On this basis, Westerman (2004, p. 3) remarks that Indigenous concepts of mental ill-health need to: '...take into account the entirety of one's experiences, including physical, mental, emotional, spiritual and obviously, cultural states of being'. In contrast to the Western model of mental illness, Indigenous concepts of mental health are inextricably linked with relationships to family, land and culture (Vicary & Westerman 2004, p. 6). Importantly, Westerman (2004, p.3) also notes that Indigenous mental health concepts are not understood in terms of a mind/body dichotomy. Hence, Westerman (2004, p.3) emphasizes the importance of understanding the extent to which socio-historical and socio-political factors such as the impact of colonialism, intergenerational trauma, the loss of land and culture, and the impact of social inequity and racism may be implicated in Indigenous mental health. In this particular study, Westerman (2004) concludes that depressive symptomatology can be seen as largely corresponding to the diagnostic criteria of clinical depression as defined by the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*: the DSM-IV is a universal classification system developed by the American Psychiatric Association that is used to diagnose mental disorders). However, Westerman (2004, p.3) emphasizes that the attributional belief systems of Indigenous people are often markedly different from members of the dominant culture. For example, external factors are often seen to be the cause of a person's illness, such as a lack of resolution over having committed a cultural transgression, severance from family or country, or the influence of malevolent spirits. Moreover, according to some of the participants interviewed, a person's mental health difficulties

can often become normalised or accommodated within his/her community until that person exhibits overt signs of uncharacteristic behaviour. Correspondingly, participants remarked that this increases the likelihood that people with mental health difficulties will not receive the level of assistance that they require, or conversely, may present to services during an acute phase of their illness. It is important to note that that because of differences in attributional belief systems, the majority of people interviewed did not perceive depression as a discrete diagnostic entity or as a state that was amenable to ‘treatment’, given that mainstream therapeutic interventions are generally targeted at the level of the individual (Vicary & Westerman 2004, p. 6). Thus, Vicary & Westerman (2004, p. 4) conclude that this research informs an evidence-base which suggests that differences may exist in the phenomenology and aetiology of all mental health disorders within Indigenous populations. These findings also raise questions about the development of culturally appropriate methodologies to identify and assess mental health disorders within Indigenous Australian populations and the modes of intervention that are likely to be effective with Indigenous clients.

The development of culturally appropriate methodologies to identify and assess mental health disorders within Indigenous Australian populations.

Westerman (2002, p. 2) has emphasised that the basis of any effective therapeutic intervention must begin with an accurate identification and assessment of psychological disorders as they present within Indigenous communities. Perhaps the hallmark of Westerman’s (2000) contribution to research lies in the development of a culturally validated scale for measuring suicide risk factors among Indigenous youth. In recognising the limitations of using mainstream procedures to identify and gauge the severity of depressive symptomatology among Indigenous youth, Westerman & Vicary (2000, pp. 471-480) have developed a new instrument that has been specifically normed and validated among 13-17 year olds entitled the ‘Westerman Aboriginal Symptom Checklist – Youth’. Although the validity of this instrument has not yet been replicated across other sectors of the Indigenous community, it represents the first attempt to develop a scale that identifies risk factors for suicidal behaviours that are unique among Indigenous youth. Thus far, it is the only available tool of its kind in Australia, given that the majority of instruments that are currently available

for screening mental health dysfunction have not been validated or adapted for use with people of Indigenous or diverse cultural backgrounds (Kowal, Gunthorpe & Bailie 2007, p. 3). The importance of such a scale must be evaluated against research which suggests that there are critical differences in the aetiology of Indigenous suicide when compared to those within the general population (Elliott-Farrelly 2004, p.7). Westerman (2000) identifies a range of socio-historical-political factors that have been implicated in self-harm behaviour among Indigenous people, including the impact of removal policies on social cohesion and identity, the effects of substance misuse, transgenerational trauma, compounded grief reactions, and disrupted attachment behaviour. This is further corroborated by the research findings of Hunter (2007, p. 90) and Elliott-Farrelly (2004, pp. 3-4) who have identified drug and alcohol misuse, social exclusion and alienation, disintegration of family, and a persistent cycle of grief as being among the factors that have played a distinct role in contributing to suicidal risk among Indigenous Australian populations. Moreover, international research investigating suicidal behaviour in New Zealand and Canada such as those conducted by Yurkovich, Clairmont & Grandbois, 2002; Katz et al, 2006; and Beautrais et al, 2006; indicate that Indigenous populations have been shown to have elevated risks of suicidal plans and ideation due to a multiple layer of determinants including: ‘...loss of culture, history of traumatic events, community factors, individual factors, and family factors’. On these grounds, Westerman & Vicary (2000, p. 476) and Elliott-Farrelly (2004, p.7) have argued for the need to develop an Indigenous suicidology within a framework which is separate to that of mainstream applications for suicide prevention.

Westerman (2004, p. 5) argues that a guiding principle in determining whether an assessment is ‘culturally’ valid is to investigate the extent to which the disorder is impairing a person’s ability to function across both cultures. For example, if a client’s verbal and behavioural presentation has been deemed to be consistent with a diagnosis of schizophrenia according to the criteria specified within the DSM-IV, Westerman (2004, p. 5) suggests that certain questions need to be asked in order to examine the cross-cultural validity of the diagnosis. Questions may be framed in an attempt to elicit an understanding of the client’s circumstances and whether their presentation warrants further assessment. The assessment process needs to include how the client understands and explains their difficulties; critically examines whether the clinician

has an understanding of the client's cultural idioms of distress; takes into account all cultural factors within the client's presentation, and lastly, explores if there are indications that the client has become adversely affected by the identified issues within their own culture.

Where culturally specific differences in symptom manifestation do exist, Westerman (2004, p. 5) refers to these as 'culture-bound' disorders, defined as those belonging to a particular culture and therefore unable to be subsumed within DSM categories. Westerman (2004, p. 5) contends that the challenge for the clinician becomes a process of learning to identify and differentiate between 'clinical disorders' and 'culture-bound' disorders so that culture-bound disorders may become accommodated in formulating an appropriate treatment regime. Examples of presenting issues around which questions may be asked to be able to differentiate between 'clinical' and 'culture-bound' disorders may include whether 'sorry cuts' can be understood as an accepted expression of grief within some Indigenous cultures, or as a potential indication of self-harm or self mutilation; and at what point hearing the voice of a recently deceased relative, (which, for an Indigenous person may be an accepted and commonly occurring experience within their culture during the grieving process) may be understood as indicative of psychosis. Westerman (2004, p. 5) suggests that such questions, when asked strategically, may assist the clinician to extrapolate information to determine when such behaviours may be deemed to have crossed the line of 'normality' or be interpreted as evidence of 'psychopathology'. Such questions are vexed and difficult to answer, however, Westerman (2004, p. 5) contends that it is incumbent upon the clinician to develop both 'cultural' and 'clinical' competencies in order to be better placed to undertake what is referred to as: '...a differential cultural diagnosis'. *Clinical competency* is defined as: '...the extent to which certain therapeutic techniques are proven to be useful treatments for certain disorders' and *cultural competency* is defined as: '...the ability of practitioners to identify, intervene and treat mental health complaints in ways that recognise the central role that culture plays in mental illness' ((Raphael, 1992; Spence, 1994; National Health Priority Areas 1998, cited in Westerman 2004, p.2). Westerman (2004, p. 2) concedes that the process of acquiring both sets of competencies often results in a dual struggle which becomes inequitable due to the level of privilege bestowed by the psychological profession in the acquisition of 'clinical competence.' Such a model presupposes the

universality of DSM categories and treats them as unproblematic in their application to the understanding of presenting symptomatology among Indigenous people. This contrasts with Indigenous conceptualisations of mental health as embodied in the notion of ‘social and emotional well being’ and is further discussed in Chapter five.

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Culturally validated models of intervention for the treatment of mental health disorders within the Indigenous community.

Finally, Westerman (2004, p. 2) identifies the need to integrate clinical and cultural competencies at the level of mental health service delivery. This research has contributed to the development of a *Model of Cultural Validation of Health Problems*, which provides clinicians with guidelines to not only ensure that cultural factors have been incorporated into the assessment process, but outlines a culturally acceptable framework that includes all aspects of the therapeutic encounter, ranging from the process of engagement, the conduct of assessment, and the implementation of therapeutic interventions. Such guidelines also address how to overcome the barriers that are commonly encountered by Indigenous people in being able to access mainstream mental health services. This model of intervention outlines acceptable protocols at both the individual practitioner level and at the systems level that need to be followed in order to begin the process of engagement (Vicary, 2000; Vicary & Bishop, 2005; Garvey, 2008). It includes recommendations for the use of cultural consultants at every stage of the therapeutic exchange and makes suggestions for culturally appropriate interview styles and counselling techniques. It also includes the use of a ‘Scale of Acculturation’ to assist the practitioner to address the issue of cultural heterogeneity amongst Indigenous clients (Westerman 2002, p. 4). Such an instrument enables the practitioner to assess the degree to which they have become acculturated within mainstream society and hence to determine whether the Indigenous worldview is relevant to an understanding of their difficulties. It emphasises the need to respect and incorporate: ‘...existing frameworks of healing within Indigenous communities, and in particular those pertaining to the resolution of culture-bound disorders’ (Westerman 2004, p. 5). This entails working within what Vicary (2000, p. 426) has referred to as: ‘...the hierarchical structure of Aboriginal problem resolution’ that would be applied when a person became unwell, presumably

within a traditional Indigenous community context. While it is beyond the scope of this paper to describe this process in detail, Vicary (2000, p. 428) explains that it may involve a traditional healer using traditionally known methods for resolving mental health problems. Finally, in recognising that there is an absence of: ‘...specialist therapeutic interventions, which are steeped in conceptual, evidence based treatment models’, Vicary & Westerman (2004, p. 7) propose a combined approach to treatment which may involve a blend of both Indigenous and Western approaches in delivering mental health care, depending on client preference and local context. The following chapter demonstrates the limitations of empiricist methodologies in the understanding of mental health disorders and draws upon the insights generated from disciplines such as Anthropology and Sociology which have been derived from interpretative and hermeneutic approaches to the study of Indigenous experiences of disadvantage.

CHAPTER 3:

Review of interdisciplinary contributions to the understanding of mental health dysfunction within Indigenous Australian populations.

Atkinson's research on transgenerational trauma within Indigenous communities.

