Exploring Spirituality, Religion and Traditional Healing as Protective Factors in Transcultural Mental Healthcare

Deborah Mitchell-Macaulay
PhD Candidate
School of Social Work
Griffith University

Submitted in fulfilment of the requirements of the degree of Doctor of Philosophy

November, 2017
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed: XXXXXXXXXXXX

Date: 1st November 2017
**Acknowledgements**

There are a number of individuals and groups that I would like to acknowledge. These include:

- I would like to thank my parents, Pearl and Ullen Mitchell to whom I dedicate this thesis and all of my family who allowed me to embark on this international educational journey;

- I would like to thank participants in my study who gave of their time and shared their knowledge and experiences in the subject area of the research;

- I would like to thank Professor Lesley Chenoweth and Associate Professor Lynne Briggs from Griffith University for their invaluable support, encouragement, patience and guidance;

- My husband James for his patience, love and support;

- My work colleagues at Queensland Transcultural Mental Health;

- Friends who have given me encouragement and support.
# CONTENTS

PROLOGUE ........................................... i

ABSTRACT ........................................... iv

LIST OF ABBREVIATIONS ......................... vii

CHAPTER 1. INTRODUCTION ....................... 1
  1.1 Introduction .................................. 1
  1.2 Cultural responsiveness in mental health .... 3
  1.3 Significance of current study ............... 4
  1.4 Aims of the research ....................... 9
  1.5 Methodology .................................. 11
  1.6 Theoretical framework ...................... 11
  1.7 Thesis structure .............................. 12

CHAPTER 2. LITERATURE REVIEW: The Immigrant Journey .. 14
  2.1 Introduction .................................. 14
  2.2 Spirituality ................................... 16
  2.3 Religion ..................................... 24
    2.3.1 Relationship between spirituality and religion .... 26
    2.3.2 Historical and contemporary religious populations in Australia ........ 28
  2.4 Traditional healing ......................... 31
  2.5 Protective and risk factors for CALD populations .... 38
    2.5.1 Spirituality and religion as protective factors in mental health ........ 41
  2.6 Why transcultural mental health ............. 45
    2.6.1 Culture .................................. 48
    2.6.2 Cultural and linguistic diversity .............. 50
    2.6.3 Language .................................. 55
    2.6.4 Immigration and resettlement .................. 57
    2.6.5 Acculturation ................................ 59
    2.6.6 Intergenerational complexities ................ 64
    2.6.7 Examples of CALD explanatory models .......... 68
  2.7 Conclusion .................................... 70

CHAPTER 3. LITERATURE REVIEW: Treatment Approaches .... 71
  3.1 Introduction .................................. 71
    3.1.1 CALD perceptions of mental health services .... 71
    3.1.2 Western healthcare model .................... 79
3.2 Transcultural mental health 83
3.3 Clinical response: Transcultural mental health treatment 98
   3.3.1 Australian mental health services 98
   3.3.2 Practitioner clinical response 105
3.4 Conclusion 107

CHAPTER 4. THEORETICAL FRAMEWORK 109
4.1 Introduction 109
4.2 Explanatory models 110
   4.2.1 Culture and the explanatory model 116
   4.2.2 Culturally responsive mental healthcare 119
4.3 Conclusion 124

CHAPTER 5. METHODOLOGY 125
5.1 Introduction 125
5.2 Aims of the research 126
5.3 Research design 127
   5.3.1 Setting 127
   5.3.2 Sampling technique 127
   5.3.3 Informal reference group 128
   5.3.4 Advisory group 130
5.4 Ethics 131
5.5 Participants 133
   5.5.1 Recruitment 133
   5.5.2 Participant characteristics 134
   5.5.3 Rationale for diversity of practitioner perspectives 137
   5.5.4 Practitioner groups 139
5.6 Data collection 142
5.7 Data analysis 143
5.8 Conclusion 145

CHAPTER 6. RESULTS 146
6.1 Introduction and overview 146
6.2 Results 147
   6.2.1 Definition of spirituality 147
   6.2.2 Spirituality sub-themes 148
   6.2.3 Definition of religion 154
   6.2.4 Religion sub-themes 155
   6.2.5 Definition of traditional healing 165
   6.2.6 Traditional healing sub-themes 170
   6.2.7 Continuity of practice in home country and Australia 176
   6.2.8 Change in definitions of spirituality, religion and traditional healing 178
   6.2.9 Focus group understanding of mental health 179
   6.2.10 Protective and risk factors in personal mental health 180
PROLOGUE

My experiences growing up as an African American in Chicago, United States of America, are best regarded as the starting point for my journey to this PhD. The history of African Americans bears the indelible imprint of slavery, starting from the capture and transportation of our ancestors, who were living on the African continent some 400 years ago until they were forced into slavery under the harsh rule of European Americans. That oppression continued for a long period of time until the Abolition of Slavery in the United States of America at the end of the American Civil War. This was effected in the Emancipation Proclamation in 1863, while slavery was formally ended with ratification of the Thirteenth Amendment to the Constitution coming into force in December 1865.

That history of slavery for my people has left a burden of collective pain and social dysfunction, which has had long-term intergenerational effects right up to the present time. This may have resulted in significant alienation of some sections of the African American community from the mainstream population, potentially manifesting as drug abuse, unemployment, crime, domestic violence and high rates of incarceration for members – particularly males – of the African American community.

The United States of America has a highly multicultural population with a mix of European, African, Hispanic, Chinese, Japanese and of course Native Americans, the latter of whom were the first settlers on the North American continent over 15,000 years ago. These influences from my African American culture and other cultures with which I've been in contact have informed my formative years and have done much to spark my initial interest in the subject for this PhD, which has been further developed by later experience.

With the background outlined above, I then went through my own personal immigration experience. Having won a prestigious scholarship to study internationally, I studied for a Master’s Degree at Melbourne University in Australia.
The immigration experience brought with it, not only a high level of “culture shock” but also feelings of loneliness, alienation and fear. While culture and language in the United States of America and Australia are fairly similar, the experience shook me deeply. It gave me a sense of the much greater anguish that an immigrant from a very different, collectivist culture would experience on relocating to another country such as Australia, which has a Western individualist culture. I found the cultural gap daunting and also felt that I was frequently misunderstood.

The pain and anguish that I felt in this situation was deep and it caused me to withdraw and look inwards. In finding a way to cope with my feelings, I turned to the resources of spirituality and religion for help. Fortunately, the church that I had attended in the United States of America also had a branch in Melbourne and the support and encouragement from that source was of great assistance to me in managing the situation I faced. Communing with nature in the beautiful parks near my apartment also helped to bring about a calming effect. The thought that God would not have brought me all the way to Australia to fall flat on my face also helped me to persevere and keep going.

After completing my Master’s Degree, I returned to the United States of America only to be invited back to Melbourne to do a PhD a little later on. The return to Australia under a study visa brought with it financial hardship as I was limited to only working a maximum of twenty hours per week which did not provide sufficient income to live on. I later applied for a Permanent Resident Visa which I found to be an enormously challenging experience in navigating all the processes and expenses involved. I struggled to find work for a long time. After months of looking, a colleague explained that in Australia, emphasis is placed on skill sets and experience rather than education in order to secure a work placement. Eventually I did find work and that was a great relief after the prolonged period of financial stress and anguish that I had been through.

Subsequently, I ended up staying and continuing to work in Australia which fully brought home to me the realisation that all my family members – father, mother,
brothers and sisters – were living on the other side of the world in the United States of America, and I would not be seeing nearly as much of them anymore. When I did plan visits to my country of birth, it would be an expensive and time-consuming exercise. That situation evoked a great sense of loss, as we had always been a very close-knit family.

My life in Australia ultimately brought me to live and work in Brisbane, Queensland, where I was privileged to gain employment in transcultural mental healthcare – a field about which I am very passionate. Australia has one of the most diverse multicultural populations in the world and that has exposed me to people from many cultures and ethnicities with a wide spread of languages. Some of the clients of this service have migrated of their own free will and others are refugees from war, civil strife and religious persecution. Many of these refugees went through horrific experiences that may have affected them in such a way that they are left with emotional scars and symptoms of post-traumatic stress disorder.

What has become clear to me from my work with culturally and linguistically diverse clients is that as immigrants, they are under a great deal of acculturative stress. Moreover, their needs are not being properly met by Western-oriented mental healthcare systems, which take the view that “one approach fits all” is sufficient. Also, my work experience has shown that mental health practitioners need to be equipped to meet the needs of such clients.

It is based on the combination of my African American background (that being a disadvantaged minority), my difficult immigration experience, and my work experience with culturally and linguistically diverse clients, that I am undertaking this PhD research with the hope that it will lead to better mental healthcare for people from culturally and ethnically diverse backgrounds. I believe the experiences that I have been through myself better equip me to undertake this PhD research and also to offer more appropriate and effective treatment in the work that I do in transcultural mental healthcare.
ABSTRACT

This study details the results of a qualitative investigation into the role and importance of spirituality, religion and traditional healing, as perceived by mental health practitioners working with culturally and linguistically diverse (CALD) individuals. A qualitative method was used to extract deeper meaning from discussion content. This was considered particularly important in catering to CALD communities, both in terms of how well they understood the meanings of questions, and how well they conveyed their intended meanings in responses.

The histories of many practitioner participants in this study were informed by ongoing conflict in their home countries, where they reported distrusting government-run institutions. Many of them entered this study still bearing the emotional effects from their experience of war, and many also struggled with language and other cultural differences. In addition, some had strained relations with medical systems in their countries of origin. The research design therefore allowed for subtle nuances to be expressed during focus group discussions, and was sensitive to the cultural and socio-political issues plaguing these communities, both in Australia and abroad. Close attention was paid to building rapport and creating a safe environment for the full participation of each person. This is why transcultural mental health as a treatment approach was utilised to meaningfully examine the context in which people exist and the local and global implications of being estranged from one’s homeland.

Research addressing sensitive topics with people from CALD backgrounds can present challenges that are difficult to address using conventional methods, as many of these communities may feel over-researched in a way that sets them up to feel exploited and more vulnerable to Western influence. Many of these people speak English as a second language, and so may feel that since they have been accepted into this country, they cannot disagree with what medical personnel ask of them. The study was carried out using informal community collaboration, the key
factor to the success of this research, which optimised the development of research questions and engendered a trusting research environment. Most research in this field to date has been conducted from the perspective of Western medical practice; however, in contrast, this study gains insight into the perspectives of a range of CALD communities, in terms of how they address mental health issues within their respective communities.

The study combined perspectives from a range of mental health practitioner participants, including professional and para-professional mental health workers from both CALD and non-CALD backgrounds. Services provided by these groups are routinely accessed by CALD people at the onset of their wellbeing issues. Participants included government and non-government mental health practitioners from various academic disciplines, and there was a balanced representation of gender and country of origin.

As immigration is taking place globally at an unprecedented rate, consumers from many CALD communities are presenting in mental health systems with a range of emotional needs. As a result, mental health services are finding themselves faced with assessment and treatment challenges. The immigrant journey consists of complex resettlement issues often associated with visa status, ongoing grief and loss issues, and trauma from leaving one’s homeland for a host of ecological, socio-political or religious reasons. Immigration is often accompanied by stressful adaptation to a new host environment, which can be challenging even if the migrant is welcomed by their new country and given all the benefits of being able to begin a new life there.

This study demonstrated that mental health practitioners working with CALD clients should approach treatment while considering the acculturation process involved in resettlement, as this may be more traumatic for the individual or community when they are not accepted, directly or indirectly, by the host environment. Such a situation, in which the individual or community has been taken away from everything familiar to them, often leads to an existential crisis. Many of these
individuals are placed in detention or are left within the wider Brisbane community with no financial benefits or resources. This heightens their reliance on a higher power, as many feel they are stripped bare of all earthly relationships and possessions and left with only their spiritual, religious and traditional dimensions.

The data from this study show clear evidence for the importance of spirituality, religion and traditional healing in transcultural mental healthcare, while at the same time pointing to a level of reluctance on the part of practitioners and management to fully integrate these issues into their approach. The CALD participants overwhelmingly agreed that spirituality, religion and traditional healing were essential cultural entities which form the foundation for who they are as people, and to forego these practices in, of all places, mental healthcare, would be counter-productive. The results from this study have implications for current and future mental health practice, for mental health policy, for training of mental health personnel and for future research.

