

**School of Psychology and Speech Pathology**

**Towards a cross-cultural psychotherapeutic framework for Psychologists  
working with Western Australian Aboriginal people**

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**of**

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## Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature:

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke extending to the right.

Date:

February 10<sup>th</sup> 2016

*I think for a lot of Indigenous people, they are so sick of talk, we will do this, we will do that, we will do this, so they have come to the point where it's like, "what are you going to do for me" and until you do something ... it's so fascinating, because you sit there and go what do you mean what am I going to do for you...*

**Clinical Psychologist**

*He had to see a counsellor...he said he didn't want to talk to him...he said all they did was just talk, talk, talk all the time...or they just asked questions all the time and he didn't like answering questions all the time.*

**Community member, Community Forum**

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## Operational Definitions of Key Concepts

It is important to note the following operational definitions as they apply to this thesis:

The terms “Aboriginal” and “Indigenous” are used interchangeably throughout the thesis and refer to: Indigenous Australians, including both Aboriginal and Torres Strait Islander people (Swan & Raphael, 1995).

The term “non-Aboriginal” will be defined as: “those Australians that do not identify themselves as being Aboriginal – this is an all-inclusive category with members having a range of cultural backgrounds – however, the remainder of members have Anglo-Celtic or European backgrounds” (Vicary, 2002, p.3). This term will be used interchangeably with “non-Indigenous.”

The words “therapist” or “counsellor” are used interchangeably and are defined as: A professional with tertiary qualifications that allow them to work as a psychotherapist or counsellor (e.g. psychologists, social workers, psychiatrists, occupational therapists, and psychiatric nurses) (Vicary, 2002).

## **Abstract**

Aboriginal people are disadvantaged on a variety of key mental health indicators including rates of depression, suicide, and self-harm. This occurs in a context of colonisation, racism, and oppression. Despite the disadvantage, there are few studies informing the systematic and effective use of existing empirically supported treatments with Indigenous clients. Treatment and assessment is mainly provided from a Western framework by non-Indigenous therapists. There have been some recommendations made in regard to working with Aboriginal and Torres Strait Islander people; however, these emphasise non-specific factors. While a number of specific Western psychological interventions are known to be effective with mainstream populations but the question remains: how can these approaches be modified for Indigenous Australians? The intent behind this research was to identify specific modifications to psychological therapies delivered to Indigenous people by non-Indigenous therapists by discussing experiences of non-Indigenous therapists and Indigenous clients in delivering and participating in therapy.

Following recommendations regarding conducting research in Aboriginal communities, an Indigenous Steering Committee was formed. This Committee directed the research and determined that the first phase of research would involve interviews with Non-Aboriginal psychologists/counsellors/mental health professionals who work with Aboriginal people, families and communities to obtain an understanding of their knowledge base prior to data collection with Aboriginal participants/communities. The information obtained through these interviews was discussed with and elaborated upon by an Indigenous men's group, an Indigenous

women's group and at a whole of community forum consisting of individuals that had either first-hand experience of therapy or had been involved in the care of family members that had attended therapy.

Thematic analysis of the transcripts of each of the recorded conversations and focus group discussions was employed to identify emergent themes and subthemes from the data and these were coded accordingly. Both the process and emergent themes were discussed with members of the Steering Committee to moderate possible researcher bias and to ensure consistency.

When discussing psychological interventions provided by non-Indigenous therapists to Indigenous people, both therapists and Aboriginal participants highlighted the importance of relationship. Additional themes identified by non-Indigenous therapists included: the development of cultural knowledge; and general modifications to therapy. When discussing psychological interventions provided by non-Indigenous therapists with Indigenous groups the emergent themes included: past experience of therapy and mental health; the need for education; and structural issues.

The results suggest that changes in service delivery are required to assist in overcoming obstacles to engagement with services. Use of a stepped care approach to treatment involving community resources, community controlled health care agencies and mainstream services is recommended. A need for increases in the Indigenous mental health workforce and the role of Aboriginal Mental Health workers in service provision was identified.

## Chapter 1 - Introduction

### AIM

The aims of Chapter 1 are to provide an introduction to the topic of Indigenous Mental Health by establishing the context within which interventions by Non-Aboriginal Mental Health Professionals, and in particular psychologists, takes place. Indigenous history pre- and post-colonisation is reviewed and the impact that the differences in world view and values had on the way that the Indigenous peoples of Australia were perceived and treated. The role of the researcher along with the experiences that led to the development of the study are outlined. Finally, an overview of the thesis and the contents of subsequent chapters is provided.

Any discussion of Indigenous issues must take place within a historical context in order to understand and appreciate cultural differences and the contemporary impact of colonisation and marginalisation upon Aboriginal people. As Collard (2000) states, we are shaped by the events that precede our present and by understanding the past we hope to avoid the repeat of past tragedies. However, when attempting to understand Australian culture by looking back at the past through an Aboriginal perspective several questions are asked. The first is: Why rake up the past? It is worth noting that this question is most often asked by white Australians. Harris (2003) argues that white Australians ask this since they have forgotten the past; for Aboriginal Australians the events of the past are part of their lived experience and self-understanding. Collard (2000) and Garvey (2007) note that it is difficult to “get over it and move on” when how you are known is tied to the history that you are asked to forget, trivialise or rationalise. The second question asked by many white Australians is: “Why weren’t we told?” (Reynolds, 1999).

Given the amount of information on race relations in Australia, perhaps a more important question would be, “Why didn’t you listen?” (Rolls, 2010). It is important to remember that history is not only about what happened and when, but also – and more importantly – why and how it happened.

Many of Australia’s contemporary practices and traditions have their origins in the past (Collard, 2000). Attitudes to Australia’s Indigenous peoples (Aboriginal and Torres Strait Islander peoples) held by the broader non-Aboriginal society have been influenced by the way Aboriginal people have been portrayed historically. This historical portrayal has resulted in many erroneous beliefs about Aboriginal people becoming entrenched within society that then further impact upon the way Aboriginal people are treated or responded to (Pedersen, Clarke, Dudgeon & Griffiths, 2005). Misconceptions such as “Aboriginal history is not Australian history,” “Aboriginal people have no more connection to the land than I do,” and “*Real* Aborigines live in the outback” affect funding, foster resentments and racist attitudes and affect Aboriginal people all over Australia (ATSIC 1998, p.6).

## **1. Pre-colonial**

There was no written history of Australia prior to European colonisation and what we know about the traditional society of Australia’s Indigenous peoples is somewhat speculative. There were complex and intricate recordings of historical events through traditions such as songs, stories, dance, art and ceremony that have been passed down through the generations and contribute to knowledge about traditional society (Collard, 2000). Agreement on the length of time there has been a human presence on the Australian continent varies depending on the evidence one chooses to focus on (Dudgeon, Wright, Paradies, Garvey & Walker, 2014; Garvey,

2007). Time frames range from “time immemorial” through to 50,000 years or even up to 150,000 years (Hunter, 2007; Ranzjin, McConnochie & Nolan, 2009). By way of contrast, European settlement dates from 1788 with the Indigenous experience of first contact commencing from 1606 and extending into the 1970s (Hunter, 2007; Lewis, 2005).

There are various estimates of the Indigenous population of Australia at the time of European settlement ranging from 300,000 to more than 1 million (ATSIC, 1998). This population was spread across 500 different clan groups, each with their own distinctive territory, history, dialect and culture (Garvey, 2008). Aboriginal communities were semi-nomadic hunters and gatherers, foraging for food across a defined territory, connected to other groups via trade and information networks (Broome, 1994; Lewis, 2005). For most of the year, the Aboriginal people lived and moved in small groups consisting of several families within their own part of the tribal territory (Dudgeon, Wright, Paradies, Garvey & Walker, 2014). At intervals all the people would gather for social, ceremonial or trade purposes.

The Aboriginal people emphasised plants and animals as part of a complete, living system with the relationships between and among species equally as important as the individual plants and animals themselves (Davis, 2013). They had a spiritual as well as economic relationship to the land and the natural world. The physical environment of each local area was created and shaped by the actions of spiritual ancestors travelling across the landscape (Broome, 1994; Dudgeon, Wright, Paradies, Garvey & Walker, 2014). For example, in the Perth area, the Rainbow Serpent, the Waakal, created and shaped the land from Fremantle to Mandurah (Collard & Bracknell, 2012). Special significance was given to the creation and

resting places of the great ancestors who had moved across the tribal territory during the Dreamtime (Broome, 1994). The lives of the Aboriginal people were shaped by their Dreamtime (or Dreaming) stories. These stories were both an explanation of how the world came to be and instructions on how the people were to conduct their behaviours and social relations. The Dreamtime shaped the physical, moral and spiritual world (Collard & Bracknell, 2012). Their relationship to land and country was constantly enacted and re-enacted through ceremony, song and dance, and in the everyday (Davis, 2013). Thus, when Aboriginal people moved across their territory, they saw a richly symbolic and religious world (Dudgeon, Garvey & Pickett, 2000; Dudgeon, Wright, Paradies, Garvey & Walker, 2014). Conflict was minimised by an intricate kinship system that was interwoven with economic and religious life and featured punishment and communally determined, restorative processes for conflict resolution (Garvey, 2008). Arguably, prior to colonisation, Aboriginal people knew by and large who they were, where they belonged, and what this knowledge meant in terms of responsibilities, relationships and connections to others (Garvey, 2008). There were rituals and societal mechanisms in place to maintain mental health and occasions of mental illness, whilst occurring, were rare (Parker, 2012).

## **2. Colonisation**

On 26 January 1788, 290 seamen, soldiers and officials, and 717 convicts sailed into what is now called Port Jackson in New South Wales. The Europeans came to establish a colony. For the Aboriginal people of Australia, it was the beginning of an invasion. Calma (2015) describes the raising of the British flag as the ‘first act’ of a process of discrimination against Aboriginal and Torres Strait Islanders that continues to this day. To mainstream Australia January 26 is known as Australia Day, to many Aboriginal people January 26 is ‘Invasion Day.’

The Europeans brought with them a philosophy that emphasised materialism, progress and change; a philosophy that was directly at odds with the Dreamtime philosophy which stressed continuity over change (Broome, 1994). Three factors influenced this meeting of cultures. The British: a) were establishing a penal colony, b) brought with them preconceived notions about Indigenous peoples that they applied to Aboriginal people and, c) dispossessed the Aboriginal people of their land without even offering them a treaty (Broome, 1994).

The bulk of the new colony was comprised of convicts drawn from the ranks of the “casual poor” that emerged in Britain during the transition to industrialisation in the 18<sup>th</sup> century (Dodsworth, 2013; Shore, 2003). They possessed traits of brutality, mistrust, irresponsibility and alienation stemming from broken family lives and dismal social and economic environments. The bulk of those who were to comprise the new colony were generally poor material to undertake the task of meeting and understanding a complex Aboriginal culture that was vastly different to theirs in many ways (Broome, 1994).

Additionally, the British did not place any value on the Aboriginal way of life (Davis, 2013; Lewis, 2005). Two preconceptions about Indigenous peoples – the “noble savage” versus the “savage” – were common around the time of colonisation (Davis, 2013) and these notions became lenses through which relations with Aboriginal people were viewed. Overall there was agreement that Aboriginals were “lower down” on the scale of civilisation than the European (Twomey, 2002), however the educated minority were inclined to romanticise them as “noble,” while the uneducated majority tended to prejudge them as “savage” (Broome, 1994). As savages, Aboriginal people were spoken of as being sly, no-good, dishonest,

untrustworthy and lazy (O'Shane, 1995). As "noble" the Aboriginal people were considered to represent modern specimens of an idealised austere and virtuous lifestyle lead in classical times (Davis, 2013). The existence of these preconceptions meant that Aboriginal people were seen as either angels or devils. As a result, the colonists failed to place any value on the Aboriginal way of life.

The third factor shaping race relations in the early days of settlement was the British intent to take possession of the continent (Davis, 2013). Cook had been instructed to seek native "consent" *only* if the land appeared to have been used in ways that the British understood, i.e. housing and agriculture (Broome, 1994). Lacking an understanding and appreciation of the Aboriginal way of life, Australia was colonised on the legal fiction of terra nullius (i.e. a land belonging to no-one; Collard, 2000). This was maintained until 1992 when the High Court of Australia ruled in the Mabo case that Native Title existed and that Australia had never been terra nullius (Jonas, Langton & AIATSIS, 1994). However, for over two hundred years the Aboriginal people were defined as occupants, not owners, of the land and this injustice was state sanctioned (Collard, 2000; Finzsch, 2005). The Aboriginal people attempted to get their entitlement to their own lands recognised soon after settlement and continued to do so even to the present day. Demands and petitions were sent off to Governors, missionaries, and even the Colonial Office in London within a few years of the first arrivals from England (O'Shane, 1995). The Aboriginal people attempted to repel the invaders of their country. The English guns were more effective than the Aboriginal spears and so Aboriginal people were killed or driven off their land which was then appropriated by the Crown (Harris, 2003; O'Shane, 1995). Aboriginal resistance was labelled as rebellion rather than war – a difference that would set the tone for most future relations (Garvey, 2008).

As European settlement expanded, the Aboriginal peoples of Australia experienced a disruption to their traditional lifestyle and family structure as well as a dramatic reduction in population (Taylor, Schmidt & Roy, 2003). The decline in population was influenced by three factors: 1) introduced diseases; 2) violence and killing; and 3) loss of access to land and resources (Harris, 2003). About 20,000 deaths can be attributed to frontier violence at the cost of between 2000 to 5000 European deaths (Brown, 2001). There have been attempts (e.g. Windschuttle, 2003) to 'revise' Australian history by questioning the extent of this violence. Harris (2003) notes that Windschuttle was inconsistent in his exploration of frontier violence as he discounted some information relating to massacres and violence and also elevated the importance of others. Maynard (2003), Harris (2003) and Brock (2004) cite missionary reports, oral history from Aboriginal communities and other historical documents and suggest that the number of Aboriginal deaths by violence may be higher than 20,000. As Harris (2003, p.81) states: "The...one fact which transcends all other facts and all other estimates, reconstructions, analyses, guesses, misrepresentations, truths, half-truths and lies, is the fact of the immense and appalling reduction to the Aboriginal population." By the 1890s the Aboriginal population had been reduced by 95% to a low point of around 60,000 (Broome, 1994; Brown, 2001). The Aboriginal population recovered from this low point and has increased. In the 2011 census nationally 548,370 people identified as Aboriginal or Torres Strait Islander, 60,550 of whom spoke an Indigenous language (Biddle, 2014). In Western Australia the population was 88,277 (Australian Indigenous HealthInfoNet, 2013).

### 3. Government Policies and Social Responses

Eckermann et al (2005) identified several major policy eras from the 1880s through to the 1990s. These were: a) segregation (1890-1950); b) assimilation (1950-1960); c) integration (1967-1972); e) self-determination (1972-1975); and f) self-management (1975 – on). The colonial administration did not implement any overarching policies during the period from 1788 to 1890, however approaches inspired by missionary zeal were applied in piecemeal fashion. Such approaches were based on a limited understanding of Indigenous culture and took place within a climate of general neglect.

Pre-Darwinian racial thought and contemporary ideas about ‘habit’ influenced early approaches to the treatment of Aboriginal people (Dodsworth, 2002; Twomey, 2002). Moves to incorporate the Aboriginal people into the white colonial community drew upon ideas and activities associated with similar attempts in Britain to shape the working class into ‘sober and industrious’ citizens (Twomey, 2002). The British focused on “civilising” the Aboriginal people through converting them to Christianity, encouraging them to farm land and obtain a “western” education. These attempts to civilise were not successful, posing a problem for the colonists.

The British could not understand why Aboriginal people either lacked interest in, or outright refused, the benefits of Christianity and civilised society (Ranzjin, McConnochie & Nolan, 2009). The only explanation that fitted their world view was that Aboriginal people were too “stupid” or “primitive” to appreciate what was being offered to them. By stereotyping the Aboriginal people as “genetically incapable” of surviving in the new civilised society, the failure of attempts to civilise could be attributed to the Aboriginal people and not be the result of a lack of

understanding by the British (Ranzjin, McConnochie & Nolan, 2009). Again and again the pattern was to identify the problem as residing in the Aboriginal people so that the British did not need to address their failure to understand the Indigenous culture (Collard, 2000). There was never any suggestion that the British could learn from the Aboriginal people. Increasingly the colonists came to hold a pessimistic view of the Aboriginal people's abilities and worth (Broome, 1994). The pathologising of the Aboriginal people had begun.

The expansion of the colony changed the approach of the colonisers to the colonised (Dudgeon, Wright, Paradies, Garvey & Walker, 2010). By 1860, 4000 Europeans – along with 20 million sheep – were occupying 400 million hectares of land ranging from South Australia to Southern Queensland (Ranzjin, McConnochie & Nolan, 2009). The presence of Aboriginal people on land they had a spiritual and intimate connection to represented an obstacle to the Europeans who viewed land as a commodity or resource to be used. The existence of Aboriginal people became a problem that needed to be 'solved' so that land could be appropriated, allocated to settlers and used. As van Krieken (1999) notes, British attempts to bring civilisation to the Aboriginal people revolved around essentially violent policies and practices. Some individuals in the colony were aware of the impact of this as indicated by the following excerpt from a letter in the Newcastle Herald in 1869:

We have not only taken possession of the lands of the [A]boriginal tribes of this colony, and driven them from their territories, but we have also kept up unrelenting hostility towards them, as if they were not worthy of being classed with human beings, but simply regarded as inferior to some of the lower animals of creation (Newcastle Herald, 1869, cited in Maynard, 2004, p140-141).

However, the majority of the colonists were silent.

Aboriginal people were viewed as genetically incapable of becoming civilised due to their 'primitive' and 'childlike' natures. With a Darwinian belief that this meant the Aboriginal peoples would become extinct, the colonial administrators felt justified in their decision to 'protect' them by placing Aboriginal people on isolated reserves until they 'died out.' This convenient justification also had the effect of removing Aboriginal people from land they had been connected to for many generations 'for their own good', enabling settlers to be granted it by the Crown (Ranzjin, McConnochie & Nolan, 2009). Dispossession was formalised through legislation and government policies under which land was expropriated from the Aboriginal people and then given to other interests – frequently wealthy, powerful, white agricultural and pastoral landholders (O'Shane, 1995). The Aboriginal people were relocated to reserves that were located in areas considered by the Europeans to be unusable for pastoral or agricultural enterprise and which were well distant from the new towns and villages that were being established (O'Shane, 1995). These reserves were situated on Crown land and so the Aboriginal people could be relocated when towns grew out to the reserves or when the land acquired economic value. This disrupted the Aboriginal people's connection to place, to country, removing the traditional way of life for many (O'Shane, 1995; Ranzjin, McConnochie & Nolan, 2009). The reserve system resulted in much traditional culture and knowledge being lost.

By the time the colonial administration formalised its policies and practices in legislation (1870-1890), concepts of racial superiority, both in individual attitudes and the operations of major social institutions, were well established (Vicary, 2000).

The prevailing belief in the latter part of the 19<sup>th</sup> century was that Aboriginal people were becoming extinct. Due to the certainty of this extinction, little effort was spent in providing infrastructure (e.g. education) for the Aboriginal population (Vicary, 2000). Governmental effort was instead directed towards Christianising and civilising Aboriginal people. It was believed that the only way to do this was to remove children from the influence of their families (O'Shane, 1995). Separation of children from parents was considered the only way that Aboriginal people would make the necessary leaps in social evolution to become economically and socially viable citizens (Caruso, 2012). The notion of rescuing the rising generation had been central to Church and state policies in Europe since the 16<sup>th</sup> Century (van Krieken, 1999).

The strategy here was simply to remove Aboriginal parents' rights over their children and make the State the legal guardian of all children of Aboriginal descent. State based missions were central sites of removal, however a significant number of Aboriginal children were 'unofficially' removed from their family groups as well (McCoy, 2007; Robinson, 2003). The legislation enabling this was introduced between 1905 and 1909 in all Australian states and further reinforced in the 1930s (e.g. the Western Australian Government's Native Administration Bill of 1936) by which time any child of Aboriginal descent could be forcibly removed from his or her family and placed into government 'care' (van Kreiken, 1999). This assertion of legal guardianship by the state over all Aboriginal children only ceased in the 1960s; the removal of children from their families, however, did not. The term "Stolen Generations" has been used to refer to Aboriginal children that were removed from their families during the years 1910 to 1972 (Peeters, Hamann & Kelly, 2014). These

children were raised in non-Aboriginal institutions and families and were required to adopt their cultural attitudes and ways of life (Peeters, Hamann & Kelly, 2014).

I was told I was there because my family didn't want me and that they didn't care or love me and that all Aboriginal men (they called them the dirty blacks) were dangerous.... They also said that my culture was not important and that we had to forget about it and never talk about it (Hunter, 1995, p.154)

The conception of Aboriginal rights began to change in the 1960s (Dudgeon, Wright, Paradies, Garvey & Walker, 2014). Changes in law and an emphasis on Aboriginal rights rather than civil rights acknowledged that Aboriginal people had rights that were specific to them. These changes involved land rights, prohibiting racial discrimination and movements towards self-determination (Dudgeon, Wright, Paradies, Garvey & Walker, 2014). In 1962 the Electoral Act granted the vote to Aboriginal people. In 1967 a referendum was held, and passed, changing clauses in the Australian Constitution that discriminated against Aboriginal people. The Whitlam government brought in the policy of self-determination in 1972 (Jonas, Langton & AIATSIS, 1994). Children continued to be removed. There were Royal Commissions into Aboriginal Deaths in custody (1991), consultancy reports on Indigenous mental health (Swan & Raphael, 1995), and inquiries into the removal of Aboriginal and Torres Strait Islander children from their families (NISATIC, 1997; Cunneen & Libesman, 2000). An Aboriginal and Torres Strait Islander Commission (ATSIC) was established and, later, abolished amid a narrative that reinforced the notion that the remote locations in which Aboriginal people lived was the primary cause of their impoverishment and disadvantage (Morrisey, 2006). This narrative ignored urban Aboriginal people and was echoed recently by the then Prime

Minister, Mr Abbott, in his comment that taxpayers should not subsidise “lifestyle choices” when backing a plan by the Western Australian Premier, Colin Barnett, to close more than 100 remote communities and move more than 1,000 people when Commonwealth funding for these communities lapsed (Medhora, 2015).

In 2007, reacting to what was described as alarming levels of child sexual abuse, the Howard government announced plans for interventions in Northern Territory Indigenous communities (Garvey 2008). The aim was to address the safety and wellbeing of the children in these communities. Opinions were divided, with some believing that excessive tactics were used in the initial rollout, whilst others saw these as necessary to create a strong presence (Garvey, 2008). On February 13, 2008, the then Prime Minister of Australia, Kevin Rudd, offered an apology to members of the Stolen Generations on behalf of the Parliament of Australia. Responses within and without the Aboriginal community at large varied. Some felt that his words provided closure to a painful wound, others were more cautious – waiting to see what happened next (Garvey, 2008).

#### **4. The Impact of Colonisation and Related Government Policies upon Aboriginal Mental Health**

Any discussion of the mental health of Aboriginal people must recognise the historical and socio-political context within which the Aboriginal people are situated. The impact of colonisation, trauma, loss and grief, separation of families and children, the taking away of land, the loss of culture and identity, and the impact of social inequity, stigma and racism all affect the mental health of Aboriginal people. As Gilbert (2007, p 2) wrote:

[T]hey were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. Their view of Aborigines as the most miserable people on earth was seared into Aboriginal thinking because they now controlled the provisions that allowed blacks to continue to exist at all.

Independence from them was not possible... It is my thesis that Aboriginal Australia underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is this psychological blight, more than anything else, that causes the conditions we see on the reserves and missions. And it is repeated down the generations.

The Aboriginal peoples' experience of dispossession, oppression and racism contributed significantly to mental health problems within their communities (Dudgeon, 2000a; Parker, 2010; Parker & Milroy, 2014; Swan & Raphael, 1995) Apprehension of children and incarceration resulted in breakdowns in families and culture. The role of government and state authority in this contributed to negative perceptions of institutions and government departments and a reluctance to engage with services (Swann & Raphael, 1995; Vicary & Westerman, 2004). The experience of trauma for Aboriginal Australians has been widespread, enduring, recurring and amplified across generations.

Aboriginal people are disadvantaged on a variety of key indicators including life expectancy, education, labour force participation and income (Australian Indigenous Health*Info*Net, 2013; DIA, 2005). The disadvantages faced by Aboriginal people include: a) social and economic (e.g. lower weekly median

income, higher unemployment rates, high rates of incarceration, high rates of domestic violence); b) health disadvantage (e.g. average life expectancy is lower by 20 years, infant mortality is three times that of the non-Aboriginal population); c) mental health disadvantage (e.g. rates of depression, suicide, and self-harm are higher, higher rates of mental disorders, correlated with high rates of substance misuse, over twice as many deaths associated with mental and behavioural disorders) (Bohanna & Clough, 2012; Day et al, 2008; DIA, 2005; Hunter, 2007; Hunter et al, 2012; Stanley, Kovacs, Tomison & Cripps, 2002; Sveticic, Milner & De Leo, 2012). This disadvantage occurs in a context of colonisation, racism, and oppression. These poor social and health indicators are the psychosocial results of the trauma of colonisation (Littlefield & Dudgeon, 2010).

Swann and Raphael (1995), after consulting widely with Aboriginal people and organisations and reviewing data from state reports, found that Aboriginal people were more than twice as likely to suffer degrees of stress which impaired their ability to cope with day to day living. Hogg (1992) found that the mortality patterns of Aboriginal people were higher than Maori, American First Peoples and Alaskan natives. In addition, the latter three Indigenous peoples had higher life expectancies than Aboriginal people. A comprehensive child health survey conducted in Western Australia found associations existed between the social and emotional wellbeing of Aboriginal carers and their children and the past policies and practices of forced separation of Indigenous people from their families (Zubrick, Silburn, Lawrence, Mitrou, Dalby, Blair, et al 2005). One finding from this survey was that children whose carers were forcibly separated from their families were over twice as likely to be at high risk of clinically significant emotional and behavioural difficulties. Other studies have found that many Aboriginal people that were

removed from their parents as part of governmental policy – the Stolen Generations – had symptoms consistent with a diagnosis of complex Post Traumatic Stress Disorder (PTSD; Petchkovsky, San Roque, Jurra & Butler, 2004).

Conventional conceptualisations of PTSD require an individual to have been exposed to a discrete traumatic event causing intense fear, helplessness or horror to a degree that damages the psychological development of the victim (McCausland, 2008). The experiences of many Indigenous peoples challenge this conceptualisation as it is not possible to locate their traumatisation to a discrete place or time (Hunter, 1998). The loss of culture, identity, fear that children will be removed and the effect that this anxiety has on parenting, developmental exposure to environments of widespread disturbance (e.g. substance abuse and violence), has an impact that is more severe, more complex and more enduring than PTSD as defined above – a collective trauma (Krieg, 2009). The notion of intergenerational transmission of trauma through its effects on family structure and function has been documented in the context of war trauma (e.g. Harkness, 1993) and in survivors of the Holocaust (e.g. Fonagy, 1999). Cunneen and Libesman (2000) use the term “post-colonial trauma” to refer to the effects of past colonial practices and the ongoing impacts upon Aboriginal families that removal – either via the welfare or justice systems – has on Aboriginal people today. It could be argued that Aboriginal peoples’ experience of totalitarian control, genocide and oppression has resulted in a destruction of identity akin to the ‘mental death’ associated with survivors of torture (Egbert & Dyck, 2004). This destruction of identity and powerlessness can lead to substance use, anger, violence and a profound sense of grief (Wanganeen, 2005, 2008).

In addition to trauma experienced through colonisation and governmental practices, Aboriginal people also have experienced significant losses resulting in unresolved and ongoing grief. This grief is related to the history of invasion, the ongoing impact of colonisation, loss of country and culture, high rates of premature mortality, high levels of incarceration, and high levels of family separations (particularly those as a result of the forced separation of children and parents, suicide and Aboriginal deaths in custody). Such contemporary losses lead to intense distress, separation anxiety, yearning and grief that generate their own psychological pain (McCausland, 2008). Hanssens (2008) indicates there is little information relating to suitable support for Aboriginal people and communities dealing with bereavement. Wanganeen (2008) suggests that intergenerational suppressed unresolved grief has become complicated by secondary suppressed unresolved grief for other individuals, their families and communities. This suppressed unresolved grief results in domestic violence, sexual and physical abuse, and other traumas (SWAMS, 2006). Complicating matters further, these consequences are often blamed as causes (Hunter, 1995, 1998) and the treatment attempts by mainstream services tend to address the consequences, not the underlying trauma, loss and grief.

