Treating Depression:
Towards an Indigenous Psychotherapy

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Carol Anne MOYLAN BA, Grad Dip Psych

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Abstract

There is a gap in the practice of psychotherapy that becomes clearly evident to non-Aboriginal psychologists who find themselves in the position of having to provide treatment to Aboriginal clients who present with the symptoms of depression. This is of particular importance given the increase in the incidence of depression both nationally and internationally. The problem stems from the reality that there is very little available by way of psychotherapeutic interventions that are culturally suitable in the treatment of Aboriginal clients who present with the symptoms of a depressed mood. A description of depression is given, and current psychotherapies outlined. At the same time, Aboriginal voices that explain Aboriginal culture and the expression of mental health is recognised and discussed. This study acknowledges these two culturally different systems: western psychological knowledge which often reflects individualistic, materialistic and secular philosophical underpinnings; and Australian Aboriginal knowledge which is mostly grounded in a philosophy that is communal, spiritual and ecological.

This study aims to play a role in the continuation of the development of an Aboriginal psychological intervention that may be implemented by non-Aboriginal psychologists and that makes a contribution toward filling the present gap in psychotherapy. To achieve this aim this study recognises that Aboriginal people around Australia are the custodians of the knowledge relating to Aboriginal psychology and, as such, provide the voices that express their own philosophy and culture. This study accepts the invitation to learn from Aboriginal people and the site chosen to learn from is North Queensland.

The limitations of western psychotherapy in non-western and multicultural settings are illuminated and current literature confirms that philosophy and culture are determinants not only of human behaviour but also of psychotherapy. Contemporary western psychotherapies and their theoretical and philosophical underpinnings are revisited so that expression may be given to the salience of the manner in which western philosophy and culture permeates western psychotherapy. By doing this, the gaze then moves toward considering the ways in which mainstream western psychotherapy has tried, in the past, to develop culturally appropriate treatments by indigenising psychotherapy. It also acknowledges the implications for the therapeutic relationship. Subsequently, good reason is given for acknowledging that other cultures have always had their own forms of psychotherapies. This opens the portals to learn and listen to Aboriginal articulations about their worldviews and culture. By doing so, justification is given to the hypothesis of this study that Aboriginal psychology is determined by its own philosophy and culture and this, by definition, determines a culturally appropriate psychotherapy. This leads to the research question which asks Aboriginal people what it is that they do to help someone who is suffering from depression.

The data for this study was gathered over a two-year period (January 2002 – December 2003) in North Queensland. Interviews were conducted with Aboriginal Australians employed at an urban Community Controlled Health Service, Aboriginal academics, Aboriginal people from a North Queensland urban community and elders from that same North Queensland urban community. Because there are no Aboriginal psychologists in North Queensland, an Aboriginal psychologist from another part of

Northern Australia was interviewed. On the advice of local Aboriginal consultants, a well-regarded non-Indigenous psychiatrist who has worked for many years with Aboriginal people in North Queensland was also interviewed. Indigenous research paradigms are discussed and a qualitative research design is implemented. The author used a 'free association' narrative and interview methodology and interpretive analysis to analyse the transcripts. Justification is given with regard to how data was gathered for this study and methodological issues are reviewed.

The findings indicate that there is an Aboriginal psychology. It is grounded in a theory of connectedness and relatedness to all things. Through the voices of the research participants, recognition is given to Aboriginal philosophical thought and cultural worldviews. Aboriginal voices explain the importance of connectedness and relatedness to all things in their ways of healing. These findings offer a theoretical underpinning for the development of an Aboriginal psychotherapy that is available to non-Indigenous psychologists who treat Aboriginal clients. Examples of ways of applying a psychotherapeutic intervention within an Aboriginal paradigm are given.

Findings also indicate the importance of resolving the tensions arising from the unconscious defence mechanisms brought to this encounter between Aboriginal participants and the non-Aboriginal psychologist, all of whom are viewed as psychosocial subjects. The concept of the 'contact zone' is applied to address these tensions within the asymmetrical power in this relationship that stems from a shared history of colonisation which places the non-Indigenous psychologist in the position of coloniser and the Aboriginal participant in the position of the colonised.

Conclusions drawn from these findings support the need to transform both psychotherapy and the non-Aboriginal psychologist. Firstly, it builds on the works in progress, both here in Australia and overseas, in that it responds to the need to rewrite psychotherapy so that it is both inclusive of, and reflective of, a framework that is grounded in Aboriginal philosophy, history and culture; and secondly, it responds to the need to retrain non-Aboriginal psychologists who are working with Aboriginal clients. In responding to these needs, non-Aboriginal psychologists are provided with greater confidence in making a contribution toward filling the present gap in psychotherapy. It offers the non-Indigenous psychologist a culturally appropriate treatment for depression with improved sensitivity, respect, confidence and efficacy when working with an Aboriginal clientele.

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Aboriginal and Torres Strait Islander people are advised that this document contains the transcribed voices of people who have passed away.

Preamble

In 1995, I attended a congress held by the North American Society of Hypnosis in Banff Alberta Canada where I was introduced to the world of Indigenous culture and traditional ways of healing. The keynote address was given by Armand Huet De Grenier, a well-known North American shaman. The theme of his address was the role of hypnotic trance in ritual and healing.

The assembly of approximately one hundred and twenty people, consisting of professionals from the fields of psychology, psychiatry, general medical practice and dentistry, was mesmerised as this unassuming speaker started proceedings in what I now know to be a traditional ‘yarning’ kind of way by asking us where we were all from. He then acknowledged our ancestors and welcomed us to his country. This shaman then went on to ‘yarn’ about the manner in which traditional people engaged in hypnotic trance as a part of their ritual and healing practices. In order to actually experience this process of healing, the shaman issued us with an invitation to attend an impromptu workshop that would demonstrate our ability to heal through our connectedness to nature by meeting with our ‘power animal’ or totem through hypnotic trance - like journeying. It all seemed at bit ‘new agey’ to me, but as everyone else was going along, I decided to accept the invitation to embark on that journey. As it turned out, the experience of the journey came to be a watershed moment in both my personal and professional life as it provided me with an understanding of the relatedness and the inter-connectedness of all things. Since that time, I have steadily pursued that journey into traditional ways of healing by attending further

congresses, conferences and workshops, both locally and overseas, focusing on the role of trance in ritual and traditional Indigenous healing practices.

Over time, I have gradually integrated some of the techniques that I have been learning into the therapeutic repertoire of my private practice as a psychologist. I did this because I noticed that, in my day-to-day work, many people mentioned feelings of disconnection, isolation and dispiritedness. Mainstream training and techniques alone did not always bring about complete recovery and the integration of techniques that were based upon the relatedness of all things seemed to bring relief to some people who were anxious and depressed. At the same time, I observed a general interest in the community in healing processes that come from traditional Indigenous cultures. I noticed the proliferation of new age workshops of various sorts that promised, for example, meetings with one's 'spirit-guide' so that one may live life free of anxiety or depression. I also became increasingly aware that such workshops were unregulated and, as such, were often conducted with seemingly little regard to any theoretical underpinning or respect for the origins of such knowledge.

In order to enable me to learn more about Indigenous culture, I handed over my private practice to another psychologist in December 2001 and enrolled as a post graduate student on a full-time basis at the School of Indigenous Australian Studies at James Cook University in Townsville. I chose to enrol at the School of Indigenous Australian Studies with the expectation that staff would mentor me and that I would study under the guidance of those who are Aboriginal; who understood Indigenous culture, knowledge, ethics, sensitivities and protocols. I also consulted as a psychologist at the Townsville Aboriginal and Islanders Health Service from February 2002 to December 2003.

At a deeper level of consciousness, I found myself engaging in a family history search to do with my mother who was a Queenslander. As well as being on a journey of professional development, I was also on a journey of personal growth and understanding. I had come to North Queensland in the hope of understanding my mother better and, by extension, to understand myself even further. Being located in this part of Queensland also provided me with the opportunity to engage for the first time with members of my extended family, many of whom are Aboriginal Australians.

As I now reflect on these events and the experiences that have shaped my thoughts and actions, I recognise the similarities between my journey and the journey of Santiago, the Andalusian shepherd boy from the Paulo Coelho (1993) novel 'The Alchemist'. "To realize one's Personal Legend is a person's only real obligation. All things are one. And when you want something, all the universe conspires in helping you to achieve it" (Coelho, 1993, p.22).

Chapter One

The Gap in Psychotherapy

1.1 An invitation to learn

> Aboriginal and Torres Strait Islander people are of the Land and Sea. We fit into it, we are shaped by it. Our teaching comes from the Earth itself, by knowing the Mangrove, how deep its story, or the Eucalypt tree, where does it go down to, what level. Knowing the earth is the centre of our wisdom. Among us there have been no written laws; our traditions are passed down through the spoken word from one generation to the next. Unity, not division, sharing rather than hoarding is our way. So now, we write to you in your language with our timeless wisdom. Learn from us, as we have had to learn from you. (Mandawuy Yunupingu, cited in McConchie, 2003, p. vi)

Taking up a position as a psychologist and as a member of the Social Health Unit at the Townsville Aboriginal and Islanders Health Service led me to the awareness of the gaps in my knowledge and skills and, ultimately, to the gaps in psychotherapy. This study is an investigation into that particular gap in psychological knowledge. This gap becomes palpably evident to psychologists when treating Aboriginal Australians who suffer from depression because Aboriginal ontology, epistemology, philosophy and worldviews are noticeably absent from the general texts and training given to non-Indigenous psychologists.

In the pages that follow of this introductory chapter, I will outline how this gap in psychotherapy is a problem and why the problem is worth investigating. I will also give an explanation and definition of the mental illness known as depression. I will then describe counselling and psychotherapy and how these interventions are applicable in the treatment of depression. Attention is given to the fact that western psychological knowledge is at variance with Aboriginal psychological knowledge. This leads to the explanation of the aim and the scope of this study. I will then give an overview of the structure of this thesis that is contained in the subsequent chapters.

1.2 The problem

The main problem for psychologists treating Aboriginal clients who indicate symptoms of depression arises at the 'coal-face' of psychological practice where, as Vicary (2000) confirms, there are very few culturally appropriate psychotherapeutic treatments or interventions available to non-Indigenous psychologists. "Past approaches to understanding and treating mental health needs of Aboriginal Australians has largely been through the application of generic (westernised) conceptualisations of health and well-being" (Vicary & Andrews, 2000 cited in Westerman, 2003, p. 42). Westerman states that, "[o]ften such frameworks are inappropriate, primarily because they fail to recognise that both culture and spirituality have strong roles to play in the development and maintenance of mental health in Aboriginal people" (2003, p.42).

When placed in this situation, psychologists are faced with few options. One option taken by many psychologists is to simply leave the field. When I told some

other psychologists that I had started to practice at the *Community Controlled Health Service* (CCHS) in Townsville, I was issued dire warnings such as 'do you know what you are getting yourself into? Working with Indigenous people is 'fraught'!' (JC18, personal communication, 1 March 2003). (So that the privacy of participants is assured, interviews, diary notes, personal conversations, field notes and observations are coded and listed in Appendix A.) Another option, taken by some psychologists who do not wish to leave the field, is to assume a universalist approach and apply mainstream western techniques in the belief that psychotherapy is common to all people, but make comments such as 'what else can I do but apply what I know and what I have been trained in. There is nothing else available' (JC19, personal communication, 7 March 2003). Speaking at the 38th Annual Conference of the *Australian Psychological Society* (APS), Vicary (2003) commented that formal professional training that would equip non-Indigenous psychologists with the skills to deliver culturally appropriate therapy is exceedingly limited. Other psychologists, who I met in North Queensland, mentioned in conversation that they often modified mainstream psychotherapeutic interventions when working with Aboriginal clients with varied results and one psychologist commented that she sometimes used techniques she had learned from the North American First Nations people (JC20, personal communication, 17 June 2003). Based on these conversations, such well-intentioned but fragmented psychological interventions confirm the comments made by Misra and Gergen who note that "using a concept from an alien culture does not fit congenially into the Whole [gestalt] and results in a patchwork psychology with little or no meaning and much confusion" (1993, p. 235). These communications with psychologists in North Queensland corroborate the observations made by Waldegrave and Tamasese who also report that there is "an emerging consciousness

of the inadequacy of social science models that grow out of ideas from one culture being applied to another" (1993, p. 30). This supports the notion that it is not sufficient to simply modify or superimpose a mainstream model of practice over an Aboriginal model of practice.

The following personal journal entry is an example of the type of dilemma that emerges for psychologists who are treating Aboriginal clients who indicate the symptoms of depression:

> Grief and loss is ever-present when working with Aboriginal clients. A common presentation shows clients indicating symptoms of anxiety and depression. Clients often report the presence of the spirit of the deceased person. They request help in getting the spirit presence to *move along because it is time to go* so that the cycle of grief can be completed. (Personal journal entry, 16 April 2003)

The treating psychologist is confronted with the quandary of what would constitute an effective and suitable treatment plan. Sanson and Dudgeon (2000), along with Vicary (2000), remark that psychologists who are treating Aboriginal clients are faced with the scarcity of formalised knowledge and therapeutic interventions that are culturally appropriate and that also recognise the worldview of Aboriginal Australians. Vicary (2003) adds further confirmation to this gap in his comment that "there are few studies available to the mental health professional that provide a detailed and practical insight into the Aboriginal world view, in particular,

the beliefs held which pertain to psychotherapy, mental health and non-Aboriginal counsellors/therapists" (p. 287).

Further examination regarding this problem shows that most psychotherapeutic interventions are underpinned, in a theoretical sense, by western philosophical values. These values are mostly secular, individualistic and materialistic (Howard, 2000; Sampson, 1988; Tacey, 2000; Vicary, 2003). In contrast, Aboriginal Australian knowledge and values are underpinned by philosophical values that are communal, spiritual, inter-related, consensual and ecological (Cowan, 1992; Martin, 2003; McConchie, 2003; Vicary, 2003).

In discerning this contrast, Sampson (1988) proposes a framework for the understanding of Indigenous psychologies of individualism (see Table 1.1). Drawing on evidence from cross cultural, historical and intra-cultural sources, Sampson describes this contrast as *self-contained individualism* that is characterised by the "combination of firmly drawn self-other boundaries and an emphasis on personal control" (p. 16) as the western sense of *self-other*, that is distinct from "ensembled individualism" (p. 16) which is characterised by "more fluidly drawn self-non-self boundaries and field control" (1988, p. 16) as demonstrated in communal cultures, for example, the Aboriginal sense of self-other.

Table 1.1 Sampson's two indigenous psychologies of individualism

	TYPE 1 Self-Contained Individualism	TYPE 2 Ensembled Individualism
Self-Other Boundary	Firm	Fluid
Control	Personal	Field
Conception of Person/Self	Excluding	Including

Self-contained individualism most commonly underpins the western psychology; whereas ensembled individualism is generally grounded in communal psychology. Following Sampson's lead, we can see that psychologists who are trained in the western ego-centric theories are poorly prepared to apprehend the socio-centric theories that are found in the ensembled individualism of communal cultures. Ultimately, these contrasting values present a dilemma for the psychologist when faced with selecting an effective psychotherapeutic intervention for Aboriginal clients.

As a psychologist working as a member of the Social, Emotional and Health Unit within a *Community Controlled Health Service* (CCHS), I came to learn through the urgings and reminders of the Aboriginal cultural consultants, with whom I worked and studied, that for Aboriginal people good health is a many faceted concept and was counselled, "for our people here at this service, good health is about the social, emotional and cultural well being of individuals and the whole community" (CC1; CC2; CC3 & CC4, Personal communication, 26 June 2002).

Rather than good health merely being the absence of disease or illness, for Aboriginal people good health is defined as biopsychosocial, spiritual and environmental health (Dudgeon, Garvey & Pickett, 2000a). Furthermore, a sense of family, community and country is vital to a sense of self and this, in turn, is a major factor in maintaining good health. Clearly, treatment plans based on individualistic therapeutic interventions, such as psychoanalysis or cognitive behavioural therapy, alone would not be helpful in the process of restoring mental health when treating Aboriginal clients.

Other psychologists, for example, Vicary (2003) and Westerman (2003) also give emphasis to the problem of finding appropriate treatment by articulating that Aboriginal conceptualisations of mental health appear more holistic and contain elements that are both cultural and spiritual. Consequently, the standard western model of mental health that is grounded in the individualistic approach of North American, British and European psychology is often at odds with the values of Aboriginal Australian clients.

This calls for psychologists to acknowledge the discrete concept of mental health defined by Aboriginal people. One such definition, offered by Swan and Raphael (1995) in their *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*, states:

> Health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community. This

is a whole of life view and includes the cyclical concept of life-death-life. (p. 14)

Others, for example, Eckermann, Dowd, Martin, Nixon, Gray and Chong (1992) emphasise that “health to Aboriginal people is a multi-dimensional concept that embraces all aspects of living and stresses the importance of survival in harmony with the environment” (p. 174). Adding to this discussion, Knudtson and Suzuki (1992) put the view that different approaches to mental health and wellbeing that emerge show psychology which is scientific and psychology which is traditional. These are two valid cultures with valid ways of treating psychologically; one that is grounded in western scientific positivism and is evidence based whilst the other being holistic and traditional. Levi-Strauss (1966) highlights the two different approaches which stem from the dichotomy of scientific western thinking and traditional Aboriginal thinking with the belief that the physical world is approached from opposite ends in the two cases, “one [western] is supremely concrete, the other [traditional] supremely abstract; one proceeds from the angle of sensible qualities and the other from that of formal properties” (p. 269).

It is these different ways of interpreting the world that impinge on the day-to-day practise of psychologists treating Aboriginal Australian clients. These two ways of interpreting the world become operationalised when a western trained non-Indigenous psychologist, such as myself, comes to work at an Aboriginal Health Service. It is at this point that the call to provide culturally appropriate treatments offers an important challenge for psychology and non-Indigenous psychologists.

1.3 The significance of the research problem

The *beyondblue* national initiative on raising the awareness of depression shows that, while the significance of undiagnosed and untreated depression is slowly being recognised at a local (Australian) level, other organisations indicate it is also being recognised on a global scale. The report on the *National action plan for depression* (NAPD) (Commonwealth Department of Health and Aged Care (DoHAC), 2000a) and the *National health priority areas* (NHPA) report (Commonwealth Department of Health and Aged Care (DoHAC), 1998) cite the dire predictions made by both the World Bank and the World Health Organization. These organisations have forecast major increases in the rates of depression in the coming years for both first world and developing countries. Symptoms of depression and mood disorders often share co-morbidity with anxiety and with physical illnesses. In addition to the human suffering caused by depression, depression is also an economic burden that is likely to see the cost of health care, shouldered by the individual, communities and governments, soaring. The NHPA summary report, focusing on depression, comments “mental health disorders are estimated to be the fourth most expensive disease group, after digestive system diseases, circulatory disorders and musculoskeletal problems” (1998, p. 7).

Symptoms of depression and mood disorders generally respond to psychological treatment and health promotion. In fact, awareness campaigns highlighting the symptoms of depression can assist in the prevention of the illness of depression. It is also likely to bring about early intervention, thereby boosting the individual’s chances of a full recovery. As part of the national promotion and prevention strategy, the Section of the Mental Health and Special Programs Branch

of the Department of Health and Aged Care (Commonwealth Department of Health and Aged Care (DoHAC), 2000b) has already signed an agreement "to improve the health of Aboriginal and Torres Strait Islander peoples. Health Framework agreements are between the Commonwealth Government, State and Territory Governments, the Aboriginal and Torres Strait Islander Commission and the Aboriginal community controlled health sector" (p. 34). This agreement commits the signatories, in part, to "developing the infrastructure and resources to achieve comprehensive and effective primary health care for Aboriginal and Torres Strait Islander peoples" (p. 34). Included in this agreement is the responsibility for the development of "national programs and policies for addressing Aboriginal and Torres Strait Islander peoples' social and emotional health and well being" (2000b, p. 34). The flow of funding for this purpose stems from the Office for Aboriginal and Torres Strait Islander Health (OATSIH), part of DoHAC. Under the new *Shared Responsibility Agreements,* Indigenous Coordination Centres (ICC) were established and replaced the Aboriginal and Torres Strait Islander Commission (ATSIC) on 1 July 2005. The specific purpose of the ICC is to co-ordinate the Australian Government program funding and services to local Indigenous people. Funding to the ICC comes from the Commonwealth Department of Families, Community Services and Indigenous Affairs. Given knowledge of the funding resources, I now consider the mental illness known as depression.

1.4 What is depression?

In talking with the cultural consultants mentoring me at TAIHS about a tragic episode of undiagnosed and untreated depression, I have come to know that

> the young mother concerned had been feeling *down* and wanted to return with her children to her hometown out West, to be with her family. However, before the bus fares could be arranged for the following day, the young mother fatally injured her three young children and was consequently admitted to the high security psychiatric ward at Townsville General Hospital. (CC1; CC3, 18 November 2003)

Depression is an insidious illness and, as this tragedy indicates, its symptoms often go unrecognised with sometimes dramatic and often terrible consequences. Tacey (2000) writes:

> I think many people feel that we are running on empty, our spiritual fuel gauge having registered 'low' for a long time. Warning signals are evident in all walks of life: depression is now so prevalent that one in five Australians suffers acute or chronic or undiagnosed depression. (pp. 45-46)

A psychiatrist and clinical advisor to *beyondblue: the national depression initiative*, states on *beyondblue's* web site that "depression is currently Australia's most debilitating illness, with combined mental disorders accounting for 60% of all disability costs in people aged 15 to 34 years" (beyondblue, 2003).

My own observations as a practising psychologist, along with the comment from *beyondblue: the national depression initiative*, highlight the fact that depression is a condition that can assail anyone at any age and occurs across all socio-economic segments of society. Depression makes its sufferers unhappy and despondent.

Sufferers of depression are deprived of joy and satisfaction in their relationships and in life in general. Yapko (1997) writes that "for most people, depression is the product of a hurtful way of interpreting and responding to life experiences. Depression involves an intricate set of projections about yourself, life, the universe, everything" (p. xvii). Yapko goes on to suggest that the cause of depression may be understood via the biopsychosocial model of mental health. He states that:

> there is an enormous body of scientific literature indicating that depression has its roots in three general areas: biology, psychology and sociology. Within an area are many variables, each of which may play an important role and so must be considered in every case. (p. 13)

Then there are those who do not always understand the seriousness of the effects of depression. This is illustrated in the comment made by an Indigenous male and displayed on a poster as part of the *beyondblue* awareness of depression campaign targeting young males. He says "[w]hen you're growing up you're told you have to **be the strong one**, but depression doesn't care" (beyondblue, 2006). It is not surprising that depression may be left unrecognised or undiagnosed given that the actual word *depression* can be perplexing. The report on the NAPD (DoHAC, 2000a) explains that the word *depression* may be used in describing an emotion that is within the normal range of human experience, or as a symptom characterised as flatness in mood, sadness or distress that may be co-morbid with another disorder or it may be described as clinical depression, for example, bi-polar disorder.

Adding to this confusion is the manner in which people sometimes describe the experience of depression. For example, Parker (2002), in defining depression, writes "depression means different things to different people" (p. 5). Jamison (cited in Parker, 2002), a psychiatrist diagnosed with depression, commented that "even when I have been most psychotic – delusional, hallucinated, frenzied – I have been aware of finding new corners in my mind and heart" (p. 14). By contrast Milligan (cited in Parker, 2002), a well-known British comedian and author diagnosed with depression said "I do not hold with this romantic view of depression, that it has some purpose […] as far as I am concerned, it is without a redeeming feature" (pp. 13-14). At a more personal level, Parker goes on to cite Wolpert as defining his experience of an episode of depression in this way:

> I had never been seriously depressed before. I have to admit that I rather sneeringly proclaimed that I believed in the Sock School of Psychiatry – just pull them up when feeling low. But that certainly does not work with serious depression […] it was the worst experience of my life. (cited in Parker, 2002, p. 3)

Most treating practitioners of psychology call upon the quite specific definitions constructed by the American Psychiatric Association (APA) with regard to the diagnosis of depression. The Australian Medical Association (AMA) and the APS generally accept the APA definitions in the diagnosis of depression and, for treating psychologists, these definitions form an essential part of their 'tool box' as practitioners. These definitions are outlined in what is known as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychological

Association (APA), 2000). This manual describes depression in two categories. Firstly, depression may be *episodic*. That is, a person has a 'bout' of depression from which they recover and are in full remission. A depressive episode may be classified as depressive, manic, mixed and hypomanic. Secondly, depression may be classified as a mood disorder that includes major depressive disorder, dysthymic disorder, bipolar I disorder and bipolar II disorder, mood disorder due to general medical condition and substance induced mood disorder. These disorders are also classified as *clinical depression*. Clinical depression means that the symptoms of depression have been present for most of the time, or for two weeks or more and are recurrent. The depressed mood may be specified as the most recent episode or a recurrent episode. Davison and Neale (1996), editors of the textbook *Abnormal Psychology* often used in training for undergraduate psychologists, define depression as:

> an emotional state marked by great sadness and apprehension, feelings of worthlessness and guilt, withdrawal from others, loss of sleep, appetite and sexual desire or loss of interest and pleasure in usual activities […] often depression is associated with other psychological problems and with medical conditions […] clearly, anxiety also plays a part in deepening the despair. (p. 225)

To elaborate further on the presentation of the general symptoms of major depression, a profoundly sad mood, disturbances of appetite, weight, sleep, and activity level, that is, becoming either lethargic or agitated, are included. Parker (2002) also lists:

> lowered self esteem, change in mood control, change of mood through the day, change in capacity to experience and anticipate pleasure, change in the ability to tolerate pain, change in sex drive, suicidal thoughts, impaired concentration and memory, loss of motivation or drive, increase in fatigue and psychotic features, for example, delusions. (pp. 6-7)

Parker (2002) describes a normal depressive mood state as something that may be experienced as "a 'blue mood', a drop in self-esteem or self value, increased self-criticism, a lack of pleasure in life, feelings of wanting to give up and pessimism about the future" (p. 5). Such a depressive mood state is usually transient and is not of lasting duration. Parker goes on to describe clinical depression as the same mood state features as normal depression but with more conviction. The defining feature for clinical depression is that "the symptoms will nearly always have been present for more than two weeks and will be associated with both social and psychological disability" (p. 5). Parker further defines depression by what he calls "sub-types" (2002, p. 25). These sub-types include a *normal* depressed mood that falls within the range of normal human functioning. This mood is typically not of major intensity and passes within two weeks without impeding a person's usual social functioning. The next sub-type is described as *non-melancholic* depression that is described as a depressed mood state along with mood features that include some social impairment both at home and at work. The person often expresses feelings of 'being down'**.** The features of the non-melancholic depression last more than two weeks. The third sub-type, *melancholic* depression is recognised when the depressed mood state of mind is generally more severe than in the non-melancholic depression and is accompanied by significant psychomotor agitation disturbance. *Psychotic melancholia* is defined as

the fourth sub-type of depression. This sub-type is typified by the symptoms of a severely depressed mood with accompanying psychotic features such as delusions and hallucinations (Parker, 2002).

To clarify any misunderstanding in defining depression for all intents and purposes in this study, depression is identified as falling into two wide-ranging forms, that is, episodic and mood disorder. The aetiology may be either psychosocial or biological disturbance or biopsychosocial. Psychosocial depression has its root cause in the individual's reaction to exposure to stressful experiences or major adverse life events that precipitate the onset of depression in those who are vulnerable or predisposed to depression. The vulnerability may be cognitive and behavioural, for example, the thinking style of the individual, the tendency to worry or impulsivity, along with poor social skills or no social supports and an inability to effectively problem solve. Individuals experiencing these depressive disorders often respond to psychotherapy, for example, cognitive behavioural therapy. Sometimes anti-depressant medications are required. By contrast, the biological basis for depression almost always requires a pharmacological intervention with psychotherapy as an essential adjunct.

Having examined the mainstream explanation of depression, I now raise the issue of depression within Aboriginal communities.

1.5 Incidence of depression in Aboriginal communities

Depression knows no boundaries and Anderson (2004), an Aboriginal medical practitioner and researcher, notes that within Indigenous health services, mental health is often referred to as *social and emotional well-being*. He writes:

> This broader term is used to contextualise mental illness more holistically and to recognise that acute psychiatric disorders represent a fraction of the global experience of social and emotional distress encountered by Indigenous Australians. National data, however, tends to focus on formally defined psychiatric disorders. Aboriginal and Torres Strait Islander people are relatively more likely to be hospitalised for mental and behavioural disorders than the total Australian population (by a factor of 1.5 – 2) (Australian Bureau of Statistics, 2002, p. 74). There were also about twice as many hospital separations as expected for self-harm, for both Aboriginal and Torres Strait Islander males and females (Australian Bureau of Statistics 2001, p. 75). Further, suicides accounted for 2.6 times more deaths than expected for Aboriginal and Torres Strait Islander males and twice as many deaths expected for Aboriginal and Torres Strait Islander females. (p. 82-83)

In mainstream communities, the incidence of depression is on the increase. A similar, but much sharper, trend is discernable in Aboriginal communities. This upsurge in the presentation of Aboriginal clients throws a methodological challenge to non-Indigenous psychologists, for not only are there insufficient tools for culturally appropriate assessment and diagnosis of depression, there are very few culturally appropriate interventions available for a psychologist to draw upon in

order to develop and implement a standard treatment plan. Both the *National Suicide Prevention Strategy* (NSPS) (DoHAC, 2000b) and the NHPA report (DoHAC, 1998) emphasise that Indigenous mental health research shows escalating rates of mental illness, suicide, substance abuse and violence. Mainstream mental health services have generally been ineffective simply because they fail to take into account culturally valid concepts of mental health and fail to provide culturally relevant interventions. They lack appropriate mental health assessment and outcome measures (screening tools) that acknowledge the relevance of culture in determining Indigenous mental health.

In sharing medical knowledge about counselling interventions and Indigenous mental health, Armstrong (2005) states that whilst much publicity is generally given to the disproportionate numbers of Aboriginal Australians who find themselves in prison for a period of time, very little public recognition is given to the high levels of incidence of Aboriginal mental health disorders. Armstrong goes on to affirm that the "prevalence of mental disorders is between 35% and 54% amongst the Indigenous population" (p. 1). Moreover, Armstrong says that, presently, Aboriginal admissions to inpatient psychiatric units in the State of Queensland are "more than twice as likely" (p. 1) compared with such admission for other Queenslanders.

The occurrence of depression and co-morbid conditions, treated or untreated, among Aboriginal communities has been neither fully identified nor measured by mainstream health services. However, drawing on information provided by *Aboriginal Community Controlled Health Services* (ACCHS) across Australia, the NAPD reports that the "percentage of depressive illness currently present in

Aboriginal communities is very high" (2000a, p. 24) and that "rates of self-harm and suicide among Aboriginal Australians are proportionally higher than in the rest of the population" (2000a, p. 24). Factors that hasten the onset of depression are often linked to social justice issues such as disadvantages in the areas of employment, housing and education. Others (Hunter, 2000b; Hunter, Reser, Baird & Reser, 1999) note that factors contributing toward depression in Aboriginal people may include racism, high rates of premature death and disproportionate representation in custodial care, that is, alternative care of children, juvenile detention, correctional facilities and psychiatric hospitals. Whilst Aboriginal people present with some of the core symptoms of depression which may be considered universal to all cultures, other reports (DoHAC, 2000a; Wenitong, 2002) show a disturbing incidence of misdiagnosis of Aboriginal clients resulting from inappropriate assessment of the consequences of cultural influence by mainstream practitioners. When Aboriginal people seek treatment, depression may often be masked by social, interpersonal or cultural factors. The NAPD adds "recognition also needs to be given to the specific and differing needs of urban, rural and remote communities as well as to the transient lifestyle of some Aboriginal and Torres Strait Islander people" (2000a, p. 25). The extent and consequences of trans-generational trauma, social disadvantage and racism are yet to be fully assessed. For example, the NAPD points out that Aboriginal people "continue to endure alarming personal and social experiences, many related to these communities' past and ongoing history of loss and traumatisation that are known to be harmful to mental health" (2000a, p.23). Many people in Aboriginal communities also experience grief, trauma, loss and other specific risk factors known to contribute to higher rates of depression.

> An Aboriginal Elder at St. Teresa's Community tells me that one of the members of the community is unwell and that she has been sleeping poorly and is not eating properly. The community member has told the Aboriginal Elder that her ancestors have been calling her and telling her to come home. She says that her ancestors tell her she has been away for a long time. The Aboriginal Elder says that the community member needs to go back to her home country, to her people, to get better and to do 'business'. (ST1.1, 21 May 2003)

This comment, by one of the elders at St Teresa's community, is consistent with the comments made by Westerman (FN10, 3 June 2003) who points out that symptoms of depression in Aboriginal clients may be manifested as *culture bound syndromes*. In defining culture bound syndromes, DSM-IV-TR (APA, 2000) emphasises the importance of the recognition of the cultural background and cultural context of the client. During the interview process, the clinician should ensure that consideration is given to the client's cultural identity and reference group. Cawte (1974) and Westerman (2000) also stipulate that a clinician should take into consideration the client's cultural mores when seeking an explanation of the client's sickness. Aboriginal clients may present with symptoms of a depressed mood in a way that is different from non-Indigenous clients. Westerman (FN10, 3 June 2003) explains that, for Aboriginal people, culture bound syndromes result from the effects of phenomena such as being *sung* by an aggrieved person, being married *wrong way*, being *caught out* at law time, law *business, payback*, gender and cultural influences, *sorry* time that is usually related to the notion of self harm, anxiety and hysteria, psychosis, shame, physiological reaction, men's business versus women's business,

avoidance and *skin* relationships and *longing for, crying for or being sick for country*. Raguram, Weiss, Keval and Channabasavanna (2001) suggest that the biomedical understanding of depression is of itself insufficient. They have examined the practice of psychiatry in the treatment of depression in India and, like others in Australia (Anderson, 2004; Dudgeon & Pickett, 2000; Eckermann et al., 1992; Hunter, 2000b; Vicary, 2000; Westerman, 2000), they argue that the recognition of the nuances of the cultural context in which depression occurs is vital for the proper diagnosis and treatment. This leads to an examination of the psychological theories of depression.

1.6 Psychological theories of depression

For this study, it is important to revisit the psychological theories of depression because an understanding of these theories is crucial in the recognition of the nuances of the problem that is being researched. Psychological theories that explain mood disorders provide a framework for treating psychologists that ultimately influences their choice of psychotherapeutic intervention and treatment plan. The main theories in understanding the aetiology of mood disorders (depression) are *psychoanalytic, cognitive, interpersonal* and *biological*. The psychoanalytic views developed by Freud (cited in Arlow, 2000) and Jung (cited in O'Connor, 1985; cited in Storr, 1983) emphasise the unconscious conflicts associated with grief and loss that give rise to the symptoms of depression. Cognitive theories of depression have been developed by Beck (1987) and Ellis (1984). Cognitive theories of depression focus on the depressed person's self-defeating thought processes that also include the negative attributions that a person may give to their life experiences, thereby deepening their depression. Interpersonal theories (Billings, Cronkite & Moos, 1983) of depression emphasise how depressed people interact with others. It

suggests that depressed people who have sparse social support networks along with limited social skills have less ability to manage negative life events and are vulnerable to depression. Biological theories of depression concentrate on genetic data and the neuro-chemical activity of the brain. Allen (1976) found that in family studies and twin studies both bipolar disorder and unipolar depression have components that are genetically transmitted and, as a consequence, predispose the family member to depressive illnesses. Whilst our knowledge of the working brain is incomplete, it is known that the effectiveness of neuro-transmitters contributes to the well being of the person. Lowered levels of one such neuro-transmitter, serotonin, is associated with depression and suicidal behaviour as well as with impulsive and aggressive behaviours (Parker, 2002). The biopsychosocial model of psychological theory for depression developed by psychiatrist, Engel (1980), and supported by others, for example Yapko (1997), is based on general systems theory where the biological, psychological and social issues are considered in the overall theoretical understanding of depression. These standard theories on depression exclude the Aboriginal explanation of the causes of depression which adds another dimension to the research problem. It shows the way to the importance of examining current interventions of counselling and psychotherapy.

1.7 Counselling and psychotherapy

Reconsideration of the meaning of counselling and psychotherapy is vital as it goes straight to the core of this research problem in terms of the application of psychological theories in practice when treating Indigenous clients. It is not sufficient that a psychologist is merely a pair of ears to listen with or a warm heart that cares. There is much more to the act of counselling and psychotherapy.

Psychological counselling is generally understood as a relatively short process that can occur over a period of time from one, to no more than five, sessions that consist of fifty minutes each session. Psychotherapy, by contrast, usually continues for many sessions and can even carry on for many years. Both have application in the treatment of depression. According to Corsini and Wedding (2000), counselling is usually seen as problem-oriented while psychotherapy is person-oriented. The actual processes that take place in counselling and psychotherapy are identical but they do differ relative to the time spent in therapy. For all intents and purposes, Corsini and Wedding (2000) emphasise that counselling places importance on the giving of information, advice and orders by someone who is considered to be an expert in a particular area of human behaviour. Psychotherapy, on the other hand, is a process of helping people to discover why they feel, think and act in unsatisfactory ways. In essence, a counsellor is primarily a teacher whereas a psychotherapist is an investigator/discoverer. Psychotherapy is any form of treatment for mental illnesses, maladaptive behaviour and/or other problems that have their aetiology in emotional distress or trauma. Psychotherapy is a process in which a trained person establishes a professional relationship with a client with a view to helping the client to discover why they think, feel and act in ways that are not satisfying to them. Psychotherapy has an application in helping the client to deal with, and resolve, symptoms of anxiety and depression. The client seeks self-knowledge for the purpose of changing their feelings and/or behaviour. The psychotherapist, as participant-observer, promotes insightful learning by decoding and interpreting the client's unconscious messages. As part of the therapeutic relationship, some learning or change also occurs as a result of imitation, identification and various subtle influences. Campbell

(1989) reminds us that the psychotherapeutic interaction is not value-free but the highest premium is placed on the client's self-determination.

Wolberg (1954) takes the position that there are three types of psychotherapy; *supportive*, *re-educative* and *reconstructive*. Supportive psychotherapy encourages the development of the greatest and most advantageous use of the client's assets. The objectives of supportive psychotherapy are to strengthen existing defences, develop better mechanisms to maintain control and restore to an adaptive homeostatic position. Supportive psychotherapy includes guidance, environmental manipulation, externalisation of interests, reassurance, pressure and coercion, persuasion, catharsis, desensitisation and inspiration group therapy. Re-educative psychotherapy aims at giving the client insight into the more conscious conflicts with intentional efforts at goal adjustment and maximum use and development of existing potentialities. Re-educative therapy includes relationship therapy, psychobiology, reconditioning and re-educative group therapy. Reconstructive psychotherapy has a focus toward giving clients insight into their unconscious conflicts and results in the extensive revision of their personality structure. Included in reconstructive psychotherapy are psychoanalysis, analytic therapy, the treatment techniques of the cultural-interpersonal model and the psychoanalytically oriented psychotherapy. Having now explained the psychological theories of depression and the meaning of counselling and psychotherapy, the next section goes on to explain how it all comes together in practice.

1.8 The machinations of psychotherapy

Understanding how the process of psychotherapy works is fundamental in providing a background to the research problem as it highlights the assumptions embedded in western psychology and brings attention to gaps in psychotherapy when treating Indigenous clients. There is no consensus about what constitutes the basis for change in psychotherapy. In fact, at a most cynical level, Campbell (1989) states that, at the *Conference on Graduate Education in Clinical Psychology* in 1949, psychotherapy was described as "an undefined technique applied to unspecified problems with unpredictable outcomes; for this technique we recommend rigorous training" (p. 600). Despite this comment, psychotherapists have long put forward theories about what might be the most effective therapeutic intervention that brings about change in the client. Corsini (2000) suggests that it is a certain range of *cognitive*, *affective* and *behavioural* factors that assist in the mechanisms of effective psychotherapy.

Cognitive factors comprise of universalisations, insight and modelling. These mechanisms come into play when clients begin to improve upon the realisation that many other humans have similar problems and that human suffering is universal. Howe (1993) suggests that as clients gain greater insights and awareness into their motives and behaviour, they gain an increasing understanding of themselves and others. With the benefit of observing significant others, including the therapist, the client may improve their condition by modelling themselves on the therapist.

The affective factors in the mechanism of therapy include acceptance, altruism and transference. Acceptance that comes from the therapist, in the form of

unconditional positive regard and is directed toward the client, is part of the process of therapy. Nelson-Jones (2001), as well as Corsini and Wedding (2000), propose that therapeutic change is also experienced as altruism. This happens when the client is in the position of being both recipient and giver of the love and care that is exchanged during the therapeutic session, whether it is in a one-to-one setting or a group setting. The emotional bond that occurs between the therapist and client is an affective mechanism of the therapeutic process. The transference of emotion can also occur between the therapist and client or between clients in the group setting.

The behavioural factors that form part of the mechanism of therapy include reality testing, ventilation and interaction. Therapeutic change comes about when the client experiments with new behaviours in the containment of the therapeutic session. In this context, feedback from the therapist or the group may be given to the client who is testing this new reality in the form of changed behaviour. The ventilation of emotion is also an experience of the behavioural factors in the mechanism of therapy. Emotions are permitted their full expression in an environment where the client can still be accepted by the therapist and/or the group. Clients also engage in the mechanism for therapeutic change when they are able to interact more freely by openly admitting to the therapist or the group that there is something amiss with themselves or their behaviour. Noticeably, in the way that western psychotherapy works results in the omission or the exclusion of Aboriginal concepts, such as inter-relatedness, as a crucial part of the means of psychotherapy.

This omission or exclusion is next considered in the development of the relationship between the non-Indigenous psychologist and the Aboriginal client in the treatment of depression.

1.9 The psychotherapeutic relationship

The psychotherapeutic relationship is a vital part of the healing process. Forming a therapeutic alliance between the non-Indigenous psychologist and the Indigenous client accentuates the research problem because the non-Indigenous psychologist, trained in the mainstream dominant culture, may not fully recognise that, as Hunter (1993) notes in his study on the history of Aboriginal health, the Indigenous client is from a culture that is not only different from, but has been also oppressed and marginalised by, that mainstream dominant culture. As a consequence, forming a therapeutic relationship based on trust and understanding can be problematic.

Commenting on the therapeutic relationship, Feltham and Horton (2000) along with Corsini and Wedding (2000) note that, in the psychoanalytic setting, the analyst/therapist remains anonymous whilst the client develops projections toward the analyst. The analyst makes interpretations to explain to the client the meaning of current behaviour and how it relates to the client's past experiences. By contrast, the mainstay of the therapeutic relationship in person centred therapy (Rogers, 1961) is based on the qualities of the therapist. These qualities include genuineness, warmth, empathy, respect and permissiveness. This therapeutic interaction between the person/client and therapist is of crucial importance so that the client may use this relationship with the therapist to help them to transfer their learning to other

relationships. Alternatively, the therapeutic relationship between client and therapist in a cognitive behavioural therapy (Beck, 1987) setting is one where the therapist functions as a teacher and the client as a student. The therapist is directive and active and challenges clients to gain insights into their problems and then develop the practice of changing destructive thinking and acting and replacing that behaviour with new constructive ways of thinking and acting. By comparison, the therapeutic relationship in the family systems therapy (Goldenberg & Goldenberg, 2000) setting is one where the therapist functions as a teacher, coach, role model and consultant. Emphasis is placed on the process of family interaction and teaching effective patterns of communication. Unlike other therapeutic alliances, the central role in the therapeutic relationship within the existential (May & Yalom, 2000) setting is for the therapist to accurately grasp the client's being in the world and to establish a personal and authentic encounter with the client. The human-to-human client/therapist relationship and the genuineness of the here-and-now encounter are stressed.

The therapeutic relationship is problematic when a non-Indigenous psychologist tries to engage in a therapeutic relationship with Aboriginal clients because of what Hunter names "an asymmetrical power relationship" (2000a, p. 43) stemming from the effects of colonisation and cultural differences. Vicary has developed a technique that he calls "counselling as yarning" (2003, p. 242). It is a technique that acknowledges Aboriginal forms of communication because recognition is given to country, place and family as a prelude to the therapeutic alliance. This technique acknowledges the importance of the therapeutic relationship

and how that is constructed in a culturally appropriate way for those who are treating Aboriginal clients. In a similar vein, Lynn (2001) calls for the recognition of:

> a space of possibility between Indigenous and non-Indigenous practitioners that the Indigenous telling creates. This is the space between these players who do not share a common understanding, a space where players may participate in a dance of difference (dialogue) to help map a common space of understanding. (p. 903)

Briefly summarised, the *Murri Way* proposed by Lynn (2001) is based on three phases of the helping, or therapeutic, relationship that she outlines as: "1 'A yarn, a joke and a cup of tea': tuning in and sussing out; 2 'Doing Stuff': practical action; 3 'Back to Yarning'" (p. 908).

Examining these issues inherent in the therapeutic relationship gives rise to understanding the present location of psychological thinking in terms of providing psychological treatments to Aboriginal clients.

1.10 Where psychology is presently positioned

This study is guided by the belief that for psychology and psychologists, current psychotherapeutic treatments originate from the western cultural context (Corsini & Wedding, 2000; Howard, 2000). These forms of treatment represent only one of many forms of helping clients. And this other form, *Aboriginal way*, constitutes the gap in psychological knowledge and psychotherapeutic interventions that is the subject of this study. Strong with this belief is the knowledge that the

worldview of the dominant culture here in Australia is often at variance with Aboriginal culture and worldview. This study considers the question of how psychology can become more relevant and effective to the Aboriginal clients it serves.