**Key Words**

Transcultural Mental Healthcare; Spirituality; Religion; Traditional Healing; Immigration; Acculturation.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
</tr>
<tr>
<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
</tr>
<tr>
<td>DIMIA</td>
<td>Department of Immigration and Multicultural and Indigenous Affairs</td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>LCSW</td>
<td>Licensed clinical social workers</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Scheme</td>
</tr>
<tr>
<td>MHIMA</td>
<td>Mental Health in Multicultural Australia</td>
</tr>
<tr>
<td>MMHA</td>
<td>Multicultural Mental Health Australia</td>
</tr>
<tr>
<td>NESB</td>
<td>Non English speaking background</td>
</tr>
<tr>
<td>NET</td>
<td>Narrative Exposure Therapy</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>QPASTT</td>
<td>Queensland Program of Assistance to Survivors of Torture &amp; Trauma</td>
</tr>
<tr>
<td>QTMHC</td>
<td>Queensland Transcultural Mental Health Centre</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Chapter 1. INTRODUCTION

1.1 INTRODUCTION

Culturally and linguistically diverse (CALD) individuals are faced with special challenges arising from the immigration process, especially when confronted by the Western Health Care System. Specific health care needs with which CALD communities are faced is identification of ‘engagers’ in the therapeutic process (Baker, Proctor and Ferguson, 2016) as well as language difficulties impacting on both the client and practitioner, with some practitioners being uncomfortable working with people whose primary language is not English (Stocker, 2017). Issues of stigma also arise in connection with mental health in some cultures and in working with collectivist cultures it is important to consider the involvement of significant others such as family, friends and community (Baker, Proctor and Ferguson, 2016). Other issues impacting CALD individuals are possible experiences of human rights violations, trauma, suicideality and detention.

Lack of research data in relation to the CALD component of the Australian population, leads to a lack of understanding of the determinants of mental health and mental illness in CALD populations and of explanatory models of illness, beliefs and attitudes towards mental disorders and mental health services (MHIMA, 2014).

Social determinants of health are the conditions of the social world that influence the health and wellbeing of individuals and groups. These social conditions are often shaped by the distribution of wealth, power and resources at personal, local, national and international levels (MHIMA 2014). Mental health is an area of healthcare that affects the whole of society; however, immigrants, especially refugee and asylum seekers, are often disadvantaged subgroups. These groups have often experienced forced migration, which affects them traumatically. In addition to trauma and other emotional and settlement vulnerabilities, these groups experience racial and equity discrimination at both interpersonal and systemic levels. Racial discrimination is
often accompanied by a high level of psychological distress, psychosis, depression and other mental health issues (Minas et al. 2013). It is well established that forced migration is associated with health vulnerabilities and increased risk of undesirable financial, sexual, political and reproductive health outcomes (Koser 2010; WHO 2000).

Those who choose to immigrate to another country often have better health compared to the general population of their host country (Anikeeva et al. 2010). However, forced migration and prolonged periods of detention can have a marked impact on physical, spiritual, emotional and mental health, resulting in a complex range of vulnerabilities and needs (Kizito 2001; Shier, Engstrom & Graham 2011). Refugees, asylum seekers, international students and other classes of immigrants can be among the world’s most vulnerable people and they are also often highly resilient, having survived through terrible situations. Immigrants, especially refugees, may have witnessed or personally suffered violence, abuse, imprisonment and torture (Anikeeva et al. 2010). Refugees often face hazardous journeys to new settlements, life in refugee camps and prolonged loss of – or separation from – family and loved ones. These traumatic experiences can have a negative impact on their mental health and wellbeing, predisposing them to increased risk of developing post-traumatic stress disorder (Kizito 2001; Shier, Engstrom & Graham 2011).

Ongoing exposure to stressful events can weaken one’s physical and immune systems, creating increased vulnerabilities in other health areas. These higher rates of complex health issues and infectious diseases, such as hepatitis B, syphilis and tuberculosis, are consistently present in Australian refugee arrivals compared to other migrant groups and the general population (Johnson 2007; Martin & Mak 2006). Despite these findings, a Victorian study found large numbers of the participants were not sufficiently screened on arrival for infectious diseases (Tiong 2006; Tiong et al. 2006). This lack of routine screening stands to pose a potential public health risk for Australia in general, as well as many immigrant and cultural communities. This leads to
marginalisation of those community groups, in that the system does not meet the specific needs of those communities.

1.2 CULTURAL RESPONSIVENESS IN MENTAL HEALTH

Cultural responsiveness is an integral component of recovery-oriented service delivery and a critical consideration in improving the quality and safety of mental health services (MHIMA 2014). It is important to be culturally responsive in mental healthcare here in Australia, as Australia has one of the fastest growing cultural, ethnic, spiritual and religiously diverse components of its population (VicHealth 2009). The number of overseas-born Australians has increased from 23% of the total population in 2006, to 26% in 2011 (MHIMA 2014). Numbers of second generation immigrants with at least one parent born overseas are significantly higher (43% in 2011 census). The number of Australian who speak a language other than English increased from 16% of the total population in 2006, to 19% in 2011 (MHIMA 2014). The number of languages spoken in Australia has increased from 160 in 1996, to over 200 in 2011. This can be explained by the statistics which show that Australia has experienced significant increases in the number of immigrants coming from non-English-speaking countries between 2001 and 2011. For example, immigrations from India have increased by 200,000 people, and immigrations from China have increased by 176,200 (ABS 2012).

What is critical to a culturally responsive service delivery in transcultural mental healthcare is understanding the access issues and barriers, which hinder equity within service delivery. Treatment approaches to transcultural mental healthcare are comprehensively addressed in the present thesis, with particular regard to how these approaches pertain to the Australian clinical context.
1.3 SIGNIFICANCE OF CURRENT STUDY

This study examined the role of spirituality, religion and traditional healing, as perceived by mental health practitioners working with culturally and linguistically diverse (CALD) individuals. The genesis of this topic was born from many years of clinical experience in mental health, spread across two continents. It was observed therein that clients from CALD backgrounds see these issues as important to their health and wellbeing. Indeed, for some, spirituality, religion and traditional healing were so essential as to define their concepts of self.

There has been limited research conducted in Australia regarding the combined role of spirituality, religion and traditional healing as protective factors in mental health wellbeing in transcultural communities (Minas et al. 2013). Lack of research in this area has, in turn, contributed to poor understanding of how these themes impact stakeholder communities. Anecdotal evidence, gathered during formal and informal consultations between various cultural community members, has suggested there are inconsistencies between how people from CALD backgrounds utilise spirituality, religion and traditional healing to address their mental health needs, versus how mental health practitioners perceive and utilise these elements in their clinical practice. This discrepancy, combined with the lack of research addressing spirituality, religion and traditional healing in mental healthcare, as well as the attitudes and behaviours of transcultural communities, led to the development of this study.

The world is seeing increasing levels of immigration, often as a result of forced migration from war zones. This has led to more cultural and linguistic diversity in the populations of many nations around the world, including Australia. The current study explored these issues in an Australian context, specifically examining the perceptions of mental health practitioners in relation to the mental healthcare needs of CALD people.

Broadly speaking, “cultural and linguistic diversity” refers to the inherent variation that exists between groups and individuals, with respect to their religions, spiritualities, racial backgrounds, and languages. On a global scale
then, there is no one mainstream group, but a diversity of cultural and linguistic identities. In the present study, the term “culturally and linguistically diverse” was narrower in scope, and was used instead to describe groups in the host country (i.e., Australia) with non-mainstream racial, religious and/or linguistic backgrounds. Specifically for this thesis, “CALD” pertains to (first and second generation) immigrants, refugees and asylum seekers in Australia. Accordingly, the pre- and post-migration settlement experiences of such CALD groups, in addition to the risk and protective factors that interact with these experiences, form the broader focus of this study.

It may be considered disrespectful and irresponsible for any researcher (especially one who is themselves a migrant to the country) to avoid mentioning the Australian Indigenous population in any discussion involving non-mainstream Australian groups. While there are many cultures and languages within the transcultural melting pot that is Australia, interactions between “white” and Indigenous Australian groups have been ongoing since British colonisation, more than 200 years ago. Australian Aboriginal culture therefore plays a significant role in influencing the worldview of Australian people. Although the present study is not focused on the Australian Indigenous population per se, the principal investigator adheres to the perspective that a thesis whose focus is CALD individuals would lose relevance if the Australian Aboriginal cultural group was not included somewhere in the discussion.

Moreover, many of the same observations pertaining to CALD groups also apply to Australian Indigenous individuals. Social determinants of ill health (e.g., social, political and economic factors) are often embedded in Indigenous peoples’ historical experiences, in the form of loss of land and culture, transgenerational trauma, grief and loss, racism and social exclusion. These same factors are widely recognised as the leading causes of the disproportionately high rates of illness and disease found in Indigenous populations (King et al. 2009). As described further in Chapters 2 and 3, similar factors affect CALD peoples’ experiences. In addition, and with specific regard to the similarity between CALD and Indigenous groups in the present study,
some of the research participants belonged to indigenous groups from countries outside of Australia (e.g., New Zealand, Samoa, Africa).

Most of the literature has reported on studies that examine spirituality, religion and traditional healing from the perspective of Western mental healthcare, which does not take into account the CALD voice or the transcultural perspective. In Western mental healthcare, risk aversion and general systemic processes may cause the needs of CALD clients to be neglected. This study examined these issues from the perspective of mental health practitioners, with consideration given to the utility of all three protective factors – spirituality, religion and traditional healing – in mental healthcare.

This study is one of the few to look at the needs of CALD clients by seeking the views of a diverse range of mental health practitioners who come into contact with such clients. The principal investigator was interested in understanding the barriers to effective transcultural mental healthcare in dealing with CALD clients, and how mental health practitioners and the healthcare system interface and deal with these issues. The principal investigator contends that thorough research looking at such a diverse range of participants has not been done before.

This thesis seeks to provide better understanding as to the roles that spirituality, religion and traditional healing have in the conceptualisation, treatment, planning and associated clinical decisions pertaining to CALD consumers. The research presented here will elucidate where these themes sit within the cognitive and practice space of professionals with whom CALD consumers come in contact (Scott et al. 2016). Some researchers have addressed the impact of the counsellor’s religious or spiritual values on client care (e.g., Balkin, Watts & Ali 2014). Over the past decade, researchers have also taken a closer look at the roles of spirituality, religion and faith in the lives of clients seen by professional counsellors (Cashwell & Young 2011; Cashwell et al. 2013; Gingrich & Worthington 2007; Richards & Bergin 2005). However, these researchers tended to look at spirituality and religion and faith-based issues as
standalone constructs, rather than cultural variations that may intersect with other cultural variables and counselling settings (Scott et al. 2016). In addition, researchers to date have not examined the complex cultural variables that are not necessarily in concert with one another (Scott et al. 2016).

The principal investigator, while working with clients from CALD backgrounds who had a range of different mental health illnesses, has continually faced challenges with integrating spiritual, religious and traditional healing beliefs and explanatory models into client-based work. During such work, the CALD community has always appeared clear about wanting spirituality, religion and traditional healing to be integrated into treatment. The challenge around integration of these beliefs often came about because it was in opposition to secular cultural influences, as well as mental health systems abdicating responsibility for what was deemed to be a private matter and not a health matter. In addition, determining a clear understanding of what one means by culture and the interplay with clients presenting concerns has always been contentious (Scott et al. 2016). While other studies in the literature look at religion as a single theme, that was not the case for the research presented in this thesis. Based on the diversity of responses given by participants with different religious affiliations in this study, it appears that religion may be accorded varying degrees of importance, depending on the exact background of the responder.

An important consideration in evaluating this area of research is that highly committed religious clients use religious constructs and worldviews in thinking and decision-making (Ferguson & Kamenia 2014; Worthington 1988). Research has indicated that counsellors or mental health professionals who support, rather than challenge religious values, are preferred, and that challenging the values of highly religious clients can result in negative responses from the client (Morrow, Worthington & McCullough 1993). Clients who are highly committed to their spiritual, religious and traditional healing values will often seek out practitioners whose counselling practices are aligned with their beliefs (Cragun & Friedlander 2012), even though these counsellors or practitioners may not be
geographically accessible. Indeed, some individuals are so highly committed to such values that they may perceive spirituality and religion as defining their very being. Even so, the evidence in this regard is limited by the fact that most other studies reported in the literature have focused on a single ethnic or cultural group. This study, in contrast, looked at a wide range of CALD communities.

Increasing cultural and linguistic diversity within the Australian population provided justification for undertaking this research. This study was designed in order to explore how CALD and mainstream mental health practitioners perceive spirituality, religion and traditional healing, and how they apply these themes within a Western mental healthcare system. This also allowed for potentially more effective approaches to mental healthcare for such clients to be identified. More specifically, spirituality, religion and traditional healing were highlighted as areas to be integrated into the mental healthcare afforded to CALD communities. An understanding of these factors on the part of mental health practitioners is essential in order that they might develop and implement appropriate services and facilitate optimal mental wellbeing for these individuals who are often distressed because of limited healthcare options.

Understanding determinants of health, such as behaviour, knowledge, attitudes, beliefs, and socio-cultural context, engenders a more meaningful appreciation of the factors that influence illness. Intergenerational exploration of these issues, and the variants that influence these understandings from a local and cultural context, can facilitate the development and implementation of effective and culturally appropriate treatment programs. It is important to fully explore the multi-generational effects of forced migration and other types of migration patterns, as these may negatively affect the notions of identity, family and community.

