Aboriginal Concepts of Place and Country and their Meaning in Mental Health

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There is a lack of knowledge within Western psychology about Australian Aboriginal conceptions of mental health. The majority of psychological services available to Aboriginal people are based on Western world-views, and are of questionable benefit. Because of the ethnocentrism apparent inherent in services, many Aboriginal people avoid psychological assistance. If there is to be any change in the state of Indigenous mental health, there needs to be a change in the type of services provided to Aboriginal people, and in the value systems of practitioners. This research extends the work of Vicary (2002) by looking specifically at the importance of place in Aboriginal world-views. There exists a wide gulf between Aboriginal and non-Aboriginal understandings of mental health, in particular, a culture more generally. Concepts such as 'country' need to be understood by non-Aboriginal practitioners for them to be able to provide a quality service that is culturally appropriate.

Within Australian psychology there is a lack of culturally appropriate psychological resources, services and interventions for Indigenous[1] people (Australian Institute for Health and Welfare, 2009; Berry, 2009; Garvey, 2000; Graham, Reser, Scuderi, Zubrick, Smith, & Turley, 2000; Hunter, 2007; Vicary & Bishop, 2005; Westerman, 2004, 2010). While there has been significant governmental policy change, there is a lack of training or education in cultural propriety for non-Indigenous practitioners (Vicary & Bishop, 2005; Zubrick, Kelly & Walker, 2010). This lack of practical information regarding interventions with Aboriginal clientele is generally not recognised until a non-Indigenous practitioner attempts to work with an Indigenous community. It then becomes clear that there are few studies available to mental health practitioners that provide any useful insight into the Indigenous world-view (Dockery, 2010; Gonzales, 2000; Vicary & Andrews, 2001; Wand, Eades & Corr, 2010). This lack of understanding of the

Indigenous world-view is problematic as it causes Indigenous people to feel discouraged from accessing mental health services proactively (Brown, 2001; Eley, Young, Hunter, Baker, Hunter, & Hannah, 2007; Hall, Hunter & Spargo, 1993; Hunter, 2004; Vass, Mitchell, & Dhurrkay, 2011; Westerman, 2004, 2010). Consequently, Indigenous people are generally only seen in a mental health services setting when they reach a crisis point or have had a long history of psychiatric symptomology, and are thus over-represented in psychiatric admissions (Hunter & Harvey, 2002; Zubrick et al., 2005).

Indigenous people are disadvantaged in the Western mental health system (Hunter, 2007), and there is a need for empowerment and self-determination in the provision of psychological services for Indigenous people (Casey, 2000; Dudgeon, Grogan, Collard & Pickett, 1993; Hunter, 2007; Peeters, 2010; Zubrick et al., 2005). International writers have argued that use of Western

psychotherapeutic techniques on indigenous people is another insidious form of colonisation (Appo & Haertel, 2003; Holdstock, 2000; Tapping, 1993) and that attempting to employ a monoculturally-designed western mental health system with Indigenous people is actually a form of racism (Appo & Haertel, 2003; Paradies, 2006; Riggs, 2004; Riggs & Augoustinos, 2005; Waldegrave, 1985; Westerman, 2010).

Dudgeon et al. (1993) have suggested blending Indigenous and non-Indigenous forms of intervention and models of mental health to create a service for Indigenous people that is culturally sensitive and of high quality. Others suggest the creation of population specific psychologies (PSPs), arguing that no two populations, communities, or cultures are exactly alike, with different pressures operating on them (Watts, 1994). Therefore, it is argued that different methods of intervention should be developed and utilised to address the individual needs of the specific population, community, or culture.

The Legacy of Colonisation

It is an unfortunate fact that many Australians remain unaware of the Indigenous version of Australia's history, both pre- and post-colonisation (Dudgeon, 2003; Parker, 2010). The dominant notion within Australia of forgetting the past and 'getting on with the future' indicates the denial that exists within Australia about significant elements of its past (Collard, 2000). Furthermore, humans are products of our history; we engage in retrospective thought and discussion in an attempt to contextualise our present. An awareness of our past situates us in our present (Collard, 2000). Therefore, it is necessary to provide an account of what colonisation meant – and continues to mean – for Aboriginal people before the reader can reach a thorough understanding of the psychological ramifications of the process of colonisation. Any attempt to understand the Aboriginal world-view is incomplete without an awareness of the history of contact between Aboriginal and non-Aboriginal people (Dudgeon, 2000a; Dudgeon, Wright, Paradies, Garvey, & Walker, 2010).