The broader Australian community's approach to issues of Aboriginal and Torres Strait Islander mental health progressed from ethnographic fascination in the 1950s and 1960s, to an understanding of the social determinants of ill health in the 1970s and then to increasing empowerment of Aboriginal and Torres Strait Islander health organisations in the 1980s and 1990s (Hunter, 1997). The *Ways Forward* document (Swan & Raphael, 1995) recommended a range of initiatives to address mental health issues within the Aboriginal and Torres Strait Islander population such as a holistic approach to mental health, improved co-ordination of service delivery

and the development of Aboriginal Mental Health Workers (AMHW). Current policy frameworks such as the *Social and Emotional Wellbeing Framework 2004-2009* (SHRG, 2004) built on the themes that emerged from the *Ways Forward*. Zubrick and his colleagues (Zubrick, Holland, Kelly, Calma & Walker, 2014) outline how Australian, state and territory government policy has attempted to specifically address mental health and social and emotional wellbeing. Zubrick et al (2014) note that the development of policy in this area often lacks a coherent strategic purpose. To improve the mental health and wellbeing of Aboriginal and Torres Strait Islander people policies need to be revised and commitments made to improve services, service delivery, community capacity and the development of programs specifically targeted to Aboriginal and Torres Strait Islander mental health and wellbeing (Parker & Milroy, 2014).

## **5. The role of Psychology**

Psychology in Australia has been slow to respond to the needs of Aboriginal people (Garvey, Dudgeon & Kearins, 2000). As a science, and as a profession, psychology has affected knowledge and perceptions about Aboriginal and Torres Strait Islander mental health. Garvey, Dudgeon and Kearins (2000, p231) state that “Australian psychology has a black history,” reflecting that Aboriginal people were part of the earliest investigations into mental/psychological functioning both internationally and nationally. Early scientific relationships were influenced by evolutionary views – social Darwinism – with the perception that the Indigenous peoples of Australia were at an ‘early’ stage of development which accounted for differences in terms of duration of illness and cognition (Hunter, 1991). These views resulted in treating Aboriginal people as test subjects that could be studied as a contrast and comparison to ‘civilised’ (i.e. white) man. Attempts to assess the mental

capacities of Aboriginal people were employed, with the majority suggesting that Aboriginal adults performed at generally lower levels than normative samples (Dudgeon, Rickwood, Garvey & Gridley, 2014). These findings supported educational, vocational and social policies that disadvantaged Aboriginal people and did not take into account the differences in how 'intelligence' is constructed across cultures, cultural biases implicit in the assessment instruments and processes employed, nor the differences in contexts between Indigenous people and the normative sample (Dudgeon, Rickwood, Garvey & Gridley, 2014; Garvey, Dudgeon & Kearins, 2000; Rickwood, Dudgeon & Gridley, 2010).

At the same time, the discipline's consideration, treatment and reference to Aboriginal people at the time would today be considered unethical and inappropriate. Psychology has been complicit in the colonising process, has objectified, dehumanised and devalued different cultural groups and has been used to justify oppressive practices (Dudgeon, Rickwood, Garvey & Gridley, 2014; Ranzijn, McConnochie, Clarke & Nolan, 2007). Psychology has represented prejudice as a 'natural' human process, supporting institutionalised racism and placing the origins of prejudice within the individual rather than society. As professional practice, the use of a deficits model in psychology, the use of mainstream assimilationist intervention approaches and psychologists assuming 'expertise' has profoundly impacted upon health and human welfare service delivery. Dudgeon and Pickett (2000, p.86) state: "Australian psychology needs to recognise Australian Indigenous history and cultural difference, and more, to celebrate cultural difference. The understanding of Indigenous history must include awareness of contemporary Indigenous life and the diversity of Indigenous people."

Changes occurred in the 1960s with the increased awareness of Aboriginal issues in the lead up and aftermath of the 1967 referendum. Social change overseas, race protests in America, the development of similar protest movements within Australia and the rejection of imposed mental health constructions by Indigenous people shifted the focus to the social determinants of mental ill health for Indigenous people (Garvey, Dudgeon and Kearins, 2000). By the 1980s Aboriginal people were developing their own analyses of situations and highlighting both Indigenous disadvantage and the inappropriateness of mainstream service.

In 1988 – the bicentennial of European invasion/settlement – the 24<sup>th</sup> International Congress of Psychology took place in Sydney. There was a perception – amongst white psychologists – that Australian psychology had “come of age” (Gridley, Davidson, Dudgeon, Pickett & Sanson, 2000, p.88). However, tellingly, there was no Indigenous content in the program, no recognition of Indigenous people in events or ceremonies and when this was highlighted – by a non-Australian psychologist – this individual was removed from the event. The Australian Psychological Society’s (APS) Board of Community Psychologists began making changes, using the annual APS conference as a vehicle for raising awareness. In 1995, Rob Riley, Aboriginal leader and activist, presented a paper at the Perth APS conference. In it, he challenged the practice of psychology to facilitate self-determination for Aboriginal peoples. He asked:

What part can the discipline of psychology and you as psychologists play in the pursuit of social justice? How many psychologists have an understanding of Aboriginal people? How many of you have an understanding of Aboriginal culture, history and contemporary issues? For many of you this knowledge is

crucial considering the social conditions and your work environments.... It is your responsibility to seek that knowledge and understanding now, and to ensure that it is available for future generations of psychologists, in psychology training and educational programs (Riley, 2014, pxvii-xviii).

The APS developed guidelines for the provision of psychological services for and the conduct of research with Aboriginal and Torres Strait Islander people, which were adopted in 1996 and became part of the ethical guidelines companion book to the APS code of ethics (Gridley, Davidson, Dudgeon, Pickett & Sanson, 2000). These guidelines have been recently revised (APS, 2015). Whole journal issues (e.g. The Australian Psychologist volume 35, no.2, July 2000, the Australian Community Psychologist, volume 18, No.1 April 2006) were devoted to psychology, reconciliation, and Indigenous issues. The APS developed a position paper on racism and prejudice (Sanson et al, 1997). In 2011, the APS committed to developing a Reconciliation Action Plan (RAP; APS, 2011) in partnership with the Australian Indigenous Psychologists Association (itself established in 2008). The RAP identifies the following four areas as priorities: respectful relationships, governance, cultural competence, and Aboriginal and Torres Strait Islander education and employment. Despite all this there remains a dearth of information on the application of specific psychological techniques in the treatment of Aboriginal mental health.

## **6. The Researcher**

Before continuing to outline the structure of the thesis, I first need to position myself and provide a context for the rest of the thesis, much like Garvey (2007) describes in his work.

But first, a story.

It was April 2004; I had recently become employed as a Clinical Psychologist at a local Aboriginal Medical Service (AMS) in the South West of Western Australia. As a recent Clinical Psychology graduate, I had been providing an in-reach role for domestic violence services at the AMS through my work with a local counselling agency and had, after some months, been offered a job at the Social and Emotional Wellbeing (SEWB) unit of the AMS. After discussing the offer with my clinical supervisor, I accepted. I had no idea what I was doing.

One day in April soon after I commenced working at the AMS, I was told by my manager to drive out to a house in a town about half an hour out of Bunbury and meet with a young Aboriginal man who was having difficulties. This was to be my first client. Feeling excited and full of psychological theory and ideas for intervention and treatment, I drove to the house and got out of the car. Ahead of me, on the veranda was a group of Noongar women of various ages all sitting in a row and looking very, very interested at the car and at me. I called out and introduced myself. Laughter and muffled conversation between each was the response. I am sure I shrank visibly. I told them who I worked for and asked after the young man in question. More laughter, more muffled conversation and giggles. I was told that the young man was not around. I shrank some more. I couldn't understand why I was there if the client wasn't. It did not fit. I asked if they could just let him know that I had called by. More whispers. More laughter. Then – sure - came the response. I got back in the car, head spinning, feeling a lot smaller than my 180 centimetres and drove back to Bunbury. I didn't understand.

I worked for two more years as part of the SEWB team at the AMS. All the while I had no idea what I was doing. I tried to apply the Cognitive Behavioural

Therapy (CBT) interventions I had learnt at University and in further training courses to the clients I met. I was unsure as to the results I got or the benefit I gave. I asked lots of questions to my supervisor, read a lot of works on cross cultural psychology, reviewed my practice, kept a journal, attended cultural competency training, read up on the history of the local area and Indigenous experience post colonisation (I had not learnt much of this in school, nor at University where I had done a few units on Australian history, including colonial history, during my undergraduate years).

As a result of discussions with my manager about what good therapy with Indigenous clients looked like I began to read about Narrative therapy. Fortunately for me, around this time I was able to attend a training course presented by Michael White in Perth. Afterwards, armed with post-course enthusiasm, I sat with a client and attempted to apply the principles I had learnt. After all, this was a therapy that, anecdotally at least, was considered to be a good fit for working with Indigenous people. I thought I was doing well, applying the model correctly, however halfway through the session my client got up and walked out of the room. I – it appeared – still didn't understand.

I learnt to be more of a social worker than a psychologist. I even had a conversation with a staff member from the prison who, upon finding out my qualifications, asked to speak to someone “more practical: like a social worker”. I recall being very pleased with myself when I was able to help with the enquiry! I spoke to my colleagues and to the Aboriginal Health workers and other staff. I struggled. Whilst I was working in the AMS I was trying to see what aspects of my training, what treatments if you like, worked. Through a discussion with my

supervisor for specialist registration as a Clinical Psychologist, the idea for a thesis examining what aspects of Western psychological therapies worked with Aboriginal people and what might need to be changed to make them more culturally appropriate emerged.

The above information provides a context that helps explain how this thesis came about, however to situate *me* within that context a little more information is needed. The youngest son of a Scotsman and a Kentish maid, I was 8 months old when I emigrated with my parents, older brother and sister to Western Australia in the late 1960s. My siblings and I strongly identified with our Scottish heritage and largely ignored our English side somewhat to our mother's chagrin and our father's amusement. I grew up in a town south of Perth called Armadale and had little to no contact with Aboriginal people from primary school, into high school (a Catholic school several suburbs away) and then University. Indeed, one of the authors I have frequently cited in this thesis – Pat Dudgeon – was several years ahead of me in the Psychology course I eventually found myself doing, and I had no idea she was Indigenous. I learnt very little about Aboriginal history both national and local – despite taking a University level minor in Australian history and travelling around Australia during semester breaks - and remained so until I started in-reach at the AMS. By that time, I had been married, had two children and finished a Master's degree. Since leaving the AMS and commencing this dissertation, I have divorced, remarried and added to the number of children I attempt to be a good father towards. I now work at a local public mental health service where, I am happy to say, attempts to appropriately engage and work with Indigenous people are being made by staff and supported by the fantastic workers in the State-wide Specialist Aboriginal Mental Health Service team.

## **7. Structure of the Thesis**

This chapter has reviewed Aboriginal history pre-colonisation, the impact of colonisation and the historical treatment of Australia's Indigenous peoples by the British, State and Federal governments of Australia and by the discipline of psychology itself. This treatment has influenced how Aboriginal and Torres Strait Islander people are viewed, how they have been treated in terms of mental health and other services and, significantly, this treatment has impacted upon the health and wellbeing of Australia's Indigenous peoples. This chapter serves to provide a context within which the research is situated.

The cross-cultural literature, specifically attempts to provide culturally appropriate psychological interventions, is reviewed in Chapter Two. The difficulty applying interventions derived from one culture to another and impacts of this are discussed. Indigenous peoples' conceptualisations of mental health and implications of this for interventions are outlined; first as it applies to Indigenous American peoples and some others, and, then, as it may apply to Aboriginal and Torres Strait Islander peoples more specifically. Attempts to provide psychological interventions to Aboriginal and Torres Strait Islander peoples are reviewed as are recent attempts to apply CBT to this diverse population. The rationale and aims of this research are also outlined.

In Chapter Three, the methodology employed in this research is outlined. The reasoning behind the methodology and processes involved in recruiting participants and developing links into the community along with the establishment of the Steering Committee are discussed. Ethical issues and a timeline of the ethics process are provided as this had an impact in the way that the research evolved over time.

Chapters Four and Five outline the themes that emerged from the data collected. Chapter Four reviews the themes that emerged from analysis of the interviews held with non-Aboriginal psychologists and therapists that agreed to participate in the research. Chapter Five explores the themes that emerged out of discussions with a Men's Group, a Women's Group and the Community Forum.

Chapter Six reviews the research findings with reference to Australian and international literature. Themes common between non-Aboriginal therapists and Aboriginal participants are discussed. The implications of the findings for the delivery of specific therapeutic interventions is reviewed and service delivery models and workforce issues will be discussed. Finally, methodological issues and recommendations for future research are outlined.

## Chapter 2 – Culture and psychological practice

### AIM

This chapter reviews the cross-cultural literature, considering issues involved in the provision of culturally appropriate psychological interventions. The difficulty applying interventions derived from one culture to another and impacts of this are discussed. Indigenous peoples' conceptualisations of mental health and implications of this for interventions are outlined; first as it applies to Indigenous peoples in the international context, and, then, Aboriginal and Torres Strait Islander peoples more specifically. Attempts to provide psychological interventions to Aboriginal and Torres Strait Islander peoples are reviewed as are recent attempts to apply CBT to this diverse population. The rationale and aims of this research are also outlined.

Culture can be described as “communal patterns of activity, interaction and interpretation” (Gone, 2011, p.235). All aspects of our lives are interpreted, and our actions take meaning against the back drop of culture (Angel & Williams, 2000). Thus, culture frames experiences of self, relationship, place and experiences of health and ill-health.

### 1. Culture and Mental Health

Culture affects the way that mental health problems are expressed, understood, experienced and the appropriateness and acceptability of treatment and outcome (Good & Hannah, 2015; Kirmayer, 2012a, 2012b; SHRG, 2004). It influences the way that people think and behave as well as their help seeking behaviour (O'Brien, 2000). Over the past decade there has been a move away from the position that cultural processes be omitted from theoretical or empirical work

towards increasing attention to the role played by culture in mental health, however there is still a tendency to treat culture as a “nuisance variable” in the treatment of mental health issues (Christopher, Wendt, Marecek & Goodman, 2014).

It has been argued that psychologists are trained and culturally conditioned to assume universality - that most psychological mechanisms and processes are universal and that variations in terms of culture explains little in terms of individual functioning (Cooper & Denner, 1998; Sue, Arredondo & McDavis, 1992; Sue, Bingham, Porche-Burke & Vasquez, 1999). The notion of universal psychological processes is important to the extent that it influences the development of interventions designed to solve psychological and social problems. Interventions addressing child abuse in the favelas of Brazil, to reduce poverty in Nigerian villages or address the needs of the mentally ill people in the Philippines are grounded in the idea that there is universal agreement on the meaning and psychological nature of these problems (Norenzayan & Heine, 2005). Presentations associated with psychosocial adversity often lie on a continuum between distress and disorder (Jacobs, 2013). Determining where an individual’s presentation sits on this continuum is difficult as ethno-cultural variations exist across many parameters of psychopathology including perceptions of the causes, nature, onset patterns, symptom expression, disability levels, idioms of distress, course and outcome. There are also differences in the way mental health and mental illnesses are described (Simich, Maiter, Moorlag & Ochocka, 2009). This has been identified for depressive and schizophrenic disorders (Marsella & Yamada, 2000). For example, depression in non-Western cultures is often expressed in terms of the somatic or interpersonal domains, without the associated existential problems found in the West (Brown, Scales, Beever, Rickards, Rowley & O’Dea, 2012). For schizophrenic disorders,

there are variations in secondary symptoms, the course, rate and outcome (Marsella & Yamada, 2000).

If the expression of abnormal behaviour is affected by culture and life experiences then much of current clinical practice is culture bound and inappropriate for racial/ethnic minorities as it is derived from a mono-cultural world view that insists that it is objective, generalizable and value-free (Breen & Darlaston-Jones, 2010; Ranzijn, McConnochie, Clarke & Nolan, 2007; Sue & Sue, 2003). Indeed, research indicates that empirically supported treatments that universalise behaviour are not effective across all ethnic minority populations in the United States (Smith, Rodriguez & Bernal, 2011; Roysircar, 2009) and that the services provided to ethnic minorities are inadequate (Sue & Zane, 2009). Part of the reason for this is that most models of psychotherapy initially arose out of a generic dominant group of humanity and then attempts were made to fit everyone else into those parameters – rarely with success (Brown, 2009). With close ties to the cultural traditions of Europe and the United States and a historical focus upon the therapeutic needs of the upper and middle classes within these societies, the discipline and practice of psychology is culture blind and culture bound (Berry, 2013; Griner & Smith, 2006). Much of the work in psychology has been developed within a western cultural context and, as such, is culturally valid for that population and culturally invalid for cultural and racial minorities (Hill, Lau & Sue, 2010; Leong & Lee, 2006). Applying interventions developed from a western cultural context to non-western cultures increases the risk that the interventions will not be valid, nor appropriate, within that culture. For example, traditional western models of psychotherapy do not consider cultural identity or acculturation – factors shown to be significant moderators of outcome for racial and minority groups (Leong & Lee, 2006).

Christopher and colleagues (Christopher et al, 2014) provide an example of the impact that applying U.S.-centric models and practices without regard for the cultural sensibilities of a specific region can have. Following the Indian Ocean Tsunami of 2004, psychologists delivered Western derived interventions such as Eye Movement Desensitisation and Reprocessing (EMDR), Critical Incident Stress Debriefing (CISD), grief counselling and Cognitive Behavioural Therapy (CBT) to people in Sri Lanka. These interventions were contrary to local ideas of appropriate social interaction and local norms concerning privacy and family solidarity (Christopher et al, 2014). Lacking local knowledge, these psychologists wasted their efforts and, in many cases, caused additional damage as culturally inappropriate demands for disclosure resulted in conflicts within and between families.

Christopher and colleagues' (2014) article is a good example of the impact of cultural disparities or cultural 'gaps' that arose from lack of attention – or awareness – of crucial elements specific to another cultural population. Not considering cultural factors can result in individuals ending therapy prematurely, services not being accessed or used and the development of negative attitudes regarding the usefulness of services (Jacobs, 1999; Roysircar, 2009).

Further, the lack of attention to social determinants in traditional western psychotherapy also impacts upon its effectiveness across cultures and minority groups. Social and systemic factors – along with cultural and personal factors – influence mental health experiences as the struggles of individuals, families and communities to adapt and integrate are also sources of mental distress (Kirmayer, 2012a&b; Simich, Maiter, Mooriag & Ochaka, 2009). Mental health is not only

about biology and psychology, but also about education, religion, politics, social structure and economics.

There can be no mental health where there is powerlessness, because powerlessness breeds despair. There can be no mental health where there is poverty, because poverty breeds hopelessness. There can be no mental health where there is inequality, because inequality breeds anger and resentment. There can be no mental health where there is racism, because racism breeds low self-esteem, and self-denigration; and lastly there can be no mental health where there is cultural disintegration and destruction, because cultural disintegration and destruction breed confusion and conflict (Marsella & Yamada, 2000, p. 10).

There is a need for treatment approaches to be developed that take culture into account and apply evidence-based practice in a culturally appropriate way.

Therapists also need to have cultural sensitivity and awareness of the many elements that can impact upon an individual's mental health (Day 2014; Smith, Chambers & Bratini, 2009; Sperry, 2010).

## **2. Cultural Competence and Culturally Sensitive Treatments**

Clinical and counselling psychologists need to cultivate critical cultural awareness in order to devise appropriate and acceptable psychological interventions that can be applied across international or cultural boundaries (Christopher et al, 2014). This critical cultural awareness requires both cultural sensitivity – an awareness of how cultural variables may affect the process of treatment (Hansen et al, 2006; Sperry, 2010) – and cultural competence. The need for cultural competence rests on the assumption that most therapists are unfamiliar with cultural backgrounds of various ethnic groups and their training has primarily been oriented to delivering

services to mainstream, or Anglo, individuals (Sue & Zane, 2009; Sue, Zane, Nagayama Hall & Berger, 2009). Cultural competence has been defined as:

A set of therapist variables that include the capacity for a therapist to be self-aware in regard to her or his own identities and cultural norms, sensitive to the realities of human difference and possessed of an epistemology of difference that allows for creative responses to the ways in which strengths and resiliencies inherent in identities inform, transform and are also distorted by distress and dysfunction. (Brown, 2009, pp.341-342).

Competency is thus understood as a personal process whereby the therapist gains awareness and knowledge pertaining to certain cultures and then uses this to establish a therapeutic relationship, assess, diagnose and treat individuals from that culture (Day, 2014). Brown's definition centres upon the individual therapist, however cultural competency also needs to be addressed and expressed at the systems level and also in regards to models of intervention (Hernandez et al, 2006; Kirmayer, 2012a). Kirmayer (2012b) simplifies the definition of cultural competence somewhat by defining it as "the capacity of practitioners and health services to respond appropriately and effectively to patients' cultural backgrounds, identities and concerns" (p. 251).

Considered an essential skill set, numerous approaches to assisting professionals to become more culturally competent and extensive lists of specific competencies have been developed and disseminated (Kirmayer, 2012b; Sue, Arredondo & McDavis, 1992; Sue & Sue, 2003; Sue, Zane, Nagayama Hall & Berger, 2009). The most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 2013) includes an outline for cultural formulation to

aid clinicians in assessing cultural features of an individual's mental health problem and its relationship to a social, cultural and historical context. It must be noted that, whilst gaining considerable popularity among mental health professionals, the concept of cultural competence is controversial due to limited empirical support and its association with cultural essentialism (Sue, Zane, Nagayama Hall & Berger, 2009; Wendt & Gone, 2011). Many models of cultural competence assume culture to be a function of membership of groups with shared traits, values, beliefs and attitudes that influence behaviour (Kirmayer, 2012a). Development of cultural competence becomes a matter of acquiring data or algorithms about various types of people – an approach variously described as “cookbook” (Sue & Zane, 2009) or rote learning in the absence of epistemology (Christopher et al, 2014). Current approaches to cultural competency tend to view culture as devoid of power, nor do they analyse whiteness or offer a critique upon systems of power such as racism (Durey, Wynaden & O’Kane, 2014). There is also tension between training clinicians to be culturally competent and those same clinicians applying evidence based practices that approach mental health issues from a universalistic position (Good & Hannah, 2015).

To address these concerns suggestions of alternative concepts such as ‘cultural safety’ (Papps & Ramsden, 1996) and ‘cultural responsiveness’ (Sue, Fujino, Hu, Takeuchi & Zane, 1991) have been offered. However, the concept of cultural safety has been criticised for being conceptually problematic and difficult to apply to multi-cultural contexts (Johnstone & Kanitsaki, 2007). Approaching this issue from another direction, various authors (Roysircar, 2009; Sperry, 2010; Wendt & Gone, 2011) recommend a shift away from culturally competent therapists to culturally commensurate or culturally sensitive therapies. Roysircar (2009) and

Sperry (2010) identify three types of culturally sensitive treatment: 1) healing methods consistent with a client's belief system (cultural intervention, e.g. traditional healers, exorcism); 2) psychotherapeutic interventions that directly address clients' cultural characteristics; and 3) western psychotherapeutic interventions that have been adapted or modified to respond to client's cultural characteristics.

There have been few studies informing the systematic and effective use of existing empirically supported treatments with ethnic and cultural minority clients which limits conclusions about their utility and generalisability (Lyon, Lau, McCauley, Vander Stoep & Chorpita, 2014). Evidenced based practice integrates the best available research with a clinician's expertise in the context of understanding a client's worldview (Roysircar, 2009). This becomes difficult when basic criteria for demonstrating efficacy with ethnic minorities is seldom met (Huey & Polo, 2008). In the United States the number of research and treatment approaches including race and ethnicity in their formulations is growing, however in Australia the number of communities, each with their own language and traditions, geographical factors, funding issues, and limited number of Indigenous psychologists means that culturally adapting psychotherapies is somewhat more challenging (La Roche, Davis & D'Angelo, 2015). Issues associated with sample sizes in research and questions regarding the point at which the need for an evidence base outweighs the cultural security of clients also impact on research into evidence based practices in Australia (Westerman, 2007).

There are a number of models that exist to facilitate cultural adaptation (e.g. Hwang's FMAP model, Hwang, 2009), but development of such interventions facilitated by these models has been slow and there is conflicting evidence

surrounding whether adapted treatments are any more effective than treatments that haven't been adapted (Lyon et al, 2014). A culturally grounded approach to development of interventions, that places values, beliefs, practices and sociohistorical perspectives at the centre of treatment design may create an effective and appropriate intervention for a specific local population, however this approach suffers from longer development timelines and limited scalability (Lyon et al, 2014). It seems that the default approach is to adapt western psychotherapeutic interventions and for many Indigenous peoples this, arguably, is another form of colonisation (Hill, Lau & Sue, 2010). Such interventions are steeped in the cultural biases of the colonisers and result in further oppression and marginalisation of the colonised.

### **3. Indigenous People and Mental Health**

American First Nations (FN) peoples and the Aboriginal and Torres Strait Islander people of Australia have a shared history of colonisation, dispossession and genocide (Hartman & Gone, 2013), and experience disparities in health when compared with the broader population as well as educational, social and economic disadvantage (Bigfoot & Schmidt, 2010; Gone, 2008). Gone (2004) notes that modern First Nations people are younger, poorer, less educated and less healthy than an 'average' American – a statement that could just as easily describe modern Australian Indigenous people in comparison to the 'average' Australian. Similarly, they share many of the same key mental health issues – alcohol and substance misuse, high rates of suicide and incarceration, behavioural problems, and post-traumatic stress – and have a low take-up (and high drop-out rate) of mental health services (Thomas & Bellefeuille, 2006).

Gone and his colleagues (Gone, 2008a&b, 2011; Gone & Alcantara, 2010; Gone & Calf Looking, in press; Hartmann & Gone, 2012; Kirmayer, Gone & Moses, 2014; Wexler et al, 2015) and others (Glass & Bieber, 1997; Robbins, 2001) have written extensively in regard to mental health issues and evidence based treatments for American Indian (AI)/Alaskan Native(AN)/First Nations peoples in the US and Canada. These authors review the application of Western mental health treatments (Bigfoot & Schmidt, 2012a&b; Beckstead, Lambert, DuBose, & Linehan, 2015; De Coteau, Anderson & Hope, 2006; Jackson, Wenzel, Schmutzer & Tyler, 2006), cultural competence (Wendt & Gone, 2011) and the integration of traditional cultural practices and ways of healing with contemporary psychotherapy (Gone, 2010, 2013a&b; McCabe, 2007; Rowan et al, 2014).

Researchers in Canada and America have explored ways of healing unresolved grief caused by colonisation (Brave Heart & DeBruyn, 1998), the use of Elders and traditional healing in treatment (e.g. Ellerby & Ellerby, 1998), Elders' perception of cross-cultural mental health training (Mehl-Madrone, 2009), cultural elements in recovery from alcohol abuse (Mohatt, et al, 2008) and factors associated with depression and subjective well-being (Krause, Coker, Charlifue & Whiteneck, 1999). Hartmann and Gone (2013) note that there are moves to address the cultural discordance experienced by First Nations clients attending mental health services through a combination of adapting Western therapies and cultural competency training for clinicians.

Bigfoot and Schmidt (2010) note that mental health interventions are commonly first designed for the general population and then the efficacy of this is evaluated with different groups. Such an approach may fail to adapt the treatment in

ways that are meaningful and relevant for culturally diverse populations. Helpful and meaningful treatments need to be based upon an understanding of Indigenous world views (Bigfoot & Schmidt, 2010). Gone (2004) suggests that it is difficult for mental health professionals to concede that the therapeutic technologies and techniques they have learned and favour may be another form of colonisation causing further cultural displacement for those individuals receiving it. He stresses the importance of first understanding the cultural underpinnings of wellness from the perspective of the culture: after all, altering clinical interventions without seriously questioning psychotherapy as a mode of practice altogether is an example of “cultural proselytisation” to Western norms (Gone, 2004). Gone (2007) suggests that this poses a dilemma for Western therapists: how do they simultaneously avoid the re-colonising, subjugating and displacing Indigenous subjectivities and yet remain genuinely therapeutic for those individuals suffering from debilitating distress? He suggests that the answer is to cultivate and develop therapeutic institutions and activities that resonate with local thought and practice – “they better learn some culture and traditions and some respect first...” (Gone, 2007, p. 298).

In reviewing the ‘discourse of distress’ within American Indian communities, Gone (2007) notes that there are clear cultural divergences between the professional practices and principles that guide clinical work in mental health service delivery and the local explanatory models and idioms of distress characterising mental health in these communities. Evidence based practice results in positive clinical interventions, however the research on evidence based practice with Indigenous peoples is limited. Gone and Alacantha (2007) reviewed 56 articles and chapters focusing on mental health interventions for American Indian/Alaskan Native peoples. They found only

two that provided interpretable results relative to the identification of evidence based practice with that population.

One such evidence based practice adapted for American Indian/Alaskan Native communities is described by Bigfoot and colleagues (Bigfoot & Schmidt, 2010, 2012a, 2012b; Chaffin, Bard, Bigfoot & Maher, 2012). Bigfoot and Schmidt describe a process through which trauma focused cognitive behavioural therapy (TF-CBT) was adapted for treating trauma related symptomatology in American Indian (AI) and Alaskan Native (AN) children and youth. Bigfoot and Schmidt (2010) indicate that many traditional tribal American Indian and Alaskan Native healing and cultural practices rely on the interplay between thoughts, feelings and behaviours and are complementary to CBT principles. *Honoring Children, Mending The Circle* (Bigfoot & Schmidt, 2010) is an adaptation of TF-CBT incorporating traditional concepts based on American Indian/Alaskan Native worldviews such as extended family, beliefs about the interconnectedness between healing and spirituality combined with components of treatment that facilitate the learning and skill building process for children and their parents. The approach also has training tools to assist therapists in conceptualising how American Indian/Alaskan Native health practices fit into TF-CBT. These tools highlight the healing practice, and identify the purpose and meaningfulness of that practice to American Indian/Alaskan Native peoples – a useful training element educating non-Indigenous therapists working with this population (Bigfoot & Schmidt, 2010).