Spirituality and religion are entering into the forefront of our lives in many ways. As we debate the ethical implications of in-vitro fertilisation, abortion, test tube conceptions, surrogacy, the extension of life through artificial organs, and the effects of detention on refugees and asylum seekers (Boddington 2010). It is
clear that spiritual and religious views have found their way into the heart of how
we practice healthcare (Canda & Furman 2010). Nowhere is this more
prevalent than in mental healthcare, and in particular, transcultural mental
health.

Boddington states:

The conditions of detention, including access to health services,
seem to be such that we could expect physical ill health to be
common but it is perhaps mental health that seems to be more
ubiquitously threatened by the harsh regimes, by alleged violations
of human rights, and even by the very fact of detention (2010, p 57).

Similarly, Nordenfelt (2007) discusses the complex philosophical and moral
issues that have entered into healthcare debates, stating that more thought
must now be given to how we practise, not only as practitioners and
professionals, but as human beings. The consequences of health decisions are
no longer simply academic, but are ethical and moral in tone (Nordenfelt 2007).
Contemporary philosophy of health is a responsibility which is entering into the
healing vocabularies of all levels of care (Nordenfelt 2007).

The aims this research were thus framed having regard to the challenges faced
by CALD people within the prevailing transcultural mental health care system in
Queensland, Australia with probable applicability within the wider Australian and
international context.

1.4 AIMS OF THE RESEARCH

This introductory chapter has presented a background discussion of the
immigration journey and settlement processes many transcultural communities
undertake in Australia, and the effects these have on the wellbeing of individual
members and the community as a collective. To best cater to the needs of
CALD mental health clients, it is essential to have an understanding of different
transcultural community backgrounds, as well as how the health and wellbeing of these populations are influenced by interfacing with Western treatment modalities. The chapter will continue with an overview of the present research aims, along with the methodological approach and theoretical framework underpinning the study.

This study was undertaken to understand the perspectives of clinicians and practitioners working alongside CALD groups. More specifically, the research study investigated how spirituality, religion and traditional healing were perceived by these practitioners, and how they were utilised as protective factors during the clinical encounter. Implications for clients from those communities as well as practitioners were also explored. For the purpose of this study, the term “mental health practitioner” has been expanded to include Community Elders and other community para-professionals. Utilising an explanatory model framework, incorporating Jungian theories of the collective unconscious, this study relied on the principal investigator’s current work and practice knowledge in the transcultural mental health sector to gain access to mental health participants from both mainstream and CALD communities.

The following research questions were addressed:

1. Do mainstream and CALD mental health practitioners (who work with CALD clients) perceive spirituality, religion and traditional healing as important protective factors, within a professional context?

2. How do mainstream and CALD mental health practitioners perceive spirituality, religion and traditional healing as being embedded in a clinical setting?

3. How do CALD-specific factors (e.g., acculturation, immigration) influence practitioners’ perception of spirituality, religion and traditional healing?

4. Do CALD practitioners engage in similar spiritual, religious and traditional healing practices in their home country as in Australia?

5. Do mainstream and CALD mental health practitioners (who work with CALD clients) access spirituality, religion and traditional healing for their own personal mental health and wellbeing?
1.5 METHODOLOGY

This study used a qualitative approach to investigate the importance of spirituality, religion and traditional healing in transcultural mental healthcare. The qualitative method allowed for in-depth analyses of participants’ responses elicited during focus group discussion, thereby providing the means of extracting important information and elucidating certain nuances. Information was gathered during six focus group discussions and three focus interviews with individual participants. A number of questions were put to each group for discussion and the responses of participants were voice-recorded and later transcribed.

Eight questions were asked of Community Elders, while twelve questions were asked of the mental health practitioners (who comprised five focus groups and two individual interviews). While the questions asked of Community Elders were very similar to those asked of mental health practitioners, the wording was modified slightly as appropriate to their situation within their community, and also due to language considerations.

1.6 THEORETICAL FRAMEWORK

In focusing on explanatory models of mental health, mental health practitioners and consumers may come from different cultural backgrounds and their explanatory models of illness are often very different. The explanatory framework adopted for this study is used to question current narratives, traditional concepts and aspects of organised existence. Explanatory models seek, through a process of deconstruction, to demystify the social world and thus to reveal the hidden inner world or structure through the collective unconscious.

The pioneering work of German-born psychiatrist Carl Jung revolutionised the approach to transcultural psychiatry. Jung refused to accept life as it was presented, but questioned the higher dimensions of humanity and the purer nature of our inner selves. He was interested in the people behind the masks
and felt that humans pushed their true natures aside to engage in day-to-day existences, usually at the expense of their higher selves. These higher or “spiritual” selves remain the purest form of our identities. Jung postulated that entities such as spirituality, religion and traditional healing were archetypes or ongoing symbolic representations of historical collective thoughts. His work brought about a deeper, more profound understanding of the different stages of human consciousness, as he explored the influence of culture and spirituality and how they are embedded in the “collective unconscious” of all human beings.

1.7 THESIS STRUCTURE

This thesis is organised into eight separate chapters. Chapter 1 introduces the reason and purpose for conducting the study, by putting the work in context and justifying the research undertaken. Chapters 2 and 3 comprise literature reviews pertaining to transcultural mental healthcare and treatment models of care, respectively. In Chapter 2, specific areas for exploration include spirituality, religion and traditional healing, taking into consideration historical and contemporary issues as they relate to these themes. This chapter also examines the literature on protective and risk factors for CALD clients. Transcultural mental health issues as they pertain to CALD populations include immigration and resettlement issues, acculturation, and various other cultural factors. In Chapter 3, existing treatment approaches aligning with the Western mental healthcare model are discussed, as are the ways in which these approaches meet the treatment needs of transcultural client groups. Explanatory models of care are reviewed. This is followed in Chapter 4 by an explanation of the theoretical framework based on an explanatory model with a Jungian focus on which the current study was based.

Chapters 5 through 7 describe the current study itself. In Chapter 5, the methodological approach is presented, with justification given for the qualitative approach which was used to extract nuanced responses from practitioner
participants in the study. Chapter 6 presents the results from focus group discussions, which exemplified the importance of spirituality, religion and traditional healing in transcultural mental healthcare, and proposed suggestions (provided by participants) for integrating these protective factors into treatment. Chapter 7 expands on these findings to discuss and analyse the significance of findings in the context of related research literature. Recommendations are also provided here for improved approaches presumed to lead to better treatment outcomes for transcultural clients. Implications for future clinical practice, policy and research are also described in Chapter 7.
Chapter 2. LITERATURE REVIEW:
THE IMMIGRANT JOURNEY

2.1 INTRODUCTION

Issues that have entered the broad healthcare space in recent years include euthanasia, test tube conceptions, electro convulsive therapy, and medications for children and the elderly. Within the transcultural mental health space, additional issues exist relating to, among other things, the running of detention centres, warehousing of people through prison systems, detention of children, and asylum seekers being charged for services for which they are unable to pay. It may thus be increasingly important to advocate for a less intrusive way to engage with transcultural clients, and to allow them access to wellbeing experiences in a creative but organic way. This change may come in the form of spirituality and religion, which are centred on the deepest values and meanings by which individuals live their lives. Spirituality and religion embrace the idea of there being an ultimate or an alleged innovative reality – a reality wherein a person can discover the essence of their being. Spirituality and religion, along with traditional healing, can refer to a health process of re-formation which aims to recover something that was lost or misplaced; it can enable people to pursue and recapture a more “authentic” form of themselves through a cultural quest that can involve a faith belief in something usually external to ourselves.

The terms “religion”, “spirituality” and “traditional healing” will be used throughout the present thesis, as defined briefly in the following ways. A *religion* is an organised system of worship with prescribed beliefs, rituals and practices. These institutional values are shared by members of the one group, and they may develop over time (Canda & Furman 1999). *Spirituality* is any sacred activity, place, person or situation that an individual can engage with to achieve some form of transformational outcome. It is a tool for accessing connection with a higher power, force or energy. *Traditional healing* involves the use of certain prescribed elements to elicit good health in an individual. The choice of these elements may be based on the dictates of a certain belief system –
whether spiritual, religious, ancestor wisdom, or other. Traditional healing may involve certain rituals, and may also necessitate the input of a recognised “healer” to enact the healing process. Importantly, traditional healing practices are not specific to CALD (i.e., minority) populations. Those belonging to the mainstream cultural group of a Western-dominant country may believe in the healing qualities of, for example, a glass of rum with warm water, or honey and lemon in tea.

There is considerable overlap between spirituality, religion and traditional healing (and between religion and spirituality in particular). Yet, they are distinct concepts: a person can be spiritual without being religious, for example, and a person can be religious without being spiritual. Likewise, spiritual and religious practices can be used in traditional healing, though they are not integral to the definition of “traditional healing” itself. The three key terms of “religion”, “spirituality” and “traditional” healing and the complexities of their individual definitions will be explored in detail in this chapter.

There can be no health without considering one’s individual and collective mental health. Literature related to protective factors for transcultural mental health clients is scarce, with most research dominated by a Western-based perspective in which CALD practitioners and communities are voiceless. Much of this literature refers to people from diverse backgrounds from a third-person or Western-based lens, rather than reflecting on the perspectives of CALD people themselves.

It is estimated that 70% to 90% of self-recognised episodes of sickness in the transcultural community are managed exclusively outside of the formal healthcare system (Zola 1972), which provides a key insight into how well the Western healthcare system is addressing the needs of the CALD community. The literature review in this chapter addresses issues associated with transculturalism, protective factors, explanatory models of mental health and mitigating factors, as they relate to the major thesis themes of spirituality, religion and traditional healing.


2.2 SPIRITUALITY

Spirituality has been defined in various ways over the centuries. Like culture, spirituality is non-static and forever changing; it is stressed and reconfigured to include many dimensions of everyday life. Many attach spirituality to a particular religious faith, or to an intentional community of believers. Others may connect it to social justice movements, or to general altruistic acts that benefit the community around them. Canda and Furman (2010) succinctly define spirituality as a universal quality of human beings and their cultures related to the ongoing quest for meaning, purpose, morality, transcendence, wellbeing, and profound relations with oneself, others and ultimately, reality. At the core of spirituality is the concept of helping (Canda & Furman 2010). Simply put, it is the heart of empathy and care, the pulse of compassion, the vital flow of practice wisdom and the driving energy and force of service.

In the specific context of the current study, Canda states:

A transcultural spiritual perspective would enhance diversity and commonality. Transcultural spirituality goes to the heart and centre of what it is to be a human being. When we “centre” ourselves, we come to a clear awareness of who we are most deeply and fundamentally, before and beyond cultural considerations, social roles, and personal idiosyncrasies (1998, p 101).

Spirituality can take the form of many different paths of self or group expression. Examples of spirituality include the Serenity Prayer recited at the end of every Alcoholics Anonymous meeting, religious texts (e.g., Bible, Torah and Qur’an), and the individual exercise, peacefulness, mindfulness meditations and centring techniques that Yoga provides.

Although it remains problematic to claim consistency of usage, spirituality is often used to refer to one or a few notions: a search for a sense of meaning and purpose, beliefs about the functioning of the universe, a personal moral code,
and a connection to the transcendent dimension outside of one’s self (Canda & Furman 1999; Cascio 1998; Derezotes 1995; Sermabeikian 1994).

Hodge (2005) defines spirituality as an ongoing search for meaningfulness and sacredness. According to this description, it refers to a state of examination of one’s life, wherein the individual pursues meaning and universal connectedness to the divine. This is part of an evolutionary process of human consciousness, which grows as one’s concept of self develops. Similarly, spirituality can also be seen as a deep and passionate connection to a “worldly cause” such as the environment, “right to life” moments, world peace, and physical health, just to name a few.

Much of the literature acknowledges the difficulty of obtaining an agreed upon definition, particularly in terms of quantifying spirituality, because it is such an individual experience (e.g., Zinnbauer et al., 1997). Zinnbauer and colleagues (1997) define spirituality factors as both individually experienced and universally shared. Similarly, Matthews and Clark (1999) define it as an individual’s private search for meaning and connection with a higher power.

In reviewing the literature, one of the key elements to spirituality is that it provides a way to understand uncomfortable life events such as pain and suffering. Every human being will at some time or other experience significant loss, whether this is losing parents, going through a divorce, or separating temporarily or permanently from family or loved ones. Spirituality is often used by an individual experiencing trauma, as it helps them to instigate another existential narrative. Spirituality and religion can also be used to allow the individual to reflect on themes of loss, hopelessness and trauma. It is another explanatory vehicle which can be utilised to help a person adjust and move from instability to stability. An individual can transition from spiritual emergency to spiritual stability – from spiritual disease to spiritual peace (Kliewer & Saultz 2006). Mathai and North (2003) refer to spirituality as a means by which one can undergo a process of self-examination. Such examination takes place when a person experiences a change to their eco-system. One way an individual
copes with trauma is to reassess their place in the world, and spirituality is the avenue by which a deeper questioning is ignited. This, in turn, can lead to powerful experiences of transcendence and reconfiguration of how the event is experienced and ultimately internalised.