British colonisation severely impacted Indigenous peoples. The disruption to well-established patterns of living, dispossession of land, marginalisation through various government acts and discrimination has led to trauma (Atkinson, 2002; Atkinson, Nelson & Atkinson, 2010; Dudgeon, Mallard, Oxenham & Fielder, 2002; Dudgeon et al., 2010; O'Shane, 1995). While Australia is currently undergoing a reassessment of government responsibility to Indigenous needs in an alleged effort to promote self-determinism and empowerment within Indigenous peoples, new policies are proving to be just as damaging to Indigenous life as previous policies, having resulted in the creation of dependencies and dysfunctions adding to the trauma suffered by Indigenous peoples (Atkinson, 2002). Hage (1998) discusses the White nation fantasy, whereby the voice of the ethnic other is silenced and constructed as a passive object by both white racists and white multiculturalists. The ongoing debate between the white racists and the white multiculturalists is such that it excludes Aboriginal people themselves from participating in that debate. Aboriginal people will continue to be prevented from becoming empowered unless they are allowed to shape their own debates and articulate for themselves what change is needed within Australian society.

Ongoing colonialism is predominantly responsible for the continuing health problems of Indigenous communities (O'Shane, 1995). As such, no treatment will be effective in addressing these problems unless health professionals themselves develop an understanding of the impact of colonialism, and have taken measures to identify and extinguish ongoing practices of colonialism, and properly acknowledge the

effects of the ongoing history of colonisation (O'Shane, 1995). There is a documented relationship between powerlessness, substance abuse, and violence to self and others, including rape, self-mutilation, homicide, suicide, child neglect and abuse (Berry, 2009; Dudgeon, 2003; Graham et al., 2000; Hunter & Harvey, 2002). Post-colonial Australian history has been built on racism and oppression – "the systematic conflict, removal, displacement and incursion of people into prisons, reserves and missions" (Dudgeon, 2003, p. 40), while at the same time this history is denied. Atkinson et al. (2010) discuss echoes of the past, and the transgenerational impacts on communities leading to many dysfunctions. For Indigenous Australians to enjoy the same respect, socio-economic conditions, and quality of life as other Australians there needs to be a change in our political climate and this challenges health professionals to join the political campaigns aiming for these goals (O'Shane, 1995).

Australian Psychology and Indigenous Research

While there is currently a lack of research being done *with* Indigenous Australians to expand non-Indigenous practitioners' understandings of Indigenous world-views, Australian psychology has a long history of research conducted *on* Indigenous people (Bishop, 2007; Garvey, Dudgeon & Kearins, 2000; Vicary & Bishop, 2005). This has resulted in a general scientific perception that Indigenous people are culturally and genetically inferior, and so has been used as a justification for the forced cultural dislocation of these people (Wilson, 1997).

Research into the psychology of Indigenous Australians has been conducted for over a century, with the vast majority of this research serving to validate the practice of colonialism and cultural suppression (Bishop, 2007; Davidson, Sanson, & Gridley, 2000; Garvey, 2007). European visits to Australia almost four centuries ago led to reports about the appearance and apparent lifestyle of Australia's Indigenous people. Much of the late 19th and early 20th century scientific and psychological literature was based on the racist, primitive, and derogatory premises that these early reports provide (Dudgeon, 2003; Garvey, 2007; Gould, 1981; Moane, 1999; Prilleltensky & Gonick, 1996; Prilleltensky & Nelson, 2002). Early studies focusing on the cognitive and social limitations of Indigenous children and adults in education and employment found theoretical grounding in social Darwinism, or social evolutionary theory (Garvey et al., 2000). Problems and limitations were attributed to genetic inferiority, and subsequently to cultural inferiority (Davidson et al., 2000). This type of research constructed Indigenous adults as inferior role models and incapable parents, thus supporting the forced removal of children from their families and communities (Wilson, 1997).