Judy Atkinson (2002, 2007) is an Indigenous academic who has principally focussed on the study of violence and relational trauma within Indigenous communities. Atkinson's (2002) theorisation has led to the development of effective approaches to healing, emanating from her work within remote Indigenous communities where violence in some regions has reached endemic proportions. Atkinson's (2002, 2007) approach to healing has been significantly informed by the wisdom of inherited collective knowledge of traditional Indigenous healing practices with the aim of transmitting this knowledge through established tertiary institutions for the benefit of future generations. Atkinson (2007) alludes to Psychology's complicit role in its history of instituting oppressive practises toward members of the 'stolen generation' and appeals to the need for an open dialogue between Psychologists and Indigenous healers to allow an opportunity for the development of culturally responsive approaches to trauma healing. A model for understanding the multi-layered impacts of trauma at the level of the self, the family and the community is proposed (Atkinson, 2002, 2007). In so doing, Atkinson (2007) is conscious of avoiding over-generalised accounts of the impact of colonisation on Indigenous people or of adopting a romanticised view of Indigenous cultures as they may have existed prior to colonisation. Atkinson (2007) and Astbury et al (2000, p. 430) contend that among the reasons for the escalation of violence within Indigenous communities have been:

...the breakdown of cultural lore and behaviours that were previously functional in conflict resolution processes (that) have become unstructured and damaging when used under the influence of alcohol or other drugs (author's insertion).

Atkinson (2007) does not therefore reinforce the perception of pre-contact Indigenous societies as being devoid of conflict, but argues that traditional approaches to dispute or conflict resolution have become displaced so that pent-up anger remains unable to be channelled appropriately. Within this context, the impact of trauma is understood

as a fragmentation of the sense of self, the family and of the community that provides structure to human lives. Atkinson (2007) suggests that the potential for healing resides in an awakening of a person's unmet needs by acknowledging deep-seated, unexpressed pain, and involves a gradual process of restoring a sense of wholeness, integrity and belonging. Without an opportunity to externalise and transform these unmet needs, the cycle of violence may become repeated, often unconsciously. Such insights resonate with American Indian healing practices which recognise that healing takes place when a person begins to feel a connection between: '...themselves and the healer and between themselves and something larger than self or science' (Yurkovich, Clairmont & Grandbois 2002, p. 156).

Atkinson (2002, p. 17) reminds us that it is our fundamental inter-relatedness as human beings that lies at the basis of our ability to restore our health and begin the process of healing. Atkinson (2002, p. 17) argues that such processes have been at the heart of Indigenous cultural healing practices as reflected in: 'ceremonial practices' and Indigenous 'being-in-the-world' relationships, a process that Psychology as a contemporary science is only beginning to grapple with in its revamping of Indigenous and Eastern traditions in the name of therapies based on 'mindfulness', for example. Regardless of the kind of therapeutic approach employed, Atkinson (2007) reiterates that it is through the therapeutic relationship that human beings are able to reconnect with one another, thereby awakening the ability to begin the process of healing, a factor which is only granted cursory mention within mainstream psychological discourse. Mainstream approaches within Psychology in its positivistic form, along with Psychiatry, have been instrumental in promulgating a bio-medical model of mental illness and have presented a compartmentalised understanding of 'mental states' and 'mental health' (Bracken & Thomas 2005, p. 14). In so doing, Atkinson (2007 p.) implies that it has overlooked the interdependent nature of relational activities as being at the core of healing practises. Atkinson (2007) concedes to the enormity of the task of reconciling two disparate approaches, one entrenched within a scientific paradigm, and the other remaining steeped within practices that are perceived as lacking an 'evidence-base' according to the criteria of scientific empiricism. However, Atkinson (2007) makes an impassioned plea to find 'a bridge' between Western Psychological and Indigenous approaches to healing:

I give – you give- we share, we grow together. The processes and the principle has not previously been a part of the relationships between Western trained Psychologists and Indigenous healing practitioners, but rather one of hierarchy and privilege. Various groups, on both sides of the divide are now walking across the bridge, to develop better ways of working together (Atkinson 2007).

Significantly, Atkinson (2007) concludes by contesting the unilateral relationship that is assumed between Psychology and Indigenous approaches to healing and invokes a challenge to the idea that scientific theory informs clinical practice, a central tenet that is encapsulated by the ‘scientist-practitioner’ model upon which mainstream psychological theorisation has been based:

Psychology and Indigenous healing practitioners must also work together to develop new ways of attending to Indigenous pain and distress, and in research that turns action into practice and practice into evidence. Teaching practice should be informed by what is happening on the ground, for the text books have not yet been written (Atkinson, 2007).

This is a view that acknowledges the unique insights that Indigenous lived experiences and constructions of knowledge can bring to bear on Psychologists’ understanding of Indigenous experiences of distress. This is further examined in chapter seven against a backdrop of the emergence of theories of therapy which are rapidly moving toward hermeneutic and interpretative positions in which there is a shared construction of meaning, as reflected in the narrative approach to therapy.

Feminist perspectives on the relationship between ‘race’, ‘culture’ and Indigenous mental health.

In a powerful exegesis on intraracial rape within Indigenous communities, Bell (1991, p. 385) argues for the need to develop a cross-cultural collaboration in the interests of finding common ground between Indigenous and non-Indigenous womens’ experience of violence. Given the high degree of fear and scepticism that has been generated through engagement in open discussions about violence toward women, particularly in view of the sense of taboo and censorship that surrounds topics relating to intraracial rape toward Indigenous women, Bell (1991, p. 387) argues that a new platform for theorisation about race and gender is urgently required. Bell (1991, p. 387) cites alarming statistics indicating that over the last ten years, the number of Indigenous female deaths have exceeded male deaths in custody in Queensland and

the Northern Territory (Balendra 1990, p. 2, cited in Bell 1991, p. 386). However, the magnitude of the problem has been variously concealed as 'domestic violence', 'customary practice' or an 'expression of distress' (Bell 1991, p. 386). Given the gravity of the issue in question, Bell (1991, p. 392) perceives the need for a collaboration between women in a manner which transcends and conflates the demarcations that have been created by the constructs of 'race' and 'gender'. Bell (1991, pp. 385-388) argues that it is the relationality and connectedness between women that needs to be at the basis of further developments in the theorisation of issues of race and gender. Bell (1991) contends that feminist theorisation has been hitherto constrained by the artificial boundaries created by 'fixed' notions of race and gender. Notwithstanding that race is an important dimension that has often remained invisible within feminist discourse, Bell (1991, pp. 411-412) vehemently objects to the use of generalised notions of 'culture' to justify acts of violence inflicted upon Indigenous women by Indigenous men. As a demonstration of the manner in which reified notions of race and culture have harmed women, Bell (1991, p. 389) cites examples of objections that have been directed toward Indigenous women who have brought rape to public attention. For instance, women who have chosen to expose these issues have been accused of colluding with white institutional practices that have placed Indigenous men at further risk of incarceration (Greer 2008, pp. 81-89). Another is that: '...violence against women is a matter of culture and to interfere is to undermine customary law' (Bell 1991, p. 389). Bell (1991) uses these arguments to illustrate not only that such claims are unverified, but the extent to which Indigenous women have been silenced and disempowered by them. Bell (1991, pp. 386-387) highlights the fact that: '...women's traditional bases of power - religious and economic - have been fundamentally transformed by the loss of their lands'. Bell (1991, p. 389) argues that women are therefore less able to participate in self-determination and decision-making processes to the extent that it was possible prior to colonisation. Within such an analysis, Bell (1991) is able to demonstrate how the impact of colonisation impinges differently on the lives of men and women such that: '...Aboriginal men are dying in custody and while some women also die in custody, many more are being brutalised in their home communities' (Bell 1991, p. 387). Hence, Bell (1991, p. 386) proposes that what is required is a deconstruction of social categories such as gender, race and culture, and the polarised debates (Indigenous / White) that have hindered the possibility of developing a cross-cultural collaboration

between Indigenous and non-Indigenous women. In accordance with Atkinson (2002, 2007) Bell (1991) suggests that it is our fundamental relatedness as human beings that provides the basis from which to: ‘...create new spaces of discourse’ and to ‘...rewrite cultural narratives’ (de Lauretis 1987, p. 25 cited in Bell 1991, p. 387) in order that the specific needs of Indigenous women may be addressed. Feminist theorisation has traditionally remained oblivious to dimensions such as race and culture and the extent to which they have impacted on womens’ lived experiences of discrimination and violence. Bell (1991), however, implores us to deconstruct globalised notions of race and culture to enable a greater understanding of the commonalities between womens’ experiences of discrimination and violence. In so doing, Bell’s (1991) thesis emphasizes that it is the developing relationship between two individuals that is at the basis of being able to generate dialogically shared meanings, rather than remaining confined by pre-determined categorical assumptions as contained within the notions of race and culture. This is also at the basis of the narrative approach to therapy which will be further discussed in chapters six and seven.

Anthropological perspectives on Indigenous notions of ‘culture’.

Researchers such as Brady (1995, 1997) and Sutton (2001, 2009) have begun to broach topics within previously forbidden territory in examining the influence of race and culture on issues relating to Indigenous well-being. Peter Sutton (2001, pp. 148-149), for example, is an anthropologist who has made the contentious claim that what is consistently missing within the dominant discourse on the underpinnings of Indigenous disadvantage, is an exploration of how aspects of Indigenous culture may be playing a part in the perpetuation of disadvantage. Sutton (2001, 2009) is wary of being seen as resorting to ‘blame the victim’ arguments or of condoning negative stereotypes that preside about the supposed inferiority of Indigenous cultures, claims which are emphasized as being patently erroneous as they are misleading. Rather, Sutton (2001, p. 140) insists that such preconceptions should not stultify further explorations about how Indigenous cultures have intersected with the dominant culture to create positions within contemporary society that have remained dysfunctional and resistant to change. In so doing, Sutton (2001, 2009) has

emphasized the importance of examining Indigenous culture in a much more nuanced and critical light.

To this effect, Maggie Brady (1995, 1997), also an anthropologist, has conducted extensive studies on the uses of culture as a form of healing within addiction treatment programs for Indigenous Australians and Indigenous North Americans. Brady (1995, p. 1487) observes that Indigenous people of North America and Australia have consciously chosen to incorporate a variety of spiritual and cultural traditions in the treatment of drug and alcohol abuse rather than adopting mainstream models of intervention to suit their needs. In so doing, the idea of reconnecting people to their cultural roots is seen as ‘...a pathway out of addiction’ (Brady 1995, p. 1487). Hence there is strong endorsement among Indigenous people of addiction treatment models emphasizing a renewal of cultural identification or affiliation. Brady (1995, p. 1490) suggests that the appeal of such models stems from Indigenous understandings of the aetiology of addiction which associate the fragmentation of cultural beliefs and practices with the impact of colonisation. Brady (1995, p. 1490) acknowledges the ideological sway that such a position holds for Indigenous people given the investment in promoting the idea of cultural revivification as a means of countering the effects of absorption and assimilation. As compelling as these arguments may be, Brady (1995, p. 1491) presents confounding evidence which appears to contradict the premise upon which such arguments are based. Given that high levels of substance abuse have continued to prevail within communities in which cultural identity and beliefs have remained relatively intact or least affected by the impact of colonisation, Brady (1995, pp. 1490-1496) highlights the need for a critical examination of the notions of ‘culture’ upon which such programs have been based. Brady (1995, pp. 1490-1496) suggests that a deconstruction of Indigenous notions of culture would allow for a clearer delineation of those aspects of culture which may be playing an actively ameliorative role without obscuring those aspects of Indigenous culture which may mitigate or even undermine a person’s capacity to benefit from an addiction program. It is within this context that Hunter (2004, p. 2) cites Brady (2004) as providing insight into the unintended consequences of Indigenous interests in placing an emphasis on the distinctive differences between ‘Indigenous’ and ‘Western’ conceptualisations of mental health:

Many official representations of what are said to be Aboriginal understandings and definitions of health emphasise cultural differences and attention is often directed to their exotic and supernatural features rather than their natural and prosaic ones. (Brady 2004, p. 91 cited in Hunter 2004, p. 2).