Spirituality, like religion and traditional healing, creates healing environments and spaces which allow for a divine healing presence (Jonas & Crawford 2004). According to Jonas and Crawford (2004), religious and spiritual traditions from many different cultures describe a loving presence contributing to some extent to the healing process. The same special presence is also commonly believed to exude from certain traditional healing practitioners. Such practitioners are involved in creating healing relationships, and are selected based on their special talents and their unique role in the community. Whether we call these practitioners “doctors”, “social workers”, “spiritualists” or “healers” – they have been empowered by the community to enact the spiritual forces that generate healing outcomes.

According to Falicov (2009), religious, spiritual and traditional healing practices are enduring aspects of CALD personhood, which cannot be replaced with the beliefs of the dominant host culture. This resistance can provide immigrants with the means to retain their values in a new environment, and to cope with new stressors therein, as they can turn towards the comfort and continuity of past traditions.

Spirituality is therefore experienced as having little to do with doctrines, ideas, or rituals, which makes it quite easy to discuss for most people. It appears to be an easy and non-confrontational topic for people to engage with, in large part because it is not dependant on consensus. Spirituality has more to do with inner feelings, movement, or impact within the world of emotions and the realm of the heart (Kliewer & Saultz 2006). Spirituality is a personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the
development of religious rituals and formation of community (Koenig, McCullough & Carson 2001).

This observation aligns well with the words of Eltaiba (2005), who emphasises the importance of religion and spirituality to many people. Mental health professionals should consider that and acknowledge that the purpose of religion is to enlighten us about our humanistic strengths and weaknesses, and guide us in negotiating barriers to a state of wellbeing. Further to this, Koenig stresses that, “spirituality is increasingly being examined as a construct related to mental and physical health. The definition of spirituality, however, has been changing. Traditionally, spirituality was used to describe the deeply religious person, but it has now expanded to include the superficially religious person, the religious seeker, the seeker of wellbeing and happiness, and the completely secular person” (Koenig 2008, p 349). Tyminski and Cooke too speak of the importance of spirituality: “The role of spirituality in our world is … one that addresses problems of deep alienation, cultural isolation, economic displacement and fanaticism. Jungians have long explored this territory” (2016, p 533).

Starnino and Sullivan (2017) express how significant mental illness is, stating that spirituality and religion can be common vehicles that provide a platform for coherence and meaning to life. They can have a restorative effect when a person has increased exposure to trauma-inducing events. Many theorise that spirituality is important to the human condition because it is a reality that exists within all other realities. It is universal in that all communities have a worldview and understanding of its practice in some form or another. Therefore, its importance in mental health and wellbeing is significant. The literature suggests that spirituality contributes to explanatory models regarding transcultural mental health and in particular, that it provides a worldview regarding pain and suffering (Eltaiba 2005) as well as inspiration to examine how we manage a particular health crisis (Mathai & North 2003). Spirituality also gives permission to explore the divinity and vastness of life (Eltaiba 2005) and encouragement to go deeper in our understanding of what it means to be human (Eltaiba 2005). Further to this, it provides an environment in which we can refocus our lives and it allows
us to bring in a mediating bi-directional mindset (Canda 2001). It is impossible to understand the human experience in any other total context, as spirituality affects every aspect of our daily lives (Livingston 1989).

An important feature of spirituality is its private or self-focused nature, which has a significant bearing on how it is perceived. Individualism is attractive to most Westerners as the ideology on which many post-modern societies are based. Individualism builds on the notion that each person has the right to live, speak, listen, communicate and practise in a way that accommodates that individual’s personal belief. Bhagwan (2002) identified that one’s personal belief system is always mitigated by other issues such as sexuality, culture, ethnicity and gender, to name a few, and that they are also deeply embedded within the spiritual paradigm.

Initially, the relationship between spirituality and mental health is not outwardly obvious, and some may even believe they should have nothing to do with each other. The spiritual dimension of an individual’s wellbeing is, at best, overlooked, and, at worst, dismissed as irrelevant or misunderstood (Maxwell 2001). The healing potential for the individual and the networks for investigating these mystical aspects, however, are seen to bring about a deeper understanding of mental health issues and unlock treatment potentials. Some professionals in the mental health field are becoming increasingly aware of how certain aspects of spirituality can offer real benefits for mental health (Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group /Executive Committee 2010). The extent to which this is true within a Queensland mental health context is unknown, and this is one of the focuses of the present thesis.

The results of numerous studies attest to the integral role of spirituality as a protective factor in mental healthcare. Scott et al. (2016) conducted a study which sought to better understand the role of faith in client conceptualisation, treatment planning and associated clinical decisions. The participants were provided with a hypothetical scenario not uncommon in clinical practice. The
scenario contained a complex interaction of spirituality, faith, family systems, culture, and LGBT considerations for a client and family structure. Outcomes of the study found that although counsellors readily recognised the importance of faith as a cultural construct and as an essential component of individual and family identity, they were generally hesitant to integrate faith into the treatment, which indicates there is a clear disconnect between how counsellors perceive the role of faith and how they prioritise it in the treatment process. The study verified that faith plays an important and prominent role in the lives of individuals and families, which is supported by other research literature (e.g., Princeton Religion Research Center 2000; University of Pennsylvania 2003). The participants in the study by Scott et al. (2016) state that faith is powerful, defining, and an element of core identity.

Furthermore, Cashwell, et al. (2013) noted that 67% of practising counsellors feel confident with their ability to address spiritual and faith-based considerations. However, the majority of those interviewed who did not feel confident indicated a need for more training in addressing faith, spirituality and religion in sessions. The results reported by Cashwell et al. (2013) therefore suggest that the counsellors were very open to all aspects of the topic.

In partial contrast with the above findings, Rosen-Galvin (2005) and Hage (2006) highlighted a lack of formal training in spirituality and a general reluctance by supervisors to broach faith-based topics. Within counsellor education, Balkin et al. (2014) reported that counsellors leave their training experience with the guided belief that they are not allowed to discuss faith unless the client specifically requests that faith be included in the work; suggesting that counsellors and other professionals in training are lacking both the academic and clinical preparation to adequately and effectively address issues related to spirituality and religion.

Rice and McAuliffe (2009) conducted a study using an electronically administered survey data collection tool with over 3,000 members of the Australian Association of Social Workers. The study consisted of similar
questions gathered from two independent online survey studies conducted one year apart. Groups from both of the studies were similar in having a higher representation of Christian participants (50.1% in Study group 1 and 46.8% in Study group 2). The figures are consistent with the Christian-Judeo religious identification of the broader Australian population (Hughes, Thompson, Provor & Bouma 1995). Of note in the study by Rice and McAuliffe (2009) were the high numbers of participants identifying as “other spiritual”, which may reflect the societal trend away from affiliations with established religious traditions and institutions, towards individually constructed or customised notions of spirituality and religion (Hughes & Bond 2003; Rice 2005; Tacey 2003).

Rice and McAuliffe (2009) also explored the appropriateness and usage of praying with clients at the client’s request. This practice was considered by half of the total participants to be either ethical or conditionally ethical (combined = 71.7%), with 62% in study group 2 indicating this activity was unconditionally appropriate. However, although social workers evidently felt it was ethical and acceptable to pray with clients at their request, fewer admitted to actually practising this activity.

Rice and McAuliffe (2009) also examined the perceptions of social workers regarding the use of herbs or alternative therapies. Fewer participants felt that these forms of intervention were as appropriate as praying with a client at their request. In study group 1, 48% considered the intervention to be appropriate, while the figure in study group 2 was 60.1%. Of the participants in study groups 1 and 2, 34.5% and 48.5% respectively had actually suggested to clients that they use herbs or alternative therapies. Given that many herb-based traditional healing interventions originate from Eastern and earth healing or spiritual traditions, it is possible that the perceived secular nature of the use to herbs and alternative therapies was thought to be less sensitive or controversial than praying with a client and consequently less ethically challenging. Use or suggestion of techniques such as Yoga Tai Chi or Reiki were strongly supported across both studies. For example, in study group 1, 80.9% of participants indicated that these activities were either appropriate or appropriate
in some situations, and 84.9% of study group 2 participants were also accepting of these activities as practice interventions.

In another study involving a national survey of licensed clinical social workers (LCSW), views and behaviours related to integrating religion and spirituality into clinical practice were examined (Oxhandler, Parris, Torres & Achenbaum 2015). A total of 442 LCSWs from across the United States were involved, with results indicting that LCSWs have positive attitudes and high levels of self-efficacy. Moreover, the participants perceived such integration of spirituality and clinical practice as feasible, but reported low levels of engagement with integrating clients’ religious and spiritual beliefs into practice. Two important variables emerged as significant predictors for LCSWs’ overall orientation toward integrating clients’ religion and spirituality into practice: the practitioner’s intrinsic religiosity, and their prior training (i.e., course work or continuing education). The study by Oxhandler et al. (2015) was the first national multivariate study of LCSWs, looking at a range of issues as they relate to integrating clients’ religious and spiritual perspectives into practice, thereby providing an important contribution and useful information for future planning and practice training on this topic.

Evans and Devlin (2016) focused on the professional practice habits of Christian social workers and counsellors, exploring dynamics of good practice when working therapeutically with clients who are asking to discuss issues of spirituality, religion and faith. This qualitative study was conducted in a large Australian faith-based organisation with a Christian mission, which provided welfare service incorporating a number of counselling teams in different locations (Evans & Devlin 2016). Interviews were conducted with 10 senior practitioners, who were also practising Christians. Results revealed several common themes in the feedback given by practitioners working with clients who are actively seeking to explore faith based issues and spirituality: (1) use flexibility, discernment, and a client-led approach; (2) trust in God and have spiritual receptiveness; and; (3) manage tensions between professional, personal, and organisational values. The implications from the study by Evans
and Devlin (2016) highlight the requirements for professional integrity and knowledge of how to practise within one’s range of competence. Additionally, there was an emphasis on the positive value of ongoing professional development to support good practices when working with religious clients (Evans & Devlin 2016).

The majority of counsellors interviewed by Evans and Devlin (2016) had gained social work or psychology qualifications in Australian higher education settings; none had received any formal instruction on the benefits of using spiritual interventions in practice, during their undergraduate degree programs. Other contentious issues highlighted by the authors related to how a practitioner should respond to non-Christian religious clients asking to discuss their faith or spirituality, and how to resolve the perceived tension between professional values and the mission of the employing organisation (Evans & Devlin 2016). Ultimately, the study by Evans and Devlin (2016) is valuable in providing a grassroots or “close-to-the ground” description of how experienced Christian practitioners attempt to negotiate challenges when clients come into the clinical encounter and ask to discuss faith and spirituality.

2.3 RELIGION

“Religion” is commonly defined as an institutionalised pattern of beliefs, behaviours, and experiences, oriented toward spiritual concerns and shared by a community to be transmitted over time via traditions (Canda & Furman 1999). Similarly, Hodge (2005) defines “religion” as the beliefs, practices and guiding principles espoused by a faith-based organisation. Many align religion with spirituality, and indeed religion can be considered as the structural framework in which spiritual beliefs or practices are confined. That is, religion is the paradigm in which spirituality is contained, and it gives meaning and structure to accommodate the views and beliefs of a particular community. Religious practices are “supported by rituals that acknowledge, worship, communicate with, or approach the sacred, the Divine, God...or ultimate truth, reality, or nirvana” (Koenig 2008, p.11).
The significant role of religion is acknowledged by Abdel-Khaleka (2011), who states that religion is a universal phenomenon. Broadly speaking, it has played an important role as one of the most powerful forces in life, death, health and disease. Religion is an important, perhaps central, dimension of human experience across the lifespan. Even among groups thought to be unconcerned with spiritual matters, religious concern is active (Emmons, Barrett & Schnitker 2008). There is a growing body of research on the role of religion in psychological health, suggesting that believing in God results in living a good life (Aghababaei & Blachnio 2014; Ghorbani et al. 2010; Wnuk & Marcinkowski 2014). Organisations for community support also play a role, in terms of providing material assistance, emotional support or political advocacy, although these may be directly or indirectly related to spirituality.