There was a profound moment of truth for modern psychology and psychological practice in Australia during the closing ceremony of 24th International Congress of Psychology held in Sydney in 1988. An incident occurred where a community psychologist from New Zealand questioned the Congress organisers about the lack of Indigenous Australian content in the Congress program. In scrutinising this incident, Gridley, Davidson, Dudgeon, Pickett and Sanson (2000) note that, apart from the fact that the questioner was almost "ejected by the security guards" (p. 88), this simple question served to expose an embarrassing but illuminating truth to the Australian Psychological Society (APS). The truth was that, at that Congress, there was no Aboriginal content in the formal program. At no stage during the Congress proceedings was any thought or acknowledgment given to Aboriginal culture, such as 'Welcoming to Country', in the opening ceremony or in any of the Congress social program. In reflecting on this incident at the Congress, Gridley et al. (2000) observed that the only reference to Aboriginal culture was of a photographic exhibition which included images of Aboriginal skulls collected by "craniometrists, anthropometrists and psychometrists" (p. 88) displayed without any sensitivity, apology or regard for Aboriginal people and their culture. Turtle and Orr (1989, cited in Gridley et al., 2000,) point out this exhibition demonstrated the fascination held by early psychologists who saw Aboriginal people as "a new and distinctive racial type" (2000, p. 88). Through the Board of Community

Psychologists, the APS then began to give serious attention to this grave omission (Garvey, Dudgeon & Kearins, 2000a; Gridley et al., 2000). Consequently, since the 1990s, the lens of psychology has turned its gaze on philosophical and methodological change. This is reflected, for example, in the July 2000 special issue of the *Australian Psychologist* that devoted its entire attention to Australian Indigenous Psychologies. Sanson and Dudgeon, as guest editors of that special issue, write that "psychology has been part of the past oppression of Indigenous people. Indigenous people have been seen as objects of study and studied from western perspectives, using western methods, tests, and interpretations, in a decontextualised way" (2000, p. 80). Through this special issue of their professional journal, the APS acknowledged past practices and offered a review of current practices along with a focus toward the provision of culturally appropriate services to Aboriginal Australians. This study is intended to build on the review.

In the past, the primary involvement of psychology in Australia with Aboriginal people was at the investigative research level. Aboriginal people were seen as a phenomenon of interest to be studied. Research was conducted with an emphasis on the mental, intellectual and psychological functioning of Aboriginal people as exemplified by the development of McElwain's Queensland Test (Garvey, Dudgeon & Kearins, 2000b). This test was later shown to demonstrate that it is not possible to devise a culture-free assessment of mental ability, intellectual functioning and psychological functioning.

The 1990s gave rise to the Indigenous mental health movement. The 'Ways Forward': National Consultancy on Aboriginal and Torres Strait Islanders Mental

Health (Swan & Raphael, 1995) saw the beginnings of collaboration between Aboriginal and non-Indigenous people working in mental health. Of significance is the glimmer of change by non-Indigenous psychologists in perceptions of Aboriginal mental health. Rather than working from the westernised *disease* model, the main emphasis became holistic. In the holistic model, emphasis is given to the importance of wellness in mind, body and spirit and interventions that are more culturally relevant and outlined in the work carried out by Swan and Raphael (1995).

The 1988 Congress in Sydney, mentioned earlier, also coincided with the beginnings of the reconciliation movement in Australia and, since that time, more formal opportunities for mutually beneficial collaboration between psychology and Aboriginal people have been created. A number of formal innovative and uniquely Aboriginal alternative theories and methodologies are emerging. Some techniques have been formally written down. Roe (2000), for example, developed the concept of "*Ngarlu*" (p. 396). Roe describes the concept of *Ngarlu*, an Aboriginal word from the Kimberley region in northern Western Australia, as defining the place of the inner spirit and how that relates to mental health and wellbeing. Roe reasons that, from an Aboriginal perspective on mental health, if the *Ngarlu* is strong, the person is strong, but if the *Ngarlu* is weakened for whatever reason, for example, alcohol abuse, then the person is weakened. The aim of healing is to keep the *Ngarlu* strong. Roe's example is a psychological perspective that is steeped in Aboriginal reality. It is this example of Aboriginal knowledge and practice, been oppressed since colonisation, that now, in the fullness of time and with the advent of the reconciliation movement, demonstrates that Aboriginal culture and practice is in the process of what Smith (1999) calls "revitalisation" (p. 147) which forms part of the twenty-five Indigenous

projects. Revitalisation is about reviving Indigenous languages, arts and cultural practices. It opens the way to make a space for the recognition and development of specific psychologies for oppressed groups, more especially for those who have been oppressed on the basis of race and, in this case, Aboriginal people whose knowledge and culture have been oppressed through colonisation.

At an international level, recognition and legitimacy is being given to other non-western psychologies. Demands are being made for psychotherapy to be defined not only from the western but also from other perspectives, for example, the African perspective. The recent International Society for Theoretical Psychology Conference and the International Critical Psychology Conference, both in 2005, included symposia that raised questions about psychology's place in the South African context. Baloyi (2005) made a call for "African traditional cultural practices to assume a key role in South African psychology and consider how this could be practically realised in contexts such as psychotherapy and professional training" (p. 9). Adding strength to the themes of *Indigenous* psychology and *decolonising* psychology, as well as the reawakening of non-western psychological knowledge and practice, Gavala (2005) focused on Indigenous knowledges and biculturalism in Aoetearoa/New Zealand and the articulation of Indigenous Maori psychological theory.

Smith (1999) puts forward the notion that there is a great need for Indigenous people to decolonise their history by expressing their knowledge and their culture. She goes on to state that Indigenous people must develop theories to make sense of reality grounded in Indigenous ontology and epistemology:

> As a site of struggle research has significance for Indigenous peoples that is embedded in our history under the gaze of western imperialism and western science. It is framed by our attempt to escape penetration and surveillance of that gaze whilst simultaneously recording and reconstituting ourselves as Indigenous human beings in a state of ongoing crisis. Research has not been neutral in its objectification of the Other. Objectification is a process of dehumanisation. (1999, p. 39)

Following this logic it then seems appropriate to engage in the process of decolonising psychology if psychology as a profession is serious about providing meaningful and effective psychotherapeutic services and interventions to Aboriginal people. This opens the way for the non-Indigenous psychologist to ask Aboriginal people about these non-western knowledge frameworks. This opening is the gap in which this research project is positioned. Bastian, an anthropologist, asks "where is the site for this knowledge? Is it at the workplace, or in the community? Or in the day-to-day reality of Aboriginal people in North Queensland?" (RB, personal communication, 6 June 2002). In essence, the knowledge is not just in the local Aboriginal and Islanders Health Service, nor is it simply confined to the university. It is also sited in the broader community context.

This research into treating depression when working with Aboriginal clients leads to an examination of the way psychological services are provided and considers the psychological training for the effective provision of such services. As Indigenous researchers, Dudgeon and Pickett (2000) suggest key elements in psychological research and provision of psychological services are to include a philosophical

approach of empowerment and self-determination. This implies a collaborative approach that sees Aboriginal people fully engaged in the process of this particular research project. This includes the interaction between the non-Indigenous psychologist and the Aboriginal people in this research. Dudgeon and Pickett state "the psychologist needs to consider working in a directed partnership with the Indigenous client and community" (2000, p. 85). This comment flags a reminder to non-Indigenous psychologists to ensure that, through their work, they do not repeat past behaviours of complicity in the oppression or psychological injury to Aboriginal people. There needs to be a constant awareness that psychology is on the cusp of either falling into past behaviours of oppression and assimilation or learning to work collaboratively by accepting the direction of Aboriginal consultants, supervisors, community members and research participants.

Collaborative research and practice offers the promise to make psychology become more relevant to (the local) Aboriginal clients that it serves. Dudgeon and Pickett summarise collaboration by commenting that:

> psychology is well placed to understand and to help facilitate Indigenous culturally based processes of healing and survival. However, the discipline also has an equal potential to be enlisted as an agent of assimilation, oppression and control, as so much of its past has documented. The profession needs to learn to see the difference and act accordingly. Fundamentally, the call for partnerships in the reconciliation process is a call for psychologists to develop the awareness, knowledge, skills and motivation

> that enable working with and within Indigenous cultural direction on issues affecting the lives of Indigenous people. (2000, p. 86)

This study is grounded in the position that western mainstream culture guides and informs western psychological knowledge whilst traditional Aboriginal cultures guide and inform Aboriginal traditional psychological knowledges. It is at this interface of research and healing that mainstream *western* psychological ontology and epistemology meet with the *traditional* ontology and epistemology of Aboriginal Australia. For this study, the point of asking Aboriginal people about what they do to treat Aboriginal people who are suffering from depression is to give voice to Aboriginal ways and provide an insight into the Aboriginal culture. This opens the way for non-Indigenous psychologists to learn and to provide a psychological therapy that is culturally sensitive and culturally appropriate. This study assumes to bring together psychotherapeutic techniques that are grounded in Indigenous philosophical underpinnings that are appropriate for both Indigenous and non-Indigenous psychologists to utilise, in the collaborative sense, for the treatment of depression with Aboriginal Australian clients.

To reiterate, it is the intention of this study to contribute to the ongoing development of a culturally appropriate psychological intervention that is grounded in Aboriginal ontology and epistemology which may be utilised by psychologists, both Indigenous and non-Indigenous, in response to the increasing numbers of Aboriginal clients who present with the symptoms of depression.

1.11 Scope of this research

This research project is not about the measurement or diagnosis of depression. Others are carrying out this work, for example, the Westerman Aboriginal Symptom Checklist for Youth (Westerman, 2002). This study is about a treatment for depression. Torres Strait Islander people are not included in this study because the cultural differences between Aboriginal and Torres Strait Islander people are significant. This research encompasses the Aboriginal people living in North Queensland. It includes expert knowledge from an Aboriginal psychologist who resides outside Queensland and expert knowledge from a non-Indigenous psychiatrist residing in North Queensland, held in high esteem by Aboriginal people in that region. This study is a reflection of their voices. Given the diversity of Aboriginal people, the proposed approach may not be suitable for all Aboriginal people.

This study is not simply about developing new techniques for the delivery of psychological services. Rather, it strongly argues that counselling/psychotherapy and psychological competence that is disconnected from, or devoid of, the relevant cultural theoretical underpinnings is ineffective.

And finally, whilst this study recognises the importance of reconciliation and social justice, the central focus of this research is on psychological healing and recovery. At the same time, this study is also about acknowledging what Bell (1998) along with Dudgeon and Oxenham (1990) identify as a resurgence in Aboriginal ontology and epistemology into the Australian consciousness, and that includes psychology as it is practised in this country.

1.12 The aim of this research

Bearing in mind this resurgence into the Australian consciousness of Aboriginal knowledge, the aim of this study, then, is to continue with the development of a psychological intervention that is grounded in Aboriginal philosophical thought and may be utilised by a non-Indigenous psychologist that ultimately makes a contribution toward filling the present gap in psychotherapy. To achieve this aim, this study recognises that Aboriginal people around Australia are the custodians of the knowledge relating to Aboriginal psychology. The site chosen to learn from is North Queensland. It is only one site where the knowledge exists and it exists in a form that is particular to the Aboriginal people of North Queensland.

The challenge in achieving this research aim lies in the action of the researcher/practitioner stepping back from the usual scientific evidence based psychological thinking and practice of western psychology and opening up to the traditional Aboriginal psychological thinking. It is a challenge which calls for a stepping away from the security of the position of what is known into the uncertainty surrounding the unknown.

This study explores the role of psychotherapy in the treatment of depression at the interface of mainstream psychology and Aboriginal knowledge. For the purposes of this study, the word *interface* is defined as “the place at which independent systems meet and act upon or communicate with each other” (Websters 7th New Collegiate Dictionary, 1969). These independent systems are located within mainstream psychological knowledge and Aboriginal psychological knowledge. It is at this interface, that the call for the researcher to suspend their usual belief system

and, as Levi-Strauss says, “begin to see the world of the Aboriginal and the scientific as parallel modes of acquiring knowledge about the Universe that have managed to give birth independently to two distinct though equally positive sciences” (1966, p. 9).

Aboriginal people are the *keepers of the knowledge*. They are the experts in what it is to be Aboriginal. With that in mind, this study is an acceptance of that invitation to learn from Aboriginal people their way(s) of understanding the world and their way(s) of experiencing the world. By learning and understanding about the way(s) in which Aboriginal people experience the world, non-Indigenous psychologists can begin to provide services and treatments in a way that is culturally appropriate. The central proposition of this overall research is that a working knowledge of, or at least an understanding of, Australian Aboriginal worldviews combined with a sincere respect for Aboriginal culture is a minimum prerequisite to addressing the gap in psychological counselling and psychotherapy when treating Aboriginal clients. It is imperative to understand the philosophical underpinnings that guide and inform psychological practice when working with Aboriginal Australian people who are suffering from depression.

For this study, the justification of asking Aboriginal people about what they do to treat their own people who are suffering from depression lies in the opportunity for Aboriginal people to give voice to their cultural ways of healing people who are depressed. At the same time, an insight into the Aboriginal culture is opened up, offering non-Indigenous psychologists the chance to learn about what they need to

know and to then feel compelled to embark on a journey of discovery, learning and re-evaluation of their own beliefs and practices.

There is a body of knowledge known as Aboriginal psychology that is explored. This research project is intent on demonstrating that the development of a psychotherapy that is grounded in Aboriginal philosophical thought and culture should also lead to the design and delivery of specialised training programs so that, as practitioners, psychologists, especially if they are from a non-Aboriginal background, may be better equipped with a range of tailored psychotherapeutic interventions that are effective with Aboriginal clients.

1.13 Summary

In the introduction to this study, I have raised the fact that the incidence of depression is increasing significantly both nationally and internationally. I have shown that there is a knowledge gap in psychotherapy that becomes exposed when psychologists find themselves in the position of delivering psychological services to Aboriginal clients, particularly in the treatment of depression. The symptoms of depression have been explained and the theories about depression have been described. Counselling and psychotherapy as interventions in the treatment of depression have been outlined. This has led to the exposure of the omission of Aboriginal psychological knowledge in the training of psychologists and in the application of psychotherapy in the context of an Aboriginal Community Controlled Health Service. By recognising the effects of the gap in psychotherapy as a result of the past exclusion of Aboriginal knowledge, this study aims to bring about a

contribution toward the continuing development of the inclusion of Aboriginal psychotherapy.

In Chapter Two, philosophy and culture, as determinants of current psychotherapies, are examined and the relationship between the client, culture and therapist is considered. Cross-cultural, multicultural and trans-cultural psychologies are deliberated on and the *etic* versus *emic* argument centred on the universalist indigenisation of psychotherapy is challenged by the relativists indigenous psychotherapy. This raises themes of Aboriginal psychology that, in turn, ask the research question about what and how do Aboriginal people help in the recovery of those who are depressed.

Chapter Three outlines the historical background that contextualises this research topic. The methodology chosen for this study is examined and justification is made with regard to the choice of interviews as the primary method of data gathering and the problems encountered. It also examines the impact of the experience as a non-Indigenous researcher psychologist gathering data from Aboriginal people.

Chapter Four gives voice to the Aboriginal participants in response to the research question about their treatment for those who suffer from depression. These findings show that Aboriginal philosophy, culture, ontology and epistemology stands in its own truth as a compelling body of knowledge, which takes its position alongside other bodies of world knowledge. Building on this knowledge discussion is raised on the finding that Aboriginal psychology is holistic and is grounded in a

philosophy of connectedness and relatedness to all things. As such, there is no place for western psychology to try to superimpose its own ways over Aboriginal ways in attempting to provide psychological treatment for depression. Rather, these findings indicate the need for a paradigm shift within psychology as a profession because they have implications for current psychotherapies. They point toward the need for psychology as a profession to rewrite, retrain and reframe current psychotherapies with a view to moving toward a psychotherapy that is grounded in Aboriginal philosophical thought and culture and forms a theoretical framework for the practice of psychology which is collaborative and that is available for non-Indigenous psychologists to apply in the treatment of depression.

Chapter Five builds on the findings of Chapter Four and gives particular attention to the effects of the encounter between the non-Indigenous psychologist and the Aboriginal research participants by analysing and interpreting the findings where both the researcher and the participants are seen as psychosocial 'defended' subjects who are affected by their own cultures and histories. Implications for the non-Indigenous psychologist at a professional level are raised.

Chapter Six concludes that retraining toward the transformation of the non-Indigenous psychologist is necessary if they are to work effectively with Aboriginal clients. Additionally, the transformation of psychotherapy requiring the rewriting of psychotherapy and practice, which builds on a theoretical framework that is grounded in Aboriginal philosophy and culture, begins to fill the gap in psychotherapy. Such transformations will better equip the non-Indigenous

psychologist in providing a more suitable and effective treatment to Aboriginal people who are depressed.

Chapter Two

Philosophy, Culture and Current Psychotherapies

2.1 Introduction

Treating depression effectively requires a good understanding of psychotherapy. This chapter paints a landscape showing that philosophy and culture are determinants, not only of human behaviour, but also of psychotherapy. Current mainstream psychotherapies and their theoretical and philosophical underpinnings are reviewed so that expression may be given to the manner in which western philosophy and culture permeates western psychotherapy. It is necessary to do this to show the limitations of western psychotherapy in non-western and multicultural settings. Within this milieu, I examine the ways in which mainstream western psychotherapy has tried to develop culturally appropriate treatments by indigenising psychotherapy. I acknowledge that other cultures have always had their own forms of psychotherapies, and this includes Aboriginal articulations about their worldviews and culture. Justification is given to the hypothesis of this study that Aboriginal psychology is determined by its own philosophy and culture and this, by definition, determines a culturally appropriate psychotherapy. I draw on the words of Aboriginal researcher and academic, Lester-Irabinna Rigney (2001)who writes:

> We as Indigenous peoples remain dissatisfied with scientific philosophies and practices that underpin Western knowledge systems. Before we can begin to investigate scientific methods that move beyond Western cultural models, the Indigenous scholar must first understand the basis of Western ontological and epistemological principles on which science stands. (p. 2)

Conversely, this study assumes that the same could be said in reverse for non-Indigenous people who wish to understand Indigenous ontological and epistemological principles on which Aboriginal psychology stands.

2.2 Philosophy and how it relates to culture, behaviour and psychotherapy

> Philosophy is the search, by logical reasoning, for understanding of the basic truths and principles of the Universe, life and morals and of human perception and behaviour and an understanding of these. Philosophy can also be defined as a particular system or set of beliefs reached by such a search; a system of principles for the conduct of life. (The Australian Modern Oxford Dictionary, 1998)

So that societies may function effectively, it is generally accepted that they operate with a core set of values and beliefs or truths that form the basis of the guidelines that govern ways of knowing, being and doing. These values and beliefs manifest themselves in the day-to-day lives of individuals. They inform and govern their actions. They support them in crisis. They give order, stability and predictability to life. They also give human actions meaning and validity.

Philosophy, at its best, informs, grounds, steers and sets up boundaries for practice in therapy as well as in other places. As words and theories that do not point to action and commitment become devoid of meaning, so too, actions that are detached from philosophy and theory lack wisdom or perspective. The importance of philosophical thought is not always fully acknowledged in the general practice of psychology. Sometimes, much attention is given to actions and techniques and not enough concern to examine the presuppositions and their underlying philosophical origins. Howard (2000) sees philosophy as grounding therapy as a process towards healing, direction, identity and meaning for both the practitioner and the client. This observation is supported by Yalom (1998) who suggests that the discipline of psychology is a reflection of western philosophical thought and culture that began long before, in the scientific experiments of "Pavlov and Wundt" (p. 269). He proposes:

> the discipline of psychology began in the works of the great psychological thinkers who wrote about innermost human motivations: Sophocles, Aeschylus, Euripides, Epicurus, Lucretius, Shakespeare, and especially (for me) the great psychological novelists Dostoevsky, Tolstoy, and later, Mann, Sartre, and Camus. Freud identified himself as a scientist, yet not a single one of his great insights was born of science: invariably they arose from his own intuition, his artistic imagination, his deep knowledge of literature and philosophy. (p. 269)

By reminding ourselves of the influence of philosophical thought, I now explain the way in which this inspires contemporary psychology.

2.2.1 How philosophical and cultural knowledge give rise to psychological knowledge

Others have put forward the view that philosophical and cultural traditions give rise to psychological knowledge. For example, in examining cultural and philosophical factors in psychotherapy Berry, Poortinga, Segall and Dasen (1992) note:

> Among the range of these indigenous psychotherapies are those rooted in Japanese culture and thought: *Morita* therapy (Miura & Usa, 1970) and *Naikan* therapy (Tanaka-Matsumi, 1979). According to Murase (1982, p. 317), both of these therapies are "revivalistic, and oriented towards a rediscovery of the core values of Japanese society." These core values are *amae* and *sunao*, and are related to *Morita* and *Naikan* respectively, although both values are thought to enter to some extent into both therapies. (p. 365)

Commenting further on the importance of philosophical thought and culture underpinning the non-western and Indigenous methods of healing, Sue and Sue (2002) note:

> As counselors and therapists will increasingly come into contact with client groups who differ from them in race, culture and ethnicity, it seems important to study and understand indigenous healing practices in order to (a) understand the worldview of culturally diverse clients, (b) anticipate potential conflicts in belief systems that might hinder our ability to be therapeutically effective, and (c) develop an appreciation for the richness of these older forms of treatment. (p. 177)

Furthering the discourse on the cultural and philosophical foundations and concepts relating to culture and mental health, Cuellar and Paniagua (2000) define culture as psycho-behavioural:

> Shared learned meanings and behaviors that are transmitted from within a social activity context for purposes of promoting individual/societal adjustment, growth, and development. Culture has both *external* (i.e., artifacts, roles, activity contexts, institutions) and *internal* (i.e., values, beliefs, attitudes, activity contexts, patterns of consciousness, personality styles, epistemology) representations. The shared meanings and behaviors are subject to continuous change and modification in response to changing internal and external circumstance. (p. 12)

In acknowledging, claiming and explaining Aboriginal philosophy and culture in Australia, Grieves (2002) states:

> Like all human societies, Aboriginal society has operated on a core set of values and beliefs that are complex and that form the basis for religious practice and ways of being and doing. This philosophy constitutes a set of "truths" for people that define the parameters of knowledge, reality and cultural practice. (p. 1)

It is clear from these studies that the western philosophical thought that guides mainstream culture and psychotherapy is not always applicable in a multicultural or Indigenous context. Consequently, psychotherapeutic approaches

such as psychoanalysis, analytic psychotherapy, cognitive and behavioural therapy, interpersonal psychotherapy, humanistic and existential psychotherapy, biopsychosocial psychotherapy and biological therapies demonstrate their basis in philosophical thoughts which are deeply embedded in western culture that is primarily individualistic and secular (Corsini & Wedding, 2000). By supporting the notion that these psychotherapeutic approaches are steeped in western philosophical thought and culture, confirmation is given to Sampson's (1988, 1991) views about Indigenous psychologies of individualism raised in Chapter One.

In analysing the relationship between philosophy, counselling and psychotherapy, Howard's (2000) proposition is that the philosophical principles of stoicism are found within cognitive behavioural therapy and rational emotive therapy. In coping with the distressing symptoms of anxiety and depression, stoics apply self-discipline and control of self-defeating attitudes. The philosophical thought of Spinoza (1632-1677), an arch rationalist, asserts that existence might be understood via mathematical analysis and deduction. Humanistic therapy is person-centred and integrates the philosophy of Rousseau (1712-1778) where emphasis is given to personal development through finding oneself. Kierkegaard (1813-1855), Nietzsche (1844-1900) and Sartre (1905-1980) are the philosophical thinkers who guide the existential approach in psychotherapy. For Kierkegaard, the father of existentialism, the self is seen as a balance between our unbounded potential and our finite reality. Nietzsche claimed we should have faith and hope in our potential, our actual existence and ourselves. Sartre calls attention to *the self*. Self for Sartre became its own god. Decisions and interactions count for more than past circumstances. For Sartre, what matters is what we make of environments and

events. We make meaning within what we choose, engage with and intend. In existential psychotherapy meaning is given to what is happening in the here and now. Underpinning the psychological concept of perception, the philosophical ideas of Kant (1724-1804) raise questions about the concept of empathy. Kant declared that we could arrive at the truth by reason and observation. However, Kantian philosophy then offers a challenge by asking how do we perceive and interpret that observation. The foundations of narrative psychotherapy are essentially from the philosophy of Sophocles (*c*.496-406) where story telling, such as a Greek tragedy, is a valuable medium for exploring the human psyche and circumstance. The philosophical ideas of Marx (1818-1883) are evident in counselling and psychotherapy when the client issues and problems are seen as primarily social, political and economic rather than simply psychological. Psychoanalytic therapy is steeped in the philosophy of Schopenhauer (1788-1860) who stresses the importance of sexuality and power as the key determinants of human behaviour and expresses the view that life is about pain and boredom. The basis of current psychotherapy includes factors that are cognitive, affective and behavioural which Knudson and Suzuki (1992) claim are generally grounded in "Judeo-Christian and Greek thought" (p. 9). It implies that, through our cognitions, we come to know ourselves. Affective factors are about love for our neighbour and it is through the behavioural factors that we do good works.

This very brief summary of the different philosophical influences on psychology, shown in this analysis by Howard (2000) and others (Knudtson & Suzuki, 1992), draws attention to the importance of the fundamental philosophy behind these major thinkers and gives depth to understanding current psychotherapies. It is within this context that I now examine current psychotherapies

in the treatment of depression and, more importantly, shed light on how therapies underpinned by western philosophical thought are, or are not, applicable when treating Aboriginal clients.

2.2.2 Current psychotherapies

Corsini and Wedding comment "all psychotherapies are methods of learning. All psychotherapies are intended to change people: to make them think differently (cognition), to make them feel differently (affection), and to make them act differently (behaviour)" (2000, p. 6).

Current psychotherapies in the treatment of depression include: *psychoanalytic, analytic, interpersonal, cognitive and behavioural, humanistic and existential, biological and biopsychosocial.* As I have already pointed out in the previous paragraph, these approaches are steeped in western philosophical thought. The goal of psychoanalytic psychotherapy is to uncover and make conscious the inner unconscious life of the psyche (Arlow, 2000). This is accomplished by assisting clients in reliving earlier experiences and working through repressed conflicts. Psychotherapeutic tools implemented include interpretation, dream analysis, free association, analysis of resistance and analysis of transference. The resolution of conflict alleviates the psychological discomfort such as anxiety and depression.

Analytic psychotherapy builds on from psychoanalytic psychology (Douglas, 2000). Analytic psychology formulates the central notion of the *collective unconscious* which is defined by Aizenstat as the "inherited psychic storehouse of

the human species" (1995, p. 92). The collective unconscious is made up of common psychological forms known as archetypes. The term archetypes, in the analytic sense, refers to psychological patterns that appear throughout the general human experience and can be seen in the themes of age-old myths, legends and fairytales found in every culture throughout the history of humankind. Analytic psychology places greater emphasis on dreams in terms of the archetypal patterns of the collective unconscious (Jung, 1962). From the perspectives of both psychoanalytic and analytic psychotherapy, the approaches to dreams are designed with the purpose of exploring the psychic life as it relates to the self or the individual. Douglas explains the goal of analytic psychotherapy as "re-integration, self-knowledge and individuation" (2000. p. 99).

Coming from another perspective, Sullivan (1996) puts forward the concept of interpersonal psychotherapy. The core of interpersonal psychotherapy is to examine ways in which the client's current interpersonal behaviour might interfere with obtaining pleasure from relationships. Interpersonal psychotherapy focuses on the present day interactions between the depressed person and the social environment.

Humanistic and existential psychotherapies (Frankl, 1963; May & Yalom, 2000; Rogers, 1961; Yontef & Jacobs, 2000) are experiential and insight focused approaches. The goal of therapy is to increase the individual's awareness of their motivations and needs. Emphasis is placed on the individual's freedom of choice along with the responsibility to shape one's life and for self-determination.

The groundwork for cognitive and behavioural therapy started with Beck (1987) and was developed by Ellis and Dryden (1997). It is framed around the cognitions and behaviour of the individual with emphasis on thinking, deciding, questioning, doing and deciding to think and act differently. Cognitive and behavioural therapy is intensely educational, cognitive and action orientated therapy. It is a therapeutic learning process that includes acquiring and practicing new skills as well as new ways of thinking and behaving. Consequently, changes in thinking and behaving overcome anxiety and depression.

The biopsychosocial psychotherapeutic intervention links the client's biological, psychological and environmental factors and offers a resolution of these factors in overcoming depression. Davison and Neale (1996) point out that the biological approach in therapy assumes a deficiency in a particular biochemical substance that causes mental health problems such as depression. By correcting this imbalance with a psychopharmacological intervention, the client recovers from depression.

This brief overview of contemporary models of psychotherapy and counselling outlines the key concepts and goals of therapy. Applications and approaches taken in these current models are linked to the underpinning of western philosophical thought that informs contemporary psychology. These contemporary models are useful in the mainstream context, however, because of the importance of the need to recognise the philosophical thoughts and cultural values that underpin psychotherapy, this study questions their relevance and validity in multicultural and Indigenous settings.

2.2.3 Limitations of western psychotherapy in the multicultural setting

Berry et al., (1992), Cuellar and Paniagua (2000) and Sue and Sue (2002) point toward the limitations of western psychotherapy in multicultural settings that are also made evident by Corsini and Wedding (2000). In outlining these limitations, Corsini and Wedding point out that psychoanalytic therapy is limited in the multicultural setting because it has no focus on teaching coping skills to clients who require such skills for dealing with pressing daily concerns. The internal focus of the client is often in conflict with cultural values that stress an interpersonal and environmental focus. Consequently, because of its emphasis on individualism, psychoanalytic psychotherapy as an effective intervention may be limited in its application within the context of multicultural counselling because some communities place greater importance on the community. Because person-centred psychotherapy has, as its main strength, a respect for individual client's values, worldviews and prizing of cultural diversity, it is in a position to make a contribution to multicultural counselling. However, limitations to person-centred therapy may arise when its philosophical framework of individualism is at odds with the cultural framework of the client whose culture is communal and where, for example, the accepted definition of Aboriginal mental health is one that embraces the physical wellbeing of the individual along with social, emotional, spiritual and cultural wellbeing of the whole community which is a whole of life view and includes the cyclical concept of life-death-life (National Health and Medical Research Council, 2003). With cognitive and behavioural therapy, the psycho-educational dimension of this approach is often useful in exploring cultural conflicts and teaching new behaviour. The focus on teaching and learning tends to avoid the stigma of mental illness. Existential therapy makes a contribution to multicultural counselling in that

focus is on understanding the phenomenological world of the client. This includes the cultural background of the client. For clients who live in a society where they are oppressed, existential therapy can be empowering. Clients are assisted in the examination of the options for change within the context of their cultural realities. Cultural values of collectivism, respect for tradition and deference to authority may come into conflict with existential therapy that values individuality, freedom, autonomy and self-realisation.

In summary, the recognition of the limitations of contemporary psychotherapies stressed by Corsini and Wedding (2000) gives further weight to the justification of examining the important links between culture, behaviour and psychology.

2.3 Culture, behaviour and psychology

Jahoda (1992) points out that, since the late 1940s, there has been a growth in interest in the relationship between psychology and culture that drew psychology into the debate concerning culture and behaviour. This debate showed the way toward the necessity of conducting studies across various world cultures and Berry et al. (1992) comment that, by 1980, "sufficient material had amassed to produce a six volume "*Handbook of cross cultural psychology"* (p. x). By the 1960s, Sue and Sue (2002) noted that a shift occurred with emphasis now being placed on the problematisation of the client who is culturally different. Emphasis was placed on the assimilation and adaptation of the client to the mainstream culture. By the 1990s, the focus shifted to the point where the therapist was seen as the problem. This led to prominence being given to counselling and psychotherapy expanding into areas such as *cultural*

competencies along with racial identity theories where culture and race were seen as independent and objective variables in models of multicultural counselling and psychotherapy. Berry et al. (1992), Cuellar and Paniagua (2000) and Sue and Sue (2002) stress the importance of cultural competence and clinical practice in multicultural settings. A cultural shift began to emerge with the inclusion of gender, race, ethnicity, sexual orientations and class as key variables in multicultural counselling and psychotherapy. However, Langton (2006), in her presentation at a Multicultural Forum in Melbourne, was scathing in her comment regarding the failure by the dominant culture in Australia to address the lack of representation of Aboriginal culture. In the psychological setting, this stems in part from a failure to either fully recognise or understand Indigenous cultural healing contexts. The principle of multiculturalism and diversity in counselling and psychotherapy, where the end game is universalism, is challenged by the relativism of Aboriginal culture in counselling and psychotherapy. Examination is now given to the interface of culture and the therapeutic encounter.

2.3.1 Culture and the therapeutic encounter

In psychological practice, Berry et al. assume that there is a "triangular relationship" (1992, p. 364) between the therapist, the client and the culture and that within that relationship, all three share a common culture. When an intercultural situation arises, as in the case of cross-cultural psychotherapy, Berry et al. point to the "serious misunderstandings" (1992, p. 365) that may result when western based theory and methods are used to assist persons of other cultures.

Sue and Sue (2002) comment that in the therapeutic encounter, it is a simplistic notion to accept the adage, ‘good counselling is good counselling’. This belief holds that phenomena such as anxiety and depression are present in all cultures and societies and all the practitioner psychologist has to do is to modify the existing assessment tools and therapies to suit the culture. It is a universalist approach grounded in concepts of assimilation and adaptation. Coinciding with that notion is the view that a western perception of what is considered to be typical and atypical behaviour and thinking is deemed to be universal and equally applicable across cultures. Others (Fadiman, 1997; Marsella & Yamada, 2000) emphasise the dangers of the premise that ‘good counselling is good counselling’ because it ignores the importance of cultural differences. The premise ‘good counselling is good counselling’ fundamentally dismisses the centrality of culture in the definition of counselling and psychotherapy. It ignores the truth that theories of counselling and psychotherapy are culture bound.

The fact that theories of counselling and psychotherapy are culture bound is significant to this study and this phenomenon is explored, more particularly in the context of the therapeutic relationship. Tensions may arise within the client or the therapist when examining their own cultural constructs. For example, Corsini and Wedding (2000) suggest that Jungian psychology acknowledges the importance of culture and cultural factors in the psyche. They emphasise the need of therapists to examine the cultural or ethnic construct of their own inheritances and experiences as well as the varied inheritances and experiences of their clients. This indeed can be especially confronting for the under-prepared non-Indigenous psychologists who find

themselves in a position of delivering psychological treatments to Indigenous peoples.

Cultural subtleties that may arise within contemporary psychotherapeutic interactions are referred to in various texts and the exploration of this interaction from the vantage point of theory and practice exposes some of these nuances. To begin with, commenting on the theory and practice issues in treating people from culturally diverse backgrounds, Sue and Sue (2002) give general consideration to the significance of the therapeutic relationship by emphasising the notion that culture informs the psychotherapeutic interaction between the therapist and the client. Others, for example, Corsini and Wedding (2000) and Berry et al., (1992) draw attention to the limitations of therapies as psychoanalysis, humanistic, cognitive and behavioural and existential approaches where the therapist and the client are culturally different. For example, the process of psychoanalysis, in which the psychoanalyst remains anonymous and the therapy supports the notion of individualism that underpins psychoanalytic theory, may be at variance with the client whose culture is communal (Sampson, 1988). The therapist in the humanistic therapeutic setting facilitates open dialogue, engages in active listening and displays a non-judgemental attitude. The therapist willingly allows clients to set the agenda for the issues to be explored during the session of psychotherapy. From a cultural perspective, limitations to humanistic or person-centred therapy may arise when the philosophical framework is at odds with the cultural framework of the client. A further drawback in person-centred psychotherapy is raised by Minas and McKendrick (1994). They comment that confusion may occur when the client, who is seeking help, skill development and direction from the therapist who, although

viewed as a knowledgeable professional, engages in non-directive therapy. For cognitive and behavioural therapy, the role of the psychotherapist is to be challenging and directive. Therapists may implement a variety of cognitive, emotive and behavioural techniques that are tailored to suit individual clients. Some techniques include challenging irrational beliefs, carrying out homework assignments, changing language and thinking patterns, role playing and confronting faulty beliefs. In a multicultural setting, the strength of cognitive behavioural therapy lies in the collaborative approach between the client and the therapist as they deal with the areas of concern. Some clients also respond well to the active and directive stance of the therapist. In a multicultural setting, limitations to cognitive behavioural therapy may arise when the therapist engages in examining the clients' cognitions without understanding and respecting their worldview (Minas & McKendrick, 1994). As a result, clients may have some qualms about questioning their values and beliefs that are culturally driven. Few techniques flow from the existentialist approach because it calls attention to understanding first and to technique second (Corsini & Wedding, 2000). As a consequence, the therapist may take an eclectic approach or borrow and adapt techniques from other approaches and incorporate them into an existential framework.

Exploration of theory and practice shows the general limitations imposed between the client and the therapist and their cultural differences. The therapist needs to be aware of potential limitations that may come into conflict with cultural worldviews such as individuation, self-actualisation, self-determination and self-expression. Minas and McKendrick (1994) remind those who engage in multicultural

settings that the cultural value of keeping problems within the family, in order to avoid social shame, makes it difficult to explore conflicts openly.

In summary, by reviewing the triangular relationship between the client, the therapist and culture within the context of the therapeutic encounter, Corsini and Wedding (2000) and others such as Berry et al., (1992) show that the suppositions embedded in western forms of therapy reaffirm the cultural disparity between the non-Indigenous psychologist and the Aboriginal client. This means that mainstream western counselling and psychotherapy are entrenched in certain philosophical propositions and values which are strongly sanctioned by western civilisations and are not necessarily the values of Aboriginal clients. This raises the quintessential debate on universalism versus cultural relativism in the context of psychology.

2.4 The universalist versus relativist debate in psychology

In opening up this debate, Sue and Sue (2002) point out that, on the one hand, there are the culture specific (*emic*) beliefs that people are unique and that the psychosocial unit of operation is the individual, whilst on the other hand, there are the universal (*etic*) beliefs that the clients are all the same and that the goals and techniques of counselling and psychotherapy are equally applicable across all groups. In the therapeutic situation, it can be tempting to assume that all clients share a background as human beings with universal life experiences and that the *one size fits all* approach in therapy is effective with all clients.

This study challenges that notion as a flawed belief and holds that the individual is seen in gestalt. Misra and Gergen support the concept of

"interconnectedness, Whole or Gestalt" (1993, p. 235) and consider that the whole of the person is greater than the sum of its parts. They state that "using a concept from an alien culture does not fit congenially into the Whole and results in a patchwork psychology with little or no meaning and much confusion" (1993, p. 235). Supporting this notion, Lee and Ramirez III claim that multicultural psychotherapy that includes culture specific approaches risks potential crisis "when too many theories are available to therapists and the salience of multiculturalism becomes trivialized" (2000, p. 286).

Understanding the ways in which social and cultural forces shape human behaviour is important to this study. One way of gaining insight into these forces is through the concept of cross-cultural psychology that is explained by Kim and Berry (1993). They take a scientific approach and support the notion expressed earlier by Berry (1980) that cross-cultural psychology is essentially universalist and has the following three goals:

> to transport and test existing psychological theories in different cultural settings to verify their generalisability and applicability, to explore and develop psychological understanding grounded in a particular cultural context, and to compare knowledge obtained through the first two goals and integrate them to arrive at a more universal description and explanation. (Kim & Berry, 1993, pp. 21-22)

This research differs from those who support the cross-cultural globalised position and supports the view expressed by Moodley and West (2005) who suggest that, under the guise of promoting cultural and social equity, cross-culturalism and

multiculturalism has, in fact, led to the fragmentation and disempowerment of many cultural groups. They argue that multiculturalism has remained resistant to changing the status quo of the dominant culture. This is problematic for psychotherapy researchers and others to find meaningful understanding of how to apply multicultural ideas in their clinical work.

This study is also at variance with views held by critical cross-cultural psychology where those, such as Gonzales (2000), claim that traditional cross-cultural psychology has not delivered what it should in the context of a culturally diverse Australia. Gonzales puts forward, in part, the view that critical-cross cultural psychology needs to "go beyond internal factors such as causal explanation of behaviour, and establish association of external factors with the ideological context and its implications on social justice issues" (2000, p. 309).

In engaging with the discussion surrounding the proposition of the universal versus culture-specific debate, Lee and Ramirez III cite Fukuyama (1990) and others (Fischer, Jome & Atkinson, 1998; McFadden, 1999; Patterson, 1996) who endorse "the inherent role of culture in all theories of psychotherapy" (2000, p.285) and articulate a transcultural/universalist approach that acknowledges common experiences among different populations, for example, discrimination, oppression, matching worldviews, need for identity and value of validation and empowerment and "integrates this knowledge into existing theories and processes of psychotherapy" (2000, p. 285). In counterpoint to Fukuyama's universal approach to counselling and psychotherapy, Lee and Ramirez III (2000) cite Locke (1990, 1992) who argues for culture specific interventions stating "this approach to psychotherapy

has led to revisions in traditional models, as well as to the development of indigenous or culture specific psychotherapy" (2000, p. 285). Sayeed (2005) has taken a relativist approach and developed what is known as *psychology of the third kind* which is grounded in the notion of Indigenous psychological practice based on the local cultural and ecological frame of reference. Sayeed's view opens the way to respond to the call for recognition to be given to Indigenous psychologies.

2.4.1 Multicultural, cross-cultural and Indigenous psychology

Moodley and West (2005) believe that "a paradigm shift that includes and integrates traditional healing methods into mainstream counselling and psychotherapy will provide a mental healthcare process for oppressed/colonized people. Additionally, it will enrich and broaden psychotherapy and counselling generally" (2005, p. xvii). They support Langton's (2006) call for coexistence between cultures.

In examining the historical relationship between psychology and culture Berry et al., (1992) suggest that in cross-cultural research, psychology acknowledges the multiplicity of human behaviour in the world as well as the linking relationship between individual behaviour and the cultural context in which it occurs. Essentially, cross-cultural psychology draws on the scientific tradition of general psychology, which is by nature an individualistic discipline as well as other associated disciplines, for example, anthropology has gained much of its recognition from using more naturalistic and observational methodologies. As such, cross-cultural psychology, according to Berry et al., is viewed as an "inter-discipline operating in a space that has been left vacant" (1992, p. 14).

A case for *transdisciplinary* research and practice is put forward by Christie who proposes that:

> *transdisciplinary* research is different from interdisciplinary research because it moves beyond the disciplinarity of the university and takes into account knowledge practices, which the university will never fully understand. Indigenous knowledge traditions resist definition from a western academic perspective. (2006, p. 78)

This study goes beyond the cross-cultural, critical cross-cultural and current multicultural notions. It goes beyond theoretical approaches, methods and interventions that are developed in western culture and transposed or even imposed on to another culture. Sometimes issues related to social justice have the potential to turn the treating practitioner into an advocate rather than a healer. The transdisciplinary view proposed by Christie (2006) adopts the proposition made by Kim and Berry (1993) which argues strongly that Aboriginal people are investigated in their respective cultural context which is "informed by *their* views, and *their* understanding of what *their* cognitive life is about" (1993, p. 22). Extending this view, Davidson (1992) discusses the complexities for the advancement of applied Aboriginal psychologies and states:

> The preconditions for an applied Aboriginal psychology will include (a) the extent to which an indigenous Aboriginal psychology reflecting Aboriginal worlds is developed by trained Aboriginal psychologists, and (b) the extent to which there is change in non-Aboriginal psychology to allow for the

> recognition of indigenous constructions of Aboriginal lives in cultural and historical context, and of alternative methodologies which pass interpretive control from non-Aboriginal psychologists to Aborigines. In other words, […] such a change must allow Aborigines' perceptions of psychology as a profession, vis-à-vis other professions to determine how psychology can reflect Aboriginal cultural values and how psychology can work for and in Aboriginal communities. (p. 17)

2.5 Aboriginal philosophical thought

> "They (white people) see us living in the white way and often they don't realise that we are still living by the beliefs and ways of our ancestors." (Pryor, 1998)

This salient comment articulates the fact that Aboriginal philosophical thought, knowledge and culture continues to be lived today. As mentioned earlier in this chapter, the exploration of philosophical thought is important to this research because, as Howard (2000) points out, philosophy grounds therapy as a process toward healing, direction, identity and meaning for both the practitioner and the client. Psychologists working with Aboriginal clients need to have an appreciation of Aboriginal philosophical thought because the understanding that arises from such an appreciation will be the key paradigm for a culturally appropriate psychotherapeutic intervention. Aboriginal worldviews, culture and history give meaning and validity to therapeutic interventions for Aboriginal people.