Other researchers (Jackson, Wenzel, Schmutzer & Tyler, 2006) examined the applicability of CBT to American Indian individuals. A mixed methods design with a college population of American Indian individuals was used to identify what

specific components of CBT were more or less applicable to American Indian clients. Using this information Jackson, Wenzel, Schmutzer and Tyler (2006) then identified ways in which CBT could be modified to make it more appropriate for American Indian clients from a more traditional background. They noted that the extent to which modifications were needed depended upon the degree to which individuals could be considered 'acculturated' to Western culture, with more acculturated individuals requiring less modifications. However, the relationship between self-identified race, cultural identity and decisions about what mental health treatments to provide is a complex one (Hack, Larrison & Gone, 2014; Schiefer & Krahe, 2014).

An alternative approach to treatment has been to theorise Indigenous culture as a mental health treatment (Gone, 2013a&b; Gone & Calf Looking, in press). Ways to situate culture within treatment and use culture as a treatment have been explored by McCormick (1996), Brady (1995), Jackson and Hodge (2010), Lavallee and Poole (2010), McCabe (2007) and Kirmayer, Simpson and Cargo (2003) among others. Applying traditional healing practices to current problems arising from the effects of colonisation has been viewed as a practical and viable way to improve all aspects – physical, emotional, spiritual and mental – of health of NA peoples. Participation in traditional cultural practices and the shifts in identity, purpose and meaning construction that accompany this de-emphasise therapeutic technique as the mechanism of change and serve to de-colonise Indigenous communities (Gone, 2013a). Indigenous cultural models give rise to holistic and integrative ways of working that acknowledge the impact of colonisation and honour local knowledge of well-being and harmony (Bowers, 2010; Hill, Lau & Sue, 2010).

Differences between Indigenous American and Western conceptualisations of mental health are seen as central to the need for a different approach to healing with this population (Bowers, 2010; Lavalley & Poole, 2010; Ojelade, McCray, Meyers & Ashby, 2014). Treatments that do not perceive health as a balance between the physical, emotional, spiritual and mental realms are likely to be less effective with Indigenous populations than those that do. Cultural diversity and connection to culture are seen as integral to recovery for Indigenous people (Lavalley & Poole, 2010). The deep mystical experience associated with traditional healing methods and invocation of the spirit world is something not provided by mainstream therapy and is a significant point of difference (McCabe, 2007).

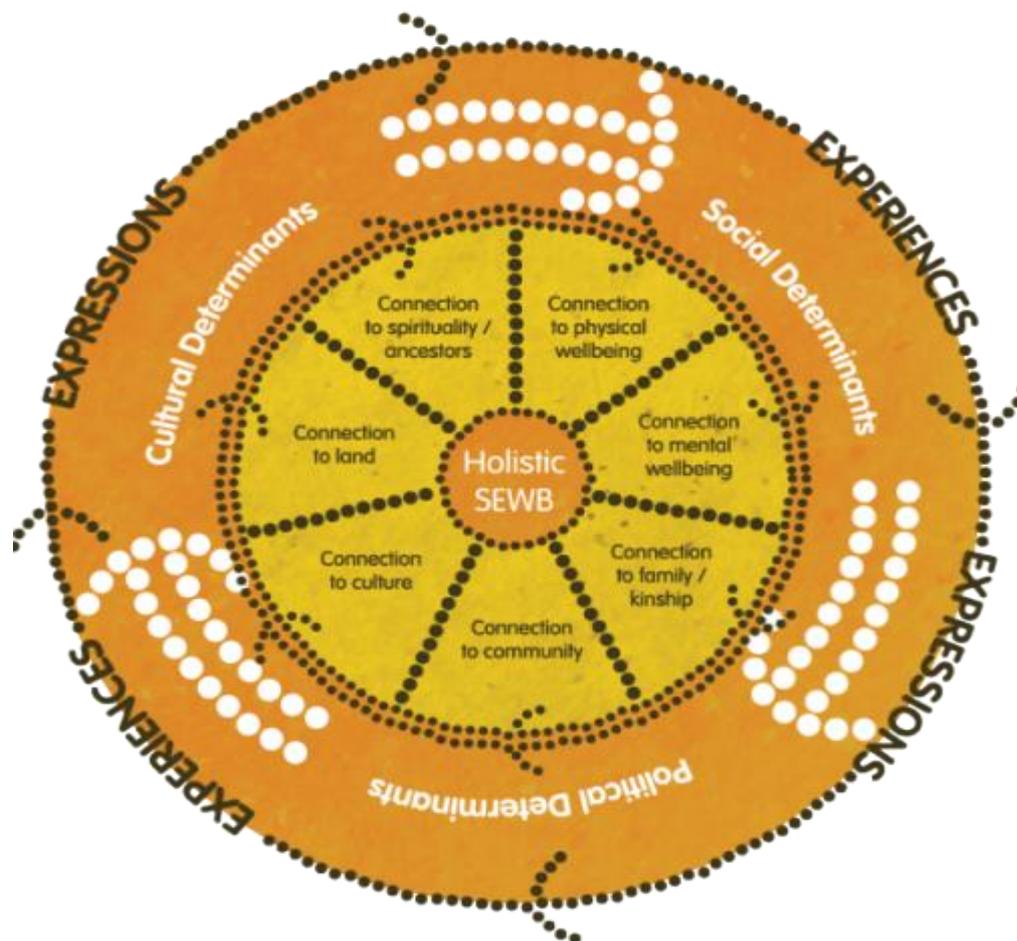
#### **4. Indigenous Australians' Mental Health and Social and Emotional Well-being**

There are differences, too, between mental health as it is conceptualised by Western society and as it is by Indigenous Australian cultures (Vicary, 2002). The term "Social and emotional well-being" (SEWB) is often used when describing issues pertaining to mental health and mental illness, however the holistic approach to health taken by Indigenous Australians means that this term has a broader scope than simply mental health (Dudgeon et al, 2014). The term includes, and extends, conventional understandings of mental health, recognising the importance of connection to land, culture, spirituality, ancestry, family and community as well as the way that these connections have been shaped across generations. It is a whole of life view that includes the interdependent relationships between communities, sea, spirit, land and families (Dudgeon et al, 2014). The relationship between SEWB and mental health is an interactive one, as the two may influence each other (Gee, Dudgeon, Schultz, Hart & Kelly, 2014). An individual may have good mental health yet experience SEWB problems or vice versa.

SEWB problems may include grief, loss, trauma, abuse, violence, substance misuse, problems with physical health, developmental problems, issues with gender identity, apprehension and removal of children, incarceration, cultural dislocation, racism and social disadvantage (Holland, Dudgeon & Milroy, 2013). Many of these problems are well established risk factors for various mental health disorders such as anxiety, depression, post-traumatic stress, self-harm and psychotic disorders (Gee et al., 2014). Whilst these problems are risk factors for various mental health disorders it is important not to rely solely upon Western psychiatric classification when attempting to identify and treat patterns of distress in Aboriginal and Torres Strait Islander populations (Gee et al., 2014). Culture bound disorders (e.g. longing for country) often mimic mental health disorders but are triggered and maintained by an individual's cultural beliefs and require resolution at a cultural level (Westerman, 2004, 2011). Disorders such as depression and anxiety may be expressed differently from mainstream populations (Alderman & Campbell, 2010; Brown et al, 2012). Parker and Milroy (2014) suggest that mental health disorders are likely to be symptomatic of greater SEWB disturbance for Aboriginal people. Positioning mental health within a broad SEWB, rather than equating it with SEWB helps make explicit the fact that, for many Aboriginal and Torres Strait Islander peoples and communities, mental health issues are still entwined with past injustices experienced and associated with colonisation (Gee et al, 2014).

The concepts and understandings of the ways in which SEWB is maintained and restored differ markedly to those associated with mental health and recovery within mainstream programs. The design of mainstream programs does not support Indigenous people to address the issues that affect their SEWB (Dudgeon et al, 2012). Mainstream programs conducted by non-Indigenous clinicians appear to find

it difficult to operationalise the concepts associated with SEWB in ways that are effective. Members of the Australian Indigenous Psychologists Association (AIPA) have endeavoured to frame SEWB in ways that have utility for non-Aboriginal mental health practitioners (Gee et al., 2014). Figure 1 shows some of the domains that typically characterise Aboriginal and Torres Strait Islander definitions of SEWB.



**Figure 1. Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islander's perspective.**

Reproduced with permission from Gee, Dudgeon, Schultz, Hart & Kelly (2014) p.57

Examination of the diagram shows that connections to body, mind and emotions, family and kinship, community, culture, land and spirituality shape the SEWB of individuals, families and communities (Gee et al., 2014). The term

‘connection’ refers to the many ways that the domains of SEWB are experienced and expressed by people throughout their lives. These connections also vary according to the different needs of individuals across the lifespan (Gee et al., 2014). People may experience healthy connections – and a sense of resilience – in some of the domains, whilst simultaneously having difficulties and/or needing healing in others. Disrupted connections are associated with poorer SEWB and, conversely, restoring or strengthening each of these domains is associated with increased SEWB (Gee et al., 2014).

There has been relatively little scrutiny of the relationship between social factors and the SEWB of Indigenous Australians (Garvey, 2008; Zubrick et al., 2014). This is partly due to difficulties associated with measuring mental health in culturally distinct populations as well as a lack of adequate measures (Dudgeon, Walker et al, 2014). The available evidence base highlights that the gaps are pronounced and increasing areas such as suicide and hospitalisation for mental health problems (ABS, 2014; AIHW, 2009; Newton, Day, Gilies & Fernandez, 2015). Indigenous mental health has been described as a significant social issue (Craven & Bodkin-Andrews, 2006) and there are continued calls to address this (Nagel et al., 2011). Culturally appropriate, effective psychological interventions are needed.

## **5. Engagement in Mental Health by Indigenous Australians**

Often Aboriginal people do not access services even when they meet criteria for a mental illness (Isaacs, Mayberry & Gruis, 2012). Aboriginal men in particular find it hard to seek help for their mental health problems and usually only do so when they are in a crisis (Isaacs & Lampitt, 2014). There are several factors that

prevent Aboriginal and Torres Strait Islanders people from seeking help when they are mentally unwell including lack of awareness of the signs and symptoms of mental illness as well as shame and reluctance to disclose one's problems. The stigma of being labelled with a mental illness is particularly severe (Isaacs & Lampitt, 2014). Unlike the general population, for Aboriginal and Torres Strait Islander people barriers to seeking and obtaining help don't ease once contact with a service is made. In Australia a racialized social structure underpins the models of care employed in health systems which privileges white, Anglo-Australian knowledge and ways of working, whilst at the same time subjugating and minimising Indigenous knowledge, beliefs and values (Durey et al., 2014; Kowal, 2011). Experiences of racism can lead to a lack of trust in mainstream services, poor communication due to cultural and language differences can lead to clients' lacking understanding of diagnosis and treatment, and a lack of understanding of the stigma associated with mental illness by health services can lead to ineffective responses (Durey et al., 2014).

Westerman (2004) narrowed barriers hindering engagement of Indigenous people in mental health services to two constructs: "a) the cultural appropriateness of the processes used by practitioners and b) qualities intrinsic to the practitioner-client relationship" (p. 2). Many Indigenous people feel that their holistic beliefs about health and mental illness are not taken into account by Western treatment models (Vicary & Westerman, 2004). In addition, Indigenous people experience many practical obstacles, such as lack of transport, long waiting hours, problems with health insurance and difficulties understanding the language used by service providers (Isaacs et al., 2010; Isaacs, Mayberry & Gruis, 2012).

Building relationships is important for help seeking (Isaacs et al., 2012). The process of building relationship can be affected by distrust and a lack of cultural competency. Distrust borne out of generations of negative experiences (well described by Cox, 2007) deters Aboriginal people from engagement with mental health services. Further, a lack of cultural competency in service delivery can impede meaningful engagement. The way that mental health services operate, e.g. conducting assessments in closed environment, maintaining eye contact and use of jargon, can also cause distress for clients and adversely affect willingness to engage (Isaacs et al, 2012; Westerman, 2010). This is then compounded by a lack of Aboriginal staff in mental health services (Isaacs et al, 2012).

Aboriginal staff, when employed by a mainstream service, are often perceived differently by other employees with limited value placed upon their role or qualifications (Brideson, 2004, has described this as “seasonal worker syndrome”). Often the role of Aboriginal workers is to make the organisation look like it is providing a comprehensive service. Issues such as recruitment and retention of staff and clarity around the Aboriginal Health Worker role (cultural liaison versus clinical versus some combination of the two) has meant that there is no standard or accepted model for the involvement of Aboriginal staff in mental health services. There have been recommendations made regarding the development of models and staffing (NMHCS, 2014), however it is unclear if these have or will be implemented.

The unsuitability of current mainstream mental health services for Aboriginal people has been highlighted by Vicary (2002), Vicary and Bishop (2005), Vicary and Westerman (2004) and Westerman (2004, 2007, 2010). The majority of Australia’s mental health services are not set up to incorporate cultural presentations,

assessment, management plans or culturally safe admissions to inpatient units (O'Brien, Boddy & Hardy, 2007). Few researchers have explored the possibility of combining Indigenous healing practices with Western psychological treatments (Dudgeon, 2000a, 2000b; Tchacos & Vallance, 2004; Vicary & Andrews, 2000, 2001; Vicary & Bishop, 2005; Vicary, 2002). Combining mainstream and traditional ways of healing may improve engagement with mental health services and improve outcomes. Mainstream mental health services need to be culturally sensitive, develop special places of healing for Indigenous people, consider alternative service models and ensure that non-Aboriginal workers are appropriately trained in Aboriginal culture and history (O'Brien, Boddy & Hardy, 2007).

There have been some attempts to consider alternative models and provide culturally sensitive treatments. For example, an attempt to deliver psychosis prevention services to Indigenous communities through mainstream services has been investigated by Catts and colleagues (Catts, O'Toole, Carr et al, 2013; Catts, O'Toole, Neil et al, 2013). Following a consultation process with Indigenous mental health workers and reviewing an existing program on the Sunshine Coast in Queensland, Australia, Catts, O'Toole, Neil et al (2013) found that embedding an Indigenous sub-team within a mainstream health service was associated with substantially improved engagement with young Indigenous people. This approach may have application for the delivery of adult specialist mental health services for a variety of other mental health problems.

Another approach to delivering mental health services to Indigenous communities that has been explored is to utilise Aboriginal Community Controlled Health Services (ACCHS). Such an approach was investigated by Lugharne,

Glennen and Austin (2002). A strength of this approach was the community controlled nature of the ACCHS which had the trust of the majority of the local community. Aboriginal Health Workers played an important role in establishing initial contacts and following people up in the community. Non-Aboriginal staff were required to become more flexible and adaptable in terms of work patterns and service development in response to community needs (Lugharne, Glennen & Austin, 2002). A responsive approach rather than an appointment based system was employed and determined to be effective in enabling full assessment and ongoing management.

Services can also be delivered in the community itself. Using a collaborative approach that involved Elders, the community, and avoided the use of the word “mental,” Isaacs and Lampitt (2014) describe the design, implementation and outcomes of a men’s health day. The assembly line approach adopted by the program along with transport to the venue and lunch being provided helped to negate some of the barriers faced by men seeking help for their mental illness. This approach was considered a promising start, however the labour intensive nature of follow-up and participants moving away from the catchment area covered by this particular service affected the ability of this approach to provide effective care (Isaacs & Lampitt, 2014).

There are also projects delivering mental health or “healing” services through use of culture. The Healing Foundation (Gilmour, 2013) commenced funding 21 projects in 2011 under the banner *Our Healing Our Solutions*. These projects covered a range of activities, however the role of traditional models and cultural practices in these activities was identified as critical to successful outcomes. Projects

were designed, developed and delivered by Aboriginal and Torres Strait Islander peoples with 92% of participants reporting improved physical, emotional, social, spiritual and cultural wellbeing as a result of participating in the healing projects.

## **6. Psychological Assessment and Treatment of Australian Indigenous People**

What is known about best psychological practice for Australia's Indigenous people has fallen behind other countries approaches to working with – and alongside – their Indigenous populations (Bennett & Babbage, 2014). There is an absence of published empirical data relevant to identifying what might be considered “good practice” in providing services. This area appears to be characterised by commentary and ad hoc approaches to funding rather than by empirical data and this affects the ways that services are provided and outcomes assessed (Zubrick, Holland, et al, 2014). There is an awareness that working with Indigenous people is different (Westerman, 2002), however articulating these differences in ways that are useful to the average clinician has been difficult as it is not possible for those outside a culture to completely understand a different culture (Vicary & Bishop, 2005). Due to the lack of services that can meet the cultural requirements of Indigenous people, treatment and assessment is mainly provided from a Western framework by non-Indigenous therapists. Whilst there are some protocols or guidelines for delivering mental health services in Indigenous communities (e.g. Haswell et al, 2009) the majority of services are provided through mainstream agencies employing western models of care and interventions. Assessment and treatment are socially and culturally mediated practices (Arzubiaga et al 2008; Drew, 2000) and using dominant cultural methods of assessment and treatment or methods developed for other populations is a form of racism that re-enacts the traumas experienced by

Indigenous people (Gillies, 2013; Koolmatrie & Williams, 2000; Waldegrave, 2003). There is a need for culturally safe assessment and treatment that does not compartmentalise the wellbeing of Indigenous people, but considers wellbeing as holistic in nature (Parker & Milroy, 2014).

## **6.1 Psychological Assessment**

Appropriately assessing individuals enables psychologists and other professionals to make effective decisions in regard to diagnosis and treatment and relies upon standardised assessment measures (Macfarlane, Blampied & Macfarlane, 2011; Newton, Day, Gillies & Fernandez, 2015). However, applying assessment measures developed within the cultural context of Western society to groups that have different worldviews or cultural backgrounds may disadvantage those groups. Over the past decade there have been improvements in our understanding of the issues of assessment with diverse cultural groups internationally (e.g. Gone, 2007), and within Australia (Garvey 2007). There has been some research on development of models of assessment for use across cultures. For example, Dana (2000) proposes a model of assessment and intervention for use with multicultural populations in the United States. O'Brien (2000) and Macfarlane, Blampied and Macfarlane (2011) outline developments in assessment processes for Maori peoples in New Zealand. In Australia, however, this process has been somewhat slower.

Macfarlane, Blampied and Macfarlane (2011) identify three dimensions of assessment – who wants to know, how is the information to be used and what information is sought – along which potential cultural significance and concern grows moving outwards along each dimension. Conceptualising assessment as a shared process between client and professional, Macfarlane and colleagues

(Macfarlane, Blampied & Macfarlane 2011) attempt to incorporate Indigenous worldviews/philosophies with scientific, clinically anchored paradigms.

Professionals need to learn more about the worldviews of the Indigenous peoples they assess so they can incorporate social and behavioural nuances specific to that culture. The process of assessment must also involve attention to individual socialisation patterns and involve socio-cultural guidance and support from cultural consultants (Macfarlane, Blampied & Macfarlane 2011; Westerman, 2011). Whilst developed for Maori, this approach to assessment could be applied to working with Australian Aboriginal and Torres Strait Islanders with minor modifications, mostly pertaining to practitioner knowledge and understanding of Australian Indigenous culture broadly and knowledge of local customs specifically.

Dana (2000) proposes a model that presumes that universal instruments (etics) may become available in the future, but are not available at present. Clarification of an individual's cultural orientation then informs a culture specific (emic) approach that may or may not – depending on the availability of an assessment tool for that cultural orientation – result in the selection and application of a specific assessment measure/process. Dana (2000) considers the stress of cross cultural interaction to informing a culture specific conceptualisation and then specific treatments. This process may be applicable in a U.S context where considerable work has occurred in terms of developing culturally appropriate interventions, but may not translate to an Australian context which is lagging behind in terms of cultural specific conceptualisations and cultural specific interventions.

Culturally fair assessment of Aboriginal and Torres Strait Islander people is difficult due to a lack of validated tools and a lack of consistency in the application

of standardised tests across clinicians (Dingwall & Cairney, 2009; Dingwall, Pinkerton & Linderman, 2013). Use of standardised assessments that are based on Western norms and values excludes culturally relevant data and can serve to further marginalise Aboriginal and Torres Strait Islander people restricting access to services (Adams, Drew & Walker, 2014; Haswell-Elkins, Sebasio, Hunter & Mar, 2007). Assessment with Aboriginal and Torres Strait Islander people is most effective when it considers context, qualitative information, explores function and is undertaken from an Aboriginal perspective (Drew, Adams & Walker, 2010; Sheldon, 1997, 2010). Participants in the interviews described by Nolan and McConnochie (2008) and McConnochie et al (2012) employed less formal strategies such as observation of behaviour and working closely with families. In Dingwall et al (2013) it was noted that informal methods of assessing cognition or adapting mainstream measures were used. Experience and clinical judgement are factors that influence selection, delivery and interpretation of assessment measures, however this disadvantages inexperienced clinicians, and, by extension, any Indigenous people they assess.

There is a lack of Indigenous specific psychometric tools and in some cases this may result in those that do exist being utilised in circumstances for which they were not designed. Dingwall et al (2013) note that the Kimberly Indigenous Cognitive Assessment (KICA) – a dementia screening tool – was applied for other purposes than for assessing dementia such as acquired brain injury in young people or substance misuse injuries. There is also a lack of validated instruments assessing SEWB which has limited the development of evidence based practise (Newton et al, 2015). Further Newton et al (2015) observe that there are number of measures, either published or under development, which lack information to guide their use.

One model for assessment with Indigenous people is the ‘Mental Health Stay Strong Care Plan’ (Nagel & Thompson, 2006). This provides a series of culturally appropriate stages of assessment and care planning for mental health issues in Indigenous communities (Drew et al, 2010). An understanding of the holistic nature of Indigenous health and mental health is incorporated into the package. The approach combines the visual with the written word (e.g. the “Grow Strong Mental Health Tree”) to explain mental health issues and also provides a framework for the exploration of such issues within a cultural context.

Screening tools such as the Here and Now Aboriginal Assessment (HANAA) and Westerman Aboriginal Symptoms Checklist – Youth (WASC-Y) have been developed to assist in assessing SEWB and mental health issues for Indigenous people. The HANAA uses a semi structured yarn to facilitate the client to tell their own story. The HANAA explores 10 SEWB and mental health domains using prompts or their local equivalent. Each of these domains is explored to determine if there are any problems in the here and now (Janca et al, 2015). At present there is little evidence regarding the utility of the HANAA, however data is being collected to review its utility (Janca et al, 2015). The application of the WASC-Y as a screening tool for mental health problems for Indigenous youth in custody was reviewed by Stathis et al (2012). The WASC-Y is a 53 item self-report measure for youth at risk for depression, suicidal behaviours, substance use, impulsivity and anxiety (Westerman, 2011). It also includes a cultural resilience subscale. Stathis et al (2012) identified that 95% of males and 100% of females in their sample (youth entering detention) scored above the clinical cut-off in at least one of the WASC-Y’s subscales. As cultural engagement has been shown to have positive effects on health issues such as substance use (Torres Stone, Whitbeck, Chen, Johnson & Olsen,

2006) there have been attempts to develop measures of cultural engagement (Berry, Crowe & Deanne, 2012; Westerman, 2011). The intent behind this is to aid the development of interventions that better meet the cultural needs of Aboriginal people within health services, including mental health. Until culturally valid assessments exist it will not be possible to effectively evaluate the outcomes of any mental health intervention, though there have been attempts to apply and adapt existing outcome measures such as the Health of the Nation Outcome Scale (HoNOS) and Life Skills Profile (LSP) for routine outcome assessments (Trauer & Nagel, 2012). These adaptations have not been fully assessed or reviewed, meaning that their utility – along with other assessment measures – remains in question.

## **6.2 Psychological Treatment**

Issues with appropriately assessing Indigenous people flow on to issues with providing effective treatments for Indigenous people. The “*Ways Forward*” report (Swan & Raphael, 1995) recommended the provision of counselling for Aboriginal mental health. The *WA Mental Health Towards 2020: Consultation Paper* (Mental Health Commission, 2010) cites as initiative 21.4 the need to “develop culturally appropriate models of care for Aboriginal people” (p.128). Nevertheless, there are few defined models of counselling for Indigenous people; or models that have involved “talking treatments” that have been shown to be effective for Aboriginal clients. There have been few effectiveness evaluations of any type of mental health intervention culturally adapted for Indigenous Australians in the literature (Catts, O’Toole, Carr et al, 2013). There is a strong need to establish an evidence base for the use of culturally informed interventions for Aboriginal and Torres Strait Islander peoples.

### 6.2.1 Structured Intervention Programs

Many commentators argue that structured interventions per se are not appropriate in Aboriginal communities, that they conflict with concepts of time, relationship and obligation, the rhythm of community life (Robinson & Tyler 2008). Most family focused interventions developed for Aboriginal people are either more or less loosely structured community programs of talk and activity, largely untheorized in terms of therapeutic rationale; or they are reactive individualised crisis interventions, such as child protection case work or sometimes mental health work (Robinson & Tyler 2008). Programs with firm professional input and culturally grounded methods and practices with a basis in theory and evidence are lacking.

Robinson and Tyler (2008) explored the adaptation and delivery of the Exploring Together Program (ETP), a multi group intervention in the Tiwi Islands that aimed at improving parenting skills of adults and the social and emotional learning of their children. Implementing the program required engaging the Tiwi communities in ways that were responsive to local context, culture and patterns of family life whilst remaining committed to the core elements of the intervention. The project engaged Tiwi community members to redevelop the content to recognise important themes in Tiwi parenting and family life. At the same time the project maintained a cognitive-behavioural approach to parenting with behaviour management plans linked to the ABC of Antecedents, Behaviour and Consequences (Robinson & Tyler 2008). The authors note that there was a degree of foreignness about the idea of behaviour management and the styles of thinking associated with this idea due to differences in parenting styles and also in terms of distinctive antecedents and consequences in the Tiwi family context. Robinson and Tyler (2008) were unable to obtain definitive evidence of the program's effectiveness, however

note that teacher assessments were suggestive of positive outcomes. Whilst demonstrating that structured interventions are possible in Aboriginal settings, the program also highlighted deficits in providing and evaluating these interventions. The program was funded by a mix of grants and originated in the health service which meant that there was limited skills transfer to the schools which also did not achieve the capacity to conduct the program independent of funding (Robinson & Tyler, 2008).

Nagel, Robinson, Trauer and Condon (2008) (see also Nagel, Robinson, Condon & Trauer, 2009; Nagel, Thompson, Spencer, Judd & Williams, 2009) combined motivational interviewing principles, problem solving therapy, and chronic disease self-management with traditional storytelling to develop a motivational care planning intervention designed to assist participants in understanding symptoms and signs of mental illness, in problem solving, and in developing a set of strategies to manage relapse and pursue lifestyle goals. Aspects of the intervention such as flexibility of location for assessment and intervention sessions, along with a collaborative approach involving Aboriginal Health Workers, clients and carers, built on more than 12 months of consultation and relationship development. The motivational interviewing intervention focused on change in the context of family and community, rather than for the individual (Nagel et al, 2008). A follow-up session 2-6 weeks later reviewed progress and developed new strategies as appropriate. Initial results showed evidence of interest and engagement in goal setting and collaborative planning. No further results are currently available in the literature.

There is evidence (see Dudgeon, Walker et al, 2014) that programs intended to strengthen Aboriginal and Torres Strait Islander people’s mental health and SEWB which are developed or implemented in ways that take into account the 9 guiding principles underpinning the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2004-2009 (SHRG 2004; see Table 1) are more likely to be effective and have positive outcomes than those that do not. These principles are intended to provide an integrated and consistent approach to mental health from an Aboriginal perspective (Zubrick, Holland, Kelly, Calma & Walker, 2014). Fan (2007) proposed a model focusing on bridging the gap between mental health services and Indigenous people. The key aspects of the model are: cultural competence, building trust and provision of practical assistance. These elements then allow for exploration and treatment and also for interagency co-operation and involvement (Fan 2007). Despite describing this as an “intervention model,” Fan does not provide information pertaining to cultural modifications to therapeutic interventions, focusing upon reducing the barriers to engaging with Indigenous clients.