Research shows that attending to a client’s religious and spiritual needs can positively affect a variety of health and behavioural health outcomes (Koenig, King, & Carson 2012; Koenig et al. 2001). Behaviourally, belonging to a religious community promotes healthier lifestyles and offers social support (Haas 2012; Moll 2014). Akin to exercise, religion offers true protective effects against heart disease, depression, and even cognitive decline (Dein et al. 2010). Religion is correlated positively with improved mental health and physical wellbeing, and is important for people coping with trauma and other highly stressful events (Thomas 2016). Increased involvement in a spiritual or faith community strengthens the positive impact it can have (Moll 2014). It is thought that spirituality and religion impact human health psychologically, socially and physically, because most religious traditions encourage healthier lifestyle choices and philanthropic acts (Koenig et al. 2001; Levin 2002). People who identify as religious have lower rates of mental health problems, particularly depression or depressive symptoms (Newberg & d’Aquili 2008).

Generally speaking, all major religions have fundamental similarities, whether Islam, Christianity, Judaism, Buddhism or an oriental philosophy such as Confucianism or Taoism. They all provide their believers with a social, relational, social justice and governing view of how to interact with oneself, each
other, and the higher governing forces in one’s life. Religion provides the structure in which its members can congregate and follow a similar set of beliefs. Its location is limitless, given that worship can take place at home, in someone else’s home, on a park bench or within oneself. The physical meeting place is just that – it is a place where members of a faith decide to gather, practise, honour their deity and carry out their spirituality. People of all religious faiths believe that it becomes their duty to offer social support when they see others in great need, even if illness or personal problems prevent them from giving much back (Hodges 2012). This may explain why social support from religious communities yields greater health benefits than other types (Thomas 2016).

2.3.1 Relationship between Spirituality and Religion
There is a strong overlap between spirituality and religion. In more contemporary times, spirituality has picked up greater prominence in people’s lives, as it has become synonymous with many activities and causes. An ongoing collective practice of these activities can be classified as a religion. As both concepts are self-defined and self-directed, it is important to enquire about the specific ways in which an individual is using spirituality and religion, and how they define the terms. On the issue of religion and spirituality, Canda and Furman (2010) expand on the different conceptual relations one can have with spirituality and religion. One may, for example, define themselves as “spiritual but not religious”. This person in all likelihood does not participate in a religious group, but is concerned about matters of meaning, purpose and morality. Those with ambivalent relationships with spirituality or religion growing up may adopt this worldview. A separate group of people may describe spirituality as being a part of their “whole life”. These people may be wholeheartedly devoted to their spiritual beliefs. Similarly, others may describe spirituality as being part of their “culture”; this pertains specifically to traditional communities, such as those that include Australian Indigenous Aboriginal, American Indian, or Māori indigenous individuals. For such groups, the spirituality dimension is inseparable from collective everyday awareness and cultural identity, as they see everything as imbued with spirituality (Nash & Stewart 2002).
Canda and Furman (2010) further categorise religious identities based on the same or similar parameters. One group comprises those who are “religious but not spiritual”; these people may participate in religious activities such as church-going, but mainly for personal or social benefits. They have no interest in deeper matters of meaning, purpose, or experience of the sacred. Those for whom religion is their “whole life” may instead identify with a particular religious tradition and engage in all its activities. Those for whom religion is their “culture” most commonly belong to traditional or indigenous cultures in which all of life is viewed as sacred and the sacred is associated with religion. An example is traditional Islam, in which faith and religion are fused together throughout culture and daily life (Crabtree, Husain & Spalek 2008).

Religion and spirituality are complex, multifaceted, overlapping terms (Ingersoll 1994; Kilpatrick & Holland 1990; Maidment 2006; Tangenberg 2005). While conceptualisations of spirituality may be blurred by that of religion, the attraction of spirituality is “that it is not contained by a theological wall or any specific ideological system or framework”; nor is it “considered an equivalent with religion, religiosity, or theology” (Cowley & Derezotes, cited in Bhagwan 2002, p 2). Spirituality is more a “human search for purpose and meaning of life experiences, which may or may not involve expressions within a formal religious institution” (Sheridan, Wilmer & Atcheson 1994, p 40).

Several authors have highlighted a disconnect between religion and spirituality (Hill et al. 2000; Sheldrake 1992; Zinnbauer, Pargament & Scott 1999). Religion as a topic has become increasingly contentious in contemporary society, perceived in terms of denominations, theological belief systems, and major world traditions (Wuff, 1997). As a result, religion has come to represent participation in some theological system, while spirituality represents one understanding as part of a larger spiritual force. Of note is that the two need not be mutually exclusive, although they are often perceived as such by the general population (Zinnbauer et al., 1997; 1999).
With spirituality and religion being central to CALD communities, the potential challenge in healthcare is to respond holistically to these needs (Rice & McAuliffe 2009). This requires that the clinician is aware of spiritually inclusive practice and the significance of spirituality and faith in areas of intervention (Gale, Bolzan & McRae-McMahon 2007). Supporting this, Turbott (1996) reports on evidence that religious faith may be a protective factor against mental illness. In some instances, the effectiveness of health promotion and treatment programmes with an explicitly spiritual or value-based framework has been empirically established (Turbott 1996).

From the literature reviewed, there are a few studies written in Africa, Asia, South America and Central America. The Western-based perspective looms large, but voices from within cultural communities are beginning to rise. It is the principal investigator’s opinion that communities from non-European backgrounds will begin to take more ownership of written and oral information being disseminated about cultural variance, as in the work by noted Māori author and practitioner, Mason Durie, and the work being generated by the Pacific Islander communities in New Zealand. Despite this, spirituality and religion are not at the forefront of clinicians’ framework for practice. However, Kliewer and Saultz (2006) ask healthcare providers to examine and explore the spiritual and religious domains as one would any other relationship.

2.3.2 Historical and Contemporary Religious Populations in Australia

According to the 2006 Australian Bureau of Statistics (ABS) census figures, Australia’s population is ever-diversifying. This diversity of course begins with the Aboriginal people, who lived in Australia for at least 60,000 years before the British began to settle the country in 1788 for use as a penal colony. From this time until the early 1900s, migrants settling in the country were mainly of Anglo-Saxon and Celtic origin (ABS 2006). In the 1920s and 1930s, there were increasing levels of migration from Italy, while in the immediate post-war period, there were rising levels of European migration. From the 1970s to the 1990s, increasing migration levels from Asian countries took place. In recent years,
levels of migration from the Middle East and India have increased considerably (ABS 2006).

Changes in the religious orientation of the Australian population are demonstrated by the ABS figures between 2011 and 2016, which show the percentage growth in the number of Christians and other key religions in Australia. Table 2.1, below, shows a negative growth of the Christian population and a rapid growth in religions which are prominent in Asia and the Middle East.


<table>
<thead>
<tr>
<th>Religion</th>
<th>2011 - % of Total Population</th>
<th>2016 - % of Total Population</th>
<th>% Change - 2011 to 2016</th>
<th>Change within each Group Relative to 2011 Base (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Christian</td>
<td>61.1</td>
<td>52.1</td>
<td>-9.0</td>
<td>-14.7</td>
</tr>
<tr>
<td>Buddhism</td>
<td>2.5</td>
<td>2.4</td>
<td>-0.1</td>
<td>-4.0</td>
</tr>
<tr>
<td>Islam</td>
<td>2.2</td>
<td>2.6</td>
<td>+0.4</td>
<td>+18.2</td>
</tr>
<tr>
<td>Hinduism</td>
<td>1.3</td>
<td>1.9</td>
<td>+0.6</td>
<td>+46.2</td>
</tr>
<tr>
<td>Sikhism</td>
<td>0.3</td>
<td>0.5</td>
<td>+0.2</td>
<td>+66.7</td>
</tr>
<tr>
<td>Judaism</td>
<td>0.5</td>
<td>0.4</td>
<td>-0.1</td>
<td>-20.0</td>
</tr>
<tr>
<td>Other Religion</td>
<td>0.4</td>
<td>0.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>No Religion</td>
<td>22.3</td>
<td>30.1</td>
<td>+7.8</td>
<td>+35.0</td>
</tr>
</tbody>
</table>

Changing patterns of migration have brought about significant changes in the ethnic mix of the Australian population. At the same time, the differing religious and spiritual orientations of the various migrant groups have brought about distinct changes in the religious and spiritual make-up of the Australian
population (ABS 2006). Early European settlers brought their religious beliefs with them, as formed by the Protestant, Methodist, Catholic, Baptist, Presbyterian, and Anglican churches (ABS 2006). Table 2.2, below, shows a breakdown of the religious affiliations in Australia from the 2011 Australian census.

Table 2.2. Religious Affiliations in Australia (ABS 2011).

<table>
<thead>
<tr>
<th>Religion</th>
<th>% Total Population</th>
<th>% Born Overseas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>61.1</td>
<td>22.9</td>
</tr>
<tr>
<td>Catholic</td>
<td>25.3</td>
<td>24.0</td>
</tr>
<tr>
<td>Anglican</td>
<td>17.1</td>
<td>17.5</td>
</tr>
<tr>
<td>Uniting Church</td>
<td>5.0</td>
<td>11.4</td>
</tr>
<tr>
<td>Presbyterian &amp; Reformed</td>
<td>2.8</td>
<td>26.3</td>
</tr>
<tr>
<td>Eastern Orthodox</td>
<td>2.6</td>
<td>43.6</td>
</tr>
<tr>
<td>Baptist</td>
<td>1.6</td>
<td>28.8</td>
</tr>
<tr>
<td>Lutheran</td>
<td>1.2</td>
<td>24.5</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>1.1</td>
<td>32.6</td>
</tr>
<tr>
<td>Other Christian</td>
<td>4.5</td>
<td>31.0</td>
</tr>
<tr>
<td>Non-Christian</td>
<td>7.2</td>
<td>67.0</td>
</tr>
<tr>
<td>Buddhism</td>
<td>2.5</td>
<td>69.4</td>
</tr>
<tr>
<td>Islam</td>
<td>2.2</td>
<td>61.5</td>
</tr>
<tr>
<td>Hinduism</td>
<td>1.3</td>
<td>84.3</td>
</tr>
<tr>
<td>Judaism</td>
<td>0.5</td>
<td>48.9</td>
</tr>
<tr>
<td>Other Non-Christian</td>
<td>0.8</td>
<td>57.2</td>
</tr>
<tr>
<td>No Religion</td>
<td>22.3</td>
<td>22.5</td>
</tr>
</tbody>
</table>

Between 2001 and 2011, the number of people aligning with a non-Christian faith increased from 0.9 million to 1.5 million, accounting for 7.2% of the total population (up from 4.9% in 2001). The most common non-Christian religions in
2011 were Buddhism (accounting for 2.5% of the population), Islam (2.2%) and Hinduism (1.3%). Of these religions, Hinduism has experienced the fastest growth since 2001 (189% to 275,000) followed by Islam (69% to 476,300) and Buddhism (48% to 529,000). Australia, like many other Western countries, remains largely Christian, with Christian doctrine sometimes influencing political and societal beliefs and practices.

Since the growth rate of non-Christian religions is so high (Table 2.1), and the CALD community is a small proportion of the Australian community compared with the broader, predominantly Christian Australian population (Table 2.2), this points to significant issues that must be addressed in policy development and clinical treatment when addressing the needs of the CALD community.

2.4 TRADITIONAL HEALING

Traditional healing is one of the oldest forms of structured medicine that has an underlying set of principles by which to practice. Traditional healing refers to health practices, approaches, knowledge and beliefs incorporating cultural information alongside wellness. It often involves ceremonies, or the use of earth-bearing substances such as plants, water, trees, and energetic therapies to achieve wellbeing.

Within the existing research literature, “traditional healing” has been defined as the cultural practices embedded and steeped in a culture’s way of treating disease, illness and ailments (Ae-Ngibise et al. 2010). It can range from activities such as singing, to the use of local herbs and other natural or supernatural artefacts (Ae-Ngibise et al. 2010). Just as spirituality and religion are universal dimensions of the human experience, so is traditional healing. Traditional healing is an essential ingredient for all humans and occupies a large cultural space for members of CALD communities. It is the principal investigator’s contention that traditional healing can act as the way CALD communities heal from within.
Berg (2003) states that most of South Africa’s people consult traditional healers and that at the core of these practices lies ancestor reverence. According to Berg, the “belief system and its accompanying rituals may positively influence the mental health of the individual and family” (2003, p 194). For example, the Xhosa-speaking peoples’ relationship with their ancestors is given expression in life cycle rituals that have much in common with Western psychotherapeutic principles and practices. Indeed, when exploring dominant understandings of the causes of mental disorders, there is evidence – both from the current study and from past research literature – that mental illness may be understood as “spiritual illness”, with some members of CALD communities making references to “supernatural powers” and “evil spirits” (Berg 2003).

Since humanity has undoubtedly practised spirituality and religion everywhere and at all times (Livingston 1989), then the same must be true of humanity’s natural healing rituals. According to Livingston (1989), a ritual is carried out in order to combat an individual crisis (e.g., illness) or a group-level crisis (e.g., drought). The concern given to health is inherent to all human religions, and thus religious rituals that protect against supernatural forces are seen as a form of treatment. This is particularly the case in non-literate or primitive societies, in which disease is often attributed to supernatural causes (Livingston 1989).