In the last three decades Australian psychologists have recognised the lack of culturally appropriate services for Aboriginal people, and have taken measures to improve the quality and availability of these services. Since the 1970s, Aboriginal mental health professionals have been working to establish within Australian psychology a place and a voice for the issues surrounding and involving Aboriginal mental health (Gridley, Davidson, Dudgeon, Pickett, & Sanson, 2000). The formation of the National Aboriginal Mental Health Association in 1979 highlighted the concern held by Aboriginal mental health professionals that mental health providers were guilty of the neglect of Aboriginal mental health problems. As a consequence, mental health training was incorporated into all Aboriginal health worker training over the next 20 years (Gridley et al., 2000). At the Australian Psychological Society's (APS) annual conference in 2008, the Australian Indigenous Psychologists Association was created.

The APS (2007) Code of Ethics now includes guidelines for the conduct of

research and the provision of services for Indigenous Australians and advocates the following principle:

> They [psychologists] have a high regard for the diversity and uniqueness of people and their right to linguistically and culturally appropriate services. *Psychologists* acknowledge people's right to be treated fairly without discrimination or favouritism, and they endeavour to ensure that all people have reasonable and fair access to *psychological services* and share in the benefits that the practice of psychology can offer. (p. 11)

The implications of these additions to the code of ethics are positive, however the real problem of the lack of cultural knowledge and understanding currently available to non-Aboriginal practitioners is not addressed (Vicary, 2002; Vicary & Bishop, 2005). Indigenous people still experience rates of physical and psychological illness that are far higher than national averages (Australian Medical Association, 2002; Graham et al., 2000; Hunter, 2007; Zubrick et al., 2005). For example, they remain at risk of self-harm and substance abuse, and continue to suffer from physical, emotional, and sexual abuse (Gordon, 2002; Silburn, Glaskin, Henry & Drew, 2010; Thomson et al., 2012). For non-Aboriginal practitioners to provide a quality service to Aboriginal clientele they must have an understanding of the Aboriginal world-view. The cultural, historical, and social issues and pressures surrounding Aboriginal people must be understood and used to guide therapy and interventions in an empowering manner (Dudgeon, 2003).

Garvey (1995, 2007, 2010) discusses cultural appropriateness as a dynamic, interactive and conscious process, employing cognitive, behavioural, and affective dimensions. If psychology is to truly adopt notions of cultural appropriateness, it must consider differences in interpretation, perception, and explanation of phenomena – the subjective reality and consequent interpretations of that reality. The focus of application must shift from the production of a culturally appropriate end product to include the process of initial assessment, rapport-building, intervention and evaluation – the means are just as important as the end. Practitioners implementing cultural appropriateness may experience emotional responses; the nature of cultural appropriateness is such that it requires us to leave our comfort zones in an effort to transcend the limitations of our own experiences and understandings, however it is an important step in changing and challenging the status quo. It is vital to be aware that cultural appropriateness is a process of continuing review and refinement, and psychologists must be aware of change.

Sense of Community and the Importance of Country

There is a conceptual problem associated with notions of Aboriginal communities. The use of the term Aboriginal community contains an intrinsic implication that Aboriginal society is homogenous, with shared interests, and positive forms of collectivity (Dudgeon, 2003). As mentioned above, this conceptualisation of Aboriginal community is misleading and problematic in terms of the provision of appropriate psychological services for Aboriginal people (Vicary, 2002). Furthermore, the use of the term community in relation to Aboriginal groups has direct connotations to delivery of services and funding. From a governmental perspective, "it is cheaper to call a group of 500 or more black or brown skinned human beings a community, than a town" (Dudgeon et al., 2002, p. 255). By labelling such a group or groups as a community, governments can avoid the costs involved with the provision of the infrastructure that is

necessary for a town. As Garvey (2010) argues "the jargon used to reflect 'community', merely serves to erect linguistic and technical barriers that cement the divide between you [psychologists] and them [Aboriginal people]" (p. 9).

Having issued that caveat about the use of the term community, Dudgeon et al. (2010) have argued that the Indigenous conception of the community differs from that of non-Indigenous people and is fundamental to the concept of self. Dudgeon et al. (2002) report the diverse and pluralistic nature of the Aboriginal community. While there is no precise definition of the notion of community within Aboriginal society, there are a number of core values, beliefs, and attitudes concerning community. Aboriginal communities can be conceptualised as geographical, social, and political (Dudgeon et al., 2010). They report the defining dimensions of Aboriginal conceptions of communities as sense of belonging based on family lines and country, or area of origin. Therefore, community can be considered in terms of two dimensions – filiation and affiliation. The primary family and clan connection to a specific geographical area represent the filial dimension of community, with Aboriginal people defining themselves as belonging to a particular region or country.