In accordance with Brady (2004) and Bell (1991), Hunter (2004, p. 3) concludes that within the domain of Indigenous mental health, it is important to be aware of and acknowledge cultural differences without: ‘...being blinded by them. It should require consideration of difference but awareness of commonality’ (Hunter 2004, p.3). The idea that there are irreducible cultural differences between Indigenous and non-Indigenous concepts of mental health have strengthened arguments for a more culturally responsive approach to the delivery of mental health services, but may have simultaneously eschewed the development of a contextualised theorisation of Indigenous mental health issues within a cross-cultural framework (Hunter 2004, p. 2).

Summary

This section has reviewed some of the main research contributions to the understanding of mental health within Indigenous Australian populations. Westerman (2002, 2003, 2004, 2007) represents one of the main exponents of psychological theory in the understanding of psychopathology within Indigenous populations. In investigating the aetiology and phenomenology of depression for example, Westerman (2002, 2003, 2004, 2007) highlights the centrality of culture and the importance of contextual factors in the understanding of the manifestations of mental disorders among Indigenous people. In so doing, Westerman (2002, 2003, 2004, 2007) illustrates the dissonance between Western models of Clinical Psychology and Indigenous models of mental health. Westerman (2002, 2003, 2004, 2007) proposes that the capacity to reconcile Western methodologies for interpreting and assessing mental illness with Indigenous approaches to mental health resides in the integration of specific ‘cultural’ and ‘clinical’ competencies at both the individual practitioner and systems level. This is argued on the grounds that the specific integration of cultural competencies within psychological practice is likely to minimise the risk that

cultural differences in symptom manifestation may be misinterpreted as evidence of psychopathology.

Atkinson (2002, 2007) provides a model of healing grounded within traditional Indigenous healing practises that has originated from her work with trauma within Indigenous communities. It is an approach in which the intra and inter psychological effects of trauma are clearly articulated and synthesised from Western based understandings of mental health whilst incorporating spiritual elements which are shared among a number of Indigenous healing practices worldwide. Bell (1991) has attempted to cross the cultural divide by suggesting that a theorisation of race and gender needs to be based on cross-cultural understandings of women's shared experiences of violence rather than becoming embroiled within circular arguments premised on fixed notions of race and gender. Brady (1995) has also called for the need to critically examine the notions of culture upon which Indigenous models of treatment for substance abuse have been based. Brady (1995) and Sutton (2001, 2009) argue that the monolithic, and often generalised notions of Indigenous culture that underpin these models, along with the assumption that forging stronger links to culture can only be advantageous, need to be questioned. A salient point that has been made by both Atkinson (2007) and Bell (1991) is that it is our common humanity and our interrelatedness as human beings that lies at the basis of our health and ability to heal.

This thesis will argue that Westerman's (2002, 2003, 2004, 2007) approach to the understanding of mental health within Indigenous populations remains firmly embedded within the dominant paradigm upon which Western approaches to Clinical Psychology are based. Westerman's (2002, 2003, 2004, 2007) attempt at reconciling Western and Indigenous approaches to mental health does not appear to include a significant deconstruction of the conceptual foundations of each of these approaches. Although it is clear that Westerman (2002, 2003, 2004, 2007) remains cognisant of the limitations of dominant methodologies in the understanding of Indigenous mental health, it appears that a fusion of Indigenous and Western perspectives has been proposed without compromising the assumptive basis underlying each approach. Although Vicary and Westerman (2004) have argued that the assessment process must accommodate an exploration of the spiritual and cultural dimensions of a

person's difficulties, Garvey (2008, p. 10) insists that there remains an uncertainty among mental health professionals as to how this may be carried out. In practise, this often means that practitioners will resort to working within dominant paradigms that impose Western beliefs (Garvey 2008, p. 10). It will therefore be argued that the conceptual premises of the conventional discourses of Clinical Psychology and Indigenous concepts of mental health present serious constraints to their reconciliation. What is necessary is a systematic deconstruction and critical analysis of the main conceptual foundations of both discourses in a manner that is both logically coherent and dynamic. This will allow further progress in the understanding of Indigenous mental health issues rather than falling into a circular reiteration of firmly held positions. It is hoped that this will facilitate a reformulation of both discourses into a critical cross-cultural psychology theorisation and this will be discussed in detail in Chapters six and seven. The next chapter will examine the history of Psychology as a contemporary scientific discipline and its relationship to Indigenous people.

CHAPTER 4:

History of Psychology and its relationship with Indigenous Australians.

The racist implications of early psychological research.

The relationship of the theory and practice of Psychology with Indigenous people will firstly be explored by examining both its historical pattern of involvement within Indigenous communities and the issues that have emerged in its continuing attempt to come to terms with the legacies of its past. Many of Psychology's failings have been attributed to the imposition of a dominant monocultural perspective which rests on universal assumptions of human behaviour (Riggs 2004, p. 120). One of the predominant concerns that have emerged from criticisms about mainstream Psychology's relationship to Indigenous people is that it has contributed to their history of oppression. Over the last decade, there have been urgent calls for a re-examination of its underlying assumptions in the interests of developing a Psychology which is firmly committed to reconciliation (Dudgeon & Pickett, 2000; Sanson et al, 1998). Alternative perspectives have been developed as a collaborative effort between Indigenous and non – Indigenous Psychologists which is argued as signifying the beginning of a paradigm shift within Psychology (Ranzijn, McConnochie, Nolan & Day 2007, pp. 10-11; Garvey 2007, p. 125). These include the emergence of critical, cross-cultural and community perspectives within Psychology which have as their central aim the 'decolonisation' of its methodology and practice in the interests of promoting empowerment and social transformation within a social justice framework (Smith 1999; Dudgeon & Pickett 2000, p. 82). This thesis will argue that although many positive moves have been made by the Australian Psychological Society (APS) in an effort to renegotiate Psychology's relationship with Indigenous people, it is questionable as to whether they constitute a paradigm shift. It is argued that new models which have been developed from anthropological, critical cross-cultural and Indigenous frameworks for understanding mental health will need to be integrated within its worldview and foundational basis before it may proffer claims toward the achievement of reconciliation.

Within their aptly entitled article, 'Australian Psychology has a Black History', Garvey, Dudgeon & Kearins (2000, p. 231) have demonstrated that research which was conducted by Psychologists within Indigenous Australian populations had often unwittingly reflected the racial preconceptions which prevailed during the late nineteenth and early twentieth centuries. Garvey, Dudgeon & Kearins (2000, p. 231) have argued that errors made as a result of the assessments conducted were not committed out of malicious intent, but can be seen as reflecting an unconscious application of ethnocentric practices and the limitations of the methodologies that were being used during the early contact period. During the late nineteenth century, for example, Psychologists became exposed to the theories of social Darwinism and the supposed science of eugenics. To the social Darwinists, Aboriginal people and their culture were considered to be the relics of an early stage of human development on the evolutionary scale (Garvey, Dudgeon & Kearins 2000, p. 233). It was also assumed that their mental capacity would be correspondingly low in alignment with their early level of development. Francis Galton (in Garvey, Dudgeon & Kearins 2000, p. 233), a proponent of craniometry (the 'science' of the measurement of the human skull which was thought to indicate level of intellectual development), set out to prove such theories by using a number of sensorimotor tests that he believed could gauge a person's intellectual capacity. These tests were initially used on the people of the Torres Strait Islands because it was thought that they would: '...provide eminently suitable subjects for the study of primitive man' (Garvey, Dudgeon & Kearins 2000, p. 233). Although no evidence was found to support this theory, researchers nonetheless adhered to the notion that Aboriginal Australians belonged to the lowest rungs of the evolutionary ladder in terms of their intellectual development (Garvey, Dudgeon & Kearins 2000, p. 234).

Porteus (in Garvey, Dudgeon & Kearins 2000, p. 235), a teacher at a special school during the early part of the last century, devised a series of maze tests which were to be used as a screening device for intellectually disabled children. Porteus (in Garvey, Dudgeon & Kearins 2000, p. 235) was later reported to have used these tests to investigate the capacities of Aboriginal adults of the northwestern and central regions of Australia. In general, Porteus's (in Garvey, Dudgeon & Kearins 2000, p. 235) results showed that these adults performed at lower levels than the samples upon which the test was normed. Significantly, it was later demonstrated that lower test

results were indicative of the degree of exposure to the Western education system rather than innate ability *per se*. Porteus (in Garvey, Dudgeon & Kearins 2000, p. 235) nonetheless arrived at conclusions which did not deviate from the prevailing assumptions of his time.

More recent evidence exists demonstrating the extent to which Psychologists became enlisted as agents of oppression and social control in their involvement with Aboriginal people. For example, the Human Rights and Equal Opportunity Commission report of the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (1997) documents a number of instances where psychologists became instrumental in the decisions to remove children from their families without due regard for cultural differences in child rearing practices. Similarly, ethnocentric biases in psychological assessments were used to define juveniles at risk and to implement decisions in relation to adoption and custody (HREOC 1997, pp. 545-546). Such practices can be understood to have resulted from the uncritical application of assessment tools that have been normed against a white, educated, middle class sample of the population. This invariably results in the discrimination of people of Indigenous and non-English speaking backgrounds. It has effectively resulted in the perpetuation of negative stereotypes of members of minority cultures, and at worst, it provided explanatory value as to their marginal place in society.

Criticisms of Psychology as a 'value-free' science as embodied within the 'scientist-practitioner' model.

