Mental Health
Assessment of Aboriginal Clients

Pre-workshop Reading Material
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ARTICLE 1:


The concept of the spirit has not been widely written about within Aboriginal culture, and this article looks at the concept of the Ngarlu or inner spirit as defined by the Karajarri people of the Kimberley region of Western Australia. The Karajarri people see the Ngarlu as being ‘three in one’ – or three different ‘parts’ to the spirit – these being the Ngarlu (the centre of our being and emotions), the Rai (spirit from the country) and the Bilyurr (the spirit from within). He describes an assessment model that he has used in a mental health environment as well as an intervention process which is based on strengthening the spirit which he argues has been weakened through oppression, marginalization, racism and so forth.

A few questions for you to ponder

Consider:
What is the importance of the Ngarlu or lian for Aboriginal people and how can this be of relevance when considering mental health functioning?

If the Rai represents spirit from the country – does this make connection to land and country an important consideration in assessment of Aboriginal people? How is this so?

Consider: do mental health workers have a role in working with the spirit of Aboriginal people?

If so, how can we make sure that we are culturally respectful

If not, how do we make sure that we working with our client in the appropriate way that incorporate all parts of their wellness and unwellness?
Ngarlu: A cultural and spiritual strengthening model

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From a transcript of an interview in Broome, discussions and graphics from the associated training program.

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**Ngarlu**

Ngarlu is the Karajarri word for defining the place of the inner spirit. This place in our stomach is the centre of our emotions and wellbeing. When a group makes a decision there is a sense of group Ngarlu: their feeling and thinking is the same. This is known as ‘Waraja Ngarlu’, which is to agree to be of one stomach and to be of one mind. There is a similar term to Ngarlu in many groups in the area.

Contained within our Ngarlu is our Bilyurr and Rai (see Model 1). Bilyurr is our spirit from within, which is in oneness with the physical body. After death the Bilyurr goes on its journey to a special place. Rai is our spirit from the country. The father dreams or sees the ‘child spirit’ that wandered away from the group dwelling place which is called Yadungal. He is now aware that his wife is or will be pregnant and that the child’s spiritual connection in the form of an animal, fish, plant or a particular area in the land will coincide during pregnancy, and be his/her Rai. The physical and spiritual conceptual place of birth becomes the central part of the identity of that person and he also becomes a protector/custodian. When we pass away our Rai (spirit from the country) goes back to the country where it pre-existed and becomes a ‘child spirit’ again, and remains in the group at the Yadungal awaiting another spiritual rebirth.

**Working with Ngarlu**

Ngarlu has been weakened by the colonisation process which has led to things like changed lifestyles, dispossession, disempowerment, alcohol and drugs. Ngarlu was what kept people strong and healthy. Ngarlu gave a strong sense of self, where the spirit came from, ‘if you feel no good here, (pointing to the gut or stomach) then you feel sad or weak’. Ngarlu is more than an intuitive or gut feeling; an Aboriginal person can will themselves to die when the Ngarlu has been broken or weakened and is very sorrowful.

Some of the older ones know and understand this. They can connect with and work with it. For the young ones it is part of a cultural loss; they have to be taught it.
A traditional person may say: ‘not feel too good here’, and point to the stomach, referring to Ngarlu. Often this may get misinterpreted as a belly ache when in fact it is indication of a spiritual or emotional problem.

![Diagram of Ngarlu Assessment Model]

Model 1: Ngarlu Assessment Model

We thought it important to base our workshop on healing - to strengthen the Ngarlu or ‘lian’ that has been weakened through disempowerment, to make that strong again. This is what has kept the people strong.

This is put in a cultural context with young people. Worldwide, young people have lost their spiritual beliefs and they have nothing to hold on to. We point out to young people to be aware of your Ngarlu - why is it sad, question why you are feeling low, angry. We suppress a lot of feelings, and keep anger and shame down there. We have to get it out, because that has been the Aboriginal way. It is important to work on healing our Ngarlu. The effects of the stolen generations and our historical experiences, is what has contributed to weakening our Ngarlu. To start to heal it is important to start in our own Ngarlu, which will help us to deal with our bitterness, anger and sadness.

In Aboriginal culture before, if a person felt bad about another person, they would approach them, express their feelings and get it out, instead of suppressing it. They would clear their Ngarlu. This used to be their strong point when the culture was strong.

In Law time before, the boys would be taken for initiation. If one had a bad feeling for another person he would approach that person and talk to him, even if it meant having a fight. It was important to clear one’s Ngarlu before going into that ceremony. Aboriginal people had ways of clearing. If Ngarlu was sore, one should not keep it for too long. ‘White man’s way is the other way - take it, tight lipped, keep it down. Our way is to get rid of it quick or it will kill you. It will kill your spirit.
We are trying to work towards this way of healing. Some communities are working with trying to strengthen these cultural ways.

Our approach is about keeping the spirit strong. If one is drinking too much for example, the spirit falls away, dragging the person away from culture, and cultural responsibility to family, community and country. Other Aboriginal people are independently coming up with awareness of the need for this type of approach: ‘Hey that’s the thing I’m talkin’ about, I’m not the only one talking about it. I can understand better now’. All different groups are coming from the same perspective. If we deliver this program in a workshop, we focus on Ngarlu. For example if we are working with stolen generation people, we also focus on Ngarlu - on hate, anger and shame.

Working with men: mental health

My role with Northwest Mental Health Services is to work with men in their recovery from a major psychiatric illness. We are at the stage where we are just starting to implement rehabilitation programs to help instill some practical life skills and assist them in taking responsibility for their illness.

An underlying issue is that society no longer provides Aboriginal men a role to play in the wider community. I run one session for the Kimberley Offenders program for men in prison. This is intended to help them realise that drugs and alcohol are killing our culture; and to talk about taking responsibility, and strengthening our Ngarlu. The aim of the workshop is to ask: ‘If your generation, that is you, are in goal, who is going to talk to the young kids’?

It is hard to get them to look inside their problem. This is very hard with people in general but it is especially so with people in prison. They are often at the blaming stage and it is hard to get them to take responsibility. They tend to blame everyone around, but not themselves. They are angry it is directed outwards.

We trace the process from colonisation, how the violence was internalised, and how it shows now in anger, rage, suicide or taking it out on others, particularly those close to you.

It is hard to get men to talk about their problems. Instead, Aboriginal men often blame their partners. They keep their feelings down rather than express them. They prefer to not talk about it; when it comes out they explode. When visited in prison by support agencies, they usually don’t want to talk about what they’ve done and how they feel, and when they are released, these feelings all explode out, often against their partners.