Prior to colonisation/invasion, Aboriginal people occupied the whole continent, hunting and gathering in defined areas. Each group had a special relationship with its country. These people did not own the land; rather they belonged to certain areas, with the land being similar to a religious text, in that it formed, and forms, the basis of spiritual life. As such they were – and in some areas still are – obligated to look after their country by caring for their sacred sites and performing ceremonies for the well-being of the country. Certain sites hold particular significance as ancestral beings performed special actions at the time of creation on these sites. Thus different groups become the custodians of different stories,

with much knowledge of sacred sites being earned or gender specific (Dudgeon, 2003; Dudgeon et al., 2010).

Approximately 500 different clan groups existed within Australia before it was colonised/invaded, and each group associated with a different territory, history, dialect and culture (Collard, 2000). The Dreamings of each society communicated the oral traditions of the land, the seasons, and religious spirituality. While the land provided sustenance for its people, it also represented a physical reflection of the journeys of spiritual ancestors from the period of creation. The land was and is a representation of spiritual life and may be thus conceptualised as a type of religious text (Collard, 2000). Cowan (1992) describes a Dreaming landscape, a physical incarnation of spiritual and mystical realities that cannot be easily translated into words. Therefore, the Dreaming represents the land as a symbol, an expression of the mystical nature of individual attachment to it. The Dreaming can be seen as "the pragmatic voice, the geographical articulation and the mytho-poetic dream thoughts of the country" (San Roque, Japaljarri, & Petchovsky, 2001). The Dreaming represents a pattern of connectivity, joining lines of sites, lines of songs, and lines of familial relationship, along lines of country – it serves to link country to all other aspects of life. The Dreaming forms a channel through which all cultural associations pass through the generations (Atkinson, 2002), and provides a basis for decisions to be made regarding relationships, law, marriage, and cultural and intellectual power and politics (San Roque et al., 2001). Furthermore, the Dreaming is not something that happened a long time in the past, rather it is "the processes of human action in co-creation with the great Creators and the ancestral beings, which continue in the present, the continuing birth, life, death, rebirth, renewal that is human activity across millennia" (Atkinson, 2002, p. 32).

Groups belonged to certain areas of land or country – rather than owning the land,

Aboriginal people had specific relationships to the land, with spiritual and familial bonds existing between individuals and their country (Dudgeon, Garvey, & Pickett, 2000). Land, or country, is central to the formation of identity in Aboriginal people, as it provides a guide for all human interaction. Within Aboriginal culture, country is not seen as something separate from the self. Rather, country forms one aspect of the self and the identity of the individual and the group. Furthermore, subjectivity is attributed to all beings, including non-human (Petchovsky, 2001). Country is perceived as being alive, in a sense, and capable of thought and reflection (Bishop, Colquhoun, & Johnson, 2006). Country also provides a sense of wellness – that is, the wellness of the people reflects the wellness of the country – if the country is sick, then so are its people; and conversely, if the country is well, then so are its people (Atkinson, 2002). So the maintenance of country – and thus the maintenance of the Dreaming – becomes important as a psychological process, maintaining the health of the people, the country, and the nation (San Roque et al., 2001). Sites of conception and birth are highly significant as they establish much of the physical journeying of the individual, and the inter-relationships with others. These are re-enacted at death, with such rituals allowing the spirit to continue its journey into other realms and realities (Atkinson, 2002). These values and ways of operating continue today in many Indigenous Australian peoples, even those that appear – on the surface – to be completely western, and to have rejected their cultural heritage (Dudgeon et al., 2010).

Methodology

Vicary's Study

Before commencing his research, Vicary (2002) spent 18 months in consultation with Aboriginal people throughout the Kimberley and the metropolitan areas of Western Australia, speaking to male and female Elders,

Aboriginal health workers, Aboriginal policy and program personnel and individuals within the Aboriginal community with direct experience of the mental health system. This consultation process involved the discussion of the main areas of interest and aims of the research, and identification of any potential problems. Through this consultation process, Vicary found that many Aboriginal people experienced frustration when dealing with the western mental health system, with a general impression that non-Aboriginal practitioners were confused about Indigenous concepts of mental health, and that the myths surrounding Aboriginal culture and traditional health practices made it more difficult to develop a relationship with a non-Aboriginal practitioner.