**Table 1. Nine guiding principles that underpin SEWB (Gee et al. 2014, p 57)**

<b>1</b>	<b><i>Health as holistic</i></b>
<b>2</b>	<b><i>The right to self determination</i></b>
<b>3</b>	<b><i>The need for cultural understanding</i></b>
<b>4</b>	<b><i>The impact of history in trauma and loss</i></b>
<b>5</b>	<b><i>Recognition of human rights</i></b>
<b>6</b>	<b><i>The impact of racism and stigma</i></b>
<b>7</b>	<b><i>Recognition of the centrality of kinship</i></b>
<b>8</b>	<b><i>Recognition of cultural diversity</i></b>
<b>9</b>	<b><i>Recognition of Aboriginal strengths</i></b>

## 6.2.2 Individual Psychological Therapy

Australia's Better Access program identifies Cognitive Behavioural Therapy (CBT) as the preferred psychological treatment for mental health disorders.

However, there is a caveat to this: when working with Aboriginal and Torres Strait Islander peoples' narrative therapy approaches are recommended (Creed, 2014; Waldegrave, Tamese, Tuhaka, Campbell, 2003; Wingard & Lester, 2001). The potential of narrative therapy as a treatment for substance misuse among Indigenous Australians was explored by Bacon (2007). However, beyond noting that narrative therapy had potential based on anecdotal reports by Narrative practitioners no evidence – qualitative nor quantitative – was provided to support this. There is little literature on the effectiveness of narrative therapy over CBT for either the general population or for Aboriginal and Torres Strait Islander people. There are suggestions that CBT is not effective for Aboriginal and Torres Strait Islander people due to issues such as: a) its focus on the here and now neglecting the impact of generational and historical influences that are important for the individual; b) its dominant culture emphasis on individual independence, assertiveness, talking, linear cognitive style and secular world view de-emphasises contextual and cultural factors; and, c) the impact and usefulness of challenging/disputing thoughts that may be contextually appropriate given the circumstances and day to day experience of Indigenous people (Day, 2003; Hays, 2009, 2014; O'Brien et al, 2010). Thus applying CBT to Indigenous Australian clients increases the likelihood of accumulating bias and providing ill-informed interventions (Gillies, 2013). Despite this, CBT continues to have appeal as a therapy based on its perceived flexibility and direct responsiveness to client distress (Merrick & Dattilio, 2006).

In an invited contribution to the *Australian Psychologist* journal, Bennett-Levy et al (2014) asked whether CBT could be effective for Aboriginal Australians. Noting that some writers have suggested CBT has promise as a psychological therapy for Aboriginal people whilst others have suggested that it does not, Bennett-Levy et al (2014) used participatory action research methods to examine the effectiveness of CBT applied by university educated Aboriginal counsellors with their clients. Participants indicated that they found CBT enhanced their client's well-being, their own clinical skills and reduced burnout. The adaptability, pragmatism and structure of CBT were perceived to be most effective by study participants. Five adaptations that would be important in working with Indigenous Australians were identified (i.e., use a variety of presentation methods, translate CBT language in culturally appropriate ways, adapt therapy to informal spaces, develop culturally safe low intensity interventions, consider which interventions may not work or require adapting for different Aboriginal people/communities) however limited guidance was offered for making these adaptations (Creed, 2014). Four of the five adaptations suggested were around the client's individual characteristics. An important question, not reported on by Bennett-Levy et al. (2014) is: which components of CBT were not culturally consistent with Aboriginal Australian culture?

That the study had a limited number of participants and that it focussed on counsellor's perceptions of CBT rather than the experience of the clients were identified as limitations. The authors note the subjective nature of the participants' perceptions on the efficacy of CBT, admitting the possibility that the positive responses be the result of bias following a yearlong collaboration and training (Bennett-Levy et al, 2014; Creed 2014). Another issue with this research, not discussed in detail, was that the therapists were themselves Aboriginal and likely to

be considerably more aware of cultural issues, spirituality and community relationships than a non-Aboriginal therapist would be. In addition, it is likely that the therapists may have been better able to translate the formal language of CBT in culturally appropriate ways – an area that non-Indigenous therapists may require considerably more support or training. This may have been a confounding variable in the study and one that was not identified.

In their commentary, Dudgeon and Kelly (2014) challenge the use of the term participatory action research given that the voices of the clients are silent in the study. They suggest that this and the lack of detail regarding counselling settings or the nature of the client groups represents a missed opportunity and that Bennett-Levy et al merely provide anecdotal evidence to support their claims that the study is a “significant” move towards evidence based practice. The different roles of the Indigenous and non-Indigenous co-researchers, with the Indigenous researchers receiving training, delivering interventions and reporting back to the non-Indigenous researcher appears at odds with the notion of participatory research and could be considered evidence of continued colonisation and appropriation of Indigenous knowledge (Dudgeon & Kelly 2014). Dudgeon and Kelly note that there was no mention of attempts to adapt CBT during the training to suit application with Aboriginal or Torres Strait Islander peoples. Nelson et al. (2014) note that they could not offer CBT in an adapted form as it was unknown what sort of adaptations would be beneficial. This does pose a catch-22 conundrum in which the recommendation is for culturally adapted forms of intervention to be provided whilst those providing the intervention are unclear how to adapt the intervention effectively.

Nelson et al (2014) state that their experience suggests that CBT is successful precisely because it embodies a number of psychological principles that may have general applicability in human beings. For example, goal setting, problem solving, identifying negative thoughts and images, linking thoughts with emotions, testing out thoughts in everyday life to see if they hold true (behavioural experiments), transforming negative images, and creating positive images are strategies that appear to be helpful across cultures and quite possibly have universal value (Nelson et al, 2014). Competently delivered face to face CBT encompasses key therapeutic elements of empathy, goal setting, collaborative relationships, positive regard, genuineness, and getting client feedback, which, as well as being empirically supported relational elements in their own right (Norcross & Lambert, 2011; Norcross & Wampold, 2011) are among the most important factors in determining outcomes in cross cultural therapies. Nelson et al conclude that CBT can be effective for Aboriginal and Torres Strait Islander peoples and recommend more formal efficacy studies.

## **7. Rationale and Aims**

### **7.1 Rationale**

Few effectiveness evaluations of any type of mental health interventions culturally adapted for Indigenous populations have been published in the scientific literature (Catts, O'Toole, Carr et al, 2013). Contributing to this are the differences in Indigenous conceptualisations of mental health (Vicary, 2002), Indigenous people's experience of research as another form of colonisation (Gone, 2004; Smith 1999), the complexity of obtaining ethical and community approval for research and the promotion of low quality qualitative studies as the most culturally appropriate research methodology instead of more scientifically rigorous approaches (Catts,

O'Toole, Carr et al 2013). It was only during the 1990s that papers began to be published on therapeutic approaches to work with Indigenous Australians (Fan, 2007). However, the number of these was not large – a content analysis determining the research status on mental health within the general Australian population found that Indigenous mental health issues accounted for only 1.1% of the total articles reviewed (Jorm, Griffiths, Christensen & Medway, 2002; Ypinazar, Margolis, Haswell-Elkins & Tsey, 2007). The publication of such works as *Working with Indigenous Australians: A Handbook for Psychologists* (Dudgeon, Garvey & Pickett, 2000b) and *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Purdie, Dudgeon & Walker, 2010; Dudgeon, Milroy & Walker, 2014) has been a significant contribution to exploring culturally appropriate ways of working and therapy, however the policies and practices of many service organisations working with Aboriginal and Torres Strait Islander people do not yet fully reflect or embrace culturally appropriate ways of working (Westerman, 2004, 2011).

Notwithstanding the requirement of many University based programs for courses on cultural issues, most practitioners working with Aboriginal clients still develop their skills by experience and from the anecdotal evidence of peers and colleagues (McConnochie et al., 2012; Vicary & Bishop, 2005). This means that while some practitioners have begun to present their work in journals and conference papers, access to systematic research in these domains is limited (Drew et al, 2010). A review of recommendations when working with Aboriginal and Torres Strait Islander people (e.g. Fan, 2007; McConnochie et al., 2012) shows a tendency to emphasise non-specific factors. However, a number of specific interventions are known to be effective and important components of Western Psychology. How – if

at all – can these approaches be modified for Indigenous Australians? Bennett-Levy et al. (2014) explored how one specific intervention (CBT) could be employed with Indigenous clients, however their research focused on Indigenous therapists – not non-Indigenous therapists - delivering low-intensity CBT to Indigenous clients. As Dudgeon and Kelly (2014) noted, there was no mention of the client's experience of therapy. Additionally, McConnochie et al (2012) explored non-Indigenous therapist's experience of working in Indigenous contexts however detail regarding modifications to specific therapies were not identified.

The intent behind this research was to identify specific modifications to psychological therapies delivered to Indigenous people by non-Indigenous therapists by discussing experiences of delivering and participating in therapy with both non-Indigenous therapists and Indigenous clients. Knowledge of specific modifications would provide a foundation for more successful interventions and allow therapists to grow in confidence and experience. It was hoped that the research would lead to increased knowledge of how to apply psychological techniques for intervention with Aboriginal clients in non-Indigenous mental health professionals. Such information would help to reduce the anxiety felt by many non-Indigenous psychologists about working with Aboriginal people, increase their involvement with this group, reduce the likelihood of therapist burnout and improve mental health outcomes for Aboriginal clients through the use of culturally appropriate treatment (Mahood, 2012; Vicary, 2002). Without such information the risk is that psychological treatments will continue to fail to meet the needs of this population and the effects of colonisation and dispossession will be perpetuated rather than addressed. Through an understanding of how to apply psychological techniques to Indigenous grief, loss and trauma we can act to reduce the high rates of mental illness, suicide and so on

within the Indigenous community. The Australian Psychological Society (2007) may recognise the impact of colonisation upon the Indigenous peoples of Australia, but the need remains to actually do something about it.

## **7.2 Aims of the study**

Initially the objectives of this study were:

1. Investigate and describe culturally appropriate mental health interventions inherent in Aboriginal communities in terms of traditional healing.
2. Investigate and describe culturally appropriate mental health interventions inherent in Aboriginal communities in terms of Western healing.
3. Investigate and describe the techniques/theoretical approaches used in treatment by non-Indigenous practitioners of rural and urban Aboriginals, specifically focusing on PTSD, grief and loss and depression, given their impact on Indigenous mental health as described above.
4. Explore and describe a culturally appropriate intervention approach suggested by the Aboriginal people (from the target populations) for non-Indigenous mental health practitioners.

Through discussion with the Steering Committee, these were simplified to:

1. How do non-Aboriginal therapists adapt treatments for Aboriginal clients?
2. What do Aboriginal people think of Western psychological therapy?
3. What do Aboriginal people think is important when being treated?
4. What would a culturally appropriate psychological therapy look like?

## Chapter 3 - Methodology

### AIM

This chapter reviews the overall design considerations involved when conducting research with Indigenous people. The formative preparation and initial consultation to ensure the cultural relevance and appropriateness of the study along with ethical and procedural concerns are outlined. The formation of the Aboriginal Steering Committee and the research process are also discussed. Each phase of the research is reviewed including characteristics of study participants, data analysis and the processes employed to ensure quality of research findings.

### 1. Introduction

Dudgeon, Kelly and Walker (2010) note that, historically, research on Indigenous groups by non-Indigenous researchers has benefitted the careers of the researchers with little benefit, and more often harm, to the Indigenous peoples researched. Indeed, Smith (1999) emphasises the cynical attitudes held by most Indigenous peoples in regard to research when noting that ‘research’ is inextricably linked to colonisation. Research within Indigenous settings often uses models and methods that have been developed by and for members of the dominant culture and which extinguish culturally relevant data continuing the dynamic of colonisation (Gillies, 2013). Western knowledge and ways of building knowledge are privileged and positioned as superior.

With respect to Australia, what is known about Aboriginal and Torres Strait Islander people, their culture and histories, is generally known from a Western perspective and serves a non-Indigenous research agenda (Fielder, Roberts &

Abdullah, 2000). Indigenous knowledge has not been validated or recognised as being unique, and, over time, even when recognised as unique there have attempts by non-Indigenous researchers to take control of this knowledge (Smith, 1999). Thus it is important that this research occur in a manner that is ethical, culturally sensitive and culturally appropriate.

The National Health and Medical Research Council (NHMRC) issued *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Research* in 1991 which have since been reviewed and updated (NHMRC, 2003). These guidelines informed the Australian Psychological Society's (APS) *Guidelines for the Provision of Psychological Services for and the Conduct of Psychological Research with Aboriginal People of Australia* (1997; since updated see: APS, 2015). Adding to the NHMRC guidelines is the NHMRC document *Keeping Research on Track: A guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics* (2005). These documents directed and informed the research process and methodology.

In terms of research the APS recommends that researchers follow the NHMRC guidelines and be aware of, and follow, the human research ethics policies of the APS, their institution and/or funding source/agency/participant bodies and seek advice from researchers or Indigenous representative organisations. In addition, the APS encourages researchers to be aware of, and show respect for, the value systems and authority structures operating in the Indigenous communities for whom they provide services as well as possessing an awareness of the socio-political issues (i.e. racism, colonisation, dispossession, poverty) that might adversely affect the wellbeing of Indigenous clients and the effectiveness of the services provided.

Jamieson et al (2012) summarise principles of best practice regarding research among Indigenous Australian populations. They note that implementing any research methodology among Indigenous Australian groups will work best when these principles are met. Among these principles are conducting research within a mutually respectful partnership framework, and maintaining flexibility in implementation while maintaining rigour and supporting community ownership (Jamieson et al, 2012).

The intent behind all these guidelines is to ensure that research is conducted from an Indigenous, rather than Western, perspective as this will provide information that is valid, relevant and respectful of the Indigenous world view (Fielder et al, 2000). Research from an Indigenous perspective requires a sincere cultural exchange between individuals and groups. As noted by Fielder et al. (2000, p353):

The practical challenge for non-Indigenous researchers is clear: to develop equitable, and constructive research practices that shift away from the patterns in the past. This will involve negotiation, understanding, perseverance, and collaboration. Researchers will have to deal with historical relationships that have bred a combination of distrust, anger, cynicism, fear and disengagement – dealing with this legacy involves an intellectual problem for both the researcher and the participant of the study.

## **2. Overall Design Considerations**

Bishop, Vicary, Andrews and Pearson (2006) and others (Dudgeon et al, 2010; Fielder et al., 2000; Jamieson et al, 2012; Tchacos & Vallance, 2004) have made suggestions that incorporate the NHMRC and APS guidelines, Indigenous

lived experience and context, and place Indigenous people in a significant and active role within the research rather than simply as subjects to whom research is 'done.'

Fielder et al. (2000) argue that the following procedures can be applied across a range of research methods and strategies:

- a) Form an Indigenous Steering Committee (or reference group) to guide the formulation and direction of research projects wherever possible;
- b) Identify key Indigenous stakeholders for the research topic and include them throughout the research process;
- c) Wherever possible, inform sponsors of the research of the need for, and value in, consultations with relevant Indigenous groups – ideally from the outset, so that the worthiness and value of the project is confirmed and owned by Indigenous people; and
- d) Ensure that Indigenous participants are acknowledged and valued for their input and cultural expertise – it may be appropriate and equitable to make payments for specialised Indigenous services (p.354).

In working with the Aboriginal community with the aim of undertaking a constructive research relationship, there are challenging issues to navigate (Fielder et al, 2000). The navigation of such issues requires time, patience, and good communication skills. Fielder et al (2000, p.355) identify eight issues including:

- a) Selecting who to speak to in the community – by identifying who the key players are in relation to the research topic;
- b) Working at good attendance and participation of research participants in meetings

- c) Building a trusting and positive relationship;
- d) Meeting deadlines whilst also allowing time and space for establishing good relationships and feedback at every stage of the research process;
- e) Dealing with cultural differences;
- f) Discovering that the messiness of community politics in the Indigenous domain is as real as the messiness of institutional politics in the Western domain;
- g) Acknowledging one's own ethnocentric tendencies; and
- h) Being aware of ownership of outcomes and the foregrounding of Indigenous voices in the research.

In line with the above guidelines (for conducting research with Indigenous people) this research project consisted of several stages including formative preparation/consultation, the establishment of a Steering Committee, the development of a culturally sensitive data collection methodology, several data collection phases and the use of cultural consultants. It is important to note that these stages fed back into each other over the course of the research project. For example, the Steering committee provided input in regards to the questions used, the interview process, the data fed back to participants and so on.

### **3. Preparation and Initial Consultation**

As part of my preparation for this research, I consulted with Aboriginal people in the South West region of Western Australia. Whilst working as a Clinical Psychologist for the South West Aboriginal Medical Service (SWAMS) I spoke with Aboriginal Health Workers and members of the Aboriginal Community with first-hand experience of the mental health system. A number of people indicated that

trauma, grief and depression were significant issues facing the community. It was observed that services delivered by non-Aboriginal therapists were not able to engage or treat Aboriginal clients as effectively as desired due to culturally inappropriate techniques and logistical issues. It was suggested that developing a process to assist Non-Indigenous workers would help the broader Aboriginal community. They felt that culturally appropriate intervention strategies would result in improved mental health services to Indigenous people.

This experience was further reinforced when I obtained employment as a Clinical Psychologist in the State Public Health system. Few Aboriginal clients were admitted to the service, those that were admitted were usually in situations of extreme crisis and there were difficulties observed in engaging them in treatment. This, along with discussions with my supervisor for Specialist registration, resulted in an initial proposal to undertake the research.

I met with members of the SWAMS board in December 2011 to discuss this research. I discussed the potential health benefits of the research with them. Board Members were initially sceptical and articulated the sort of concerns raised by Smith (1999) and Fielder et al (2000) among others. At that time Board Members asked about my willingness to modify this research according to community values and aspirations. I indicated that the research methodology was sensitive to the values and aspirations of the community and would be shaped by them. I noted that I was willing to modify this research if required by the community. For example, I noted that the processes involved in the establishment of a steering committee, the development of a culturally sensitive data collection methodology, cultural

validation focus groups, and use of cultural consultants would all shape input in a way that responded to the aspirations of the community.

The initial consultation stage also involved discussing the research with Elders and significant members of the community. I met with Aboriginal Health workers working in the Hospital sector, in non-Government agencies (e.g. Drug and Alcohol, Suicide Prevention) and also attended a meeting with an Elders group to discuss the research.

#### **4. Ethical Considerations**

This research needed to comply with Curtin University's Human Research Ethics Committee guidelines which incorporate the NHRMC (2003) values and principles relating to research with Aboriginal and Torres Strait Islander people. This is based on the six core values of reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity (NHRMC, 2003).

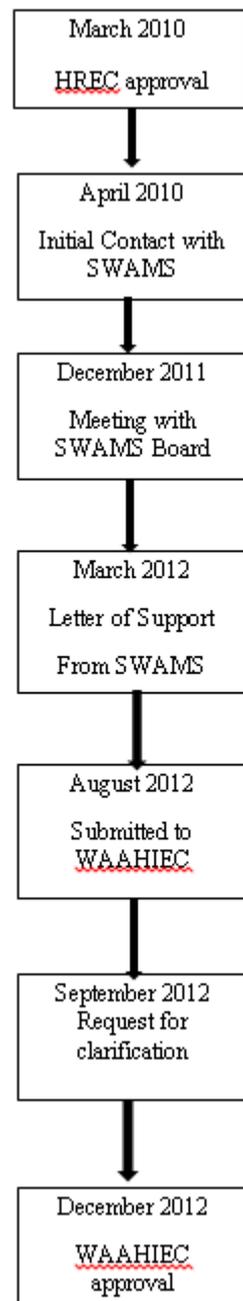
It has been emphasised that, where possible, Indigenous people should be part of the research planning, that the research benefit the community, that Indigenous knowledge systems and processes be respected, that Indigenous researchers and community members should be an active part of the research and that informed understanding and consent is a necessary characteristic throughout the research process (Dudgeon, Kelly & Walker, 2010). The processes involved in obtaining ethical approval for the research reinforced this requirement.

Ethics approval was obtained from the University's Human Research Ethics Committee in March 2010. As the research involved Indigenous people, the research proposal also was required to be submitted to the Western Australian Aboriginal

Health Information and Ethics Committee (WAAHIEC) for approval. WAAHIEC required demonstration that relevant Aboriginal groups had been consulted prior to the proposal and that processes are in place to communicate, disseminate and translate research with community involvement along with a requirement to go through the Aboriginal Community Controlled Health Service (in this case, SWAMS). This requirement posed a problem during the initial stages (i.e. March 2010 through to December 2011) of the research project as community politics - one of the eight issues identified by Fielder et al (2000) – had left SWAMS without a Board of Directors. Without the consent and support of the SWAMS Board, approval for the research could not be given. I was encouraged to remain in contact with SWAMS and to try again in a year or two. Figure 2 illustrates the timeline of the process involved in obtaining ethics approval.

I maintained contact with the Social and Emotional Wellbeing unit of SWAMS and, after two years, was informed that SWAMS now had a Board of Directors and was able to meet with me to discuss the research. I met with the SWAMS Board in December 2011 to discuss the research. I was able to obtain the support of the SEWB unit, SWAMS Chief Executive Officer when presenting to the Board and ultimately obtained permission to undertake the research. This was then forwarded to WAAHIEC and ethical approval granted. However, this delay significantly affected the research timeline, reducing the length of time available to form a Steering Committee and undertake the research.

**Figure 2. Timeline of processes involved in gaining ethics approval**



## **5. Development of the Steering Committee**

Once ethical approval had been obtained the next step was to form a Steering Committee. The purpose of the Steering Committee was to provide guidance and evaluate all aspects of the study from Aboriginal terms of reference. The Committee provides many functions during the research including providing information to

participants and prospective participants about the study and the interpretations drawn. The Committee also guides and advises the researcher about cultural aspects of research content, process and methodology (Bishop et al, 2006; Vicary, 2002). One significant function served by the Steering Committee is assistance with the entry into the research setting (i.e. the Indigenous community). This is important due to the relationship that the initial entry has with the validity of the data that is collected and the development of trust in the researcher and the research itself (Patton 2002).

Ideally, the Steering committee arises out of the consultative process. Some Committee members may be individuals who expressed willingness to help in the formative consultative phase of the research, with others being identified as possible Committee members during the same process (Bishop et al, 2006). In the case of this research difficulty obtaining support from SWAMS and, by extension, ethics clearance from WAAHEIC reduced the length of time available for the research. This reduced time frame, as well as competing demands upon many key people in the community, affected the development and formation of the Steering Committee.

Fortunately, a State-wide Specialist Aboriginal Mental Health Service (SSAMHS) was funded by the State Government in 2011 and co-located within the Bunbury Community Adult Mental Health Service. This consisted of four Aboriginal Mental Health workers from the Bunbury/Busselton region. I discussed my research with them and asked if they would be willing to act as a Steering Committee during the research. They agreed. Bishop et al (2006) suggest that Steering Committee members be representative in terms of age, gender and geographic location. The two male members of the Steering Committee were Bunbury residents whilst the initial

two female members of the Committee were from Busselton, a smaller town some 45 minutes south of Bunbury. Two members (one female and one male) of the initial Steering Committee were aged 20-35, whilst the other two members were over 50 years of age. In addition, Steering Committee members also had involvement in, or links to, other Indigenous Community agencies (e.g. one member of the Steering Committee was also a board member for the local Aboriginal Medical Service).

The constitution of the Steering Committee changed over time due to one Committee member leaving to focus on caring for their family and another becoming ill, with a third not having their contract renewed. When new staff members were recruited to fill these positions and were asked on, or shortly after, commencement if they wanted to be part of the Committee. All agreed.

As part of the process of establishing the Committee, roles and expectations were clarified. The Steering Committee requested the power to veto any part of the project identified as culturally inappropriate and discuss the development of more culturally sensitive alternatives.

The Steering Committee was informed of the nature of the research and the expectation – in line with Bishop et al's (2006) guidelines – that qualitative research methods would be used. The Committee agreed with this, noting that quantitative methods were inappropriate and could adversely affect the development of a relationship with participants and the community as a whole. It was noted that, as the research was focusing on individuals' experiences of therapy, qualitative methods would be more effective in allowing people to tell their story.

The initial research questions (see p.65) were discussed with the Steering Committee. The Committee members expressed concern regarding the phrasing of the research questions, noting that the research questions were formal in tone and used terms that could best be described as “professional jargon.” They noted that discussing the questions with community members in their proposed format may pose a barrier to engagement due to this. Committee members suggested that the language and tone of the questions be simplified in order to make discussing the research more straightforward and more likely to create engagement with the topic.

The Steering Committee made another important contribution to the direction of the research very early. In the initial research proposal, interviews with Aboriginal people with experiences of therapy with Non-Aboriginal (NA) therapists were to occur first, with this information being discussed with Non-Aboriginal therapists and then contrasted with their experience. Steering Committee members indicated that this has the potential to be another example of more “taking” from the community with nothing coming back. It was recommended that the researcher speak with Non-Aboriginal therapists initially and then bring the results of those discussions back into discussions with the community.

The Steering Committee also recommended that a group focus, rather than an individual focus, form a significant part of the research. It was identified that yarning as part of a group was less threatening than a one-to-one interview. The Steering Committee recommended that Indigenous participants be recompensed for their time and involvement. It was suggested that gift cards and lunch be provided to participants. Attendees at the initial focus groups received gift cards, and in the case

of the Women's group, lunch, with participants of the community forum provided with lunch and entered into a lottery to receive one of the remaining gift cards.

Members of the Steering Committee facilitated meetings with key individuals to further discuss the research. They also assisted in "vouching" for the research and researcher. "Vouching" meant that members of the Steering Committee would convey positive information about the research and the non-Indigenous researcher to potential informants (Bishop et al, 2006; Gillies, 2013). Members of the Steering Committee also assisted at the community forum as described below.

## **6. Research Methodology**

Given the nature of the research, and in line with recommendations by Vicary (2002), and Bishop et al (2006), qualitative research methods were identified as most appropriate for this research. Qualitative research methodologies allow the researcher a certain amount of flexibility in carrying out the research. Qualitative methods allow participants and their communities an ongoing role, are flexible, provide a theoretical framework and can identify theories to be tested (Patton, 2002; Vicary, 2002). Qualitative research methods hold promise for discovery of more culturally relevant interventions as this methodology allows for the discovery of culturally based ways of conceptualising and developing paradigms that are grounded in the collective experiences of those participating (Strickland, 1999).

Two qualitative methods (field observation and interviewing) were used to facilitate access to the information required in this study. These techniques are consistent with the strategies of thematic analysis and the multi-method approach aids in triangulation to ensure validity and reliability (Annells, 2006; Burck, 2005; Patton 2002). In addition, the cultural validation/focus groups also formed part of the

quality assurance process, allowing additional input and recommendations to be made in regard to study findings and processes.

In terms of field observation, observations were made about the way that Aboriginal people “yarn” with each other, the responses given by those consulted about the research during its formative stages, the reactions of the Aboriginal communities and individuals approached about the research and the research closure process. Observations were made during interviews, adding process notes to the audio-taped interview content in order to add further detail to the data analysis. These observations were written in a diary with a record of the time, date and context of the observation. Observations were made of the non-Indigenous therapists during interviews, however no direct observation of their therapeutic practice took place.

There are many advantages to using field observation in this study. First, through direct observations the inquirer is better able to understand and capture the context within which people interact and this is essential to a holistic perspective (Patton 2002). Second, firsthand experience allows an inquirer to be open, discovery oriented and inductive because, by being on-site, there is less need to rely on prior conceptualisations of the setting. Third, the inquirer has the opportunity to see things that routinely escape awareness among the people in the setting (Patton 2002). Fourth, observation provides a chance to learn things that people would be unwilling to talk about in an interview. Fifth, it provides the opportunity to move beyond the selective perceptions of others. Observers can arrive at a more comprehensive view of the setting being studied than if forced to rely entirely on second-hand reports through interviews. Finally, getting close to the people in a setting through firsthand experience permits the inquirer to draw on personal knowledge during the formal

interpretation stage of analysis. Observations become part of the data to be used in attempting to understand a setting and the people who inhabit it (Patton 2002).

However, given that those things we cannot directly observe are not accessible through observation (Patton 2002) the qualitative technique of open-ended interviewing was also used as a method of gathering data. As Strickland (1999) notes open-ended interviewing aims to gain a full understanding of how the topic under discussion is perceived and understood and helps access those values and beliefs held by the person being interviewed. Bessarab and Ng'andu (2010) note that this forms a conversation in which information is conveyed and received and then processed, leading to different understandings of the subject at hand.

Aboriginal people have rules, language and protocols for conducting conversations. The term 'yarning' is frequently used to describe this process (Bessarab & Ng'andu, 2010). Yarning has been described as a "process of making meaning, communicating and passing on history and knowledge" (Terzack, quoted in Bessarab & Ng'andu, 2010, p. 38). Bessarab and Ng'andu (2010) further distinguish forms of yarning – social, research topic, collaborative and therapeutic. In this research the social yarn and the research topic yarn were of significant interest.

The social yarn is integral to the set-up of the research interview. Boundaries and protocols of engagement are negotiated through the sharing of personal information, with the Aboriginal participants listening and observing the verbal exchange with the researcher (Bessarab & Ng'andu, 2010). It determines what each brings to the research yarn and holds the researcher accountable to the process. This is important given concerns regarding the colonisation of Indigenous peoples

through the use of Western research methods (Carpenter & McMurchy-Pilkington, 2008; Smith, 1999).