Traditional or folk healing systems are embedded in a psycho-cultural context in which human behaviour is mediated by multiple forces, both natural and supernatural (Lefley, Sandoval & Charles 1998). Healers’ skills range from knowledge of appropriate medicinal herbs to modes of negotiation with powerful spirits. Although some folk systems clearly distinguish the roles of medicinal herb doctors and priest-healers, most modes of traditional healing, whether for somatic, psychological, social or spiritual ailments, incorporate a supernatural or religious element (Lefley, Sandoval & Charles 1998).

Without religion and spiritual beliefs, there is no coherent framework for understanding suffering. We may identify the proximal causes, but the distal causes are largely neglected (Dein & Lipsedge 1998). Many people from CALD
backgrounds are reared with the worldview that suffering and emotional afflictions are the result of evil spirits or demonic possessions which require the use of a healer or spiritualist to mediate on their behalf. Shamans, witch doctors, herbalists and medicine men play a crucial role in technologically simple societies, since it is often believed that they possess special powers for dealing with the supernatural (Livingston 1989).

Kuhn (1970), who popularised the term “paradigm” states that “it stands for the entire constellation of beliefs, values, techniques and so on shared by the members of a given community” (1970, p 175). The dominant paradigm of a culture signifies the “basic ways of perceiving, thinking, valuing and doing associated with a particular view of reality” (Harman 1988, p 10). As stated by Ponce (cited in Okpaku):

\[
\text{Regardless of one’s paradigmatic persuasions, the point is that individual or collective paradigms dictate what one looks for (e.g., demonic possession? neurochemical imbalance? irrational beliefs? poverty?), where one looks for it [(e.g., internally from within oneself or spirituality, or externally from nature, relationships, society, historical occurrences)] and what measures one uses to ensure one has found it [(e.g., exorcism, prayer, medicinal interventions or psychological healing)] (1998, p 72).}
\]

Traditional healing, which is a major paradigm in CALD communities, can refer to the relationship between illness and religion, history, social relationships, cosmology and land. A person is therefore contextualised as part of a family and larger community rather than as an isolated individual (Crawford & Lipsedge 2004). Many cultures, such as the Zulu people of South Africa, believe that sorcery is a common cause of mental illness, and that it is usually enacted by someone who bears a grudge against another person (Crawford & Lipsedge 2004). Witches and other demonic beings are thought to exist in the spiritual realm and inflict harm against others. If a person is suspected of being a witch, he or she will be feared and treated with extreme politeness. Witches are
thought to have special helpers or “familiars” which may take the form of animals or of dead people. Laubscher (1937) emphasises the sexual nature of the familiars, describing a Zulu belief that some familiars will have sex with women while they sleep. Ancestral forms of traditional healing in many cultures involve ancestors who are thought to be responsible for protecting and supporting their living relatives (Crawford & Lipsedge 2004). The most powerful are the patrilineal ancestors of the preceding two generations. The spirits of dead children and unmarried people are thought to have power over the living but accompany the other ancestors (Crawford & Lipsedge 2004). Ancestors may cause illness but these illnesses are different from the ones caused by evil spirits or witchcraft.

Traditional healers are often consulted in cases of misfortune or persistent illness. Most illnesses are regarded as a lack of harmony between a person and their environment. Traditional healers will identify the cause of the imbalance and prescribe treatments in the way of herbs, baths or rituals, to restore equilibrium to the person or family in question (Crawford and Lipsedge 2004). Rashid, Copello and Birchwood (2012) found that the Muslim population in the United Kingdom seeks spiritual advice from traditional faith healers for psychiatric and other related problems.

The important role of religious beliefs in forming perceptions of mental illness and substance misuse warrants further investigation. Oftentimes, families or traditional healers may prefer that cultural explanations are used as explanatory models, since such explanations for mental illness or psychological distress are associated with fewer stigmas than a formal diagnosis of schizophrenia (Niehaus et al. 2004).

A study by Rashid, Copello and Birchwood (2012) revealed the importance of faith healing practices to clients experiencing symptoms of psychosis. Healers told stories of how clients with serious physical and mental problems recovered by praying to Allah that their health be restored. The healers were believed to be powerful mediums, which helped with the healing process. Literature in this
area has shown that those who practise their faith have decreased levels of
depression and anxiety, higher levels of life satisfaction and wellbeing, and
better skills in adapting to the rigors of personal loss, physical illness and
disability (Koenig 1997). It may there be important for mental health workers to
take into account the power of faith healing, without branding such individuals
as religiously deluded, as a study by DeSousa (2007) found that mental health
patients felt they could not talk about their religious beliefs for fear of being
labelled in such a way and consequently being involuntarily hospitalised.

Another factor in the relationship between mental health and religion is that
ailments may be seen to present because Allah or God had willed it: such
religious attributions are another source of conflict between disciplines or beliefs
(Rashid, Copello & Birchwood 2012). Hamdy (2009) has argued that among
Western observers, faith in the divine may often be interpreted as passivity,
inaction and anti-science, a common assumption being that religion acts as a
“constraint” against the presumed benefits of science and technology, or that it
constitutes “resistance” against the Western origins of techno-science.

Tied in with this incompatibility is the religiosity gap between service users and
mental health workers, as identified in the study by Rashid, Copello and
Birchwood (2012). One of the healers in their participant group argued that
making referrals to faith healers could bridge this gap. Cultural awareness
programs may involve collaboration with Muslim physicians as well, given the
work done by Padela and colleagues (2008) in which it was found that having a
spiritual dimension adds to the physicians’ work. Collaboration with faith healers
and faith-specific physicians may allow service users and family members to
access information about both Western and traditional forms of healing, which
can work alongside one another (Rashid, Copello & Birchwood 2012). Cox
(1996) argues that collaboration occurs when explanatory models of faith
healers refer to the complex nature of mental disorders, including biological
factors and the range of treatments. Similarly, psychiatrists may show a parallel
respect for the theological insights of spiritual leaders and an understanding of
their healing abilities.
This supposition is consistent with the findings of numerous studies, in which CALD practitioners advocated for the use of both traditional healing methods of mental healthcare and Western science-based mental healthcare. By way of example, Al Rawi et al. (2012) said that several GPs from the Muslim community encouraged patients to recite prayers and verses from the Qur’an as a way of treating mental health issues. Both the consumers and the GPs were reportedly glad that their religion is being used as a first line of defence.

Al Rawi et al. (2012) also investigated the traditional healing practices of American Muslims and the perceptions of twelve Muslim community leaders. They conducted semi-structured interviews with the community leaders to record their commentary on various religious activities and forms of therapy, pertaining to Islamic text, worship and folk healing. American Muslims from the study were found to use similar practices to their non-Muslim counterparts, when it came to maintaining their health.

Probing into the traditional healing practices of American Muslims raised several challenges and implications for healthcare practitioners caring for American Muslim patients. Individuals may not disclose their traditional healing practices to their healthcare providers, which raises serious concerns when patients begin to self-medicate and the potential for severe adverse reactions is present (Al Rawi et al. 2012). Many of the Muslims who participated in that study concurred that they are seeing many in their communities who utilise traditional health methods, but who are hesitant to disclose this to their treatment providers if they feel it would not be supported. Al Rawi and colleagues (2012) call for all healthcare practitioners to be aware, when caring for American Muslims, of the potential influence of religious text, worship and other folk practices involved in health and healing traditions.

Brown (2009) describes one unique situation in which traditional healing practices are integrated into a hospital context. At Mercy Medical Centre in Merced, where roughly four patients a day are Hmong from northern Laos,
healing involves more than IV drips, syringes and blood glucose monitors. Because many Hmong rely on their spiritual beliefs to get them through illnesses, the hospital’s new Hmong shaman policy, the country’s first, formally recognises the cultural role of traditional healers, inviting them to perform nine approved ceremonies in the hospital. The policy and a novel training program to introduce shamans to the principles of Western medicine are part of a national movement to consider patients’ cultural beliefs and values when deciding on medical treatment. Certified shamans, with their embroidered jackets and official badges, have the same unrestricted access to patients given to clergymen. Shamans do not take insurance or any other payment, although they have been known to accept a live chicken (Brown 2009).

From a Western perspective, traditional forms of healing are also utilised among members of those populations. In the United States of America, the top ten most commonly used Complementary and Alternative Medicine (CAM) therapies were diet-based therapies, mind body therapies (e.g., meditation), and manual therapies (e.g., chiropractic manipulations; Barnes et al. 2002).

Traditional healing is important to many indigenous communities, as well as the wider CALD population. The principal investigator contends and strongly advocates that for any research being conducted in Australia, it is appropriate to specifically consider the role of spirituality, religion and traditional healing along with Indigenous health care frameworks, as well as in the context of how the various Aboriginal communities practise wellbeing.

Spirituality, religion and traditional healing have been identified in the literature as key to the CALD identity and protective factors that are integral as clinical treatment components. In order to understand these themes in more depth, we must situate them within the transcultural methodological mental healthcare framework. It is essential to understand the socio-cultural and political context into which immigrants relocate, with all the ensuing mental health risk factors to which they become exposed during resettlement. Immigration can be
associated with many predisposing stressors which will be discussed in more
detail in the next section of this chapter.

2.5 PROTECTIVE AND RISK FACTORS FOR
CALD POPULATIONS

When providing emotional wellbeing services to clients from CALD
b Berkgrounds, a range of additional risks and protective factors need to be taken
into consideration. The factors that are particularly essential are immigration,
acculturation, intergenerational complexities, racial discrimination, equity,
language issues and resettlement. These factors are inter-related and can
either exacerbate ill-health symptoms, or conversely protect against the
development or chronicity of such symptom presentation (MHIMA 2014).

Potocky-Tripodi (2006) provides a simple definition of protective factors, as
those entities that “have a moderating effect whereby they ‘buffer’ the
relationship between risk factors and outcomes” (p 12). Protective factors can
be whatever the person identifies as comforting in a time of particular distress.
Adherence to traditional values of family hierarchy (according to age and sex)
are reportedly a significant protective factor, as is the presence of kin contacts
and the same people who form one’s own ethnic group (Fazel et al. 2012;
Potocky-Tripodi 2006). That said, a factor’s status as “protective” is dependent
on context. If, for example, the family hierarchy or community of whom one is a
part elicits feelings of stress, that same factor could become a risk factor for
mental illness in another context. An example of protective and risk factors is
when certain males from cultural backgrounds are revered in their country of
origin (communities when males are considered more highly than women) but
when they immigrate to Australia, their role is seen as less important and their
cultural and gender background becomes more of a liability.

When working with CALD clients, practitioners should be aware while a refugee
or asylum seeker may have a trauma history, that does not necessarily mean
they must experience a resultant mental illness; rather, the stress resulting from
settlement and acculturation may be more acutely problematic in refugees and asylum seekers attaining or maintaining good mental health. Refugees and asylum seekers who experience mental health problems as a result of trauma experiences need to be provided with culturally appropriate and responsive treatment and care so they can go on to experience good mental health and engage more fully with community life in Australia. This culturally responsive care can take the form of psycho education in which clients are educated about the cross-cultural differences between their home country versus Australia. Such education may relate to how clients can access a doctor, their healthcare expectations, and oration obligations when describing symptoms and medical history. Communicative differences may arise if an individual does not have “speaking rights” in a particular culture and are thus reliant on a senior family member or a male figure to discuss these issues on their behalf. In some countries, women can only access medical care via males in the family. Such families would consider this process to be a protective factor, and may therefore respond negatively if Western practitioners challenged the process by projecting their own value systems.

Other important protective factors are social and cultural inclusion, which can serve to counter the impact of racism and discrimination (MHIMA 2014). The converse risk factors are social and cultural exclusion, as this can reduce rates of participation in a wide range of community activities that are known to be protective factors. Exclusion can negatively affect social interaction, the formation of friendship groups and community networks, language acquisition, employment, and the likelihood of demonstrating help-seeking behaviour (MHIMA 2014). At an individual level, such factors can also impact on self-worth. If a client or community engages in structural struggles long term, enduring hardships affect their ability to connect, engage and adequately function within society. This, in turn, has broader effects for cultural security and safety.

A key protective factor for clients from CALD backgrounds is the concept of cultural safety. Cultural safety emerged in the late 1980s as a framework for the
delivery of more appropriate health services for the Māori people of New Zealand. More recently, it is recognised as useful in all healthcare settings – not just those involving indigenous peoples of New Zealand, but also with individuals and communities overall. Cultural safety refers to a protective way of working with CALD communities, which are composed of individuals and groups who have been exposed to severe ecological distress. It is important to “do no further harm” by ensuring that these individuals are not exposed to further risk and allowing them to maintain their sense of dignity.