This program tries to get them to reflect, to look at themselves, and to accept part of the responsibility. With these types of programs facilitated by senior Aboriginal men, they can be appropriately challenged. When these types of programs are facilitated by female workers this can be considered culturally inappropriate because they tend to push their views aside, stating that it is not a woman’s place to challenge their behaviour, especially if the men have been through traditional law.

Part of the empowerment process in supporting men to take back responsibility for their behaviour, requires men to facilitate that process. This could be seen as ‘men’s business’ and by utilising male Aboriginal workers to deliver these programs will enhance program outcomes.

When culture was strong, young uninitiated men never lived with girls as husband and wife; that wasn’t Aboriginal culture. When a young fella turns adolescent, at 13-14 years old, he begins to go through Law. That is his learning time - his initiation - and he is taught about country. Then there is more Law. By the time they take their partners they are nearly 20 years old; that was the proper way. We see young people today doing the reverse, living together, having two to three kids.
Often they can’t cope any more, and there is domestic violence, substance abuse, psychological/social problems which can lead to suicide.

Also, in the old times, the Skin system controlled who married who and directed responsibility that was collectively shared by the tribe. The Skin system worked well. When there is a breakdown of the Skin system, they can just go with anyone, and this causes more problems. In the program we go into regional Skin systems, where each person fits, and the personal and collective responsibilities entailed in this.

One should not marry into one’s mother’s or father’s skin group; this protected communities from the effects of genetic closeness. Today with the influence of modern society, especially with the influence of alcohol, people don’t care, even to not observing protocols about not talking to one’s mother-in-law.

In the proper way culturally, most girls were promised at 14-15 years old to older men. Controls were in place and younger men had to wait. In that time there might be fights for women. A young man supposed to take a wife may be made to wait while an old man may have three to four wives. That is when trouble can begin. He might start running around with others; fighting and so on. The social controls have broken down even in remote communities. In other communities, the Law may be strong, and some have held and been carried through.

**Culture and community: diversity**

Mental health workers have to be sensitive to the diversity within the Aboriginal culture and to the people they are working with. Some communities have just about completely lost their culture in the sense of traditional values and practices. It is in those communities one finds more problems, for example, family violence, substance abuse, elder abuse and child abuse. In those communities the people are so disempowered and feel so hopeless that they just don’t seem to care any more. In other communities there won’t be so much of these problems because their culture is a little stronger.

It is important that even the professionals have to be aware of the sort of community they are dealing with. Because of different impacts of colonisation and the influence of imposed religions which disregard culture, it appears that where there tends to be the greatest culture loss, there is the highest level of other serious problems. With others where the language and culture has found some way of being maintained, the situation tends to not be so difficult.

All sorts of psychosocial problems are very complex. Mental illness, suicide, alcohol and drug abuse and sexual abuse are the end results from the ongoing effects of the colonisation process.

**Traditional healers**

Sometimes traditional healers can play a significant and at times even a main role in working with patients with mental illness. When this is so, people will generally request it. It can be important to know who is requesting it. Sometimes if it is somebody who has very little actual knowledge of their own culture - someone who lost their culture - it can be a sign that this person may be quite mentally ill. However within that they may be saying something quite significant that is important for a deeper understanding of their mental and emotional state. In comparison, for the very traditional person from very traditional communities, it’s a living part of their belief.
Whether the person comes from an urbanised background is not necessarily an indicator, as sometimes urban Aboriginal people can have strong cultural beliefs. To understand properly we need to take more notice of the cultural background of that client. We need to involve the family so we can work it out together. Practitioners need to be aware of the diversity of Aboriginal people and this needs to be included in the assessment. Acknowledging that some people may ask for a Traditional Healer needs to be included in the initial treatment process.

What is appropriate for practitioners to do in this situation is not to feel that the Western way is the only way, but to try to work along with this other cultural alternative as well, to work together. Practitioners should contact someone appropriate in the community about it, to seek advice about where they should go from there. Have a talk about it, try to find out and get a bigger picture to work on; the mental state examination can be very narrow, sometimes through not understanding the cultural ways and not including the spiritual concepts of health.

It’s best to consult with the team you are working with, including your, or the service’s, cultural reference group. Rather than make an individual decision, discuss it as part of case management. If necessary, an appropriate cultural person will maybe arrange for a mabarn man (traditional healer) to have a look at the patient. Sometimes this is a request from the family who may look for other cultural alternatives before they are satisfied that the person is really mentally ill.

Consulting a mabarn can be an aid to confirming diagnosis, especially in determining whether it is a traditional matter or not. They can be a useful part of the process.

More traditional people have a world-view of Aboriginal things happening to them, but today in this contemporary way, young Aboriginal kids are not knowing this culture. With them it could be a non-cultural issue such as alcohol and drug related psychosis.

Since the 1970s, ‘80s and ‘90’s there has been more involvement with alcohol and drugs and we are getting younger people with mental illness. There are other things, but drugs are there as well. Without these drugs before, there was not this level of mental illness; maybe excessive drug use has tipped them off the other side. However, additionally a lot of other things may also be happening, like family violence and child abuse.

It is very rarely that we use a mabarn, but do so if it is to satisfy a client or the client’s family. Use them first or in partnership with a psychiatrist and medication. I don’t think medication alone is appropriate without considering both the possibility of cultural matters and also that a traumatic thing might have happened to that person. Many traumatic things have happened to Aboriginal people.

Some mabarn men are born with this healing power. There are two-ways, healing doesn’t always have to be by a mabarn man. An Elder Law man [Purrku] who has gained advanced traditional knowledge can use his Law powers to heal people as well. People have to be careful of that as well, to heal in some ways one doesn’t have to be a mabarn man, and it’s important not to call this other one mabarn. Either the Aboriginal mental health worker or the family will organise these matters, not the practitioner. An appropriate Indigenous person will manage it.

The NWMHS team includes a range of mental health professionals, Psychiatrists, Community Mental Health Nurses, Social Workers, Psychologists, Aboriginal Emotional/Social/Spiritual Wellbeing Workers and Community Drug Service Workers.
Counselling and Ngarlu

Pinikara Counselling Service was started here because there was only the Aboriginal Visitors Scheme, which was only for people in prison and the lock-up. Yet these were the same people who were attempting suicide and getting into distress on the outside as well. We don’t get too many men coming to these services, because to them they are not the ones who have psychosocial problems such as domestic violence, drugs and alcohol. To them it doesn’t matter. If it does, they don’t know where to start.

Looking at the drug and alcohol problem, they need to find out what is causing them to be in that state all the time. They need to find out whether there is something they don’t want to remember, or whether they have given up so that alcohol and drug use is a way of escaping these sorts of problems. We find it very hard to get men to come voluntarily to us. But if it is done as part of a court order, then we can talk to them. It takes quite a while and a lot of education to develop their insight and confidence in expressing what is bothering them, why they are angry, and why they are abusing substances.