Many of the consultants expressed concern at the generic use of Aboriginal programs, and believed that this practice was due to the misguided belief that Aboriginal groups are homogenous. Lack of consultation with Aboriginal members of the community was another concern, with the belief that consultation with the Aboriginal community would greatly assist in developing an understanding of the Aboriginal world-view. Overall, Vicary (2002) received an enthusiastic response to the proposed research, with the belief that the information gathered could benefit Aboriginal communities, in improving mental health services to Aboriginal people through the application of culturally derived work practices. Some concerns were expressed regarding the methodology, resulting in the recommendation of a number of pre-conditions for effective research with Aboriginal people:

1. developing a relationship with and collecting data from a potential study participant by 'yarning' with them;
2. working with local Aboriginal cultural consultants;
3. providing feedback to study participants;

4. involving the Aboriginal community as much as possible; and

5. assembling an Aboriginal Steering Committee (Vicary & Bishop, 2005).

Vicary (2002) formed a Steering Committee and met with them on a regular basis for guidance and advice on cultural aspects of the research, process and methodology. The Steering Committee included Aboriginal men and women from the Kimberley and Perth metropolitan areas, who had extensive experience with Indigenous research. They recommended a qualitative research design, so that relationships were developed between the researcher and the participants, and that the research be conducted in a transparent and non-threatening manner. To achieve the goals of the Steering Committee, it was further recommended that:

1. the study's target cohorts be informed and regularly updated about the progress of the study;

2. the Aboriginal community be consulted regularly;

3. potential participants be completely comfortable with data collection methodology;

4. potential participants be clear about the objectives of the study;

5. the results of the project be returned to participants for their comments;

6. the data be collected primarily through an informal interview or 'yarn';

7. local Aboriginal cultural consultants provide guidance and advice to the researcher; and

8. the research be easily understood and presented in language familiar to Aboriginals (Vicary & Bishop, 2005).

The Steering Committee identified potential participants, and 'vouched' for the researcher, expressing positive information about the research. The Committee sent a document to various agencies outlining the objectives, proposed questions and areas of interest of the study, informing participants of the research, the possible questions, objectives, and its confidential and voluntary nature. Vicary obtained ethical approval from Academic Supervisors, the Steering Committee, the School of Psychology Doctoral Research Committee, the Curtin University of Technology Ethics Committee, and Family and Children's Services.

The questions to be used in the interviews were developed with the aide of the Steering Committee and representatives of the Aboriginal community in both the Kimberley and the Perth metropolitan area. Through this consultation process, a total of 380 questions were generated and then screened for cultural propriety, use of language, question content, clarity, nature of the question, and relevance. This process resulted in the elimination of all but nine semi-structured questions. This questionnaire was then piloted on the members of the Steering Committee, with generally positive feedback, however it was recommended that the order of the questions be reversed, allowing participants to become more relaxed, providing a context for their answers, and increasing the face validity of responses.

Interviews were conducted by Vicary, the primary researcher, and Pearson, who was then a Senior Aboriginal Advisor for Family and Children's Services. Respondents were given the choice of locality for the interview to take place, with most choosing their place of work. No time restrictions were placed on the interviews, with the length of interviews ranging from 40-310 minutes. A total of 70 interviews were included in Vicary's study, with 35 participants from each geographical location ranging in age from 19-68 years, with a mean age of 38 years. The Kimberley group consisted of 11 men and 24 women, while in the Perth group there were 19 females and 16 males. All participants had completed secondary school, with well over half having also completed tertiary study.

Procedure

The transcripts of the 70 interviews were analysed to see to what extent the issue of country had been discussed. As Vicary's (2002) original research was concerned with Aboriginal conceptions of mental health, the notion of country was not discussed in all of the interviews. Therefore it was necessary to examine the interviews in terms of the degree to which each interview addressed the notion of country. From the original 70 interviews, 34 were found to address the notion of country in enough depth to be useful for the purposes of the current research. These 34 interviews comprised 300 pages of data. The 34 interviews were thematically analysed using NVivo (Richards, 1998).