During the formation of Psychology as a contemporary discipline, it sought epistemic authority by emulating the methods of the physical sciences in its study of the human mind (John 1998, p. 25). Psychology was based on a conceptualisation of science that purported to be 'value-free' and therefore able to transcend moral, political and cultural considerations in order to uncover universal truths about the workings of the human mind (John 1998, p. 25). These methods entailed the isolation of variables using controlled laboratory experiments (Larner 2001, p. 36). The 'scientist-practitioner' model continues to be the framework within which Psychology is taught

at Australian universities. It imparts the idea that knowledge gleaned from scientific research can be directly applied by the practitioner within the therapeutic context (Larner 2001. p. 36). Importantly, it implies a unilateral relationship that privileges knowledge based on empirical methodologies and devalues knowledge based on experience and subjective interpretations of the world. It also marginalises other forms of knowledge construction that have been derived from Indigenous and non-Western cultures (Darlaston–Jones cited in Garvey 2007, p. 20; Sonn cited in Garvey 2007, p.52). At the clinical level, such a model overlooks the fact that practitioners often encounter a myriad of variables that remain unaccounted for in controlled experiments and within the laboratory setting. The practitioner also engages in a complex mode of interaction with the client that is not quantifiable and draws from a knowledge base that comes from experience within the clinical setting (Larner 2001. p. 36). Hence, Psychologists are socialised within an institution which encourages them to: ‘...position themselves as detached objective observers of the way things are, and to treat scientific psychological knowledge claims as neutral descriptions of the world ‘ (John 1998, p. 26). John (1998, p. 26) cogently argues that such a model neither encourages self-reflection nor self-understanding on the part of the Psychologist. By the same token, it cannot be assumed that the knowledge that has been generated using such a methodology will be necessarily used for the benefit of society.

Individualistic assumptions underlying the dominant paradigm within Psychology.

In contrast to disciplines such as Anthropology and Sociology, Psychology is centred upon the individual rather than the social, historical and cultural contexts within which that individual has been socialised. By decontextualising a person from their historical, socio-economic and cultural background, it ignores the structural and systemic barriers that they may be facing (Sanson et al 1998, p. 162). The atomistic perspective of the dominant paradigm becomes problematic for people whose cultures are collectivistic and for whom their sense of self is not separate from the family and the community to which they belong (Andary, Stolk & Klimidis 2003, pp. 32-39). Indigenous people presenting with psychological disorders for example, may be also be considered as manifestations of community hardship and intergenerational trauma.

Vicary & Westerman (2004, pp. 2-3) have amply demonstrated that mental health disorders within Indigenous populations are better understood within the context of a people who have been systematically oppressed and subjugated under sanctioned practices which served to fragment their cultures. It is on these grounds that Dudgeon and Pickett (2000, p. 84) have contended that the: ‘...acontextual image of humanity has assimilationist implications, as diversity is ignored. It is not acknowledged that the context of human groups includes cultural, historical and social realities.’ It is this homogenised image of humanity as promulgated by mainstream psychological perspectives which not only ignore but pathologise cultural differences. In the APS position paper *Racism and Prejudice: Psychological Perspectives*, Sanson et al (1998, p. 162) have demonstrated that it was the uncritical acceptance of the dominant individualistic perspective that have enabled Psychologists, often unwittingly, to engage in racist practices in the past. Far from suggesting that Psychologists have since become inoculated from committing similar errors in the future, however, it is argued that the uncritical application of dominant methodologies to assess people of indigenous and non-English speaking backgrounds continues to be fraught with difficulties at the most fundamental level and can serve to perpetuate racial stereotypes and inequities. It can be seen that the uncritical application of Psychology to the study of people of Indigenous and other minority cultures posed serious limitations which have called for a re-examination of the assumptive basis from which it has been operating. This has in turn led to a greater receptiveness to Indigenous forms of knowledge and cross-cultural perspectives within Psychology and is discussed in greater detail in chapters five and six.

CHAPTER 5:

Competing paradigms in the assessment of psychopathology across cultures.

'Emic' versus 'etic' approaches toward the study of psychopathology across cultures.

Cross-cultural researchers have developed divergent perspectives on the study of the influence of culture in the manifestation of depression and anxiety (Tanaka-Matsumi & Chang 2002, p. 2). The *universalist* paradigm or *etic* position is most commonly held by Western researchers who maintain that psychopathology is the same in every culture. Hence the DSM –IV (*Diagnostic and Statistical Manual of Mental Disorders*) or the ICD-10 (*International Statistical Classification of Diseases and Related Health Problems*) provide universal classification systems that are used as templates in the understanding of psychopathology across cultures. Although there is an acknowledgement that culture may influence the way in which psychopathology is expressed, the *etic* approach assumes that there are core universal aspects of psychological functioning across cultures. Adherents of this position would maintain that there are bio-medical causes underlying mental disorders which have universal explanatory power. Sam & Moreira (2002, p. 3) have highlighted that it is the bio-medical model which underlies the theoretical position of the universalist paradigm. That is, by insisting on bio-medical explanations for mental disorders, culture is thought to be irrelevant to the understanding or meaning of human distress. This position is also reinforced by the pharmaceutical industry which rests on bio-medical explanations of mental disorders in order to justify the use of medications as treatment for mental health disorders (Sam & Moreira 2002, p. 3; Bracken & Thomas 2005, p. 175). By asserting that these claims have universal validity and are therefore beyond disputation, mainstream models of Psychology and Psychiatry are able to continue to confer their dominance in the understanding and interpretation of psychopathology across cultures.

In contrast, the *relativist* paradigm or *emic* approach to research acknowledges the fundamental role of culture in the experience, expression and interpretation of psychopathology. Researchers using this approach have emphasized that the uncritical

application of universal classification systems to understand the manifestations of psychopathology in other cultures involves a ‘category fallacy’ and is likely to result in misdiagnosis (Andary, Stolk & Klimidis 2003, p. 11). Adherents of this approach have queried whether the same syndromes exist in a similar form in other cultures and tend to focus on differences in the belief systems of patients, healers and community members about the causes and consequences of mental health disorders. Irrespective of theoretical orientation, most researchers would agree that culture exerts some degree of influence in the manifestation of mental disorders (Sam & Moreira 2002, p. 3).

‘Evidence-based’ practice and what it means within a Western psychotherapeutic context.

Bracken & Thomas (2005, p. 168) explain that as Psychiatry sees its main endeavour: ‘...the development of treatment technologies designed to eliminate disease entities’ (in reference to mental health disorders), it has embraced the idea of adhering to ‘evidence-based practice’. Evidence-based treatments are based on the concept of the clinical trial where one form of treatment is administered to a group of patients whilst another group receives a rival or disguised form of treatment in order that its effectiveness may be tested. However, evidence-based practise has been narrowly defined according to the dictates of medical science, that is, the effectiveness of various forms of psychiatric intervention have been evaluated in the same way that the medical sciences might compare different forms of treatment for cancer (Bracken & Thomas 2005, p. 168). This approach rests on the assumption that elements of a psychotherapeutic encounter between a therapist and a client may be reduced to experimental variables that may be subjected to an objective analysis

Atkinson (2007) has questioned the assumptions inherent within the scientist-practitioner model which implies that scientific evidence must inform and guide therapeutic practice. Conversely, Atkinson (2007) and Sanson (in Garvey 2007, p. 130) have argued that an evidence-base must be informed by research that is seen as relevant to the people who are in close contact with the needs of their communities.

Atkinson (2007) also argues that researchers should be guided by ‘Indigenous terms of reference’ by remaining conscious of framing their research to encompass Indigenous concepts of social and emotional wellbeing. Garvey (2008, p. 22) quotes Sherwood (2005) who stated that:

I have observed that mental health services separate mental health from health and they have compartmentalised it into another body. It is this model that does not work for Aboriginal people. We do not need to be fragmented or torn apart any further. Mental health services for Indigenous people need to reflect our worldview and vision of how we see things at the moment...

Psychology in its positivistic form, privileges only one way of knowing. Darlaston-Jones (in Garvey 2007, pp. 20-21) has stated that Indigenous ways of knowing have become marginalised and considered less important than Western methods of knowledge construction, and this can be seen as a form of ‘cultural imperialism’. Indigenous educator Karen Martin (2003, p. 205) positions herself as an educator who actively embraces Indigenous ontology as a framework for research. As such, Martin (2003) demonstrates that there are many different ‘ways of knowing’ and that Indigenous ‘ways of relating’, ‘knowing’, ‘doing’ and ‘being’ are equally legitimate forms of knowledge construction (Martin 2003, pp. 208-211). It has been suggested that a paradigm shift can only be realised by ‘decentering’ the dominant discourse within Psychology to provide: ‘...space for different forms and expressions of knowledge to be legitimised.’(Darlaston-Jones in Garvey 2007, pp. 20-21).

Indigenous and Western conceptualisations of mental health.

To deepen an understanding of Indigenous mental health necessitates stepping outside of pre-conceived categories and notions as defined by Western bio-medical models of mental illness. The term ‘illness’ connotes the Western notion of psychological disorders as distinct entities which can be categorised and diagnosed according to the criteria that are specified within universal classification systems. It also attributes psychopathology to the individual rather than acknowledging the impact of political, environmental, and socio-economic factors on a person’s wellbeing. In contrast, concepts of Indigenous mental health are more holistic and are not recognised in terms of a mind/body dichotomy (Westerman 2004, p. 3). Indigenous

conceptualisations of mental health have been clearly articulated in a position paper on Aboriginal Mental Health of the National Aboriginal Community Controlled Health Organisation (NACCHO) (Vicary & Westerman 2004, p. 3). Crucially, it highlights distinctive differences in the manifestations of mental health and acknowledges the impact of socio-historical factors on Indigenous wellbeing. The notion of ‘social and emotional well-being’ was conceived by Indigenous people to convey social interrelatedness as an essential aspect of well-being (Garvey, 2008; Roxbee & Wallace, 2003). The term ‘social and emotional wellbeing’ is thought by Indigenous people to better reflect an understanding of mental health that encompasses: ‘...(i) culture and spirituality; (ii) family and community kinships; (iii) historical, social and economic factors; (iv) fear and education; and (v) loss.’ (Garvey 2008, p. 7). The key to arriving at a more contextualised and holistic understanding of Indigenous mental health is to assess the extent to which socio-historical factors such as the loss of land and culture have impacted on the individual. Garvey (2008, p. 5) suggests that although Indigenous mental health remains a highly contested area in terms of how it is defined, who determines its parameters and how this translates into effective services, it is thought that the development of shared mental health literacies is helping to progress this further. In this thesis, it is argued that embedding Indigenous mental health concepts within a critical cross cultural framework will enable extended insights into the commonalities not only with other first nation cultures, but with non-Western (e.g. Asian) and ‘non-White’ (e.g. Southern European), collectivistic cultures. In addition, the development of new ways of conceptualising mental health disorders facilitates the formulation of a model for understanding and working with Indigenous people presenting with mental health disorders, as will be outlined below.

CHAPTER 6:

The way forward: new paradigms, new models of Psychology.

Objectification and instrumentality versus intersubjective dialogue.