The Ngarlu approach is to try to look for the source of it. With all this buildup of problems where are you going to start? There is denial of problems, blaming others and everything else, not looking at themselves. It is very hard for men to say: ‘I’ve got an anger problem’, or, ‘it’s my fault’, because there is such a history in their lives and in the lives of those before, of terrible treatment and accumulated oppression and trauma.

Through the generations this has been passed down; the message that you’re no good, that you are useless/hopeless, and so they give up. The people we are dealing with don’t feel good about themselves.

If we have a look at youth suicide, we have to look at the group that is vulnerable - alienated, kicked out of school, and put in a corner feeling they’re no good. They start to form into the ones going down that track. Certain kids are just pushed aside, expelled from school for a while. There is no place for them where someone can take a hold of them and try something. Maybe a different sort of education - the fundamentals of life - at least so they feel good about themselves, instead of feeling: ‘What’s the use, I’m going to be put in a corner’.

This leads to a sense of hopelessness, lack of confidence and self-esteem that is also handed down from parent to child. Many young people especially young Aboriginal males have turned to alcohol and drugs as a means to create a new form of male identity, one that is thrill seeking, violent and different to the authority of senior Aboriginal men and White society alike.

Training

Wendy Casey from the Kimberley Drug Service and myself facilitate Cross-cultural Training (Ways of Working Together) for the non-Aboriginal professionals who find it very hard to see how it will work. First it starts with acknowledging things that have happened to us. For non-Aboriginal people to acknowledge the things that happened to Aboriginal people, for example, when we talk about internalised oppression, they find it difficult to see that as important, instead of just thinking: ‘How can I work to empower these young people?’

Finally during the training, the professionals participating might develop good action plans but when they get back to their departments it is hard to implement them. An example was ‘sorry day’. The strong reaction of one group was: ‘Why should we say sorry?’ If you really interpret what sorry means in Aboriginal terms, it can be a grieving; not actually telling people you’re sorry
about it, but rather ‘sorry time’ like grieving time. But the media and people in politics misinterpret and distort it and throw out of context what sorry day is supposed to be. It is really acknowledging what happened. That is part of reconciliation. Sharing the grief means acknowledging the truth and injustice, and then seeking forgiveness. It’s not sufficient to just say: ‘I’m sorry’ without acknowledging and working with the other three aspects. We have worked through this for various non-Aboriginal professionals. It means not only bringing back the past even though some find it very uneasy because for some it is as if it never happened. It is not about blaming anybody; it is just asking to let us have a look at it together and seek some shared understanding and compassion.

Successful counselling and community development need to include empowering Aboriginal people to bring back their systems of care control and responsibility that once existed. We had it before when Aboriginal society was complete. We are in a state where we are picking these things up, trying to look for the best of both before and now.

Reconciliation

Some communities don’t feel good about themselves so they are projecting it out on others. For instance, with the land rights/native title situation, people are fighting one another. It is another form of internalised oppression. People are considering more what is in it for them and their family rather than what is there for all of us. It is not caring for others any more. Others who haven’t been brought up with that traditional background and with their education may try to stand over the very traditional people as though they themselves are the traditional owners now. There has been a large cultural mix over the generations among Aboriginal people, and a high degree of removal from connections with traditional land, practices and peoples. Many claimed citizenship as non-Aboriginal or identified as being of another culture, but now there is considerable reclaiming of Aboriginal identity and issues of traditional ownership are raised in this context.

These are some of the realities complicating Aboriginal life and affecting our feelings toward one another and our capacity and willingness to work together. We have to sort out the effects of this ourselves, besides the reconciliation between black and white; it is between black and black as well. There is much infighting, based mostly on the dislocation and the other effects of our past and present treatment by the whites. Apart from reconciliation between black and white, we need to reconcile amongst ourselves. It is very hard for us to get that to work. For example, we are really all one and shouldn’t call one another ‘coconuts’ (challenging the authenticity of identity) and things like that, but it is difficult when you grow up in it. Also, nepotism in Aboriginal organisations is another problem, a different example of black and black conflict.

For these reasons we run these programs for both our people and for non-Aboriginal people. We need to get out people to see these things as well. We can’t just say it’s an issue for non-Aboriginal people, because it is a problem for our people too. It is important for both, for reconciliation of black and black as well as black and white.

Internalised oppression is hindering the process of self-determination. It is creating difficulties working together for the self-determination of Aboriginal people as a whole, especially when some people and groups are worried only about themselves and position themselves against others. We should be sorting our own business out and getting together cooperative claims, but people are still divided. Perhaps a cultural centre would facilitate this, as in other regions, where everybody benefits.
When we work with communities, specifically when addressing the alcohol and drugs issue in that context, this type of approach has worked. Participants brainstorm their own ideas and can see what they are capable of. It develops as their action group it is not us as the facilitators telling them. They explore what can they do to help their youth with drug and alcohol problems. They come out with great ideas and commitment to follow through such as teaching them culture again, including taking them out and showing them where all the Dreamtime stories about the country relate to. Within that model we then have a look at what the ‘contact’ history has done. Each of our stories might be a little different but the whole idea is the same and they really understand that. When we present to remote community people, we do it in a way that begins with our Skin name, who we are, our identity as an Aboriginal person and they really open up then.

With the healing model they understand the concept Ngarlu. They realise their Ngarlu has been weakened and that the task is to find ways to prevent this happening further; ways to protect it and other positive ways to strengthen it. In this way the whole system is practical, meaningful and powerful. Priority is usually given to working with the family system, to strengthening the family: ‘You don’t leave your family behind, you help them’. They know about that.
ARTICLE 2:


This article describes some of the complexities involved in the assessment of Indigenous mental health from a monocultural perspective. The author starts by discussing the evidence related to culture bound syndromes and the extent to which this provides a strong enough theoretical foundation upon which practitioners are able to determine the difference between cultural afflictions or clinical unwellness (mental health disorders). The author argues that there are clear differences in how wellness or unwellness is understood and this clearly places a greater level of onus upon practitioners to not only understand the cultural, but also clinical manifestations of disorders. It is only through having strong foundations in both that Aboriginal clients will truly be provided with treatments that are consistent with their worldview and result in better treatment outcomes.

Consider:

Is there a cultural suppression factor that may be operating regarding how mental illness (and particularly psychoses) is viewed by Aboriginal people (i.e. that the culture views abnormality in a different way than non-Aboriginal people)? If so, what are the likely impacts of this?

How is this reality best understood and incorporated in clinical practice?