Aboriginal Australians' set of values and beliefs is grounded in the concept of connectedness and relatedness (Cameron, 1992; Grieves, 2002; Harrison, 2003; Martin, 2003; Musgrave, 2003; Stanner, 1979). Connectedness is embodied in the principles handed down by the supreme beings that created the landscape, all species and humans. Dudgeon, Garvey and Pickett (2000a) describe this connection and relatedness through the concept of *kinship*:

> In a broad and yet powerful sense, kinship determines how one person stands to another in Indigenous Australian societies, shaping expectations and obligations one to the other, and conveying a strong overall sense of relatedness. Notions of kinship were – and even today in large parts of Australia – reinforced symbolically in totemic systems and in the 'skin' systems found across much of the continent. (p. 28)

This core set of values and beliefs has, and continues to be, transmitted from one generation to the next through the Aboriginal oral tradition. Story-telling (Dudgeon, Garvey & Pickett, 2000b; Randall, 2003) is the main conduit for the stories inherited from the supreme beings in the *dreaming*. Dudgeon et al., (2000a) explain the dreaming as:

> timeless, like another dimension that exists parallel with the present world. Activities that are undertaken in the present world connect back through to the dreaming. Ceremonies were held to ensure the wellbeing of all things and their connection into the dreaming. Some such ceremonies are still part of cultural practice today. (p. 28)

Stories are, essentially, an expression of the profoundly held philosophy of Aboriginal Australian people (Cameron, 1992; Cowan, 1992; Dudgeon et al., 2000a). Aboriginal philosophy emanates from the time of creation, at a time when supreme beings that assumed human and animal form simultaneously, were powerful enough to create a sense of order in a world. There were no boundaries between life forms. All the natural species, the land and the humans were part of the same ongoing life force. When the supreme beings completed their work they settled down and remained as features of the landscape. The places where the ancestral beings live on are known as sacred or special sites. The stories connected to each site give Aboriginal people an identity and an understanding of the relationship between the natural world and human beings (Chatwin, 1987; McConchie, 2003). Dudgeon et al., (2000a) further define dreaming as:

> A period of creation when, in the dawn of time, the great spirit ancestors arose and created the land and all living things. Taking different forms they wandered the earth. After their journeys, some went to the sky and others went to waterholes or the earth leaving behind signs of their earthly existence. These were in the form of caves, hills, rocks, rivers and other natural features. (p. 28)

In the beliefs inherited from the ancestral beings, humans, animals, land, weather, sun, moon, sky and stars belong to a conceptual, spiritual and social whole. Ultimately, these beliefs give Aboriginal people an essential sense of being connected to land and to the whole of creation. For Martin (2003), connectedness comes with a set of obligations and is embodied in cultural practices. Ceremonies are

the expression of human ties and responsibilities to the land; initiation rites express the ways of making men and women in the proper way of knowledge and awareness; mourning ceremonies guide spirits back to their sacred, totem site; and healing and harming rituals call on the power of the spirit ancestors for assistance.

In exploring the significance of Australia's sacred sites, Kohn (2002) refers to the *Tjukurpa* otherwise known as the *Law*, as an example of an Aboriginal philosophy. Its beginnings came about at the time when heroic beings, merged with attributes that were both human and animal, camped and travelled across the land. As they journeyed, these heroic beings shaped and created the features of the landscape. The actions of the heroic beings created and instituted a code of behaviour that regulates all aspects of life, from managing the landscape through to social relationships and identity. The *Tjukurpa* is expressed through story-telling, song, ritual and ceremony, art and the landscape itself. Aboriginal peoples in Australia have a culture that accords the nature of existence and of truth and knowledge, most importantly to place rather than time. By contrast, Knudtson and Suzuki (1992) point out that Europeans view their culture and philosophy through the lens of time and history.

> Aboriginal societies across Australia have a culture that accords metaphysical primacy to place rather than time. Thus, while Europeans ignore the Aboriginal notion of being in the world, of connectedness to place, kin, community, all species and the natural world, they have insisted on the perspective of time and history. (Grieves, 2002, p.2)

In exploring the cultural and psycho-spiritual meaning of the *Dreamtime*, Cameron (1992) explains that the Aranda people in Central Australia name it, "Alcheringa. The sacred Dreaming. The Eternal Now" (p. 77). Cameron states that the dreaming is "dynamic and has within itself the resources by which the shock of new experience can be absorbed" (p. 80). As mentioned earlier, unlike western philosophical thought that is locked into time and historical events (history), the *Alcheringa* is capable of change. According to Cameron (1992) and Stanner (1972), the *alcheringa* (dreaming) is eternal. Whatever the challenge, there is reason to believe that the dream will not die. For example, when a young Aboriginal Australian man was asked by a television news reporter on Australia Day, 26 January 2004, about what he thought of all the celebrations, I noted that the young man replied that it was okay as it was part of his dreaming now.

> As to time, Elkin accepts that the Aboriginal does "recognize a past as distinct from the immediacy of today: but it is not a past that stretches very far back – at the most two or three generations", and "it is not a past that is gone forever". Elkin explains that under this conception man and natural phenomena do not exist *now*, and the events do not happen *now*, as a result of a chain of events extending back to a long-past period – a 'Dreamtime' – a beginning. They exist and they happen because that Dreamtime is also here and now. It is The Dreaming, the condition or ground of existence. (Stanner, 1976, p.33)

Aboriginal philosophy can be seen as a holistic set of guidelines for a way of life adapted to the Australian environment. The English language, as a vehicle of

western consciousness (values), is a largely inadequate vernacular when applied to the interpretation of Aboriginal ways of being and doing. In the Aboriginal ontology, individuals or communities do not own land as an asset. Connection to the land is not envisaged from the point of view of attachment to individual property. Rather, land is very much a part of the creation story, of the dreaming. It is inextricably tied to ceremonial obligations, kinship and custodianship. In Aboriginal philosophical thought, the land is the basis of Aboriginal life. This cultural difference was recently highlighted in the film, *One night the moon* (Perkins, Lucas, Humfress & Whitehead, 2001) where the Aboriginal person identifies himself 'as' the land by claiming "I am the land – this land is me" and the European person identifies 'with' the land by stating, "this land is mine – I own it."

Aboriginal worldviews have, in the past, been dismissed as having no validity by the colonising powers. Aboriginal Australians were seen as being primitive, preliterate, stone age and simplistic. The colonisers ignored the depth and significance of Aboriginal religious practice. Looking beyond the past dismissive attitudes of the colonial powers, the validity and reality of Aboriginal philosophical thought is grounded in Aboriginal culture and worldviews. The strength of Aboriginal philosophy is expressed in traditional religious practice. Religious practice is a symbolic representation of people's relationship with their universe. It governs their behaviour, supports them in distress, brings order to their lives and gives value and soundness to their actions.

Through this lens of Aboriginal philosophical and cultural thought, the way of experiencing the world is remarkably different from the experience of non-

Indigenous people. This is felt most keenly in the field of mental health. The words of the following song written by Jimmy Chi (1996), an Aboriginal musician and performer, describes the predicament for both the treating practitioner and the client when the therapy and the patient are operating from two culturally different positions of perception relating to mental health:

He's a Modern Doctor of Psychiatry
And he's trained in Freudian psychotherapy
And when something works he says "bugger me"
He's a Modern Doctor of Psychiatry
There's no money for research in psychiatry
But lot of money made by the drug companies
And the drugs bugger you up physically
And there's never any help for the family
We are modern doctors of psychiatry
And we're trained in Modern Pharmacology
And when something works we say, "bugger me"
We are Modern Doctors of Psychiatry
Most hospital admissions in all countries
Are for those disturbed emotionally
With a rising cost to Society
But no money for research in Psychiatry
Now the patients form the homeless in the worlds' cities
And they're ostracised by society
And the sick keep suffering needlessly

Cause there's very little funding for the agencies

He's a Modern Doctor of Psychiatry

And he's trained in Freudian Psychotherapy

All alone he thinks something's bothering me

Cause he's never never ever cured nobody.

Jimmy Chi has captured the quintessential failings of contemporary western psychotherapies, psychopharmacology and research with regard to their efficacy and appropriateness when treating Aboriginal people and Koolmatrie (1998) gives a further example of such a mismatch. She expresses her concern with regard to some techniques implemented by some non-Indigenous psychologists who are working with Aboriginal clients:

> For instance, cognitive therapies can be very useful for healing up to a certain point, but they can also be damaging. When a person has lost their family, lost their culture, it's no good saying to them "You've got to change the way you think." The way they feel has to be validated as a natural response to extreme trauma […] or when a therapist tells a suicidal person that it's their thinking that is wrong, and that person can't change the way they think, they may go out and suicide because they feel hopeless and no good because they can't change their thoughts. (p. 17)

The mismatches described by Chi and Koolmatrie are clear. They show how contemporary psychology ignores Aboriginal culture in mental health with the consequence of falling short of being helpful in the treatment and recovery process

for Aboriginal people. Trying to resolve these mismatches has led to the discussions on the *indigenisation* of psychology as opposed to *Indigenous* psychology.

2.6 The indigenisation of psychotherapy versus Indigenous psychology

Part of the problem for non-Indigenous psychologists that are mentioned in Chapter One raises the point that researchers in the past have attempted to understand mental illness among Aboriginal peoples by "applying Western categories" (Minas & McKendrick, 1994). This is exemplified in what Berry et al. (1992) name as the *indigenisation* of psychology which they describe as taking an imported psychotherapy and then engaging in the process of adapting that imported psychology to local culture. Indigenising psychology is explained by Berry et al. (1992) as "doing psychology *in*" (p. 379) a culture and supports a universalist approach, whereas Indigenous psychology is expressed as "doing psychology *of*" (p. 379) a culture, which supports a relativist approach. Indigenous psychology, as distinct from indigenised psychology, is defined by Berry et al. (1992) as "a system of psychological thought and practice that is rooted in a particular tradition" (p. 380). This is an important point because, by indigenising psychotherapy, psychologists working with Aboriginal clients may well end up playing the role that Berry et al. (1992) call "inadvertent acculturators" (p. 380). As a consequence, this causes further injury to the client by aggravating their condition through the use of an inappropriate attempt at psychotherapy, the comments made earlier by Koolmatrie, being one such case in point. Minas and McKendrick remind us that "the mental health of Aboriginal groups cannot be separated from physical, spiritual, social and cultural life" (p. 301).

Early scientific research into multi-cultural and cross-cultural psychology took the view that the natural sciences tradition and the cultural science tradition were “complimentary rather than mutually exclusive” (Kim & Berry, 1993). It was presumed that individual psychological processes could be systematically investigated in a laboratory setting through controlled experimentation. However, cultural patterns cannot be brought into the laboratory to be analysed and quantified, so in order to accommodate cultural differences, western psychology has often engaged in a process of indigenising psychology.

As mentioned in Chapter One, Vicary (2000) makes the salient point that non-Indigenous psychologists generally have no formal understanding of, let alone training in, Aboriginal culture or Aboriginal psychology; they are left with few strategies. Berry et al., citing Moghaddam (1989), note that because psychologists are generally trained in an environment that is focused on western topics “the psychologist is ill-equipped to deal with broader issues set in complex local cultural settings” (1989, cited in Berry et al., 1992, p. 380). Consequently, they have generally drawn on therapeutic interventions that are grounded in western philosophical thinking and informally modified them to suit the local cultural situation.

It is through the process of indigenisation, that psychologists have sometimes tried to fill the gap in psychotherapy mentioned in Chapter One. By modifying their own skills and knowledge, they ignore the possibility of other cultural knowledges and pay no heed to the fact that, historically, societies have always had their own

cultural healing knowledges and their own healers. Consequently, it is worthwhile to revisit the origins of psychotherapy.

2.6.1. The origins of psychotherapy

Systems embodying ancient knowledge providing the solutions to health problems, whether such problems are diagnosed as physical or psychological, have been kept under the guardianship of traditional healers from time immemorial. Certain techniques that have always been implemented by traditional healers are now sometimes used in contemporary psychological practice, for example, altered states of consciousness (hypnotic trance), guided visual imagery and anxiety reduction (Harner, 1990b). Walsh (2000) puts forward the notion that:

> Historically, the earliest psychotherapists were shamans or traditional healers who functioned as doctors of traditional medicine, individual therapeutic healers and tribal counsellors. Through various techniques such as drumming, fasting and dancing, the shaman alters his state of consciousness and with heightened sensitivity, is able to access intuitive knowledge to make diagnoses and recommend treatments. (p. 413)

Shamans, also known as traditional healers, still practice in most countries of the world (Eliade, 1989; Walsh, 2000) making their techniques and ways of healing the psyche the most resilient and durable over time. Shamans or traditional healers devised “the world’s first projective test” (Walsh, 2000, p. 414). The tests consist of the patient being told to find a rock and then describe what images they see on each side of it and what these images mean to them. The problem is that modern

psychotherapies have generally sought to understand traditional healing techniques through western paradigms. For example, in trying to make sense of this particular technique, Walsh (2000) has yielded to the temptation of interpreting the traditional healing technique by gazing at it through the lens of western thought and, subsequently, superimposing a western mainstream psychological explanation of a shamanic or traditional healer's technique, in other words, indigenising a traditional healing technique. Walsh's explanation is worth challenging because what seems to be ignored here are the two vastly differing philosophical and cultural underpinnings that guide this technique. Corsini and Wedding (2000) explain this technique as a projective test, in the mainstream sense of psychology, which is grounded in psychodynamic thinking. In counter-point, Gray (1995) offers a challenge to Walsh's explanation by pointing out that in shamanic or traditional healing, such a technique is grounded in ancient traditional knowledge and worldviews that engage the mind, body and spirit as well as connectedness with the natural world.

> That's one theory. There are many theories and one can entertain them all simultaneously. An Indigenous person might see this rock divination as one of the stone people coming as an ally to a person seeking help. The language of the rock is its ability to show the seeker images […] the key point here is that we native people experience such healing images as a gift from the rock, and we express gratitude. What Western psychology has done with the so-called projective principle is to diagnose and categorize people – not to *directly* heal people. (Gray, 1995, p. 178)

In addition, not only may Walsh's explanation be considered to be furthering the oppression of traditional culture but as also seen as unethical and a form of what others (Dudgeon & Oxenham, 1990; JC17, 15 January 2004) call *new assimilationist* thinking. The important lesson to be gained through Walsh's example is that although what may appear to be a projective test or technique can in fact be underpinned by two different cultures. So, whilst the psychotherapeutic technique with the stone may look like a projective test, it may in fact be very different because of the traditional healing culture that informs the process when used by shamans or traditional healers.

A fundamental pitfall that comes from disregarding the importance of culture is frequently evident within the New Age movement that often poses as an unregulated alternative psychotherapy with *borrowed* traditional techniques for healing. Kirmayer, Brass and Tait (2000) claim that, like many other Indigenous ways of healing, Aboriginal traditional healing knowledge seems to be at risk of being misappropriated by the New Age phenomena. The New Age culture generally seems to function in a kind of consumerist mode by creating a spiritual item for consumption that becomes a form of spiritual consumerism that packages and markets ancient wisdoms and Indigenous understandings of the creation of the universe in order to satisfy the current spiritual yearnings of the western psyche. One such critic of the New Age movement is Helena Gulash, a *Gubbi Gubbi* Aboriginal activist who sums up the criticism expressed by some Aboriginal people about the New Age movement in Australia that they see as exploitative of Aboriginal culture (Cuthbert & Grossman, 1997). Gulash addresses this criticism of the New Age movement in an interview with Cuthbert and Grossman (1997) titled *Crossing*

Cultures. Cuthbert and Grossman cite some aspects of the Woodford (formerly Maleny) Folk Festival in North Queensland as examples of such exploitation and state Gulash's concern about:

> the ways in which a lot of people in the New Age movement actually adopt practices which they take out of context and then attribute them as being part of Aboriginal culture […] there were lots of concerns at the last Woodford Festival because there were a lot things happening, apart from some of the more obvious things like non-Murri people selling Murri artifacts, didgeridoos and boomerangs and playing didges and that sort of thing, which we do see as cultural appropriation and also offensive. (1997, p. 3)

Other examples given by Gulash in her interview with Cuthbert and Grossman (1997) include advertising of healing methods that involve using the didgeridoo and non-Indigenous people advertising themselves as healers who tap into the healing energies of the sacred *tjuringa* stone. According to Gulash, the concern among some Aboriginal people lies in their fear that some of the New Age practitioners might misunderstand and misuse the practices of Aboriginal culture, especially Aboriginal spirituality, particularly when it comes to healing. Adding further emphasis to this concern, Cuthbert and Grossman (1997) refer to Aboriginal historian Jackie Huggins, who likens the behaviours of many non-Indigenous people at the Woodford/Maleny festival to those that motivated Marlo Morgan. Morgan's book, *Mutant Message Down Under* (1994), is a somewhat fictional account of the author's life changing experiences over a four-month period of engagement with Aboriginal people from a remote community. It is one such example of the misuse

and disrespect of Aboriginal spirituality and healing methods and Huggins calls such New Age desires to access Indigenous cultures “exotic tourism” (cited in Cuthbert & Grossman, 1997, p. 2).

It is important and prudent to make sure that Indigenous therapies do not simply become a series of techniques (Wilson, 2003). What is really important is the context of the therapy and the Indigenous theoretical underpinnings that guide and inform the therapeutic techniques within an Indigenous paradigm. To treat Indigenous clients without the knowledge of Indigenous theoretical underpinnings, is like trying to practice modern psychological techniques without understanding the theories of those such as Freud, Jung or Skinner. Literature is filled with examples of indigenisation of psychotherapy.

> Indeed confusion can result when “the techniques and ideology of modern psychology are […] overlaid, in some cases in considerable haste, upon an ideological background composed variously of Hinduism, Islam, Buddhism, Taoism, Confucianism, Shintoism and Marxism and Leninism, themselves occurring in a range of combinations. (Turtle, 1987 cited in Berry et al., 1992, p. 379)

Like indigenisation, the concept of bricolage (Levi-Strauss, 1966) claims, in part, that by adapting interventions that are essentially mainstream western and putting these to different uses that are relevant and consistent to Aboriginal people constitutes a suitable psychotherapy. The supposition is that the overall holistic goal of the healing process may be successful because it considers the relevance of

Aboriginal culture. Singh's (2000) psychotherapeutic intervention, based on the modified multimodal assessment and therapy, is one such example of bricolage. Multimodal therapy developed by Lazarus is based on the belief that "patients are usually troubled by the multitude of specific problems that should be dealt with by a broad range of specific methods" (2000, p. 340). Multimodal therapy goes beyond the standard behavioural tradition by adding a unique assessment procedure and by dealing in great depth and detail with sensory, imagery, cognitive and interpersonal factors and their interactive effects. Crucial to multimodal therapy is the multimodal assessment known as the BASIC.ID, an acronym that stands for Behaviour, Affect, Sensation, Imagery, Cognition, Interpersonal relationships and Drugs/biology. Multimodal therapy is personalised and individualistic. The modification by Singh (2000) to the BASIC.ID assessment has resulted in the development of what he calls the BASSIC.ID psychiatric assessment protocol whereby spiritual aspects of the self are added on to the existing assessment protocol as an acknowledgement of the importance of spirituality among Aboriginal people and therapy includes the *spiritual* aspect of the individual and how spirituality influences their lives (Singh, 2000). Bearing in mind the cultural sensitivity and cultural competence required by mental health workers when treating Indigenous clients, Singh's motivation has been to make assessment questionnaires and therapeutic interventions more culturally sensitive. However, from an indigenisation position, Singh's work does not recognise Aboriginal ontology and epistemology in its fullness and views spirituality simply as another variable.

Shamanism, has long been thought of as part of the heritage of analytical psychology (Sandner, 1997; Walsh, 2000). These two branches of learning appear to

follow similar patterns. For the client, the dynamics of traditional healing seem to be an experience similar to the archetypal processes of analytical psychology. That is to say that the dynamics of traditional healing, which include the inner journey, encounters with magic animals, the ease of movement through time and space, the supernatural control of elements and the death and rebirth experience, are all part of the interior encounter of the contemporary analytic client. In attempting to understand traditional healing, the psychologist trained in western psychotherapy needs to be mindful of the pitfalls of *indigenisation* as a way of interpreting traditional cultural ways and techniques of healing. Dudgeon and Oxenham (1990) counsel psychologists against engaging in such behaviour and falling into the position of *new assimilationism*. What is perhaps more useful is to examine the points of agreement between these two bodies of psychological knowledge.

2.6.2. Points of agreement between western and Aboriginal psychology

Whilst western psychology and Aboriginal psychology are grounded in worldviews that are philosophically and culturally different, the literature shows that there are some *points of agreement* at the interface between analytic psychology and traditional healing practices. Aizenstat (1995), Cameron (1992), Eliade (1989), Gray (1995), Harner (1990b), Hillman (1995), Knudtson and Suzuki (1992), Sandner (1997), Tacey (2000) and Wilber (1994) show that the trance experienced in traditional healing is a concept and experience that runs parallel with the concept of active imagination in analytic psychology. In both traditional healing and analytic psychology there is a quest to seek direct experience with an inner world. In analytic psychology, this is expressed as archetypes and the *collective unconscious*. In traditional healing, the experience is expressed as the spirit world with spirit helpers.

Both traditional healing and analytic psychology acknowledge a separate space to which the psyche has access. Traditional healing and analytic psychology follow remarkably corresponding patterns. The archetypal processes of analytic psychology provide the client with the experiences of the dynamics of traditional healing. The inner journey, encounters with magic animals, the ease of movement through time and space, the magical control of elements and the death and rebirth experience of traditional healing parallel the experience of the modern analytic client. Traditional healing practices and analytic psychology are clearly externally dissimilar and yet so inwardly juxtaposed, offer something to teach and learn from each other. Both traditional healing practices and analytic psychology focus on the healing and growth (individuation) of the psyche and work toward creating a state of wholeness both within and without the client/patient.

At this interface where the points of agreement between western and traditional healing become apparent, Knudtson and Suzuki (1992) give attention to the ongoing interest and dialogue between values and concepts stemming from these two divergent cultures and worldviews. Levi-Strauss (1966) refers to the world of the traditional native healers and the world of the western scientific healers as two parallel modes of acquiring knowledge about the universe that have managed to create and develop autonomously two distinct, though equally positive, sciences.

There is a growing appreciation of the distinctive qualities of Aboriginal culture and thought. As mentioned earlier in this chapter, the historical sources of psychological treatment reach back to tribal rites and ancient practices of tribal healers. From the viewpoint of traditional healing, personal empowerment is basic to

health under all conditions of one's life (Moodley & West, 2005; Walsh, 2000). It resonates with the findings of Swan and Raphael (1995) in relation to the current priorities of self-determination, self-management and empowering Aboriginal people with regard to their physical health and their social and emotional wellbeing. Aboriginal people have always had their own healers.

2.7 Aboriginal healers in Australia

Harner (1990a), citing Elkin (1945), states:

> […] Aboriginal medicine-men, so far from being rogues, charlatans or ignoramuses, are men of *high* degree; that is, men who have taken a degree in the secret life beyond that taken by most adult males – a step which implies discipline, mental training, courage and perseverance […] they are of immense social significance, the psychological health of the group largely depending on faith in their powers […] the various psychic powers attributed to them must not be too readily dismissed as mere primitive magic and 'make believe', for many of them have specialized in the working of the human mind, and in the influence of mind on body and of mind on mind. (1990a, p. ix)

Musgrave (2003) gives further evidence to the reality of Aboriginal traditional healing in Australia as he describes his experience of working through his totem. He says:

> I work through the water eagle. My body in this chair here, no one touches me, they know I'm with the eagle. Everyone leaves me alone when I am like this. I can look down from the sky. I'm like a doctor man. My totem, that's the fish eagle. (pp. 100-101)

There has been an increasing interest and awareness in traditional forms of healing in recent times which seems to stem from the recent development of holistic health approaches that actively employ the mind to help in healing and the maintenance of wellbeing (Harner, 1990b). Specific techniques long used by traditional healers, such as an altered state of consciousness, that is, hypnotic trance, stress-reduction, visualisation, positive thinking and assistance from non-ordinary sources, for example, spiritual sources, are some of the interventions that are widely implemented in contemporary holistic practice. Traditional healing methods of entry into trance state often take the form of a droning or repetitive percussion sound to enter this altered state of consciousness.

Writing about Aboriginal mental health and Aboriginal culture, Cawte (1974, 1996) supports the importance of traditional healing research and practice with Aboriginal peoples in Northern Australia. In a similar vein, Wanganeen (1994) developed a psychotherapeutic process that she calls the *Tangka Manninendi* ceremony which, translated, means "to alter the mind for the better" (p. 10). This ceremony consists of seven phases and stems from Wanganeen's personal healing process regarding her experience of being removed from her family, alienated from her culture and her difficult journey *home* again. As well, Harrison (2003) describes the way in which traditional healing can take place by taking people to walk the land

together. He maintains that healing occurs by stepping out of the ego and into the spirit and listening and watching. By walking the land, Harrison refers to "bushwalking-watching the waters-listening to the wind-hearing the bird sing-watching the antics of the animals, watching the birth of a flower" (2003, p. 8). Those who hold the title of *Grannies* in the Indigenous communities assist in the mental health care of the Aborigines. Recognising the importance of family as part of the healing process, Seru (1994) suggests that the role of grannies has involved child supervision, teaching children, informal group therapy through basket weaving, food gathering and cooking, psychological development, growth and healing. Traditional and modern tribal songs, stories, dance and art, often taught or fostered by the grannies, are also forms of psychotherapies integrated into the repertoire of Aboriginal traditional healing techniques. As mentioned in Chapter One, an Aboriginal concept of traditional healing has been developed by Roe (2000). This concept of healing includes the place of the inner spirit that he calls *Ngarlu* and is grounded in Aboriginal culture. The healing concept of *Ngarlu* is holistic. It includes Aboriginal concepts of emotional, spiritual and social wellbeing. In recognising two cultural styles of psychotherapy, Koolmatrie and Williams (2000) claim that mainstream psychological techniques can be utilised in a collaborative manner with Aboriginal interventions, then narrative therapy, group therapy and psychoanalytic therapy may be seen as useful adjunctive interventions for healing.

Aboriginal peoples have their own system and comments that mental health was always there and it is there with strength (Sambono, 1993). He says that Aboriginal systems need to be conducted in parallel with western systems of psychological treatment. Indigenous psychotherapies include men's ceremonies and

women's ceremonies. He makes it clear that Aboriginal people know who to go to in their community if someone is sick or in trouble. Aboriginal people know their kin system as a way of communication between other tribes and communities. Sambono urges psychologists to go to the old people and the young people and to listen to what they say. Consequently, psychologists are urged to listen to Aboriginal people, to look at their problems, to understand their way of life and to understand their traditions and values. Sambono comments that there needs to be recognition by those who train Aboriginal Health workers of Aboriginal ways and western ways and states that "we need to work together" (1993, p. 43).

2.8 Summary

The main conclusion reached from the review of the literature is that there is a need to move beyond the present *universalist* cross-cultural or multicultural approach of the dominant western culture in psychotherapy when working with Aboriginal clients. We need to move beyond problematising the Aboriginal client or simply focusing on the competency of the psychologist. This thesis addresses the challenge toward developing an Indigenous psychotherapy that is clearly embedded in Aboriginal philosophy and is theoretically grounded in Aboriginal ontology and epistemology that is expressed in a culturally appropriate technique which may be applied in practice by non-Indigenous psychologists in the treatment of depression. The transdisciplinary paradigm proposed by Christie (2006) offers a way of bringing into consciousness traditional psychological healing that may be accessible in collaboration with current psychotherapies, and this is supported by Moodley and West (2005), that opens toward an Indigenous and *comparative* psychotherapy.

The next step is to go to the Aboriginal people and to listen to them when they reply to the question “what do Aboriginal people do to help someone to recover from depression?”

Chapter Three

Gathering Research Data with Aboriginal Participants

3.1 Introduction

In the preceding chapters, I outline the problem faced by non-Indigenous psychologists who find themselves in the position of providing psychological treatment to Aboriginal clients suffering from depression. Cross-cultural and multicultural approaches in psychotherapy are critiqued and a case has been put forward for an Indigenous psychotherapy that is imbued with Aboriginal culture and philosophical thought. This chapter continues the theme of the interface of the knowledge systems; one drawn from traditional western psychological thinking, the other from Aboriginal thinking. I do this because I recognise that there is a plurality of knowledge systems. For this thesis, I deal with theories drawn from Western influences because it is the Western knowledge system that underpins my formal training as a psychologist. I deal with theories from an Aboriginal world view because it is a knowledge system that Aboriginal people bring with them into the research and therapeutic situations. I explain how data was gathered and interpreted towards an Indigenous psychotherapy. Indigenous research paradigms are discussed and a qualitative research design is implemented. Methodological issues are reviewed. A *free association*, narrative and interview method is adopted and both the

subject and the researcher are seen as psychosocial defended subjects. An explanation is given of the analysis and interpretation of data collected.

3.2 Methodology

Indigenous psychology points to the current debate surrounding the questioning and decentring of western dominated psychological research. Allwood and Berry (2006) state that Indigenous psychology:

> can also be seen as attempts to root psychological research in the conceptual systems that are indigenous to a culture, including the philosophical, theological, and scientific ideas that are part of the historical and contemporary lives of people and their institutions. (p. 241)

As a non-Indigenous researcher, it is vital in this study with Aboriginal participants to engage in the discussion about Indigenous research and Indigenous research projects. This is because, as I mention in Chapter Two, theory is culturally and philosophically driven thereby underpinning how data is gathered and how this data is analysed. In contributing to the discussion about Indigenous research projects, Smith (1999) makes the following comment:

> I draw on Sandra Harding's very simple distinction between methodology and method, that is, 'A research methodology is a theory and analysis of how research does or should proceed…' and, 'A research method is a technique for (or way of proceeding in) gathering evidence.' Methodology is important because it frames the questions being asked, determines the set of instruments

> and methods to be employed and shapes the analysis. Within an Indigenous framework, methodological debates are ones concerned with the broader politics and strategic goals of Indigenous research. It is at this level that researchers have to clarify and justify their intentions. Methods become the means and procedures through which the central problems of the research are addressed. Indigenous methodologies are often a mix of existing methodological approaches and Indigenous practices. (p. 143)

I have mentioned in Chapter Two, that philosophy and culture underpin psychotherapy, it is recognised that philosophy and culture underpin research theory and practice. In further developing and progressing toward an Indigenous research paradigm, Wilson (2003) puts forward the view that "paradigms shape our view of the world around us and how we walk through that world" (p. 161) both consciously and unconsciously. For Wilson, such a paradigm includes Aboriginal ontology and epistemology as well as Aboriginal ethics and methodology. To add further emphasis to his argument, Wilson cites Rigney (1997) who says "Indigenous people are at a stage where they want research and research design to contribute to their self-determination and liberation struggles, as it is defined and controlled by their communities" (cited in Wilson, 2003, p. 163). Wilson continues his line of reasoning by noting that the major difference between the dominant western research paradigms and an Indigenous research paradigm is that:

> dominant paradigms build on the fundamental belief that knowledge is an individual entity: the researcher is an individual in search of knowledge, knowledge is something that is gained and therefore, knowledge is owned by

> an individual. An Indigenous paradigm comes from the fundamental belief that knowledge is relational. Knowledge is shared with all creation. (p. 169)

For the non-Indigenous researcher, the notion of culturally different research theories and methodologies is critical to this research project, given that the participants are Aboriginal. Christie (2006) argues for what he calls *transdisciplinary* research, which he claims to be different from *interdisciplinary* research, as a way of approaching the question of an Indigenous methodology. His approach is grounded in sociological knowledge and ethno-epistemology and recognises that "knowledge is always produced in a socio-political context, always contingent, always culturally-determined" (p. 78). Contributing further to the discussion, Rigney (2001) rejects the universalist tendency of western research traditions to "homogenise Indigenous identities and cultures" (p. 7). Rigney comments further that the return to traditional forms of Indigenous knowledge and cultural realisation see what he calls an emergent "contemporary Indigenous Australian critical studies" (2001, p. 11). Martin (2003), drawing on Rigney's work, proposes an *Indigenist* theoretical framework and methodology called "ways of knowing, ways of being and ways of doing" (2003, p. 211). Martin explains:

> Indigenist research occurs through centring Aboriginal Ways of Knowing, Ways of Being and Ways of Doing in alignment with aspects of western qualitative research frameworks. This alignment or harmonisation occurs in both the structure of the research and in the research procedures. (2003, p. 211)

Discussing Indigenous research methodology within the context of the discipline of social work research and education, Baskin (2005) claims that knowledge is based on experiences that are both individual and collective which ultimately make contributions to the culture of a community. Therefore, according to Baskin, research itself involves the researcher steering a course through "two sets of knowledges" (2005, p. 105) and protocols, that is, Aboriginal and western. A similar perspective is put forward by Durie (2004) who describes his research methodology as research at the interface of Indigenous knowledge and science. Durie states that "there is room for each system to find accommodation by the other without distorting the fundamental values and principles upon which each rests" (p. 7) and suggests that science is one body of knowledge and Indigenous knowledge is another (2004).

3.2.1 The conceptual framework

Following the perspective of Indigenous research paradigms, the image of the double stranded double helix of DNA (see Figure 3.1) provides an apt metaphor to describe the conceptual framework for this study.

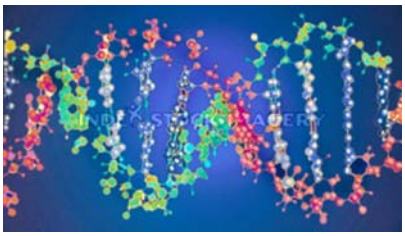

Figure 3.1 Double Stranded Double Helix[1]

[1] Source: Index Stock Imagery Inc.

One strand of this symbol is the western scientific knowledge (psychology/psychotherapy) addressing the issues of depression treatments guided by and contextualised within western scientific philosophical thought. On the other strand is Aboriginal knowledge (traditional knowledge) addressing issues of depression treatments guided by and contextualised within Aboriginal culture and philosophical thinking. It is the research questions about what and how therapeutic interventions are provided to Aboriginal people who are depressed, that connect these two strands with communications travelling back and forth between the two knowledge systems. The psychological scientific western and Aboriginal traditional strands twist and spiral around these questions in an ongoing interaction, creating codes of understanding and points of agreement that are expressed in better clinical therapeutic care and, in this case, a more culturally appropriate psychotherapy. This metaphorical research concept is the structure from which I seek to explore what is happening in the little researched and little understood area of Aboriginal ways of healing the psyche. I seek to open up Aboriginal ways of treating depression. Insights into Aboriginal ontology and epistemology begin to fill the gap in current psychotherapeutic interventions through the development of a framework that may be utilised by non-Indigenous psychologists. Consequently, the research design is of critical importance to the gathering of data for this study.

3.2.2 Research design

Whilst this study acknowledges that in the science of psychology the most common approach to research is quantitative, for this particular study a qualitative approach has been chosen. This is because “qualitative research involves understanding the complexity of people’s lives by examining individual perspectives

in context", (Heppner, Kivlighan Jr & Wampole, 1999, p.235). The research design takes a gestalt approach. This style of inquiry gives rise to the notion that the whole is greater than the sum of its parts and is interpreted within that framework. As such, this gestalt approach is relevant, it is appropriate and it supports the research intention. It has application to the research intention because, as Miller and Crabtree (2000) along with Heppner et al. (1999) claim, qualitative research, in part, recognises that the therapeutic or healing process occurs not only in the clinical moment, but also in the life between clinical events. Miller and Crabtree state that, in research, the participants bring with them "all of their past ghosts; the emotional, physical, conceptual, sociocultural and spiritual contingencies and competing demands of their presents; and their hopes and fears for their futures" (2000, p. 612). Unlike quantitative research methodology, qualitative research methodology can be a more holistic strategy. Qualitative research is "underpinned by the philosophy that the experiences, thoughts, opinions and perceptions of people matter, and because this is so, they have a very valid place in relation to research" (Lincoln & Denzin, 1984, cited in Yalambirra, (2005) p. 108). Yalamabirra believes that this is important to *Wiradjuri* people and affirms "perhaps an increase in qualitative research will give more voice to Indigenous peoples" (2005, p. 108). It is often the convention for psychologists engaged in research to adopt a quantitative approach with little regard given to qualitative research methodology. These two research methodologies are fundamentally different ways to approach inquiry that will shed knowledge and understanding. The philosophical foundation of quantitative research lies in the mathematical and scientific *cause and effect* approach often taken by positivism and post-positivism. It is reductionist when applied to human experience. Quantitative methodology follows on the traditions of thinkers such as Descartes and Wittgenstein

(Heppner et al., 1999; Howard, 2000; Rigney, 2001). By contrast, the philosophical foundation of qualitative research lies in anthropological ethnography and is inductionist by nature. According to Heppner et al., qualitative research focuses its inquiry on "the mind and on attributions of meaning including anthropology, linguistics, philosophy and literature" (1999, p. 245). Qualitative methodology lies in the tradition of thinkers such as Kant and Weber (Heppner et al., 1999; Howard, 2000; Rigney, 2001). As Heppner et al. state, this tradition rejects the proposition that "humans respond deterministically to sensory inputs and instead placed emphasis on the active mind that gives meaning to actions," (1999, p. 245). The constructivist paradigm, emanating from a qualitative design, is germane to this study because, according to Heppner et al., it assumes that "reality is created by the participants of any system" (p. 238). What is significant within the constructivist paradigm is "the meaning that is attributed to that event that is important in determining social relations and behaviour" (1999, p. 238). This notion of attribution is supported by earlier work:

> if we view those attributions as meanings within Aboriginal cultural worlds rather than as individual psychological states of mind, as psychology would have us do, then we are starting to understand something about Aboriginal psychology and how it is different from Western psychology. (1992)

3.2.3 Pertinent concepts from Aboriginal ontology that underpin this methodology

Accordingly, the *indigenist* research paradigm supported by Martin (2003) provides a pertinent framework for this research. Martin draws on the works of other

Indigenous critical scholars (Nakata, 1997; Rigney, 2001; Wilson, 2003) and identifies the concept of an Indigenous research methodology framework as *Ways of knowing, Ways of being and Ways of doing*. Martin suggests that ways of knowing, being and doing are ontologically distinct in prescribing place and group specific knowledge, belief and behaviour.

The occasion of Indigenous research is seen as "ceremony" (2003):

> ceremony is the required preparation that happens long before the event. It is, in Atkinson's (2002) translation, *dadirri*: the many ways and forms and levels of listening. It is in Martin's (2003) terminology, Ways of Knowing, Ways of Being and Ways of Doing. It is the knowing and the respectful re-enforcement that all things are related and connected. It is the voice from our ancestors that tells us when it is right and when it is not. Indigenous research is a life-changing ceremony. (p. 171)

The research seeks to learn about Aboriginal ways of treating depression as distinct from western psychotherapeutic interventions. The research methodology and methods are designed to hear and recognise the voices of Aboriginal people giving expression to their ways of treating depression.

It is the intention of this study to explore Aboriginal ways of healing, more particularly in the treatment of depression, within the setting of a health service that is owned, controlled and guided by the wider Aboriginal community that it serves in Townsville North Queensland Australia.

The expectation in this study is that, within this setting, I learn from, and am guided by, Aboriginal people who act as participants, cultural consultants and mentors. This method of guided listening and learning allows me, as researcher, to come to know and understand what it is that guides and informs Aboriginal practices in the healing of depression. This method is the foundation on which I develop, with them, a framework for the treatment of depression so that non-Indigenous psychologists may offer a more culturally appropriate response when treating Aboriginal clients who present with the symptoms of depression.

Nakata (1997) urges researchers to explore the *cultural interface* as the space in which Indigenous knowledge and western knowledge come together. To meet this objective, as previously mentioned, it is necessary for the researcher to come to learn and understand Aboriginal Australian ontology and epistemology. In essence, it is essential for me, as researcher/psychologist, to begin to open my mind to another reality.

3.2.4 Theoretical research beliefs

As mentioned earlier, the basic set of beliefs that guide this research project lie within the constructivist paradigm (Bogdan & Bicklen, 1982; Lincoln & Guba, 1996; Lofland & Lofland, 1984) which assumes a relativist ontology, by recognising there are multiple realities. The basic tenet of the constructivist perspective is that there are multiple perceptions in the construction of reality (Robson, 2002). In the case of this study, there is the reality of mainstream psychological meanings and knowledge that is interfaced with the reality of Aboriginal psychological meanings and knowledge. The constructivist paradigm supports the *naturalistic* axioms

outlined by Lincoln and Guba who claim that “realities are multiple, constructed and holistic” (1985, p. 37). The assumption is that these multiple constructed realities can be studied only holistically and that such research is likely to result in some level of understanding by non-Indigenous researcher/psychologists about Aboriginal realities.

Within the constructivist paradigm the researcher and the respondent co-create understandings. The naturalistic axioms defined by Lincoln and Guba that state, “the knower and the known are interactive and inseparable” (1985, p. 37). In other words, the researcher and the research participant interact to influence one another during the research process. For this study, the belief is that the non-Indigenous mainstream trained psychologist/researcher and the Aboriginal participants will co-create these understandings.

The methodological procedures within the constructivist paradigm are naturalistic and the findings are presented in a form that follows the tenets of grounded theory (Robson, 2002). The criteria for this constructivist paradigm are trustworthiness, credibility, transferability and confirmability. They steer away from the positivist approach which, according to Lincoln and Guba (1985), aims to develop a universalist body of knowledge in the form of generalisations that are *truth* statements free from time and contexts. For this study, the naturalistic approach aims to develop what Lincoln and Guba call an “idiographic body of knowledge in the form of ‘working hypotheses’ that describe the individual case” (1985, p. 38) or project. For this naturalistic study, it is understood that the findings are a reflection of the knowledge voiced by the Aboriginal participants and are not necessarily generalisable.

Incorporated into this flexible research design is the ongoing monitoring of the researcher themselves that gives rise to reflective practice. The tenets of naturalistic inquiry hold that, unlike the positivist approach which aims to be *value-free*, naturalistic inquiry is *value bound* (Lincoln & Guba, 1985). These values are expressed by the choices made by the researcher, for example, the choice of problem, choice of research paradigm, choice of what Lincoln and Guba name "*substantive theory* utilized to guide the collection and analysis of data and in the interpretation of findings" (1985, p. 38).

In keeping with the axioms of naturalistic inquiry regarding the acceptance by the researcher that the inquiry is value bound (Robson, 2002), at a personal philosophical level I adopt an existentialist framework for this particular study. This is because existentialism, according to May and Yalom (2000), asks:

> deep questions about the nature of the human being and the nature of anxiety, despair, grief, loneliness, isolation and anomie. It also deals centrally with the questions of creativity and love. Out of the understanding of the meaning of these human experiences, existential psychotherapists have devised methods of therapy that do not fall into the common error of distorting human beings in the very effort of trying to help them. (pp. 273-274)

By taking an existentialist approach as researcher, I reason that it allows for me to hear from Aboriginal people about their meanings for their realities and for their life. I am also mindful of the pertinent comment made by Rigney (2001) that:

> Western ontology and epistemology are based on principles of 'validity', 'reliability', and the authority of positivism that view the nature of 'reality' as mechanistic. The notion that science is 'authoritative', 'neutral', and 'universal', privileges science. It gives science the status of a standard measure against which all other 'realities' may be evaluated and judged to be either 'rational' or otherwise. If science indicates to us that there is no such thing as Indigenous Dreaming, then the Indigenous Australians whose realities are informed by the logics of Dreaming are therefore deemed irrational. Indigenous realities that are unique and may appear to defy the logic of science are challenged as legitimate systems of knowledge. (p. 3)

Claims to universality (*etic* approach to research) may be seen as imposing one's culture's beliefs upon another. Niblo and Jackson (2004) suggest that, for qualitative study, the researcher engages in *emic* research by immersing oneself in the community and culture that one wishes to come to know and understand. For this study, as researcher, I am immersed in the Aboriginal community in North Queensland at the Aboriginal and Islanders Health Service, St Teresa's parish community and the School of Indigenous Australian Studies at James Cook University Townsville.

3.2.5 Aboriginal terms of reference

Within this immersed context as the researcher, I became mindful of Aboriginal terms of reference which have significance for both Aboriginal and non-Aboriginal people. As I noted previously, naturalistic inquiry accepts the axiom that the researcher is value bound (Robson, 2002), heed must be paid to the Aboriginal

terms of reference for this study. Oxenham describes terms of reference "as epistemology, as a paradigm, as a cultural discourse and as counter-discourse" (2000, p. 124). Terms of reference are an affirmation of the validity and currency of Aboriginal cultural practices. For non-Aboriginal people, terms of reference can increase their awareness of Aboriginal matters and positions. Whilst Oxenham stresses the importance of reminding non-Aboriginal practitioners that they "should not be involved in the construction of Aboriginal knowledge" (2000, p.110), she does state that the terms of reference provide the non-Aboriginal researchers and psychologists with an awareness of Aboriginal ways of doing things, as well as those things that Aboriginal people value and their worldviews. Consequently and of major significance, these terms of reference may guide the practice of both Aboriginal and non-Aboriginal psychologists. In essence, Aboriginal terms of reference provide a framework for both research and practice. There are many layers to the notion of Aboriginal terms of reference and Oxenham (2000) cites those given by Lilla Watson (1985):

> Murri terms of reference or Murri law, include the following:
>
> The earth is our mother;
>
> Preservation and conservation;
>
> Sharing and caring;
>
> Each other's keeper – accountability;
>
> Group-based society;
>
> Decision making by consensus;
>
> Harmony between people, and between people and the land;

> Knowledge to be sought, acquired, given and used in a proper way. The importance of oral tradition needs to be explored and understood in this context. (cited in Oxenham, 2000, p. 109)

These terms of reference are distinctive and, like Christie (2006), Oxenham (2000) makes a strong case for the recognition that these terms of reference are often "the antithesis of those embodied in educative institutions in this country: eg., hierarchical, authoritarian, individualistic, competitive, knowledge is power" (2000, p.109). Oxenham expands on the definition of terms of reference that provides guidelines for what she calls *principled practice* in Aboriginal contexts that includes relationships between marginalised groups and dominant society. To emphasise this point, Oxenham says:

> The concept of Aboriginal terms of reference incorporates a set of principles, core values and a process for applying a framework to determine an Indigenous viewpoint on an issue in an Indigenous context. This encompasses the cultural knowledge, understanding and experiences that are associated with a commitment to Indigenous ways of thinking, working and reflecting, incorporating specific and implicit cultural values, beliefs and priorities from which Indigenous standards are derived, validated and practiced. These standards will and can vary according to the diverse range of cultural values, beliefs and priorities from within local settings or specific contexts. (2000, p. 111)

Researchers need to challenge the mono-culturalism of psychology and move toward a more socially accountable pedagogy and practice. Riggs takes a "constructionist approach to understanding psychical processes that values multiple, contextual understandings *of* knowledge production", (2004) and concludes that non-Indigenous psychologists need to "pay attention to the 'politics of therapy' and the privileges they hold" (2004, p. 118). The same may be said of the politics of research. In doing so, the Aboriginal terms of reference outlined provide strong guidelines for a code of ethics and behaviour for non-Aboriginal people who engage in research and practice with Aboriginal people. As such, these terms of reference outlined are accepted in the conduct of this research methodology and method.