Within the scientist practitioner model, the Psychologist is taught to conceptualise their role as detached impartial observers whose task is to assess a client's presenting symptoms in order to diagnose a client's mental state (Bracken & Thomas 2005, p. 108). Bishop (in Garvey 2007, p. 72) states that whether we are referring to conducting an assessment or conducting research, Psychology has been dominated by traditional positivist methodology which places the Psychologist in the position of the 'expert' and the client in the position of the 'subject/ object' or passive respondent. John (1998, p. 26) has argued that such a model neither encourages self-reflection nor self-understanding on the part of the Psychologist. Dudgeon (2000, p. 249) argues that the process of engaging therapeutically with a client must start with the therapist. Critical self-reflection or 'turning the gaze inward' is an essential precursor for effective engagement with an Indigenous client and indeed for all clients, irrespective of ethnicity. That is, a therapist needs to remain cognisant of how his or her own values, motivations, presuppositions, and cultural background may affect their ability to work effectively with an Indigenous client. This process of self-reflection also entails a critical examination of the values and assumptions upon which their profession is based.

Petchkovsky et al (2004, p. 1) have emphasized that the process of conducting a culturally appropriate assessment does not merely entail the objective application of a standardised instrument to measure the degree to which an individual may be psychologically impaired. Such an approach is firmly embedded within a Western framework and is fraught with a myriad of assumptions about the nature of the relationship between the therapist and the client, ideology and conceptualisation underpinning Western notions of mental health, the mode of mental health service delivery and the dominant values implicit in assessment methodologies used. Bracken & Thomas (2005, p.110) have highlighted that the main belief underlying this approach is that psychological realities can be observed, analysed and ordered in the

same way that our physical symptoms and bodily processes can. However, the transposition of the methods of the physical sciences to understand psychological phenomena fundamentally ignores meaning, context and interpersonal subjectivity. In other words, unlike physiological processes, psychological events cannot be described in isolation from the contexts in which they occur and are intimately connected to linguistic, cultural and social realities (Bracken & Thomas 2005, p. 110).

Westerman (2007) warns that adopting the position of a detached observer will almost certainly result in failure to engage an Indigenous client and may further entrench a sense of alienation. At a deeply moving, personal level, Pat O'Shane (1995, pp. 28-29) discloses details of the dehumanising, invalidating experiences of being labelled as 'manic-depressive' and of the inconceivably radical form of treatment that was recommended by a Psychiatrist. Without having established a relationship of trust and a sense that the Psychiatrist had been able to demonstrate empathy and understanding at the most fundamental human level, O'Shane (1995, pp. 28-29) demonstrates the deeply destructive impact of this psychiatric diagnosis and the resultant hampering of personal growth that lies at the basis of healing and transformation. By remaining oblivious to the historical, contextual and familial events that directly impinged upon O'Shane's (1995) life at both a personal and intergenerational level, the Psychiatrist was able to decontextualise, objectify and medicalise her symptoms. The process of healing for O'Shane (1995, p. 29) began from the moment the decision had been made to: '....(throw) all my Parnate, Mellerll, Lithium, Stelazine, Tryptanol, and whatever else used to rattle around my medicine cabinet, into the toilet bowl....' (author's insertion).

Bracken & Thomas (2005, pp. 110-123) have argued that one of the key differences between the physical and the mental sciences is that the 'object' of study is not inanimate or impersonal and hence cannot be divorced from contexts, meaning, values, and ethics that form an inextricable part of the interpersonal exchange between two people. The therapeutic encounter is necessarily relational, i.e., it involves an intersubjective engagement and exchange between two people, both of whom will inevitably be affected and transformed through the ensuing therapeutic relationship. Langton (1993, p. 33) has proposed that knowledge about each other occurs via an intersubjective dialogue, where knowledge is continually being made

and revised over and over again: ‘...Aboriginal and non-Aboriginal people enter into a dialogue with each other that produces mutual, testing models in order to find a space for mutual comprehension’. Garvey (2007, p. 4) has stated that during the therapeutic exchange, the narrative approach enables people’s own description of their lives to unfold, relying more on the individual’s or the community’s interpretations, understandings and worldview, rather than an *a priori* reliance on assessment tools and procedures.

Atkinson (2002, pp. 15-20) has conducted her research of intergenerational trauma using methodologies based on the ‘Dadirri’. The *dadirri* is an Indigenous concept that includes, but extends well beyond the Rogerian principle of unconditional positive regard for a client during the therapeutic encounter. It involves quiet observation and deep listening, building knowledge through awareness, contemplation and reflection (Atkinson 2002, p. 17). Atkinson (2002, pp. 15-20) is careful to explain that it is not a research methodology in the traditional Western scientific sense, but a ‘way of life’. Fundamentally, it is a philosophy that recognises the: ‘...intersubjectivity within this sense of community’ in which all people belong and: ‘...all people matter’, with the view that all people are connected and informed by one another (Atkinson 2002, p. 17). Atkinson (2002, p. 17) argues therefore, that healing cannot take place: ‘...unless it is experienced and understood in the inter-relationships of diverse cultural protocols and practices.’ This is a view that emphasizes ‘meanings’ as created and experienced by individuals interacting with one another where one does not claim superiority over the other. In pursuit of this new theoretical base, the next section develops a number of ideas that amount to a significant shift in the way in which mental health disorders are conceptualised that have far reaching implications for the way in which therapy with Indigenous people may be developed.

Categorical versus dimensional conceptualisations of mental health.

There have been several landmark studies conducted internationally which have contested the presumption that Western diagnostic categories have universal applicability. Ryder, Yang & Heini (2002, pp. 3-4) for example, have provided examples of reports which have consistently indicated the apparent rarity of the

incidence of depression among Chinese cultures. Given that depression has grown in epidemic proportions worldwide, these findings represented somewhat of an enigma for researchers in cultural psychopathology (Hansen in Radden (ed.) 2004, p. 36). In a hospital study of psychiatric patients in Hong Kong, Ryder, Yang & Heini (2002, p. 4), found that although one third of patients presented with symptoms that were associated with depression and anxiety, only ten percent exhibited symptoms that corresponded to the DSM-IV definition of depression. Ryder, Yang & Heini (2002, p. 4) concluded that an imported Western based classificatory system may therefore fail to detect individuals whose symptoms are manifested differently. Sam & Moreira (2002, p. 5) draw on the findings of Scheiffelin (1985) who did not find a single case of depression during his 20 year study among the Kaluli people of New Guinea to demonstrate that 'depression' as defined by the DSM-IV is not a universally valid and applicable category. Similarly, Marsella (2003, p. 5) in his review of depression and culture, concluded that: '...1. There is no universal conceptualisation of depressive disorders; 2. The experience, meaning, expression of depressive experience varies as a function of the cultural context in which it occurs;...'

At a national level, Petchkovsky et al (2004, p. 4) and Elliott-Farrelly (2004) found cultural differences in the manifestation of mental disorders among Indigenous people which do not entirely conform to DSM-IV diagnostic categories. For example, Petchkovsky et al (2004, p. 1) interviewed a number of members of the 'Stolen Generation' using structured interviews and standard psychiatric instruments to enable an assessment of the extent to which they were suffering from psychological disorders as defined by Western diagnostic categories. They found that all of the individuals interviewed reported a coherent pattern of sustained trauma and severe chronic distress which could not be neatly subsumed under universal classification systems such as the DSM-IV or ICD-10. In separate studies conducted by Westerman (2004, p 4), the results indicated that Indigenous conceptualisations of depression do not entirely conform to DSM categories. Similarly, Atkinson (2007) uses an example of a young Indigenous man with a history of violence to demonstrate that:

Eric's symptomatology is obviously severe and chronic. It is clear that he deals with many deep emotional wounds that do not clearly fit (a Post Traumatic Stress Disorder) diagnostic classification. His deep sense of loss and abandonment, his sense of alienation, and his gross sense of betrayal and mistrust are normal responses to a tragic life cycle.

Such studies continue to inform an evidence-base which supports the validity of the *emic* approach to the study of psychopathology across cultures.

In this thesis, it is argued that Westerman's (2003) articulation of the attempt to reconcile Indigenous and Western conceptualisations of mental health remain firmly couched within the Western framework as encapsulated within the DSM-IV. This is reflected in Westerman's (2003) uncritical use of the term 'culture bound syndrome' to describe clusters of symptoms within Indigenous populations that deviate from or do not fit into the DSM-IV categorisations. 'Culture bound syndromes' have been included in the DSM-IV to denote culture specific disorders that do not correspond to the main diagnostic categories that comprise the DSM-IV. It is also evident in Westerman's (2002, p. 2) comments about how to conduct a differential diagnosis to enable a clinician to determine when a presenting syndrome is 'culturally specific' and when it is 'real', i.e., evidence of psychopathology. Such a statement presupposes that mental health disorders as defined by the DSM-IV are 'real' and those that do not fit into DSM categories are relegated to the status of being aberrant or peculiar to Indigenous cultures, hence the term 'culture bound syndromes'.

There is a growing body of cross-cultural literature that has criticised the universal assumptions underlying the DSM-IV (e.g., Marsella 2003, p.8; Sam & Moreira 2002, p. 5; Andary, Stolk & Klimidis 2003, p. 10). Andary, Stolk & Klimidis (2003, p. 7), for example, have argued that 'culture bound syndromes' cannot be clearly distinguished from the 'core' syndromes that are described within the DSM-IV. This distinction has been made on the basis that core symptoms are thought to occur throughout the world, whereas culture bound syndromes are regarded as specific to a culture because of their localised presentation. In this sense, the main DSM categories are thought to have universal validity. However, a number of researchers have pointed out that the assumption of universality, even for the main DSM categories cannot be sustained, given that they have been conceived from within an Anglo-American cultural point of view. In this sense, it is argued that all of the DSM categories could be regarded as 'culture bound syndromes,' particularly those that tend to occur

specifically within this cultural context, e.g., *anorexia nervosa* (Marsella 2003, p.8; Sam & Moreira 2002, p. 5; Andary, Stolk & Klimidis 2003, p. 10).

Bentall (2006, p. 221) offers a profound and far reaching critique of the diagnostic framework (referred to as the 'Kraepelinian paradigm') from which the DSM has been derived. Bentall (2006, p. 221) uncovers some of the main assumptions and premises underlying the categorical system for understanding mental health disorders. In brief, some of these are as follows:

- 1) 'that psychiatry should use modern scientific methodologies and base its practise on scientific knowledge';
- 2) 'there is a boundary between the normal and the sick';
- 3) 'there are discrete mental illnesses' and
- 4) 'the focus of psychiatric physicians should be particularly on the biological aspects of mental illness'.

As none of these assumptions have held up to empirical scrutiny, in addition to difficulties with inter-rater consistency and reliability in the use of a diagnostic system, Bentall (2000, p. 223) advocates the need for a new system which recognises mental disorders not as categories but as dimensions. This would enable the focus to shift from an attempt to explain a person's difficulties within preconceived diagnostic terms, to an attempt to address and explain the actual symptoms or complaints that the client/ a person presents with. Bentall (2006, p.229) argues that a: '...complaint-orientated approach' facilitates the ability to explore clients' histories and experiences in order that the aetiology of their presenting difficulties may be better understood. A critical understanding of the concept of culture, both as it manifests at the level of the individual and the collective is an important starting point in enabling an understanding of how a person's degree of acculturation within traditional Indigenous cultures may influence the way they may perceive, express, and cope with affective disorders.