Two levels of analysis were utilised to generate a number of themes and phenomena. The first stage of analysis – open coding – generated eighteen themes relating to country. These were traditional law, traditional beliefs, spiritual connection, traditional explanations of mental illness, reconnecting, feeling whole, sense of belonging, sense of identity, kinship, effects of separation, grieving, burials, security, loss of culture, wellness, imprisonment, infrastructure, and therapeutic approach. Axial coding (Miles & Huberman, 1994) was used to develop the second level of analysis and four phenomena central to the notion of country, within which each of the eighteen themes existed were identified. These central phenomena interrelate to shape conceptualisations and beliefs about country, as will be discussed below.

Findings

Analysis of the interview transcripts identified the importance of country as a cultural phenomenon, with participant responses in general being fairly similar across the sample. There were no real differences in conceptualisations of country between the various regions included in the research. One factor that seemed to influence variations in responses was that of cultural magnitude. Participants who had experienced a stronger

traditional cultural influence throughout their lives were more likely to provide answers that were more strongly grounded in traditional beliefs. However, there were no major conceptual differences arising between the groups.

The open coding phase of analysis generated nineteen categories in relation to country. Axial coding identified four central phenomena within which these categories exist: Traditional Elements, Identity, Physical Attachment, and Provision of Services. Traditional Elements includes the categories of traditional law, beliefs, spiritual connections, and traditional explanations of mental illnesses. The Identity phenomenon involves reconnecting, feeling whole, sense of belonging, sense of identity, and kinship. Physical Attachment includes effects of separation, grieving, burial, security, loss of culture, and wellness. Provision of Services concerns imprisonment, infrastructure, and therapeutic approach. Each of the central phenomena identified interrelate with each other to shape the general notion of country.

Traditional Elements

The central phenomenon of Traditional Elements included the general categories of traditional beliefs, traditional law, cultural explanations of mental illness, and spiritual connection. Participants in Vicary's study expressed that there are traditional and cultural explanations for behaviours that within a Western framework may be diagnosed as mental illness. Factors such as being away from country for too long, and walking on sacred sites or on sites for women's or men's business without permission may result in behaviours identifiable from a Western perspective as mental illness. However, if treatment for these behaviours does not address the cultural or traditional cause of the problem, then the treatment is likely to be ineffective.

This issue relates back to Kleinman's (1973) discussion of symbolic pathways. A symbolic pathway comprises words, feelings,

values, expectations, and beliefs. It connects events and forms with affective and physiological processes. The nature of this symbolic pathway is such that the description, diagnosis, and treatment of a disorder constitute a symbolic reality for individuals, communities, and practitioners. Therefore, any therapies or treatments must consider the clients symbolic pathway before they can be effective.

The issue of traditional explanations for mental illness highlights the importance of implementing culturally appropriate processes and services, and the significance of context in working with Aboriginal clients and communities. Practitioners must conceptualise reality as subjective, and consider the clients interpretation of reality within delivery of therapeutic services (Garvey, 1995, 2008). Furthermore, given that Aboriginal communities are not homogenous, and that there exists great cultural variation between communities (Vicary 2002), it is important that practitioners consult with members of the community in question, and determine from them the traditional explanations for mental illness.

Furthermore, the role of traditional healers within the therapeutic process should not be overlooked. Aboriginal people often experience some difficulty in communicating the nature and interpretation of their problems to non-Aboriginal practitioners, with the concern that spiritual issues may be misrepresented or misunderstood by a non-Aboriginal practitioner. In such cases, access to traditional healers may assist in the therapeutic process (Swan & Raphael, 1995). However, practitioners must be aware that a traditional healer should only be involved at the request of the client, or those responsible for the client (Dudgeon, 2000a).

The spiritual connection to country interrelates with traditional beliefs and law to affect identity formation and sense of self. As country is not separate from the self, but forms a part of the whole individual (Bishop et al., 2006; Petchkovsky, 2001; San Roque et al., 2001), the spiritual connection to country – and consequent problems associated with separation – must be considered as an important contributing factor to any therapeutic process.

Identity

The Identity phenomenon incorporates the categories of sense of identity, sense of belonging, feeling whole, kinship, and reconnecting. "As Aboriginal people your country is actually you and you are your country". History, ancestry, and cultural heritage are all specific to country. Different regions have specific Dreaming and stories, providing a context of rules, values and norms by which individuals live their lives. Individuals need to be aware of their history before they can determine where they belong, establish their place in society and look to their future (Collard, 2000).

As previously discussed, place identity forms a fundamental part of the development of self and social identity (Cuba & Hummon, 1993), with place existing as an autobiography or extension of the self. Practitioners should be aware of the importance of country to the formation of identity when working with Aboriginal clients, as many presenting problems are likely to be identity-related, and so also related to issues of country.