The research topic yarn takes place in either an un- or semi- structured interview. The purpose is to gather information through participants' stories which are related to the research topic (Bessarab & Ngandu, 2010). It is relaxed and interactive, whilst also purposeful with a defined beginning and end. Thus, research topic yarning is a conversation with a purpose (Bessarab & Ngandu, 2010).

To ensure that the approach fitted with a research topic yarn, a semi structured interview was used. This offered the interviewer flexibility in probing and in determining when it was appropriate to explore certain subjects in greater depth, or even to pose questions about new areas of enquiry that were not originally anticipated in the interview instrument's development (Patton 2002). The questions used in the study were developed through discussion with the Steering Committee and community members (see Appendices C and F). These interviews were recorded and transcribed.

Initially, it was envisaged that individual interviews with Aboriginal people that had attended therapy with non-Aboriginal therapists would occur. Time constraints and discussions with the Steering committee and members of the community lead to a focus group approach being used instead. Focus groups are a form of group interview that typically emphasize a specific theme or topic in depth (Bryman, 2004; Pozzar, Stamp & Allen, 2013; Redmond & Curtis, 2009; Willis, Green, Daly, Williamson & Bandyopadhyay, 2009). They are group discussions exploring a specific set of issues considered 'focused' as they involve some form of collective activity (Webb & Kevern, 2001). Used extensively with Western

populations, focus groups have also proved useful in accessing and engaging ethnic minority groups in community based participatory research in order to find out about elements of health service delivery such as service use, health beliefs, preferences and experiences (Barbour, 2005; Barnack-Tavlaris, Garcini, Sanchez, Hernandez & Navarro, 2013; Daley et al., 2010; Drury, Chiang, Esterhuizen, Freshwater & Taylor, 2014; Jakobsen, 2012; McParland & Flowers, 2012; Shaw, Brown, Khan, Mau & Dillard, 2013).

The success of focus groups with culturally diverse groups is dependent upon the cultural competence of the researcher and the research questions (Halcomb, Gholizadeh, DiGiacomo, Phillips & Davidson, 2007). Visandjee, Abdool and Dupere (2002) explored the impact of culture in conducting focus groups in rural India. They note that awareness of communication patterns, relationships, roles and traditions as well as knowledge of a range of factors (including political and socio-economic) are all essential in ensuring culturally competent focus groups. Drury et al. (2014) note that cultural values may affect group dynamics, communication styles and time. In addition, rapport and trust must be developed in a culturally acceptable way to facilitate open communication. In the case of this research, social yarning and research topic yarning created a collaborative yarn during which ideas around the research topic were discussed (Bessarab & Ng'andu, 2010).

The research process had 3 phases. These were:

- 1) Interviews with Non-Aboriginal therapists;
- 2) Focus Groups (Men's Group and Women's Group); and
- 3) Community Forum (Focus Group).

Each will be described in detail below.

### **7. Phase 1: Interviews with Non-Aboriginal Therapists**

The Steering Committee decided that the first phase of research would involve interviews with Non-Aboriginal psychologists/counsellors/mental health professionals who work with Aboriginal people, families and communities to obtain an understanding of their knowledge base prior to data collection with Aboriginal participants/communities. It was intended that this would provide information for discussion with Indigenous communities.

Through consultation with the Steering Committee an interview schedule was developed. This took the form of a semi-structured interview. The advantage of using a semi-structured interview is that it enhances the development of rapport and allows the researcher to probe and follow interesting areas and issues without influencing a participant's beliefs or value system (Patton, 2002; Vicary, 2002).

As this phase was intended to inform subsequent phases of the research purposive sampling was employed. Purposeful sampling provides a limited number of cases for examination; but it also involves studying rich cases in depth and detail to understand and illuminate important concepts rather than generalising from a sample to a population (Patton 2002). Participants were 9 non-Aboriginal therapists in the Bunbury/Perth Metropolitan area selected on the basis of work history with Aboriginal clients (i.e. each was working in a setting which had a significant, or exclusive, proportion of Aboriginal clients). Each therapist was approached by the researcher via email or telephone, informed of the nature of the research and invited to participate. All agreed. Two of the therapists were men and seven women. Their ages ranged from 30 to 61 years. In terms of professional background two were

Social Workers, six were Clinical Psychologists and one a registered Psychologist. All had obtained their qualifications in Australia. Their work background and experience comprised of work in the forensic, child protection and welfare, specialist mental health and Social and Emotional Wellbeing units of Aboriginal Medical Services. Participants had between 18 months to over twenty years of working with Aboriginal clients. The percentage of Aboriginal clients on their caseload varied from the lowest at 20% of clients to 100% of clients.

Each participant was approached for their consent to participate in the study. Each participant was advised that their participation was voluntary; and were also informed about the nature and goals of the study. Participants were informed that they could withdraw from the study at any time and retract any information provided. Participants were assured of complete confidentiality with all collected data being securely stored by the researcher for the duration of the study and then for an additional period in line with University policy (see Appendices B and E).

Each interview lasted between 60 and 90 minutes and was transcribed verbatim. The transcriptions were given to study participants for their comment and to provide an opportunity to clarify their responses and voice concerns. No participant recommended any changes to their transcription. The recording of one interview was accidentally deleted and this had to be rescheduled and repeated.

## **8. Phase 2: Focus Groups**

The information obtained from the interviews with non-Aboriginal therapists was discussed with the Steering Committee and it was suggested to discuss it further with Indigenous groups within the community.

Steering Committee members had connections to a local Indigenous agency that held separate Men's and Women's groups within the community. These groups were linked to the local Aboriginal Medical Services (AMS) and functioned as support groups for community members. The groups also served as a way that agencies could provide information and education to the community on health issues, new services and programme changes. The researcher was encouraged to contact the facilitators/convenor of these groups and meet with them to discuss the results and the implications of these in terms of the research.

The researcher met with each group for two hours and discussed the research. There were 12 men at the Men's group and 6 women at the Women's group. The age of participants at the Men's group were between 30 to 60 years. The ages of the women at the Women's group were between 20 and 50 years. All participants indicated that they had attended therapy in the past or had been involved in the care of a family member that had attended therapy.

Each Aboriginal and non-Aboriginal participant was approached for their consent to participate in the study. Each participant was advised that their participation was voluntary; they were informed about the nature and goals of the study. They were informed that they could withdraw from the study at any time and retract any information provided. Participants were assured of complete confidentiality with all collected data being securely stored by the researcher for the duration of the study and then for an additional period in line with University policy (See appendices D and E). These discussions were recorded and transcribed verbatim.

At each group, the researcher introduced the research and outlined the findings from the interviews with non-Aboriginal therapists. Participants were then encouraged to offer their opinions and feedback on the findings and to offer further comment on therapeutic aspects that they considered important. Participants engaged with the topic and were willing to provide input and suggestions on the findings as well as ideas to improve therapy or overcome obstacles. In the men's group younger participants deferred to older men, often agreeing or adding small comments to the comments of the older men. The men's group began with one participant, an Elder, "growling" (Westerman, 2011) at me. I had been informed prior to attending that this was likely and advised of the best way to manage this. Once I had been "growled" the Elder sat back and the group participated in an animated conversation relating to the topic. I was not "growled" at during the women's group and there was no issue identified with a male non-Indigenous researcher meeting with a group of Aboriginal women. Participants of both groups were provided with gift cards and, in the case of the Women's group, lunch.

### **9. Phase 3: Community Forum**

A consistent response from focus groups, discussion with Steering Committee members and from discussions with other individuals within the community was that the issues within the research may be best discussed at a whole of community forum.

Participants of the Men's group identified a suitable venue, noting it had connections to the local Aboriginal community. It was recommended that an afternoon forum with lunch provided take place. A flyer advertising the forum was designed and discussed with the Steering Committee. A member of the Steering

Committee disseminated the flyer more broadly to his networks and obtained additional feedback. Feedback on the flyer suggested that, whilst the day and time of the forum were appropriate, the flyer could be more colourful and eye catching. The flyer was revised and recirculated. Further feedback was positive and numerous flyers were printed to be handed out within the community and emailed to key individuals. Additionally, further meetings with key stakeholders took place advising of the forum and requesting their assistance in promoting it. Assistance with locating a catering service within the community occurred as part of these meetings.

The Community Forum was attended by 12 participants; 5 female, 7 male (one of whom was non-Aboriginal). The participants' ages ranged from 25 to 65 years. The non-Aboriginal participant was attending as part of their role in a local Aboriginal community led agency. The Forum commenced with lunch and social yarning (Bessarab & Ng'andu, 2010). Social yarning serves as an entry point in developing a connection and building a relationship. This form of yarning lays the groundwork for exploration of the research to occur (Bessarab & Ng'andu, 2010).

The researcher introduced the research and outlined the findings from the interviews with non-Aboriginal therapists and the previous focus groups. Participants were then encouraged to offer their opinions and feedback on the findings and to offer further comment on therapeutic aspects that they considered important.

Each participant was advised that their participation was voluntary; they were informed about the nature and goals of the study. They were informed that they could withdraw from the study at any time and retract any information provided. Participants were assured of complete confidentiality with all collected data being

securely stored by the researcher for the duration of the study and then for an additional period in line with University policy (See appendices D and E).

Participants were provided with gift cards. The community forum was recorded and transcribed verbatim.

## **10. Data Analysis**

As the purpose of this research was to produce conceptually informed interpretations of data rather than generate a theory or model of social processes, thematic analysis (TA) was chosen as the method of data analysis. Thematic analysis is a method for identifying and analysing patterns in qualitative data (Boyatzis, 1998; Clarke & Braun, 2013; Guest, McQueen & Namey, 2012; Joffe, 2012). It differs from other analytical methods that seek to describe patterns across qualitative data in that it is not wedded to any pre-existing theoretical framework and therefore can be used within different theoretical frameworks (Braun & Clarke, 2006). TA shares many of the principles and procedures of content analysis (CA) which involves establishing categories and then counting the number of times they are used in a text or image (Joffe, 2012). TA goes beyond observable data to tacit preferences to concepts shared in groups. TA enables the researcher to analyse frequency of codes along with their tacit meanings (Joffe, 2012).

A theme refers to a specific pattern of meaning or ideas found within the data (Guest, McQueen & Namey, 2012; Joffe, 2012). It may contain manifest content (i.e. something directly observable) or more latent content (i.e. implicit references within the data set). The end result of a TA should highlight the most salient constellations of meanings present in the data set (Braun & Clarke, 2006; Joffe, 2012). The primary goal of TA is to describe and understand how people feel, think, and behave within a

particular context relative to a specific research question (Guest, McQueen & Namey, 2012). In this research themes emerged through the process of coding and were then reviewed and discussed with Steering Committee members. In this manner, salient constellations of meaning were drawn from the data.

Clarke and Braun (2013; see also Braun & Clarke, 2006) identify six stages of TA. They note that TA is a recursive process, not a linear one. The stages are:

1. Familiarisation with the data
2. Coding
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Writing up

Data was analysed manually, with the researcher reading and re-reading transcripts of interviews and focus groups. Initially the interviews were read without intent to code and then on subsequent readings key phrases or aspects of each interview were identified. Commonalities among phrases lead to the grouping of these, from which overarching themes emerged. These themes were reviewed and sub-themes drawn from them. The process of reviewing the data and identifying themes was discussed with members of the Steering Committee and with thesis supervisors. Themes were organised in order of frequency.

Data analysis was an ongoing process which included data collection and feedback of results. Feedback of results to the respondents was a vital piece of research methodology as it allowed the individuals and communities taking part in

the study to see the community's input and study findings. Feedback has been identified (Bishop et al 2006; NHRMC, 2003, 2005; Tchacos & Vallance, 2004) as important when conducting research in Indigenous communities.

## **11. Quality**

Qualitative methods of research are designed for managing, describing and analysing complex non numerical and unstructured data. According to Henwood and Pidgeon (1992) qualitative methods typically generate a rich, deep and well integrated conceptual system organised at a variety of levels of theoretical abstraction all of which articulate the data in some way. Qualitative methods draw on language to provide in-depth contextualised accounts of personal experience and processes through which meanings are constructed (Povee & Roberts, 2014). Qualitative research can also be used to generate and elaborate theory within psychology (Kidd, 2002).

While qualitative methodology has a number of advantages there is a perception that such research is not as rigorous, reliable and valid as quantitative research (Povee & Roberts, 2014). Cooper, Chenail and Fleming (2012) believe that this tendency to judge qualitative research by the standards of quantitative research is a function of the influence of traditional scientific models of research. Indeed, some authors (e.g. Patton, 2002) believe that qualitative research should still be conducted with the rigour of quantitative research and address issues of reliability and validity. It is worth noting that others (e.g. Spencer & Ritchie, 2012) argue that the terms reliability and validity emerged out of a quantitative tradition and have no value in qualitative inquiry, and that the nature of qualitative research makes it impossible to assess quality in the sense of applying a set of formalised criteria. Other terms have

been generated, among them 'credibility' (Spencer & Ritchie, 2012), referring to the confidence in the truth of the findings. Marks and Yardley (2004) refer to such concepts as sensitivity to context, transparency and coherence as important when considering the rigour and quality of research. These concepts and principles were considered to be more relevant to the process of undertaking culturally appropriate research than the application of a formal set of criteria rooted in the quantitative tradition.

To enhance the rigour of qualitative analysis a variety of techniques can be employed. These include using multiple methods or data sources (triangulation), eliciting feedback from participants (participant review), developing and using a precise codebook, creation of an audit trail, and supporting themes and interpretations with quotes (Guest, McQueen & Namey, 2012). These address concerns regarding the appropriateness of research decisions, the dependability of evidence and the general safe conduct of the research (Spencer & Ritchie, 2012).

Triangulation contributes to the verification and validation of qualitative analysis (Stake, 2005; Annells, 2006). In this study sources and analysts were triangulated. In terms of sources, this involved comparing and cross checking the consistency of information derived at different times and by different means within qualitative methods (e.g. comparing observations with interviews).

Themes emerging from the research and related conclusions were discussed with the Steering Committee in an attempt to reduce potential bias from a single person and provide a means of more directly assessing the consistency of the data obtained (Patton 2002). It is possible to learn a great deal about the accuracy, fairness and perceived credibility of the data analysis by having those described in

the analysis react to what is described and concluded (Kamberelis & Dimitriadis, 2005).

Findings from the research were provided to the Aboriginal Community and participants as they became available from each phase of the study. This enhanced rigour of the data through triangulation and ensured a constructive research practice (Fielder et al, 2000). Participants were asked to provide feedback about the validity of the interpretations made by the researcher as a means of determining the accuracy of the information collected.

A reflexive journal was kept to record methodological decisions and the reasons for them as well as the logistics of the research and reflections upon what was happening in terms of the researcher's own values and interests, contributing to an audit trail. Findings from the research were presented at the 2015 Rural and Remote Mental Health Conference to an audience of Indigenous Mental Health Workers, including staff from the State-wide Specialist Aboriginal Mental Health Service (SSAMHS). Feedback from these workers was supportive in terms of the findings and the cultural appropriateness of the methodology used. SSAMHS staff also expressed interest in pursuing the research further.

## **12. Conclusion**

It was intended that this research occur in a manner that was ethical, culturally sensitive and culturally appropriate. Consultation with individuals and community agencies along with the formation of a Steering Committee assisted in the development of the research methodology and ensured that the approach taken was responsive and flexible. The use of qualitative methods and accessing community centres and resources fostered engagement with the research. An

iterative process in which each phase was informed by the previous and opinions and feedback sought from participants and the Steering Committee also assisted in ensuring a culturally appropriate research process. The following chapters describe the themes derived from the analysis of the semi structured interviews conducted in phase 1 and of the focus groups conducted in phases 2 and 3.

## Chapter 4 - Findings – non-Indigenous therapists

### AIM

A thematic analysis of the nine semi-structured interviews conducted with non-Aboriginal therapists as part of this study was undertaken. The resultant themes and subthemes are described. Themes included: (1) relationship; (2) knowledge; and (3) conducting therapy.

Upon completion of the semi-structured interviews the investigator conducted an analysis of the transcripts of each of the recorded conversations and reviewed notes taken from those conversations. Thematic analysis (Boyatzis, 1998) was employed to identify emergent themes and subthemes from the data and these were coded accordingly. Both the process and emergent themes were discussed with members of the Steering Committee to moderate possible researcher bias and to ensure consistency.

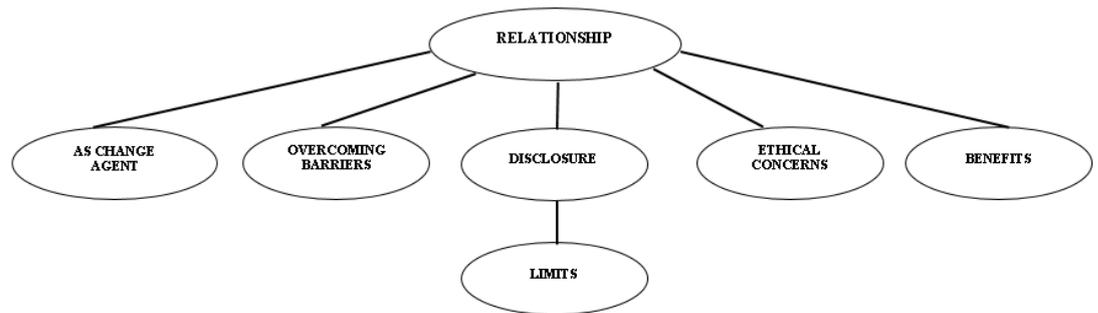
When discussing psychological interventions provided by non-Indigenous therapists to Indigenous people the salient themes emerging from the data included: relationship; knowledge; and therapy. Within each theme several subthemes were elicited.

### **1. Relationship**

Participants identified the relationship as of central importance when working with Indigenous people. Effectively building a relationship was deemed vital and formed the basis upon which everything else depended. The relationship between client and therapist was seen as an important intervention in and of itself regardless of therapeutic model used. An effective relationship addressed power imbalances and demonstrated an awareness of barriers that may get in the way of attending

services or participating in therapy. Ethical issues and the requirements of disclosure were also raised as issues to be negotiated.

**Figure 3. Subthemes - Relationship**



*I take comfort in the fact that there is literature and evidence to support engagement as being the key.... The main thing is about how the client perceives the therapeutic relationship with engagement, so at first, the first, key thing for me is to build that engagement first...*

NA1, Female Clinical Psychologist

*Certainly the rapport building I think is extremely important...in the rapport building stage, it is all about the yarning, about building that relationship.*

NA7, Female Clinical Psychologist

This relationship appeared to have different aspects to a traditional western psychotherapeutic relationship. Notions of connectedness and having a sense of the therapist as a person rather than a detached professional were considered important. Connection resulted in enhanced understanding and engagement whilst knowing the

therapist as a person was considered vital in terms of being able to undertake any therapeutic work.

*I think Aboriginal blokes want to know that you are a good bloke. They want to know that you (have) nous...very basic, down to earth, understanding and acceptance and I think that's what a lot of Aboriginal blokes want to know. Once you have got that, once you get that..., then you can start to work with them. If they don't kind of accept you at that level, then it's stuffed.*

NA4, Male Psychologist

*People want you to be connected, they want that so bad and you know when I first started I had that experience of people going through seriously, twenty or thirty names until I went, "Oh yeah, I know that person", and it was like then the person relaxed because they could put me somewhere. Now that's important because when we get back to that collective understandings, like when we see things in a collective way, people have to know where to put you, you have to be connected in some way. Doesn't mean you have to be their best friend, it just means that they have to go, "oh, okay, she sits there" cause she knows them, so I can sit you now in my understanding of the world ...you have a place.*

NA9, Female Social Worker

Whilst the majority of participants interviewed considered the relationship between the client and therapist to be important, few considered the broader context within which the relationship took place. One participant, examining relationship

more systematically, considered that this relationship needed to incorporate connections with families and the Indigenous community itself to be of benefit.

*Look, developing good relationships with people is good (but)...it's never about developing a relationship with individuals..., it's never just about one-to-one work with an individual; it's also about developing the trust of that family and that you are going to do the right thing.*

NA6, Male Social Worker

### **1.1 Relationship as agent of change**

When discussing change processes or interventions used in therapy, participants deemed the relationship to be the main change agent. It was identified that joining with a person to understand them, to meet them, to reflect their existence – the Rogerian notion of ‘unconditional positive regard’ – generated therapeutic change. Participants did not consider this to be too dissimilar to working with Non-Indigenous clients.

*It is similar to working with non-Aboriginal people in terms of developing that relationship and that therapeutic alliance being the main agent of change in working therapeutically with people.*

NA5, Female Clinical Psychologist

*...just giving people a deeper level of conversation than what they have ever had, so really allowing and exploring for them some of these experiences,*

*I think just leaves with them more of that feeling of lightness and actually having disclosed it and being understood or at least heard and validated.*

NA8, Female Clinical Psychologist

*Without that level of connection, nothing much else can take place, but I actually believe too that on that level of connection, stuff takes place without actually doing anything. What do I mean by that? ... a lot of the blokes (I work with) have never had anyone...who accepts them as they are without being judgemental and perhaps trying to be...have that kind of one upmanship. When I work with them I don't have any of that...I don't put myself at that "better than" level, so think that a lot of the blokes just start to feel more accepted and more okay with themselves and I think that that creates their own sense of inner movement if you like ...and that can happen without doing any other stuff.*

NA4 Male Psychologist

## **1.2 Relationship as means of overcoming barriers**

Participants acknowledged the impact that past experiences with government agencies and the effects of colonisation and racism have had upon Indigenous peoples and the effect of these upon their willingness to engage or become involved with services. It was identified that, for some therapists, their work in the justice sector or child welfare, placed them in a context where there was a considerable power imbalance. They identified the establishment of a good relationship as a means of building trust and showing respect which in time would mitigate these barriers.

*I think one of the unfortunate things we are up against when we are working in health and welfare services is that it was also health and welfare services that were in the front line of removal of children and so there is a great deal of suspicion and reluctance to engage initially, until you can prove yourself and not be seen as a threat; be seen as someone who is going to be willing to learn you know, while you are working with them.*

NA6, Male Social Worker

*There is so much groundwork to be done I think from a white person/Aboriginal person perspective in the first instance with this population ... (because) there is this huge potential barrier between you and I don't think you can pretend it's not there. I could throw whatever therapy I wanted and unless I have penetrated that and that person has seen me as reasonably genuine and "she's all right – she's doing the right thing", I think it would all bounce back in my face.*

NA2, Female Clinical psychologist

*With clients that sort of sense of respect is critical; I think that there is a risk in the service models that are around that people can end up feeling like a widget, you know sort of two phone calls that don't get returned and then a letter...can be experienced as profoundly disrespectful and profoundly alienating for people and can resonate badly with a history of experience, particularly with relation to government funded service of any kind.*

NA3, Female Clinical Psychologist

### 1.3 Disclosure as part of relationship

The participants indicated that the process of developing an effective relationship involved self-disclosure to a degree that was different to work with non-Indigenous people. There was a sense that the therapist needed to approach this relationship from a place closer to their human identity than their professional identity. Therapists believed that they needed to meet the client on the client's level, as a person, not a diagnosis. Therapists believed that having the client knowing them as a person first, getting an idea as to the sort of person they were fostered a sense of active participation and reciprocity within the relationship that was beneficial.

*You have to be okay with putting yourself out there in terms of where you are from, who you are, what kind of person you might be.*

NA8, Female Clinical Psychologist

*I take a little longer with an Aboriginal client, maybe giving a bit more of my own personal information in that process, a bit more self-disclosure perhaps than I would with a non-Aboriginal client if I thought it was something that was important to them in finding out where I am from and my family as part of that sharing with their own information, which is what you ask them to do in this process, so I definitely think giving the time to do that.*

NA5, Female Clinical Psychologist

### 1.3.1 Issues with disclosure

This also caused tensions for participants where their professional boundaries, training or past experiences came into conflict with the need to disclose. Participants identified strategies and processes that they used to accommodate this as well as identifying limits to the extent of their disclosure. Past experience in other work settings was also a factor in influencing willingness to disclose.

*Disclosure I found quite different. I had come from a prison based system, so I was very cautious about self-disclosure; I found that I did start to disclose bits and pieces; mostly about where I came from and you know sometimes a little bit about if I have children and things like that because that seems to be really important in the building of trust with the clients*

NA7 Female Clinical Psychologist

*In terms of disclosure, I guess I have in my own mind, limits personally; personal limits as to what I will disclose. What I do disclose and what I use quite freely is my day-to-day sort of experiences as a human being...*

NA2, Female Clinical Psychologist

## 1.4 Ethical dilemmas

The process of developing an effective relationship and self-disclosure posed other problems for participants. Ethical issues were identified within the establishment and maintenance of the relationship. Issues such as how to relate to clients ‘on the street’ – an experience that was quite common for therapists residing in a regional centre – and confidentiality were raised.

*And also you know the mainstream where you get told don't out that person if you see them out in the community, don't talk to them because they might you know ... people might not know that they are having "therapy", so you might out them in some way and oh if you have seen some relative of theirs or you know their friend or their family in some aspect, you must declare that as a potential conflict ... those sorts of things, I mean it's completely the opposite when working in the Aboriginal community.*

NA9, Female Social Worker

*In western psychology you can work with individuals, but in Aboriginal communities you have to work with the community, you never get far trying to work with a singular individual. So some of the ethical dilemmas, you know as a psychologist, you go in trying to have all this confidentiality, you know not mentioning names, but it's so difficult when they find out that you work in (town) and it's like: "Do you know this and this mob?"*

NA1, Female Clinical Psychologist

### **1.5 Benefits versus Resources**

Within this process of negotiating dilemmas, disclosure and barriers, taking time to develop a relationship, engaging with individuals, the community and families, participants noticed that putting in the effort generated results. This was not necessarily obvious and also involved experiences of frustration and use of therapeutic resources that might be considered "wasteful" from a mainstream service perspective. One participant summed up this process as follows:

*Things like organising for a psychiatry home visit and having the appointment the week before and we do all the set up for it and get the absolute reassurance this is what I need; turn up on the day and nobody there...ring – no answer... ring, oh we are just around the corner ... sit around... go away for half an hour, come back in half an hour – still not there ... go away again, come back again half an hour later... just can feel incredibly wasteful, incredibly one way in terms of respect, but then you know, coming back ... a year later seeing that the psychiatrist has built a rapport, has been able to make a difference.*

NA3, Female Clinical Psychologist

## **2. Knowledge**

The importance of a knowledge base was highlighted by participants. Lack of specific, or even general, knowledge of Indigenous culture, community, family connections, and spirituality were noted as impacting upon effective practice. Participants identified limited training in their University – and earlier – education. This lack of knowledge contributed to anxiety and uncertainty when initially working with Indigenous people. Participants identified that their knowledge had been, to some degree, acquired ‘on the job.

Participants noted that lacking knowledge could result in making adverse judgements of Indigenous people in terms of capacity. In addition, participants were aware that a lack of knowledge may result in making mistakes that could adversely affect engagement or the therapy process. Participants noted that knowledge gaps also affected their approach to therapy.

*Understanding how that came to be, because of the historical context, would have been helpful, because it was sort of like you were thrown into it and there is all that judgement obviously that comes with it, all that frustration because you are making assessment of peoples' capacity, but believing that it is more attitudinal than limitations.*

NA1, Female Clinical Psychologist

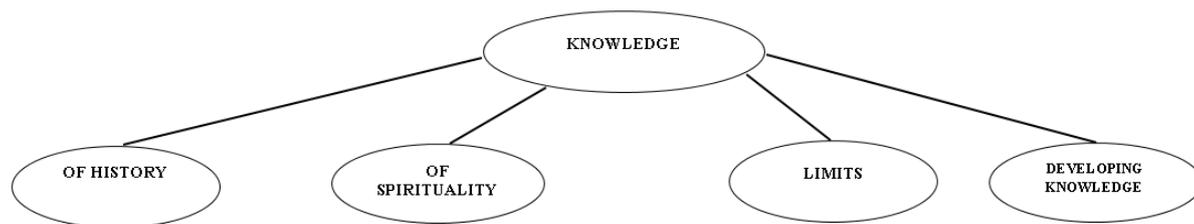
*I have some caution around my work, but I don't know what I don't know and so...as much as I want to be natural around my client, there is a sense of caution.*

NA2, Female Clinical Psychologist

*Well early on, I wouldn't have even...I don't think I even heard about it because I had no knowledge of it...things like, you know, some of the spiritual beliefs and culture bound syndromes and stuff like that, because I suppose if you don't know something, you don't ask about it and even though you try not to be directive, I suppose you miss a whole lot of someone by having quite a narrow understanding, so I definitely would have liked to have known about the spiritual side of things, specifically the culture bound syndromes, the names of the.. you know the maaman and stuff like that and the healers and who they might be in the community and how do people access that even, just being aware of that kind of stuff would have been really helpful.*

NA8 Female Clinical Psychologist

Figure 4. Sub themes - Knowledge



## 2.1 Knowing the history

Participants identified that knowing the history of Indigenous people post-colonisation was vital. This knowledge assisted therapists to gain a context within which their clients experience could be situated. It helped the therapist with an understanding of issues and barriers impacting upon Indigenous people. Knowing about these barriers was seen as important in undertaking therapeutic work with Indigenous people.