Cultural safety is when cultural norms, values and beliefs are handled in such a way that the individual or collective community feels comfortable enough to be vulnerable, or to take the risk of sharing a part of themselves. The term could apply to the expression of a particular viewpoint which is contrary or different to the dominant or mainstream thought. Cultural safety is carried out when there is a contact between the practitioner and a CALD person or community, and there is an absence of fear, ridicule, discrimination, retaliation or stigma for the CALD party expressing or representing themselves in a cultural context.

On a personal note, the principal investigator is reminded of an instance wherein cultural safety was demonstrated during a professional encounter with a young woman from a traditional Vietnamese community. The woman was hospitalised initially for medical reasons, but emotional and mental health issues began to surface soon thereafter. During the time she was in hospital, she was placed in a room with number of older males. The staff could not understand why she would not settle at night, and they developed a “blind spot” in relation to her situation. The woman later reported her discomfort, although due to her “politeness”, which was perhaps related to the social norms of her Vietnamese culture, she did not want to inconvenience members of the host country. In the Vietnamese culture, when people are trying to help you, it is important to take what help is on offer and not to complain, and as a Buddhist, it would be seen as improper to project discontent into the world, as it would convey that these thoughts and feelings are first and foremost in your mind. The young woman and her family would likely have tolerated the situational
discomfort to the detriment of their cultural values, and may also have quietly refused to seek services again should the client become symptomatic. From a gendered, cultural and religious perspective, many infractions occurred in this situation, although the treating team would not have been made aware of such infractions had the principal investigator not intervened. Upon being notified, the nurses said that there was a shortage of beds and that they needed to accommodate all of the medical emergencies; although the mix of genders was not ideal, they felt that it was better to hospitalise people and get them medical care than to compromise care for gender safety issues. The principal investigator insisted that they change the room arrangements and create a safe space for this young lady to recuperate. The initial two-hour session with this client was spent on the room change, after which point the principal investigator informed her (via an interpreter) that an assessment would take place in a few days. The unit and the client were surprised with the principal investigator’s strong stance, but it was felt that the process of restoring cultural safety was integral to the client’s wellbeing and restoration of trust in medical personnel. Here, cultural safety was prioritised above logistical considerations.

2.5.1 Spirituality and Religion as Protective Factors in Mental Health
Looking at risk and protective factors in another cultural setting, Sujoldzic and colleagues (2006) provide examples of protective and cultural factors for Bosnian adolescents resettled in Austria and Croatia. They found that religious commitments (assessed as a composite of frequency of participation in religious activities and degree of subjective personal belief) were associated with low anxiety and reduction in depressive symptoms.

In a comprehensive literature review, VicHealth (2007) found a strong relationship between religious belief and positive mental health outcomes. Specifically, it is reported that religiousness may protect against depression, anxiety and suicide, and assist in psychological adjustments following traumatic
events. Overall, it may also be associated with better psychological wellbeing and life satisfaction.

According to Ano and Vasconcelles (2005) individuals who use positive religious coping strategies and have an intrinsic religious orientation are more likely to adjust well to stressful situations or trauma. At the same time, those who use negative religious coping strategies may experience a poorer psychological adjustment, as this is thought to place additional psychological burden on already stressful events (Ano & Vasconcelles 2005).

Religious acts may therefore form a protective factor against mental illness or terminal illness. The act of praying and reading Holy Scriptures is believed to facilitate help, not to cure. Of prime importance is having the faith that a higher power or being had the power to engender transformative change (Rashid, Copello & Birchwood 2012). Spirituality, religion and traditional healing are a few of the essential protective and cultural safety factors which must be considered when interacting with CALD communities. It is important to inquire about these safety issues along with protective and risk factors during any type of assessment or subsequent work.

In 2014, the New York Times described the results of a study that compared two groups, one of which received therapy for suicidal thoughts and one that did not (Walker 2018). The article reported that therapy prevented 145 suicide attempts and 30 deaths by suicide in the group studied, which amounted to a reduction of 26%. Based on the findings from that research, policy was formulated that the army must implement mandatory, preventive cognitive therapy for all soldiers in order to increase spiritual fitness, strengthen resilience and prevent soldier suicide (Walker 2018).

In 2015, the US Department of Defense reported that 266 active-duty soldiers and 209 reserve-component soldiers had killed themselves (Franklin 2016). This evidence presents an enormous deficit in soldier support, with respect to their exposure to pre- and post-traumatic stress disorder (PTSD) and
depression (Franklin 2016). In 2010, a study reported by Walker (2018) found that “spiritual fitness” was key to ensuring optimal force readiness and protection, and to maintaining resilience and promoting recovery following combat-related trauma. Key to the prevention of trauma is identification of spiritual risk factors in individuals (Walker 2018). Thomas (2016) also stresses the powerful mental health protective effects offered by spirituality and religiosity to military personnel faced with severely stressful situations in their combat roles. Such situations can cause PTSD in military personnel and similar levels of stress may have been experienced by immigrants and asylum seekers escaping from war zones.

The importance of spirituality and religion in the context of assessing and treating CALD clients with mental illness can be considered from a number of perspectives (Leavey, Dura-Vila & King 2012). Firstly, healing, in theological terms and from a socio-anthropological viewpoint, is a central function of most religions (Csordas & Lewton 1998; Durkheim 1951). From a biomedical viewpoint, a large body of literature strongly suggests that religion and spirituality promote health (Leavey, Dura-Vila & King 2012).

Spirituality and religion have re-emerged as important parts of the discourse around public service provision – oftentimes for negative reasons. Conflicts are seen to arise between moral and doctrinal perspectives, with regard to such topics as discrimination against minority groups, IVF treatments, and asylum seeking (Leavey, Dura-Vila & King 2012). To be understood, these issues must be contextualised within the social, political and cultural environment in which they arise, as they affect community acceptance, belonging and participation for marginalised groups.

On the other hand, religious communities may sometimes provide a moral framework for positively oriented health behaviour (e.g., abstaining from sexual promiscuity or substance abuse; Leavey, Dura-Vila & King 2012). Spiritual and religious values and practices are also thought to energise healthy coping
styles, through acts of forgiveness, acceptance, meditation and prayer (Leavey, Dura-Vila & King 2012).

The relevance of spirituality and religion for people from a CALD background should be acknowledged, given their potential role as central organising constructs to their identity. Spirituality and religion are important because they are part of a universal language understood by all nations. All nations have some way of constructing religion and spirituality.

Many non-Western forms of healing incorporate spiritual or cosmic elements in seeking cures. The term “shaman” refers to a person, often otherwise called a witch, witch doctor, wizard, medicine man or woman, sorcerer or magician. These individuals are believed to possess the power to enter an altered state of consciousness, and from there to take part in a healing ritual journey in other planes of existence beyond the physical world (Sue & Sue 2003; 1990).

Some indigenous beliefs come from a metaphysical tradition, acquiring the interconnectedness of cosmic forms of energy or matter. The ancient Chinese practice of acupuncture and the alignment of chakras in Indian Yoga philosophy involve the use of subtly manipulating matter to rebalance and heal the body and mind (Highlen 1996). Chinese medical theory is concerned with the balance of yin (cold) and yang (hot) and it is believed that strong emotional states, as well as an imbalance in the types of foods eaten, may influence illness (Lee 1996; Mullavey-O’Byrne 1993).

Naikan and Morita therapies, which derive from Buddhist traditions in Japan, attempt to move clients so they are more in tune with others (Ishiyama 1986; Walsh 1995). Similarly, spirituality has always been a major aspect of life and interpersonal relationships in Africa. This was also true during the slavery era in the United States. Today, the African American church still has a strong influence over the lives of many black people, and it is often the hub of religious, social, economic and political life. Religion is not separate from the daily functions of the church.
Many mental health professionals are increasingly open to the potential benefits of spirituality as a means of coping with helplessness, identity issues and feelings of powerlessness (Fukuyama & Sevig 1999). Spirituality and religion can be central to client engagement if clinicians are motivated to use them. For example, Gozdziak (2002) highlights the importance of spirituality and religion in sustaining refugees who are undergoing forced migration and integration into a host society.

People from CALD backgrounds are likely to find spirituality and religion easier to understand than complex psychological theories or dialogue. If clinicians are enabled, through their discussion with a CALD client, to learn about these aspects of a client’s culture, this leads to a more meaningful professional relationship, as all dimensions of the person may thereafter be explored. The practitioner too is encouraged to stay in touch with their own spiritual views and religious roadblocks, bringing a spiritual dimension to their own lives, as well as to the lives of clients during open discussions that take place about this universal part of humanity. The knowledge of different treatment tools or options can be discussed in the treatment context to help both practitioner and client better understand each other, thus creating a more meaningful professional dialogue. In this case, the practitioner does not need to be the expert, but instead utilises their skills in cultural competency to work towards a collaborative, balanced relationship.

2.6 WHY TRANSCULTURAL MENTAL HEALTH

“Transcultural mental healthcare” is concerned with the social and cultural determinants of psychopathology, and with psychosocial treatments for mental illness in individuals, families and communities. In addition to clinical research methods of psychiatry, transcultural mental healthcare practices are based on other disciplines, such as epidemiology, anthropology, social work and psychology (Transcultural Psychiatry 1999). Treatment approaches within transcultural mental healthcare are applied across the lifespan, taking into
consideration historical factors and migration patterns, as well as spiritual, religious and traditional healing beliefs that are individual to the client.

More broadly, transcultural mental health is the international perspective on different aspects of wellbeing. It is the area of study, research and practice that prioritises improved wellbeing for people all over the world, by examining equity in mental health service provision (Patel & Prince 2010). Transcultural mental health takes into account cultural differences and country-specific conditions, in terms of the epidemiology of mental disorders, treatment options, mental health education, politics, financial issues, mental healthcare system structures, human resources within mental health, and human rights issues, both inter and intra-country (Patel & Prince 2010). The overall aim of such an approach is to strengthen mental health all over the world by providing a global perspective, identifying mental healthcare needs, and developing cost-effective programs to meet those specific needs (Prince et al. 2007). Culture influences how individuals, groups and communities manifest symptoms, communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment remedies (Eshun & Gurung 2009).

It is easy to confuse transcultural care with multicultural care, as both connote a collective view of a specialised population. Multiculturalism is often referred to as cultural diversity or cross-culturalism, and although it acknowledges the existence of a vast range of ethno-cultural groups, it fails to account for diversity within ethnic groups in the same way as transculturalism. It also does not prescribe a model for service delivery that is suited to the needs of all CALD clients. For example, most Western counties, such as the United States of America, Canada, New Zealand and the United Kingdom, favour an ethno-specific approach, with ethnic matching between practitioner and client for the delivery of mental healthcare services, in order to better address the issues faced by ethnic minorities. This approach is essentially based on the multicultural model. Within the United States and other countries, these types of ethno-specific models are commonplace and successful at meeting the needs of a particular population, although they may not suit all culturally or ethnically
diverse groups. These ethnic specific approaches have their strengths, but challenges as well.

In contrast, transculturalism seeks to illuminate various gradients of culture and explain the ways in which social or cultural groups interact and experience tension (Kirmayer 1998). It is a branch of mental health that focuses on working with trans-nationals of many different ethnic groups simultaneously, while incorporating a greater focus on recent arrivals and immigration patterns. There is an inherent understanding in transculturalism that language and materiality continually interact with unstable or changing historical conditions, so its focus is on the socio-cultural and political aspects of the individual, versus just the mental health (Tseng 2003).

Transcultural psychiatry was first referred to in 1956 by Eric Wittkower (Wittkower & Dubreuil 1971). Wright and van de Watt (2010) give an excellent summary of the features and differences between transcultural and multicultural approaches: in transcultural mental healthcare, the emphasis is on the interactive process between practitioner and client. In this interaction, the practitioner must put aside their cultural orientation and be willing to learn about the cultural views and belief systems of the client. Both parties in the clinical encounter therefore respect each other’s culture and belief systems. Multicultural approaches incorporate the views and frameworks of both the practitioner and client, as it is assumed that client and practitioner may be from the same cultural group. The perspective of the practitioner is not considered, and little to no emphasis is placed on how they affect or impact the treatment encounter.

The ever-increasing degree of cultural and linguistic diversity of the Australian population is a product of massive migration waves that took place during the 20th Century (Bhugra & Minas 2007). Such diversity can present challenges to clinical practice (Kiropoulos, Blashki & Klimidis 2005) and the organisation and delivery of mental health services (Minas 2007). Importantly, cultural diversity pertains not only to ethnicity, but also to generational divides in perspective.
There are differences in terms of the language, beliefs, values and rules that govern each distinct generational community.

Unlike transcultural mental health, other forms of cross-cultural work are not necessarily situated in a historical context. Transcultural health is concerned with ancestral past, but also advocates for social justice in a contemporary context. It focuses on sameness (we are all entitled to the same rights as everyone else) more than difference (each culture is unique) and thus tends to have a broader scope of cultural inclusion.