Other ethical considerations

Clients who were being treated for depression through the Health Service were not part of the research project. These people were considered by the researcher to be psychologically vulnerable. Referring to the research ethics outlined by the National Health and Medical Research Council (2003) for those engaging with Aboriginal and Torres Strait Islander people, I chose not to risk the potential to cause an exacerbation of their symptoms of depression by engaging in this research project with such people. The guidelines for the ethical provision of services and conduct of research laid down by the Australian Psychological Society (2003) were fully accepted and also served as a clear guideline and standard for this study. This research project sought and gained approval from the Ethics Committee at James Cook University and abided by those ethical guidelines for research with Aboriginal and Islander people laid down by that Ethics Committee.

Aboriginal participants selected in principle for this study consisted of Aboriginal people employed at an urban Community Controlled Health Service, Aboriginal academics, Aboriginal people from a North Queensland urban community and elders from that same North Queensland urban community. Because there are no Aboriginal psychologists in North Queensland, an Aboriginal psychologist from another part of Northern Australia participated. On the advice of local Aboriginal consultants, a well-regarded non-Indigenous psychiatrist who has worked for many years with Aboriginal people in North Queensland participated. As I mentioned in Chapter One, in order to maintain the privacy and confidentiality of participants, diary notes, field notes, personal communications, observations and interviews are coded and listed in Appendix A.

Indigenous researchers, Langton (2001) and Smith (1999), as well as some non-Indigenous researchers, Hunter (2001), point out that past experiences have positioned Indigenous communities as powerless and research as disempowering. Martin (2001) and Rigney (1997) bring to mind that the methods of previous research of Aboriginal Australians and Torres Strait Islanders have had the effect of leaving Indigenous people feeling marginalised, mistreated and mismanaged, which has resulted in feelings of distrust, caution, fear of exploitation and misrepresentation, not only of themselves, but of their lands, skies and waterways. This distrust of research encompasses inadequate levels of protection and preservation of Aboriginal knowledge systems, moral systems and life systems.

Current ethical requirements create a space for negotiating research relationships that are a vast improvement on the research relationships of earlier

times. There is an expectation that, today, research is to contribute to the quality of life for those involved. Cadet-James (2001) emphasises that it is critical that, at the beginning, researchers need to develop a relationship with the community long before any research is discussed.

As a researcher it is vital that I observe the codes of ethical behaviour of my own professional and personal worlds as well as the world of the Indigenous Health Service and the community to whom it belongs. Crucial to the welfare of the research participants is a respect for their needs, priorities and wellbeing so that they may remain strong and even gain in strength after the research.

3.3 Method section: where the knowledge is

This research is located at the interface where mainstream psychological knowledge meets Aboriginal knowledge in the treatment of depression. For the purposes of this study, the word *interface* is defined as the place at which independent systems meet and act upon or communicate with each other (Websters 7th New Collegiate Dictionary, 1969). This interface may be understood through the concept of the double helix, referred to earlier, as a metaphor for this research design. It may also be understood through the interface described by Nakata (1997). This research space is found at both the abstract and concrete levels of psychology. It occurs where non-Indigenous psychological theory and practice meet Indigenous psychological theory and practice. It is at this meeting point that western philosophical thought converses with traditional thought. The Townsville (see Figure 3.2) Aboriginal and Islanders Health Service is one such meeting point, as is the Townsville Community of Aboriginal people.

Figure 3.2 Map of Australia Showing Location of Townsville

3.3.1 The history of North Queensland since European occupation

In order to justify the choice of Townsville as *a place where the knowledge is*, it is helpful to understand the specificity of the historical and political context of Far North Queensland because, all too often, acknowledgement of Aboriginal occupation of the land and the effects of colonisation in this region are ignored by the dominant culture. In the present spirit of reconciliation, both Indigenous and non-Indigenous people need to take ownership of our history, as we are, inherently, products of that past history. It is by knowing our past that we can understand our present. Prior to European occupation of Australia in 1788, Aboriginal people inhabited Australia (see Figure 3.3). Aboriginal tribes in this region lived off this land that holds spiritual, religious, economic, protective and recreational significance.

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Figure 3.3 Map of Aboriginal Australia[2]

According to local historians (*Townsville heritage*, 2006), European settlement, or occupation, of Townsville (originally named Castletown) commenced in 1865 and, in February 1866, Townsville was declared a municipality. In 2007 Townsville, also known by the locals as *garrison city* because of the presence of Australian Defence Force bases, had a population of approximately 160,000 people. Townsville is the second largest regional economy in the State of Queensland. As such, it is part of the North Queensland diverse economic base that includes, for example, mining and agriculture, with no single dominating sector. Consequently, this is translated into an economy that is stable and resilient to market fluctuations. Townville has a strong education base, ranging from primary education through to tertiary education. Sport, arts and cultural events form a regular feature of life in Townsville.

[2] Source: AIATSIS – David Horton's Map of Aboriginal Australia

Townsville is itself a kind of frontier town, where the memory of its founding father, Robert Towns, is in dispute. Whilst Towns was a successful entrepreneur and businessman, he has also been accused of introducing slavery to Queensland (Department of the Premier and Cabinet (Queensland), 2003). In 1859, Queensland became a colony separate from New South Wales. In writing about the recent history of North Queensland**,** Kelly and Lenthall (1997) cite Loos (1982) who observes that frontier conflict escalated and the Police Commissioner reported that "the coast country all along from Townsville to Mackay is inhabited by blacks of the most hostile character" (p. 5). A kind of ongoing racial tension has been a feature of Townsville since European occupation. From time to time, these tensions escalate within the Townsville community, one of the more recent being tensions in relation to the death in custody at Palm Island of Mulrunji Doomadgee on 19 November 2004.

Historically, the first phase of the frontier of European expansionism gradually extended towards the Gulf of Carpentaria and into Cape York during the middle to late 1800s. In 1873, the Palmer River gold fields were opened. Consequently, a gold rush began. This was followed by the timber-getters who moved into the far north part of Queensland. Reynolds (1999) notes that, during this period of time, Aboriginal people sustained a "guerrilla type" (p. 146) struggle. This initial phase of occupation by European people was achieved by the dispersing of Aboriginal people. This action ultimately resulted in a dramatic reduction in the population of Aboriginal people in North Queensland.

The second phase saw the remnants of Aboriginal tribes permitted to live on the outer edges of frontier towns and stations because, by that time, they were no longer considered as a threat to the European occupiers. By 1897, with the passing of the *Aboriginal Protection and Restriction of the Sale of Opium Act*, the triumph over Aboriginal resistance in North Queensland had been accomplished by the European people (Loos, 1982). This Act, which was in place up until 1965, saw Aboriginal people of mixed racial blood removed onto, and between, reserves. It also gave the State Government authority to hold Aboriginal children in dormitories. The Queensland Government then developed policies that saw the isolation and segregation of Aboriginal people from European society. These policies found their origins in the expectation that Aboriginal people would eventually die out. In documenting historical race relations in North Queensland, Evans, Saunders and Cronin (1975) note that many Aboriginal people were placed on reserves where they were not allowed to practice their traditional rites and customs. Most devastating of all was the fact that the authorities did not allow Aboriginal people to speak in their own language. Instead, they spoke the English language and were punished if they spoke their own tribal language.

With the Commonwealth Government change from a policy of isolation and segregation to a new policy of *assimilation*, the Queensland Government repealed the *Aboriginals Protection and Restriction of the Sale of Opium Act* and passed the *Aboriginals Preservation and Protection Act (Protection Act)* to replace it in 1937. As a consequence, all Aborigines who were termed *half-castes* became wards of the State. An *assimilationist* approach was designed to absorb Aboriginal people into the wider European community. In continuing to tell the story of the effects of the

European occupation upon Aboriginal people, Reynolds (2003) notes that assimilation basically meant that Aboriginal people were obliged to become like the European people and assimilate as well as integrate into European culture, worldviews and values. All of this at the expense of their Aboriginal worldview, culture and values.

In 1972, the Commonwealth Government changed its policy approach to that of *self-determination* and *self-management*. It was based on the premise that Aboriginal people should be in charge of their own affairs. In 1973, the Queensland Government refused to acknowledge Commonwealth precedence in these matters as part of the policy approach toward Aboriginal self-determination. Kelly and Lenthall (1997) cite the Queensland Premier at that time, Sir Joh Bjelke-Petersen, who strongly argued that "Queensland legislation is designed for the ultimate and total assimilation of Aboriginals and Islanders" (p. 18). This prevailing attitude toward Aboriginal self-determination and self-management by the Queensland Government was at odds with the other Australian states. Eventually, due to changes to the Queensland Government, changes occurred to bring Queensland into line with the other states regarding policies of self-determination and self-management for Aboriginal Australians. These policies of self-determination and self-management remain current. Continuing to endure the effects of colonisation, three main tribes of Aboriginal people remain in Townsville.

3.3.2 Aboriginal people in Townsville community

The *Birra Gubbi*, *Wulgurukaba* and *Bindal* people are the traditional owners/inhabitants of Townsville. They are essentially coastal tribes. During the

government protection era when Aboriginal people were being gathered up and sent to Aboriginal reserves throughout Queensland, approximately five families continued to live on the mainland of Townsville. They became the fringe-dwellers and resided in ramshackle huts at Rowes Bay, Town Common, Happy Valley and Garbutt (Kelly & Lenthall, 1997). Today, the population of Townsville includes approximately 10,000 people of Aboriginal and Islander descent. The Townsville area includes Palm Island, home to approximately 2,500 Aboriginal people. It lies some forty nautical miles north of Townsville. Kelly and Lenthall (1997) mention that the "Queensland Government saw the existence of what were termed 'half-castes' as an affront to the 'moral' community" (p. 11) and Palm Island, designated as an Aboriginal Reserve in 1918, was the place where such people were sent. This action stemmed from the Queensland policy approach which was to both isolate and segregate Aboriginal people. Kelly and Lenthall comment, "Aboriginal people were able to be imprisoned without trial if deemed 'uncontrollable' (in practice, sent to Yarrabah or Palm Island)" (1997, p. 11). According to Broome (1982) this action was carried out without any consideration given to tribal boundaries and nations. All of this dislocation has seen the ongoing deleterious and severe effects on Aboriginal health and wellbeing.

3.3.3 Taking control of health matters

In providing a summary of Aboriginal health status relative to non-Indigenous Australians, Anderson (2004) states that death rates among Aboriginal people are nine times greater than in the wider population. The average life expectancy of Aboriginal males is 56.3 years. For females, the average life expectancy is 62.8 years. Life expectancy for non-Indigenous males is 77 years and

for non-Indigenous females, the life expectancy rate is 82.4 years. Infant mortality rate for Aboriginal Australians is 10.6 deaths per 1,000 live births whereas the infant mortality rate for non-Indigenous Australians is 5.3 per 1,000 live births. As Kelly and Lenthall (1997) remark, the *sorry* business of death and burial continues to be a frequent and significant event within Aboriginal communities today. Clearly, there is a need for culturally appropriate Health Service provision to Aboriginal people.

In order to improve Aboriginal health and life expectancy, Aboriginal Community Controlled Health Services (ACCHS) were established. The movement to set up ACCHS sprang in response to major problems with accessibility and suitability of mainstream health services for the Aboriginal and Torres Strait Islander population. The ACCHS have grown out of the desire of Aboriginal and Torres Strait Islander communities to take control both of their own health and of how suitable health care services are delivered to and within their communities. For Aboriginal people, health is understood to mean the total wellbeing of a person and the community which, as mentioned earlier, includes physical, social, emotional, cultural, spiritual and economic wellbeing (Swan & Raphael, 1995) and the ACCHS are intended to reflect this understanding. Eckermann et al.(1992) cite Foley (1982) who points out that:

> Unlike virtually all other health centres in the world, Aboriginal Medical Services are not run by doctors or other medically qualified people. Also, rather than doctors being considered the most important people in our services, they are the least important. The most important people to us in our Services are the patients, the Aboriginal people, who, in turn, are the people

who run the Service through the annually elected Aboriginal Board of Directors. (cited in Eckermann et al., 1992, p. 181)

During the 1960s,Vincent Lingiari inspired black Australians to stand up for their rights, which gave incentive to Indigenous groups to start to organise themselves into active social and political groups. This included activities surrounding Aboriginal health. Some years later when the Whitlam government came to power during the 1970s, financial support was made available directly to Aboriginal and Torres Strait Islander registered companies through the creation of a Federal Aboriginal Affairs Department (Department of Aboriginal Affairs). An Aboriginal women's conference was conducted at James Cook University Townsville in 1973. Mrs Briggs and her daughters, Leah and Frances, (all of whom were involved with the setting up of the Victorian Aboriginal Medical Service) attended the conference. They informed the conference about the developments to Aboriginal and Islander Health Services in Victoria. As part of this process, the late Mary Tapim took the information back to the Island Women's Council. A meeting of the local community took place and, from this meeting, the idea of the medical centre was born. The late Charles Perkins came to Townsville in 1974. A general meeting was held at the Arts Centre in Walker Street Townsville. Over 300 people from the Aboriginal and Islanders Community attended and voted overwhelmingly in favour of a medical centre. With premises donated by the Catholic Church and staffed with volunteer workers, the Health Service was established and commenced services in 1974. With donated medical equipment and supplies, the clinic operated three times a week (Townsville Aboriginal & Islanders Health Service (TAIHS), 2002).

It was the second community controlled health service in Australia after Redfern in Sydney which opened in 1971. Today, the Townsville Aboriginal and Islanders Health Service is a company limited by guarantee, registered under the Australian Securities and Investments Commission (ASIC) and incorporated since 1979.

Central to the *vision* of this community-controlled health service, is the provision of a holistic, culturally appropriate and culturally safe health service. This includes promoting economic independence and financial security for clients, recognising that ill health and sickness are often caused by poverty and poor living conditions. The principles of self determination and self management are at the core of the vision for this particular health service (Townsville et al., 2002).

The Townsville Aboriginal and Islanders Health Service is the main provider of primary health care services to the Aboriginal people in Townsville and surrounding areas. It is a relatively large service providing health services to approximately 10,000 clients, largely Aboriginal and Torres Strait Islanders. One of the important differences between this Aboriginal and Islander community controlled health service and other services, such as mainstream health services, is the level of community involvement. A board of directors elected by the local Townsville Aboriginal and Islander community manages the health service. Fundamental to this health service is the role of Indigenous health workers in providing culturally appropriate health care services.

According to the board of directors, (Townsville et al., 2002) this ACCHS provides health services that reflect the needs, cultural beliefs and values of the community it serves in Townsville and surrounds. This includes the residents of Palm Island, the 'Park People', the Happy Valley people and a transient population. This *culturally appropriate* service is defined as a service that is acceptable, accessible and affordable to the targeted community in that the services, aspirations and content will reflect the community's protocol, needs, cultural beliefs and values. The service focus at the Townsville Aboriginal and Islanders Health Service is on holistic health with an emphasis on primary health care. As such, it provides a wide range of curative and preventive health services, some public health and outreach programs, and has a network of specialists and allied health professionals who provide services at the Centre.

Core services include general medical, specialist medical, clinical services, herbal clinic, diabetes clinics and education, dental health, social and emotional wellbeing services, Stolen Generation counselling, illicit drugs diversion, bereavement support, hearing health, eye health, maternal and child health, overnight crisis accommodation, short-term accommodation, child protection and shared care and a youth shelter. Many related programs are conducted from the Townsville Aboriginal and Islanders Health Services premises at Garbutt, with the local Aboriginal and Islander community feeling a strong sense of ownership of the actual centre.

At the time of this study (2002-2003), the Townsville Aboriginal and Islanders Health Service employed between 75 and 80 people, over three-quarters

being of Aboriginal and/or Torres Strait Islander descent. The day-to-day management of the health service is the responsibility of the Chief Executive Officer who reports directly to the board of directors at monthly board meetings. The main recurrent funding for the Townsville Aboriginal and Islanders Health Service comes from the Commonwealth Department of Health and Ageing, Office of Aboriginal and Torres Strait Islander Health. The Department of Families funds the Supported Accommodation Assisted Program (SAAP) and the Townsville Aboriginal and Islanders Child Care Service and Youth Shelter. Self-generated funds come through the Health Insurance Commission Medicare bulk billing system (TAIHS, 2002).

Why an Aboriginal and Islanders' health service

The participants who contributed to this research were primarily Aboriginal people from the Townsville Community, many employed in a variety of positions at the Aboriginal and Islanders Health Service. To add expert knowledge to this study, one of my Aboriginal research project supervisors recommended to me that a non-Indigenous psychiatrist, who has practiced for some twenty years in North Queensland/Cape York, be invited to participate in the research in order to inform this project about mental health service delivery to Aboriginal patients in North Queensland. Additionally, my research supervisor also recommended that an Aboriginal academic and psychologist from Western Australia be invited to give an interview to give expert insight into this research project. I was employed as a psychologist at the Townsville Aboriginal and Islanders Health Service between January 2002 and December 2003, placing me as both a practitioner and a researcher. I was in a position to be mentored by Aboriginal people. They acted as participants, cultural consultants and guides for this study. In addition to this, being located in this

health service created the opportunity for my co-workers and research participants to form an opinion of me on both a professional and personal basis. At the same time, it afforded me the opportunity to come to build the necessary relationship previously described by Cadet-James (2001). Most importantly, research for this study was only able to commence following the necessary approval from the TAIHS Chairman of the Board, Mr Alex Illin, of the Townsville Aboriginal and Islanders Health Service.

3.3.4 Linking the research question to the purpose of the study

The research question about what interventions Aboriginal people utilise to treat those who are suffering from depression is designed to provide the link toward the development of an Indigenous psychotherapy. As an exploratory study, this research focuses on the knowledge and information that Aboriginal people consider to be permissible to disclose to non-Indigenous people. It gives attention to what Aboriginal people say about what non-Indigenous psychologists need to know in order to work with Aboriginal people in the treatment of depression. What techniques or therapies are applied? How are they applied? How do they fit in with Aboriginal cultural thinking? To reiterate, the aim of this investigation is to learn about Aboriginal ways of healing, more particularly in the treatment of depression, so that a psychotherapeutic intervention that is representative of, and reflective of, Aboriginal ontology and epistemology would be developed for non-Indigenous psychologists to use. As a consequence, Indigenous people have been involved in filling the gap in psychotherapy and voice is given to an Indigenous psychology that is representative of the North Queensland context. So that meaningful data is gathered, the selection of interview style became an important feature of the research method.

3.4 Producing data through the process of interviewing

Following the tenets of qualitative research design, this study subscribes to the primary method of gathering data through interviews with research participants. Holloway and Jefferson (2000) examining qualitative research methodologies outline four approaches to interviewing: “traditional, feminist, narrative and clinical” (p. 31).

Hollway and Jefferson (2000) describe traditional interviewing as a technique whereby the skilled interviewer gathers data from the informant. The preferred *modus operandi* of the interviewer tends to be based on a structured question-and-answer style. The role of the interviewee is to respond to the questions put forward by the researcher. The researcher sets the schedule of questions and, in principle, controls the process which in turn controls the information that is gathered. The interviewer is seen as being scientific and impartial throughout the process. The emphasis is on the interviewing skills of the researcher who is supposedly neutral and detached from the interviewee who is objectified by the researcher during the data gathering process.

In contrast, Hollway and Jefferson (2000) state that feminist researchers reject the idea of the objectification of the interviewee and the supposed impartiality of the researcher. Like the traditional interviewing style, the feminist mode is also through the structured question-and-answer technique where the function of the interviewee is to act as a respondent. A feminist approach to interviewing pays attention to the power relations between the researcher and the informant. By utilising a feminist approach, the interviewer is mindful of unequal power relations, for example, gender, race and class.

Narrative approaches outlined by Hollway and Jefferson (2000) step away from the structured and semi-structured question-and-answer mode toward gathering data. As a consequence of this, the interviewee is free to tell their story because there is no pressure to act in accordance with the agenda set by the interviewer. Narrative approaches give emphasis to the meaning that is created within interaction between the researcher and the subject. The role of the interviewee is that of a storyteller who is accountable for making the relevance of the story clear. The interviewee is not merely a respondent.

The clinical case study defined by Hollway and Jefferson (2000) is an approach whereby knowledge is gathered through the interview that is based on the psychoanalytic model. The clinical interview is yet another step further away from the survey-type research. The psychoanalytic approach is characterised by its emphasis on the researcher to be responsible for their own engagement in the research process of understanding the interviewee in a gestalt way. The psychoanalytic enquiry claims that the researcher cannot be detached from the process. Consequently, the researcher must be mindful enough to examine their subjective participation because it influences the manner in which the data that is gathered through the interview is interpreted. This approach to interviewing understands the interviewer/researcher as subject who acknowledges not only the conscious forces but also the unconscious and conflicted ones. This process of self-scrutiny by the researcher is difficult because both the interviewer and the interviewee are simultaneously influencing each other.

These four styles of interviewing demonstrate that choosing the style of interview is crucial. It was crucial for this study because it determined the quality and the quantity of data provided by participants.

3.4.1 The development of the interview style for this study

Originally, a traditional interviewing approach was developed to gather data for this study. I chose this approach because the traditional interviewing style is one with which I felt reasonably confident. This is because it is a style that I used previously in my undergraduate and post-graduate studies in psychology. It is also an approach that I utilise in my day-to-day work as a Counselling Psychologist. Two cultural consultants who were Aboriginal employees at TAIHS and my supervisors at the School of Indigenous Australian Studies at James Cook University assisted, guided and advised me in the development of the research project. A pilot interview was arranged and carried out with an Aboriginal health worker. I then planned to carry out interviews with fourteen Aboriginal people whom I considered would be the keepers of the knowledge that I sought because some were connected with Aboriginal health through their employment at TAIHS. Others were involved with Aboriginal health and wellbeing within their North Queensland communities. Others were Aboriginal academics from the School of Indigenous Australian Studies. As mentioned earlier, an Aboriginal psychologist/academic from Western Australia was also included. This resulted in a total of eighteen participants, including the non-Indigenous psychiatrist from Cairns. Research diaries (Schatzman & Strauss, 1973) in the forms of field notes, observations and informal conversations (LeCompte & Schensul, 1999) were recorded in my interactions with members of St Teresa's Catholic Aboriginal community and with Aboriginal people with whom I interacted

on cultural field trips. I chose this method, because research diaries provide a form to view the interfacing of the subjective and objective characteristics of doing research which may then be openly recognised and brought into a productive relationship (Bogdan & Taylor, 1975). I also kept a personal journal as part of the utilisation of reflexivity (Bogdan & Taylor, 1975; Hastrup, 1992; Hollway & Jefferson, 2000; Robson, 2002) in my practice as a researcher/psychologist. Transcripts came to a total of seventy-two hours. Following the carefully crafted interview questions, as researcher, I made times that were mutually convenient to both participants and myself so that the interviews could be conducted.

Despite a good pilot interview, I found that, after three attempts at interviewing three of the participants, the data was not flowing. Interviews were cut short by closed responses to the questions, such as being told “Aboriginal people did not have depression before European people came to this country”; or “Aboriginal people don’t get depression”; or “if Aboriginal people get depressed, we just block it out!”

Arising from discussions with my supervisors, I realised that the problem was that, as researcher, I formulated the research questions and, whilst the questions were open-ended, the format was quite structured. I was taken aback in coming to the conscious realisation that I had unconsciously tried to keep the power and control over the whole interview process. Robson (2002) in citing Lofland and Lofland (1995) would call this style an *intensive* interview, which emphasises the importance of an interview *guide*. Robson describes this guide as “a list of things to be sure to ask about when talking to the person being interviewed” (cited in Robson, 2002, p.

281). This approach did not bring forward the responses or data I had anticipated regarding my list of things to ask in relation to the research question about how Aboriginal people treat those who are depressed. As a result of this crisis, I was forced to review the interview methodology and to analyse my own reaction. Therefore, I shall deal firstly with an explanation of what I did in the face of this dilemma that emerged in my initial research interview method. I will then justify what I did to remedy the problem situation so that I could gather the data crucial to this research project. I shall also explain how I processed my own reactions to this initial failure to gather the data I sought.

In re-assessing and reviewing my initial interview method I discovered that Hollway and Jefferson (2000) experienced similar difficulties in the initial stages of their research relating to the fear of crime. In analysing their initial failures in pilot interviews, Hollway and Jefferson contended that more meaningful data could be gathered by moving away from the usual question and answer style of interviewing and shifting toward the narrative interview. In doing so, Hollway and Jefferson comment, “fortuitously, we stumbled across the biographical-interpretive method first developed by German sociologists producing accounts of the lives of holocaust survivors and Nazi soldiers” (2000, p. 34). This biographical-interpretive method has its foundations in the narrative tradition. However, the narrative interview leaves no opening for what Hollway and Jefferson call the *defended* subject (2000). This concept recognises the effects of defences against anxiety on people’s actions and their stories about them.

Hollway and Jefferson (2000) took into consideration their understanding of the way in which unconscious defences affect the information that is produced in the research relationship and the way in which it is interpreted. They incorporated the idea of the *defended* subject into their use of a narrative method. Through the concept of the defended subject, I began to see that the 'closed' response of the Aboriginal participants in the initial interviews was part of a defence. After all, as a researcher, I represented the non-Indigenous and mainstream and as such based on much of the Aboriginal historical experience, not to be easily trusted with information. At the same time, I began to understand that my reaction to this dilemma was also a defence. I assumed that if I asked a question as a researcher, I would receive a reply that would satisfy me. The next part of the process involved an examination of what happened and what I did when two defended subjects interact. I wanted the communication at this interface to be a fruitful experience to both parties. To do this I drew on Hollway and Jefferson (2000) who argue that the concept of a defended subject may be explained through psychoanalytic theory.

3.4.2 Psychosocial nature of the defended subject

The term *defended* subject stems from Klein's (Grosskurth, 1986) explanations of the paranoid-schizoid and depressive defences against anxiety. In psychoanalytic theory, these defence mechanisms are defined as complex responses to events and people in the social world, both present and past. With regard to the participants in this study, psychoanalytic theory maintains that defences against anxiety affect the discourses through which people perceive depression and their actions in the treatment of depression.

It is this theoretical underpinning that ultimately gave me the methodology and the method to elicit meaningful data as well as a framework within which I could analyse and interpret the information given by the research participants. It also gave me a framework to analyse and interpret my own reactions during this research process. When participants take part in the research interview, they bring with them not only their present information. They also bring to the interview all of their past experiences, along with the emotional, physical, socio-cultural and spiritual contingencies. At the same time, they bring the stresses of their present as well as their hopes and fears for their futures. Hollway and Jefferson (2000) explain:

> the concept of an anxious, defended subject is simultaneously psychic and social. It is psychic because it is a product of a unique biography of anxiety provoking life events and the manner in which they have been unconsciously defended against. It is social in three ways: first, because such defensive activities affect and are affected by discourses (systems of meaning which are a product of the social world); secondly, because the unconscious defences that we describe are intersubjective processes (that is, they affect and are affected by others); and thirdly, because of the real events in the external, social world which are discursively and defensively appropriated. (p. 24)

It is this psychosocial perception of the subject that Hollway and Jefferson (2000) believe is most compatible with a serious engagement in researching the *what*, *how* and *who* of topics. To do this, Hollway and Jefferson adapted the biographical-interpretive method of interviewing and named it the *free association, narrative* interview method (2000).

Davison and Neale (1996) explain that *free association* is a technique used by psychoanalysts. Free association works on the premise that any person, when asked to talk about whatever comes to mind, will produce a narrative that is structured by unconscious logic rather than rationally structured conscious logic. That is, the associations follow pathways defined by emotional motivations rather than rational intentions.

Because the participant is also seen as psychosocial by the researcher, it means that the information gained through the narrative is part of the gestalt of the participant who, in psychoanalytic terms, presents as a defended subject. The psychoanalytic interviewing technique not only recognises the role of unconscious defence mechanisms against anxiety in mediating a person's relationship to reality, but also gives honour to the importance of unconscious inter-subjectivity. Consequently, the free-association narrative interview reveals significant personal meanings that are made available to the researcher in the form of rich (and meaningful) data. Importantly, the researcher, as well as the participant, is also seen as psychosocial and I deal with this more fully in Section 3.5.

The relevance of the free association narrative interview is that it offers a way through which participants' defences may be accessed. In emphasising this point, Hollway and Jefferson (2000) state that it is the job of the interviewer to "elicit stories intact and not destroy through following their own concerns" (p. 34). Their method of interviewing is based on four principles. Firstly, to use open ended rather than closed questions. Secondly, to elicit stories because this anchors the person's account to events and time. Such accounts engage with reality even while

compromising the service of self-protection. Thirdly, avoid the *why* questions because such questions elicit an intellectualisation type response. And fourthly, to follow-up using respondents' ordering and phrasing. This ensures that the themes, order and meanings of the respondents are followed rather than those of the interviewer. It allows for respect and retains the respondent's meaning-frame.

For all intents and purposes, Hollway and Jefferson (2000) theorise that by eliciting a narrative structured according to the principles of free association, access may be gained to a person's concerns that would probably not be visible using a more traditional method. It is different from the *long interview* advocated by McCracken (1988), which is basically an ethnographic style during which the respondent is asked to talk about their life. It is also different again from the *non-directive interview* developed by Carl Rogers (1945). The Rogerian non-directive interview is a style where the course of the interview and the areas covered are totally in the control of the interviewee. Even though this approach has had considerable influence on interviewing styles, particularly in the clinical setting, it is not practical in the research setting because, as Robson (2002) points out, "the interview is initiated by the client, not the therapist" (p. 282). Furthermore, the motivation and the purpose of the non-directive interview in the clinical setting are to seek help with a problem. This motivation and purpose are at variance with the research setting, which is to seek knowledge and information. For this study, by perceiving the participants as psychosocial defended subjects, the way is opened for a meaningful encounter in studying the treating of depression *Aboriginal way*.

Given that this study accepts the participant as a defended psychosocial subject, Aboriginal ontology and epistemology are recognised as defence mechanisms of the participant. Aboriginal participants bring to the interview with them the psychosocial gestalt that includes their culture and worldviews (ontology), their knowledge (epistemology) and their experiences of their culture and their society, the effects of colonisation and their responses to their world today.

3.5 The researcher and the defended subject

Hollway and Jefferson (2000), McMahon (1998) and Heppner et al. (1999) affirm that the data gathered during the interview process is always a creation of the interaction between the interviewer and the interviewee. Portrayals given by research participants are produced through the interaction between the interviewer and the interviewee. It is the research question that frames both the participant whom the researcher investigates as well as the personal history of the researcher.

As mentioned earlier, this approach is grounded in critical realism (Hollway & Jefferson, 2000; Robson, 2002). It assumes that there is a reality that exists independently of our awareness of it and asserts that the research subject cannot be known except through another subject, in this case, the research investigator. This offers an invitation to further explore the interaction between the participant and researcher and recognise their unconscious *defence mechanisms* that subsequently open the way for more meaningful data. For the purpose of this study, I use the definition of defence mechanism as the unconscious “means by which the organism protects itself against impulse and affects” (Campbell, 1989). I use this term interchangeably with defences, defence response and defensive organization. When

examining the complex relationship between researcher and participant, it is worth acknowledging the phenomenon of *defensive response*.

In the case of this research project, I found through the initial failed interviewing process that, as a non-Indigenous researcher, I did not have the required level of awareness and understanding of the defence mechanism embedded in the responses of Aboriginal informants who bear the scars of the history of colonisation in Australia in their psyche. At the same time, I became aware as a non-Indigenous researcher of my need to acknowledge a potential blind-spot in my psyche and to recognise that I did not know what I did not know until I felt the discomfort in research. These acknowledgements are prerequisite to a productive relationship between the researcher and participant. For the process of gathering data in this study, they also resulted in a radical reframing of the original research question and a review of the research method.

All of this helped to explain why my initial attempts at interviewing and eliciting responses failed as I came to realise that, what I thought were open ended questions were not and, furthermore, this line of interviewing was inconsistent with the non-directive Rogerian approach that I had unconsciously tried to take in eliciting responses. As the researcher, I mistakenly felt strongly that it was my prerogative to order the questions of the selected topic. I expressed the interview questions in my own language. In other words, I took a traditional intensive interviewing style whilst at the same time keeping a tight control over the whole process. My meaning frame rather than the meaning frame of the research participants dominated the process which resulted in a failure to initially gather data.

Through the process of psychoanalysis, I came to see that my defences were about power and control. This, after all, feels, albeit unconscious, like the natural position for me in the dominant mainstream roles of researcher and practitioner. This framework explains why my reaction to these closed responses was to feel angry, disempowered, disarmed, embarrassed and let down by the fact that my usual interview skills did not bring me the results that I sought. As the research investigator, I felt confused and vacillated between wanting to walk away from the research project and wanting to stay so that I could understand what was happening so that the project could be completed. In the search for understanding and meaning, I returned to the literature and found that my reaction resonated with Mushin's et al. (2003) research. This research shows that mainstream non-Indigenous health workers networking with the Victorian Aboriginal counselling service for children had to come to terms with the experience of the discomfort of finding themselves at the interface of western psychological practice and Aboriginal psychological practice before they could engage fully with their Aboriginal clientele. As outsiders coming into an Aboriginal service provider context, they had to learn to accept and deal with the anxieties arising from that situation and to confront their defensive response. This leads to the importance of understanding the defensive response of the researcher and the participant in this study.

To do this, it is important to recognise that in the context of this study, the non-Indigenous researcher and the Aboriginal participants are constructed as defended subjects. During the process of gathering data through the interview method, mental boundaries between the non-Indigenous researcher and the Aboriginal participants are permeable where unconscious matter is concerned. This

means that, during the interview process, both will be subject to transference and counter-transference. Hollway and Jefferson (2000) call this phenomenon *inter-subjectivity*. In a similar vein to reflexivity, which is like a social science tool for identifying areas of potential researcher bias, inter-subjectivity has its basis in psychoanalytic thinking. It allows for depth of knowledge by examining the feelings that are anchored in the unconscious mind and are evoked by our interactions with others. For this study, such feelings surfaced at the initial stage of interviewing which resulted in an intensive examination of the researcher with regard to the dynamics of the researcher and the participants. This was accomplished through the lens of psychoanalytic thought and the guidance of Aboriginal mentors.

Such an analysis of the researcher and participants as defended and psychosocial subjects is vital to this study as it is inextricably linked to the manner in which the data is analysed and interpreted.

3.5.1 Analysis and interpretation of data

In analysing and interpreting the findings of their studies, Hollway and Jefferson (2000) comment:

> If we wish to do justice to the complexity of our subjects, an interpretive approach is unavoidable. It can also be fair, democratic and not patronising, as long as this approach to knowing people through their accounts is applied to the researcher as well as the researched. (p. 3)

The analysis of the data gathered for this study was initially based on the code and retrieve method. Participants use their voice to give a logical and articulate account to the research inquiry. As a consequence of this, data analysis was motivated by the rationalised self-descriptions of participants. This method exposed themes that emerged in the data. It also created problems by fragmenting the data and broke up the gestalt of the free association, narrative interview. I found that it ignores the unconscious motivations that are unstated by the participants but are embedded in their experiences and personal histories. It is their pasts which unconsciously moderate their responses in the present resulting in valuable information that in other methodological approaches may otherwise be unobserved by the researcher during the process of analysis and interpretation of the data. To overcome this, I drew upon the theoretical approach developed by Hollway and Jefferson (2000) that is "both similar to and different from a clinical psychoanalytic approach" (p. 5) and "goes beyond the hermeneutic circle" (p. 5). It goes beyond the hermeneutic circle because the basic concepts and questions the investigator brings to a study are recognised as an important part of the research. Interpretive research enters the hermeneutic circle by placing the researcher and the subject in the centre of the research process. The interpretive, hermeneutic, phenomenological works of Heidegger (Coser, 1971) position an interpretive circle surrounding the research process. Denzin (1989) argues that the researcher can never get outside the interpretive process and that he or she is always part of what is studied. In contrast, Hollway and Jefferson (2000) argue that the researcher can be liberated from the hermeneutic circle. They suggest that there is a relationship between people's ambiguous representations and their experiences that they claim can be explained through the mechanism of *critical*

realism (2000). Hollway and Jefferson (2000) explain critical realism in the following comment:

> We intend to argue for the need to posit research subjects whose inner worlds cannot be understood without knowledge of their experiences in the world, and whose experiences of the world cannot be understood without knowledge of the way in which their inner worlds allow them to experience the outer world. (p. 4)

Hollway and Jefferson (2000) utilise critical realism to interpret their data. It is about the détente between clinical psychoanalysis and scientific knowledge. They do this through the notion of the psychosocial subject. Using psychoanalytic methodology as part of understanding the psychosocial subject, it is possible to broaden the reach of interpretation. It is a gestalt approach and the method is based on the principle of working with the whole data and paying attention to links and contradictions within that whole. Hollway and Jefferson (2000) cite objectivity and reliability as key scientific methods for interpretation of data and recognise triangulation as another form of validating data. The theory of critical realism offers a fitting paradigm to guide this study because it recognises the compelling truth that the researcher and the participant bring their own realities to the research project. It recognises that the inner worlds which inform the free association narrative of the Aboriginal research participants and the non-Indigenous psychologist's research question are understood by having a knowledge of their experiences of their outer worlds and how that in turn mitigates their own perceptions and responses to their experiences of the outer world.

3.5.2 Psychoanalysis and the psychosocial defended subject as the gestalt paradigm for analysing data from Aboriginal participants

In putting forward this approach to analysing and interpreting data, Hollway and Jefferson (2000) state that the researcher looks for, and considers and analyses, contradictions, inconsistencies and tones, for example, that form the research data provided by the participant. This results in deeper, richer and more meaningful data. It is different from clinical psychoanalysis. Researchers, not being clinicians who interpret meaning into the encounter at the time, will interpret meaning outside the encounter with the participant.

In essence, this approach advocates the recognition of the part played by the individual's defence against anxiety and how this defence mechanism mediates one's relationship to reality. The importance of unconscious inter-subjectivity (transference and counter-transference) is identified. Free associations give access to unconscious material that is not driven by the rational conscious mind. This method allows for layers of meaning to be accessed and to come forward or surface in the interpretation of the data. The approach to the interpretation of data is grounded in the theory of the participant being understood as the psychosocial defended subject.

The strength of the free association, narrative and interview as a methodology for gathering data in a qualitative research design is demonstrated when the research question involves understanding the participant's experiences through their own meaning frame, for example in this research, treatments for depression seen through the meaning frame of the effects of colonisation. Disclosure in these contexts is viewed as an experience of reciprocity that is fundamental to Aboriginal culture.

3.6 Reflexivity and inter-subjectivity in research

Phenomenological approaches to qualitative research emphasise the crucial nature of researcher reflexivity. The capability on the part of the researcher to identify and then set aside personal feelings and presumptions is a function of the skill of the researcher to be reflexive rather than a demonstration of objectivity. True objectivity cannot take place because it is not possible for researchers to set aside the things of which they are not consciously aware (Robson, 2002). Hollway and Jefferson (2000) take this one step further. They introduce the notion of inter-subjectivity and claim that the feelings that emerge during the interview process are data. Most importantly, Hollway and Jefferson go on to state that by understanding the concept of inter-subjectivity through the psychoanalytic concepts of recognition and containment, the development of trust is promoted in the relationship between the researcher and the participant (2000).

Walkerdine (1997) asserts that it is critical to recognise the importance of analysing the researcher's emotions that are brought into consciousness during the interview process as well as during the analysis and interpretation of the data that has been gathered. To gain a greater insight into this experience, I will begin by introducing the concept of the *contact zone* (Pratt, 1992) that I have borrowed from the discipline of anthropology. The concept of the contact zone is one prism through which this experience can be analysed in depth.

3.6.1 The contact zone in gathering data

Pratt (1992), an anthropologist, defines the contact zone in the following way:

> A contact perspective emphasizes how subjects are constituted in and by their relations to each other. It treats the relations among colonisers and the colonised not in terms of separateness or apartheid, but in terms of co-presence, interaction, interlocking understandings and practices, often within radically asymmetrical relations of power. (pp. 6-7)

As researcher, I then recognised that a similar contact zone emerged during the interview phase of this research process. The interview meetings became the place and point where western psychological knowledge came face-to-face with Aboriginal psychological knowledge. This process brought into light the asymmetrical power relationship existing between the non-Indigenous researcher and the Aboriginal participant. During this process I, as the non-Indigenous psychologist/researcher, came to represent the coloniser with the Aboriginal informant representing the colonised. The event of the research interview is seen as a place of encounter and passage that is experienced by both the non-Indigenous researcher and the Aboriginal participant. It is at this point in the research project that, as a non-Indigenous researcher, I had to address the power dynamics of the interview process. That meant that I had to adjust my methodology and process the discomfort stemming from the power dynamics, so that I could engage with the participants in a meaningful way.

Addressing this issue of discomfort, Dr Barry Lavallee, a visiting North American First Nations general medical practitioner, suggested that non-Indigenous researchers and practitioners (including psychologists) need to follow this simple routine when starting a session or an interview with an Aboriginal person for the first

time by “always asking the Aboriginal participant or client if he or she is comfortable being in this interview given that you, as the interviewer are non-Indigenous and have not grown up Aboriginal way” (FN9, October, 2003).

This simple routine, which acknowledges the discomfort inherent to the notion of the contact zone, calls upon the non-Indigenous psychologist/researcher to let go of some of their sense of power and control. This power and control is related to the defence mechanisms that are embedded in the knowledge and experiences of mainstream psychological training, research and practice. It is through the use of the research diaries which allows for the analysis and deeper insight into the significance of reflective practice in research.

3.6.2 Reframing the research question – from questioning to yarning

In summary, Riggs (2004) comments that there is a need for psychology to be reflexive about the historical foundations that it rests upon. There is also a need for the psychologist/researcher to be reflexive about the way in which these historical foundations are played out in the research and practitioner setting. Essentially, reflexivity is about the awareness and recognition of researcher bias and how it impacts on the research process, but inter-subjectivity goes beyond researcher bias and recognises the unconscious defence mechanisms as valuable data to the overall research process. Acknowledging the psychosocial defence mechanisms experienced in the initial attempts in gathering data for this study, Selby (2003) describes the uneasiness that she felt in her study when she writes “[i]n considering research as a cultural process, I argue the need to forefront the discomfort in the process of gaining knowledge, which if left un-theorised, misrepresents the process” (p. 358).

Having recognised and processed this discomfort, the interview method moved into viewing the research participants and the researcher as psychosocial defended subjects and the free association, narrative and interview method is applied. Attention is also given to the phenomenon of inter-subjectivity as part of the process as it contributes meaningful data. This style of interviewing fits with the *yarning* style outlined by Vicary (2003) who explains that yarning is a process whereby Aboriginal people create a frame of meaning. Upon first meeting, connections are made by asking 'what is your name, where are you from, where is your country, who are your people'? This yarning method provides a biographical-interpretive method for gaining insight into a participant as the psychosocial defended subject. In essence, yarning is a term utilised by Aboriginal people that provides a gestalt for the beginnings of the recognition of, and understanding of, the psychosocial defended subject when gathering data. Yarning is a culturally appropriate way of gathering data because it recognises Aboriginal ontology and epistemology. For the researcher, yarning can also contribute to some discomfort because it challenges the researcher's recognition and acceptance of the knowledge of Aboriginal ontology and epistemology as well as the knowledge of the historical effects of colonisation and subsequent legislation relating to Aboriginal people. For me, as a non-Indigenous psychologist, yarning also challenged my formal training. I was taught that 'self-disclosure' whilst interviewing is inappropriate because the focus of the interview shifts from the interviewee on to the interviewer. My way of overcoming this dilemma was to be mindful that I needed to put aside my mainstream training and learn to conduct myself in the context of Aboriginal cultural values such as reciprocity. It is from this position of understanding and insight that the research question is adapted and operationalised.

Yarning provides a gestalt for gathering rich data. From the initial question and answer methodology, the research process moves into yarning where the whole of the participant, who is seen as psychosocial and defended, is viewed as greater than the sum of their parts and, as the research question was reframed, the data began to flow. Aboriginal participants began to share their knowledge with me about some of the ways in which they help those who are depressed.