*...it's about understanding the history of where Aboriginal people have had systemic issues to deal with, from Stolen Generation, to the sort of social economic difficulties, the barriers in place*

NA1, Female Clinical Psychologist

There was also a sense that having this knowledge was expected of therapists working with Indigenous people, that Indigenous peoples' experiences of the Stolen Generation and traumas associated with colonisation was often central to their presentation and that not having this knowledge could adversely affect the effectiveness of the therapist or the process of therapy itself. Being aware of the complexity, knowing – even an abstract knowledge – about Indigenous culture and

history was considered helpful and something that could be built upon through the work itself.

*I think in a way the clients expect you to know...and they might talk about Stolen Generation, that will come up a lot...they will talk about the impact of violence and abuse and I think if you don't really have even a textbook understanding of what the impact of that might have been on families, because they will look at you and say, oh well you know...you know...so you have to know*

NA8, Female Clinical Psychologist

## **2.2 Knowledge of Indigenous Spirituality**

Other than Indigenous history, participants identified a preference for, and a lack of, knowledge or education around aspects of Indigenous spirituality. The difficulty distinguishing between mental health symptoms and spiritual aspects of culture created some tension and ambiguity in terms of effectively treating presenting issues. Some participants noted that not knowing what direction to approach a situation from created anxiety and, sometimes, a mismatch between presentation and therapeutic approach.

*I would have liked to have known as well, is things like Aboriginal spirituality and practices that blurs the line between mental health symptoms and symptom management versus culture*

NA1, Female Clinical Psychologist

### 2.2.1 Limits to Knowledge

Participants noted that it was difficult – even impossible – to gain a complete understanding of many of the spiritual aspects of the culture. They acknowledged that their knowledge could only ever be incomplete whilst reflecting that this also made communication around this difficult at times.

*Someone ... gave a talk at trans-cultural mental health network thing, where she spoke of Aboriginal spirituality and you know straight off she said there are many things I can't discuss. So again that sort of shroud around ... the shrouded thing about culture and appropriateness of discussion makes it difficult, because when you are working in a mental health area, you are coming face to face and unless that person has the capacity to explain it to you*

NA1 Female Clinical Psychologist

Other difficulties regarding knowledge were identified. Participants identified that being outsiders to the culture set limits on what they could effectively know or understand as there may be no words or culturally similar concepts that could translate across the cultures. They noted instances in which these limits to knowledge were brought to their attention. Possession of an open, curious mind and willingness to learn often could not mitigate a lack of a shared experiential knowledge base. This created a sense of caution regarding the appropriateness of certain topics and reinforced awareness of the impact of different world views upon understanding.

*I have to say that I have had one young person, when I asked her to explain something to me about places...she was talking about coming from the*

*place where she was born and going to somewhere else and I asked her to explain what that meant and she just looked at me and just said, “there is no point in me trying to explain that to you because you are never going to understand what that means to me” , so that I think is really interesting feedback to have as well, that you can come into it with a really open and enquiring mind and for someone to say that our beliefs are just so different and our way of looking at the world, I can’t even try and explain that to you, that’s really interesting*

NA5, Female Clinical Psychologist

### **2.3 Development of Knowledge**

The majority of participants reported that most of their initial knowledge regarding Indigenous culture and society had come through cultural competency training. This was identified as a useful first step, however the quality of some training and the tendency towards formulaic generalisations were not seen as helpful. One participants’ experience of cultural awareness training encouraged them to actively explore whiteness and privilege in order to gain an appreciation and understanding of the Indigenous experience, that of “other” within society, however this was the exception, not the norm. Many noted that cultural awareness training was, at best, a start and needed to be built upon through actively experiencing cultural and ‘on the job training.’

*Look the ... I don't want to step on anybody's toes, but the cultural awareness training that I have done is pretty crappy in that it was things like when you are sitting with an Aboriginal bloke, you never look them in the eyes and sometimes that is true, but for the majority of times, it's not...So the*

*overall training wasn't that practical, wasn't that direct specific or maybe it was that long ago that I have forgotten it all.*

NA4, Male Psychologist

*It is so much about ... I was just thinking about cultural competency then ... it's about knowing...it's about knowing the culture really well, but I don't necessarily abide or agree a lot with the generalisations; for instance, about females can't work with males, that personally has never been an issue with me.*

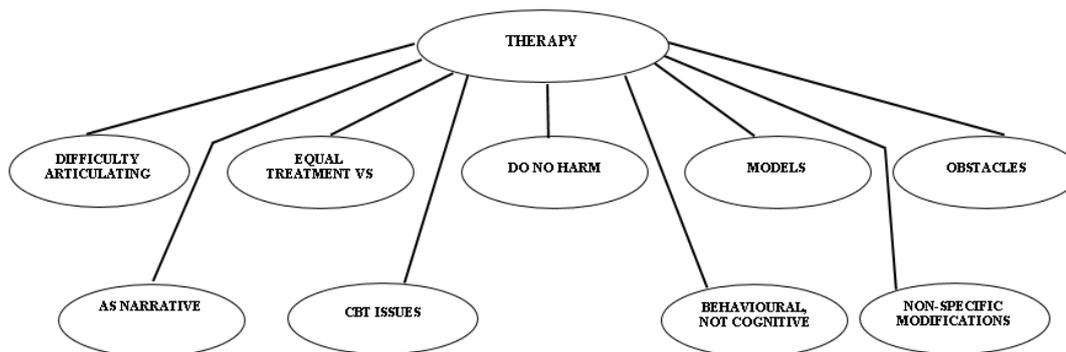
NA7, Female Clinical Psychologist

### **3. Therapy**

Many aspects of therapy were discussed with participants. Participants described working with an awareness of multiple levels of the therapeutic process, being aware of the impact of history, attempting to build engagement, attempting to maintain an effective pace to a session, being aware of their own baggage and noted that this was, in many cases, much more work than would be done with a non-Indigenous person because with a non-Indigenous person so much could be taken for granted as part of a similarity of shared experience.

Within the theme of therapy, subthemes concerning difficulty articulating modification, treating everyone the same versus an active awareness of a person as Indigenous, obstacles to therapy, treating therapy as narrative, doing no harm and difficulties applying the CBT model emerged. Adaptations to CBT based on experience and some basic considerations were also discussed.

Figure 5. Subthemes – Therapy



### 3.1 Difficulty articulating

During the interviews, therapists were asked to describe specific modifications or alterations that they had made when engaging in therapy with Indigenous people. This proved a difficult task with participants discussing more of the non-specific aspects of their therapy process than the specific aspects. This difficulty was not dependent upon therapeutic orientation or professional qualification. Several participants indicated that they had a background in CBT and would use this primarily, however could not express modifications to the model beyond generalities. Within this was also a sense that therapists were guided at times by a combination of intuition and desperation.

*I didn't do it because it was all knowing, it was a sense of intuition plus...not really having anything else that was going to work.*

NA1, Female Clinical Psychologist

*It's hard to articulate and so much of it is you know going...going with the feel of what is happening in the session. ...It's not about putting into neat little boxes and labelling...it's a feel you know, it's the art of counselling...*

NA7, Female Clinical Psychologist

### **3.2 Treating everyone equally vs ...**

A theme of treating every client the same regardless of cultural background versus actively considering a persons' status as Indigenous emerged. Most therapists stated that they considered a persons' culture/race within initial and subsequent sessions. Some described their approach as the same no matter what the clients' background and believed that this was effective.

*Always having...taking into consideration in assessment, in planning, conceptualising, working with people, that they are Aboriginal, that that's part of who they are and their identity and their culture and their sense of themselves and trying to understand that and take that into account in all those areas and using someone like...a cultural consultant to help do that.*

NA5, Female Clinical Psychologist

*I am not sure that I can actually identify anything specific other than what I try to be aware of with all clients and that is really just how the person is; how the person is presenting in terms of the level of anxiety, their level of openness, their level of desire to be there, their motivation, commitment, all of that sort of thing.*

NA4, Male Psychologist.

Interestingly one such participants' point of view appeared to change through the interview with an initial hesitance about doing anything differently giving way to the possibility that something may be left out by doing this, something which may result in better outcomes.

*Well, because of that kind of nagging thought that has been in the back of my head for a long time that maybe I don't know enough about... by treating everybody as... with equity...or by treating everybody the same, trying to give equity am I not...am I overlooking something? Am I overlooking something inherent in Indigenous people that if I knew about, that I might be able to offer a better service... offer something, you know, more fulfilling for them.*

NA4, Male Psychologist

### **3.3 Do no harm**

When discussing therapy with Indigenous people, participants had difficulty in articulating exactly what they did within sessions specifically, however they were able to articulate their intent for the experience to be positive and encouraging. Participants noted that issues of attendance often meant that treatment was 'hit and miss' and, as such, wanted to ensure that the client had had an experience that would result in them considering approaching a therapist again in future.

*I know we keep coming back to the relationship, but often I just think that if you build enough relationship that somewhere down the track, someone just might have that as an option of engaging again as a really positive outcome*

NA7, Female Clinical Psychologist

*I guess I want to provide an experience, if nothing else, if they don't want to engage therapeutically...if they don't want to, at least they have had that experience*

NA2, Female Clinical Psychologist

*...if the person comes in, has a very practical issue, gets that addressed, feels helped and goes away after one session, or feels like they have moved onto the next step and goes away after one session just with a vague sense that...psychologist...useful person...nice to talk to.*

NA3, Female Clinical Psychologist

### **3.4 Models**

In terms of therapeutic approach, participants mainly identified as being informed by CBT. Many adopted an eclectic style, utilising a variety of therapeutic models based on clients presenting issue, level of engagement and what amounted to an intuitive assessment of what might fit. However, they also believed that there was potential in most approaches as there needed to be an ability to adapt and be flexible. Within discussion of therapeutic models, the importance of the relationship was highlighted as a necessary precondition for effective therapy.

*I think everything has potential...I think... you would know, you need to be adaptable to what people's needs are and what those expectations are etc. and I think, you know, I think that it is just that establishment phase is the important thing. I think you can use (and people respond to) all sorts of*

*therapy if it is offered, but they are not going to unless they've got that trust and feel that they have that acceptance from you as well*

NA6, Male Social Worker

*I don't think that any of them work unless you have done the groundwork of getting to know this person and being...having the capacity yourself to be somewhat open with them*

NA2, Female Clinical Psychologist

### **3.5 Obstacles in therapy**

Participants expressed some despair at times with the difficulty of facilitating some sort of change with the realities faced by some Indigenous people. Participants working in child protection or the justice area would identify that clients may be referred to them with an expectation of change by a mandatory agency, however the process of facilitating this change could be affected by social circumstances and cultural obligations that were not amenable to change.

*...you just don't expect that they are going to be able to do because most Indigenous people walk out of there and they get swept away with life and family dynamics...that whole concept of kinship and family obligations is so reactive that the idea that you can focus on yourself and make changes for yourself just kind of slips into the background...it's not the priority.*

NA8, Female Clinical Psychologist

*It's hard to provide, I suppose a lot of therapeutic interventions when you have clients sitting in front of you who are homeless or living in a house*

*with twenty others who have come from you know...a few generations now of heavy substance use now, heavy violence... I mean when you look at Maslow's hierarchy of needs, you know, you have to get the basic needs (the food, the shelter) not getting fulfilled; how can you possibly start hitting a lot of psychological interventions*

NA7, Female Clinical Psychologist

### **3.6 Therapy as Narrative**

When discussing the therapeutic process, therapists frequently resorted to describing this as a 'narrative.' Therapists would indicate that they were exploring the stories told by the client and seeking meaning behind the story to feedback and explore with the client. Therapists described a process of Narrative Therapy, however did not link this explicitly to the Narrative Therapy approach of White and Epston (1990). Their use of narrative was more of a story-telling approach, with one participant noting that they did not follow White's narrative structure, but more the intent underlying his model.

*...more the general term of (Narrative), you know, trying to get a sense of them trying to build an identity in the here and now versus what their life history has been, what their...struggles have been and a lot of it has been about kind of, I think, helping them connect with the grief that feels very stuck and through talking...and allowing them to express their feelings – and I suppose resolve a bit of it – then they don't feel like that so strongly anymore...*

NA8, Female Clinical Psychologist

*I get the client to tell me their story and then from that I will get an understanding or an idea of where they are at and what I need to adjust ... how I need to adjust to them and as part of that what I might also do is grab particular...listen for and grab particular issues that they might be saying and then I might just feed them back, but maybe in a metaphor or another story that I might create and then see what happens in that person to try and then trigger something off or to try and get them to move into a particular direction or just to develop that*

NA4, Male Psychologist

*...a narrative as talking therapy really taking it exactly in its like...literal form to mean just talking about things, so just talking you know you are going to get somewhere, but not following the structure as Michael (White) had intended to like question this way, do that way, go to the next process, but more about using the symbolic means or metaphors of narrative therapy as a tool to help them understand and then like getting that audience for it.*

NA1, Female Clinical Psychologist

### **3.7 Issues with applying CBT model**

Many participants noted that they had been formally trained in CBT and that they had attempted to employ this within the context of therapy with Indigenous people. It was noted that applying a ‘purist’ form of CBT did not tend to work due to issues with readiness, and aspects of an individuals’ social environment. Participants

described early attempts to apply CBT structures to sessions as meeting with little success.

*I think that therapy needs to be available as the person is available to engage and it won't look like a nice neat text book, work book, manualised intervention...When I think about those sorts of manualised approaches and stuff that can be one way of delivering psychotherapy, when you think about it, to deliver a manualised approach like that you are expecting a lot of readiness and functionality from your client.*

NA3, Female Clinical Psychologist

*When I am working with an Indigenous person who has got a very complex history, very traumatised, when you go where is the evidence for this ...like you know there is evidence everywhere for why they should have prosecutorial thoughts, there is evidence everywhere in their life about why they should have antisocial traits, why it's a dog-eat-dog world, why they should look to strengths and not be vulnerable; it's a very racist community that they live in and they are disenfranchised, so using the pure CBT form of here is a thought, thoughts lead to feelings, and feelings and thoughts lead to behaviours and if you want to change something, just change the way you think...No.*

NA1, Female Clinical Psychologist

Participants reflected upon their attempts to employ aspects of CBT with clients and the outcome of this. It appeared that therapists had used trial and error to determine what aspects of the model they could use. Therapist's attempts at

employing some aspects had been influenced by feedback from the client or from an awareness of the broader environment within which the client sat.

*I have sort of started talking along those lines of like pay attention to what you are thinking about and maybe starting to keep some sort of simple record of some of the things you might think about during the day and not had much interest from that point, so have gone onto something else and I haven't really pushed the point at all*

NA5, Female Clinical Psychologist

*...and homework, I don't think that works – sending clients away with the idea of, you know, monitoring themselves when they're...a lot of them just want to get fed and have a roof over their head*

NA8, Female Clinical Psychologist

### **3.8 Behavioural, not cognitive**

When discussing adaptations to CBT, therapists believed that behaviourally based interventions worked more effectively than cognitive ones. Again this had been based on feedback from clients within session. Behaviourally based techniques were viewed as more practical and easier to communicate than the cognitive techniques. Cognitive techniques were perceived as more reliant on writing and affected by issues of literacy. There were concerns that using written methods could cause shame in those clients with poor literacy and result in people dropping out of therapy. Behavioural methods were perceived as being something that could fit in with what clients were already doing and that could have a more direct, and noticeable, benefit to the client than cognitive techniques.

*Probably more those behavioural things than necessarily the cognitive stuff...I don't find that I have had that much success doing cognitive restructuring...or not found anyone that's interested in my thought detective approaches are anything like that.*

NA5, Female Clinical Psychologist

*I don't provide a lot of bibliotherapy or any of the standard sheets... I wouldn't ever give sort of written stuff, just out of an awareness of literacy, but also that I think generally their way is to chat and talk, rather than write, so it's more like the doing stuff they get ... they don't kind of intellectualise things, they're more at the behavioural level, so I probably focus more on behavioural interventions than cognitive ones.*

NA8, Female Clinical Psychologist

### **3.9 Non-specific modifications**

Within the general approach to a therapy session, participants were able to articulate a number of non-specific modifications to work with Indigenous people. This involved being attentive to body language, the pacing of the session, using a variety of methods to explain things, and drawing from the client the things that they were doing that were helpful in difficult situations.

*What I would do is couch...watch my language. So I would...probably not use the same kind of language that I might use to a middle class white fella*

NA4, Male Psychologist

*I do a lot of diagrammatic stuff, so if I am trying to explain something, I will draw so that is more concrete and I guess; I would take from what they have said and try to do that kind of schematically to get more of a picture of it rather than words*

NA4, Male Psychologist

*I have used different types of relaxation training...I have made up little sheets...just very simple steps to remind them of different...you know, progressive muscle relaxation using lots of pictures to help remind them, to help prompt them.*

NA5, Female Clinical Psychologist

*I would look at what they are doing themselves... What I would do is finding out from them, what it is that allows them to settle, to relax and encourage them to do more or whatever that is. Talking to them again about, in a sense, more practical type stuff; of anxiety in terms of like...rather than what are your thoughts, so what goes on in your head? What's that voice doing? So that sort of stuff and then what do you do when you get that voice and where do you go? Can you get out and go for a walk and go and have some time for yourself and do you go and talk to mates, so it's very practically based rather than the more esoteric*

NA4, Male Psychologist

#### **4. Summary**

Nine non-Aboriginal therapists that had some degree of involvement with Aboriginal clients were interviewed as part of this research. Themes emerging from these interviews included: the importance of relationship in therapy, having relevant knowledge of Indigenous history and some cultural awareness. When discussing delivering therapeutic interventions, participants found it difficult to articulate the ways that they specifically modified or adapted the therapeutic interventions they were familiar with to be more appropriate or effective with Aboriginal clients. Participants outlined broad, non-specific modifications to their approach along with difficulties they experienced in delivery of services.

The next chapter outlines the results from the focus groups comprising Indigenous community members.

## Chapter 5 - Findings – focus groups

### AIM

A thematic analysis of the three focus groups conducted as part of this study was undertaken. The resultant themes and subthemes are described. These include: (1) past experience; (2) the need for education; (3) relationship; and (4) structural issues. Subthemes within each theme are outlined.

Upon completion of the focus groups the investigator conducted an analysis of the transcripts of each of the recorded group conversations and reviewed the notes taken from those group conversations. Thematic analysis (Boyatzis, 1998) was employed to identify emergent themes and subthemes from the data and these were coded accordingly. Both the process and emergent themes were reviewed by members of the Steering Committee to moderate possible researcher bias and to ensure consistency.

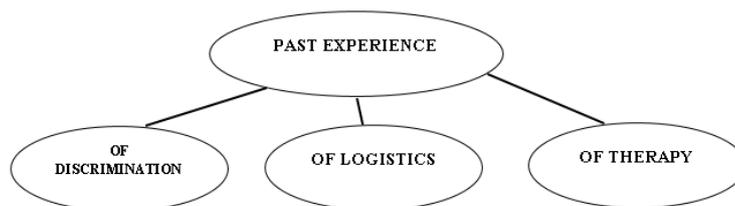
When discussing psychological interventions provided by non-Indigenous therapists to Indigenous people the emergent themes included: past experience; the need for education; relationship; and structural issues. Within each theme several subthemes were elicited.

#### **1. Past experience**

Past experiences of participants, family members and the community itself when dealing with mental health services was identified as a key theme. These

experiences influenced people's willingness to engage, seek help and disclose information. Within this three subthemes dealing with experiences of discrimination, judgement and racism, experiences relating to logistics and experiences of therapy itself emerged.

**Figure 6. Subthemes – Past Experience**



Focus group participants clearly indicated that the past experiences of therapy provided to them had influenced their willingness to undertake further therapy. This experience was not just of them specifically, but included their family and others known to them. This experience was also not necessarily grounded in the present, but also drew from past associations and events.

*“I think for a lot of us (the word) therapy is still associated with Graylands. People that go to Graylands, they stay there and they die there.”*

Female Participant, Community Forum.

*“(Based on our history) ...lots of people don't want to be coming to clinical situations.”*

Female Participant, Women's Group.

*“It’s just the wording – counsellors, psychologists, therapists...just puts everybody off. So it’s all those connotations that we all have with ‘therapy’ and that...yarning is fine. Everyone is happy to yarn. Therapy? Nup. Counselling? Nup.”*

Female Participant, Community Forum.

Past experience did not just relate to admissions to mental health facilities, but also of attempts to tell their story to therapists that were not helpful or able to meet their needs. Participants told of having experiences with therapists that did not appear to listen or were unwilling to take the time to establish a relationship. Participants reported that feeling judged or discriminated against by the therapist contributed to an unwillingness to engage in therapy. For some participants, experiences of being directed to other services and being required to tell their story again were not considered helpful. Participants expressed interest in “one-stop” shops where they could attend and have their needs or concerns attended to in one place, rather than being directed to a variety of services in the community that did not appear to exchange information with each other.

*“You get some counsellors like in Welfare that shouldn’t be in that job.”*

Male Participant, Community Forum.

*“The family builds them up to go there and once they go there, if they get a terrible person on that side... the therapist or counsellor... it’s going back to where they started.”*

Female Participant, Community Forum.

*“A lot of times...you go to see a therapist and you telling everything and then that person may not be able to help you anyway, so you go to someone else and it’s just that repeating everything all along and then after a while, it’s like: ‘Aaah, I’ve done all this before...”*

Female Participant, Community Forum.

Participants identified difficulties with accessing organisations or individual therapists. These difficulties ranged from feeling judged by staff when attending to staff not taking time to identify issues of concern. They noted that services applied strict criteria towards admission and engagements (e.g. “three strikes” policies where after three missed appointments individuals were discharged from the service or “taken off the books”) which conflicted with family or community requirements. Participants identified that some services were more willing to work with them, however the majority of the time they did not.

*“They didn’t take the time to get know all of what was going on for me. They just jumped to conclusions. They just heard what they wanted (to hear) without caring.”*

Female Participant, Women’s Group.

*“They didn’t take me seriously. I know what is wrong. I need to be listened to.”*

Female Participant, Women’s Group.

Participants identified concerns regarding services being quick to jump to conclusions, medicalise issues and treat with medication rather than taking the time

to identify issues of concern and work with the individual and their family.

Participants identified that some services or therapists would not explore the context within which the issues were occurring, but rather appeared to look for quick answers than would not take much time to address. Participants described difficulties experienced with getting some systems to consider things more broadly and to actually listen to their concerns and their lived experience.

*“These Wadjellas; they reduce many things to one thing. That’s not good.”*

Male Participant, Men’s Group.

*“The school psychologist called me in and told me that (my son) would have to have ADD...and I was like, no he hasn’t. And they go, oh yes...So it was like sort of like they told you that’s the...rule.”*

Female Participant, Community Forum

*“There’s a lack of thoroughness (with diagnosis and treatment). They see one problem and decide: ‘That’s it.’ Then they don’t go any further. I had a relative go to Emergency with pain in his belly and they called it pancreatitis from drinking when it was appendicitis.”*

Male Participant, Men’s Group.

Linked to this experience were descriptions of the physical environment associated with therapy. This included the length of time available for therapy and experiences associated with government agencies, such as Community Mental Health Services or Corrective Services. Participants noted that the security systems –

locked doors and swipe cards – did not make these agencies welcoming places and, as such, they were reluctant to attend. Participants stated that the setting in which therapy occurred was just as important, and perhaps even more important, than the therapy itself. They noted that it sometimes took more time than allocated for them to feel comfortable enough to discuss issues of concern for them.

*“People won’t go to that place (Community Mental Health) because it reminds them of gaol.”*

Male Participant, Men’s Group.

*“Sitting in a (room with) white walls all around you like you’re sitting in intensive care and you’re frightened to say your words.”*

Male Participant, Community Forum.

*“Seeing someone sitting in a room for 50 minutes, white therapy. That way don’t work.”*

Male Participant, Men’s Group.

Participants described difficulties with organisations that were separate to the community, did not take the time to become involved with the community and appear to “demand” the community fit in with them and their processes. They described experiences of limited, if any, consultation around needs. Linked to this were comments regarding agencies and individuals promising much and delivering little, resulting in suspicion and caution among community members. Participants noted that this experience was common for the community. They indicated that there

had also been times when the services provided had not been services that were needed.

*“There are services that don’t engage with the community. They expect the community to fit in with them.”*

Male Participant, Men’s Group.

*“Too many people came out and say they will do this and then they don’t.”*

Male Participant, Men’s Group.

## **2. Education**

Education was considered important. Participants indicated that education was a two-way street; that is, both clients and therapists needed to be educated. For therapists, participants highlighted the importance of knowing about the culture, the history of colonisation and of the local area, and of individuals who could act as consultants. Participants described instances when therapists, lacking knowledge of local contexts and of history, had simply treated them “like everyone else.” It was noted that this was off-putting and reduced individual’s faith in the therapist. Participants stressed the need for therapists working with Aboriginal people to engage with the community and learn in more direct, hands on ways than reading about local history.

*“There’s lots of misinformation about Indigenous people. Lots of people don’t know the history; they just take on what other people tell them.”*

Female Participant, Women’s Group.

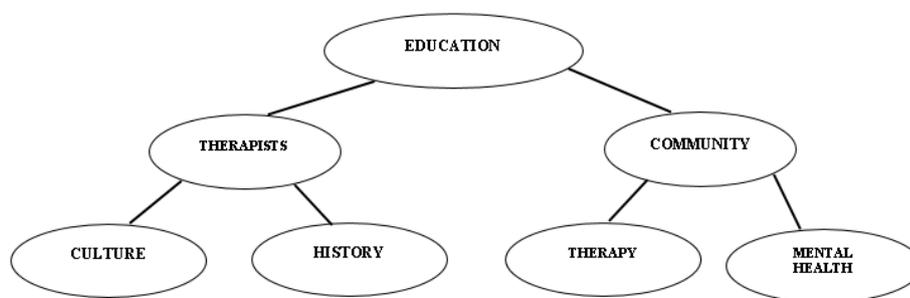
*“Wadjellas learn from books. You have to get beyond that.”*

Female Participant, Women’s Group.

*“You need to educate them therapists, not about specific techniques, but about the way to engage with us.”*

Male Participant, Men’s Group.

**Figure 7. Subthemes – Education**



Cultural awareness was mentioned by participants, but the existing practice of attending short cultural awareness courses was not considered to be sufficient to fully understand the complexities of working with Indigenous people. Participants believed that cultural awareness training provided an overview of issues relevant to Aboriginal people, but needed to be followed up with active and ongoing learning through contact with the community and cultural supervision. One participant offered to take me out to the bush and teach me about various plants and animals in the local area to give him a better understanding of the local country. I have yet to take him up on his offer, but fully intend to do so in the near future.

*“Cultural awareness is a good first step.”*

Male Participant, Men’s Group

*“You don’t just turn up to a four-day cultural training session and understand it, but you know, immerse yourself...”*

Male Participant, Community Forum

Participants identified that there was a lack of awareness within the community about the role of therapy and of psychologists. This, along with a lack of understanding and shame about mental illness, was identified as a barrier to accessing treatment. The stigma associated with mental illness was considered a significant obstacle to seeking help in a timely fashion and often resulted in presentations in crisis or acute states which lead to experiences of services that were adverse (e.g. being placed in locked wards etc.). It was suggested that educating individuals and the community about the role of psychologists and about mental health could reduce shame and lead to more people accessing services. Involvement by therapists within the community in community activities – “showing face” – was considered to be one way that informal education could occur. Participants suggested that more formal opportunities would also be helpful especially if Aboriginal health workers or significant people within the community were involved as well.

*“What would you want to see a psychologist for? You need to educate people about the difference.”*

Female Participant, Women’s Group.

*“Well what if you mention you should go and see a psychologist, it’s like: ‘What do you think, I’m mad?’”*

Female Participant, Community Forum.

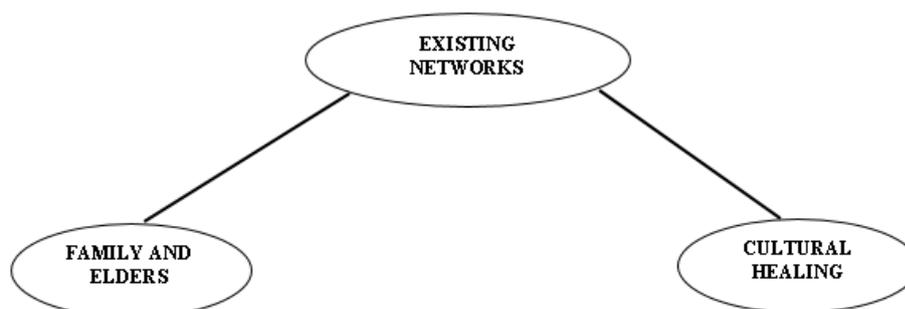
*“Before going and doing (group program), I didn’t have a clue about mental illness or anything and that just sort of opened my eyes.”*

Female Participant, Community Forum.