The conceptualisation of culture.

In much of psychological literature, but particularly evident in Westerman's (2002, 2003, 2004, 2007) writing, the term 'culture' is used in a global, undifferentiated, apparently unproblematic and unconditionally positive way. Hunter (2004) has argued that this has understandably emanated from a tendency to polarise differences between Indigenous and non-Indigenous cultures to strengthen arguments for the allocation of resources toward the development of culturally specific mental health services for Indigenous people. Sutton (2001, 2009) and Brady (1995) have specified that a more developed theorisation of culture is required in order to better understand how specific aspects of the interface between Indigenous and dominant cultures have impacted on Indigenous mental health and have perpetuated the inequities that continue to be experienced by Indigenous people today. Brady (1995) observes a trend among Indigenous people to venerate the role of culture in potentiating the healing process. In light of evidence indicating that high levels of substance misuse have persisted within communities in which cultural identification remains strong, Brady (1995) has argued that the notion of 'culture' as a panacea for all ills needs to be brought into question.

In an examination of 70 abnormal Psychology textbooks published from the 1920s to the present, Tanaka-Matsumi & Chang (2002, p. 6) rarely found substantial definitions of culture. What they found instead were dichotomous/binary descriptions and labelling of cultures, and this is evident in much of the psychological research on Indigenous mental health in reference to: '...Western – non-Western', 'Indigenous-non-Indigenous' conceptualisations of mental health. De Munck (2001, p. 16) has noted that there are: '...few if any cultural anthropologists who explicitly hold (or ever held) the view that culture is a discrete entity...yet social scientists tend to reify culture'. Finally, De Munck (2001, p. 20) argues that a well formed theory of culture must include how the various aspects of culture are represented in the individual, as well as developing an understanding of the commonalities among members of the same cultural group. De Munck (2001) has developed a modular understanding of culture as represented within the individual and this is discussed in more detail below.

The relationship between language and culture: the primary role of language in managing cultural difference.

There is a large body of evidence showing that language is the main mediating mechanism between the individual and culture (Foley, 1997; Deacon, 1997; Cuellar & Paniagua, 2000). Language is the principal medium of construction and transmission of personal and cultural meaning. Culture and language are inextricable from the person's cognition, affect and behaviour, conscious or unconscious. Professor William Foley (1997) from Sydney University, thus summarises the relationship of language to culture:

If cultural practises are those meaningful practises through which humans in relationships sustain ongoing histories of social structural coupling, then the foremost of these must be linguistic practises. What people do incessantly in every known society is talk. Linguistic practices are the most pervasive way in which humans make meanings and sustain social systems: they do not exhaust human cultural practices, but are clearly primary among them. Humans could be succinctly defined as social beings encultured through language (Foley 1997, p. 24).

While cultural and linguistic sensitivities are mentioned in Westerman's (2002) guidelines for the delivery of mental health services to Indigenous people, no definition or theory of culture, or of language and its relationship to culture, are mentioned in these proposals. Foley (1997) observes that there is a great amount of confusion amongst the general public and mental health professionals alike as to the meaning of 'culture', and, as mentioned, this has often resulted in both a mystification and oversimplification that characterises the discussions in which they arise.

For the purposes of this thesis, it may be sufficient to say that culture is not a unitary, fixed and impermeable entity. It is in fact exactly the opposite, especially for those who are living in a minority culture. Members of minority cultures, such as Indigenous and NESB people in Australia, are inevitably confronted with the relativity of their own culture, forced to question it explicitly and implicitly, and to negotiate a cultural migration for themselves, with various degrees of 'success'. The impact of culture on the individual happens at the symbolic level, that is, environmental elements, individual and collective behaviours are interpreted to 'make sense' and culture offers a code for deciphering them. As described by De Munck (2001, pp. 13-14):

One makes an 'effort after meaning' by applying representations or models of meaning onto experience. These models are cultural in that they are constructed out of shared symbols that are arranged into a dynamic 'image' or what is referred to by some theorists as 'an organic theory of knowledge' because it can be affected by both internal and external factors...the dynamic image, called 'cultural model' by contemporary cognitive anthropologists is the basic elemental unit of culture...there is likely to be a cultural model for 'intelligence', 'marriage', 'money' and all the things, events and processes in the world to which we ascribe meaning.

Language is the human tool for symbolic transactions and the articulation of cultural models. T. Deacon (1997), in 'The Symbolic Species', explains how human language is the cultural, species specific tool of symbolic transaction for humans. Language and culture cannot be dissociated, and a language carries the conceptual structure and symbolic content of a culture. Learning any language, and therefore learning the language of the majority culture, is to import its cultural constructs, the 'culture models', and to try and accommodate them alongside one's already existing representation of the world and its meanings. Imported and pre-existing cultural models may conflict, coexist with ongoing tension without ever being resolved, extinguish, or prevail momentarily, only to be overturned when in the company of persons who share his/ her original culture. This is what is referred to as the process of 'acculturation'.

It is notable that most acculturation scales include a number of questions about language use and proficiency. To speak of accessing a person's culture without using that person's language is therefore nonsensical. Westerman (2002) has developed an acculturation scale to determine to what extent an Indigenous person has become acculturated within the dominant culture. Without having access to this scale, it is not possible to evaluate the extent to which it addresses the centrality of language in the understanding of culture. Burton (cited in Garvey 2007, p. 121) has commented that: '...Communication involves not just an understanding of language in terms of protocol, it requires a deeper understanding of how culture can affect the communication process.' Such a statement conveys the importance of culture as integral to an understanding of a person's style of communication, whilst simultaneously appearing to understate the role of language itself as the medium through which cultural differences may be understood. Hence culture has not only remained absent in much of psychological theorisation, but when included, it is often discussed in generalised terms. The following section discusses the importance not

only of embracing culture as a dimension which is integral the understanding of how psychological disorders may be manifested, but also highlights the pitfalls of using it in unreflexively and uncritically as if it were an objective 'independent variable'.

Situating Indigenous mental health issues within a critical cross-cultural Psychology framework.

Culture or cultural factors have either remained absent or have been regarded as peripheral to mainstream psychological concerns. Psychology has traditionally treated culture as a nuisance or confounding variable that needs to be controlled or reduced. Gonzales (2000, p. 306) warns that traditional approaches to cross-cultural Psychology similarly treat cultures as novel, external variables rather than seeing culture as constitutive of its epistemological and ideological basis. Similarly, Sam & Moreira (2002, p. 6) have observed that: '...Cross-cultural psychology has been quick to put on the white lab coat of the scientist as though it had forgotten about culture.' Traditional approaches within cross-cultural Psychology have tended to adopt *etic* approaches to research with the aim of discovering universal truths across different cultural groups. These approaches rest on an impoverished view of culture which do not facilitate an understanding of the nexus between psychopathology and culture as the medium through which meanings, values and interpretations of reality are constructed. As has been discussed, Sutton (2001) and Brady (1995) have both commented on the limitations of adhering to a naïve concept of culture. Sam & Moreira (2002, p.6) have also emphasised the need to develop a more sophisticated anthropological understanding of culture to allow for: '...a phenomenological focus of research that searches for the meaning of an experience as lived out by the subject.' Bracken & Thomas (2005, pp. 108-112) have qualified this further by specifying that what is necessary is to move beyond the 'phenomenological approach' that has been adopted by most contemporary Psychiatrists who have interpreted it as comprising: '...the precise description of psychopathology' (Mortimer 1992, p. 293 in Bracken & Thomas 2005, p. 108). Instead, they have argued that:

.....the hermeneutic turn taken by continental phenomenology in later decades offers a much richer grounding for psychological theory. In this, the role played by meaning and context in structuring human reality is no longer an 'inconvenience' but instead becomes the central focus (Bracken & Thomas 2005, p. 112).

The *individualist-collectivist* dimension forms an important part of cross-cultural psychological understandings of the relationship between culture and the individual (Andary, Stolk & Klimidis 2003, pp. 32-48). It is here that collectivistic and individualistic cultures may be contrasted to enable a greater understanding of the concept of self within a cross-cultural framework (Ryder, Yang & Heine 2002, p. 9). Much of Western Psychology has based its theorisation of psychopathology on a model of the self as a separate and autonomous entity which in turn causes behaviour. A healthy sense of self is therefore defined as one that is clearly separate from that of others and is able to maintain distinct boundaries within diverse social environments. This is the sense of self upon which individualistic cultures are based. On the other hand, collectivistic cultures such as Indigenous and many other Asian and Southern European cultures have a more fluid and permeable sense of self that is not as sharply individuated from the cultural group. These cultures place a greater importance on interconnectedness, the maintenance of good relationships, and consideration of the thoughts, emotions and behaviours of others (Ryder, Yang & Heine 2002, p. 9). Such theorisation can elucidate many of the differences in the manifestations of psychopathology across cultures. Ryder, Yang & Heine (2002, pp. 9-10) suggest that the collectivist cultural emphasis on subordinating the self to the needs of the group may explain why mental disorders that have become interpersonally disruptive are particularly stigmatised. It may also explain why depressed clients with a strong interdependent sense of self may tend to somatise their symptoms to a greater degree than those from an individualistic culture. Such a theory has been suggested by Ryder, Yang & Heine (2002, p. 10) as being able to explain possible differences in the degree of somatization between Chinese and American patients with a diagnosis of depression. It has also been postulated that collectivistic cultures do not conceptualise the mind and the body dualistically, but view mind and body as being an integral whole which is inseparable from social context. This is reflected by the lack of linguistic equivalents for the English words 'anxiety' and 'depression' in the Chinese language (Altarriba, Basnight & Canary 2003, pp. 4-5). Similarly, Andary, Stolk &

Klimidis (2003, p. 56) have illustrated that the English word 'sad', when translated in Pintupi, an Indigenous language, has multiple meanings that cannot be dissociated from the interpersonal context in which it is experienced. Hence, Cheung 1995, cited in Ryder, Yang & Heine (2002, pp. 9-10) suggests that: ...

...psychological, physical, and social factors combine to contribute to the Chinese sense of self as well as to the development of specific illnesses, and are viewed as being inseparable. This conceptualisation of self is often used as an underpinning for more focussed theories of East-West differences, including the independent and inter-dependent selves.

Such statements can be said to apply equally to Indigenous Australians and people of many other collectivistic cultures. This also provides an overview of the varied ways in which a cross-cultural theorisation may extend further insights into Indigenous mental health. Hence, a critical cross cultural theorisation provides greater scope in being able to understand how an individual's culture may have shaped their sense of self and their interrelatedness with others, and this forms the basis for an understanding of how individual psychopathology may be manifested emotionally and behaviourally both at an individual and a collective level. Such theorisation is at the basis of the development of a critical cross-cultural approach to psychological assessment and therapy with Indigenous Australians and is discussed in further detail in chapter seven.