In the next chapter, the findings relating to this research yarning style about the way in which Aboriginal people recover from depression are outlined and interpreted. A framework for psychologists to be guided by has emerged from the findings. This psychotherapeutic framework may be utilised at the interface in counselling psychology when the non-Indigenous psychologist meets with an Aboriginal client.

Chapter Four

Creating Spaces for Aboriginal Healers' Voices

4.1 Introduction

In this chapter, I will report the findings of my investigation in answer to the question about how to work toward an Indigenous psychotherapy in the treatment of depression when working with Aboriginal clients. The information shared by the participants raises many insights that I now list and then go on to give a fuller interpretation and explanation. Additionally, I triangulate:

(a) what the Aboriginal participants in this study have told me

(b) what has been previously written about Aboriginal knowledge

(c) discuss how this knowledge makes a contribution toward the development of a culturally appropriate psychotherapy that may be utilised by non-Indigenous psychologists in the treatment of Aboriginal people who are depressed.

4.2 Aboriginal philosophy, culture and worldviews: a discrete body of knowledge

> This is our country. The place of our ancestors. You have to know that way to understand Aboriginal way. The land gives us what we need. Food, shelter, tradition, law, dance. They were put there in the dreaming. That way we live.

> All things work together: the land, the law, the culture, the heritage. That way things work. (JC7.2, 18 November 2003)

As outlined in Chapter Two, western psychology has its foundations in the world of science whilst Aboriginal psychology has its foundations in the natural world. An explanation of this by the research participants is evident in the themes that lay emphasis on the importance of connectedness and relatedness to land and how this is critical to recovery from depression. For example, at a presentation to post graduate students at Southern Cross University on 21 March 2003, Aboriginal academic and researcher Karen Martin (FN4.1, 21 March 2003) gave an illustration of Aboriginal relatedness, lore and knowledge by identifying the concept of an 'Indigenist' framework as *Ways of Knowing, Ways of Being and Ways of Doing* and suggests that they are ontologically distinct in prescribing place and group specific knowledge, beliefs and behaviour. She explains Aboriginal ontology and epistemology through a series of photographs and drawings and starts the presentation with a cultural map and the comment that Aboriginal worldview is holistic and that, "the whole is greater than the sum of its parts. The worldview of our people is that we are in relationship with everything" (FN4.1, 21 March 2003). Identity is explained by stating where she is from and who her people are. She states "this map, this is my home. These are the groupings of my people. This is my country, North Stradbroke Island. We are *Noonuccal* people" (FN4.1, 21 March 2003). Martin and others (Rigney, 2001; Wilson, 2003) elaborate further upon this Aboriginal philosophical and cultural framework.

Martin explains the concept of kinship in this way, “[m]y ancestors here tell me who I am. My family includes features of the land like you see in these photographs of Brown Lake and Adder Rock. They are entities” (FN4.1, 21 March 2003). She explains the spiritual connectedness of the entities that are in the features of the land by saying:

> The creator spirit of this land is Kabul. It is a knowledge map. It contains the stories of this country. The knowledge of this plant for example, sometimes known as ‘black boy’ has more than one meaning. At a practical level it is used for making spears. At the same time, because it is lore that says to respect growth and maturity, we do not cut this plant when it is green. (FN4.1, 21 March 2003)

The consideration expressed by other research participants supports the deliberations of Martin’s presentation and indicates Aboriginal philosophical thought stands alongside other bodies of knowledge, such as European philosophical thought, Eastern philosophical thought, North American First Nations philosophical thought and African philosophical thought for example, a valid ontology and epistemology. Aboriginal cosmology, ontology and epistemology are expressed through what is known as the ‘Dreaming’ (Stanner, 1979).

These stories of ancestral beings that describe how the landscape was formed are known as Aboriginal lore. The lore that is expressed through stories, dance, song and art tell about local resources, customs and conduct, Aboriginal philosophy and science, or, as Cameron (1992) explains, that the term ‘Dreamtime’ refers to “the

times of the Spirit Ancestors who on their epic journeys, created features of the land. It is the sacred past that is ever present. It is the eternal now" (p. 6).

In terms of the main site for this research study, the dreaming story about Townsville, according to Aboriginal cosmology, is:

> The most important story for Townsville is the one about Castle Hill and the tip of Cape Cleveland … the dingo and the kangaroo … this is part of the Dreaming … the Guliman story … it extends from Babinda to Townsville. Castle Hill is the dingo. The front paws are Melton Terrace. The dingo's head and shoulders are the lookout. The road going up is the backbone. The dingo's back leg is Yarrawonga and its tail goes out to West End. The tip of Cape Cleveland is the last eastern grey kangaroo. The lighthouse at Cape Cleveland sits on the head of that kangaroo. The story is that the dingo saw the kangaroo taking his breakfast. The dingo chased the kangaroo out of the rainforest. The kangaroo was the very last one of the eastern grey kangaroos. You won't find the eastern grey kangaroos now past Rollinstone. The kangaroo went through the water from Halifax to Cape Bowling Green to the tip of Cape Cleveland. No dingo will jump in the water. This dingo knows that if it enters the water, the kangaroo will hold his head down and he will drown. So the dingo waits and observes. The kangaroo also waits and observes. There is tension in this story between the dingo and the kangaroo and within these two entities. They eventually turn to stone. It is a story about patience and discipline. (JC15, 31 October, 2005)

Figure 4.1 Townsville Story – The Dingo and The Kangaroo

Adding strength to importance of non-Indigenous psychologists coming to understand *the dreaming*, an Aboriginal community Elder tells another cosmological story from this country of the *Walgurukaba, Birra Gubbi* and *Bindal* people:

> that carpet snake, Biame … it made its creation journey when it left the mainland at Lucinda … and all the islands are her eggs being dropped along the way. Palm Island. Magnetic Island. And she came up the Ross River and back up on to the land again. Rainbow serpent is the connection/bond between the sky-world and earth. (ST1.4, 16 July 2003)

These findings have the power to begin to turn the lens of psychology to focus on the way in which Aboriginal people from this North Queensland community view the world. By focusing attention on the way in which land and identity are inextricably woven is one such case in point that will be explained by various research participants.

It is my belief that this framework for Aboriginal knowledge, beliefs and behaviours is the very paradigm upon which a psychotherapeutic intervention may be built that, in turn, may be available to non-Aboriginal psychologists.

4.2.1 Land as attachment and identity

Attachment to land can be seen in the many dimensions of Aboriginal life. Attachment to land is psychological, spiritual, cultural, physical and historical.

> In Aboriginal culture, country (the land) means place of origin, literally, culturally or spiritually. It can have a political meaning of nation that refers to a clan or tribal area. Country also refers to all of the values, places, resources, stories and cultural obligations associated with that geographical area. For coastal Aboriginal peoples (and Torres Strait Islanders), 'country' also includes both land and sea area, which are regarded as inseparable from each other. (AA1.1, 24 February 2003)

For the participants in this study, landscapes and places also have a spiritual dimension. People are attached to these landscapes and places because they are in spiritual discourse with them. Being in ‘country’ holds healing properties because

this is where the connection with ancestral spirits is renewed. Attachment is expressed as follows, “[m]y *special place* in my country up north is where there is a beautiful waterfall. The water has a healing energy. And my ancestors, the old ones, are always there. I can feel the presence of the spirits here”. (AHW8, 3 April 2003)

A similar opinion about attachment and identity to land and country with a different slant is given:

> My belonging-ness and where I have my connection is down in M…. And where I grew up, at R…, I mean it's probably the most important part of my Aboriginality. It is that sense of going back there and I get that sense of being revitalised. Spiritually revitalised. It does regenerate me. It does give me a sense of "I'm fine. I belong. I am part of something." And like all human beings, we've got to be part of something. Or belong somewhere. And it's ironic. It's the bush in M… that I get all of that back. And that's my telling who I am and my existence on this earth, I suppose. So that gives you identity. And I am very protective of that area. (HW4.1, 14 July 2003)

Explaining attachment to the land and country at a deeper level and thereby demonstrating a different way relating and connecting to land from western ways of relating to land is clarified in the following comments:

> The G… (River). It is so significant in relation to who I am. Sadly, part of the riverbank has eroded … and whereas, I don't own that land … no ownership to it whatsoever … I belong to that part. That land owns me, I suppose. And

> that River … and that area sort of owns me and that's where I go back to for my wellbeing, what the land means for us, I think that spiritually, it's all innate. And it is part of, I would say, from me personally, it is part of who I am. It's my identity. It's my sense of belonging. (AHW4.1, 14 July 2003)

The point that connection to land and country can be felt even when a person is far away and it gives strength and support is made:

> My country is on the other side of the country. And I will always have the energies of that country in my head, and I'll always know what my Grannie taught me. And so that is kind of, I suppose, in a sense something that grounds you. (AA4.1, 30 July 2003)

A sense of identity and personal strength through connection to both country and family is expressed this way:

> It is important to know where you come from. Knowing who your family is. My family on dad's side is from Hopevale and mum was born on Palm Island. This connection to land, to country and to family makes me strong and gives me identity. (AHW3.1, 22 May 2003)

Attachment and identity to land and country provide a sense of social and emotional wellbeing to Aboriginal people. If attention is not given to the importance of this attachment, emotional distress may occur. Longing for, yearning for or crying for country is considered to be a culture bound syndrome that causes emotional

illness among some Aboriginal people. One of the research participants, also a Community Elder, spoke of a female community member who was indicating such signs of emotional distress:

> She has been away from her country for too long … her 'people' visit her at night … she sees them at the end of her bed … they tell her it is time for her to come home … She needs to go out to Bedourie, that is her country … it is time for her to go back to visit. (ST1.2, 11 June 2003)

This culture bound syndrome affects some of the Stolen Generation in the most dramatic and cruel way, for the lost connection to land, country and family may not always be repaired, as one of the Aboriginal research participant shares:

> … in some circumstances, some of our Stolen Generation, people when they do return may not find that immediate connection with families or where they belong in families. And that's where a lot of work needs to be done … because that's also part of the healing thing. Like, you're my mother, you're my sister, you're my family somewhere. I think that is part of the healing process. But a bigger part is to know where you come from and who your people are and what area you area from. (AHW4.1, 14 July 2003)

Most importantly, it is essential to know that connection to land and country is as vital as it is vulnerable to external disturbance or ecological damage. As one participant whose family wellbeing was affected by the mining industry on Cape York stated:

> At *old* Marpoon when the mining came, landscape was damaged … the mining operations affect the spirituality and connection to this land. People were moved to *new* Marpoon but my mother said it was not the same. (AHW8, 3 April 2003)

The different appreciation of land as attachment is expressed in this study to the non-Aboriginal researcher/psychologist as the differentiation between feelings experienced as 'an average Australian with a mortgage' and as an Aboriginal woman paying off a house and land in Townsville and her attachment to the specific place of her home country in the *Yorta Yorta* nation. She states:

> So it is interesting when you compare it to … well, I work here everyday. And I work hard to pay for a block of land and my house. And it's a security thing I suppose … very much a safe place to go home and sleep … because I am paying for this spot. But it [this block of land] has nowhere near the significance and meaning to me as what it [the land] does when I go back home … .(AHW4.2, 5 August 2003)

In deepening the importance of attachment in western psychology and philosophical thought, Grosskurth (1986) cites Klein's attachment theory which is about the relationship between mother and child and how that affects the psychic development of the child. This mother-child attachment theory in western psychology, as a way of viewing the psychic development of the person, is classically individualistic. The stories told by Aboriginal participants in this study signify a holistic connection to land and country which opens up to another way of

viewing attachment and psychic development. Grieves (2002) points out that ceremonies include the expression of human attachment and responsibility to the land; initiation rites that serve the purpose of making men and women in the right way about Aboriginal knowledge and consciousness; mourning ceremonies that involve the responsibility to guide spirits back to their own country and sacred site; and, the ceremonies for healing and harming that call on the ancestral spirits to assist.

Flowing out of the Aboriginal belief system about land, attachment and identity is the central concept of kinship.

4.2.2 Kinship - relatedness and connectedness and obligations

In Aboriginal culture, kinship is a model for the universe and the place of people in it. For Aboriginal people, obligation and cultural practices are designed to ensure the protection and maintenance of the natural world. Relatedness to the animals and the landscape, as kin, is an expression of their connection to the natural world. This worldview is re-enforced by Karen Martin who, in her presentation mentioned earlier, states, “the kinship system … everything is connected to everything else … it is about our relatedness … it is about respect and reciprocity” (FN4.1, 21 March 2003).

The magnitude of kinship must be understood, as it is considered by Aboriginal people to be the source from which the guidance for social conduct, exchange and obligation emanates:

> Fundamental to the philosophy of land as the underpinning of Aboriginal philosophical thought is the concept of relatedness and connectedness to land. With the concepts of relatedness and connectedness comes the sense of the duty of obligation that is a fundamental part of the kinship system. (AHW4.2, 5 August 2003)

Kinship, obligation and reciprocity are demonstrated in the following comment:

> One of the main features of Aboriginal communities is the concept of reciprocity. It is about patterns of sharing that are followed by everyone. This includes and outlines everyone's rights, duties, responsibilities and obligations to their particular community. It is an important part of the kinship system. (JC14, 9 July 2003)

Another expression of kinship and obligation is explained this way:

> Our family totem is the bronze winged pigeon, and we have to look after this. Your totem is part of your kinship system … and the land … different plants. And the totems that are given have a special meaning. It is more than just saying this is a totem. It is like a part of the person. It's like the mother, the earth, and the plants are also part of the earth. And it is integrated into a kinship system if you like … you know, like someone's brother and sister and those sort of things. (AA1.2, 16 April 2003)

In learning about the land and country as well as the kinship system, obligation and reciprocity, an Aboriginal Elder told me, “the totems for Townsville are the Brolga and the Pelican” (FN6.2, 10 April 2003).

Whilst on a field trip to Alligator Creek, located near Townsville, with two Aboriginal consultants, one fed the fish in the water with some bread that he had brought along and explained:

> These fish are known as ‘Jungle Perch’ and ‘Sooty Grunter.’ These fish are part of my totem, and I have to look after them. That means I cannot catch and eat them, even though it might be easy to do so. It would be like killing and eating your grandfather”. (FN1, 29 April 2003)

Figure 4.2 Kinship with Nature

The allocation of kinship positions allows for a protocol or set of instructions for social behaviour with people in Aboriginal communities:

> Every person, non-Indigenous as well as Indigenous, is assigned with some kind of kinship position. Because I was actually involved with the training and involved with everybody, I had to fit within that Indigenous Community Group. Whereas, if you go and work in a remote community, nine times out of ten, you are actually given a skin name because you have to fit within that community. And it's not about being accepted or anything like that. It is about the fact that everything has to fit in that community. (AA3.1, 1 May 2003)

So, this sense of obligation can be so strong that for many Aboriginal people it can be difficult to fit in with requirements of living in western society. Obligations at 'sorry' time are one such example: "They [mainstream organisations] need to be flexible when they are dealing with Aboriginal people, for example, funerals" (ACM1.1, 17 April 2003).

The sense of responsibility can also be so strong that Aboriginal people would risk anything not to default on obligations. Whilst working at the Aboriginal and Islanders Health Service, my cultural consultant informed me, "I would cause my family 'shame' if I did not attend a family funeral. Even if it meant losing my job, I would always go home for 'sorry' business" (CC3, 28 May 2003).

Kinship obligations are connected to ceremonies that have their framework grounded in Aboriginal philosophy. Furthermore, it was pointed out to me that

Aboriginal people can become very depressed if they cannot attend to duties, due to external circumstances, for example, a hospital stay:

> I have looked after people in hospital who have that part of the obligations of the kinship system, particularly tied in with the ceremonies and all those things that have to happen to make sure that everything is protected and everything in the cycle of life continues. I have known people who have been quite sick physically and they have still managed to get home because there has been some obligation on their part, to be part of a ceremony or some part of the teachings or they are connected with something, at the time. So, they actually discharge themselves and go home. Or be quite depressed if they are so sick, they might be in traction or something, so they can't go home, so then psychologically, they become quite depressed because the obligation to be part of whatever they have to be part of, is extremely strong and is all closely linked to the kinship system and how different people are obligated, and how different people have different parts of the knowledge, and how they are the only ones who can pass on that part of the knowledge and be involved in the passing down of that knowledge or the ceremony can't go ahead because their part in that ceremony is … they need to be there for it and there are certain things that they need to do. So it becomes quite complex. Yes. And those obligations can be so strong, that people can become so depressed if they aren't able to participate because of health or other problems, because they need to. (AA1.1, 24 February 2003)

Additionally, when obligations are not met, I am told in the following comment that it is the role of the Aboriginal Lawman to remedy this situation:

> It has been well written and talked about in Indigenous circles about what people might consider as sorcery or witchcraft or what ever you want to say that is caused by people not doing the right thing or they were supposed to do something that they didn't. Some obligations that they had to carry out and didn't. This might cause physical sickness or psychological sickness. And those things can only be healed when that person actually does the right thing. A certain treatment or certain processes are carried out to make the wrong right again. (AA1.1, 24 February 2003)

Further evidence of Aboriginal law being active within communities is given. "A community police officer, very well educated. And he was from the D…R…region. He was a senior lawman for that area. They still practice business in that area" (AA3.1, 1 May 2003).

Others support this comment, such as Pryor (1998), who gives recognition to the fact that Traditional Aboriginal Law is still being practised, even in an urban setting such as Townsville.

Visiting Aboriginal sites around Townsville and Laura in the Cape York region, gave me an opportunity to learn from Aboriginal people the significance of the rock art. At the Quinkan Rock Art Gallery at Laura in the Cape York region, the following explanation is given. "The paintings on these rocks tell us of food

available in the area. They also tell of the spirits in the area" (FN6.1, 9 July 2002) and it begins to become clearer, as a non-Indigenous psychologist, about the manner in which Aboriginal cultural knowledge is transmitted. At Blue Serpent Rock, near Townsville, it is explained:

> The pictures and the paintings of the past are our link with the present. This place here is a burial preparation site. The rock itself is a ceremonial site. There is an expectation that the spiritual presences will assist in the healing". (FN6.2, 10 April 2003)

The method of healing is described by one of the Aboriginal cultural consultants as 'learning to keep things simple'. For example, it is explained that people can simply sit on the rock to solve problems, to meditate, lower anxiety, listen to the wind in the trees, to influence physiological responses, such as lowering the heart rate. Similar to the lore that gives meaning to the images seen in rock art, storytelling is also about Aboriginal wisdom, teachings, knowledge and traditions. This is demonstrated through the process of explaining that when working with Aboriginal children, telling them a story, for example, 'How the black crow got its name', is one way of passing on Aboriginal ontology and epistemology. The method described is one where the children are asked to lie down with their eyes closed. The storyteller narrates the story of 'How the black crow got its name'. The children are then asked to 'see' the pictures of this in their mind. When the narration is completed, the children are asked to draw a picture of what they have seen (FN6.2, 10 April 2003).

4.2.3 The Politics of Knowledge

Grieves (2002), in discussing culture and Aboriginal philosophy, writes that the heart of Aboriginal philosophy and tradition is subjected to secrecy and that knowledge is divulged on a 'need to know' basis. These sentiments are confirmed in the following comment made by one of the Aboriginal academic participants who stated, "I guess the other thing with Traditional Medicine is that it is not for everyone to have the knowledge about. Or to be able to practice so that has implications in itself" (AA1.2, 16 April 2003).

This is confirmed by a tribal elder from the *Birra Gubbi* people in conversation with the researcher and an Aboriginal cultural consultant/health worker. He stated:

> People ask me about my tribal ways. It's not for me to tell because I have got to see my elders before me. And that's how it is. And if he gives you the 'okay' I have to have a witness with me to verify that it will be okay to speak on the lesson. (JC7.1, 30 October 2003)

Within Aboriginal society, people are chosen as the keepers of such knowledge. I am told this is how it works. "The tradition, the elder people say, is that no one particular person holds all of the knowledge. So everyone has a role to play and no-one is of greater importance than anyone else" (AA1.2,16 April 2003).

A note of warning is given to me regarding what constitutes Aboriginal spirituality and traditional healing, especially in the light of current interest in traditional ways of healing:

> They've seen Spirits all over the place and it's almost like the 'poltergeist' or whatever. And you think, 'get a grip'. To me, that's not, to me, that's not Aboriginal and that's my own judgement. It's more a western form of spirituality, a belief in the supernatural *a là* Hollywood and a *New Ageism* that we have taken on as well. So I think there is always a *New Ageism* in influencing Indigenous spirituality which we might learn to take on in parts, but I think for me, it is acknowledging that yes this is a western aspect, I don't just mean recognition that the clinical hard-nosed science type are from a dominant western influence, but also 'alternative' approaches. I am a bit suspicious of what is called 'Indigenous'. And I think you just have to be careful of that. (AP1.1, 29 September 2003)

The question of who should be practising is also a matter of offering clients a choice or a range of alternatives, rather than imposing a streamlined treatment indiscriminately. The question of choice is closely connected to the principle of self-determination that has been at the fore of Aboriginal revindication for decades. This is clearly stated by one of the research participants in the following comment:

> I guess it is in tune with the old 'family business' in western Society, you know. Where you make jobs for your family and looked after them and that

> sort of stuff. I guess ours is a bit different because of the kinship system orientation. It is about self-determination. (AA1.1, 24 February 2003)

The question of what and who should be practising what kind of therapy is inextricably linked to the Aboriginal politics of knowledge, especially at this time where, as Tacey (2000) says, there is a general interest in 'spirituality'.

4.3 Healing depression Aboriginal way

The research participants gave eminence to Aboriginal philosophy, culture, ontology and epistemology as standing in its own truth as a legitimate body of knowledge. Within this body of knowledge, the fundamental healing processes are to be found in the connection to land and country. This is how it is explained to me:

> Visiting country encourages healing. It comes from the power of being in one's country. The most important thing is about coming back to culture. It is a means of guidance. It is also a way of healing and strengthening and this includes depression. (JC12.1, 1 May 2003)

Passing on further experiences of healing Aboriginal way, I am told by one of the Aboriginal health workers that when she went to the Townsville General Hospital for minor surgery, she asked the hospital medical staff if she could "go out and stand on the grass to be outside for a few hours just to connect with the healing power of nature and the earth". She went on to instruct, "[i]f you walk ankle deep in the water along the Strand, let each wave carry away your sadness. Be aware of the healing power of water" (AHW7.2, 3 April 2003).

The process of understanding Aboriginal culture and working in collaboration with mainstream psychology is slow and deliberate. An Aboriginal psychologist and academic points out to me:

> Joe Roe's paper is very important. He is an Aboriginal man who is trying to use that whole Kimberley Indigenous concept of the spiritual self and healing and this is key in mental wellness etcetera. But I don't think that there are any 'quick fixes'. (AP1.1, 29 September 2003)

Even a culturally based approach cannot ignore standard (personal) factors, like family pressure, community expectation, difficult relationships, work expectation and ambient racism. An Aboriginal general medical practitioner gave the example of a young patient who had recently left her community to go to a bigger town for work and presented at the medical practice with the symptoms of depression. He states:

> We practice holistic medicine. What needs to be considered of course is the whole person…and I suppose that their present situation, that is, who they are living with, what's happening at home, what's happening back in their communities. And the expectations for somebody, for example, this young lady who came from her community, the expectation on her would have been quite high and having left the community to work in another community, where things were expected to be a little bit more complex performance wise. That's something that obviously that has a bearing on how [depressed] she felt. (AHW5.1, 9 October 2003)

In discussing Aboriginal ways of healing, confirmation of Aboriginal psychology came from one of the Aboriginal academic participants who made the following statement to me:

> I really think that there needs to be recognition by western society that healing has happened, psychological and physical healing, has been done by our traditional healers over many years and that people still turn to that sort of healing. And, it might be used by itself or it might be used in conjunction with western medicine. (AA1.2, 16 April 2003)

Family plays a major role in the recovery process of helping those who are unwell, depression being a case in point. I am told that "Indigenous people have a big extended family and I think, in a lot of cases, that is where they get their support. So, often it is from the family first … and seeking other services later" (AA1.2, 16 April 2003).

Many Aboriginal people who experience psychological distress access Aboriginal traditional healing:

> It has been my experience in health that when anyone needs treatment and if they believe in traditional healers, then they have sought and received that treatment, their recovery, if you like, has been quite positive. As opposed to someone who has been put in a psychiatric unit or treated for depression with drugs and that sort of thing without recognising there may be an alternative means of treatment. (AA1.2,16 April 2003)

And, commenting on the same point, states, “[t]here is still a belief in the traditional healers within the Indigenous Communities” (JC2, 1 May 2003).

What's more, I am further told:

> I think that the people who seek traditional healers probably would not go to a western person to deal with it [depression]. And you would never know about it. I know that a lot of my relatives still go to what they call 'clever people.' You know, the medicine men that do the healing. But because traditional healing has not been explored [by the westerners] many people see it as sorcery and not scientific. It is interesting, you know, how acupuncture and things like that [traditional Chinese medicine] have only recently been accepted and in some areas it is still not accepted. So traditional medicine still has a long way to go to be fully accepted by non-Indigenous people. (AA1.2, 16 April 2003)

Anderson (2003) supports these comments. Like many of the research participants, he notes, “poor access to services [by Aboriginal people] is merely a consequence of a residual tribal logic” (p. 50). He writes that Aboriginal people are well aware of the functions of hospitals and medical centres. However, these services need to respond to specific Aboriginal claims for service or to demographic or economic or other systemic barriers to access.

4.3.1 Aboriginal consciousness and perceptions of reality

Participants raise the concept of 'Aboriginal consciousness'. This concept brings into our awareness of the way in which Aboriginal people perceive and relate to their environment and how Aboriginal culture shapes their reality and, by extension, shapes their ways of healing.

In giving an address at the School of Indigenous Australian Studies, one Aboriginal academic mentioned the notion of 'Aboriginal consciousness'. As this academic was also a research participant, I asked her if she would elaborate on the meaning of Aboriginal consciousness. She stated:

> Aboriginal consciousness? Well it's just being conscious – conscious of whom you are, I guess. When Aboriginal people talk about their experience or their experiences, they are kind of coming from that thing of knowledge, that is, knowing who they are. Consciousness is about how you experience the world. Aboriginal consciousness is about how Aboriginal people experience the world [Aboriginal way]. (AA4.1, 30 July 2003)

To illustrate further the perceptions of reality that stem from two separate streams of consciousness, the example of the way in which Aboriginal people and non-Indigenous people perceive land, she comments:

> It is the non-Indigenous people who identify **with** the land whereas, Aboriginal people identify **as** the land. So, for example, we've talked about how each of us [Indigenous staff at SIAS] feels like when we travel. We

> really like to be able to drive, because we like to be in the landscape. By contrast, western consciousness is experiential *spiritual tourism* Aboriginal consciousness is *connectedness*. For Aboriginal people, they *become* the landscape [entity]. (AA4.1, 30 July 2003)

These differing perceptions of reality regarding land are confirmed in a most dramatic style that is one of the main themes of the film 'One night the moon'. The non-Indigenous settler/farmer claims "this land is mine" and the Aboriginal whose country it is claims "this land is me" (Perkins et al., 2001). Adding further insight, an Aboriginal PhD candidate comments, during the presentation of his studies on the environment and natural disasters at the School of Indigenous Australian Studies, on the Aboriginal perceptions of the environment and cyclonic events. He stated, "the natural environment on Mornington Island is seen as an entity. The entity of water, the sea, is always there. Cyclones themselves are perceived as an entity" (FN7, 26 April 2003).

These examples begin to demonstrate the meanings of the differing perceptions of reality and are consistent with the comments by Grieves (2002). They show that whilst non-Indigenous people generally function from the perspective of time and history, Aboriginal people operate from the idea of connectedness to place, community, kin, all species and the natural world. Highlighting this other way of learning and experiencing the world is explained to me by an Aboriginal consultant who gives an example about the way in which a particular tree indicates events in the natural world and its healing ability:

This is a Cocky Apple Tree. We also call it a Calendar Tree because when the leaves change their colours, it indicates certain things, for example, when the leaves of this tree turn yellow, it means that the barramundi are pregnant and fat. Red leaves indicate the breeding season. The inner bark of this tree is also used in traditional medicine. (FN1, 29 April 2003)

Figure 4.3 The Cocky Apple Tree, also called The Calendar Tree

4.3.2 Healing as a two part process

Recovery and healing from depression, as a two-part process, is explained by one of the Aboriginal health workers:

> The first part of the healing process relies strongly on self-knowledge and identity and a sense of belonging to land and family. This begins to give a sense of connection to everything. That is, eventually coming to know where you fit in the big picture. (AHW4.1, 14 July 2003)

She elaborates a specific collaborative methodology that is centred round the importance of land, family, belonging and connection:

> I think **the first part** of any healing process is to know who you are and where you come from. And to further that healing, you would really need to go back to that place … once you find where you belong. You go because part of that healing would be that Spiritual connection to that land. And it is not just the land. It is also that water, or there are other things that are part of where you come from that gives you back some sense of belonging … some sense of identity … you have to get all that back then feel … get your identity back first. And that part of gaining your identity, know where you've come from, where you belong, who your mob is and try and get some sort of connection back into that Country. I think there is another part and this is perhaps where that can be done through people who will assist you to find who you are and all that. That is crucial and the crux of the healing part. The second part is more person-centred, centred on individual experiences. This is

particularly relevant to people, like the stolen generation for example who need to be helped to recover from their feelings of grief and loss. (AHW4.1, 14 July 2003)

She then goes on to explain this second stage, or part, of this healing process through the implementation of western psychotherapy in collaboration with Aboriginal ways:

So the **second stage** would be then, to deal with what happened to you. Why were you removed from me? And then you deal with all the blaming and then all that sort of thing so that is the other part. But if you give that identity back first, then the second phase of healing is going to be a little bit stronger because they do have an identity and they know where they fit and where they belong. And in the second part, you will need to do the counselling healing part … the rejection … the removal from your families … being taken away. And dealing with the government … the way the government is today, with regard to the Stolen Generation … the grief and loss. The most powerful feeling I have, is where I belong. All the tragedies in my life, all the sadness in my life, I have a lot more strength to deal with because I do fit in this world as an Aboriginal woman. And I belong somewhere. And I am accepted where I belong. And I could be away from home for years and years, and I go down, I mean, it's not just my mob back there that welcomes me back, it's all that other things like culture, land, the whole works! (AHW4.1,14 July 2003)

Making another contribution toward this study, an Aboriginal health worker narrated her views about healing Aboriginal way:

> When people are depressed, they often don't talk about it. They block out the memories or the feelings. They go for long walks. It is helpful to go near water. When you know that someone is not feeling right, ie., depressed, just sit with him or her. You do not have to say anything first. Just be with them. Then the person will speak. They might say, 'I am not well' or 'I think I have been caught'. People will speak when they are ready. Sometimes a person gets sick and a Traditional Healer is called in to help. People 'go bush' to heal, but someone is always watching the person. Sometimes they go 'walkabout'. (AHW7.3, 18 November 2003)

With experience and greater awareness of Aboriginal culture, mental health practitioners who have worked with Aboriginal clients are starting to outline and define the contour of Aboriginal psychological interventions that may be used by non-Aboriginal psychologists.

4.4 Rethinking psychology and psychotherapy Aboriginal way

Rigney (2001) and Smith (1999) argue for the decolonisation of existing research methodology and the acknowledgement of an Indigenist framework. The *Indigenist* research paradigm and methodology is theorised by Rigney (2001) and Wilson (2003). Martin (2003) theorises Indigenist research epistemology as *Ways of knowing, ways of being and ways of doing*. Martin proposes that for Aboriginal people, "[w]ays of knowing and knowledge are specific to ontology (worldviews)

and entities (spirits) of land, animals, plants, waterways, skies, climate and the spiritual systems of Aboriginal groups" (p. 209). She states:

> Ways of knowing inform Aboriginal ways of being. We are part of the world as much as it is part of us, involved in a network of reciprocal relations that cannot be de-contextualised. This determines and defines our Ways of Being and informs us the beliefs, laws, morals, values and ethics. These guide us in our behaviour, how to relate to others and they also determine the consequences for infringements. Ways of being evolve as contexts change especially after colonisation.
>
> Ways of doing is a fusion and coherent expression of Aboriginal ways of knowing and ways of being. Our languages, our art, our rituals, traditions and ceremonies are articulations of our ways of knowing and being. These are the expressions and behaviours of our knowledge and beliefs. They are the observable ways Aboriginal people conduct their own behaviour and engage in relations with others. Ways of doing defines who we are, what we do and how we do this. (Martin, 2001, 2003)

This provides a possible framework for psychotherapy.

4.4.1 Land/Country as an Aboriginal research paradigm: a paradigm for psychology and psychotherapy

The worldviews expressed by the participants strongly highlighted the role of land and country as the foundation paradigm for any Indigenous research. One of the Aboriginal academics puts forward the following proposition:

> The land is the underpinning philosophy for research. It is an underpinning for Aboriginal ontology and epistemology. The notion of land sort of underpinning our research theory and methodology is uniquely Aboriginal. It's under everything. So if you are looking at health or education or media or whatever, you need to do it with a notion of, you know, how important the land is in the way [it shapes the manner] in which [Aboriginal] people are thinking or operating or whatever. (AA4.1, 30 July 2003)

Supporting this notion, of land and country as a philosophical and theoretical foundation to Indigenous research, is the comment by the Aboriginal psychologist who states "the underpinning of Aboriginal philosophical thought is the concept of relatedness and connectedness to land" (AP1.2, 31 October 2003).

In a similar vein that is both inclusive and collaborative, an Aboriginal academic stated:

> I want to do something about exploring that, the importance of land from both Indigenous and non-Indigenous perspectives. I would like to write something about that. Because what I want to do, when we are looking at our

researchers is to have the land as the under-pinning philosophy. (AA4.2, 18 August 2003)

A note of caution is expressed to psychologists with regard to what it is to be Aboriginal. They tell non-Indigenous psychologists not to assume that, simply because a person is Aboriginal, they must therefore think and behave in a particular way. The caution is issued in this way:

> I think you are trying to say Aboriginal people feel like this. And I don't think that that is a given. I think that the degree of diversity that exists in the way in which Aboriginal people have been raised in the past 100 years or so means that, yes, there will still be some people that feel very close to nature. There will be some people who feel something but they don't know what it is that they feel. (AA4.1, 30 July 2003)

Similarly, the Aboriginal psychologist points to the perils of non-Indigenous psychologists engaging in what she terms 'new assimilationism' in the following comment:

> It seems that there are a lot of 'purists' going on about what should Aboriginal people do, from our own people and non-Aboriginal people working in that area. They are determining our realities, our issues and problems and also the solutions. Sometimes, these can be inaccurate and still a form of 'outsider' conceptualisation imposed on the group. And I don't like that. It smacks to me of a different form of missionary zeal. I actually wrote a

> paper which was never published called the ‘The new assimilationists’ where I felt very oppressed by the new prescriptions that were about, often from non-Aboriginal people, on how to be Aboriginal. Or what we should be doing. Or what concepts we should be embracing and ultimately this gave non-Aboriginal people a place, I guess, and they called themselves the progressive ones. And to me, it is very challenging. (AP1.1, 29 September 2003)

These warnings from Aboriginal participants about presuming perceptions of Aboriginal reality serve to remind non-Indigenous psychologists, yet again, to never assume they know what it is to be Aboriginal but to listen carefully and deeply to Aboriginal people when they speak, to recognise that they have their own culture and tell their own story and to also be mindful of the impact of colonisation upon these traditional land owners.

4.5 Rethinking psychotherapy Aboriginal way

Some research participants point toward the need for psychologists to retrain and rewrite theory and techniques in the treatment of depression. An Aboriginal health worker exemplifies the way in which she sought mainstream medical help for her depressed mood, then engaged in self-help and followed this by engaging in support from members of her community:

> My husband went away for work, a month at a time. He works on the road/rail building a new line from Mackay. I felt upset and sad. I went to the doctor and he prescribed anti-depressants. I wanted him to give me something

> to cheer me up … some happy pills. I did not take them. Instead, I did a course in craft scrap book work. I did one for my son for his twenty-first birthday and another for our wedding photos. I went to classes twice a week. They were held in the evening at the staff kitchen/dining area at the health service. I actually enjoyed, most of all, the contact with the other ladies in the group who are part of my community. My sad mood lifted. (JC11, 8 April 2003)

Aboriginal participants raise the importance and, to some degree, the sense of urgency to the call to retrain our thoughts as well as the need to rewrite psychological theory, psychotherapy and the delivery of psychological services. This is because the standard presentation of the symptoms of depression, Aboriginal way, is different from the presentation of symptoms outlined in standard mainstream training manuals and treatments are generally based on the western models of treatment. A non-Indigenous psychiatrist, who has worked with Indigenous people in the Top End of Australia for many years, makes the comment that relates to one of the ways he engages Aboriginal people in therapy. He states:

> And a lot of times, one of the first things I do, the very first thing I do with everybody I see, is to draw a genogram … and I try and make that as extensive as possible. And I do that for a couple of reasons. One is, it tells me a lot [about family]. It also invites someone to participate in an activity at the outset of this meeting, that they are the *expert.* And this is very much a visual thing, so I start doing it. I'll get corrected. I will go through people, "where's that person" and go through who is the mother for this one and that one

> etcetera. So in addition to this, I just can't emphasise how important that is, particularly in a clinic setting. It just changes the dynamics, especially if you make the cup of tea. You know, and I kind of joke about things or me, always in language that may seem to be paternalistic, but it is to put people at ease. (NI1.1, 30 April 2003)

An Aboriginal actor and teacher, giving a presentation at the National Conference on Indigenous Education on 2 July 2002, states that when he is working with Aboriginal people, children in particular, he asks them to consider for themselves the following questions, "where have I come from, where am I now and where am I going" (FN8, 2 July 2002). These questions open the way to acknowledge Aboriginal culture, present kinship and future direction and are, indeed, a form of insight psychotherapy. Psychotherapeutic interventions need to be rewritten so that their meaning is founded in Aboriginal philosophical thought. This has implications for the delivery of psychological services.

4.5.1 Retraining our thoughts.

In a similar vein to Smith's (1999) "twenty five Indigenous projects" (p. 142), this theme about retraining our thoughts draws attention to findings that indicate that the psychotherapeutic techniques applied in Aboriginal psychology may, at times, look quite similar to mainstream western psychology. We need to rethink and retrain our thoughts to recognise that Aboriginal psychology is grounded in Aboriginal philosophical thought. Shawn Wilson, North American First Nations man from the *Cree* people, commented to me, "[m]ake sure that the Indigenous psychotherapy project does not simply become a series of techniques. Context is

important and Indigenous ontology, epistemology and axiology provides the theoretical underpinnings for these techniques" (JC8.2, 26 March 2003).

Emphasis is given to reminding the researcher/psychologist of the point that, in psychotherapy, technique is grounded in a philosophy and body of knowledge that is at the core of their respective cultures. One of the research participants, an Aboriginal academic and psychologist, pointed out the following to me:

> I think that psychotherapy, (and I found in doing the Handbook I edited) that we tend to 'villainise' western psychology, psychologists and psychotherapy of any form. And in my Introduction, I actually talk about that, how we do get past these artificial dichotomies, like black/white and so on. I think that probably, there is a lot more in common amongst us as people, although we can't deny that cultural differences may need to be taken into context. (AP1.1, 29 September 2003)

Aboriginal clients can often present with depressive symptomatology and behaviour that is culturally specific and that can be mistaken as 'atypical' by western standards of depression. An Aboriginal general medical practitioner notes:

> Depression is one of those disorders that is, well, the most common of all of them [mental illnesses]. And, I find that with Aboriginal clients, somebody who is depressed, it is not easily recognisable at first because obviously there are so many other physical and emotional issues that are at the forefront. The symptoms of depression are often not evident. (AHW5.1, 9 October 2003)

An example of the cultural specificity of Aboriginal presentation of depressive symptomatology and behaviour is given:

> It was his quietness. The patient just didn't, we just didn't, I just didn't recognise this depression, and I think that we have to be very perceptive. And I think as with him, that, I would never have gotten anything on the first visit, maybe something on the second, but possibly something on the third. So, he was not a typical presentation. The fact that he was so quiet, he was reticent to speak about his mental health issues and I think a lot of our people present with this sort of behaviour. (AHW5.1, 9 October 2003)

The necessity of reworking the methods/techniques for the identification and treatments of depressive symptoms in Aboriginal clients is expressed by an Aboriginal general medical practitioner this way:

> We are rewriting, if you like, the whole issue Aboriginal culture into psychiatry or psychotherapy. So, I think we have to retrain our thoughts when looking at people with depression. I think that depression is under-diagnosed or perhaps just not even considered because, I mean, Aboriginal people don't show the features, they don't have the appearance, or often their appearance is unemotional. And I think we have to rewrite the standard presentation. He [the Aboriginal male patient] didn't necessarily have any of the symptoms. I think we have to retrain our thoughts when looking at people with depression. Depression is a major problem in our community. (AHW5.1, 9 October 2003)

In treating Aboriginal clients there is a prerequisite for flexibility, understanding and tolerance on the part of the treating practitioner and the same Aboriginal general medical practitioner remarks:

> It often takes two or three presentations before a patient will open up. But I think we have to ask the question [about feeling depressed] and having asked the question, I think we need to make them feel comfortable about what it is that they are feeling at the time. (AHW5.1, 9 October 2003)

There is also a need for health practitioners to be tolerant and to understand interruptions to the treatment program. For example, there may be a death in the family or the person may be called home to a ceremony. The issue of continuity of treatment among transient Aboriginal clients becomes particularly acute:

> So it [depression] is very, very difficult to treat. We are trying to establish a recall system, which will work for the better, hopefully. Tracking them [patients] down is a very common problem. Getting people back. Obviously there are ways through the family. We certainly have a fairly transient population. Certainly a minority of people are transient coming from here to their communities in Queensland. (AHW5.1, 9 October 2003)

Attitudes held by some members of Aboriginal communities can sometimes run counter-productive to the standard treatment programs. Drawing on his experience, one general medical practitioner remarks:

> People in our communities often have that perception of 'you've got to live for today and tomorrow, you may not be here'. I think that's part of the problem as well. You think of today, doing what we have to do today, forgetting about tomorrow, and I think that until we train people that there is tomorrow and that things are going to get better, I think that people's health generally is not going to improve that much. Facilities like this, Aboriginal and Islander Community Controlled Health Services, make it a little bit easier. But treating depression, certainly, what I try to do is refer them directly to a counsellor. Just getting people involved in that process, if possible. (AHW5.1, 9 October 2003)

The pressures of acculturative stress and the symptoms of depression at a personal level are illustrated in the following comments made by one of the Aboriginal health workers. "Indigenous people just give up because living in the two cultures [mainstream and indigenous] is very difficult" (JC9, 4 April 2003).

An Aboriginal psychologist and academic summarises the presentation of the experience of depression with Aboriginal people in the following way:

> I don't think Aboriginal depression is different, the feeling of it, than for non-Aboriginal people. I think our experience of depression is probably no different from a white person … and the articulation of some [Aboriginal people] is really different. (AP1.1, 29 September 2003)

The difficulty of getting young people to open up and speak about their problems and to engage with mental health services is pointed to by an Aboriginal youth worker who observes, “[o]ne of the hardest things is to get them [young Aboriginal people] to talk about their problems. So it can be a slow process. But it is just talking a lot. It is a very informal process … a yarning process as well” (AHW3.1, 22 May 2003).

Consistent with the comments made by Anderson (2004), Trudgen (2000) and Wenitong (2002), the incidence of depression, particularly in young Aboriginal males, is both complex and at crisis point:

> I think that a lot of young people get depressed in Indigenous society, more particularly the males. They don't know what they are supposed to do. They don't know what their responsibilities are. They grow up in situations where there's domestic violence and all those sort of things. And so they sometimes take that as being normal. And then, on the one hand being told to do this by mainstream European/Australian society and being told to do that by another society, the Aboriginal/Indigenous society, and so it makes it difficult for them. And I think they are very confused. I think they don't know where they are in terms of their identity. You know … what does it actually mean that I am an Indigenous person? All they hear about is, you know, you're black, you're dirty, and you’re drunk and all those sort of things. They don't have good education outcomes. They don't get jobs. So they are on the dole or unskilled labouring that is usually casual work anyway. So there are all these things. Whereas, I think that women, still have a set role in society in terms of

> they are still the child-bearer. You know, they give birth to the child. They usually look after the child in most cases and at least, they have some sort of role in society that stands them in good stead to actually have that responsibility and to have something to do. It is an activity that is seen as they have something to do. Not always so for the guys … particularly the young ones. I think that they are very confused. I think that a lot of them are depressed and don't know it. And then of course, we have the cycle of alcohol and other drugs and all that sort of stuff … domestic violence. They feel shame because they just don't feature into anything, in the greater scheme of things. (AA1.2, 16 April 2003)

In some communities, grief, loss and shame are emotions that often go unrecognised. As a consequence, many people do not wish to speak or engage with psychotherapy and, as a result, may be left to endure the pain of untreated depression:

> Grief and loss are ever-present emotions in the daily lives of Aboriginal people. With Indigenous people, we have communities that may have up to twenty funerals, deaths and funerals, in one year. So I don't think that people realise that they are in a continual state of grieving. And I think that surely at some stage, you know … if people aren't handling it, this turns into depression. But people don't actually realise that they are depressed because of the constant loss and grieving. (AA1.2, 16 April 2003)

Western training and symptom checklists are not always helpful in recognising depression in Aboriginal clients. Likewise, Westerman (2003), an Aboriginal psychologist training mental health workers, stresses the importance of recognising the way in which Aboriginal clients indicate the presence of a depressed mood, by stating that such seemingly 'atypical' symptoms are also present in young Aboriginal people. Whist attending her workshop titled 'Psychological assessments and working with suicide and depression in Aboriginal people', she stated to the group of Aboriginal health workers present, "symptoms of depression with Aboriginal clients are often masked" (FN3, 3 June 2003).