Imagine the following scenarios. As an Aboriginal practitioner, steady streams of referrals come across your desk from predominantly white, middle class male doctors. Unusually, these are for “severely depressed, young Aboriginal girls”. As an Aboriginal practitioner, you recognise the need to obtain some sense of “normal” functioning within a cultural context. In clinical terms, whether the ‘symptoms’ reported have resulted in impairment to her functioning within her usual environment. The first thing you do is to observe the young lady within her community to obtain this cultural perspective. She appears to be functional, and there are no obvious symptoms of depression when you assess her clinically. But is this sufficient? In terms of assessment, it is always necessary to obtain the community's view on how functional the person is, and assess the degree to which it fits with your clinical assessment. In this case, these young ladies were also viewed within their communities as functioning normally. So who is correct?

A second scenario, which takes culture-bound syndromes and the complexity of culturally valid assessment one-step further, is as follows. A young lady who had been experiencing significant disorders of perception and ideation was referred. She believed that ants were continually crawling all over her and that everyone in the community had “put the ants there” to drive her away. The local agencies had known of her for some time and simply assumed that disorders of perception such as this were “common” within the Aboriginal culture, that these perceptions were the result of the significance of spirituality for Aboriginal people, and that it would be ‘dealt with’ culturally. No one had bothered to ask the community people or the woman herself if anything cultural was involved in these hallucinations. The community was clearly saying that this was not “normal” and that this woman needed help in the “white man’s way”. It took some six months of arguing with local authorities for this woman to be assessed.

Other problems include the fact that Aboriginal people who present in situations which are considered to be foreign to them (outside of their cultural context) are likely to appear more agitated and distressed than in their normal, cultural environment (Hunter 1991d). The concept of shame in the presence of non-Aboriginal authority figures has also been cited as a factor that has been misconstrued as depression or low self-esteem. The possibility of situationally determined behavioural presentation is not an issue which is factored into assessments which are primarily based on Westernised perceptions of mental ill health when faced with an Aboriginal client. Difficulties with communication and problems associated with an unfamiliar and sterile setting also means that Aboriginal people often find it difficult to communicate their distress, and for professionals to question Aboriginal people about their feelings as discussed in Chapter Three (Hunter 1993).
Understanding culture-bound syndromes

As an Aboriginal practitioner, referrals for Aboriginal clients experiencing “brief reactive psychoses”, or “psychoses” generally are fairly commonly reported despite their low prevalence in the general population. On presentation, the young person seemingly acknowledges hallucinations of different forms, most commonly reported as seeing the spirit of a deceased loved one. The DSM-IV, has two essential criteria for the diagnosis of psychosis, that being hallucinations, and delusional thoughts. However, in formulating diagnoses from a cultural context, it is also apparent that this type of behaviour whilst viewed as “pathological” within a mainstream setting, is a normal aspect of grieving, and interestingly, of a culture for whom the spiritual dimension encompasses a significant part of the belief system. Certainly, the most widely accepted definitions of Aboriginal mental health view spiritual and cultural concepts as part of the manifestation of mental health complaints for Aboriginal people. What this means in reality is that reports of spiritual visits from Aboriginal people are not likely to be challenged from within the Aboriginal community in the way that they would be for non-Aboriginal people given that these experiences are considered to be a normal aspect of the Aboriginal culture. The obvious question for practitioners then is: “At what point is something ‘normal’ culturally or an actual psychosis and how do I tell the difference between the two?”

This brief paper will explore the evidence base for culture-bound syndromes within Aboriginal populations. While there are anecdotal examples such as those already cited regarding culture bound disorders in Aboriginal populations, these have only been validated via the PhD research of Westerman (2003) an Aboriginal psychologist. Until this research is more widely available and validated more extensively across the diverse Aboriginal cultures within Australia there still remains a number of obvious difficulties with making a distinction between what is psychopathology and what is a culture-related condition. What seems beyond argument is that an appropriate set of guidelines, which enable clinicians to make this distinction in clinical assessments, is essential. The “Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes” of the DSM-IV has paved the way for such a process to occur, however, concretised and Aboriginal-specific processes have so far eluded the indigenous mental health field. The work of Cuellar (1995; 1998; 2000) internationally has provided a framework for the identification of possible sources of cultural bias within the assessment process. However, this model assumes a fairly high level of cultural competence from practitioners to operationalise. In effect, clinicians are left to decide what constitutes culturally normal or abnormal behaviour when engaging clients; during questioning regarding symptomatology and client/family history, as well as constructing appropriate interventions. Most criticism directed at the field, particularly by NA practitioners, is in relation to the practical application of many theoretical models. As most of the ‘solution-based’ literature comes from indigenous practitioners, incorporating culture into practice is often automatic. Therefore, the solutions which appear self-explanatory from the indigenous perspective are not often so when attempting to be interpreted from the non Aboriginal perspective.
Sheldon (2001) in fact argues that there exist a number of sensitive topics within the assessment process, and which clearly impact upon client presentation. These areas include issues of bereavement, the breaking of taboos, ceremonial business, sexuality and fertility and domestic habits. A number of other researchers have similarly pointed to cultural differences that may impact on the ability of indigenous and NA people to develop understandings of each other. However, little of this research has focused on how these differences impact on mental health presentation. The following section will provide an overview of consistently reported cultural differences, and attempt to extrapolate how these issues may impact at a clinical level.

**Men’s versus women’s business**

Men’s versus women’s business is discussed as an important process of problem resolution in indigenous communities. It is accepted that private discussions as well as daily interactions within Aboriginal communities are conducted separately for males and females. Whilst awareness raising is an important factor in addressing this reality, the stage of implementation of this cultural difference is pivotal to engagement and assessment of Aboriginal mental health clients. Ensuring that therapeutic interactions occur with clinicians that are of the same sex as the Aboriginal client is a process, which should be obvious to all practitioners. In instances where this is not possible, practitioners should engage an appropriate cultural consultant as an obvious method of minimising the impact of these gender differences.

**Skin and avoidance relationships**

When an Aboriginal child is born, they are automatically assigned to a ‘skin group’. Ordinarily, the mother’s skin group determines this skin name. Skin groups are important in that they determine how relationships are conducted within the person’s community. As children grow, they are taught how to relate to people based on their skin group. The ‘skin’ will determine who they can marry, who they are able to speak to, make fun of and so on. In line with this, Aboriginal people often talk of marrying people who are their ‘straight skin’, or having to be sure that someone is ‘straight for them’. This is in reference to the skin group classification. Skin groups therefore determine avoidance relationships, and this has an enormous impact upon engagement in mental health services as well as behavioural presentation in a number of ways. First, there have been documented instances of intervention occurring, which require representation from family members (i.e., family therapy) in order to resolve the issue. Given the existence of avoidance relationships within family groups, often family members will not participate, and will not offer explanations as to why. This is due to the expressed ‘shame’ that Aboriginal people feel when explaining to NA people of the existence of avoidance relationships (Westerman 1997). Additionally, it can also be due to the perception from Aboriginal people that they will not be believed (Swan and Raphael 1995).