CHAPTER 7:

General Summary, Conclusions and Implications.

Characteristics of a critical cross-cultural approach to psychological assessment and therapy (CCCAPAT), with a focus on the restoration of emotional well-being in Indigenous Australians.

From the foregoing, there emerge the main features of a coherent, flexible and dynamic approach to mental health assessment and therapy which represent refinements, extensions and an integration of the approaches and views of those authors reviewed in chapters two and three. The purpose of this chapter is to try and articulate the main components/ dimensions into an integrated, practical and coherent system. The characteristics of a critical cross-cultural approach to psychological assessment and therapy or CCCAPAT, for the sake of brevity, will be based on the following assumptions:

1. The fact of existential relational primacy as epistemological foundation (Atkinson 2002, 2007).
2. Ethics first, before, during, and after assessment and therapeutic activity (Garvey, 2007, 2008; Dudgeon, 2000; Foxcroft, 2002).
3. The intentional intersubjective dialogue mode rather than the objectifying/manipulative mode (Atkinson, 2002, 2007; Langton, 1993; Garvey, 2007, 2008; Dudgeon, 2000; Bracken & Thomas, 2005).
4. The narrative open-ended format rather than the finite 'single case experimental design' made explicit in the conventional 'scientist-practitioner' model of clinical psychology (John, 1998; Lerner, 2001; Garvey, 2007, 2008; Eley et al, 2006).
5. A complex-flexible-dynamic and 'connected-modular' view of the relationship between individuals and culture rather than a global-static-

deterministic view (Marsella, 2003; De Munck, 2001; Bell, 1991; Brady, 1995, 1997; Sutton, 2001, 2009).

6. The linguistic mediation of culture, interactions and identity (Foley, 1997; Deacon, 1997).
7. A dimensional, contextualised and historicized view of psychological distress rather than a DSM-type categorical classification (Andary, Stolk & Klimidis, 2003; Garvey, 2007, 2008; Dudgeon, 2000; Westerman, 2002, 2003, 2004).
8. The negotiated process of developing culturally appropriate therapeutic techniques and assessment instruments when necessary (Westerman, 2002, 2003, 2004; Vicary, 2000; Vicary & Andrews, 2000).
9. The related/ interconnected/ non-individualistic/ client-centred and client-driven evaluation approach which ultimately feeds back recurrently into the ethical and subsequently into the other dimensions of the approach.

Each of these aspects of the CCCAPAT emerge from the foregoing literature review with various degrees of directness and clarity, and they will not be referenced to the literature in this section. I will simply attempt to explain them, and to connect them as coherently as possible into a framework for Clinical Psychology practice with Indigenous Australians with a focus on recovery of social and emotional well-being. Some of these elements are not new and are already present in the work of some of the authors reviewed earlier. Nevertheless, the refinements, extensions and integrations of those aspects already present in other authors, together with their articulation into a hierarchical model, offers the possibility of making more explicit, flexible and manageable, the kind of work pioneered by Tracy Westerman (2002, 2003, 2004, 2007), and to allow it to be developed theoretically and practically as a more widely generalisable Critical Cross-Cultural model of assessment and intervention.

1) Relational Primacy: Human existence is as fundamentally and unavoidably relational as it is somatic. As true as it is that a human being exists as a body, is the fact that a human being is relational from the very beginning to the very end, and even after death. One's relational being is as real and fundamental to one's existence as one's physical or somatic existence. Stating this is not a theoretical statement, but a pre-theoretical fact. The reason it is important that this is stated, is that much of Western Psychology implicitly occults this fact and discusses human beings and human psychology as if they exist primarily as individuals. Taking on board the primacy of relational existence allows the Psychologist access to the theories and therapeutic methodologies that are largely rejected by conventional Western perspectives within Clinical Psychology as being too 'subjective' and not 'evidence-based', where evidence is meant in the restrictive sense of information obtained from artificially contrived experiments or statistically manipulated data. One of the consequences of relational primacy is that when a Psychologist is in the presence of a client, the situation is one of two human beings in the presence of each other, and from the beginning, involved in a relationship. It is this relationship that will constitute the substance of the therapeutic or assessment transaction. The biological reality of this relational primacy has been well explored in the psychological and medical literature with phenomena such as hypnosis and psychosomatics. The healing potential of psycho-social-cultural relatedness mentioned by Atkinson (2002, 2007) and Bell (1991) are anchored in this biological/ primary reality of relational existence.

2) Ethics first: The primacy of relational existence is a pre-theoretical epistemological fact, and, as such, it has no ethical implications *per se*. In a 'helping' relationship, there will be some 'rules of engagement', whether they are made explicit or not. A recognition that regularities (rules) will occur in any case and that these rules can be negotiated and agreed upon, is a cultural event. That these rules should reflect the recognition of mutual humanity and the mutual respect of dignity and basic human aspirations, is the introduction of a certain kind of ethical code, which is the condition for the possibility of a therapeutic rather than a coercive/ oppressive relationship. It is the mutual agreement that not only will the 'law of the jungle' not be our standard, but that we accept to be 'our brother's keeper', responsible for each other's well being. A critical approach to cross-cultural psychological practice requires these ethical rules to be explicit and transparent conceptually and temporally. This is

usually expressed as: 'Ethics First'. Ethics is the practical application of values, assumptions, attitudes and rules of conduct towards other beings, mostly humans but not only, and the environment. They define how one sees oneself, and one's intentional, forwardly projected identity. As such, they inevitably play an important part in one's relationships in general, and in particular, relationships with a 'therapeutic' intent. The Psychologist, by their training, is aware of their power of influence from the inception of the relationship, and must have a commitment to putting that influence at work towards the client's recovery of his/her social and emotional well-being. From the pre-cultural reality of existence as relational, we shift to the cultural level of agreed rules to the ethical level of agreeing on rules based on mutual respect. Therefore, the Psychologist must be conscious and explicit about his/her ethical values, assumptions and attitudes. They must be compatible with a valued and respectful view of the 'client' and must be transparent to the 'client'. They form one of the important conditions for the existence of trust in the relationship. It is legitimate for the Psychologist to speak about those to both the 'client' and to his/her familial and cultural 'guardians'. An open discussion of these are part of building a safe relational environment. These ethical precepts go beyond what is generally accepted as 'good professional ethics' for Psychologists, where a 'professional distance and objectivity' and the absence of personal disclosure are the cardinal rules of the 'Scientist-Practitioner' model. Psychologists who are uncomfortable with the disclosure and openness about values, attitudes and assumptions, may not be ready to undertake critical cross-cultural work, and will need to consider appropriate preparation.

3) *The intentional, collaborative and intersubjective dialogue mode:* The intentional, collaborative and intersubjective dialogue mode stands in juxtaposition to the objectifying/manipulative/instrumental mode of conducting the therapeutic (including assessment) interaction flows from the previous steps. Section eight will demonstrate that various instruments and 'techniques' are not excluded a priori, but that they are subjected and subordinated to the preceding steps in that they are negotiated, and possibly designed collaboratively, as shown in step nine, and their effectiveness evaluated in the context of the overall interaction. This conceptualisation of the therapeutic (including assessment) endeavour, as a collaborative exercise is not always excluded in some of the 'evidence-based' approaches sanctioned by the

‘Scientist-Practitioner’ model, but they are usually justified as methods to ensure compliance with ‘homework’ or other aspect of ‘proper adherence’ to the prescribed methods. In a CCCAPAT, the Psychologist and the client share in open honesty a common endeavour, a common journey, trying together to find the way back to social and emotional well-being. This is done in an open narrative format rather than setting up a pseudo-quasi-experimentally controlled ‘single case experimental design’ where the terms imply a manipulated situation, often far less rigorous than what is implied. The relationship is in fact much closer to what is thought of in Western terms as a friendship between two people with complementary knowledge, rather than the relationship between an expert and a compliant ‘client’, as stipulated within the ‘Scientist-Practitioner’ model.

4) *The narrative, open-ended format:* A narratively articulated process does not have as its primary focus symptom reduction or elimination. The narrative format is the earliest and traditionally the universal format of shared human knowledge and wisdom. Extensive use and development of the narrative format of the therapeutic interaction was also a feature of the work of Michael White (1989) at the Dulwich Centre, in Adelaide. The narrative format is not a therapeutic technique, but a flexible, discursive and open-ended format for the ongoing interaction between the ‘therapist’ and the client which enables the client to develop, or change the way their life story makes sense. The therapist does not position themselves as the ‘all-knowing expert’ but acts as a guide or facilitator to enable the client to re-relate or reframe the events in their lives in the context of new and different meanings which can be transformative or liberating. The narrative approach is nested in the view that human action takes place in a reality of understanding that is created through social construction and dialogue. The narrative position leans on the premise that human systems are language generating and meaning generating systems (White, 1989). It is a general way in which the client can shape their identity, as an unfolding story, ‘accompanied’ by a supportive therapist and others of positive significance to them, who acts as a ‘wise and caring conversation partner’. This approach signifies a shift away from the traditional therapist-client separation. Client and therapist are instead viewed as being together in a system that continually evolves over the course of the therapeutic conversation. From this perspective, client and therapist are seen as mutually affecting each other’s meaning and are dependent on the moment-to-

moment creation of understandings that are generated from their conversation and this continues to change over time (White, 1989). It allows, at relevant points, the introduction of specific techniques to deal with specific issues or symptoms, which will be mentioned below, under section eight. The narrative format flows naturally from the intersubjective dialogical mode of the interaction described above and easily accommodates the flexible, complex/modular and dynamic relationship between the individual and their cultural influences as described in the next section.