Offering support to the notion of the necessity to rewrite psychotherapy, an eminent non-Indigenous psychiatrist who practises in the Top End of Australia states, "[f]or people to say to Indigenous communities we are going to do early intervention when we don't have basic interventions, is a problem!" (NI1.2, 9 October 2003). He goes on to comment about some rewriting and retraining that is beginning to happen:

> The area where we are developing clinical services really articulates what is clearly the fabric of family life. Komla Tsey, an Indigenous [African] academic and health worker, is developing programs called Family Well-Being which is an interesting quasi-didactic approach to family. The programs came about as a result of initiatives from South Australia. It is Indigenous driven and developed, in the aftermath of waves of suicide. Family Well-Being is now being likely to roll down through the communities in the Cape. (NI1.2, 9 October 2003)

At the same time, an Aboriginal academic/psychologist gives a cautionary statement regarding such programs. In rewriting culturally relevant interventions, she speaks about community social and emotional wellbeing programs, pointing out the importance of avoiding 'new assimilationist' thinking and behaving by substantiating foundational concepts and methods. She states:

> … that's where the 'new assimilationists' come in. Sometimes they are actually a non-Indigenous concept, but philosophically, often we take them on and we are told to take them on by our white helpers and we assimilate them and eventually they are badged as an 'Indigenous way' and they are not. Like for instance, we have a core unit in our Course of Community Development, which we believe is about social change, working with community, etcetera, etcetera. But it's not an Indigenous way. It's actually developed in the USA. I mean, it works well with Indigenous people, but we are often tempted and our white colleagues, to say, "oh yes, it's the Aboriginal way of doing things" when it's actually a process that was developed in America which works well with us. Same with 'action-based' research, it's actually a way of working with the community that is very useful and good for us. It values the community. It's good but it's not Indigenous. So there is a grey area where things are a bit fuzzy. Sometimes I think considerably unsubstantiated. (AP1.2, 31 October 2003)

Mental health service delivery to Aboriginal people by psychiatrists and psychologists have, in the past, relied on the resourcefulness of the mental health professional and whether or not that mental health professional has been accepted

into the community. One non-Indigenous psychiatrist explains the way in which he delivers services to Aboriginal people. He explains the way in which he builds trust in the therapeutic relationship to which Corsini and Wedding (2000) draw attention:

> My main issue is around the provision of service for serious disorders [the schizophrenias or mood disorders] and then develop additional activities around that structure which also allows me to develop relationships and build confidence and trust. (NI1.2, 9 October 2003)

He also points toward the merit of practitioners having a framework from which to operate in order to understand what motivates them in their manner of practice and adds:

> Other than the mechanics of delivering services, the headspace that I have around the disorders that I work with, are pretty conventional. I would hope that this is probably the case for most practitioners. I really try to locate or contextualise people's disorders, distress, whatever else, as concretely as I can. The particular headspace that I have in terms of understanding Indigenous mental health is, I guess, what you might call a social and political framework. (NI1.2 9 October 2003)

Additionally, the cost-effectiveness of inappropriate and largely ineffective service delivery of psychological interventions is outlined in the following comment:

> The government responded to the Wilson Report by giving $20 million to the Grief and Loss Counsellors. An army of grief and loss counsellors went out. Their position descriptions are unclear … this is in response to the *Bringing them home* inquiry. (NI1.2, 9 October 2003)

This comment draws attention to the fact that it is not sufficient to simply allocate government funds for psychological services that are delivered by personnel who are, in essence, *wounded healers* and not in a position to deliver such services. As Sue and Sue (2002) point out, good intentions alone are not enough. This notion of the wounded healer leads to the necessity of turning attention to applied psychotherapy because the two are inextricably linked.

4.6 Redesigning psychotherapy service delivery

Working for two years at the Townsville Aboriginal and Islanders Health Service opened my mind to providing psychological services that are guided by the local Aboriginal community. This experience made it very clear to me that cultural matters influence Aboriginal social and emotional wellbeing and call for the redesigning of psychological service delivery in the treatment of depression. I had to learn from the Aboriginal staff another way of thinking and delivering psychological treatments. One Aboriginal health worker at the Community Controlled Health Service told me:

> There is a need for culturally appropriate Healing Centres that provide alternative ways of Healing. Look at how Indigenous people would like to be healed. Gradually look at the lifestyle of Indigenous people and what makes

> them relax, for example, family, fishing and gardening. Look at the diversity in Indigenous people. Always try to sit on the ground, cross-legged. Sitting on the mat, floor, ground, is more calming. Massage is very calming and therapeutic. Singing is therapeutic. Singing also evokes memory and emotion. Hearing certain songs, triggers emotion. Photographs from local features of the land are very helpful as a starting point for therapy. It is a way of bringing country and spirit into therapy. (AHW10, 4 April 2003)

Psychological service delivery, Aboriginal way, may be conceptualised through the development of Indigenous Healing Centres that reflect Aboriginal culture as distinct from mainstream ways:

> If I was asked okay, you are going to have an Indigenous Healing Centre, what would you have in it? What elements would be important? I would say that it needs to be 'user-friendly.' Culturally user-friendly place and I would be connecting up to [culture and community] and not just going in to my clinic or health centre, but going out and about … so, a different social way of operating it. (AP1.2, 31 October 2003)

Community Controlled Health Services contribute a foundation stone to providing culturally appropriate physical, social and emotional health and wellbeing since they work hard at accommodating the specific needs of the communities they serve. This is often a cause of tension with the demands of 'good governance' placed on the management of Community Controlled Health Centres by (government)

funding bodies. The tensions of managing a Community Controlled Health Service are voiced by the general medical practice manager:

> Good governance is a constant source of tension for me in my role as practice manager … what is good governance? By that I mean that the government with a western philosophical underpinning and management style funds this health service BUT the services provided are to a culturally and philosophically different clientele. (JC10, 4 April 2003)

Following on from this comment, it stands to reason that the delivery of psychological services needs to be part of what Swan and Raphael (1995) refer to as the empowerment to Aboriginal people toward their social and emotional wellbeing. This is re-enforced in the following comment:

> I mean it's a whole new area. It's interesting and I think lots of things are happening. And I think the most important thing is that Indigenous people are trying to sort things out themselves and explore their ways of doing it. And that's probably the most important thing because, prior to that, we mainly had western healing, traditional western models to go on. Now, there are all these different models and it's really quite exciting actually. And Aboriginal people are becoming empowered to try different things as well. (AP1.2, 31 October 2003)

In an example of what Remen (1996) calls 'kitchen table wisdom' or family therapy, an Aboriginal youth worker made the following comment:

> … we sit around the table at home and talk and argue and discuss our problems and when you get up to walk away, you sort of feel lighter. Feel much better. It's like a counselling/therapy session without realising that is what is actually happening. (AHW3.1, 22 May 2003)

In Aboriginal communities, different members of the immediate family or extended family, or indeed the community, have different helping roles:

> Someone in the family, either male or female, they might be the person that every one goes and sees and talks to and gets advice. That person can also be like a mediator or sometimes like the decision-maker, for the family. (AHW3.1, 22 May 2003)

From an Aboriginal psychological perspective, this kind of therapy is grounded in the importance of family and kinship. I learned that the family and the community take responsibility to help in the healing process. A psychologist might be consulted by the family and community to provide an indirect contribution. It is a holistic approach that reflects communal rather than individual thinking. An Aboriginal health worker, who drives the community bus that ferries Aboriginal people to and from the health service, demonstrates the application of communal care. She makes the following observation:

> The clients talk about the old days while I am driving them on the bus. People talk about all sorts of things. I can tell when clients are upset or depressed by several indicators such as they may not be out of bed or functioning

> effectively enough to get themselves organised to be ready to catch the bus. Sometimes I notice the mood variations in the clients. So in terms of treatment for depression, I just listen and that seems to help people. (JC4.2, 18 July 2003)

Aboriginal people taught me that the basis for psychotherapeutic intervention acknowledges the importance of working with family and community. This is demonstrated in the manner in which the community takes responsibility in response to suicide. In working directly with community with regard to suicide prevention, an Aboriginal academic observes “and the community sort of gets back together again. And they set up actual Night Patrols. Suicides diminished after that”. (AA3.1, 1 May 2003)

In mental health standard practice terms, when someone is suicidal they are placed on ‘suicide watch’ but the responsibility is generally taken on board by the crisis assessment teams who are generally located at the mental health/psychiatric sections of the public hospital system. In essence, this Aboriginal community in North Queensland took responsibility for their own people by setting up their own watches or patrols for the people at risk of suicide in their community. This is in stark contrast to the mainstream system whereby, in my experience, the crisis assessment team that is associated with the public health system takes responsibility.

For non-Indigenous psychologists, the redesigning of psychological service delivery with Aboriginal people requires openness to different ways of thinking. An Aboriginal health worker, in the following comment, points this out to me:

> You know that Maslow theory, I think he has got it wrong for us Aboriginal people. That *self-actualisation*, that spiritual stuff at the top of the triangle/pyramid [hierarchy], well, for Aboriginal people that spirituality needs to be at the bottom. Spirituality is the first and most basic need … spiritual connections first, and then everything else follows. Without the spiritual connection, the foundation is not right. You know … . (FN5, 25 November 2003)

Coming from another perspective, the approach taken by the humanistic/existentialist psychologist Abraham Maslow (1968) suggests that in order for humans to reach their fullest potential, there is a hierarchy of needs that must be met. The first need is biological/physiological, the second is safety, third is a need to belong, fourth is self-esteem and fifth is what Maslow calls 'actualisation'. Adding to this discourse on different perceptions of Maslow's theory, an Aboriginal psychologist remarks, "I think, look at western society's pursuit for the *meaning of life*. It's back to Maslow's self-actualisation. We have met our basic needs. Now our spiritual needs in all of us, that need, that we have to pursue" (AP1.1, 29 September 2003).

Interestingly, the non-Indigenous psychiatrist who takes a social justice position in the application of psychotherapy comments that, in the context of Maslow's theory, for Aboriginal people, "basic needs [proper health care, housing and education] are unmet" (NI1.2, 9 October 2003).

So the meaning of the comment made earlier by Wilson (JC8.2, 26 March 2003) is reflected in these examples of different ways of interpreting Maslow's theory and demonstrate that techniques alone are not enough and that cultural philosophical thought must be considered.

In addition to this, the service delivery location is important when treating Aboriginal patients. This became clear during the informal discussions I had with Aboriginal people at my workplace regarding the relocation of the Townsville Hospital.

4.6.1 Townsville Hospital: the old and the new

When the hospital was relocated from the Townsville City Centre to the university site at Douglas, many Aboriginal people expressed their concern about the change:

> The old hospital looked out to the sea with view to Magnetic Island and, in the distance, Palm Island. We [Aboriginal people] believe that this connection to the sea assists in recovery during a hospital stay. Out at Douglas, you can't see the water. But during the planning and construction stages of the new hospital, provision has been made for access to the outdoors and the hospital itself is located in the foothills of Mt Stuart. But I don't know if it [the new location of the hospital] will help in the same way. (JC16,11 April 2003)

These thoughts express the concern for the need for people to understand that, for Aboriginal people, connection to the land and sea is an important part of the healing process. Therefore, the actual siting of the location for the hospital bears enormous significance.

Service delivery through means such as the Internet is raised in discussion with Aboriginal people in this study. When the usual resources such as health centres are difficult to attend, technology is sometimes utilised in mainstream for the provision of psychological services to Aboriginal people. For example, www.beyondblue.org.au is a national web site that assists with people who indicate the symptoms of depression. The potential to utilise such technology in some of the North Queensland Aboriginal communities has been previously explored and the results explained by an Aboriginal academic:

> Lot of these communities have access to computers and access to Internet, so we did this ring around the communities and that and did surveys just asking to let us know how many computers you have. What access did kids have to the computers? But there was this company in the suburbs somewhere or other in the big cities. They envisioned that they would have this web site so that kids who felt suicidal could access the web site if you were in a remote community. And we, it was a case of thinking, just imagine. Someone out there in a remote community thinking 'oh I think I am going to commit suicide, but I need to access a web site so that I can feel better about myself'. As it turned out, there were some, very few of the communities, you hear on the grapevine that they have computers. They actually have Internet and

> access to them because it was usually at the schools or the council offices. So they are not accessible after hours. The kids, in fact, were not able to use them when they felt like using them. (AA3.1, 1 May 2003)

When psychological service delivery happens via the Internet, it is clear to see the challenges at a practical and cultural level that emerge when a Traditional way of knowing, being and doing interfaces with modern western ways of knowing, being and doing in the treatment of depression. In stark contrast to this kind of electronic service delivery, research participants spoke about some of their traditional ways of healing.

4.6.2 Traditional healing: the wisdom/therapy of the elders

Aboriginal people in this study spoke with me about some of their traditional ways of healing. They again re-enforced the notion that within their own communities, the traditional healers are known. They told me that psychologists could refer an Aboriginal client suffering from depression to one of the healers through an intermediary, for example, a cultural consultant or, as in one case I was treating, through an Aboriginal nurse health worker. Specific traditional ways of healing concerning spirituality were expressed by the following participants as necessary in service delivery. In talking about healing the individual and the community Traditional way, one Aboriginal academic shared:

> So they had to actually open the New Year, they had a smoking ceremony where the ladies actually danced. And they had a big ceremony and they

> smoke everybody so, they got rid of the bad spirits - all ready for the fresh New Year. (AA3.2, 9 October 2003)

Adding to the recognition of the Aboriginal traditional ways of healing, an Aboriginal psychologist remarked, "Aboriginal psychotherapy has a spiritual aspect to it. And I think Aboriginal culture is very much aware of the spirit world. It also has an aspect that acknowledges the process of colonisation and therefore, de-colonisation" (AA3.2, 9 October 2003).

Sharing more light on traditional healing practices, an example is given of Aboriginal elders carrying out ways of healing that are culturally community specific:

> Community elders were asked to come in [to the community centre] and be part of the meeting and then to set up cultural walks. They have cultural trips where they take people out. Fishing trips and bush walks and all that sort of stuff. These activities are interventions that connect [people] with culture. (AA3.2, 9 October 2003)

An Aboriginal woman, who is also a health worker, emphasised the essential role in healing that happens when visiting one's own country. She said:

> Visiting country encourages healing … the power of being in one's country. The most important thing about coming back to country and culture is that it

> is a means of healing and strengthening and this includes recovery from illnesses like depression. (JC12.2, 2 May 2003)

An Aboriginal community member tells me that family elders who take on the responsibility of passing on Aboriginal knowledge and healing have begun to take children and adolescents back to their home country to do 'business':

> We just need an area where we can take our young people back, learning culture and stuff. My tribe now, we've got K…Cattle Station … the Herbert River Gorge. It was my husband that used to write articles in the papers in the Townsville Bulletin. Giving stories about Aboriginal tribes and that … the neighbouring tribes and that … had people starting to think a lot of their genealogy. (ACM1.1, 17 April 2003)

An Aboriginal health worker, who was part of the social, emotional and wellbeing team, speaking about the importance of returning to country for spiritual healing emphasised, "[t]he land is like a mother … land looks after us … land is sacred" (AHW7.1, 26 June 2002).

The importance of country and the profound meaning of returning the land to its traditional owners so that cultural business may be carried out is explained by an Aboriginal community member:

> We never had to fight for this restricted area my husband has got now over at Hinchinbrook … the Great Barrier Reef Marine Park. National Parks. All of

> the people, D.E.H, they've allowed him to have a restricted area. They know we don't need much. We just need an area where we can take our young people back, learning culture and stuff. (ACM1.1, 17 April 2003)

For psychologists, the acknowledgement of the importance of the provision of traditional healing becomes part good governance in the service delivery to Aboriginal clients.

Healing and recovery, I discovered can occur in several communal contexts. One Aboriginal academic spoke to me about her experiences of counselling Aboriginal students as part of her role at the James Cook University School of Indigenous Australian Studies. The School is situated in buildings in an area that Aboriginal people say is where, previously, traditional *women's business* happened:

> I sit with the student for a quiet hour while they are sorting something out in their heads … and I often think that once they have experienced that quiet sorting out in their heads on two or three occasions, it is then really useful for them to be able to sit in a group where people are exploring some of the things that have been worrying them. And I have watched students who kind of, you can see them, they might not say much, but they kind of, it is like 'oh, that's alright, what I am doing is alright'. So in a sense, it is reassuring to hear people in the group saying 'oh well, I go and do this and that or Aunty so and so did something or other,' you know? And it just sort of helps to reassure and keep them focused on it [their studies] … a kind of group therapy at the School of Indigenous Australian Studies. (AA4.2, 18 August 2003)

As I have outlined in Chapter Two, most western psychotherapy in the treatment of depression is structured toward the one-to-one interaction between the therapist and the patient. This ties in with the western philosophy of individualism. Aboriginal healing processes are generally more holistic and communal. For a non-Indigenous psychologist, this recognition opens the way to begin to see that there is such a thing as Aboriginal psychology which, in turn, gives the opportunity for the process of decolonising psychology.

4.6.3 Decolonising psychology: knowing the history and effects of colonisation

Through the experience of researching, living and working in North Queensland, I am brought face-to-face with the evidence of the effects on Aboriginal people of colonisation on a daily basis. Acknowledging the significance of history, I am told by a non-Indigenous psychiatrist, of the importance for the non-Indigenous practitioner to have an awareness and understanding of Aboriginal people since colonisation:

> I do think it is important to be able to do, I guess what I call, rather than active listening, informed listening. And by that, I mean, if somebody, if you are going to work in a particular area, I don't know much about the *Kooris* in Victoria but I know a fair bit about the social and historical background, not only to people here [North Queensland] but also in the Kimberley. And so, if I go and sit down with a group of Aboriginal people, or a person and they mention something, for example, someone mentions Stolen Generation … and I say what is the Stolen Generation? Somebody then has to start teaching and the practitioner loses the capacity to be engaged. I think it is about being

> sufficiently informed. Not as an anthropologist, but about the salient historical and social factors in the area of which we work in that allows the individual to tell their story rather than to teach history (his story). And my sense is, that people check that out. There is a kind of process of locating what seems a variable. We all do it … you know … who are your people … where are you from. (NI1.1, 30 April 2003)

The non-Indigenous psychiatrist expresses the importance for the non-Indigenous psychologist to have a good knowledge of the impact of colonisation upon Aboriginal people within the local area where psychological services are provided:

> Queensland has a hideous history, which you are probably well aware of and there is no part of Australia that has the same degree of social control and intrusion [upon Aboriginal people]. That is the case of North Queensland and Cape York, nowhere else in Australia, which has a system of totalising systems of control operating almost a century. (NI1.1, 30 April 2003)

Historical factors are to be considered as they usually arise in a situation that requires a collaborative intervention. However, because mainstream Australia has been slow in the past to acknowledge in its fullness the effects of colonisation of Aboriginal people, collaborative healing has been limited. As an Aboriginal general medical practitioner commented:

> There has never been a collaborative move to heal the nation – and people are still suffering as a result of that. We see efforts being made to counsel everyone affected by the Bali bombings or people in detention centres. I am disappointed that the same has not occurred for Aboriginal people to help them deal with the effects of colonisation. (AHW5.1, 9 October 2003)

Hearing first hand about the effects of the Protective Legislation in North Queensland from an Aboriginal health worker with whom I worked at the Aboriginal and Islanders Health Service, demonstrated to me how, as a practicing psychologist, I was ill-equipped to offer any suitable treatment. The gap in my knowledge of the ongoing effects of colonisation and Protective Legislation became increasingly clear to me as Aboriginal people with whom I interacted in this North Queensland community urged me to know the history from an Aboriginal perspective. One of the Aboriginal health workers, who was also part of the 'Stolen Generation', emphasised:

> Psychologists need to learn about our side of the history so you can understand how different people think. How they [Aboriginal people] see the world and how they see one and other and how you can best sort of work with them. Knowing the history of Aboriginal Australia since colonisation and the impact colonisation has made on the Aboriginal population is essential knowledge for a treating psychologist. (AHW6.1, 13 June 2002)

This same participant illustrates this point by disclosing his own personal experience of psychotherapy:

> I had a lot of therapy when I came up here off an Indigenous lady and she mainly … she was a psychologist, and she took into account my past and that's where she found all my problems were … from the past. And when she saw that, she helped me work through it and talk about it and share things. And the history part … you have to take into account, the history … and you have to understand that before you can move on to other areas of counselling and things like that. (AHW6.1, 13 June 2002)

For some Aboriginal people the grief and loss is exacerbated because they do not always know their own history, as is pointed out by an Aboriginal academic in the following comment:

> I mean the whole thing about 'Stolen Generation' people is that they grew up not knowing their culture and that is commonly what they say. Not knowing their land. Not having the links to the land. Not having the memories that were passed down. Not having a family. You know … their own family. (AA1.1, 24 February 2003)

It is pointed out to me to recognise the distress of some Aboriginal people who come to know their history since colonisation in its fullness:

> When they [Aboriginal students enrolled at the School of Indigenous Australian Studies] come to universities, sometimes, the first time they actually take because units all involve something of our history … looking at the impact … looking at colonisation … looking at the issues for people to

> go. And for some people, it is the first time they actually realise exactly what happened … and what impact that had on me, parents and grandparents, etcetera, and how it is still impacting on family today … and how people behave … and all the problems. And for some of them, they get very angry about it. This is the first time they have realised it. It takes a lot of working through. And often, people get depressed about it. And react in different ways. Sometimes it is anger. Sometimes it is withdrawal. (AA1.1, 24 February 2003)

It would seem that many Aboriginal people responded to colonisation and the inherent Protection Acts in an *adjustment* manner as opposed to an *adaptive* manner. The effects of adjustment, as opposed to adaptation in the psychological sense, are outlined by an Aboriginal academic in these words:

> Because of historical factors, particularly when people were not allowed to practice their culture and their customs and basically were or had to accept another way of life, I think that part of that was that people could be locked up for any basic reason, so that I think that given that as well, that is another level of complexity to it because when you have got people who are frightened of authority, and dealing with those situations, once again, they are not going to express their emotions, so all that gets suppressed deeper and deeper, and people, you know, the sort of older people, particularly my family, that always seem to be very sad all the time, and I am sure that was actually depression that was not dealt with. (AA1.1, 24 February 2003)

Advising me as a non-Indigenous psychologist, an Aboriginal health worker comments further about loss in the context of culture and identity as he draws on his own experiences:

> And another thing you [psychologists] need to look at is that they took away our culture and our identity. Way back in the old days, our old people who were on the missions and that, they weren't allowed to speak their language anymore, not allowed to practice their dancing and they were taking away their spirituality. (AHW6.1,13 June 2002)

He goes on to comment on the cultural losses surrounding the replacement of Aboriginal spirituality with Christianity:

> They tried to replace it [Aboriginal spirituality] with a new one and by making them go to church and things like that. And these things all the stuff … it's like a stone in the water, you drop a stone in and the ripples go out. Just one thing, you know, leads to another. (AHW6.1, 13 June 2002)

Drawing again from his experiences, the participant highlights the effects of the Protection Act as part of the colonisation of Aboriginal people and explains how this has affected the way in which some Aboriginal people engage in parenting:

> Also like some other kids might be children of the Stolen Generation people where plenty of Stolen Generation did not have any parenting skills. You grew up in dormitories and you were institutionalised. So when that person

> come out and try to be a parent, they don't know how to be a parent to the child. So we didn't get a chance to learn parenting skills, so their children are affected by that and so it just gets handed down from generation to generation and so many indigenous people that you come across are probably part of the stolen generation or they are children of the stolen generation. The impact of it will affect them as well. (AHW6.1, 13 June 2002)

Whilst some Aboriginal people have reconciled within themselves their history and the effects of that, others have a delayed reaction that may be triggered by a significant event:

> I have met people from the Stolen Generation who said that 'I accept what happened and that's a big sadness for what I did not know. But I am happy with my lot in life and I have had to go back and find out, just to make it complete … that I am okay'. But I think if that person didn't have a good experience, and therefore, is really traumatised by that, well then, I think they will be affected down the line, and I guess the therapy will then bring people to realise that 'yes - that did happen … yes, it was traumatic … what was traumatic about it' and all those things that you do to help people to identify those things and to assist them to work through it. And a lot of people of the Stolen Generation are not traumatised until they have their first child. And then that strikes all these things like what happened to me when I was growing up and all those sorts of things. And why do I have these feelings. (AA1.2, 16 April 2003)

In trying to understand more fully the psychological effects of colonisation, I listen to the words of an Aboriginal academic as she explains, in response to my question, that if we take the theoretical stance proposed by Martin (2001) *Ways of knowing, Ways of being and Ways of doing* at which point is the psychological injury located for Aboriginal people who have been affected by colonisation. She makes the following observation:

> If your worldview has been impacted on by what has happened, [colonisation and subsequent loss of culture] which means that you don't have the cultural knowledge that Martin calls Ways of knowing [philosophy/ontology/epistemology]. This means that you don't have the knowledge down the line, and that has an effect: the knowledge that you would have had, if people had grown up in the normal cultural way or system. They would have a particular worldview about how they perceived the world and how they perceive themselves in terms of family and community and the bigger picture stuff. Where, I guess if you learn about by taking away those things and not allowing a person to, that person now has a different worldview because other things have influenced it. Well then I think that it probably goes down the line, I would see the starting point for depression, here [Ways of knowing] and then you have impact all the way down the line because Ways of knowing inform ways of being all the way along the line to ways of doing. (AA1.2, 16 April 2003)

One Aboriginal psychologist makes another reference to the psychological effects of colonisation. She states, “I think that for Aboriginal people, the process of

colonisation has done a lot of displacement in the psychological sense" (AP1.1, 29 September 2003).

The effects of colonisation continue today. One Aboriginal academic pointed out to me that, following the changes to legislation in North Queensland, Missions that were previously conducted generally by the Christian churches were changed in an attempt to encourage Aboriginal communities to self-manage. But things did not always go according to plan. She stated, "[a]nd then there were a lot of suicides. The big problem that's over there was actually left from the liberalisation of the mission over there" (AA3.2, 9 October 2003).

An Aboriginal general medical practitioner draws from his experiences of treating Aboriginal clients who indicate the symptoms of a depressed mood. He explains the importance of taking into consideration the historical effects of colonisation upon Aboriginal people in this way:

> I think sometimes we just go for the *jugular*, if you like, rather than look at the underlying issues, past and certainly present. In this situation [with an Aboriginal patient], there was a certain past history that dated back to an early placement in a *step* family situation. (AHW5.1, 9 October 2003)

The psychological effects of the past history of that particular patient are exacerbated by his current situation as described by the Aboriginal general medical practitioner in the comment that followed:

> Being unemployed had a big bearing on his self-esteem but I don't think that was totally or fully the reason. Even if I put myself in his place and think, well if I lived in a community where the whole community were in a state of hopelessness and helplessness and there wasn't much way forward, and housing's a problem and the children were truant from school, there are a lot of issues that would have played on this man's mind. (AHW5.1, 9 October 2003)

Aboriginal people in this study have stressed to me that, as a non-Indigenous psychologist, knowing the history of colonisation and the effects upon Aboriginal people is vital if we are to work toward collaboration in the delivery of psychological services.

4.6.4 Collaboration: the considered coexistence

Drawing on her own experience, an Aboriginal community member gives an example of two cultures working together in a collaborative effort in response to Aboriginal deaths in custody:

> And I was educating them [the police] in our culture because I had a lot to do with their cultural training officer. We designed a form for arresting officers which detailed their observations of people they picked up from say the gutter outside a night club or someone in the park who showed symptoms of not being alert, or not remembering their name, just personal details that they may be questioned on by the police. They would be taken straight to the hospital and not to the watch house. And on the other side of the form, the

> doctor would be able to have details of what medical assessment was made of the person. Like blood alcohol level, tests carried out and instructions to the police to give to the watch house staff. (ACM1.2, 25 July 2003)

This example of collaboration supports the metaphor of the *double helix* with two strands of knowledge communicating back and forth that is outlined in the research methodology for this study.

Another example of two cultural bodies of knowledge that can coexist as a psychotherapeutic intervention forming part of the treatment for clients who have been part of the Stolen Generation is demonstrated in the following statement:

> Joyleen Koolmatrie's healing model is an example of culturally appropriate therapy. It is a blend [psychoanalytic and Aboriginal way]. That's how I think Aboriginal culture is now. You've got the Aboriginal aspect, but you've also got … well, we've internalised some of the mainstream aspect too. And because we are living in a society, which is as it is, and it's not a traditional Aboriginal one, we will need different concepts to cope with and different interventions to cope with what's happening. So, I think it is probably a blend. I would never advocate a total western approach. (AP1.1, 29 September 2003)

Time, patience and considered changes pave the way for what seems to be a long haul into the future, as greater recognition is given to the fact that Aboriginal knowledge stands alongside other bodies of knowledge:

> But I don't think that there are any 'quick fixes'. I think that's a really important issue. Sometimes I feel everyone wants to know the Aboriginal answer and then everything will be fine. However, it's not going to be like that. I think it's going to be an on-going journey. (AP1.1, 29 September 2003)

The invitation for non-Indigenous psychologists and Aboriginal people to work together in this on-going journey, in moving toward collaboration in the provision of culturally appropriate psychological services, is offered in the following words of an Aboriginal health worker:

> We are all in this thing together, you know. We are all in this country together and we all have to start working together. We can all start educating each other on our things [culture and history]. The better we can work together. It's like having that three-legged race. We all have to walk together. Join together as one and try and help one another the best way we can. We need to understand that history side … that's probably the biggest thing … because even on the individual thing, like myself, I had to go back to my history, my past, so I could find a better future. As a nation of Indigenous people, we need to understand the history, so that we can move on to a better future. (AHW6.1, 13 June 2002)

In summary, the findings show that firstly, Aboriginal psychology is grounded in a theory based on a philosophy of connectedness and relatedness to all things. Secondly, the findings indicate that it must be recognised by western psychology that Aboriginal philosophy, culture, ontology and epistemology stands in

its own truth as a compelling body of knowledge. This legitimate body of knowledge takes its position alongside other bodies of world knowledge. The third finding indicates that, whilst western psychology is also a valid body of knowledge, it is not sufficient on its own to be therapeutically effective when treating Aboriginal clients. The findings strongly revealed that other western psychological thought or practices cannot be superimposed over Aboriginal psychology as a means of developing an appropriate psychotherapeutic intervention. To attempt to do so disregards the fundamentally dissimilar theoretical and philosophical underpinnings that are reflective of their inherently different cultures. The fourth finding is that there is an existing body of Aboriginal knowledge and psychology for healing depression. Thus, the fifth finding shows that there is the need to rewrite, retrain and reframe current psychotherapies and the need for collaboration between Aboriginal psychology and mainstream psychology in the treatment of depression.

In conclusion, this chapter gives voice, through the research participants, to the recognition of Aboriginal philosophy, cultural worldviews and history. Aboriginal voices have explained the importance of connectedness and relatedness in their ways of healing. The next chapter goes on to examine the concept of the 'defended subject', outlined in Chapter Three, as it is crucial to the manner in which the participants are interviewed and provides a framework for the approach taken in the interpretation of the data. It also interprets the experience of the interaction between the researcher and the research participants and how this interaction leads to the transformation of psychological knowledge and practice as well as the transformation of the psychologist as a person.

Chapter Five

The Defended Subject

5.1 Unconscious defences and the defended subject

In the preceding chapter, through Aboriginal voices I made a case that Aboriginal psychology exists and how it may be utilised in the treatment of depression. Along with other Aboriginal knowledge, Aboriginal psychological knowledge has been oppressed, repressed and suppressed over the years through the ongoing effects of the process of colonisation. The central unconscious defence brought to the interaction between the non-Indigenous researcher/psychologist and the Aboriginal participants has to do with managing the anxiety linked to the 'colonisation' of Australia and in doing so, protecting the self. This chapter is about interpreting the unconscious defences which include defensive responses, defence organizations and defence mechanisms brought to the research process by both the researcher and the research participant.

I do this because simply accepting that data 'tells it like it is' only gives part of the story. As I mentioned in Chapter Three, Miller and Crabtree (2000) confirm that when people take part in the research, they bring with them their experiences of their pasts, their experience of the present and their hopes for the future. All of these unconsciously influence their thoughts and feelings and provide a context for their responses to the research question. In taking this approach, I am guided by Hollway and Jefferson (2000) who call on the theory of critical realism. I do this because it

legitimises and validates the interpretation of and the experiences of the reality of both the researcher and the participants which in turn gives the opening for greater understanding.

Critical realism (Hollway & Jefferson 2000; Robson 2002) is the relationship between people's ambiguous representations and their experiences. This relationship, to be understood, relies on a particular view of the research subject; one whose inner world is not simply a reflection of the outer world, nor is it a cognitively driven rational accommodation to it. Hollway and Jefferson (2000) suggest that the need to assume as fact research subjects whose inner worlds cannot be understood without knowledge of their experiences in the world; and whose experiences of the world cannot be understood without knowledge of the way in which their inner worlds allow them to experience the outer world. The research participant cannot be known except through another participant who, in this case, is the researcher/psychologist. Therefore, remaining true to the research methodology outlined earlier, this chapter examines and interprets the data further through the concept of the defended subject, introduced in Chapter Three. By building on the free-association narrative interview method developed by Hollway and Jefferson (2000), the approach to data analysis is interpretive and includes seeing both the researcher and the participant as psychosocial defended subjects. The strength of the free association narrative interview as a methodology for gathering data in a qualitative research design is demonstrated when the dialogic engagement involves understanding the participant's experiences through their own meaning frame. It also, by definition, requires the researcher to understand their own research meaning frame and analyses and interprets the interaction between the researcher and participant through the psychoanalytic concept of transference and counter-transference (Douglas, 2000). In

this study, the treatment of depression is seen through the meaning frame of the ongoing effects of colonisation and past government legislation upon Aboriginal people and non-Indigenous people and considers both to be part of the same thing. By that I mean the ongoing effects of colonisation do not happen in isolation. Adopting this meaning frame allows for an interpretation of data that is deep, rich and meaningful.

5.1.1 Interpreting defences

By examining the unconscious defences of the self against the effects of colonisation Hollway and Jefferson (2000) claim that we legitimate, validate and, thereby, mitigate an aspect of the past which caused suffering. This defence is unconscious, defensive and inter-subjective. It is grounded in the main feature of psychoanalytic thought; the notion that the unconscious mind is dynamic and defends itself against anxiety. Consequently, it is a major influence on people's actions, lives and relationships. These interpretations are consistent with the comments made in Chapter Three, by Evans et al (1975) and Loos (1982), regarding government policies in North Queensland in relation to Aboriginal people. They show how the unconscious defences of the research participants against the anxiety and the need to protect the self with regard to the effects of colonisation, mediate the way in which Aboriginal people speak about the treatment of depression.

The data shows that the ongoing experiences and effects of colonisation include unconscious defences against anxiety and to protect the self against the experience of removal and assimilation; grief and loss; shame; trans-generational trauma; Aboriginal health; living in two cultures; suicide; alcohol abuse; relationship

difficulties; racism; lost wages; living with the police; living under the Act; losses including land, language, culture, spirituality. To interpret this data, as the researcher/psychologist, I have adhered to the methodology outlined in Chapter Three whereby Hollway and Jefferson (2000) propose that, in order to interpret and access the richness and depth of data, the researcher looks for, considers and analyses contradictions, inconsistencies, unsolicited self-disclosures and tones, for example, that form the research data provided by the participant. It also gives exposure to the meaning frame of the research participant.

In essence, this approach advocates the recognition of the part played by the individual's defence against anxiety and how this defence mechanism mediates one's relationship to reality and protects the self. The participant is seen as psychosocial. The importance of unconscious inter-subjectivity (transference and counter-transference) between the researcher and the participant is identified. Free associations, in the psychoanalytic context, give access to unconscious material that is not driven by the rational conscious mind. This method allows for layers of meaning to be accessed and to come forward or surface in the interpretation of the data, starting first with the research participant as defended subject and then examining the researcher as a defended subject within the psychosocial context.

5.2 Research participants as psychosocial defended subjects

The mechanisms of defence are developed as a means of controlling or holding in check the impulses or affect (mood or emotion) that might occasion conflict between the world and the ego. Campbell (1989) defines the various motives for the development of the defences as:

- anxiety arising when the ego believes the instinct (id) is dangerous;
- guilt with anxiety of the ego toward the superego and fear of annihilation or decrease of narcissistic supplies;
- disgust, when the ego must reject the impulse or it will have to be vomited out; and
- shame, a fear of being looked at and despised if the impulse is not rejected (p.174).

In analysing and interpreting the data, research participants often indicate defences against anxiety, guilt, disgust or shame. This next section is designed to show examples of these defences and how they mitigate the meanings given to the responses of the participants. It begins to explain, first of all, why my initial attempts at interviewing failed and secondly, it demonstrates the importance of acknowledging and processing defences that (a) the researcher and the participant bring to the interaction; and (b) the therapist/psychologist and client interaction. It shows how the acknowledgement and processing of unconscious defences is crucial to effective treatment of depression when working with Aboriginal clients.

This study has already emphasised how colonisation, oppression, protective legislation, grief and loss and racism operate on the psyche in ways that effect peoples' positioning and investment in certain discourses rather than others. The discourse of colonisation and the positions taken up by the participants serve a defensive function. That is to say, it mitigates the participants' discourses about their experiences of the harshness, fear, grief and loss at the hands of the colonisers. In doing so, it serves to defend the self at an unconscious level. Aboriginal people

presenting for treatment or taking part in a research process, bring with themselves all of the defences that are connected to their past, their present and their future. It is their dialogue of their experience of colonialism and their expressions of the positions that they take to manage their anxiety and to protect the self that gives the quintessential meaning to their responses to the research findings.

These findings are from the voices of Aboriginal participants and represent an Indigenous (Martin, 2003; Rigney, 1997, 2001) perspective. These participants are seen as psychosocial. That is, their narratives are influenced by their psychological defences, the central defence being their need to manage their anxieties and the need to protect the self stemming primarily from the their experiences of the effects of colonisation and protective legislation.

An Aboriginal academic, who also has a professional background in health care, recounts the family story about the massacre at Kerrimar during which non-Indigenous people killed all of the tribe with the exception of the participant's grand-father who was a child of about four years. The participant's defences against anxiety were evident in the ironic comments made about the experience of colonisation, protective legislation and the contradiction associated with her observation of the churches whom she sees as, initially, oppressing Aboriginal culture and spiritual beliefs and, now, in an about-face, offering comfort:

> And the other thing that is a bit ironic, that you said when you mentioned the treatment of depression or the prevention of depression, given the historical factors, there's actually the churches, for all their purposes, has had a big

> impact on a lot of Indigenous people and I often find that people who accepted western religion, often cope with the … you know, they had something to actually help them deal with the depression, with the grief and loss. And often those people, because they do have something, sometimes cope better than the people that don't. It seems a bit ironic in the fact that what happened, what the church contributed to in the first place, that now, certainly people who have that, cope a lot better. And support from the people with the same beliefs and that sort of thing. (AA1.1, 24 February 2003)

The participant's investment in this discourse legitimates and therefore mitigates and defends her from the painful experiences of the effects of the massacre of her tribe, with the exception of her grandfather, as well as the displacement of Aboriginal beliefs with mainstream religious beliefs as part of colonisation by rationalising the past with the present. Additionally, whilst residing and working in the mainstream environment, the participant often returns with other members of her clan to 'country' for Aboriginal 'business' which includes cultural practice. By splitting the her two worlds, the past and the present along with mainstream culture and traditional culture, the participant protects the self from anxiety and is able to negotiate her way through these experiences.

5.2.1 Removal and assimilation

An Aboriginal academic, speaking about her family history of the removal of mother and aunties when they were children, the subsequent effects of their alcoholism and *party girl* behaviour along with their emotional disconnection,

mediate against the participant's defence against anxiety, shame and guilt in the following comment:

> I don't know what makes individuals different. I don't think any of us do. You can't say that it's the age that somebody went in [to the orphanage], or the upbringing that they had, or that sort of thing, because I look at my mother's family. And there are three girls. My mother was the middle. Her older sister ended up an alcoholic. Mum never drank at all. And the youngest one ended up a real sort of live-wire party girl. Probably borderline alcoholic but never quite got there, sort of thing. But, real top woman at hiding everything. And never talks about herself. My mum never talked about herself but she never talked about anything very much so people accepted that … whereas Aunty E got on with life. She never talked about the experience but she was into 'let's have another drink,' sort of thing. And yet, the same woman brought them all up. They ended up having totally different lives and approaching their life in a different way. You know, what they wanted out of life was very different. And when they went to Sr Kate's [orphanage] they were aged 8, 6 and 4 years. (AA4.2, 18 August 2003)

In commenting that what these three women "wanted out of life was very different", the participant rationalises the behaviours of her mother and her two aunties. In doing so, she mitigates the pain of her own experience of the emotional disconnection in her relationship with these three women, particularly her mother, that stems from the effects of their being placed in an orphanage at such an early age.

Speaking about the experience of removal and assimilation, one Aboriginal participant, who held a managerial position in health service delivery, showed defence against anxiety, guilt and shame whilst relating the following:

> Yes [I have been to the Museum, Bunjilaka] and next time you go, look for [the participant's family name] Family and R… because they've got millions of pictures there and in Canberra. Yes. And you will see me as a little skinny thing running around. And my house is the first house that you would see if you enter R… My house is still there. I've actually got someone now that I'm doing a … getting it all back to the first … you know, how it was when we moved here. And I rang and I said, 'You could get the Queen of England over to do it, but you still have to contact my dad and me' … because I have a memory. I was 13 years old when we were moved off.
>
> Researcher: So you remember this?
>
> Participant: Oh, every bit … every part of it. Yes. And that's one thing the government through their assimilation policy where they tried to assimilate us and I mean I was a product of that. They sent us to all these white families and we were supposed to learn how to live like white people. (AHW4.2, 5 August 2003)

By rationalising and idealising her life as she lived it 'Aboriginal' way before being moved off to live with white families, at the age of 13 years, the participant protects herself from the shame, grief and loss associated with her memories of the

experience of assimilation where she was “supposed to learn how to live like white people”.

An Aboriginal academic, who also has a past history of teaching and student welfare and guidance, indicated defences to protect the self from the pain of grief and loss that are grounded in the telling of the story of the removal of her mother and her mother’s sisters when they were young children:

> But Mum eventually talked about it. And Aunty L will talk about it. She’s getting there. Sixty years later. It’s a long time to sort of keep something locked up. You know. That’s the thing that interests me about that whole thing. I mean, should we get people to talk about it. Or is it better to let people bury those things? I don’t know … I remember as a little kid sort of, you know, Mum had a handful of friends that she would go and have a cup of tea with. And you would hear the odd sort of reference to the Mission or something that had happened to them. But it was not really a matter for discussion. I mean, I remember my mum telling me about the six foot corrugated fence. And I thought, I can’t come to grips with that one, putting children behind a six foot corrugated iron fence so they are hidden from the world and they can see no world. There is no world for them. I can’t come to grips with that. (AA4.2, 18 August 2003)

In making reference to her dilemma about whether or not to get Aboriginal people to talk about their removal, the participant, in psychoanalytic terms, unconsciously tries to split the good from the evil. It raises the question as to whether

it is ‘good’ or ‘bad’ to get your mother to talk about the effects of being removed and sent to an orphanage. The participant’s confusion is evident in the comment, ‘I can’t come to grips with that’, when talking about her mother’s story of removal. It mediates her pain in response to the fact that her mother, after a good many years, told her about the experience of being placed in an orphanage as a result of the Aborigines Protection Act.