Often avoidance relationships are not picked up on for this range of reasons, and this can result in additional (cultural) distress for clients who present to mental health services. In effect, it significantly lessens the likelihood that Aboriginal clients will present to mental health services at all, particularly those who do not understand the strength of avoidance
relationships, and are able to deal effectively with the existence of these. In instances where Aboriginal mental health clients present to services, questions should always be asked regarding the skin relationship that exists between key relationships within families. For instance, the relationship between mother-in-law and son-in-law is often one of avoidance, making direct questions, as well as contact between these two, a taboo.

The Aboriginal belief system

The Aboriginal belief system is such that bad luck, ill health, negative life circumstances are always attributed to external causes. Mental health is no exception to this, and it is for this reason that practitioners must exercise extreme caution when working with mental ill health involving Aboriginal people. External attributions are made more often than not, when instances of mental ill health occurs, and it is for this reason that many mental health problems do not necessarily come to the attention of mental health practitioners. Issues of ‘shame’, which can often result from a belief system which predicates personal culpability, can be common experiences of many Aboriginal mental health clients.

Therefore, practitioners must examine ways in which they are able to incorporate this belief system into interventions in order to be sure that work with Aboriginal mental health clients is as respectful of such beliefs wherever possible. This will result in services being recognised as more culturally appropriate, and potentially increase current levels of access to such services by Aboriginal clients.

The need for cultural validation in mental health assessments of Aboriginal Australians

Given the existence of a number of culture-bound syndromes within indigenous cultures internationally, and the developing evidence hat they also exist within Australian Aboriginal populations, this can often create difficulties in the assessment of mental health conditions. This is in part attributable to the difficulties in recognising that ‘mental health’ symptoms have a cultural origin. In addition, there is also the problem that knowledge of culture bound syndromes can create a perception that all Aboriginal people who present with complaints of mental ill health will be perceived as having cultural origins to their distress, and treated purely by these methods. This can be the danger in recognising the relevance of culture bound syndromes, without providing empirical information regarding the exact origin and nature of these.

This paper argues that the ability to discern what is culture-bound and what is a clinical disorder lies in the ability of practitioners to assess for the relevance of cultural factors within presenting conditions of Aboriginal clients. The continuum between what is normal and abnormal must be ascertained from within the culture itself, however, it is also fairly evident that the practitioner has considerable cultural as well as clinical expertise (competence) to be able to make this determination with any degree of
confidence. The combination of these two skills in a single practitioner is clearly a rare entity particularly in light of the lack of empirical research widely available in combination with the fact that Aboriginal culture is considered to be one of the most secretive cultures in the world.

REFERENCES


ARTICLE 3:


The author provides an overview of the use of psychological tests with Aboriginal clients including the historical context, strengths and limitations of these. This includes an overview of cognitive and personality assessments and the evidence base regarding their reliability and validity for use with minority populations. Some guidelines are provided as well as suggestions regarding how to use psychological testing in a manner that is respectful of the limitations that exist.

Consider:
Is there a role for the use of psychological tests with Aboriginal clients? If so, what is this? If not, why not?

What does assessment add to our knowledge base of individuals (including Aboriginal Clients?)

Does exclusion from testing further marginalize Aboriginal people?
PSYCHOLOGICAL ASSESSMENT AND INTERVENTION
Westerman, T.G. & Wettinger, M (1998)

INTRODUCTION

Prior to visiting an Aboriginal community and becoming involved in psychological testing and intervention it is suggested that the following texts be consulted:-

1. APS Guidelines for Working with Aboriginal and Torres Strait Islanders (see appendix III attached).
5. Working with Aboriginals in remote areas (1979) by DeHoog & Sherwood. This text provides guidance and detailed information about appropriate ways to work with Aboriginal people in remote communities.

It is also recommended that the worker spend time preparing themselves via:

- identifying their own strengths and areas of development
- defining their purpose of involvement
- identifying resources and skilled people within the community who can provide assistance
- becoming familiar with local newspaper editions and Interest groups as these are an excellent source of information about current events, groups and areas for further research.

For any cross-cultural assessment to be considered valid, the attributes, qualities and values being measured need to have a known/agreed significance to both the tester and tested. For example:

1. Need for agreement as to what is being measured? (Kearins 1988; Keats 1988).
3. Is the knowledge appropriate for that person to have? (Goodnow 1988; Kearins, 1988).
4. Who are you allowed to talk to? Certain men will not be approachable for women and possibly some women will be 'out of bounds' too. (Scheppers, 1991)

Sometimes it helps to be mindful that you may be the first non-Aboriginal person who has interacted with the child and carers/parents for any length of time. This is particularly the case in remote communities. It is not uncommon for Aboriginal parents to be suspicious, asking themselves, for example, what sort of knowledge would an unmarried childless woman have about my situation? They may wonder why a man is working in a child focused centre. If you are taking care of their child or spending significant periods of time with them, they may want to know what sort of person you are. Most Aboriginal parents have good reasons and historical experiences to distrust strangers and Western people, and specially "the Welfare". The role of the social worker, the psychologist, the day care worker etc., is important not only because of the impact that the workers will have on an Aboriginal child but also on how parents and other family members will perceive the individual. They will be under constant scrutiny until they are known and trusted and this can take from a number of months to years...
depending on the Aboriginal communities’ experiences and cultural boundaries (Scheppers, 1991).

**PSYCHOLOGICAL ASSESSMENT**

Formal psychological testing is considered by Goodnow (1988) to have some difficulties for children and adults of minority groups because of the frequency of the "question and answer" format in a one to one situation. In some cultures such as Aboriginal Australians, questions are only asked if you do not know the answer and also it is sometimes considered impolite to ask a question of someone who doesn't know the answer (Kearins, 1980). Hence, a prior step to formal testing may be to consider how evaluation proceeds within the social group being considered.

It is also important to consider the differences in communication styles (see Section 4 of this document) and learning strategies between Aboriginal people and White Australians. Articles by Davidson, Hansford & Moriarty (1983), Harris and Harris (1988), Kearins (1985) and Klich (1988) highlight some of these variations. Kearins (1985) in her article about child-rearing practices in Australia suggested that these practices may lead to difficulties in school. For example:
- Aboriginal children choose what they want to learn, when and from whom;
- Aboriginal children are not used to being dependent on adults.
- Children and adults do not expect to have to answer someone who speaks to them.
- Children not bound by rules can never be considered as naughty.