5) *Individuals and culture*: A flexible and dynamic understanding of the relationship between a person and culture based on a view of culture that is not monolithic or exclusive, but understood as a semi-closed internally articulated ensemble of beliefs, attitudes, feelings and behaviours around important life domains and issues (kinship, food, property, birth and death, stages of life, authority and respect etc). Culture is in fact, a complex of cognitions with associated values, beliefs, behaviours and feelings around important life-defining issues (relationships, kinship, property, birth, death, belonging, food, etc.) which De Munck (2001) labels 'culture models'. The impact of culture on the individual happens at the symbolic level, around each issue; that is, environmental elements, individual and collective behaviours are interpreted to 'make sense', and culture offers a code for deciphering them. Culture therefore, is not a unitary, fixed and impermeable entity. It is in fact exactly the opposite, particularly for those who are living in a minority culture. Members of minority cultures, such as are now Indigenous Australians and those of non-English speaking background (NESB) groups in Australia, are inevitably confronted with the relativity of their own culture, and forced to question it explicitly or implicitly, issue by issue, and negotiate a 'cultural migration' for themselves, with various degrees of 'success'. Because the Australian reality is such that people will inevitably be confronted with more than one culture, both Indigenous and non-Indigenous Australians will be confronted with several cultures, or at least two: the dominant Anglo-Australian and their own culture of origin, and more likely than not, the culture of several other ethnic minorities, other Indigenous groups, and various sub-cultures of any of those. Multiculturalism therefore is not an ideology, but a psycho-social reality. As such, the Indigenous 'client', as well as the Psychologist, Indigenous or otherwise, are under the influence of several cultures. Consciously or not, they will borrow and use elements of both cultures, depending on circumstances, environments, interlocutors, emotional states,

issues etc. They may, for example, use the cultural 'module' of one culture regarding a certain issue in one circumstance, and another one in a different circumstance. An awareness, on the part of the Psychologist that an Indigenous person is not entirely 'determined' by his/her culture, but can have variable access and response to cultural beliefs, attitudes, feelings and behaviours around particular issues depending on circumstances and emotional states. If s/he feels vulnerable, s/he may be more likely to either conform to the prevailing culture that they are in at the time, or conversely s/he may draw on the cultural models of their childhood in a state of emotional regression. In brief, a more complex but flexible and dynamic view of the relationship of the person and culture will afford more resources to the assessment and therapeutic processes, and for the 'client' to negotiate and integrate the various cultural aspects of their identity. This recognition of the complexity, flexibility and dynamism of the relationship of a person to culture also affords much greater common ground between the Psychologist, and the 'client', and the recognition of this revealed common ground enriches and strengthens trust and the 'therapeutic relationship'.

6) *Language*: A process that takes in account the importance of language and the different levels at which it works, rather than one where language is present (inevitably) but taken uncritically as a given is required, using the full array of linguistic resources available to the Psychologist and client(s) to navigate and be able to carry cultural and subjective meaning. Whether the relationship is explicitly conducted in English, or whether the Indigenous client's first and best language is or is not English, the communication characteristics of the client's English will be different from the standard English which is likely to be the vernacular of the Psychologist. If the client's first and best language is not English, and if the Psychologist is not fluent in the client's language, then a significant barrier will exist and persist, which an interpreter, even if available, experienced and formally trained, will overcome only very partially. Language is the human tool for symbolic transactions and the articulation of cultural models (Deacon, 1997). Language and culture cannot be dissociated, and a language carries the conceptual structure and symbolic content of the culture which uses it: '...Culture is not like a coat that can be taken off and discarded' (Andary, Stolk & Klimidis 2003, p. 26). Learning any language, and therefore learning the language of the majority culture, is to import its cultural constructs, and to try and accommodate them alongside one's already existing

system of representation of the world and its meanings (De Munck, 2001). To access a person's culture without using that person's language is very difficult and always limited. To speak in a patient's first or best language is to meet them on their own linguistic/ cultural home-ground; it enables them to feel safer and makes it easier to begin the process of reconciliation between cultural models, moving towards adaptive biculturalism. While the ideal situation where the Psychologist is fluent in the Indigenous client's first and/or best language will be rare, it is important that the Psychologist be fully educated in the role and power of language. It is also important that the issue of communication difficulties be discussed openly and that, through the discussions, the client remains confident that communication difficulties are not a reflection of a deficit on their part, but a shared difficulty to be overcome according to the resources and capacities of both parties. Often Psychiatrists or Psychologists will enter in their reports: "... the patient could not be assessed because she spoke very little English", rather than: "...I could not competently assess this patient because I do not speak her language and could not access an interpreter," which would be equally true and fairer, given that the professional had more power to overcome the difficulty than the patient. Language also carries messages of status and education, and is used for deception and oppression as much as it is for communication and relating authentically. Language can be a powerful therapeutic tool, in a skilled and well intentioned person, however. It is beyond the scope of this thesis to explore this area, beyond stating that a Psychologist aiming to work effectively with socially and emotionally distressed Indigenous Australians needs to address the issue of the client's language and the implications for the therapeutically intended relationship.

7) *Mental disorders as dimensions*: A dimensional, socially contextualised and historicized view of psychological distress rather than a DSM-type categorical classification. A dimensional conceptualisation of emotional and social well-being and mental 'illness' has been shown to better accommodate the phenomenology of 'mental illness' than the DSM categorical classification. It has also been convincingly argued that the survival of the DSM classification series is essentially the result of the alliance, due to convergent interests, of the pharmaceutical industry and the corporatist interests of the psychiatric profession. Bentall's (2003, 2006) articulation of this position is currently the best documented paradigm. It allows a degree of

‘depathologizing’ of the experience of emotional and social distress, a discrete examination of the dimensions of the experience (cognitive, affective, behavioural) along a continuum from low to extreme or normal to abnormal. A dimensional conceptualisation of mental illness also makes it easier to integrate the historical, social and economic factors into the aetiology and provide the client with a flexible and dynamic vocabulary to define, situate and identify himself or herself in that perspective by developing a personal narrative position, with possibilities for action. Obviously, at this level, the Psychologist should be aware the continued impact of colonisation as a lived reality for many Indigenous people and of the history of racism in the theorization of Psychology, as has been outlined in brief in chapter three.

8) *Techniques*: The negotiated process of developing culturally appropriate therapeutic techniques and assessment instruments when necessary. Using flexibly the cultural evaluation and therapeutic resources available to the client, whether material, social or spiritual. This includes traditional healing practices and access to traditional healers or supports, as articulated by Vicary and Westerman (2004). Using flexibly the assessment and therapeutic instruments to potentiate the relational encounter, in a manner that is natural, relevant, when the ‘client’ is in a position of equal power in deciding on their use, fully informed, genuinely consenting, feels and understands the usefulness and potential benefits of doing so. There is, in addition, a fast growing literature on cross-cultural assessment available to the Psychologist for consultation.

9) *Evaluation*: The related/ interconnected/ non-individualistic client-driven evaluation approach which ultimately feeds back recurrently into the ethical and subsequently into the other dimensions of the approach. The involvement of clients and communities in the evaluation of interventions and programs aimed at helping them is becoming the norm (Bracken & Thomas, 2005). Again, it is beyond the scope of this thesis to review the extensive relevant evaluation literature. The principles and approaches outlined above will obviously provide the conditions for evaluation, which will be ongoing, recursive and will have face validity as well as contextual validity.

Summary and conclusions

While the above dimensions reflect a logical hierarchy, this model hopefully offers a reasonably coherent ensemble of assumptions. In summary, these are as follows: relational primacy; principles (Ethics first); a mode of relationship (intersubjective dialogue); a format of information integration (narrative); an articulated 'modular' view of the relationship between individuals and culture; an emphasis on paying attention to the symbolic/ linguistic dimension of culture and human interaction (the many levels and functions of language); a model of social-emotional well-being (dimensional, socially and historically contextualized), all of the foregoing enabling a meaningful negotiation of specific approaches, techniques and assessments, and a client-centred and driven, but contextualized, evaluation process. It clearly moves from higher-order considerations to operational levels, feeding back into the higher order principles.

One of the main contributions that Westerman (2002, 2003, 2004, 2007) has made toward an enhanced understanding of Indigenous mental health is the development of assessment taxonomies and tools for the assessment of depression and anxiety. By couching her theorisation within Western frameworks, it could be argued that Westerman (2002, 2003, 2004, 2007) has legitimised the Indigenous voice using currently accepted methodologies for understanding mental health. Westerman (2002, 2003, 2004, 2007) has certainly tested the limits of the dominant position, but continues to be held captive to it, and therefore appears unable to develop a more integrated theorisation that is based on Indigenous knowledges and interdisciplinary methodologies. The privileging of Western methodologies within Psychology has been instrumental in marginalising Indigenous and more generally, cross-cultural contributions to an understanding of mental health (Garvey, 2007, 2008). This has no doubt contributed to Westerman's (2002, 2003, 2004, 2007) dichotomous understanding of the need to acquire both 'clinical' and 'cultural' competencies in the delivery of an effective service to Indigenous people. When this ethnocentric perspective becomes destabilised so that culture becomes central, if not constitutive of the psychological endeavour and concern, this dichotomy is rendered non-sensical. A decoupling of this false binary is made possible with the realisation that cultural

competence is integral to clinical competence and that is it is not possible to be clinically competent without being culturally competent.

The development of a model that is couched within a clinical cross cultural psychology framework affords the flexibility to enable a practitioner to work with an individual without divorcing them from the contextual domains of which they are a part. An understanding of the history and impact of colonisation as a continually lived reality for many Indigenous people can assist a therapist to contextualise the difficulties that a client may be presenting with. For example, it has been suggested that 'affective disorders' or aspects of 'emotional and social well-being' may be understood collectively as the aftermath of trans-generational trauma, fragmented identity and dispossession rather than as individual psychopathology (Westerman, 2002; Dudgeon, 2000). Atkinson (2007) has suggested that healing can begin when a person is able to recognise how these factors have impacted on them both as an individual and within the wider context of their family and community. Anthropological theorisations of culture have debunked the notion that a person's degree of socialisation within their culture of origin is necessarily positively correlated with healthy functioning. Sutton (2001, 2009) and Brady (1995) have emphasized the need to suspend the assumption that persons with a higher degree of identification with traditional or classical Indigenous cultures are more likely to remain impervious to the adverse impact of colonisation. Crucially, Sutton (2001, 2009) and Brady (1995) have emphasized the need for a more sophisticated understanding of culture that is informed by evidence from the lived experiences of Indigenous people of varying degrees of acculturation within mainstream society. A flexible and dynamic theorisation of culture can be found within critical cross-cultural anthropological and psychological literature which has paved the way for a greater understanding of the nexus between culture and psychopathology (Marsella, 2003; De Munck, 2001; Bell, 1991; Brady, 1995, 1997; Sutton, 2001, 2009; Tanaka-Matsumi & Chang, 2002; Ryder, Yang & Heini, 2002; Sam & Moreira, 2002).

A critical cross cultural theorisation of psychological disorders provides the philosophical and conceptual basis upon which the model for psychological assessment and therapy (CCCAPAT) with Indigenous Australians has been developed. It acknowledges the need for a greater understanding of the relationship

between an individual and the language and culture within which they have been socialised as critical to enabling an understanding of individual psychopathology. It adopts a narrative approach to therapy which positions the therapist not as dominating the client with expert psychological knowledge, but views their task as an attempt to understand the client from the changing perspective of the client's life experience (White, 1989). It sees therapy as a dialogue between client and therapist that is guided by the process of therapy rather than to the content (diagnosis) and change (treatment) of the presenting disorder or pathological structure as a result of a pre-determined theory or prior knowledge base (White, 1989; Bracken & Thomas, 2005; Bentall, 2003, 2006).

The above model is proposed as an additional resource and as a framework that can incorporate current good-practice models. It is hoped that it can accommodate greater complexity and add flexibility to the overwhelming challenge of providing appropriate, realistic and healing resolutions of social and emotional distress amongst people of Indigenous Australian origin, and to better equip a Psychologist to achieve this end in a relationship of genuine equal partnership.

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