An Aboriginal mental health worker employed at the health service spoke at length about his own removal from his family and his experiences in the orphanage. He indicated defences against anxiety when speaking about the effects of being one of the ‘Stolen Generations’. It is against this backdrop of self-disclosure that this participant tells:

> I told you earlier about the Stolen Generation. I'm actually one of them [the Stolen Generation]. When people look at the Stolen Generation, they think of the old folks. I'm only thirty-eight years old. I was actually taken when I was three years old, back in the 1960s. So this is how not so long ago, this thing was still happening and I was with my family down on the border of New South Wales, and we were playing. I was down at the creek actually, with my uncle. My mother, brothers and sisters were playing around the yard and the police came and he asked my mother ‘where is the other fella, the other son of yours?’ She said I was down the creek and they come down there in the truck and got me and brought me back and started questioning my mother. They asked her ‘where is the father of your kids?’ And they, we were all, my brother was a bit darker than me and my sisters a bit fairer … we were all

different shades. So they asked where the father was and she said ‘oh, they haven't got one’. And she was drinking at that stage. She’d had a couple of beers or something, and they asked her where did she get the money for the beer. She said, ‘oh, off some fellas’ and so them policeman guys said she was selling herself and that's how come we were all a different colour. So what they did, under the Policy of Removal, back there, of the half-caste kids, they took us under that Policy using that she was prostituting herself to get alcohol and they could say anything in that time … just because they had that Policy that give them the power to do it and so they grabbed all of us and put us in the van and the very next day, me and my mother and my brothers and sisters were in court and apparently, my mother didn't even say one word. They didn't even let her have her say. But my Aunty was there at court fighting for us saying that she will take us and look after us. But the judge refused the requests and so they took us to the hospital and got us checked out. And the next day after that, we were sent to an orphanage in Rockhampton where we spent the next eighteen years of our life. And it was very … what would you say … a very cruel, cruel place. And some of the things that went on there, I'll just share some of it. Just for wetting the bed, we had to go down to the toilet and do a mess and the priest would come in and flush our head down the toilet. Just for something as simple as wetting the bed. Then they made you sleep in the wet bed all night. Another case is where someone was talking at night in the bedroom, in the dormitories. They'd line us all up and they'd fill the bathtub up and they used to hang you upside down by the legs and drown you in the water, till you were just about dead. They would put you back down and send you back up to the bed all wet. You had to sleep in the

bed wet, no matter if it is winter or summer. And another instance, they had a sewerage tank where all the sewerage comes out of the toilet and they would lock you in there in sewerage up to your neck just for a simple thing like answering them back. If you answered the priest back, he would throw you in the septic tank where all the mess from the toilet comes out. You were most of the day up to your neck, in that tank … and that was the bad thing … so if you had sores on you … they always got infected. Another incident there I had where I was pushing in line, me and another bloke, we were lined up for dinner and they sent us up to the superintendent's office. He put boxing gloves on us and we were made to fight one and other for about an hour and after that, we had to fight him then. He'd knock you out about five times; he'd pick you back up and knock you out again … then after that, you had to go out and punch a tree all day … then spar the tree or the lamp post.

Another young fellow there who was in there I can remember, he was over in the girls' dormitory playing with the dolls, so that priest got him and stripped him and put a dress on him and made me and some other fellow stone him. Then he tied him up to the flagpole all night. Yeah, he was tied to the flagpole and that's where he slept. Still remember that. Yeah. A lot of other things there that are too bad to talk about so. There was a lot of sexual abuse going on there with the priest and a lot of the young boys. But through that first session [of counselling] I realised that I had no control over what happened to me. It's not my fault, what happened. You know, it's their fault. And when I understood that, I sort of, well the memories are there, but the pain has gone. And that's what happened instantly. It just never hurt no more,

> when I understood it wasn't my fault. Yes. I was blaming myself for what happened to me. For getting taken away. I thought I was a bad person. But it was the policies that were around in them days that made that happen. It wasn't my fault. I blamed my mother. She was the one that sent me away. (AHW6.2, 20 June 2002)

During the course of the interview, I stopped the tape because the participant became tearful whilst talking about his mother. Whilst the tape is stopped, he stated that whilst in the children's home, he was told by the authorities that his mother did not want him and that she prostituted herself. Years later the participant found this to be untrue. As a defence to protect the self from the effects of the abuse of those in authority, the participant gave explanation of his enduring distrust of those in mainstream authority. He also told me that if I or other non-Indigenous psychologists wanted to treat Aboriginal people for depression, it is a primary pre-requisite to know the history and their stories long before attempting to engage in any form of psychotherapeutic intervention.

5.2.2 Grief and loss

In moderating and protecting the self from the effects of the anxiety associated with death and its inevitability, an Aboriginal academic comments on the recurrent grief and loss associated with the ever-presence of death and high death rates in Aboriginal communities:

> With Indigenous people, we have communities that may have up to twenty deaths and funerals, in one year. So at any one time, people are grieving and

> then somebody else dies, like at Yarrabar. They had something like five deaths over a couple of months. And there is on-going grief and loss, like last year, when they had something like fifteen deaths. So I don't think that people realise that they are in a continual state of grieving. And I think that surely at some stage that must, you know … if people aren't handling it, turn into depression. But people don't actually realise that they are depressed because of the constant loss and grieving. (AA1.2, 16 April 2003)

The pain of grief and loss associated with shame and loss of identity is a constant theme that is engraved deeply into the unconscious defences of many Aboriginal people. It is articulated in the following words that express the ongoing psychological effects of colonisation and how it may predispose Aboriginal people toward depression:

> I know I have heard the term of shame. You know, the concept of shame. They feel shame because they just don't feature into anything, in the greater scheme of things. And that is the message that they get all of the time. You know, that they are useless and that they are drunks and you consider a person going to school, I mean it is well written about in the education service about why these kids don't go to school. And when you look at some of the research that has been done there and the messages that are given to kids all of the time, growing up with that sense of 'oh well, I am useless and my culture is no good', surely that must constitute at least a basis for depression from a very early age. You know, that sense of hopelessness or lowered self-esteem that you are not worth anything or that all your people

> are useless and seen as less valuable to society than others. (AA1.2, 16 April 2003)

5.2.3 Trans-generational trauma

An Aboriginal youth mental health worker indicated defences to protect himself from the pain of his troubled upbringing and an underlying anxiety associated with trans-generational trauma. In rationalising his feelings about why he chooses to work with troubled Aboriginal children, he defends and protects himself from his own anxieties in the following remarks:

> I do this sort of work because I feel for the kids who have nowhere to go … no family to go to or to be with. I feel sorry for them. We do have kids that have been based on Palm Island and surrounding areas but are in Townsville because one parent might be living here and they have trouble with another parent, say, in Rockhampton or somewhere. (AHW3.2, 14 July 2003)

5.2.4 Aboriginal health

An Aboriginal general medical practitioner reveals defences against anxiety that relate to an awareness of chronic health problems and mortality rates among Aboriginal people. The participant first observed the gravity of this phenomenon whilst employed in a previous profession as a teacher. The participant discloses his own personal and family experiences relating to serious health problems. This gave motivation for the participant to return to university and to take up the study of medicine which at an unconscious level, serves to protect the self from fears about death and the vulnerability associated with physical illness:

> Maybe they [Aboriginal people] accept the fact that there are illnesses there and they just have to come to terms with it. It happened to my parents. It happened to me. Where back in that era [living under the Protection Act], in terms of general physical health, there's been an acceptance of having to die at the age of 51 or 55 and that's pretty much accepted. We have to convince them [Aboriginal people] that this is not the case. (AHW5.2, 17 October 2003)

5.2.5 Living in two cultures

Other participants reveal defences that serve to mitigate the anxiety of walking in two worlds that operate in two culturally different ways, namely, the mainstream world of work and home where the respondent lives Aboriginal way. One Aboriginal academic discloses:

> I can put in my, whatever amount of time I have to put in [at work at the School of Indigenous Australian Studies], and then when I go home, I am a mother and a wife. I don't really take my work home. Switch off when I go home, and switch back on again when I start. (AA3.2, 9 October 2003)

One member of the staff at the Aboriginal and Islanders Health Service, talking about 'living in two worlds', comments "[so]me Indigenous people just give up because living in the two cultures is very difficult" (JC9, 4 April 2003).

5.2.6 Suicide, alcohol abuse, relationship difficulties

An Aboriginal academic, who is also a key community member, discloses a personal story about a family member's (nephew) suicide. She reveals in this

discourse, defences that protect the self against anxiety, shame, guilt and disgust that stem from the experiences of suicide, relationship difficulties, alcohol abuse and jealousy (interpersonal and professional) from within the family and the community in this passage of 'yarning':

> And they [the family] were all sitting outside … and he [nephew] had a job and he had a relationship … and they were all sitting around having a few drinks one night. And he went out the back. And they called him and they thought he went for a walk or something. And when they actually went outside, he had hung himself on a tree. And it wasn't until afterwards that they were saying, 'oh yes, he was always talking about dying and death'. And no one sort of took any notice. (AA3.2, 9 October 2003)

And the same participant further rationalised her anxiety regarding Aboriginal suicide as she divulged the following tragedy:

> And then, I have come across young people who have … there was a young boy who was about seventeen years old in Kuranda, and this is like, in like before we went to D… in the late '70s. He and his girlfriend actually had a row. She was sixteen and he was seventeen so he just went home and hung himself underneath the house … the broken relationship. It was all too much for him. So he hung himself. (AA3.2, 9 October 2003)

Describing his disturbing personal life experiences and the lifelong effects of institutionalisation in orphanages under the *Protection Act*, an Aboriginal health

worker discloses the psychological effects that stemmed from this experience. His comments legitimise his experience and subsequently, as a defence, mitigate and protect the self from the anxiety associated with these painful experiences:

> Many of them [Stolen Generation] committed suicide. There's a big majority of them, they've gone to mental homes and have mental illnesses and many of them are alcoholics and drug addicts. I became an alcoholic. When I left the orphanage, I was, I felt like, you see, I didn't have a place to belong. (AHW6.2, 20 June 2002)

An Aboriginal academic who had taken up a responsible management position in the university sector, indicated defences by investing in her comments about jealousy which legitimises her story and protects the self by mediating her feelings of anxiety, anger and guilt in this comment:

> The other factor with Indigenous people is jealousy. Jealousy is … while everyone says there's jealousy everywhere it is a really big issue with Indigenous people. And it is pre-morbid. The biggest cause of domestic violence or violence in communities and coming back to Queensland from the Northern Territory, the other thing that has always been evident in North Queensland is professional jealousy. You get a job and no-one ever says 'good on you.' It's all 'oh yeah, that's got to be because of whatever reason' … and that sort of thing. Like they are their own worst enemy. Like they don't give credit where credit is due to their own people. I have never been more aware of my Indigenousness till I came back [from living interstate]. It's like

this big them and us. A lot of the *Murri* people are their own worst enemy. (AA3.2, 9 October 2003)

5.2.7 Racism

Growing up on a reserve, pursuing a career as a social worker and then moving into a position of higher management of health services, an Aboriginal participant indicated unconscious defences. By her investment in her story about her experiences of racism and prejudice, even though she was well-educated and held a position of responsibility, she mitigates the pain of this story and protects herself from anxiety, shame and guilt:

> I would end up telling them, 'I am not Spanish. I am an Aboriginal from Australia [here on business or to attend a conference]'. And they were interested in that so they would talk to me more. And I could not go shopping … but it was interesting. At every airport, and I was with a group of people, I was always … I was selected out and intensively searched [by the authorities]. My bags. My shoes. Yes. And I think because I was, well when they'd look at me, they did not know what I was. And there were all sorts of nationalities over there. And imagine, because I grew up in Mooroopna, where the majority were Italians, Greeks, Aboriginals and some whites. And we picked up probably, a lot of the styles of, you know, like, my expression, my hands, or something, and at every airport, they must have thought, well, she's not … she could be Iraqi, she could be Spanish. I could be anything, you know. So we will grab her and search her bags, but I got tired of it. (AHW4.2, 5 August 2003)

Historically, there were tensions between Aboriginal people who lived under the *Protection Act*, mentioned in Chapter Three, and those who were exempted. One Aboriginal participant, who is also a social justice advocate, invested in the following story thereby unconsciously defending and protecting the self from anxiety stemming from her experiences of shame, inferiority and rejection::

> It was like a thirty year secret of mine. Because also being under the Aboriginal Protection Act, there was also a stigma attached by other Aboriginal people who weren't under the Act. Yes. They thought they were better than you. We were called *myall*. They'd see us walking along the road or the street. They'd cross over to the other side just to avoid you. A *myall* … *myall* was their favourite word … so our own people mistreated us. (ACM1.2, 25 July 2003)

An Aboriginal health worker, who spoke about his mother who grew up on Palm Island, expresses unconscious defences against anxiety stemming from the long-term effects of colonisation, in terms of managing the pain of past experiences of Indigenous and non-Indigenous relationships within the setting of a mission. He said, “Mum grew up in the dormitories. One night she told us all about it and how it has left her hating white people” (AHW3.2, 14 July 2003).

Further evidence of unconscious defences to protect the self from the painful effects of protective legislation and exemptions to the legislation are described in this

excerpt where the participant tells her story about the way in which she felt free to finally speak about her experience of living under ‘the Act’:

> And by the time you [those Aboriginal people who were exempted from the protective legislation] were eleven or twelve years old, they had a cattle station already lined up for you. So it was normal practice to go out to the cattle station. A lot of boys were cattle stock workers. And the females did the domestic. And you never knew how much you were getting … what your wages were. But it wasn't until 1985 [after the abolition of the Act] when I started to do my studies in Sydney that I brought home the books written by Professor Elkins. And he [R my husband] walks in and says, ‘have you ever heard of the Aborigine Protection Act?’ His uncle and cousins, when they used to come in to the Townsville Show, as a kid, he said ‘I used to go in with them to the police station and they would line-up outside and the police would come out and call them one by one. Then they'd come out with cheques and that and go to the bank. You know, it's the first time I was able to just talk about it, to say to my husband that I ‘lived it’ … the Act. (ACM1.2, 25 July 2003)

Many Aboriginal people were living on reserves and missions and in the following excerpt one participant discloses her experience of living under the *Protection Act*. The participant legitimises her story by splitting it into the ‘bad’ and the ‘good’ The ‘bad’ being the violence, alcoholism and social dysfunction that she experienced whilst living on a reserve and the ‘good’ being the strength of her

Aboriginality. This splitting is a defence that protects the self against the feelings of anxiety that are in the telling of her experience:

> You know, like I grew up on a reserve, like a mission and we witnessed some ugly horrible stuff, you know, living on a reserve … the violence, the alcoholism and poverty, overcrowding. The government policies and how they controlled our lives. But I think that despite all that, what made us strong and how we survived they could never take away what is innate in Aboriginal women, men … Aboriginal people. And they couldn't destroy that despite all the things they attempted. And that's one thing the government through their assimilation policy where they tried to assimilate us and I mean, I was a product of that. They sent us to all these white families and we were supposed to learn how to live like white people. Fortunately for us, it was … we had a sense of belonging. We had that extended family, our connection and all that was back in the country where we come from. And no matter all the materialistic, beautiful big mansions and three meals a day, where your mother is struggling at home, to get a bit of bread and fat that night for dinner. But at least there were all those other things that were more critical to our existence and our wellbeing than what the government's assimilation policy … . (AHW4.2, 5 August 2003)

5.2.8 Aboriginal consciousness and identity

Defence against anxiety which protects the self from the pain of intrusive questioning about the concept of Aboriginal consciousness and identity are indicated by a participant, an Aboriginal academic. She expresses a degree of annoyance when

speaking about dealing with mainstream assumptions and mainstream perceptions of what it is to be Aboriginal in the following excerpt:

> I was wondering whether my perceptions are *Aboriginal*, because I know one lady interviewed me once and it was like 'you're the expert, you're Aboriginal, so tell us all about Aboriginal depression'. And I bloody said 'I bloody don't know'! (AP1.1, 29 September 2003)

Defences against anxiety which are unconsciously grounded in the need to protect the self from what the participant saw as another form of assimilation. This discourse is based on her experience of inter-personal relationships where non-Aboriginal realities and power were being imposed through non-Indigenous people, just as the missionaries did previously. It is further expressed in this excerpt by the participant:

> I wrote a paper about this. It was written at a time when I was living with a colleague of mine. We were having these differences of opinion, he was non-Aboriginal, and I felt very disempowered because he was prescribing how I, how things should be, and if I challenged that, it was like 'there is something wrong with you'. And I thought, 'bugger you'. You're, this new assimilationist, you lot, with your prescriptions on how our realities are supposed to be. It's non-Aboriginal realities and power being imposed. Even like the missionaries years ago. (AP1.1, 29 September 2003)

The same participant indicated defence to protect the self against feelings of guilt in relation to another aspect of identity in this way:

> Because I'm independent and I live relatively well, and I'm laying in bed this morning and I've got my dog and my cat and my coffee, and I was really enjoying it … because a lot of Indigenous people can't do that. They have a lot of problems that they have to deal with relentlessly. (AP1.1, 29 September 2003)

Other participants indicated defence against anxiety to protect the self from grief and loss surrounding loss of identity and re-discovering identity. It is reflected in this excerpt about the experience of Aboriginal consciousness when talking about Aboriginal knowledge and experience in terms of identity resolution:

> And when you talk about that … it's experience … it's not knowing. I think that they are probably entwined because my experiences of the world are influenced by my knowledge of who I am. That's how I see it. The way that I experience the world is very closely linked to me knowing who I am. So yes. They are not the same, but I think they go together because your experiences are coloured by your knowledge. And your knowledge is coloured by your experience … your knowledge of yourself. (AP1.2, 31 October 2003)

The following excerpt shows how the participant, an Aboriginal academic rationalises the past realities with the present as a defence to protect the self from the anxiety associated with the need to keep things contextualised when defining

Aboriginality and Aboriginal consciousness, especially drawing on her own experiences of this:

> I remember reading interviews about the Aboriginal woman who played 'Jedda' the movie. And I remember the early interviews with her and she said she was grateful for the opportunity afforded her etcetera, etcetera. And then someone was doing a PhD on her, basically critiqued her, which is very easy to do now, looking back. But I sort of always think, oh well, if you were operating back then, you would be as racist as everything else was. I think we should challenge but keep it in context. Not to give ourselves a superiority that we assume when we are in the present. But, anyway, the interviews have changed and then different stories emerged that she had been exploited and blah, blah, blah, and I have a real problem with that and I thought, you know, the problem with, you know, I would sort of go to an Aboriginal meeting, and I hear, 'oh, I was born under a tree' and I would think, 'oh, give me a break!' And some people reinventing, to me it seems, their past to become 'more Aboriginal' and I have a real issue with that. I used to call it 'chasing the pure heart'. Because I became really quite cynical and thinking, 'oh, what is wrong with people. They are so fickle and stupid'. You know. How can they just change the story? I was concerned by the integrity of people's depictions of their realities. (AP1.2, 31 October 2003)

In further comments about Aboriginal consciousness, an Aboriginal educator and academic indicated defences to protect the self from anxiety stemming from her

need for a sense of belongingness for example, spiritual home, spirituality and landscapes:

> I will always have the energies of that country in my head, and I'll always know what my Grannie taught me. And so that is kind of, I suppose, in a sense something that grounds you. I mean, my feelings for where I come from won't ever change. That will always be home. But I will never go back there and I think you move once you've come to that decision, you can move on. So, now I find this country is becoming really important to me. So I can feel quite a sense of belonging and yet you know, ten years ago, if you had said to me, 'oh Townsville's it' I would have said, 'my God'. And yet, when I stop and think about that, there are a number of things about Townsville that are very similar to my country. And so maybe, it's those things like these trees for instance, they grow everywhere, where I come from. And the house that I grew up in, we had four of these trees in our back yard. We lived in them. So for me, this is a very, very strong connection with home. And I have never lived in a house since that had tamarind trees right here. I mean, this is as close as they were to the house that I grew up in. So that's a kind of connection. But the colours in this landscape, you know, this is such a dry arid sort of landscape. It's not as, like Broome is, red dirt. So these hills would be red. But that sparseness of cover and rock and all of that sort of stuff, you know, sort of, there are what in a sense would be your spiritual home. (AA4.2,18 August 2003)

An Aboriginal academic and psychologist indicates defence against anxiety thereby protecting the self with regard to spirituality and motherhood as identity, as well as protecting the self from feelings of guilt and shame that surround her disclosure about her inability to feel maternal love that stems from her own life experiences in the following words:

> So, I think we have to be careful not to prescribe what is 'good Indigenous spirituality' or 'identity' to each other because I think those who don't feel that might feel there is something wrong with them. It's like when you have a baby and my expectation was that I would be overcome with maternal love and I wasn't. And so you think, 'oh gosh, am I a bad mother because I don't feel like that?' I think we need to be a bit careful sometimes. Different people will experience different things. We are all diverse human beings. And now, in the first instance, and then our experiences are quite different as well. Anyway, why am I telling you all this? (AP1.1, 29 September 2003)

This last comment, "anyway, why am I telling you all this?" is a clear expression of surprise stemming from the unconscious psychological defence of the participant who, through her own intensely personal story protects herself from anxiety by emphasising the importance for non-Indigenous people to avoid generalisations about what it is to be Aboriginal in terms of consciousness, identity and behaviour, but rather to recognise the diversity among Aboriginal people.

5.2.9 Living with the police/living under the Act

Defences to mitigate anxiety which relates to the experiences of oppression and powerlessness through the omnipresence of the police and experienced in the day-to-day lives of many Aboriginal people, are evidenced in this story:

> The settlement was controlled and managed by the police service. The purpose of allowing us Aboriginal children to go to school was to be able to write our name so the finger printing that they used was to be abolished. Because I think that they knew that there were accounts being ripped off. I started work when I was twelve years old out at Greenvale Station. I worked there for seven weeks of the school holidays at that time and the purpose of that was to buy my high school textbooks. I had a school principal who believed that I could do better than wasting away on a cattle station. So he came with me and my mum to see the sergeant to ask permission that he felt that I should be able to go to high school. The sergeant said that I could but the law was that I had to go to a cattle station. Then in the end he just said, 'well alright. If she can afford her own clothes for school, I've got no problem with that'. So, they sort of bent the rules. I went to Year 10. At the end of Year 10, I got a job as a domestic at Mt Garnett. The lady used to pay me $10.00 a week and I was pleased for a couple of weeks. Then the police came with this contract for me. Contract of my wages fell from $10.00 to $6.00 a week. $2.00 was my money I got in my hand. $4.00 went to the police station. That was the only time I knew about how much wage I was making. (ACMI.3, 6 November 2003)

The stories of lost wages expressed by Aboriginal people and the difficulties surrounding gaining access to money are well known. The defences to protect the self against anxiety, shame and guilt are expressed through the experiences of the participant in this way:

> I wasn't going to ask the police because you would be interrogated. And they would ask you what did you want the money for … because they had to know of your whereabouts, everyday. If you were going to the next town or further to the doctor's or dentists for medical treatment, then you had to tell them. Like you wouldn't get a leave pass but they would have you marked down where you were going for the day. And they would check in the evening to see if you came back. [thoughtful reflection] But if people understood how you were treated under the Act, if you needed groceries and they'd ask you 'what groceries?' They would write out the grocery list. And they take it to the general store. And it was embarrassing being a young teenager at that time. I made my own clothes just to avoid being interrogated by the police officers. Yes. By two white males [police officers]. And you had to go there to get money to go and buy your underwear. I would not allow myself to be put in that situation. But these days, sex and all that is openly discussed, but back then it wasn't the right time. But I often think about how I still had these sorts of hang-ups about … that's way back then. But I still can't forget. I just won't. (ACMI.3, 6 November 2003)

The defence to protect this participant against anxiety stemming from her experiences associated with the pain of living under the *Protection Act* is further expressed by these experiences:

> It is only since 1985 when I was doing my studies, even when I got married, I never told my husband about still being under that Protection Act. And even when I had my oldest son, if the police had found me, they would have sent me to Palm Island. They probably would have taken the baby and placed him in an orphanage … [thoughtful reflection]. Well now that we have our land groups, a lot of them are coming in there but the pain is still there for a lot of us that had to live under that Protection Act. (ACMI.3, 6 November 2003)

Defences to protect the self from anxiety stemming from the pain of previous experiences with the local police and how, since changes to the *Protection Act* and the deaths in custody, there is a splitting of the 'bad' from the 'good' in the discourse about the changes in the relationship between the participant and her interactions with the police. This splitting legitimises her story and subsequently mitigates her pain as she comments on the irony of her present situation:

> Yes. Well, nine months establishing that program. I won the Police Commissioner's Medal, which is a state award. It goes to community projects. And they flew me down to Brisbane. The police watch house sergeant … he lived across the road from me in Garbutt. He and I caught the plane down. And they stuck me up at the head of the table. But I had to pinch myself quite a few times. It was a big conference room. I mean big. And I have never seen

> so many police commissioners in my life. I just sat there and thought, ‘I think I am dreaming’. [Laughter]. To think I used to 'duck and dive’ from them. [More laughter]. It took me a while to get used to that. After all, the police were my guardians. They were the decision-makers for me when I was growing up under the Aboriginal Protection Act. So they were also my oppressors! [Laughter]. So I was in hiding from August '67 to when I got my freedom in '69. And now … . (ACMI.3, 6 November 2003)

The following words indicate the depth of the defence to protect the self against anxiety arising from her fear of being controlled by another or of being disempowered by another:

> I don't wear a wedding ring, even though it's going 35 years … because, to me, no one owns me. That's how I see wedding rings. It's just me. It's my belief. Some think that is strange but … [Laughter]. (ACMI.3, 6 November 2003)

5.2.10 Confusion: western psychotherapy

The defence against anxiety to protect the self are related in the participant’s telling about the way in which her feelings were dismissed by another psychologist. This is evident in the participant’s discourse about her dilemma regarding the need to remember or forget about the pain of previous experiences and trying to heal the hurt through western psychological techniques. The participant speaks about how it was not helpful to her:

> I mean, I think that we all get bogged down in dealing with the hurts of our 'inner child', but there's got to be a point where okay, get over it. And now, when I've actually said that, a psychologist said to me, 'but you are shit-canning your inner child'. And I thought, you know, I feel like I'm schizoid and I've got all these kids running around in me! (AP1.1, 29 September 2003)

Defences that serve the purpose of protecting the self from anxiety regarding the participant's experience of cultural respect, or lack of it, were expressed by one Aboriginal participant in the following comment:

> Spiritual tourism! I notice some elders kick around, and they've usually got what I call a 'hippie hanger-onerer' and I make a joke of it. And I say 'eh, when will I be old enough to get a hippie hanger-onerer? (AP1.1, 29 September 2003)

To summarise I have examined the unconscious defences that protect the self from anxiety, guilt, disgust and shame. Such defences are found in the discourses of the participants. They function in a way that mediates the responses of the participants who are viewed as psychosocial and defended. This has resulted in the emergence of valuable data that might otherwise have been overlooked. This is what I missed in my initial attempt at gathering data. Had I simply taken a 'tell it like it is' narrative or question and answer method I would not have known that all of this information existed.

This analysis and interpretation of the defences of the research participants is guided by the proposition made by Hollway and Jefferson (2000) where, as mentioned earlier, the research participants in this project are viewed as defended psychosocial beings. By paying attention to these examples of the unconscious defences brought to the research process by the participants, the data is contextualised and another deeper layer of information is uncovered. This process fits with the tenets of qualitative research methodology expressed in Chapter Three (Hollway & Jefferson, 2000; Miller & Crabtree, 2000; Robson, 2002) where recognition is given to the research participant as a *whole* and that, as such, they bring into the research process their past and present experiences along with their hopes for the future, all of which combine to influence their responses to the research question.

As a researcher/psychologist, I experience various emotional responses as I listen to the voices of Aboriginal people as they disclose some of their experiences that stem from the effects of colonisation. This now leads to examining the defences that the researcher brings to the encounter.

5.3 Researcher as psychosocial defended subject

As mentioned previously, in analysing and interpreting the data, research participants generally indicate unconscious defences to protect the self against anxiety, guilt, disgust or shame. As such, the unconscious defences of the researcher surface and engage in the experience of the psychoanalytic notion of transference and countertransference. For this study, the experience of dealing with the emergence of researcher defences, and the subsequent psychological discomfort, surfaced at the

interface of fieldwork and practice where Aboriginal knowledge encounters western knowledge.

5.3.1 Researcher defences and the subject of power

In this section, I will explore the theme of power relations between the non-Indigenous psychologist practitioner and researcher and the Aboriginal client and participant. Firstly, I deal with the systemic power of the dominant culture and how that impacts on the research process and, secondly, how this power relationship is played out in the psychotherapeutic relationship. I will then explain, using researcher reflexivity, the experience encountered as a psychologist practitioner/researcher at this interface.

5.3.2 Power relations

So that I can explain and define more clearly what happens at the interface of Aboriginal knowledge and western knowledge, I have borrowed the term 'contact zone', which I also mentioned in Chapter Three. This is a term developed by Clifford (1997) and Pratt (1992), anthropologists, who write about museums as 'contact zones'. From this position, both Clifford and Pratt suggest that a 'contact' standpoint gives emphasis to the way in which subjects are comprised in, and by, their relationship to each other. This is consistent with Hollway and Jefferson's (2000) concept of 'inter-subjectivity' and the psychoanalytic notion of 'transference and countertransference' mentioned earlier. Rather than treating the relationship among the colonisers and the colonised in terms of separateness or apartheid, the 'contact zone' views this relationship in terms of co-presence, interaction, interlocking understandings and practices, often within radically asymmetrical relations of power.

During the research process, this acknowledgement of lopsided relations of power emerged. My defences to protect the self from anxiety were brought to the surface and manifested in the form of the experience of feelings of guilt and helplessness when one Aboriginal academic gave this perspective:

> I do not like objective research. It is an uncomfortable role to be in. It privileges the researcher and poses inappropriate power dynamics. And I feel that it is taking advantage of *Nyoongar* women. [Aboriginal women]

> And because we are living in a society, which is as it is, and it's not a traditional Aboriginal one, we will need different concepts to cope with and different interventions to cope with what's happening. So, I think it is probably a blend. I would never advocate a total western approach … . (AP1.1, 29 September 2003)

My initial reaction to these feelings was to question whether or not I should continue with this research project. As a non-Indigenous psychologist and researcher, at an unconscious level, I came to the realisation that I had always assumed a position of power. I sought the help of Aboriginal mentors and my research project supervisors. This step was taken with a view to helping me to process and resolve my feelings, and to make ultimately make an informed decision about the continuation of the research project.

I began by noticing that the dominant culture at the Townsville Aboriginal and Islanders Health Service, the School of Indigenous Australian Studies and the

wider Townsville Aboriginal community provided the context and research data or knowledge that is Aboriginal not European. The experience from the position of a mainstream non-Indigenous psychologist researcher/practitioner was that of finding myself in the situation of having to understand the experience of the disarming effect of coming into an Aboriginal context where I found myself in the strange position of being in the minority group where I experienced the feeling of asymmetrical power defined by Clifford (1997) and Pratt (1992).

Perhaps the most pertinent message to non-Indigenous psychologists with regard to acknowledging the impact of colonisation and the power differential came from a conversation at James Cook University School of Medicine with the visiting general medical practitioner and lecturer Dr Barry Lavallee, who is also a North American First Nations man. He stated, "[w]hen you as a psychologist are in a session with an Aboriginal client, you must always ask them if they are comfortable being with you, given that you are non-Indigenous or have not grown up Indigenous way" (Personal Communication, 21 August 2002). The comments and findings bring to light the fact that it cannot be assumed by the treating practitioner that Aboriginal patients always feel comfortable in the presence of non-Indigenous people because of the ongoing effects of colonisation.

On another note, the non-Indigenous psychologist, in the presumption that for Aboriginal people English is their first language, unconsciously assumes power. It cannot be assumed that the Aboriginal client speaks and understands fluent English. An Aboriginal woman, who also acted as a cultural consultant, points out, "I think that communication is a big issue in any form of treatment. Or any form of dealing

with people. Often people don't realise that English is a second or third language for many Indigenous people" (AHW2, 20 May 2003).

When writing about the experiences of non-Indigenous mental health professionals from mainstream organisations who were learning to work collaboratively with Indigenous mental health workers at a Victorian Aboriginal health service, Mushin et al. (2003) state "they [mainstream non-Indigenous mental health workers] had to learn to accept and deal with their anxieties in this situation and to confront their usual defence mechanisms" (p. S32).

From my own position as a non-Indigenous psychologist researcher and practitioner, this notion of an asymmetrical relation of power was felt most acutely whilst carrying out research and practicing at the Aboriginal and Islanders Health Service, the local Aboriginal community for example, St Teresa's and, to a lesser extent, at the School of Indigenous Australian Studies where I found myself positioned in the minority. This experience left me feeling disempowered, angry and, at times, excluded.

5.3.3 Confronting researcher defences

As I mentioned previously, I found myself faced with two options. I could walk away from the whole research and practice with Aboriginal people and return to the cosiness of mainstream private practice in Melbourne, or, I could stay and call upon my Aboriginal supervisors and cultural consultants to guide me through the experience in the expectation that I would gain a greater understanding and insight into my own defences. I chose the latter.

Through the discussions I had with my supervisors at the School of Indigenous Australian Studies and the Aboriginal and Islanders Health Service, I came to recognise that my primary defence lay in the knowledge and skills developed through my mainstream training and practice, grounded in the dominant western culture, as a psychologist. With guidance and support from Aboriginal cultural consultants and supervisors, I came to the realisation that, in this North Queensland Aboriginal context, my usual defence was stripped away when I initially came face-to-face with Aboriginal research participants and Aboriginal clients whose worldview was from a vastly different base of knowledge, experience and history. Put simply, I had to learn about the ongoing effects of colonisation upon Aboriginal people. I then had to acknowledge and accept that, as part of being a member of the dominant culture, through my research and practice with Aboriginal people I unconsciously contributed to these ongoing effects of colonisation through my lack of knowledge and skills. I had to relearn Aboriginal way. For example, I had to learn to 'yarn' (Lynn, 2001; Vicary, 2003), that is, to start to engage with Aboriginal people by asking who are your people and where is your country. The next part of the process is the expectation that I, as the psychologist, would then disclose who my people are and where I am from. Self-disclosure by the practitioner is considered to be unhelpful, as it is argued in mainstream psychology that self-disclosure may prove to be counter-productive to the relationship between the practitioner and the client or indeed the researcher and the participant. At another level, by not engaging in self-disclosure, the non- Indigenous psychologist/researcher keeps a position of power by withholding knowledge and keeping the focus on the other. By way of contrast, in Aboriginal way, self-disclosure is about locating oneself, family and country. It is

about trust and reciprocity. Disclosure in these contexts is viewed as an experience of reciprocity that is fundamental to Aboriginal culture.

5.3.4 Researcher discomfort: processing one's defence mechanisms

By engaging in critical reflexivity as part of this study, I was seeking to acknowledge the histories of oppression that structure subjectivity. Riggs (2004) comments that "there is a need for continued willingness from practitioners, academics to speak out about oppressive practices with which psychology is often complicit" (p.119).

As a researcher/psychologist, I found myself to be seriously challenged by the statement made by an Aboriginal woman who is a psychologist and academic. She said, "I think that racism and decolonisation processes need to be a part of any psychotherapy for Indigenous and non-Indigenous people" (AP1.2, 31 October 2003). This is consistent with the comments addressing researcher discomfort in relation to the balance of power. I understood the implications of racism but I was neither fully aware of, nor did I fully understand, the implications of decolonisation. In advising me to ask the client about their level of comfort, or indeed discomfort, in the psychotherapeutic session or 'contact zone', Dr LaVallee invited me to acknowledge the ongoing effects of colonisation and created the opportunity to address the *asymmetrical power relationship*. When I took up the courage to carry out this advice, I found, to my surprise, that the Aboriginal participants replied, "[n]othing against you personally, Carol, but I don't like or trust white [European] people very much". Initially, I found this to be a most unnerving experience as a researcher/psychologist because it destabilised my power base. However, through the

analysis of my own reaction, I began to see how this advice and action has the power to open the way to acknowledge the effects of colonisation.

A male Aboriginal health worker corroborates this comment:

> When you look at Aboriginal people, they don't trust European people very much because of the hurt and the impact of the invasion and the Stolen Generation and the massacres that took place here years ago. So now, you see, Indigenous people are very touchy people. They are very emotional touchy people. They can go off, especially if a European person upsets them. They just trigger something in them. Racism is a big problem that affects Indigenous people. Because of the invasion and everything that happened here [colonisation], we still carry it in our hearts. Racism is probably one of the biggest things that impacted on us. (AHW6.2, 20 June 2002)

By asking the question about client comfort and discomfort, opportunity is given for the recognition of the effects of colonisation upon Aboriginal people within the 'contact zone'/therapeutic setting. At the same time, it requires the non-Indigenous researcher/psychologist to have recognised and resolved their own discomfort if they are to be truly effective when engaging with Aboriginal people.

This critical reflexivity is evident in South African psychology where de la Rey (2003) notes that, in spite of the wide-reaching effects of the Truth and Reconciliation Commission, South African psychology still has a long way to go in remedying the effects of the years of oppression.

Learning to work in partnership with Aboriginal cultural advisors is crucial to the efficacy of psychological research and service delivery. It presumes to address the unconscious defences that arise within the non-Indigenous researcher/psychologist when dealing with Aboriginal people. It provides the groundwork upon which feelings of trust may be managed between Aboriginal people and non-Aboriginal people. When reflecting on the development of meaningful engagement with Aboriginal people, I am advised, "[y]es. Spend some time [with us] and develop the trust" (ST1.4, 16 July 2003).

> I am completely surprised by my reaction at the farewell morning tea today. As a professional, I never become emotional in public but this morning I did. As I thanked those with whom I had worked at TAIHS, I became overwhelmed with the realisation dawning on me that during the two years of my involvement, I had come to love and respect this group of Indigenous people. Through their generosity, humour, patience and guidance, I learned about myself as a person and as a professional. I gained information and learned skills that are so necessary for psychological practice with Aboriginal clients that were nowhere to be found in my mainstream training. But more than anything, my sadness is about leaving a group of people who felt like family. (Personal diary entry, 20 November 2003)

This study points to the importance of rewriting psychotherapy and the accreditation of the courses of study as part of the decolonisation of psychology so that it can be applied by non-Indigenous psychologists. It also calls for the

prerequisite experience of transformation for the non-Indigenous psychologists to see themselves as psychosocial and defended. With that in mind, Chapter Six demonstrates the way in which the findings of this study can begin to make a contribution toward filling the gap in psychotherapy that I raised in Chapter One, regarding the dilemma facing non-Indigenous psychologists who find themselves in the position of providing psychological interventions to Aboriginal clients.

Chapter Six

A Framework for an Indigenous Psychotherapy

6.1 Indigenous theoretical underpinning for practice

This study set out to make a contribution toward filling the gap in psychotherapy. It is not about bifurcating and splitting Western and Aboriginal knowledges rather, it is about respecting, recognising and including body of knowledge that has previously been ignored or excluded in Australia. It requires our usual Western mainstream perceptions of reality to be challenged. The findings show that we may now accept the opportunity of the challenge to address the gap by redefining psychotherapy itself from an *Indigenous* perspective. Crucial to this Indigenous perspective is the notion of relatedness and connectedness to all things that is expressed in the literature (Martin, 2003) and confirmed by the participants in this study. Techniques can be used but they must always be linked back to the theory of connectedness and relatedness in Aboriginal culture. Given the tenets of connectedness, relatedness and reciprocity in Aboriginal philosophy (Dudgeon et al., 2000a; Martin, 2003), psychological theory and practice needs to take into account Aboriginal values of being one with the earth as embodied in Aboriginal traditional psychological practices and make space for this to stand alongside modern western psychological practices. These tenets are also in agreement with, and build on, the notion *Ways of Knowing, Ways of Being and Ways of Doing*, put forward by Martin (2001, 2003) and the *Indigenous* frameworks developed by Rigney (1997) and

Wilson (2003). They are supported by the comments made by research participants that I have outlined in Chapter Four. The importance of this Indigenous theoretical underpinning for psychological practice is that it disrupts any kind of simplistic view of psychotherapy and encourages a rethinking of psychotherapy when treating Aboriginal clients.

The Indigenous theoretical framework that reflects Aboriginal philosophical thought that Martin (2001, 2003, 2008) proposes, also provides a possible framework for psychotherapy that will give structure for a psychological intervention which might be used by a non-Indigenous psychologist. Martin proposes that for Aboriginal people, "[w]ays of knowing and knowledge are specific to ontology (worldviews) and entities (spirits) of land, animals, plants, waterways, skies, climate and the spiritual systems of Aboriginal groups" (p. 209). She states:

> Ways of knowing inform Aboriginal ways of being. We are part of the world as much as it is part of us involved in a network of reciprocal relations that cannot be de-contextualised. This determines and defines our Ways of Being and informs us the beliefs, laws, morals, values and ethics. These guide us in our behaviour, how to relate to others and they also determine the consequences for infringements. Ways of being evolve as contexts change especially after colonisation. Ways of doing is a fusion and coherent expression of Aboriginal ways of knowing and ways of being. Our languages, our art, our rituals, traditions and ceremonies are articulations of our ways of knowing and being. These are the expressions and behaviours of our knowledge and beliefs. They are the observable ways Aboriginal people

> conduct their own behaviour and engage in relations with others. Ways of doing defines who we are, what we do and how we do this. (Martin, 2001, p. 209)

In a similar vein, one of the research participants, who is also an Aboriginal academic, makes a case for Aboriginal philosophy as the foundation paradigm for Indigenous research and practice in this comment:

> The land is the underpinning philosophy for research. It is an underpinning for Aboriginal ontology and epistemology. The notion of land sort of underpinning our research theory and methodology is uniquely Aboriginal. It's under everything. So if you are looking at health or education or media, or whatever, you need to do it with a notion of, you know, how important the land is in the way [it shapes the manner] in which [Aboriginal] people are thinking or operating. (AA4.2, 18 August 2003)

Similarly, another participant, who is an Aboriginal general medical practitioner, points to the necessity of reworking the methods/techniques for the interventions for the treatment of depressive symptoms in Aboriginal clients in the following comment. "We are rewriting, if you like, the whole issue of Aboriginal culture into psychiatry or psychotherapy. So, I think we have to retrain our thoughts when looking at people with depression" (AHW5.1, 9 October 2003). This study shows there is a need for a shift to occur in psychology that allows for an acknowledgement of Aboriginal philosophical thought that sets the groundwork for the later development of psychotherapeutic techniques and interventions.

6.1.1 Rethinking psychology: transformation of psychotherapy

Since the late 1940s, there has been a shift in the way in which psychological services are delivered to clients who are culturally different from western culture. This thesis builds on the works of others, such as Berry et al. (1992) and Sue and Sue (2002) cited in Chapter Two, who note that following the recognition of the phenomena of multiculturalism, the focus in psychology was on viewing the culturally different client as the problem. Later, the focus in cross-cultural and multicultural psychology moved to the psychologist, with emphasis being given to making or training the psychologist to become more culturally competent. Currently, the focus in psychology is turning toward the recognition and inclusion of Indigenous psychologies (Baloyi, 2005; de la Rey, 2003; Durie, 2004). In Chapter Two, I drew on the literature to demonstrate the proposition that psychological practice is always carried out within a theoretical and philosophical framework (Howard, 2000). This thesis supports the notion that Aboriginal psychology stands alongside western psychology as a separate body of knowledge and reasons that Aboriginal psychology, as a unique body of knowledge, provides the framework for the development of an *Indigenous* therapeutic intervention.

The outcomes of this study put forward the notion that Aboriginal psychology in no way seeks to diminish western psychology. It strongly supports the notion of western psychology embracing Aboriginal realities. In rethinking the way in which psychologists practice when treating Aboriginal clients, I maintain that it is important to note that, just as scientific criteria cannot be applied to validate Indigenous knowledge, scientific knowledge cannot be verified according to the principles of Indigenous knowledge. Both Indigenous and scientific knowledge are grounded in

distinctive philosophies and methodologies. By returning to the concept of the double helix outlined in Chapter Three and applying it at the interface where scientific knowledge and techniques meet with Indigenous knowledge and techniques, we are provided with a metaphor for understanding and exchanging knowledge without compromising the integrity of either scientific or Indigenous knowledge. The evidence of Aboriginal psychological knowledge is expressed through the voices of the Aboriginal participants in this research. “These testimonies open the way to make a space for the development of specific changes in paradigms and practice in psychology” (AHW5.2, 17 October 2003). They also give credence to the importance of making a contribution toward rethinking psychotherapy.

6.1.2 Applying Aboriginal terms of reference

By seeing that Aboriginal psychology is based on Aboriginal philosophical thinking and being that is based on the principles of connectedness, relatedness and reciprocity mentioned earlier, western psychology has the opportunity to embrace the psyche of the Aboriginal world. Aboriginal psychology is imbued with the Aboriginal theory for research and practice that I raised in Chapter Three and that are outlined by Martin (2001) and in the Aboriginal terms of reference outlined by Oxenham (2000) because it includes:

(1) a set of principles (Ways of Knowing)

(2) core values (Ways of Being)

(3) a framework that expresses an Aboriginal viewpoint on ways of behaving (Ways of doing).

By seeing Aboriginal psychology in this way, the profession of psychology in Australia can be opened up to taking part in the groundswell of international recognition and legitimacy that is being given to other non-western psychologies. As mentioned previously in Chapter One, the recent International Society for Theoretical Psychology Conference in 2005, Cape Town South Africa, included symposia that raised questions about psychology's place in the South African context and made a call for African traditional cultural practices to assume a key role in South African psychology and consider this could be practically realised in contexts such as psychotherapy and professional training (Baloyi, 2005). At that same conference, symposia focused on Indigenous knowledge and biculturalism in Aoetearoa/New Zealand and the articulation of Indigenous Maori psychological theory (Gavala, 2005).

There is an articulation (Bell, 1998; Dudgeon & Oxenham, 1990) of Aboriginal cultural ways of knowing, being and doing. This study recognises that Aboriginal ontology and epistemology stems from this philosophy of connectedness and relatedness of all things. "Aboriginal people have always had their own ways of healing" (AA1.2, 16 April 2003). Aboriginal psychology is grounded in Indigenous traditional ontology and epistemology and provides a sound framework for psychological theory and practice, some of which, with the permission of Aboriginal people, can be known by non-Indigenous people.

6.1.3 Connecting theory and practice when treating Aboriginal clients: the basic tenets for an Indigenous framework

Returning to the fact of the steadily increasing incidence of depression raised in Chapter One, this research gives an Indigenous theoretical framework that may be applied by non-Indigenous psychologists. Context is important, therefore, Indigenous theoretical underpinnings are critical in developing Indigenous techniques for psychological treatment. I was told this in a conversation with Shawn Wilson who advised me to, "make sure that your Indigenous psychotherapy project does not simply become a series of techniques" (JC8.1, 25 March 2003). Indigenous ontology, epistemology and axiology must guide and inform psychological practice.