Harris and Harris (1988) identified differences in learning strategies which are helpful to note when planning assessments and interventions with Aboriginal people. Their article is particular to remote Aboriginal people who have had minimal Western influence. The identified concepts to consider involve learning via:
- real-life performances not via practice in contrived settings
- mastering of context specific skills, not abstract principles
- imitation and observation rather than oral or written instruction
- personal trial and error rather than through verbally mediated instruction
- orientation towards people rather than tasks, information or systems.

Psychologists are cognisant of a number of confounds that significantly bias test results in favour of Western, middle class, educated individuals. The aim of this next section of the manual is to identify the testing materials and assessment techniques which would be functionally more appropriate when working with Aboriginal children and their families.

**Intelligence Testing - IQ Assessments**

As summarised by O'Keefe (1983) in the previous psychological manual, almost all IQ tests are culturally biased against minority groups including the Australian Aboriginal population. The formal assessment tools available such as WPPSI-R, WISC-III, WAIS-R, WMS-R and the Stanford Binet Intelligence Scales are limited in their usefulness in assessing the cognitive strengths and weaknesses of Aboriginal children and adults. These tests do not have Aboriginal norms, they contain unfamiliar items, they assume knowledge of Western society and generally favour people who have Western educational opportunities. The Queensland Test (McIwain, 1970) whilst the norms were derived from people in Queensland, Australia, they have been described as out-dated and vary considerably. The variation is hypothesised to be a result of the Aboriginal client’s degree of Western cultural contact. It is also evident that the language of some tests and test instructions may be unfamiliar and hence disadvantageous for the examinee when it comes to the scoring and interpreting of test results. Davidson (1995)
identified that the "total suspicion with which mental tests are treated by many indigenous Australians ... is also likely to influence the outcome of any individual testing activity" (p.30).

Section 4.3 of the Guidelines for the provision of psychological services to Aboriginal and Torres Strait Islander Australians, recognises that in some circumstances there is a need to employ psychological tests as an assessment procedure. For example, an assessment may be requested for the Court or be required for Criminal Injuries Compensation claims. In these instances, it is recommended that tests which are less disadvantageous to the Aboriginal person be utilised and/or the tests be used with caveats on test interpretation noted when considering the reliability and validity of the test results. It is also important that the psychologist be clear on the purpose of the assessment and they may need to question whether they are testing for educational backwardness vs general intelligence (Davidson, 1988) vs ‘cleverness’ (Kearins, 1984, 1990).

With regard to less disadvantageous tests, it has been found that Aboriginal people’s performance on non-verbal, performance-type tests such as the Raven’s Progressive Matrices (Raven, 1948) and the performance scales on the WPPSI-R, WISC-III and the WAIS-R are comparable to the existing Australian norms on these tests. This is particularly the relevant for Aboriginal people raised and living in urban situations. The Peabody Picture Vocabulary Test-Revised (Dunn & Dunn, 1981) generally gives a rough indication of the child’s educational level when considered in conjunction with their record of school attendance. You may find that some of the words used in test will require some alteration. For example, it would be more appropriate to ask the child to look for/point to the "bush" rather than the "forest" on item 48 of the Peabody and noting that some alterations were necessary given the cultural background of the child.

Should the tests be used in their complete form then a disclaimer would be required. The limits of the test and the reliability and validity of the test results will need to be considered in light of the person’s ethnic background and acculturation.

Davidson (1988), taking into account recent research in cognitive sciences, suggests that psychologists consider standardised tests being accompanied by other assessment techniques, such as clinical interviews with parents/caregivers and other adults who play a significant role in the persons life. He also recommends that an assessment also provide information on the socio-cultural background of the person. Kearins (1985) suggests that direct observational assessment of the child’s ability to cope with daily tasks and instructions be conducted to supplement and contribute to the information obtained from standardised tests. Finally, O’Keefe (1983) points out that for legal purposes all formal testing be accompanied with clinical interviews with the child’s main carer(s) including extended family with whom the child identifies with, and an unbiased Aboriginal adult who knows the child and their family.

Some recommended readings in this area include:

- Various papers included in Davidson, G. (Ed) 1988 *Ethnicity and cognitive assessment: Australian perspectives*. Australia: Darwin Institute of Technology (including the Harris & Harris article).
Personality & Mental Health Assessment

Personality assessments are mostly considered to be inappropriate for use with Aboriginal people, particularly remote-area Aboriginal people who have distinct norms for behaviour and emotional expressions. Standard questionnaires and inventories such as the MMPI-II (Hathaway & McKinley, 1989), Clinical Analysis Questionnaire (CAQ: Cattell, 1980), Eysenck Personality Questionnaire (Eysenck, 1980), Sixteen Personality Factor Questionnaire (16pf: Cattell, 1986), Millon Adolescent Clinical Inventory (MACI: Millon, 1993), High School Personality Questionnaires (Caine & Cattell) etc., and projective tests (eg. Children's Apperception Test [CAT: Bellak, 1981]; Holtzman Inkblot Technique [Holtzman]; House-tree-person projective technique [Buck]; Thematic Apperception test [TAT: Murray, 1971] etc.) can be generally misleading and if possible should be avoided.

However, projective tests and drawings can be a useful means of assessing a person's cultural identification when you cannot find this out in more direct ways. Projective techniques are sometimes useful when working with Aboriginal children, as they allow children to story tell (in the third person) which is a culturally acceptable way to pass on information and important messages. They can also be a useful tool in conjunction with the interview in exploring all social factors currently affecting the individual. It is important to note that cultural and tribal factors sometimes account for bizarre behavioural patterns and/or mental disturbances. For example, a young child who is having problems with enuresis may be fearful of the "mammu [devil man]" or "Featherfoot" who walks around in the dark and hurts people who hurt others; an adolescent male may display 'fits of hysteria' and anger when taken to an Aunt's house where he is told his grandfather died.

I attended a lecture by Diana Lawler in 1992 at the University of Western during which she mentioned that the Wagner Hand Test (1969) proved to be a useful screening device, revealing unusual personality tendencies, rather than subtle personality characteristics. She stated that whilst this test was considered to be out of date, the responses were useful as a spring board to explore the persons view of themselves which could be expanded upon during clinical interviews with the person themselves and significant others. I have not used this test myself but it one to consider given that it does not require highly developed verbal skills.

It is strongly recommended that should further assessment be required that the person be referred to the local "Community Mental Health" team. Prior to making such a referral it is important to discuss the role of the Mental Health services to the client as there is a misperception, particularly in remote communities, that any association with mental health will result in some form of incarceration, "being locked up".