### **3. Existing Networks**

Participants mentioned that there was a clear preference for using existing networks and supports within the Indigenous community rather than accessing mental health services or therapists. The shared experience and ability to relate to each other was identified as a key factor in deciding to seek support within the community rather than going to agencies. Using existing networks or supports within the community meant that relationships were already established, that there was less of a need to tell their story over and over again and that the person they were seeking support from was aware of the history and context as it was a shared history

**Figure 8. Subthemes – Existing Networks**



*“We all come from out of there, and we all of us Noongar fellas could all relate to each other ‘cause we know what it’s like.”*

Male Participant, Community Forum.

*“They’d like to go and see somebody, you know, Indigenous, so they can talk to and then they’d get a confidence, you know, a confidence and then they’ll open up. It’s like a dripping tap at first, but then later on...the waterfall.”*

Male Participant, Community Forum.

Participants indicated that the support and assistance that they had obtained from within their existing network acted to assist them in accessing additional support from non-government agencies or even government health services. Participants stated that seeking support from within the community often lead to gaining the confidence and willingness to seek support from outside the community especially when these services had been vouched for or had Indigenous workers that were trusted.

*“Most of it came from family support that was there for me at the time...and then that moved me on to going to the agencies and getting that help as well.”*

Female Participant, Community Forum.

*“You start that talk within that group or family that you’re comfortable with and then you might need some more help from someone else, but that group needs to be supporting you first off.”*

Female Participant, Community Forum.

Elders had a clear role in providing assistance to people within the community. This role was contrasted with the ability of services/therapists to respond in a timely or appropriate fashion. Participants mentioned that given the choice between calling an emergency after hours’ number and speaking to a stranger and speaking to a family member or Elder, they would prefer to speak to an Elder. It was suggested that intervention by Elders reduced the need for people to access therapists.

*“We counsel 24/7; we’re out there 24/7. We see them, so they don’t see you.”*

Male Participant, Men’s Group

*“The Elders pick up a lot of stuff; they’re flexible. They are counsellors twenty-four hours a day, seven days a week.”*

Female Participant, Women’s Group.

It was acknowledged that this flexibility and support did have some effect on those providing it. Participants noted that this affected the well-being of those that offered support at times with some people describing how stressful constantly being available for support could be. Some mentioned health impacts and the need for support people to have their own supports as well.

*“It’s like a race for us, it never ends. Wadjellas can leave. They can stop the race. We can’t.”*

Male Participant, Men’s Group.

*“(It’s) taken years and years...and it drains. Drains you!”*

Female Participant, Community Forum.

Whilst yarning with Elders and family members was mentioned as one form of assistance from within the community, participants also indicated that there were other methods used. These methods included going to country or engaging people in traditional/cultural activities like hunting or fishing.

*“We got eyes and ears, we can see, go through someone else, take them away hunting or fishing.”*

Female Participant, Women’s Group.

*“People go back to country yearly; for a weekend every year. It’s part of healing.”*

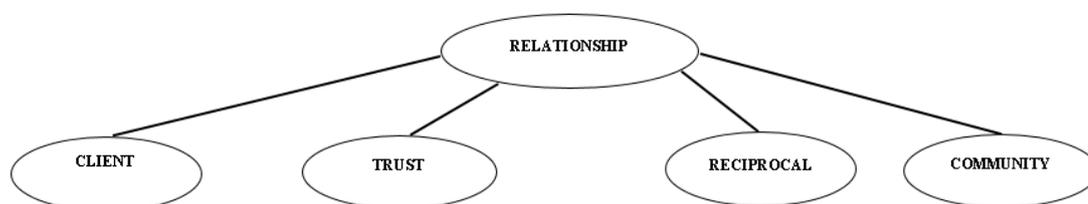
Female Participant, Women’s Group.

#### **4. Relationship**

Participants in each group highlighted the need for a relationship to exist between therapist and the individual client. The process of establishing a relationship was identified as important, with participants highlighting that relationships took time to develop. This process was contrasted with participants’ experiences of therapists that “rushed in” to treatment. Taking time to develop a positive

relationship helped reduce participants' fears and reduced stress. They talked about ways in which having a relationship enabled therapy to occur more effectively. It was also noted that this relationship also needed to exist between the therapist and the community, not just between therapist and client. Having a relationship with the community helped provide a knowledge base and facilitated understanding between therapist and client.

**Figure 9. Subthemes – Relationship**



*“The relationship is important; you can’t just launch into it. You have to talk to them, get to know them. Talk about footy, for instance.”*

Male Participant, Men’s Group.

*“You felt better knowing that person was a good person, like you were able to talk to them.”*

Female Participant, Community Forum.

Establishing a strong relationship was identified as a necessary precondition for trust. Trust was considered vital for doing therapeutic work. It was suggested that this did not “automatically” happen. Participants described experiences in which

therapists assumed trust simply based on their role as therapist and had not built this through establishing a relationship. They noted that, as clients, they would ‘assess’ the therapist to identify if they were someone with whom that relationship could develop. Participants indicated that they were watching for judgemental attitudes or behaviour as these would impact on their willingness to engage or to trust.

*“Trust... has got to be earned for us to actually sit with someone and tell them even a portion of our story.”*

Female Participant, Community Forum.

*“Blackfellas (are) not silly; they want to read you first. You say the wrong thing, they’ll shut you out.”*

Female Participant, Women’s Group

There was a sense that this was a reciprocal relationship, not as a one-way process or experience in which one person (i.e. the therapist) was positioned as expert the other as client. Participants described instances where a therapist had positioned themselves as an expert and noted that this had reduced their willingness to continue with therapy. Having a sense of the therapist as a person, rather than as a profession, and believing that they were seen as a person rather than their problem was important. Information needed to be exchanged rather than flow one way.

*“You ask me without offering anything back, I am not going to give.”*

Male Participant, Men’s Group.

Participants indicated that a relationship needed to exist between the therapist and the wider Indigenous community as well. Sitting around in a room, not “showing face” was considered a barrier to effective engagement with the community and individuals. Therapists wanting to work effectively with Aboriginal people were encouraged to make links with community agencies and significant people within the community. This demonstrated commitment, interest and also assisted with educating the therapist about the local context and history.

*“You need to get out into the community; we will forget you if you don’t remind us.”*

Male Participant, Men’s Group.

*“You have to look to ways of accessing the community. Linking in with (agencies such as) SWAMS, Goomburrup, NEEDAC.”*

Male Participant, Men’s Group.

## **5. Structural issues**

Participants suggested a number of ways to improve the experience of therapy for Indigenous people drawn from their experience and that of others. Some of these suggestions were linked to the location in which the therapy took place; others to the process and content of therapy. Participants were very clear regarding communication. They identified that professional jargon posed a barrier to engagement and successful therapy. They encouraged therapists to adjust the way that they spoke.

*“Some of the language alienates people. Modify the way you speak.”*

Female Participant, Women’s Group.

*“Don’t speak technical. Break down the language.”*

Female Participant, Women’s Group.

Participants expressed a preference for a consultative approach to therapy, where they were involved in the process. This did not simply mean formulating the problem, but included getting a clear understanding of the length of time and frequency of sessions, the location of sessions and identifying and addressing barriers such as gender. This process of consultation was identified as contributing to the relationship and helped reduce the perceived distance between therapist and client. Participants noted that being consulted and treated as experts on their own lives was important to them.

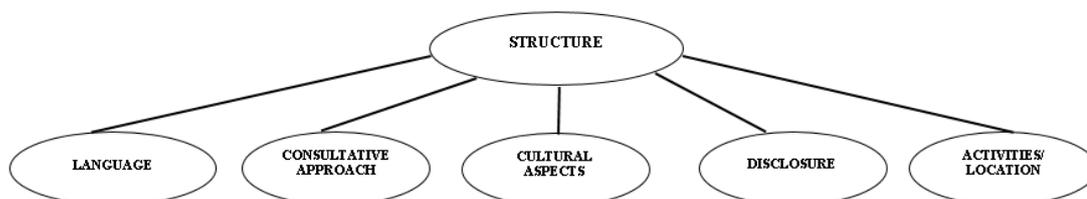
*“Ask them: how can we do it your way? How can I work with you to help? This is about you and what you want.”*

Female Participant Women’s Group.

*“Having an awareness of gender issues and having another gender present.”*

Female Participant, Women’s Group.

Figure 10. Subthemes – Structural issues



Participants believed that talking about thoughts and behaviour would be helpful, however indicated that getting to the point of talking about these things required a strong relationship between therapist and client, and the therapist themselves being flexible in their way of working. Participants pointed out that there were people within community building awareness of mental illness and “deadly thinking” and identified these people as resources that therapists should engage with. They noted that therapists being aware of, or familiar with, the “deadly thinking” framework or other methods (e.g. Stay Strong Plans) also helped with treatment. Participants believed that, through connecting with communities and learning about Indigenous people locally and broadly, therapists could figure out effective ways of talking about thoughts and behaviour.

*“You’ve got people in the community that know about that (talking about thoughts and behaviour).”*

Female Participant, Community Forum.

*“You have to know how to address it. How to approach (talking about thoughts and behaviour).”*

Female Participant, Women’s Group.

*“Watch facial expressions and listen to the language. Know when to stop and when to continue.”*

Female Participant, Women’s Group.

In terms of strategies to build relationship and enhance connection, participants identified the need to build connection through disclosure on the part of the therapist. Participants noted that checking in with a client in regard to where they came from and their mob was also effective as it suggested openness and a lack of assumptions. Participants noted that this disclosure did not have to be too detailed, however needed to be sufficient to allow them to develop a sense of the therapist as another human being within society.

*“Track them, where they are from; build connection. Ask them: where’s your mob from? Don’t just make assumptions.”*

Female Participant, Women’s Group.

*“(The therapist) needs to know that there’s a little bit that person needs to know about...then they need time to actually think about that.”*

Female Participant, Community Forum.

*“Saying who you are, where you come from, sort of where you were born and that type of thing and saying whether you have brothers and sisters is*

*really as much as they want to know to start off with because that encourages them to start talking about their family.”*

Female Participant, Community Forum.

Participants indicated that engaging in activities parallel to the therapy process would be more effective than a western style therapy session in an office with two people simply sitting on chairs. It was suggested that having activities served a dual purpose of enhancing a collaborative relationship and also serve to regulate any emotional intensity.

*“The counsellor is more successful at playing basketball with him and talking to him at the same time.”*

Female Participant, Community Forum.

*“Perhaps have some artwork on the table that they’re already starting on, that they can include that person to start artwork with them, so that there’s something that they’re doing together, to share and start yarning.”*

Female Participant, Community Forum.

*“It’s where you sort of put that deflector on...you might be doing something else, but you can still yarn about the important things...it’s not seen as just sitting at a table.”*

Female Participant, Community Forum.

Participants identified cultural specific aspects of working therapeutically, in particular the need for, and likelihood, having more than one person in a session.

This also related to the ways that therapists may receive referrals or having discussions with one person that related to another person's concerns or experience.

*“The Wadjellas have to get used to the point where there might be two people sitting in the room when you're actually working with one person.”*

Female Participant, Community Forum.

*“‘Cause you may have two brothers or father and son and the son's told the father what's worrying him...He's given Dad permission to speak for him and he'll just sit there and listen. It's those sorts of relationships that you've got to be aware of, rather than saying: 'Well, I've got to work with this person.'”*

Female Participant, Community Forum.

Participants identified location and place as factors affecting therapeutic outcomes. Therapists were encouraged to be versatile and flexible in considering where to meet for therapy. Their experience of working with therapists in office based environments was contrasted with their preference for more open settings and different ways of seating. Office based environments were considered to cause more discomfort as they were seldom experienced as welcoming or culturally appropriate.

*“Why don't we go just, like, go home, make a fire out the back and sit out the back and yarn?”*

Female Participant, Community Forum.

*“(You just) feel more comfortable expressing yourself not in an office.”*

Male Participant, Community Forum.

## **6. Summary**

Participants at a local men’s and women’s group and a community forum commented on the feedback from the non-Aboriginal therapist interviews. They also discussed their own experiences in therapy as well as the experiences of family members. Emerging from this discussion were themes concerning past experiences with therapy or with agencies, themes concerning the need for more education around mental health within the community and awareness of culture and history for therapists. The role of existing networks was discussed and the importance of establishing a good relationship for effective therapy to take place was highlighted. Participants identified non-specific structural or logistical modifications that they considered would improve the therapeutic experience.

## Chapter 6 - Discussion

### AIM

These studies have indicated that Indigenous clients and non-Indigenous therapists experience some difficulty articulating specific modifications made to improve therapeutic outcomes. Indigenous clients and non-Aboriginal therapists identified practical concerns as issues needing to be addressed prior to approaching therapy. This chapter will review the study's findings commencing with a summary of the research process. This will be followed by an integration of the findings from each of the different groups interviewed, then discuss the implications for these in terms of service delivery and practice. Methodological issues are reviewed and recommendations for further research are outlined.

### 1. Summary of the Research Process

The research process followed principles of mutual respect and partnership, community ownership and flexibility. Past research (Adams, Drew & Walker, 2014; Bennett, Flett & Babbage, 2007; Bennett-Levy et al, 2014; Ranzijin, McConnochie & Nolan, 2009; Vicary, 2002; Vicary & Bishop 2005) has found; 1) that psychologists need to work more effectively when assessing and delivering psychological interventions to Indigenous people; 2) that mainstream services experience difficulties providing effective interventions to Indigenous people, and; 3) that the current model of psychology training does not adequately equip students with the necessary training in working across cultures and, more specifically, in Indigenous contexts despite extensive evidence of need for mental health services. There have been attempts to gain understanding of the ways Non-Indigenous therapists work with Indigenous people (for example, McConnochie et al, 2012), as

well as attempts to explore how various therapeutic approaches can be applied to working with Indigenous people (for example Bennett-Levy et al, 2014) however the experience of Indigenous clients that have received psychological interventions from non-Indigenous therapists has been lacking in this area. This study attempted to add this perspective. The intent was honour the Indigenous, rather than Western, perspective in order to obtain information that was valid, relevant and respectful of the Indigenous world view. The formation of a Steering Committee to guide the research and assist with entering and engaging with the local Indigenous community and key stakeholders was central to the research.

The initial aim of this study was to gain an understanding of Indigenous clients and Non-Indigenous therapists experiences of providing or receiving therapy. It was hoped that the information gained through this process could be used to guide specific adaptations to existing therapy models to improve their effectiveness. Through insights gained during the process of meeting with the community, steering committee and individual therapists the initial aim changed. Feedback received from the Steering Committee lead to changes in the methodology. The initial plan was to conduct individual interviews with Indigenous people that had received psychological therapy from Non-Indigenous therapists and then discuss these results with non-Indigenous therapists. However, the Steering Committee recommended that interviewing non-Indigenous therapists first and then discussing those results with groups within the community. The feedback received from discussions with individual therapists suggested that gaining an idea of specific adaptations to existing therapeutic approaches was unlikely. During the interviews, therapists explained that they relied upon trial and error as well as critical self-reflection, rather than formalised learning, developing more - or less - effective strategies. They also

indicated that these approaches were not applied systematically, nor were they particularly specific.

When discussing the results of the therapist interviews, and their own experiences with therapy during community meetings, Indigenous participants raised concerns regarding processes and structures around therapy, rather than the specific interventions delivered. Further, what emerged from the data, particularly when comparing the responses of the Indigenous groups with the non-Indigenous therapists, were broader issues around relationship, knowledge and systems and how these impacted upon the experience of therapy for both Indigenous clients and non-Indigenous therapists. This is summarised in figure 5 and explored in detail below.

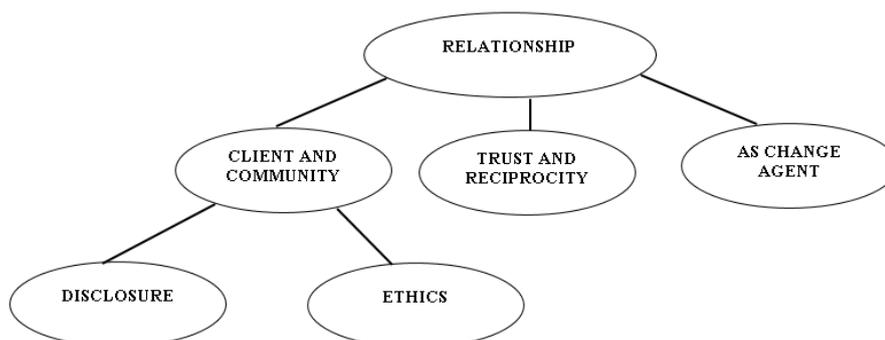
## **2. Integration of Study Findings**

### **2.1 The importance of relationship in therapy**

The centrality of the relationship to effective intervention with Indigenous people was articulated by both Indigenous groups and Non-Indigenous therapists. This echoes McDermott's (2007) suggestion that non-Indigenous workers make a commitment to relationships and to the "long haul" with Aboriginal clients and community. Therapists and Indigenous groups stressed the importance of investing in a great deal of time in both building relationships and focussing on practicalities that support the relationship. This enables negotiation toward creation of trustful and respectful spaces in which the client and the therapist can safely discuss issues and concerns (Seiuli, 2013). When working with Indigenous people relationship building, maintenance and reciprocity is an essential precursor to good therapy (Garvey, 2007).

Both therapists and groups stressed that the core to this was meeting the person where they are, working on establishing a ‘general’ relationship even before building a therapeutic alliance, working around the edges and building trust. Therapists described experiences of moving too quickly into “problem talk” and noted adverse effects on client engagement and attendance as a result. Indigenous group members described experiencing this from the other direction, indicating that they were frequently confronted by direct attempts to “get to the problem” before they were comfortable with the person and the process of therapy.

**Figure 11. Summary of themes and sub-themes NA Therapists and Focus Groups - Relationship**



Given the challenges (Isaacs, Pyett, Oakley-Browne, Gruis & Waples-Crowe, 2010; Westerman, 2004) involved for an Indigenous person attending therapy in the first place, quickly moving into a non-reciprocal, more formalised assessment process was considered off-putting by group members. This represents a significant issue to overcome when considering that the Western modes of thought influencing psychology emphasise individualistic explanations and overlook the role of culture, family and society (Ranzijn et al, 2007) as well as ethical issues experienced in working across cultures (Cole, 2008). Therapists noted differences in subsequent attendance commensurate with the amount of effort taken to develop relationships.

Group members identified that moving into a more formal therapeutic approach was confronting and experienced this as pushing them to move faster than they were comfortable. By slowing down the pace of the session, exchanging information and making conversation rather than getting straight into business, group members and therapists noted that a sense of connectedness and trust developed.

Developing trust through taking time to establish good relationships was considered vital. Group members expressed the opinion that they needed to trust the therapist in order to engage in the therapeutic work. Therapists noted that, unless the client trusted them, very little else could be done effectively. Group members noted that, once trust was established – and maintained – various therapeutic interventions could be discussed and applied. This represented a therapeutic alliance that is culturally sensitive, centred on respectfulness and trust and facilitates healing through collaboration (Seiuli, 2013). Both group members and therapists noted that without a level of trust certain topics could not be raised nor therapeutic interventions carried out.

It was noted by both Indigenous group participants and non-Indigenous therapists that a reciprocal relationship fostered trust. As Bowden (2013) notes, clients will only trust if therapists have professional transparency that helps them see beyond professional language and solutions. Developing relationships with clients and the establishment of reciprocal knowledge (e.g. where you are from, if you have kids etc.) is paramount (Garvey, 2007). Group members highlighted that this trust could not be taken as a 'given', something that therapists contrasted with their experience of working with non-Indigenous clients. Therapists noted that they

needed to be comfortable with being ‘checked out’ by Indigenous clients to see if they were suitable to work with.

Group members, and several therapists also identified that it was not simply a matter of establishing a relationship with an individual. Therapists were encouraged to form relationships with the Indigenous community and make connections to community agencies or Indigenous workers in various agencies. Garvey (2007) cites the experience of a psychologist ‘hanging out’ within a community and being available as a way in which people could develop a sense of who he was as well as enabling the psychologist to be in a better position to learn or be informed as to what was going on, what was important to that community and to gain trust. Group members noted that there were agencies and therapists that did not engage with the community and expected that Indigenous clients would conform to their processes. Therapists and group members indicated that this was not effective.

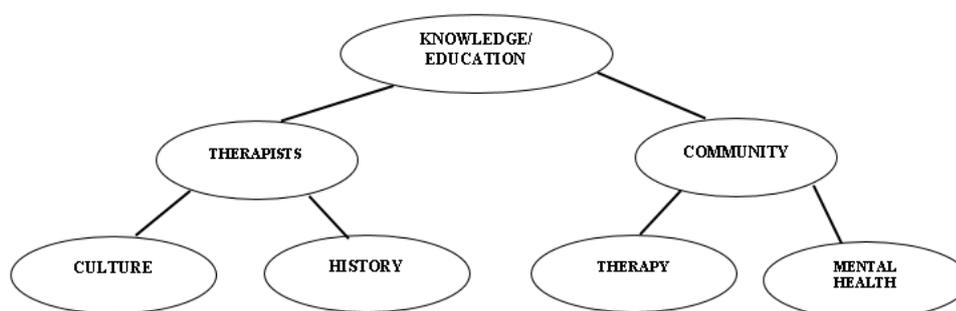
The centrality of the relationship to effective therapy, and comments by some therapists interviewed that the relationship was a key factor in therapeutic change echoes a position taken by some in the ‘culture wars’ in psychotherapy (Norcross & Lambert, 2011; Teyber, 2000). However, this longstanding debate between those that argue that psychological interventions cure people and those that consider the relationship between therapist and client to be the mechanism for healing is an unproductive dichotomy and somewhat therapist-centric (Norcross & Lambert, 2011). The process of psychotherapy is complex with many pathways through the experience and there is a need to identify what works in general (i.e. relationship elements) and what works in particular when applied to a client (i.e. treatment factors (Norcross & Wampold, 2011; Yalom & Leszcz, 2005). Good practice

integrates research, expertise and client characteristics, including culture (Morales & Norcross, 2010). An effective relationship between culturally competent therapists and clients enables this integration and improves outcomes. Group members and some therapists noted that a good relationship and sense of trust in a therapist enabled different treatment methods to be explored and discussed collaboratively resulting in more effective interventions being applied.

## 2.2 Obtaining knowledge

Both group members and therapists reported that knowledge or education was a key component for effective therapy. For the therapist, this consisted of culturally specific knowledge and - for the client - clinically relevant knowledge. This need for therapists to be aware of culture and history is consistent with other research that suggests that to work effectively with Indigenous people, professionals need to develop the knowledge, understandings and skills that are increasingly described as cultural competence (Ranzijn et al., 2009; Sonn, 2004; Walker, Schultz & Sonn 2014; Westerman 2004).

Figure 12. Summary of themes and sub-themes NA Therapists and Focus Groups - Knowledge



Developing cultural competence in Indigenous contexts in part consists of the following: 1) understanding the nature and significance of culture, 2) general

understanding of Indigenous history, culture, contemporary society etc., 3) critical reflection exploring individual, professional and societal values and attitudes (Ranzijn et al 2009). Most therapists interviewed expressed an understanding of the significance of culture and general knowledge pertaining to Indigenous history. This knowledge was developed through exposure to the culture, discussions with cultural consultants and self-directed learning. This occurred 'on the job' rather than being gained earlier through formal study. Some identified attending cultural awareness training, however did not find this significantly helpful as it "essentialised" culture (Pon, 2009; Thackrah & Thompson, 2013) and reduced it to generalised rules for working with Indigenous people that were not always considered helpful.

Only three therapists interviewed reported that they engaged in critical reflection around their practice, values and attitudes. For two of these therapists there were systems in place in their place of work that encouraged and supported this process, whilst for another this reflective process had emerged through experiences at cultural awareness training. It is unclear if other therapists engaged in such reflection as this was only explicitly reported by three participants. A number of authors (Dudgeon, 2000a; Garvey, 2000; Oxenham, 2000; Sonn & Bishop, 2000; Vicary, 2000; Walker et al, 2014) identify critical reflection as a necessary component of practice when working with Indigenous people. Ongoing critical reflection is a way through which therapists can further develop their cross-cultural competence. This goes beyond supervision as critical reflection produces new knowledge and processes within the intercultural space and could potentially improve social justice outcomes for Indigenous people, an area in which the profession of psychology could do more (Ranzijn et al, 2009; Walker et al, 2014). This may involve self-reflection upon processes and issues of subjectivity and

reflexivity, however for optimal effect it is beneficial to include Indigenous people as clients and advisors in actively negotiating understandings. The role of cultural consultant has been identified as central to effective work with Indigenous clients (Westerman, 2004, 2011 among others), however only those two therapists had structures in place – developed by their work organisation, not by themselves - to undertake cultural consultation. A third had an informal system of cultural consultants, again by virtue of their working environment. The use of cultural consultants and provision of cultural supervision is a necessary component for services that engage with Aboriginal people.

Group members noted that gaining knowledge of Indigenous culture through books was a “good start” as was attendance at cultural awareness training, however more active means of doing this, engaging in the community for example, was encouraged as a way of building on this knowledge and becoming more aware of localised issues and norms. Culturally appropriate therapy requires Aboriginal culture to be recognised and the impact of colonisation upon Aboriginal people (Dudgeon & Williams, 2000). “Non-Indigenous people should understand Indigenous people from the start, including accurate history, and white people should learn to understand the effects of how white history creates distrust” (Muller, 2014, p194). Focus group members recommended therapists actively seek knowledge about the local community through the process of engagement and relationship development. There was a strong expectation for non-Indigenous therapists to engage in reciprocal learning from Indigenous people (Muller, 2014).

Despite the Australian Psychological Society (APS) Position Paper on Racism and Prejudice recommendation that courses on cross cultural (including

Indigenous) issues, awareness and research be integrated into under-graduate psychology courses (APS 1997; APS 2015), no therapist described more than a brief introduction to Indigenous issues as part of their formal study. This may reflect the fact that all therapists interviewed had been working for considerable periods and may have completed their study prior to any implementation of such recommendations. Those therapists that had been briefly introduced to Indigenous issues relating to psychological practice reported that this provision of basic knowledge had been insufficient, however noted that this had started a process of cultural awareness and exploration that remained ongoing.

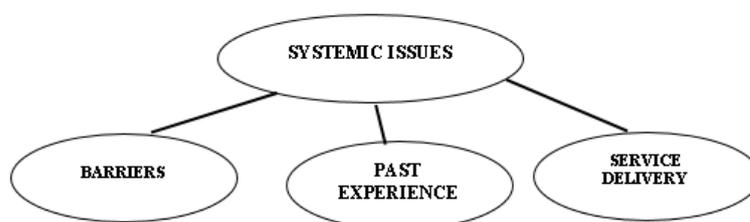
Cultural competence and being aware of, and attentive to, barriers to engagement and treatment on the part of the therapist then enables the therapist to educate clients about mental health, and psychology. Group members noted that there were individuals within the community – Aboriginal Mental Health Workers – that were raising community awareness of mental illness and treatments, whilst noting that considerable shame and reticence to seek help existed within the community. Therapists with strong relationships to the community were seen as having a role in assisting this process of education and awareness raising. Group members noted that they, or members of their family, may be referred to someone for treatment however not have a clear idea as to what that entailed. This resulted in some anxiety and impacted upon engagement, especially when the therapist they had been referred to did not take the time to establish a relationship and rushed into treatment. Therapists noted that taking the time to educate Indigenous people about the system for admission into hospital or a community mental health service or around therapeutic options assisted with engagement and treatment. Vicary and Bishop's (2005) Model of Engagement recommends a collaborative, educative

process in which assessment, diagnosis and treatment are discussed with clients rather than situating the client as passive recipient in the process. Group members expressed a preference for being consulted and informed in regard to therapy.

### 2.3 Systemic issues and obstacles

Group members and therapists noted that there are structural and organisational issues that interfere with providing appropriate interventions. Therapists described “wicked problems” associated with service delivery models suggesting that they were, in many cases, attempting to deliver psychological interventions informed by Western assumptions in a model of service to a population in which it was not going to work. Therapists identified that the service delivery model of many agencies was not consistent with the people that they are trying to deliver the service to. Group members did not identify service models per se, however noted that requirements for attendance, rigid session structure and the location of services affected their capacity and willingness to engage with services.

Figure 13. Summary of themes and sub-themes NA Therapists and Focus Groups – Systemic issues



Walker (2014), the National Practice Standards for Mental Health Services (Commonwealth of Australia, 2010) and the National Practice Standard for the Mental Health Workforce (2013) highlight the need for services and practitioners to

be actively reducing barriers to access and to provide culturally secure/culturally appropriate systems of care. Organisations, like people, need to be culturally competent (Westerman, 2011) and support practices appropriate to working with Indigenous people. However, embedding cultural awareness across corporate, organisational and care delivery models may be easier said than done. Therapists identified instances where they had come into conflict with organisational requirements in the process of attempting to deliver culturally aware service. Group members noted instances where services had ceased to be provided due to an organisational protocol being applied inflexibly. For therapists, working across culture was experienced as difficult as assessment of their work was based upon Western Models by their employers and, for group members, the community's expectations and past experiences of working with non-Indigenous therapists influenced the degree to which individuals were willing to seek assistance from agencies.