The philosophical framework for the connectedness and relatedness to land and country may be expressed in therapy in a way that is similar to using the *genogram*. One of the participants, (NI1.1, 30 April 2003), explained to me that the genogram connects to culture by acknowledging family, ancestors and country and stands in the truth of Aboriginal ontology and epistemology. Within this theoretical framework, the genogram includes people, totems and land features. In this context, pertinent questions arise such as, 'Who are you? Who are your people? Where is your country?' This builds on the *yarning* style developed by others (Lynn, 1998, 2001; Vicary, 2003). The reason for doing this is because it includes the concept of kinship and is part of the Aboriginal philosophical underpinning of connectedness and relatedness which Martin (2001) names *Ways of knowing and Ways of being*. If the client does not know all of these aspects of the genogram, for example, they might have been removed from their country as part of the 'Stolen Generation', then part of the healing process will be to assist the client in seeking that knowledge as far as it is possible.

Reciprocity is a main feature of Aboriginal ways of being and doing. I am told by one research participant that when working with Aboriginal clients, the non-Indigenous psychologist is expected to reciprocate by giving an explanation of "this is who I am, these are my family, my people, and this is where I am from" (JC14, 9 July 2003). The point of this self-disclosure is to build trust and mutual respect between the Aboriginal client and the psychologist. It is also an acknowledgement of the importance of reciprocity within Aboriginal culture and begins to place the therapeutic intervention into a collaborative style and recognisable Aboriginal context that Martin (2001) calls *Ways of doing*.

The concept of *dadirri* (Atkinson, 2002; Cameron, 1992; Ungunmerr-Bauman, 1988), defined by Ungunmerr-Bauman (1988) as "inner, deep listening and quiet, still awareness" (p.9), is a way in which Aboriginal people connect with land and country and acknowledges the philosophical thought relating to Aboriginal system of kinship. I was told by Shawn Wilson (JC8.2, 26 March 2003), that the concept of *dadirri* is not to be confused with the Rogerian (Rogers, 1961) concept of client-centred listening. This is because each form of listening is guided by the culture from which it originates. This concept paves the way for future work, in collaboration with Aboriginal people, to develop a psychotherapeutic technique or intervention that is grounded in Aboriginal philosophical thought and that may also be utilised by non-Indigenous psychologists.

6.1.4 Holistic and interrelated therapy

Because of the fusion of law and healing that is explained by some of the participants in this research and is confirmed by Martin (2001), sometimes an

ancestral or spiritual dimension comes forward during an intervention and, at this point, it is important to refer the patient to a cultural healer. This can be done in collaboration with the cultural consultant. Crucial to the Indigenous perspective is an understanding of Aboriginal philosophy and culture that includes the connection between healing and law/lore. In Aboriginal traditional medicine, philosophically speaking, healing is very much part of Aboriginal law and lore. The authority, or lore, of tradition, religion and the ritual ceremonies that involve activities such as music, dance and painting strengthens this fusion of law and healing.

Psychologists need to know and understand that the Aboriginal healing system is different in its purpose and design from the western system of healing. Western psychotherapy is generally about healing the individual whereas the purpose of Aboriginal healing is to heal the person, the community and the land at the same time because they are seen as being interrelated. For healing to occur at a psychological level, Aboriginal lore must also bring about healing at a communal and spiritual level. In essence, psychological healing requires the involvement of the client's family and community. The psychotherapeutic intervention may also include spiritual healing and ceremonies arranged by Aboriginal people from the client's community. The business of traditional medicine men and women is not limited to people only; it can include healing the land and taking care of the land. If the land is sick or damaged, the people from that land become sick. This is not the business of non-Indigenous psychologists. It is the business of traditional medicine men and women to attend to the health of both country and people. It is a holistic approach to healing and recovery.

6.1.5 Knowing the boundaries

The approach I suggest is a collaborative one. By that, I mean for non-Indigenous psychologists to work within their own boundaries of expertise and to know when and how to refer their client to the community for traditional healing.

Some countries have developed a register of cultural consultants and traditional healers for referral purposes. There are a number of examples of such registers, for instance, already in New Zealand a National Body of *tohunga*, Traditional Maori Healers, was established in 1993 (Archibald, 2006) and recently, in South Africa, a register has been established for the *sangoma*, traditional South African healers (Baloyi, 2005). It provides a structure that paves the way for a collaborative healing process. It also defines the boundaries that establish the role of the treating psychologist and the traditional healer.

Rather than establishing some kind of formal register for traditional healers, I propose that the boundaries set for non-Indigenous psychologists in Australia are governed through the collaboration and guidance within the Aboriginal communities at their Community Controlled Health Services. These boundaries also lie within the framework of Aboriginal philosophy and practice that is proposed in this thesis toward an Indigenous psychotherapy.

Some of the knowledge that has emerged from this study is hardly surprising to anyone who has learned about Aboriginal culture. The real value of this study is that it shows how this knowledge may be applied as a theoretical framework and a foundation for future research toward the development of an Indigenous

psychotherapy that may be known by non-Indigenous people. What is surprising to me is the unexpected transformation of the non-Indigenous researcher, also a psychologist, during the research process. It responds to the problem for non-Indigenous psychologists in providing psychological services outlined in Chapter One, and noted by Vicary (2003), regarding the fact that formal professional training that would equip non-Indigenous psychologists with the skills to deliver culturally appropriate therapy is exceedingly limited.

6.2 The transformation of the non-Indigenous psychologist

Quite unexpectedly, this study found that by remaining true to the tenets of qualitative research method and methodology, outlined in Chapter Three, where both the researcher and the participant are viewed as psychosocial subjects, defended and intersubjective, a surprisingly strong level of discomfort was experienced by the researcher. This experience is supported by the findings of others such as Mushin et al. (2003) and Selby (2003). It demonstrates the need for, and the importance of, the transformation of the non-Indigenous psychologist if they truly wish to work meaningfully with Aboriginal clients. I propose that one possible response to this problem requires the non-Indigenous psychologist to undergo a transformation, a reassessment of their own worldview and a recognition of Indigenous psychology as a reality, as part of their formal training. This transformation, through formal training, is designed to assist non-Indigenous psychologists to develop self-knowledge, cultural knowledge and cultural psychotherapies. This transformation begins with healing the healer.

6.2.1 Healing the healer

> "Physician, heal thyself. That's where the journey begins…" (FN4.1, 21 March 2003).

The process of healing the healer is a journey of transformation for the non-Indigenous psychologist. It implies retraining in the practice of psychology for those who wish to treat Aboriginal clients. The process of transformation begins with the requirement for non-Indigenous psychologists to see themselves as defended subjects who, like their Aboriginal clients, are not only culturally different but are also affected by, and are a part of, the process of colonisation. The notion of *inter-subjectivity* outlined by Hollway and Jefferson (2000) provides a framework for this interaction, which claims that the subject cannot be known except through another subject and, in this case, it is the non-Indigenous psychologist who cannot be known except through the Aboriginal client. This may be interpreted and understood through the psychoanalytic concept of *transference* and *countertransference* (Douglas, 2000) that refers to feelings the client/patient projects onto the therapist and to the ways in which the therapist is influenced by the client/patient projections. The main projections revealed in this research surround the issues of power, culture and colonisation.

6.3 Conclusion and recommendations

In conclusion, I return to the invitation extended by Manduwuy Yunupingu (cited in McConchie, 2003), at the commencement of Chapter One, to open the mind to Aboriginal ways and to listen to Aboriginal people. It is through the voices of the participants that this study shows Aboriginal culture and Aboriginal realities that

may be known to non-Indigenous people. This leads to the five points that are salient in beginning to fill the gap in providing psychological services to Aboriginal clients. The enabling of these five points requires dialogue between bodies such as the Australian Psychological Society and training institutions, such as universities, along with Aboriginal Communities and health services because if psychologists are not educated about how to work effectively with Aboriginal people, where else will they learn it and be able to apply it to their practice? Consequently, these five points include lines of reasoning that are philosophical, theoretical, historical, contemporary and practical.

Firstly, there exists a body of Aboriginal knowledge. It is based on a philosophy of connectedness and relatedness to all things that provides a theoretical framework for the future development of psychotherapeutic interventions that may be utilised by non-Indigenous psychologists in the treatment of Aboriginal clients. Based on the findings of this research project, it is my view that the Australian Psychological Society National Course Accreditation and Training team sets and approves a psychology curriculum to address the need for the inclusion of Indigenous knowledges, specifically in relation to Aboriginal people. This is also supported by Christine Gillies, PhD, who is an Indigenous Psychologist. She spoke at the recent inaugural New South Wales and Australian Capital Territory Australian Psychologist Society Convention in Sydney (8^{th}–10^{th} May, 2009). In talking about psychological interventions with Aboriginal clients, she stated that there is a need in the curriculum for special attention to training in Aboriginal and Indigenous psychologies for those who are training as psychologists. There is a need for workshops to form part of the training also and that these workshops be accredited

by the recently formed Indigenous Psychologists Association within the Australian Psychological Society. These accredited workshops may then be made available to intern psychologists as well as practising psychologists who are working with Aboriginal people. Such accredited curricula along with accredited workshops provide both the theoretical knowledge and the practical training for psychologists treating Aboriginal clients.

Secondly, for any meaningful engagement with Aboriginal clients, the non-Indigenous researcher/psychologist needs to fully understand the history of colonisation in Australia and the effects of this upon Aboriginal people.

Thirdly, by recognising this history of colonisation, the non-Indigenous researcher/psychologist can begin to see and understand Aboriginal clients as psychosocial with psychological defences that are present in their discourses which serve to protect the self from anxiety, shame and guilt stemming from the painful effects of colonisation and oppression. It is important that the non-Indigenous psychologist recognises these defences as a testament to the resilience and the ability to survive and for Aboriginal people to deal with their issues. It is this strength of culture, kinship, strength of elders and community that Aboriginal people bring with them to the therapeutic encounter.

Fourthly, the non-Indigenous researcher/psychologist needs to view themselves as psychosocial and to explore their own unconscious defences which arise when treating Aboriginal clients. This facilitates a transformative process. This may be made possible through the Australian Psychological Society and the training

institutions (universities) that can negotiate with Aboriginal health services and other Aboriginal services that offer psychological treatments and counselling so that internship/training may take place. During this time of engagement and transformation, the non-Indigenous psychologist will need support for a variety of situations, for example, dealing with being in the *contact zone* and to resolving their discomfort and, at the same time, learning to walk in two worlds of knowledge. It is essentially a collaboration of knowledge and training between western psychology and Aboriginal psychology. During this training, non-Indigenous psychologists are engaged in the gradual process of being *shown* Aboriginal knowledge and Aboriginal ways as the non-Indigenous psychologist becomes known to Aboriginal people. Aboriginal people, in my experience, allow for time to be spent in observing and advising the non-Indigenous person. No time frame is prescribed for this experience, as it is up to the Aboriginal people who steer and inform the process. Usually, cultural consultants who emerge acting as guides and mentors carry this out. What is important is that the non-Indigenous person does not necessarily select cultural consultants; rather, the cultural consultants will decide whether or not to select the non-Indigenous person based on the observations made during this time.

The fifth point is about transforming practice. To do this, I recommend that non-Indigenous psychologists who wish to offer psychological treatments to Aboriginal people be required, during their training, to engage in a work placement with Aboriginal people where they are in day-to-day contact with the Aboriginal community. This means that non-Indigenous psychologists need to step out of their comfort zone and go to where the Aboriginal people are, for example, an Aboriginal community controlled health service.

Additionally, psychologists who are working with Aboriginal people need to establish a relationship with the local Aboriginal medical/health centres and to have a cultural mentor or establish an Aboriginal reference group to guide and inform their practice.

The transformation of both the psychologist and psychotherapy builds on the work already being carried out by the Australian Psychological Society, particularly since the very public realisation, in 1988, of their previous omissions in psychology of Aboriginal peoples and their culture. It also builds on the spirit of the apology to Aboriginal peoples by the Australian Federal Government on 13 February 2008. These transformations are consistent with the call made by Smith (1999) for the revitalisation of traditional knowledge. In this case, it is the revitalisation of Aboriginal knowledge. It contributes to the ongoing works that address the gap in current psychotherapy. It builds on the works in progress, both here in Australia and overseas, in that it responds to the need to retrain psychologists who are working with Aboriginal clients and it responds to the need to rewrite psychotherapy that is both inclusive of, and reflective of, Aboriginal philosophy, history and culture. In responding to these needs, non-Indigenous psychologists are provided with a greater hope of treating depression with improved sensitivity, respect, confidence and efficacy within an Aboriginal clientele.

6.4 Epilogue

In December 2003, I left Townsville and returned to Melbourne. Everything is there as it was two years previously. Yet I felt as though I was seeing things with a ‘fresh eye’. And as I reflected, once again I am reminded of Santiago, the Andulusian

shepherd boy (Coelho, 1993) who, when he returns to his hometown after a long absence, finds that nothing has changed externally but that through the experience of the journey in his pursuit of treasure, he actually changes as a person. For myself, what started out as a journey to find the treasure of Aboriginal ways of treating depression also turned into a discovery within myself that was facilitated by the experiences of research and practice. I had to deal with situations I had never before experienced and adapt to the Aboriginal people and the non-Indigenous people I encountered in North Queensland. I now realise that I did not or could not have known about these things unless I took this journey.

References

Aboriginal Protection and Restriction of the Sale of Opium Act (Qld).

Aizenstat, S. (1995). Jungian psychology and the world unconscious. In T. Roszak, M. E. Gomes & A. D. Kanner (Eds.), *Ecopsychology: Restoring the earth.Healing the mind* (pp. 92-100). San Francisco: Sierra Club Books.

Allen, M.G. (1976) Twin studies of affective illness. In G.C. Davison & J. M. Neale (Eds.), *Abnormal Psycho*logy (6th ed.) (p. 240). New York: John Wiley & Sons, Inc.

Allwood, C. M., & Berry, J. W. (2006). Special issue on the indigenous psychologies. *International journal of psychology, 41*(4), 241-242.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*, (DSMIV-TR) (Fourth Edition, Text Revision). Washington DC: American Psychiatric Association.

Anderson, I. (2003). Black bit, white bit. In M. Grossman (Ed.), *Blacklines: contemporary critical writing by Indigenous Australians* (pp. 43-51). Melbourne: Melbourne University Press.

Anderson, I. (2004). Social patterns: differences in health experiences. In C. Grbich (Ed.), *Health in Australia: sociological concepts and issues* (3rd ed., pp. 75-100). Sydney: Pearson Longman.

Archibald, L. (2006). *Decolonization and Healing: Indigenous experiences in the United States, New Zealand, Australia and Greenland*. Ottawa: Aboriginal Healing Foundation.

Arlow, J. A. (2000). Psychoanalysis. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (Sixth ed., pp. 16-53). Itasca Illinois: Peacock.

Armstrong, T. (2005). *Counselling interventions and Indigenous mental health*, from http://www.medicineau.net.au/clinical/abhealth/abhealth1345.html

Atkinson, J. (2002). *Trauma trails, recreating song lines*. North Melbourne: Spinifex.

Australian Psychological Society. (2003). Ethical Guidelines, *Guidelines for the provision of psychological services for, and the conduct of psychological research with, Aboriginal and Torres Strait Islander people of Australia* (pp. 1-7). Melbourne: Australian Psychological Society Ltd.

Baloyi, L. (2005). *Towards the indigenisation of psychology in South Africa.* Paper presented at the International Society of Theoretical Psychology, Cape Town, South Africa.

Baskin, C. (2005). Centring Aboriginal worldviews in social work education. *Australian Journal of Indigenous Education,* 34, 96-106

Beck, A. (1987). Cognitive models of depression. In G. C. Davison & J. M. Neale (Eds.), *Abnormal Psychology* (6th ed., pp. 231-238). New York: John Wiley & Sons, Inc.

Bell, D. (1998). *Ngarrindjeri Wurruwarrin: a world that is, was, and will be.* North Melbourne: Spinifex.

Berry, J. W. (1980). Introduction to methodology. In H. C. Triandis & J. W. Berry (Eds.), *Handbook of cross-cultural psychology* (Vol. 2). Boston: Allyn & Bacon.

Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (1992). *Cross-cultural psychology: research and applications*. Cambridge, U.K: Cambridge University Press.

beyondblue. (2003). *beyondblue: the national depression initiative*. Retrieved 3 June 2004 from http://www.beyondblue.org.au/index.aspx?.

beyondblue. (2006). National Advertising Campaign: Depression in rural men [Poster]. Australia: Author.

Billings, A. G., Cronkite, R. C., & Moos, R. H. (1983). Social-environmental factors in unipolar depression: Comparisons of deprssed patients and nondepressed controls. In G. C. Davison & J. M. Neale (Eds.), *Abnormal Psychology* (6th ed., pp. 238). New York: John Wiley & Sons.

Bogdan, R. C., & Bicklen, S. K. (1982). *Qualitative Research for Education: an introduction to theory and methods*. Boston: Allyn and Bacon.

Bogdan, R. C., & Taylor, S. J. (1975). *Introduction to qualitative research methods: a phenomenological approach to the social sciences*. London: John Wiley & Sons.

Broome, R. (1982). *Aboriginal Australians: black responses to white dominance*. Sydney: George Allen and Unwin.

Cadet-James, Y. (2001). Challenges of Indigenous research - does Aboriginal and Torres Strait Islander research contribute to the quality of life? 7th International Health Summer School - Panel Presentation: Queensland University of Technology.

Cameron, R. (1992). Alcheringa. In *Alcheringa: the Australian experience of the Sacred* (pp. 75-80). Homebush: St. Pauls.

Campbell, R. J. (1989). *Psychiatric Dictionary* (6th ed.). Oxford: Oxford University Press.

Cawte, J. (1974). *Medicine is the law: studies in psychiatric anthropology of Australian tribal societies*. Sydney: Rigby.

Cawte, J. (1996). *Healers of Arnhem Land*. Sydney. NSW: UNSW Press.

Chatwin, B. (1987). *The songlines*. Ringwood: Penguin.

Chi, J. (1996). Corrugation Road. Broome: Angoorrabin Records.

Christie, M. (2006). Transdisciplinary research and Aboriginal knowledge. *Australian Journal of Indigenous Education, 35,* 78-89.

Clifford, J. (1997). Museums as contact zones. In *Routes: travel and translation in the late twentieth century* (pp. 191-219). Cambridge: Harvard University Press.

Coelho, P. (1993). *The alchemist*. San Francisco. USA: Harper Collins.

Commonwealth Department of Health and Aged Care (DoHAC).)1998. *National health priority areas report: Mental health a report focussing on depression.* Australian Institute of Health and Welfare. Canberra: Author

Commonwealth Department of Health and Aged Care (DoHAC) (2000a). *National action plan for depression* (NAPD). Mental Health and Special Programs Branch. Canberra: Author

Commonwealth Department of Health and Aged Care (DoHAC) (2000b). *Building partnerships, LIFE: A framework for prevention of suicide and self-harm in Australia.* Canberra: Author.

Corsini, R. J. (2000). Introduction. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed.) (pp. 1-15). Itasca. Illinois: F.E.Peacock.

Corsini, R. J., & Wedding, D. (Eds.). (2000). *Current psychotherapies* (6th ed.). Itasca. Illinois: F.E.Peacock.

Coser, L. A. (1971). *Masters of sociological thought ideas in historical and social context*. New York: Harcourt Brace Jovanovich.

Cowan, J. G. (1992). *The elements of the Aborigine tradition*. Melbourne: Element Books.

Cuellar, I., & Paniagua, F. A. (2000). *Handbook of multicultural mental health: assessment and treatment of diverse populations*. New York: Academic Press.

Cuthbert, D., & Grossman, M. (1997). Crossing cultures: an interview with Helena Gulash. (Gubbi Gubbi activist of Australia). *Hecate, 23*(2), 48 (19).

Davidson, G. (1992). Toward an applied Aboriginal psychology. *South Pacific Journal of Psychology, 5*, 1-20.

Davison, G. C., & Neale, J. M. (1996). Current paradigms in psychopathology and therapy. In *Abnormal psychology* (Revised 6th ed., pp. 27-57). New York: John Wiley & Sons Inc.

de la Rey, C. (2003). *Turning the gaze on itself: Psychology as a site of social change in South Africa.* Paper presented at the 38th APS Annual Conference - Development through Diversity, Perth WA.

Department of the Premier and Cabinet (Queensland). (2003). 'Slavery' in Queensland: www.premiers.qld.gov.au/apps/assi/workshop/body/slavery-in-qld-.htm.

Denzin, N.K. (1989). *Interpretive interactionism*. London: Sage.

Douglas, C. (2000). Analytical psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed., pp. 99-132). Itasca, Illinois: Peacock.

Dudgeon, P., Garvey, D., & Pickett, H. (2000a). A cultural history. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: a handbook for psychologists* (pp. 27-30). Perth: Gunada Press.

Dudgeon, P., Garvey, D., & Pickett, H. (Eds.). (2000b). *Working with Indigenous Australians: a handbook for psychologists*. Perth: Gunada, Curtin Indigenous Research Centre.

Dudgeon, P., & Oxenham, D. (1990). *The complexity of Aboriginal diversity: identity and kindredness*. St. Lucia: University of Queensland.

Dudgeon, P., & Pickett, H. (2000). Psychology and reconciliation: Australian perspectives. *Australian Psychologist, 35*(2), 82-87.

Durie, M. (2004). *Exploring the interface between science and Indigenous knowledge.* Paper presented at the 5th APEC research and development leaders forum: capturing value from science, Christchurch, N.Z.

Eckermann, A., Dowd, T., Martin, M., Nixon, L., Gray, R., & Chong, E. (1992). Aboriginal health: community empowerment. In *Binan Goonj: bridging cultures in Aboriginal health* (pp. 174). Armidale: University of New England Press.

Eliade, M. (1989). *Shamanism:archaic techniques of ecstasy*. Ringwood, Victoria Australia: Arkana/Penguin Boods.

Ellis, A. (1984). Rational-emotive therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed., pp. 168-204). Itasca, Illinois: Peacock.

Ellis, A., & Dryden, W. (1997). *The practice of rational-emotive behavior therapy*. New York: Springer.

Engel, G. L. (1980). *The clinical application of the biopsychosocial model*, from http://www.critpsynet.freeuk.com/Pilgrim.htm

Evans, R., Saunders, K., & Cronin, K. (1975). *Exclusion, exploitation, and extermination: race relations in colonial Queensland*. Brookvale NSW: Australia and New Zealand Book Co. Pty Ltd.

Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar Straus & Giroux.

Feltham, C., & Horton, I. (2000). *Handbook of counselling and psychotherapy*. London: Sage.

Frankl, V. (1963). *Man's search for meaning: an introduction to logotherapy*. New York: Pocket Books.

Garvey, D., Dudgeon, P., & Kearins, J. (2000a). Australian psychology has a black history. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: a handbook for psychologists* (pp. 231-247). Perth: Gunada Press.

Garvey, D., Dudgeon, P., & Kearins, J. (2000b). Australian psychology has a black history. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: a handbook for psychologists* (pp. 236). Perth: Gunada Press.

Gavala, J. (2005). *Articulating an Indigenous Maori psychological theory: first steps in a long journey*. Paper presented at the International Society of Theoretical Psychology, Cape Town, South Africa.

Goldenberg, I., & Goldenberg, H. (2000). Family therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 375-406). Itasca, Illinois: Peacock.

Gonzales, H. (2000). The mirage of traditional cross-cultural psychology in Australia. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: a handbook for psychologists* (pp. 305-310). Perth: Gunada Press.

Gray, L. (1995). Shamanic counseling and ecopsychology: an interview with Leslie Gray. In T. Roszak, M. E. Gomes & A. D. Kanner (Eds.), *Ecopsychology: Restoring the earth Healing the mind* (pp. 172-182). San Francisco: Sierra Club Books.

Gridley, H., Davidson, G., Dudgeon, P., Pickett, H., & Sanson, A. (2000). The Australian Psychological Society and Australia's Indigenous people: A decade of action. *Australian Psychologist, 35*(2), 88-91.

Grieves, V. (2002). *Aboriginal philosophy. Awaba: A database of historical materials relating to the Aborigines of the Newcastle-Lake Macquarie region.*, from <http://www.newcastle.edu.au/group/amrhd/awaba/>

Grosskurth, P. (1986). *Melanie Klein: her world and her work.* New York: Knopf.

Harner, M. (1990a). From *Aboriginal Men of High Degree* by the late Australian anthropologist A.P. Elkin (1945: 78-79). In *The way of the Shaman* (pp. ix). San Francisco: Harper & Row.

Harner, M. (1990b). *The way of the shaman* (10th anniversary ed.). San Francisco: Harper & Row.

Harrison, M. D. (2003). Healing. In P. McConchie (Ed.), *Elders: wisdom from Australia's Indigenous leaders* (pp. 1-9). Cambridge: Cambridge University Press.

Hastrup, K. (1992). Writing Ethnography - state of the Art. In J. Okely & h. Callaway (Eds.), *Anthropology and Autobiography* (pp. 116-133). London: Routledge.

Heppner, P. P., Kivlighan Jr, D. M., & Wampole, B. E. (1999). *Research design in counseling* (2nd ed.). Belmont, California, USA: Wadsworth Publishing Company.

Hillman, J. (1995). A psyche the size of the earth:a psychological forward. In T. Roszak, M. E. Gomes & A. D. Kanner (Eds.), *Ecopsychology: Restoring the earth Healing the mind* (pp. xviii-xxiii). San Francisco: Sierra Club Books.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: free association, narrative and the interview method*. London: Sage Publications.

Howard, A. (2000). *Philosophy for counselling and psychotherapy: pythagoras to post-modernism*. New York: Palgrave.

Howe, D. (1993). *On being a client" understanding the process of counselling and psychotherapy*. London: Sage.

Hunter, E. M. (1993). *Aboriginal health and history: power and prejudice in remote Australia*. Cambridge. UK: Cambridge University Press.

Hunter, E. M. (2000a). *"...the deep sleep of forgetfulness": reflecting on disremembering.* Paper presented at the The mental health of Indigenous peoples, Montreal, Quebec.

Hunter, E. M. (2000b). *An overview of suicide in Indigenous Australia.* Paper presented at The mental health of Indigenous peoples, Montreal, Quebec.

Hunter, E. M. (2001). A brief historical background to health research in Indigenous communities. *Aboriginal and Islander Health Worker, 25*(1), 6-7.

Hunter, E. M., Reser, J., Baird, M., & Reser, P. (1999). *An analysis of suicide in indigenous communities of North Queensland: The historical, cultural and symbolic landscape*. Canberra: Commonwealth Department of Health and Aged Care.

Jahoda, G. (1992). Foreward. In J. W. Berry, Y. H. Poortinga, M. H. Segall & P. R. Dasen (Eds.), *Cross-cultural psychology: research and applicattions* (pp. x-x11). Cambridge: Cambridge University Press.

Jung, C. G. (1962). *Memories, dreams, reflections*. New York: New York: Pantheon.

Kelly, K., & Lenthall, S. (Eds). (1997). *An introduction to recent Aboriginal and Torres Strait Islander history in Queensland*. Cross Cultural Mental Health Awareness Facilitating Team. Cairns: Rural Health Training Unit.

Kim, U., & Berry, J. W. (1993). Introduction. In U. Kim & J. W. Berry (Eds.), *Indigenous psychologies: research and experience in cultural context* (Vol. 17, pp. 1-27). London: Sage.

Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). *The mental halth of Aboriginal peoples: transformations of identity and community.* Paper presented at the The mental health of Indigenous peoples, Montreal Quebec.

Knudtson, P., & Suzuki, D. (1992). *Wisdom of the Elders*. Crows Nest, Sydney: Allen & Unwin.

Kohn, R. (Writer) (2002). The old country is here - Aboriginal inheritance and Uluru/Kata Tjuta [Radio]. In G. Wood (Producer), *The Spirit of things: Australia's sacred sites*. Australia: ABC Radio National.

Koolmatrie, J. (1998). Indigenous issues explored. *In-Psych. The bulletin of the Australian Psychological Society*, 20, 16-17.

Koolmatrie, J., & Williams, R. (2000). Unresolved grief and the removal of Indigenous Australian children. *Australian Psychologist, 35*(2), 158-166.

Langton, M. (2001). *The nations of Australia*. Retrieved 20th May, 2001, from http://www.abc.net.au/rn/deakin/stories/s300007.htm

Langton, M. (2006). Why isn't multiculturalism a core value in Australian life? SBS Forum on Multiculturalism (part 3 of 6) [Podcast] http://www.podcastdirectory.com/podshows/450652

Lazarus, A. A. (2000). Multimodal therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed., pp. 340-372). Itasca, Illinois: Peacock.

LeCompte, M. D., & Schensul, J. J. (1999). *Analyzing and interpreting ethnographic data*. Walnut Creek, California: AltaMira Press.

Lee, R. M., & Ramirez III, M. (2000). The history, current status, and future of multicultural psychotherapy. In I. Cuellar & F. A. Paniagua (Eds.), *The handbook of multicultural mental health* (pp. 279-309). London: Academic Press.

Levi-Strauss, C. (1966). The savage mind. In P. Knudtson & D. Suzuki (Eds.), *Wisdom of the Elders* (pp. 9). Chicago USA: University of Chicago Press.

Lincoln, Y. S., & Guba, E. (1996). Doing qualitative resesarch: circles within circles. In M. Ely (Ed.), *Doing qualitative research: circles within circles*. London: The Falmer Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, California: Sage.

Lofland, J., & Lofland, L. H. (1984). Analyzing Social Settings: A guide to qualitative observation and analysis. In C. Robson (Ed.), *Real world research* (2nd ed., pp. Chapter 2). Oxford: Blackwell Publishers Inc.

Loos, N. (1982). *Invasion and resistance*. Canberra: Australian National University Press.

Lynn, R. (1998). *Murri way: Aborigines and Torres Strait Islanders re-construct social welfare practice*. Townsville: Centre for Social Research. James Cook University.

Lynn, R. (2001). Learning from a 'Murri Way'. *British Journal of Social Work, 31*, 903-916.

Marsella, A. J., & Yamada, A. M. (2000). Culture and mental health: an introduction and overview of foundations, concepts and issues. In I. Cuellar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health: assessment and treatment of diverse populations* (pp. 3-22). London: Academic Press.

Martin, K. (2001). *Ways of knowing, ways of being and ways of doing: developing a theoretical framework and methods for Indigenous re-search and Indigenist research.* Paper presented at the AIATSIS Conference, Canberra.

Martin, K. (2003). Ways of knowing, being and doing: A theoretical framework and methods for Indigenous and Indigenist re-search. *Australian Studies, Voicing dissent. New talents 21C: Next generation Australian studies*(76), 203-260.

Martin, K. (2008). *Please knock before you enter: Aboriginal regulation of outsiders and the implications for researchers.* Teneriffe, Qld: Post Pressed Academic.

Maslow, A. H. (1968). *Toward a psychology of being*. New York: Van Nostrand-Reinhold.

May, R., & Yalom, I. (2000). Existential Psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (Sixth ed., pp. 273-302). Itasca Illinois: F.E. Peacock Publishers Inc.

McConchie, P. (2003). *Elders: Wisdom from Australia's Indigenous Leaders*. Cambridge UK: Cambridge Press.

McCracken, G. (1988). *The long interview*. Newbury Park, California: Sage.

McMahon, A. (1998). *Dammed if you do, dammed if you dont: working in child welfare*. England: Ashgate.

Miller, W. L., & Crabtree, B. F. (2000). Clinical research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 607-631). Thousand Oaks. CA: Sage.

Minas, H., & McKendrick, J. (1994). Psychiatry in a multicultural setting. In S. Bloch & B. S. Singh (Eds.), *Foundations of clinical psychiatry* (pp. 300-308). Melbourne: Melbourne University Press.

Misra, G., & Gergen, K. (1993). On the place of culture in psychological science. *International journal of psychology, 28*(2), 225-243.

Moodley, R., & West, W. (2005). *Integrating traditional healing practices into counselling and psychotherapy*. Thousand Oaks: Sage.

Morgan, M. (1994). *Mutant message down under*. New York: Harper Collins.

Musgrave, G. (2003). Ceremony and song. In P. McConchie (Ed.), *Elders: Wisdom from Australia's Indigenous leaders* (pp. 99-105). Cambridge, United Kingdom: Cambridge University Press.

Mushin, D., Potter, C., Booth, A., Geoghan, K., Krupinska, O., Paul, C., et al. (2003). Stability within the chaos: the Koori Kids mental health network. *Australasian Psychiatry:Bulletin of the Royal Australian and New Zealand College of Psychiatrists, 11*(Supplement), S29-S33.

Nakata, M. N. (1997). *The cultural interface: an exploration of the intersection of Western knowledge systems and Torres Strait Islander positions and experiences.* Unpublished Doctoral Thesis, James Cook University, Townsville.

National Health and Medical Research Council. (1996). Promoting the health of Indigenous Australians. A review of infrastructure support for Aboriginal and Torres Strait Islander health advancement. Final report and recommendations part 2: 4. Canberra.

National Health and Medical Research Council. (2003). Values and ethics: guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research. Canberra.

Nelson-Jones, R. (2001). *Theory and practice of counselling and therapy*. London: Continuum.

Niblo, D. M., & Jackson, M. S. (2004). Model for combining the qualitative emic approach with the quantitative derived etic approach. *Australian Psychologist, 39*(2), 127-133.

O'Connor, P. (1985). *Understanding Jung: understanding yourself*. North Ryde: Methuen Haynes.

Oxenham, D. (2000). Aboriginal terms of reference. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: A hand book for psychologists* (pp. 109-125). Perth: Gunada Press.

Parker, G. (2002). *Dealing with depression: a commonsense guide to mood disorder*. Crows Nest. NSW: Allen & Unwin.

Perkins, R. (Director) & Lucas, K., Humfress, P., & Whitehead, A. (Producers). (2001). *One night the moon* [Motion Picture]. Music Arts Dance Films: Australia.

Pratt, M. L. (1992). Imperial eyes: travel writing and transculturation. In (pp. 6-7). London: Routledge.

Pryor, B. (1998). *Maybe tomorrow*. Ringwood: Penguin Books.

Raguram, R., Weiss, M. G., Keval, H., & Channabasavanna, S. M. (2001). Cultural dimensions of clinical depression in Bangalore, India. *Anthropology and Medicine, 8*(1).

Randall, B. (2003). *Songman the story of an aboriginal elder*. Sydney: ABC Books.

Remen, R. N. (1996). *Kitchen Table Wisdom: stories that heal*. Sydney: Pan Macmillan.

Reynolds, H. (1999). *Why weren't we told: a personal search for the truth about our history*. Ringwood: Viking.

Reynolds, H. (2003). *North of Capricorn: the untold story of Australia's north*. Crows Nest NSW: Allen & Unwin.

Riggs, D. W. (2004). Challenging the monoculturalism of psychology: Towards a more socially accountable pedaogy and practice. *Australian Psychologist, 39*(2), 118-126.

Rigney, L. I. (1997). Internationalisation of an indigenous anti-colonial cultural critique of research methodologies: A guide to Indigenist research methodology and its principles. *Journal for Native American Studies, 14*(2), 109-121.

Rigney, L. I. (2001). A first perspective of Indigenous Australian participation in science: framing Indigenous research towards Indigenous Australian intellectual sovereignty. *Kaurna Higher Education*(7), 1-13.

Robson, C. (2002). *Real World Research* (2nd ed.). Oxford UK: Blackwell.

Roe, J. (2000). Ngarlu: a cultural and spiritual strengthening model. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: A handbook for psychologists* (pp. 395-401). Perth: Gunada Press.

Rogers, C. R. (1945). The non-directive method as a technique for social research. *American Journal of Sociology, 50*, 279-283.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Sambono, H. (1993). Providing mental health services to Aboriginal communities. *Mental Health in Australia, 5*(2), 42-45.

Sampson, E. E. (1988). The debate of individualism: Indigenous psychologies of the individual and their role in personal societal functioning. *American Psychologist, 43*, 15-22.

Sampson, E. E. (1991). *Social Worlds. Personal Lives: An introduction to social psychology*. San Diego: Harcourt Brace Jovanovich.

Sandner, D. F. (1997). Analytical psychology and shamanism. In D. F. Sandner, & Wong, S.H., (Ed.), *The sacred heritage: the influence of shamanism on Analytical psychology* (pp. 3-11). New York: Routledge.

Sanson, A., & Dudgeon, P. (2000). Guest editorial: Psychology, Indigenous issues, and reconciliation. *Australian Psychologist, 35*(2), 79-81.

Sayeed, Z. (2005). *Psychology of the third kind.* Paper presented at the Beyond the pale: International critical psychology conference. Durban: South Africa.

Schatzman, L., & Strauss, A. (1973). *Field research: strategies for a natural sociology*. Englewood Cliffs: Prentice Hall.

Selby, J. M. (2003). Discomfort in research: theorising from dynamics across Indigenous settings. In N. Stephenson, Radtke, H.L., Jorna, R.J., & Stam, H.J. (Ed.), *Theoretical advances in psychology* (pp. 358-367). Amsterdam: Kluwer.

Seru, G. (1994). Mental health issues for elders with a focus on grannies. *Aboriginal and Islander health worker, 18*(1), 13.

Singh, C. (2000). Psychiatric assessment? Don't despair! A simple and effective approach for Aboriginal and Torres Strait Islander mental health workers. *Aboriginal and Islander health worker journal, 24*(4), 7-9.

Smith, L. (1999). *Decolonizing methodologies: research and Indigenous peoples*. Dunedin: University of Otago Press.

Stanner, W. E. H. (1972). *After the dreaming: black and white Australians - an anthropologist's view* (Sixth ed.). Sydney: Australian Broadcasting Commission.

Stanner, W. E. H. (1976). Some aspects of Aboriginal religion. *Australia and New Zealand Society for Theological Studies*, 19-35.

Stanner, W. E. H. (1979). *White man got no dreaming: essays 1938-1973*. Canberra: Australian National University Press.

Storr, A. (1983). *The essential Jung*. New Jersey: Princeton University Press.

Sue, D. W., & Sue, D. (2002). *Counselling the culturally diverse: theory and practice* (4th ed.). New York: John Wiley & Sons, Inc.

Sullivan, H. S. (1996). Insight therapies. In G. C. Davison & J. M. Neale (Eds.), *Abnormal psychology* (Revised 6th ed., pp. 535-537). New York: John Wiley & Sons.

Swan, P., & Raphael, B. (1995). *Ways forward: National consultancy report on Aboriginal and Torres Strait Islander mental health*. Canberra: Australian Government Publishing Service.

Tacey, D. (2000). *ReEnchantment: The new Australian spirituality*. Sydney: HarperCollins.

The Australian modern Oxford dictionary. (1998). Melbourne: Oxford University Press.

Townsville Aboriginal & Islanders Health Service (TAIHS). (2002). Townsville Aboriginal and Islanders Health Service - Overview (pp. 1-7). Townsville: Author

Townsville heritage. (2006). from www.townsville.qld.gov.au/heritage/heritage__chronology 1.asp

Trudgen, R. (2000). *Why warriors lie down and die: towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact: djambatj mala*. Darwin: Aboriginal Resource and Development Services Inc.

Ungunmerr-Bauman, M. R. (1988). Dadirri. *Compass: A review of topical theology, 22*(Autumn/Winter), 9-11.

Vicary, D. (2000). Contemporary psychology and Indigenous people. In P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians:A handbook for psychologists* (pp. 287). Perth: Gunada Press, Curtin Indigenous Research Centre.

Vicary, D. (2003). *Counselling as yarning: Aboriginal insights into western therapy*. Paper presented at the 38th APS Annual Conference - Development through Diversity, Perth WA.

Waldegrave, C., & Tamasese, K. (1993). Cultural and gender accountability in the 'Just Therapy' approach. *Journal of Feminist Family Therapy, 5*(2), 29-45.

Walkerdine, V. (1997). Daddy's girl. In W. Hollway & T. Jefferson (Eds.), *Doing qualitative research differently: free association, narrative and the interview method* (pp. 45-46). London: Sage.

Walsh, R. (2000). Asian psychotherapies. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed., pp. 407-444). Itasca, Illinois: F.E.Peacock.

Wanganeen, R. (1994). Self healing and spiritual reconnection: how to heal and reconnect your spirituality for your own well being. *Aboriginal and Islander health worker, 18*(2), 9-15.

Websters 7th New Collegiate Dictionary. (7th ed.)(1969). Springfield, Massachusetts: G & C Merriam & Co.

Wenitong, M. (2002). *Indigenous male health: A report for Indigenous males, their families and communities, and those committed to improving Indigenous male health*. Canberra: Office for Aboriginal and Torres Strait Islander Health Commonwealth Department of Health and Ageing.

Westerman, T. (2000). *Working with suicide and depression in Aboriginal populations: the cultural manifestations of disorder.* Paper presented at the Suicide prevention Australia conference, Sydney NSW.

Westerman, T. G. (2002). *The development of a comprehensive assessment process for aboriginal youth (aged 13 to 17 years) at risk of depression, suicidal behaviours and anxiety*. Westerman Aboriginal Symptom Checklist for Youth Manual. Perth: WA.

Westerman, T. (2003). *Addressing Aboriginal suicide: A best practice model of community driven prevention.* Paper presented at the The Australia and New Zealand Association of Psychiatry, Psychology and Law (WA Branch)23rd Annual Congress - Trauma and Survival, Fremantle WA.

Wilber, K. (1994). *Grace and Grit: spirituality and healing in the life and death of Treya Killam Wilber*. Melbourne: Collins Dove.

Wilson, S. (2003). Progressing toward an Indigenous research paradigm in Canada and Australia. *Journal of Native Education, 27*(2), 161-175.

Wolberg, L. R. (1954). The technique of psychotherapy. In R. J. Campbell (Ed.), *Psychiatric dictionary* (Sixth ed., pp. 600). New York: Oxford University Press.

Yalmambirra. (2005). *Qualitative research: a Wiradjuri perspective.* Paper presented at the Voice, identity and reflexivity: the second ripple qualitative research as interpretive practice conference, Charles Sturt University, Albury Campus.

Yalom, I. D. (1998). *The Yalom reader*. New York: Basic Books.

Yapko, M. (1997). In *Breaking the patterns of depression* (pp. xvii). New York: Doubleday.

Yontef, G., & Jacobs, L. (2000). Gestalt therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed., pp. 303-372). Itasca, Illinois: Peacock.

Appendix A

List of Research Participants

Identity Code	Interview Date
Aboriginal Academics	
AA1.1	24 February 2003
AA1.2	16 April 2003
AA2	7 March 2003
AA3.1	1 May 2003
AA3.2	9 October 2003
AA4.1	30 July 2003
AA4.2	18 August 2003
AA5	26 April 2003
Aboriginal Psychologist/Academics	
AP1.1	29 September 2003
AP1.2	31 October 2003
Non-Indigenous Psychiatrists	
NI1.1	30 April 2003
NI1.2	9 October 2003
Aboriginal Community Members	
ACM1.1	17 April 2003

Identity Code	Interview Date
ACM1.2	25 July 2003
ACMI.3	6 November 2003
ACM2.1	11 September 2003
St. Teresa's Aboriginal Community (Meetings attended as part of the *Bringing them home programme.*)	
ST1.1	21 May 2003
ST1.2	11 June 2003
ST1.3	8 July 2003
ST1.4	16 July 2003
ST1.5	17 August 2003
Aboriginal Health Workers	
AHW1.1	4 March 2003
AHW1.2	14 August 2003
AHW2	20 May 2003
AHW3.1	22 May 2003
AHW3.2	14 July 2003
AHW4.1	14 July 2003
AHW4.2	5 August 2003
AHW5.1	9 October 2003
AHW5.2	17 October 2003
AHW6.1	13 June 2002
AHW6.2	20 June 2002
AHW7.1	26 June 2002

Identity Code	Interview Date
AHW7.2	3 April 2003
AHW7.3	18 November 2003
AHW8	3 April 2003
AHW9	3 April 2003
AHW10	4 April 2003
Field Notes	
FN1	29 April 2003
FN2	29 April 2003
FN3	1–6 June 2003
FN4.1	21 March 2003
FN4.2	18 October 2003
FN4.3	26 November 2003
FN5	25 November 2003
FN6.1	9 July 2002
FN6.2	10 April 2003
FN7	26 April 2003
FN8	2 July 2002
FN9	October 2003
FN10	3 June 2003
Journalised Conversations	
JC1.1	18 March 2003
JC2	1 May 2003
JC3	14 July 2003

Identity Code	Interview Date
JC4.1	3 March 2003
JC4.2	18 July 2003
JC5	9 October 2003
JC6	13 May 2003
JC7.1	30 October 2003
JC7.2	18 November 2003
JC8.1	25 March 2003
JC8.2	26 March 2003
JC9	4 April 2003
JC10	4 April 2003
JC11	8 April 2003
JC12.1	1 May 2003
JC12.2	2 May 2003
JC13	16 May 2003
JC14	9 July 2003
JC15	31 October 2005
JC16	11 April 2003
JC17	15 January 2004
JC18	3 March 2003
JC19	7 March 2003
JC20	17 June 2003
Cultural Consultants	
CC1	Weekly contact 2002-2003
CC2	Weekly contact 2002

Identity Code	Interview Date
CC3	Weekly contact 2003
CC4	Regular contact 2002 - ongoing