Some recommended readings in this area include:


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Family Assessment - Attachment and Bonding Issues

As stated by Scheppers (1991), Aboriginal children, whether they are residing in the city or the country will, to some extent, have a cultural background that has taught them:

- a strong attachment to their 'country' or 'land';
- a deep knowledge about the natural environment, for examples, plant uses, local geography, economic skills and conservation practices;
- a love of the outdoor environment;
- that material goods are of little importance and replaceable;
- the values of sharing, so that they will not have to hoard items from other children;
- that demands of religious observance and traditions (eg. funeral attendances, going through "The Law" etc.) outweigh other demands such as going to school;
- the notion of 'family' sometimes means your entire people and usually refers to an extended family group.

One of the more notable differences between Aboriginal and White Australian reared children is the Aboriginal children's high levels of independence (Kearins, 1984). In families, it is often assumed that babies and children are best able to express their own needs and that adults are there to attend to those needs. Among traditionally oriented and some suburban families there is group care of babies and young children. This means that a baby is likely to be held by someone nearly all of the time. A child may relate to several aunts as 'Mum' and be fed or put to bed in several different households as a normal experience (Scheppers, 1991).

The importance of the extended family is consistent with cultural values and the unity of the relationship to the land and to kin. Relationships with people are considered to be structured and based in Aboriginal Law and the Dreaming. Children are taught about mutual cooperation, about special duties to some extended family group, about taboos and about relationships which have special ritual significance. Behaving properly within the cultural context, to other people is an important aspect of Aboriginality. It can also be the source of misunderstanding and misrepresentation (ie. behaviour considered to be inappropriate in one culture but appropriate in another). For example, the family home may be the scene of many comings and goings where people move around, and numerous people may pick up a child from school/day-care etc. This does not mean that the mother is negligent. Knowledge of the child's community is invaluable as is the advice of Aboriginal staff as to the safety of the child and/or their family and ritual obligations.

When parents separate arrangements for children are worked out by the families involved, but generally children are cared for by the mother and her relatives. It is not uncommon for children to be reared for long periods of time by extended family rather than their parents. Among Torres Strait Islanders, whose culture is basically Melanesian, customary adoptions involving the permanent transfer of a child from one extended family member to another is widely practiced (Ban, 1993).

Issues of racism and backlash from Aboriginal land and other claims need to considered. For example, Aboriginal people have been the target of special laws and rules about where they could live and work, about the removal of their children, voting rights and even where they could sit in a public bar or cinema. Aboriginal people, today, are continually faced with taunting remarks of a derogatory nature. These attitudes and behaviours reflect other
people's experiences and learning in their own family groups. Hence, it is pivotal that the worker present a positive model of welcoming, respecting and learning from racial and cultural variety.

Table 1 provides an overview of differences in Aboriginal and White Australian child rearing practices (from previous psychological manual and recent texts). This table represents a summary of information from various text about Aboriginal women's roles in their community and child-rearing practices.

Table 1 Differences in Aboriginal and White Australian Child-rearing Practices.

<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Aboriginal Australian Children</th>
<th>White Australian Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child care responsibilities</td>
<td>Shared usually by the large, extended family group. Babies are treated with extreme indulgence by everyone in the family. In the extended family there are often others to relieve the pressure on the mother. Young children are seen as having the capacity to demand what they want. eg “She will cry if she is hungry”</td>
<td>Is usually taken by the child's mother and input from the father. In the nuclear family the mother is often has to cope on her own Babies are encouraged to adopt a regular routine which is endorsed by the main carer. Young children are seen as helpless and all decisions are made for them, &quot;Mum knows best&quot;.</td>
</tr>
<tr>
<td>Self-care</td>
<td>Children are allowed to be as independent as they wish to be.</td>
<td>Children are not expected to be independent in eating, dressing or washing until the caregiver says so or feels it is OK.</td>
</tr>
<tr>
<td>Oral Development</td>
<td>Little oral obedience training.</td>
<td>Oral obedience training begins early. eg.: understanding words such as &quot;no&quot;, &quot;stop&quot; and &quot;naughty&quot;.</td>
</tr>
<tr>
<td>The first steps to independence</td>
<td>Physical interaction - children are more often held in an upright position and are part of the family group. Sleeping - in any room or place. Young children are allowed to move away from adults. Usually in the care of older children. Older siblings and other children mix together out of mother's sight. Children accept responsibility for each other with no adults present.</td>
<td>Physical interaction - when the child is awake. Sleeping - often put to sleep in a room away from the family or lying in a basinet or bouncer. Young children are expected to stay close to adults. Children are assumed &quot;lost&quot; if they are out of the mother's sight. Siblings and other young children mix together but everyone knows that Mum is in charge.</td>
</tr>
</tbody>
</table>
### Physical Skills

- Can develop without restraints of adults. There are few verbal commands by adults, even if they are present. Children learn at an early age to judge their capacity to perform feats.
- Children also have the freedom to hurt themselves.
- Children are less skilled physically. Adults are expected to warn and to set limits. eg.: "Be careful". "That's high enough". Adults use lots of verbal commands.
- Children are not expected to cope with hurt of fear by themselves, adults have the expectation that they know best.

### Play/Activities Involvement

- These are of the child’s choosing and continue until the child wishes to stop.
- Competition is not encouraged by caregivers. There is an idea of doing what is best for the family/group.
- These are often chosen or suggested by mother. There is encouragement to do particular jobs eg. putting toys away, washing hands etc.
- Competition is often encouraged by caregivers, between siblings and peers. There is an idea of “doing what is best of the individual.”

### Possessions/Toys

- Children have few valued possessions and what they do have is available to all who visit the home.
- Children often have possessions of their own and they are encouraged to look after them. There are also certain items such as teddy bears, rugs, dolls which have exclusive ownership.

### Other

- Adults accept children who sulk
- There is an awareness of the concept of shame which often leads to withdrawal.
- When children appear in a minority they may be quite shy.
- Adults are critical of children who sulk.
- The concept of shame is not strong, more practical feelings and behaviours are emphasised.
- When children appear in a minority they may be shy, boisterous, panicry - depending on the nature of the child.

Keeping these characteristics and variations in child-rearing and development in mind, it can be helpful to devise some questions to test out during the clinical interview. It is not uncommon for children to ‘miss-out’ on some of these practices as a result of the mother’s own upbringing, historical involvement of the Department, absence of mother figures or elders in the community, implications of alcohol and drugs etc. Other methods of collecting information on the family and the networks involves using geneogrammes, kinetic drawings and with older children an adapted version of the Family Relations Test (Bene-Anthony) (eg. some psychologists within the Department have purchased multi-cultural Lego dolls and adapted some of the questions in the cards to suit the client’s cultural background). Finally, adaptations to other attachment and bonding assessment tools would also provide valuable information. From a legal perspective, the test scores or factual information of these techniques are not considered reliable or valid but they do provide supplementary information about the child’s attachments and networks as seen by the child and/or their carers. They are also a less threatening way of establishing rapport with Aboriginal children/families as there are fewer direct questions and for those with limited English language they can use drawings and family diagrams.