When Aboriginal children were taken from their families and their country, they were also deliberately – and often violently – discouraged from displaying any cultural practices, including speaking their own language. They were indoctrinated into a belief system of White supremacy, with the power dynamics observed around them reinforcing this notion (Dudgeon, 2000b). As a consequence of this forced relinquishment of identity, many health problems experienced by Aboriginal people today will be identity-related. This is especially evident in Aboriginal youth, many of who feel that they have no legitimate connection to their

Aboriginality. Because they have not had the opportunity to grow up within a traditional society, they have had less experience of outward expressions of Aboriginal culture and so are led to question their identity as Aboriginal people (Beresford & Omaji, 1996). Non-Indigenous practitioners must develop an understanding of the interaction between country and identity, and the consequent mental health problems that have arisen as a result of Aboriginal people being displaced from their country, in order to design effective therapeutic practices.

Physical Attachment

This phenomenon comprises the categories of effects of separation, burials, grieving, loss of culture, security, and wellness. Individuals reported the experience of positive feelings when they are in their country that they do not experience at other times. Similarly, when they are away from their country they experience negative feelings that dissipate once they return. This physical attachment to country is reflected in the need expressed by many, especially elderly, people to be buried in their country, and the need to return home in order to properly grieve and heal. Loss of culture is associated with separation from country. Similarly country is related to feelings of security, with comfort gained from the knowledge that there is always a place to return to; a place of belonging. Wellness is another aspect of the physical attachment to country, with wellness increasing when an individual is at home.

The importance of physical attachment to country cannot be emphasised enough in terms of its contribution to therapeutic processes. Practitioners must have knowledge of this issue if they are to work effectively with Aboriginal clients. Practitioners may find that many clients presenting with any range of problems will show a marked improvement simply by returning to their country (Vicary, 2002; Vicary & Bishop, 2005). The need expressed by many of Vicary's (2002) participants to return to their country to die and be buried is

another important issue of which practitioners should be aware, especially when dealing with clients who are elderly or sick. Similarly, when dealing with issues of grief or depression, a knowledge of the effects of separation from country may assist the practitioner in developing a more effective treatment, which may include a recommendation that the client return home.

The loss of culture experienced as a result of separation from country may be the underlying cause of many presenting problems. As previously mentioned, country can be conceptualised as a type of religious text, representing and storing the history of Aboriginal people from the time of the Dreaming (Collard, 2000; McMillan, Kamperas, Traynor, & Dewing, 2010). Country formed the basis of all life within traditional Aboriginal society – regional boundaries, social norms and practices, stories, languages, traditions, and a multitude of other factors (Dudgeon, 2003). Thus country contributed largely to the development of the identity of its people, and so many of the subsequent problems associated with loss of country, and consequent loss of culture, may also be associated with loss of identity, as discussed previously.

Within the Aboriginal world-view, health is conceptualised in terms of wellness within all aspects of life. A Western perspective identifies physical health, mental health, emotional health, and spiritual health as separate entities, requiring individual attention and study. However the Aboriginal world-view considers all of these phenomena to represent aspects of one larger entity, which may be referred to as wellness (Vicary, 2002; Vicary & Bishop, 2005). It is important that practitioners understand the concept of wellness within the Aboriginal world-view; as such an understanding will allow the practitioner a richer insight into the issues affecting the Aboriginal client. Furthermore, understanding the contribution of country to

the notion of wellness, in relation to the issues discussed above, will further aid the efficacy of the therapeutic process.

Provision of Services

The final phenomenon of Provision of Services includes the categories of therapeutic approach, imprisonment, and infrastructure. The issue of country needs to be considered within the provision of each of these services. That Aboriginal groups are not homogenous (Collard, 2000; Vicary, 2002) requires that different programs be developed for different regions. Practitioners should adopt a value of cultural relativism, and understand that each culture is unique and self-contained, and as such can and should only be understood in terms of itself (Watts, 1994). Once practitioners reach this understanding, it will then become possible to involve the community in developing therapeutic processes and programs that are congruent with their world-view. The use of the Indigenous world-views and belief systems in designing such processes and programs will result in the development of interventions that will develop the strengths, while minimising the existence and influence of conflicting values (Watts, 1994). Practitioners should not expect Western models of mental health to work for Aboriginal populations, rather there is a need for the development of new health models designed by Aboriginal people (Briscoe, 1978). Practitioners working with Aboriginal populations must have an understanding of the diverse and complex nature of Aboriginal communities (Dudgeon et al., 2002), and of the impact of spirituality, community, country, and colonisation on the lives of Aboriginal people before any processes or programs will be effective (Shelldrake, 1990).