Many therapists identified frequent non-attendance as an issue affecting therapy. Some noted that this had impacted upon their expectations for Indigenous clients in therapy, whilst others had changed their aims in sessions towards ensuring that the experience of therapy was sufficiently encouraging in order to ensure that the option of therapy would be considered in future. Therapists that worked in an outreach model reported better attendance and participation than those that worked in an agency based model. Strategies such as texts, phone calls, bus passes were identified as ways of improving attendance for agency based services with varying degrees of success. Therapists noted that being flexible and willing to meet clients out of the office or away from agencies appeared to be beneficial in terms of developing relationships, fostering engagement in the therapeutic process and

providing therapeutic interventions, however was not always possible. Group participants expressed a clear preference for appointments away from agencies and in locations that were more familiar or less clinical. Group members and therapists noted that this appeared to have a positive effect on the development of the relationship.

Workers experience an ongoing dilemma of how to justify to their employers/agencies/funding bodies the rationale for a significant investment of time and resources (i.e. the worker) into a situation that may not quickly yield tangible, measureable or apparent results (Garvey, 2007). This is more pertinent given many organisations are experiencing ongoing restrictions in terms of resources and there are increased demands to justify the time and money spent in service provision (NMHCS, 2014). Therapists indicated that they spent time explaining the need to invest in preparation and participation in order to demonstrate cultural competence in the face of conflicting needs in terms of organisational requirements. What is more important in activity based funding models is how many people attend and not necessarily what is occurring with them when they do and this occurs even with modifiers on the formulas that take into account an Indigenous client base (NMHCS, 2014). The usual metrics of services are reasonably insensitive for Indigenous people because it is not necessarily possible to demonstrate good outcomes in the ten sessions allowed via Medicare through a Better Access Mental Health Care Plan. The pace that referring bodies or agencies want tasks achieved may not always be compatible with how communities work and working in a culturally appropriate way is not always rewarded in the mainstream system (Garvey, 2007; Muller, 2014).

Issues around the length of time spent with clients emerged for both therapists and group members. The time-oriented approach has been criticised as offensive (Muller, 2014). Group members noted that the standard “therapeutic hour” was not something that they found effective. Therapists noted the need to balance agency requirements with responsiveness to client needs. Several therapists noted that they adjusted their diary when scheduling meetings with Indigenous clients in order to arrange for more time to be available to them if it was needed. Therapists and group members noted a need to be responsive to clients in the moment, noting that putting a client on a 6-12 week waiting list was detrimental to effectively engaging with them and a deterrent to participating with the service.

#### **2.4 Specific versus non-specific factors.**

Overall there is little in the literature to indicate what, if anything, is an effective treatment for Indigenous Australians. This limitation was a key driver for this project. Both non-Indigenous therapists and Indigenous participants were asked about what effective therapy consisted of. Indigenous participants noted that, with cultural understanding, appropriate disclosure and a willingness to enter into a reciprocal relationship, many approaches could work. The non-Indigenous therapists stressed that the relationship was the medium through which an intervention was provided and did not appear to favour any particular mode or model over another. This seemed to be based on therapists preferring an eclectic approach to treatment – or, as one non-Indigenous therapist said, “Whatever works” – rather than being firmly committed to a specific model. This approach allowed therapists to be more responsive or flexible depending on client needs. Thus an understanding of culturally bound client related factors influencing the client’s response to therapy was considered more important than the specific therapeutic technique used.

The non-Indigenous therapists appeared to use a mixture of evidence based and other approaches (e.g. Art therapy, Narrative therapy) in their attempts to provide effective interventions. Aboriginal participants talked about what amounted to non-specific modifications – language, use of written materials, and setting – and this was echoed by the non-Indigenous therapists. When discussing more specific factors/techniques, non-Indigenous therapists focused on behavioural techniques within the Cognitive-Behavioural framework. However, these were mentioned in broad detail and tentatively (i.e. “I might do...”) rather than as a clearly articulated therapeutic strategy.

### **3. General Recommendations**

#### **3.1 Service delivery**

The initial intent behind this study was to develop specific recommendations for modifying and adapting psychotherapeutic interventions with Indigenous people. Discussions with community members through meetings suggested that this was not going to address immediate concerns around therapy. Community members reported that the focus needs to move away from specific therapeutic approaches delivered in isolation towards broader concepts of the helping process. Delivering services in isolation whilst not attending to the broader context within which Aboriginal mental health occurs was not perceived as beneficial. This echoes Bell et al.'s (2000) statement that: “Improving Aboriginal health is not just about improving the physical well-being of an individual. It is about working towards the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being” (p.78). Mental health care needs to be an empowering and enabling experience that involves many people with different skills and contributions (Haswell, Hunter, Wargent, Hall, O’Higgins & West, 2009).

This means a shift away from a focus on what is delivered to considering the settings in which treatment is delivered and the service delivery models used.

The “traditional’ service delivery model consists of one-to-one therapy with a client, family, couple or group. This model has been described as limited in its ability to reach large numbers of people who are in need of services (Kaszdin, 2011). This model’s ability to reach Indigenous people in need is just as limited – affected by the limited number of trained therapists in rural and remote regions and the cultural competence (or lack of) of these therapists and their agencies. That is one of the reasons why Western psychological therapy might not be overly effective, because it is too narrowly focused – considering the individual, not the collective; the problem not the social context that is around it. There appears to be a mismatch between what the purpose of western therapy is and the person to whom it is being provided.

Significant investment has occurred in the development of programs that address low levels of SEWB in Aboriginal and Torres Strait Islander communities, for example the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (which included mental health as part of an approach to chronic disease) contributed approximately \$1.6 billion over 4 years, and the Healing Foundation’s Our Health Our Solutions received \$4.78 million to fund projects addressing low SEWB (Gilmour, 2013; NMHC, 2014). A key finding of the NMHC (2014) report was that individual services and programs do not work within a broader context of SEWB and that co-ordination and collaboration – how services and programmes work together – is lacking. Services are not cost-effective or efficient at a macro level due to problems at program/service level. This research

identified that mainstream services capability and accountability for service delivery to Aboriginal and Torres Strait Islander people needs to be improved with changes to the 'one size fits all' approach as well as the development and delivery of culturally competent and culturally safe services. Co-ordination between services is needed to ensure a connected journey through the mental health system and reduce the likelihood of client's disengaging or dropping out of treatment.

Working with Indigenous clients would ideally be conducted by Indigenous therapists and that this might resemble a sort of 'stepped care approach.' Stepped care models represent one attempt to maximise efficiency of resource allocation in therapy with lower cost/lower intensity interventions being tried first and then more intensive and costly interventions being applied progressively to those insufficiently assisted by the initial intervention (Davison, 2000; Haaga, 2000). Taking this approach, the first point of contact is the family/community where Elders and existing community networks/methods of healing play a role. This is consistent with group members who expressed a preference for accessing community resources and traditional methods of healing as a first step. If Elders/Aboriginal Health Workers in conjunction with the client and their family consider additional assistance is required, then subsequent steps might be to access culturally specific programs delivered through Aboriginal controlled Community Health Services (ACCHS) using flexible service models that are integrated within the community or include mental health services reaching into the ACCHS or even co-located. Services could then progress to one-to-one therapy with a psychologist or social worker with knowledge and experience in the area. Indigenous participants identified that the term 'psychologist' has associations with past poor treatment and family disruption so a title such as "specialist Aboriginal mental health worker" would be potentially

less intimidating than that of psychologist. This title would also highlight that the individual possesses specialist knowledge and awareness whilst avoiding negative associations based on past experience. This specialist Aboriginal mental health worker would have links into the community and involve cultural consultants ensuring that such specialist interventions took into account client characteristics and culture. These professionals would also employ a service model that was flexible and adaptive to community needs.

Given the preference for Indigenous people to utilise existing networks of family, extended family, Elders and traditional Healers, it appears that it is only when these resources are exhausted are mainstream services considered by Indigenous people. However, the National Mental Health Commission Secretariat (NMHCS, 2014) *Expert advice on specific challenges for Aboriginal and Torres Strait Islanders peoples' mental health* report found that current mainstream targeted interventions had several problems that rendered them ineffective at a macro level. These problems included the design of individual programmes, the way in which programme 'silos' did – or didn't – interact with each other and poor quality of linkage of patients across components. Further “multiple funding streams have led to multiple service providers...that do not integrate the care they provide with other elements of the health system...” (Submission to the Commission, NMHCS, 2014, p10). The development of a stepped care approach, being situated within an Aboriginal Community Controlled Health Service (ACCHS) may result in better outcomes and also make professional help more accessible for those people with less severe mental health problems that previously either endured their illness or adopted other ways of coping – a population described by Isaacs et al (2010) as an unmet need. Aboriginal Community Controlled Health Services (ACCHS) are the practical

expression of Indigenous self-determination in health (Bell et al, 2000). Community controlled primary health care provides accessible, culturally appropriate treatments and ensures that Indigenous people have control of issues that directly affect their communities. The ACCHS SEWB model of mental health services is more accessible and responsive to Indigenous people than the treatment oriented mainstream model however still has limitations which result in unmet need (Hunter, 2007; Isaacs et al, 2010). As many SEWB workers have only a certificate level qualification and may work with people with complex mental health needs a stepped care approach can assist with maintaining a client in a service whilst providing increasing levels of care based on their degree of need. The professional skills and support base of SEWB staff would also need to be developed through professional development and supervision, something that the “specialist Aboriginal Mental Health worker” could provide on a reciprocal basis – i.e. the “specialist” provides clinical supervision to staff whilst Indigenous health workers provide cultural supervision and support to the “specialist.” It is worth noting that a significant proportion of Aboriginal and Torres Strait Islander people do not use an ACCHS for their primary health care due to lack of a service or a preference for mainstream care, it is also important to consider how this stepped care approach may be employed in different contexts. This may be a topic for further research.

Integration of services is critical. There is a need for services involved in delivering mental health care (such as psychological interventions, community education and psychoeducation) to Indigenous communities to build strong linkages into other services and to the community itself. This may take a cultural shift in the other services as well. Mainstream services need to become more informed and have accountability measures that are about service integration and around their

responsiveness to the particular cultural needs of clients that come their way. Strategies like co-case management recognises that two services working in close co-ordination can provide better service efficacy for a client than either service working in isolation. One of the area services fall down is around transitional care so providing a continuity of presence, even whilst a client of one service under the primary jurisdiction of another is important. This interdisciplinary team/ interagency approach with equal relationships and interdependent collaboration is more consistent with social and emotional well-being values (Schultz, Walker, Bessarab, McMillan, MacLeod, & Marriott, 2014). The application of new technologies – such as smartphone apps, or e-therapy - to assist clients of services and service providers themselves could assist in improving outcomes in well-being and care (Dingwall, Puszka, Sweet & Nagel, 2015).

The National Mental Health Commission Secretariat (NMHCS, 2014) outlines a new service delivery model addressing areas of identified problems. This service delivery model consists of: 1) integrated mental health and SEWB teams in Aboriginal Community Controlled Health Services/Medical Services; 2) culturally responsive mainstream services; 3) linking and supporting patients in specialist clinical services (e.g. State-wide Specialist Aboriginal Mental Health Service team in WA); 4) developing the Aboriginal and Torres Strait Islander workforce; 5) establishing mental health as a priority and increasing funding.

An example given within the literature of a good integrated service model is that of the Western Australia State-wide Specialist Aboriginal Mental Health Service (SSAMHS). SSAMHS is attached to mainstream specialist mental health services and works with ACCHS not only to ensure that their patients journey smoothly

across the mental health system according to their needs, but also that they receive cultural support, including access to traditional healers and the support of their families and community. In recovery, the service helps connect people to community services and programs. Again, the focus is on the needs of the ‘whole person’ in a SEWB context (NMHC, 2014). The SSAMHS model demonstrates a responsiveness to people, supporting that transition from hospital back into the community or vice versa.

### **3.2 Workforce issues**

Group members identified that having Aboriginal Mental Health Workers within the community contributed to developing community knowledge and education about mental health. One of the National Mental Health Commission Secretariat (NMHCS, 2014) recommendations is to develop the Aboriginal and Torres Strait Islander mental health workforce. Indigenous people have an understandable and intrinsic capacity to engage more effectively with Indigenous people due to a lived understanding of culture. One of the challenges is that the Aboriginal mental health workforce is still growing and there is a dichotomy between what clinicians think of as the multidisciplinary team and the Indigenous workers appearing ‘bolted on’ to some mainstream services in a sense or being considered as “seasonal workers” (Brideson, 2004). This may be seen as an expression of institutional racism (Taylor & Guerin, 2010) where systems or institutions disadvantage Indigenous people through failure to provide appropriate support, training or workplace development because of a lack of understanding or consideration of cultural factors. A supportive environment for the development of the Aboriginal and Torres Strait Islander mental health workforce and professional recognition of such programs as Charles Sturt University’s Djirruwang Aboriginal

and Torres Strait Islander Mental Health Program is required (Brideson & Kanowski, 2004; Brideson, Havelka, McMillan & Kanowski, 2014). Commitment to an interdisciplinary approach may result in Aboriginal Mental Health Workers getting more appropriate support, remuneration and career pathways than at present (Schultz et al, 2014).

Psychology as a discipline needs to explore ways to encourage and support Indigenous peoples to become psychologists. The Australian Psychological Society (APS) has established several scholarships and bursaries for Aboriginal and Torres Strait Islander people (e.g. the Bendi Lango initiative and Charlie Perkins Scholarship) wishing to undertake post-graduate study in psychology. The Puggy Hunter Memorial Scholarship Scheme (PHMSS) aims to increase the representation of Aboriginal and Torres Strait Islander peoples in health professions more generally. Financial support is only one part of the puzzle, universities need to be aware of, and address, barriers such as difficulty adjusting to metropolitan areas, a lack of indigenous content and staff and cultural insensitivity from staff members (Cameron & Robinson, 2014). Providing support centres and exploring options for flexible study – to allow students to maintain contact with country – are important for growing the number of Indigenous students at an undergraduate level. This would then flow on to increases in the number of students considering post-graduate study.

In summary, practical changes might include: 1. Incentives from the government to attract more Indigenous people to train in mental health; 2. Work with Indigenous communities to establish a truly integrated model of care where the

Aboriginal Mental Health Worker has a very close relationship with the families and communities.

### **3.3 Clinical Training Programs**

There are implications of this research for clinical training programs. Many, if not all, such programs teach prospective clinicians specific interventions for specific disorders (e.g. use of schema therapy, CBT etc.), with little discussion as to cultural competence. The education is focused on what happens when the client is present in front of the therapist, however this research identified that there is a lot of work to be done well before this occurs. Teaching students about culture and building an awareness of Indigenous culture and issues as well as fostering connections with Indigenous community controlled health services and exposing students to these would aid in creating culturally aware practitioners that are able to identify and overcome barriers to engagement.

## **4. Methodological issues and recommendations for further research**

### **4.1 Methodological issues**

Indigenous people in Australia belong to different traditional communities each with their own unique culture and traditions (Isaacs et al, 2012). This study was conducted with one such community and, as such, the findings must be applied with caution. The community in which this research took place is situated in a regional centre with a range of services and therapists available, and with many Indigenous participants having an awareness or involvement with mental health or therapy providers through their own experience or that of family members. This may not be the case in a more isolated community elsewhere in the country. There were similarities between responses of the non-Aboriginal therapists and those reported in

previous research (McConnechie et al, 2012), however further conversations with other Indigenous communities around their experience of therapy would be required to see if the experience of group members is consistent with other communities. These conversations could clarify the relevance of this work to other communities and what may be required to develop policies that apply across and between different communities.

In conducting this research time was a significant issue. As part of ensuring that this research was conducted with sensitivity and respect, the process of obtaining ethical clearance, the formation of a Steering Committee and engagement with the community took longer than comparative research in a non-Indigenous context. During the group discussions I was frequently encouraged to make contact with people or groups in the community to discuss the research further. I needed to be up front to participants in terms of outlining the limits on time and the university requirements for completion. Future researchers need to be aware that this type of research will typically take more time and prepare accordingly.

Time constraints, as well as recommendations from the Steering Committee resulted in modifications to the initial research plan. Initially the intent was to meet with people that had attended therapy with non-Indigenous therapists on a one-to-one basis. To do this effectively would have required a considerable amount of time spent engaging with the community; time that I lacked due to working full-time and also the limited amount of time I had to complete the research. It is possible that one-to-one interviews combined with focus groups may have yielded additional information and enabled people who did not want to attend the groups or community forum to have had their say.

The process of research mirrored information elicited from group members in terms of what they wanted from therapy. The topic under research evolved from considerations about specific therapeutic modifications for specific disorders towards an understanding of people's experience of the process of therapy. Approaching the topic and conversations with Steering Committee members and community members with a receptive, open mind enabled the research to be more responsive to feedback and adjust to setbacks in terms of time restrictions.

The fact that much of the information that emerged from group discussion and therapist interviews echoes existing findings in the literature (Bennett, 2015; Bishop, Mitchell, Vicary & Pearson, 2012; Garvey, 2010; Jones & Brideson, 2009; McConnochie & Nolan, 2008; McConnechie et al, 2012; Vicary 2002, 2004) could suggest that changes in ways of working have not yet been applied consistently and that, perhaps, we are nowhere near ready to look at the specifics of therapy because there remain obstacles to be overcome before that can be considered. Strategies to overcome systemic barriers to attending services, providing students with the knowledge and skills to work in Indigenous contexts, building research links with communities to develop, evaluate and disseminate culturally appropriate interventions, developing flexible, responsive service models through engagement with Indigenous clients and communities, building and strengthening the Indigenous mental health workforce are all vitally important to improving outcomes. Simply providing a therapeutic intervention without an awareness or understanding of the overall context in which it occurs is not going to be enough.

## 4.2 Further research

In planning the research there was an inherent assumption that therapists would outline modifications to Cognitive Behavioural Therapy and that this would form the key parts of the group discussions. This was based on the evidence that CBT is effective for a range of issues and also that CBT had been adapted to other cultural groups in the United States and elsewhere (Bennett-Levy et al 2014; Bennett et al, 2007; Hinton, Rivera, Hoffman, Barlow & Otto, 2012; Nicholas, Arntz, Hirsch & Schmiedigen, 2009; Shen, Alden, Sochting & Tsang, 2006). This may have been a case of putting the cart before the horse. Ethnicity and culture need to be built into evidence based treatments rather than developing evidence based treatments and then making them culturally relevant (Kazdin, 2008). The question emerged: Why take CBT as the starting point? Why not start elsewhere? Why not consider alternative methodologies such as Red Dust Healing ([www.thereddust.com](http://www.thereddust.com); Cull, 2009; Powell, Ross, Kickett & Donnelly, 2014) or Deadly Thinking ([www.deadlythinking.com](http://www.deadlythinking.com); Robinson, 2011)? Red Dust Healing incorporates traditional practices and symbolism to assist participants to understand their role and responsibilities in their families and communities using tools that ‘target the heart, not the head’ (Cull, 2009, p36). These treatments incorporate culture and culturally appropriate ways of delivery, however lack a clear evidence base – despite anecdotal evidence supporting their use. Further research on these methods or integration of these methods with aspects of Western therapy is required in order to develop an evidence base supporting their use and also to attract funding for implementing these approaches and making them more accessible across communities.

The ability to provide a brief treatment within a stepped care approach may be effective given the issues group members experienced with accessing services and

therapists identified with attendance. Very brief interventions can have significant and enduring effects with significant clinical problems (Kazdin, 2008, 2011). Research on the effectiveness of providing brief targeted interventions of some description pertaining to specific presentations is also needed given resource limitations in more remote areas of Australia.

Another area for exploration could be identifying through discussion with communities those therapists that are perceived as effective in their ways of working and then discussing with them what they do, or possibly (with appropriate consent) video-recording how they deliver therapy. The recordings could be analysed and specific therapeutic techniques may be identified. These could then be discussed with communities and commented upon.

Members of the State-wide Specialist Aboriginal Mental Health team have also expressed interest continuing this research in other areas of Western Australia and possibly extending it to consider service delivery models and therapeutic interventions. It is anticipated that this process will follow the methodology outlined in this research to some degree however may also incorporate cultural consultants more actively. Discussions regarding detail about how this may occur are yet to occur, however it is envisaged that this would explore the ways that different communities perceive mental health services and obtain feedback as to recommendations for service development.

## **5. Conclusion**

This research identified that psychologists and members of other helping professions interviewed experience difficulty articulating specific modifications to their ways of working when undertaking therapy with Indigenous clients.

Psychologists need to work more effectively when delivering psychological interventions to Aboriginal people. Both therapists and clients report that establishment of a relationship is central to the effectiveness of therapy and described factors that facilitated this. It was also identified that mainstream services experience difficulties providing effective interventions to Aboriginal people. There are a variety of systemic issues and obstacles that impact upon effective service provision. Changes to service delivery models, the development of stepped care approaches and more integration with existing Indigenous health services were recommended. Investing time and money into development of an Indigenous workforce is also likely to improve outcomes. Non-Aboriginal therapists who work alongside Indigenous mental health workers may ultimately provide more effective interventions than those that do not. This also may create an environment in which ideas for culturally appropriate therapy can be discussed, trialled and evaluated.

When presenting this research at a seminar an attendee noted that the centrality of relationship and other factors identified through the research were “no different” than that emerging from the general psychotherapeutic literature for non-Aboriginal people. Whilst general factors (such as relationships, rapport, trust, positive regard etc.) may on the face of it look the same, there are crucial differences involved in the process of developing relationships that directly relate to the cultural context within which therapy with Aboriginal and Torres Strait Islander peoples takes place and the cultural differences between Indigenous clients and non-Indigenous therapists. Actively examining what is involved in doing good therapy with Indigenous people is likely to lead to better outcomes for Indigenous people and, as a serendipitous by product, point the way to good therapy with other groups of people.

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## Appendix A -Letter of Support from SWAMS

<p><b>ADMINISTRATION</b> Unit 1, 14 Rose Street BUNBURY WA 6230 PO Box 1444 BUNBURY WA 6231 Telephone: (08) 9791 1166 Facsimile: (08) 9721 4621</p>	<p><b>CLINIC</b> South West Health Campus Robertson Drive BUNBURY WA 6230 Telephone: (08) 9726 6000 Facsimile: (08) 9791 7655</p>	<p><b>SOCIAL &amp; EMOTIONAL WELLBEING TEAM</b> Unit 1, 11 Sandridge Road BUNBURY WA 6230 Telephone: (08) 9791 2779 Facsimile: (08) 9792 3742</p>	 <p><b>South West AMS</b> Aboriginal Medical Service</p>
ABN 98 241 772 591	Toll Free: 1800 779 000	Toll Free: 1800 008 860	

James McCloy  
Clinical Psychologist  
South West Mental Health Service  
South West Health Campus  
PO Box 5301  
Bunbury WA 6231

Dear James,

I am pleased to advise that the Board of SWAMS has approved this organisation participating in your research project subject to your demonstrating that the project has ethics approval through the WA Aboriginal Health Information and Ethics Committee.

The research will certainly contribute to a better understanding of the efficacy of psychological services provision to Aboriginal people, and as such the Board of SWAMS is very interested in the outcomes and progress.

Please liaise with Chris Daumuller, Manager of our SEWB service, as a point of contact / coordination for your activities with our service.

Yours sincerely



Dr Glen Power  
Chief Executive Officer

8<sup>th</sup> March 2012

## Appendix B - Non Aboriginal Therapist Information Sheet

My name is James McCloy. I am currently completing a piece of research for my Doctor of Philosophy (Psychology) at Curtin University of Technology.

Thank you for your interest in this study. Please take time to read the following information carefully and feel free to ask questions if any of the information is not clear to you or if you would like more information.

I am investigating culturally appropriate mental health interventions in Aboriginal communities in terms of Western healing. I am hoping to describe a culturally appropriate process of intervention suggested by Aboriginal people for Non Aboriginal mental health practitioners.

I would like to find out your experience of providing psychological interventions to Aboriginal people – what worked, what didn't, what you would have preferred, what you think would work better.

Participation will involve an interview with me about your experiences. This interview will be recorded and transcribed. The interview process will take approximately xx minutes.

Participation in this study is entirely voluntary. You may choose not to participate or to withdraw at any time without prejudice. Signing the consent form indicates you agree to participate.

The information that you provide will be kept separate from your personal details and I will only have access to this. The interview transcript will not have your name or any other identifying information on it and, in adherence to university policy, the interview tapes and transcribed information will be kept in a locked cabinet for five years, before it is destroyed.

This study has been reviewed and approved by the Curtin University Human Research Ethics Committee (HR145/2009). If you would like further information about the study, please feel free to contact me on 0437616496 or by email ([jimree@hotmail.com](mailto:jimree@hotmail.com)). Alternatively, you can contact my supervisor, Dr Clare Rees (phone: 9266 3039, email: [c.rees@curtin.edu.au](mailto:c.rees@curtin.edu.au)).

### **Appendix C - Interview guide for Non-Aboriginal Therapists**

The purpose of this interview is to find out about your experience of working therapeutically with Aboriginal people. I just want remind you that the things you say will be treated in the strictest confidence and you won't be identifiable in the final report. I am particularly interested in your thoughts and opinions so please answer each question in your own words – there's no right or wrong answer.

- Do you have any questions before we start?

First I would like to find out a bit about you:

- Can you tell me about your qualifications, background, and experience in working as a (insert profession)?
- What lead you to working here?
- Can you tell me about your job and your daily routine and tasks here?

Now I want to move on to talking about working with Aboriginal people:

- What do you think is important to know about working with Aboriginal people?
- What would you have liked to know before starting to work with Aboriginal people?

Now I want to talk about the therapeutic services you provide to Aboriginal people:

- How would you describe your approach/style of support and/or intervention?  
Can you give me an example?
- In your experience what therapeutic approach works best/well?
- How is it different when using this approach with Aboriginal people?
- How is it the same?
- What are the key issues in regard to working therapeutically with Aboriginal people?
- What challenges do you think you face in working with Aboriginal clients?
- What's worked well?

- What has worked not so well?
- How would you describe your level of satisfaction with the current services you provide to Aboriginal clients?
- How do you think the supports you provide could be improved? Why/How so?

Thank you for participating in this interview today. Your answers have been really helpful

- Are there any other questions you wished I had asked you or anything else you would like to add?

We've come to the end of my questions. Thank you for your time.

## Appendix D - Aboriginal Participant Information Sheet

My name is James McCloy. I am currently completing a piece of research for my Doctor of Philosophy (Psychology) at Curtin University of Technology. Thank you for your interest in this study. Please take time to read the following information carefully and discuss it with your friends, and family if you wish. Feel free to ask questions if any of the information is not clear to you or if you would like more information.

I am investigating culturally appropriate mental health interventions in Aboriginal communities in terms of Western healing. I am hoping to describe a culturally appropriate process of intervention suggested by Aboriginal people for Non Aboriginal mental health practitioners.

I would like to find out your experience of receiving psychological interventions from non-Aboriginal professionals – what worked, what didn't, what you would have preferred, what you think would work better.

Participation will involve having yarn with me about your experience. This yarn will be recorded and transcribed. The interview process will take approximately minutes. If you are interested, you can also attend a focus group to discuss the results and provide more feedback.

The South West Aboriginal Medical Service's Social and Emotional Wellbeing Team will be available to provide psychological and/or cultural support should it be required. **Their contact number is 9791 2779.**

Participation in this study is entirely voluntary. You may choose not to participate or to withdraw at any time without prejudice. Signing the consent form indicates you agree to participate.

The information that you provide will be kept separate from your personal details and I will only have access to this. The interview transcript will not have your name or any other identifying information on it and, in adherence to university policy, the interview tapes and transcribed information will be kept in a locked cabinet for five years, before it is destroyed.

This study has been reviewed and approved by the Curtin University Human Research Ethics Committee (Approval Number XXXX). If you would like further information about the study, please feel free to contact me on 0437616496 or by email ([jimree@hotmail.com](mailto:jimree@hotmail.com)). Alternatively, you can contact my supervisor, Dr Clare Rees (phone: 9266 3039, email: [c.rees@curtin.edu.au](mailto:c.rees@curtin.edu.au)).

## Appendix E - Consent form

*The development of a cross-cultural psychotherapeutic framework for Psychologists working with Western Australian Aboriginal people.*

### PARTICIPANT CONSENT FORM

- I understand the purpose and procedures of the study.
- I have been provided with the participant information sheet.
- I understand that the procedure itself may not benefit me.
- I understand that my involvement is voluntary and I can withdraw at any time without a problem.
- I understand that I may withdraw or add comments to the transcript at any time.
- I understand that no personal identifying information like my name and address will be used and that all information will be securely stored for 5 years before being destroyed.
- I have been given the opportunity to ask questions.
- I agree to participate in the study outlined to me.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Appendix F - Focus Group Guide questions**

- 1) What comes to mind when you hear the words “Therapy” or “Psychology?”
  
- 2) If you had a problem – felt sad or worried – who would you talk to? What would they need to do to be helpful? What would they need to know?
  
- 3) When you saw a non-Aboriginal therapist what was good about it? What was not so good? What would have made it better?
  
- 4) What’s the first thing a non-Aboriginal health worker or therapist needs to know before they start working with you?