Some recommended readings in this area include:

- Various texts by Rutter & Crittenden (independently) which focus on the issues related to the assessment of attachment between children and caregivers. In addition various texts focusing on child development may also be useful.

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Child Abuse in Families

As with the general population, Aboriginal children may be at high risk of abuse, failure to thrive or early disruptive behaviours, conduct disorder, traumatisation symptoms, failure of attachment and so forth (Swan & Raphael, 1995). This risk may be associated with loss and trauma for many young children having experienced recent multiple disruptions, separations, fostering, institutionalisation, social problems and so forth. We need to take into consideration “the Stolen Generation”, that is, grandparents or parent that my have been taken from their families. There are many instances where parent models and skill will have been lost to those who have not experienced adequate parenting themselves because of these separations. Family break-up, violence, alcoholism, parental incarceration, as well as high levels of demoralisation may all have a negative effect such as child abuse. As with any other assessment of child abuse we need to consider the context in which the abuse occurred as well as the injuries and problems for the child. If we follow the “Birds Eye-view” or the “Wide angled lens” approaches we are looking at the abuse incident (s) within the context of the family (immediate and extended) history and dynamics. For example, in talking with a young child about their abuse experience, I would also consult with their primary carers which may extend to several aunts, nieces, grandparents and so forth. If one of the main carers was also part to the alleged perpetrator’s extended family I would need to consider whether it would be appropriate to talk with them or introduce another worker to assess them. In some cases it would be considered inappropriate and offending for the child victim’s family and on other occasions it may be insulting to the perpetrator’s family. When faced with such a predicament it is important to consult with the victim’s family, Departmental Aboriginal officer (if possible) and Departmental managerial and principal staff.

Another point to consider when conducting an assessment of child abuse issues, namely sexual abuse, is whether it is appropriate for you to be asking sexually natured questions. For some Aboriginal groups it is inappropriate for females to talk with young (boys entering into manhood - 11-12 years old onwards) and older males and for males to talk with young and older females about sexual issues. It is also deemed offensive for White Australian’s to broach these subjects with their children without either the child’s family representation, consent or the presence of an elder male/female. This is an important social protocol which should be considered in the pre-planning of assessment and intervention with Aboriginal children on issues of child abuse whether you are working with the alleged perpetrator or the child.
survivor. From personal experience, as a young female, White Australian clinical psychologist within an isolated semi-traditional community in the Goldfields District, I found that by coming up with options of how to assess child abuse issues (with sensitivity and respect for cultural protocols) and discussing these with the children’s families, I was able to complete assessments with alleged male perpetrators and victims.

The use of assessment inventories is limited and culturally inappropriate in the area of child abuse. I found that by adapting the clinical interview on the impacts of child abuse, using developmental milestones and considering the child’s rearing, familial and cultural situation a thorough assessment could be completed for the child victim and their family. In assessing the alleged perpetrator, adaptations to the SAIF (sex abuse in families) autobiographical structured interview is useful and provides a wealth of information. It also provides an indirect way of acquiring information from clients who may be resistant to discussing their situation.

Some recommended readings in this area include:


**Psychological Intervention & Treatment Approaches**

As previously mentioned in section 4: Establishing rapport, it is important to remember that the approaches to any assessment or intervention plan must take into consideration the client’s background history, involvement with White Australians and the practicality and purpose of involvement. For example, while it may be practical to spend 2-3 days in a remote community completing an assessment, it may be several months when the worker can revisit the community for some form of intervention. The question asked here are "Can a service be practically offered?"; "What form of therapy can I offer this person on a three monthly basis?"; "What would I need to do to ensure that they receive the best possible service?"; "Who else from the community can I work with to assist on this matter?" and so forth. Hence, as with any form of intervention, it will be much dependent on the client’s cognitive level of functioning, their and the community’s motivation and commitment to receive assistance, the support networks available, the frequency of therapeutic contact, practicality of involvement and numerous other factors. It is considered paramount that when visiting communities these issues are given consideration so that when you offer a service it is one that you can deliver. For decades Aboriginal people have been subjected to psychological assessment with little or no purpose other than research for which there is little feedback to the people. Thus, it is important that you provide service arrangements that you can adhere to and this should be clearly explained to the client (ie. your purpose of involvement, feedback from assessment, and duration of involvement).

As reported by O’Keefe (1983) treatments which focus on emotions using verbal explorations are generally inappropriate with Aboriginal people because their lifestyle emphasises concrete thinking and the direct expression of feelings in actions. He comments that behavioural
approaches are generally better suited to this lifestyle provided the behaviours are clearly specified and the suggested response to the problem behaviour does not conflict with cultural norms (e.g., in some groups initiated boys will not take notice or direction from Aboriginal women - in some groups there is a norm to comply with children's demands for food and drink, however unreasonable they may be). With older children and adults, he suggests, if the psychologists conducts a negotiation session with the disputing parties, they will often suggest a compromise.

While it is common for psychologists to use contracts during negotiation processes, in consulting with psychologists within the Department and from my own experience, it has been found that verbal contracts or "agreements" are valued more than those written down. It can be speculated that the paper represents a materialistic and/or White Australian ideology which is not as valued as the spoken word in Aboriginal culture.

Other approaches which have been tried with success by psychologists within this Department include: the "Narrative Therapy" approach; Brief Solution-focused therapy; and, cognitive-behavioural therapy with groups of Aboriginal men or women dealing with general abuse related issues. Literature on Brief Therapy Solution-focused, Narrative therapy, and cognitive behaviour therapy with groups of mixed cultural descent should be consulted prior to using these methods with Aboriginal people. It is also recommended that the information in the prior four sections of this document be consulted and used in conjunction with the theories underlying these approaches.

Additionally, the National consultancy reports on Aboriginal and Torres Strait Islander Mental Health - “Ways Forward” - by Swan & Raphael (1995) makes suggestions regarding appropriate intervention for Aboriginal people with problems such as: trauma and grief; suicide and self-harm; childbirth and parenting issues; child/young people mental health issues; alcohol, drug and other substance misuse. In the reading of these papers it was interesting to note that already established programmes (e.g., Triple P parenting programme) were recommended with the advice that these should be adapted for use with Aboriginal people. Rather than provide a lengthy report of the intervention methods suggested in these articles, the psychologist should refer to the consultancy reports which are available in the Psychology Library at Family & Children’s Services - Head Office: Professional Services section.