The implications of country in the promotion of wellness, as discussed above, have direct connotations for the process of imprisonment. The purpose of rehabilitation is not assisted if it involves the removal of an Aboriginal person from his or her country, as that person will then experience some loss of

identity and sense of self. As previously discussed, country is not understood as a separate entity within Aboriginal culture (Bishop et al., 2006). Rather, country represents another aspect of the individual, similar to spirituality/religion, in that it contributes to the definition of self, and assists in answering the questions of "who am I?", "where do I belong?", and "why am I here?".

It is not always possible for Aboriginal people to live on their country as the necessary infrastructure may not be established within those areas. This relates back to the problematic use of the word community to describe a large group of Aboriginal people living within a specific geographic area. As previously mentioned, if such groups are labelled as a community rather than a town, governments are able to avoid the costs of infrastructure necessary for a town (Dudgeon et al., 2002). As such, many Aboriginal people are not able to live on their country because such infrastructure has not, and will not be provided.

Conclusions

The broadest and most important conclusion that can be made from this research is to emphasise the vastness of the cultural divide between Aboriginal and non-Aboriginal. Examination of one aspect of the Aboriginal world-view has revealed an immense difference between Aboriginal and European conceptualisations, formations and explanations of identity, mental illness, wellness, family structure, social structure, and any number of other elements impacting on individuals and communities. If other aspects of the Aboriginal world-view create similar differences in other areas of life, it becomes difficult to comprehend how western therapeutic techniques have ever been expected to work for Aboriginal people. Given the vast differences between Aboriginal and Western conceptualisations of country, it becomes clear that it is unacceptable for a non-Aboriginal

practitioner to adopt a general practice of cultural sensitivity without a thorough knowledge of this issue. The results have indicated that country is hugely important to the development of the psyche of Aboriginal people, and is one of the most important aspects of wellness and mental health within Aboriginal society. As such, non-Aboriginal practitioners cannot claim cultural sensitivity without a thorough understanding of the dynamics of country within the Aboriginal world-view.

The importance of country needs to be understood for therapeutic purposes, as it impacts on every aspect of life. Aboriginal clients may present with identity-related problems, so the practitioner would need to understand the influence of country on the formation of identity. Similarly, loss of culture as a result of displacement also affects notions of identity. If a client exhibits psychotic symptoms, the practitioner should consider the possibility that the client may have been somewhere without permission – sacred sites or sites for women's or men's business – or that they have been 'sung' as a form of punishment (a powerful spell designed to do ill to a wrongdoer). Thus country should always be considered within any therapeutic process when working with Aboriginal people, and practitioners should ensure the cultural sensitivity of not only their therapeutic process, but also their own belief systems.

Practitioners must adopt and internalise values of cultural sensitivity and respect for diversity before they will be able to work effectively with Aboriginal people. They must exert a conscious effort to understand, accept, and appreciate the unique aspects of the Aboriginal world-view, and also identify those areas where the Aboriginal and the Western world-view may overlap. It is within these areas of overlap that non-Aboriginal practitioners will be the most effective. However, until more Indigenous people become practitioners, there is still a need for non-Aboriginal practitioners to work in areas

outside of their own world-view. Practitioners working in such areas must acknowledge their lack of knowledge, and approach members of the Aboriginal community within which they are working for assistance in understanding the unique dynamics of that community. While the importance of developing a cultural understanding cannot be overemphasised, practitioners must be aware of – and acknowledge – those situations in which their cultural understanding is limited. Practitioners must also be aware that there are certain aspects of Aboriginal culture that they will never understand, and within this awareness, again approach members of the community for assistance. This assistance may exist in the form of a cultural consultant, a practitioner of the opposite sex, or a traditional healer.

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Note

[1.] There is contention about the use of the terms 'Aboriginal' and the more inclusive 'Indigenous' term which includes people from the Torres Strait. We use the latter term generally, but refer to the participants in Vicary's study as Aboriginal people.

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