Increasingly, authors are seeking to explain the association between the person and society, and more specifically, the ways in which local subjective experience is embedded in micro-level objective social structures. This therefore relates to the overall relationship between social determinants and mental health (Vega & Rumbaut 1991). Cultural factors play a significant role in all areas of illness symptomology, from perceived origins to communication, and ultimately this affects treatment options as well.

Transculturalism emphasises the traditional cultural beliefs of European and pre-European health systems, and it includes community norms or norms of the client and extended family. These inclusions have implications for collectivist cultures, given that the health of one is regarded as a symptom of the other (Durie 1995). Transcultural mental healthcare is an ideal paradigm for development and implementation of sensitive and culturally appropriate mental health services for CALD clients. Transcultural mental healthcare is associated with a number of key components, related to culture, language, and the factors that influence these.

**2.6.1 Culture**

In acknowledging diversity, an understanding of culture is essential. For the purpose of this study, “culture” is defined by Helman (2001) as a set of rules or roles acquired by members of a particular society. These rules or roles can be written down or passed on orally; they can be conscious, sub-conscious or
unconscious, passive or active. Culture affects how we respond emotionally, psychologically, naturally or spiritually to the world around us.

Supporting this, Marsella and Yamada provide a comprehensive definition of culture as follows:

[Culture is] shared learned meanings and behaviours that are transmitted from within a social activity context for purposes of promoting individual/societal adjustment, growth, and development. Culture has both external (i.e., artifacts, roles, activity contexts, institutions) and internal (i.e., values, beliefs, attitudes, activity contexts, patterns of consciousness, personality styles, epistemology) representations. The shared meanings and behaviors are subject to continuous change and modification in response to changing internal and external circumstances (2000, p 12).

Cultural identity has undergone transformation within the global sector, with increasing use of terms like ethnicity, multiculturalism, immigrants, migrants, minorities, socially disadvantaged, non-English-speaking, marginalised and diversity. The word “culture” has come to mean different things to different people. For some, it refers to an appreciation of food, literature or music; for others, it refers to clothing or worn artefacts (Bhui et al. 2008). It may also refer to relational affiliations, such as belonging to a sorority or fraternity.

Kliwer and Saultz (2006) state that individuals are composed of personal cultures, collective cultures and spiritual cultures. Personal cultures are determined by the environments in which we grew up or currently live. There are many environmental factors that may play a role in determining who we are and how we respond to the world around us, including sexual preference, birthplace, birth order, education, social class, economic situation, faith system, family of origin, nationality and rurality (Kliwer & Saultz 2006).
Each individual is thought to have their own way of conceptualising spirituality, which is the result of the interface between their personal, collective and spiritual experiences to which they have been exposed over their lifetime. Spiritual frameworks for defining culture can include components such as religious affiliation, spiritual practices (both traditional and non-traditional), past spiritual experiences and one’s own unique spiritual thinking (Kliewer & Saultz 2006). Kliewer and Saultz (2006) refer to three types of spiritual cultures: one in which the person has a pronounced religious affiliation, another in which the person does not belong to a faith community but professes to have a religious background that is important to them, and a third in which the person’s spiritual life has been impacted lightly, or not at all, by major faith systems.

In summary, the literature defines culture as a set of ascribed worldviews handed down from generation to generation – transitory and transportable in nature – which dictates how a group of people exists and interacts with the external world. Some other critical theorists consider culture as a much more complex concept. For example, Carl Jung sees culture as a dynamic system of meanings filled with contradiction, conflicts and ambiguity, which is inevitability mediated by contradiction (James 2003). In short, culture is not a self-enclosed, unified entity with stable coherent meanings; it is a way of life structured by language, discourse and power relations.

2.6.2 Cultural and Linguistic Diversity

The term “culturally and linguistically diverse” (CALD) was introduced in 1996 to replace the term “non-English-speaking background” (NESB) to refer to clients with a primary language other than English (Charles, Britt & Fahridin 2010). Both terms are used to refer to all of Australia’s ethnic groups other than the English-speaking Anglo-Saxon majority (Sawrikar & Katz 2008).

For the purposes of this study, the definition of CALD was widened to include immigrants from cultures that are different from the mainstream culture of the country to which they have relocated. Implicit in this expanded definition is the notion that language is a secondary matter to culture. Thus, even an English-
speaking person of Anglo-Saxon heritage from United States of America would fall within the definition of CALD if they immigrated to Australia; while the language is fairly similar, there are discernible differences in culture.

Queensland is home to more than approximately 200 cultures, 220 languages and 100 religious beliefs (ABS 2011). A person is considered to be from a CALD background by the ABS definition if they were born overseas, speak a language other than English, grew up with one or both parents being born overseas in a non-English-speaking country, or have a low level of acculturation (e.g., a newly arrived migrant, or someone who has been in Australia for some time but who has not acculturated to Australian norms; ABS 2011).

Research on multicultural mental health issues in Australia is limited, with much of this due to methodological challenges and limited funding (Minas 1990). A study in 2001 to identify gaps in Australian mental health research found that research dealing with CALD populations made up only 2.2% of published articles and attracted only 1.5% of competitive research funding (Jorm et al. 2002). The literature appears to be largely based on the experience and cultural meanings of countries such as New Zealand, Australia, the United States of America, Canada, England and the Netherlands. The roles of spirituality, religion and traditional healing in mental healthcare are addressed in various combinations, but all three as a collective are not.

The challenge of providing culturally competent care is increasing globally, due to greater cultural and ethnic diversity in the populations of many countries. Although there are efforts to publish more cultural psychiatry and psychology research, it has had minimal impact on the training of professionals who, by and large, work in and run mainstream mental health services. Those who work at a sensitive level (whether in the government or non-government sector) to provide culturally responsive services often do not participate in academic discussions or writings. This has a detrimental effect on the transcultural sector, as service models will not change until all who are affected by them – clinicians and healthcare professionals – participate in the process of change en masse.
There are limitations too associated with focusing solely on cultural competency issues, as this relates only to the skills (i.e., values, behaviours, attitudes, and practices) of individual providers. Instead, multi-level adaptations in mental health services should be considered, such as the clinical interface with CALD clients, organisational adaptations required in the treatment context of mental health service delivery, the relationship between mental healthcare facilities and ethnic communities, and the relationship between the mental healthcare system, other facilities and the society at large (de Jong & van Ommeren 2005). The above are features of an equitable mental health service proposed by Minas (2001), wherein the mental health service needs of the community are conceived and jointly defined by the community and its service providers, as are the types of services offered, their location, and the skills of professionals providing these services.

A review conducted in the United States of America found that strategies used to improve culturally responsive mental healthcare are often inadequate in meeting the needs of multicultural populations, as they have relied primarily on ethno-specific services (i.e., matching the ethnic background of service providers with the local population; Ton et al. 2005). Additional strategies such as training are beneficial, but not in isolation, as research indicates that clinicians may have difficulty transitioning into cultural competency principles without the assistance of cultural consultants. Ton and colleagues (2005) recommended that cultural consultation services supplement existing mental health services, to fill the gaps left by the current strategies of ethnic matching, cultural competency training and system constraints on clinicians’ time. It is specifically suggested that a bicultural expert is included in discussions, either on a face-to-face basis, over the telephone, or via videoconferencing.

Issues associated with culturally sensitive healthcare services have been translated from the academic literature to mainstream media. In his New York Times article, Ethan Watters commented on the Americanisation of mental illness, stating:
We may have yet to face one of the most remarkable effects of American-led globalisation. We have for years been busily engaged in a grand project of Americanising the world’s understanding of mental health and illness. We may indeed be far along in homogenising the way the world goes mad (2010).

Building on this, Nasser (2012) also asks whether some cultures have their own ways of “going mad”. As psychiatry revisits its manual of disorders, it faces a sticky question – what to do about culture-bound syndromes? Indeed, the lesser-known illnesses at the back of the DSM are mental illnesses that psychiatrists officially acknowledge occur within a particular society (Nasser 2012). For example, Susto is a distinctly Latin American fear that one’s soul has panicked and left one’s body, and Pibloktoq is known as “arctic hysteria”, in which Greenlandic Inuit strip off their clothes and run on the sub-zero Arctic tundra (Nasser 2012). Nasser (2012) comments, “depending on whom you ask, the notion that some cultures have their own ways of going crazy is either the ultimate in cultural sensitivity or the ultimate in Western condescension”. The author goes on in great detail to describe the power of the DSM and the American Psychiatric Association, even venturing to consider “whether someone mourning the death of a loved one can be justifiably treated for depression, or whether over diagnosis and a biased market demand for Adderall have trumped up a false ADHD epidemic”.

Mezzich and colleagues (1996) expand on this perspective, stating that knowing the role of culture and of different explanatory models associated with a specific culture is paramount in the clinical treatment of mental illness. Practitioners who work with such populations should be able to recognise culture-based factors when implementing strategies for mental illness recovery.

Kiehl speaks to the issue of “cultural difference” and its importance in the clinical encounter:
Encounters between people from different cultures or social classes bring up the whole history of the relationships between their two cultures or social classes. The unconscious impact of this history finds expression on different levels of intra-psychic and social relationships and is alive in the analytic session (2016, p 465).

Populations from Western countries, including Australia, the United States of America, the Netherlands, New Zealand, Canada and the United Kingdom, subscribe to a certain, usually individualistic, viewpoint about mental health. These societies, along with a few Eastern countries (e.g., Japan and Hong Kong) embrace the labelling and expression of individual issues. The idea that Western notions of mental health and illness – or, in other words, the pathologisation of observations and symptoms – might be contributing to the expression of illnesses in other cultures is rarely mentioned in professional literature (Watters 2010). Watters (2010) comments that there is “an impressive body of evidence suggesting that mental illnesses have never been the same the world over (either through prevalence or in form) but are inevitably sparked and shaped by the ethos of particular times and places”.

Further to this, Lolas states:

The current importance of the English language in many fields of science is not due to its more precise or rigorous expressive force, it is due to the political and economic importance of English speaking countries. The empires of the world have always imposed a Weltanschauung that can be confused with truth, orthodoxy, or purity (2010, p 5).

Similarly, and with specific reference to mental healthcare in particular, Dana (2001) reports that the DSM criteria and other related texts are imbued with a Euro-American bias in cultural perspective, which may have negative consequences for multicultural patient populations to whom the DSM is applied during mental health treatment. It is the author’s opinion that there may
therefore be a need for the latest revision of the DSM to incorporate cultural aspects and to avoid homogenisation. It is the author's opinion that the DSM would benefit from a louder voice given to deeper and more meaningful exploration of specific cultural considerations during assessment and treatment phases.

Culture doesn’t just shape what a mentally ill person calls his or her illness; it determines what counts as an illness in the first place. If this is true and it is indeed culture that determines what is “crazy” and what is reasonable behaviour, then there may be no such thing as an illness that is not culture-bound (Nasser 2012).

### 2.6.3 Language

Language is a fundamental part of culture. It is integral to all interactions within relationships, and is often even embedded in our notion of identity. It may be subtle, overt, verbal, non-verbal, silent, loud, written, spoken, acted out (psychodrama), drawn (art), individual or universal. One’s communication ability is affected by certain factors, such as the culture into which one is born or in which one lives, time, location, intelligence, experience, education, social class, economic status, occupation and social networks (Helman 2001). Different linguistic interpretations of a single concept or issue mean that the cultural setting in which that issue is being discussed must always be taken into account. Language is a part of cultural support that is critical to working with CALD people (Black et al. 2011).

The language of the country of origin will serve to preserve its culture, with regard to how its members use formal language, community slang and cultural idioms. Often, CALD family members vary in the rate of learning English, an avoidance of which is a way of maintaining culture and controlling their rate of acculturation (Lappin & Scott 1982). There are varying degrees of bilingualism; in other words, one doesn't have to speak two languages fluently to be considered bilingual. Many bilingual people who speak English perfectly or who prefer speaking English may, regardless, be asked to identify their first
language spoken. In a family context, children acculturate at a faster rate than adults, so children are more apt to reach a level of bilingualism when immigrating to another country. Hua (2008) defines a process called “codeswitching” as a natural verbal behaviour of bilingual speakers, stating that it is, in some sense, a type of conflict talk by its very nature, as differences in language choice and language preferences are on display.

Identity is closely aligned with language. Multiple meanings of each word, when contextualised by the sentence and speaker, are strongly connected with cultural meanings, symbols (both social and political) and historical and contemporary narratives. Similarly, deep-rooted socio-cultural norms may be communicated between different generations, and language is therefore integral to cultural identity across time (Hua 2008).

It is observed by the principal investigator, particularly in reflective discussion with colleagues, that language is often a challenging factor to incorporate into mental health service delivery for a CALD clientele. The environment is often fast-paced and therefore unconducive to patience, calmness, and attentiveness to the needs of clients whose primary language is not English. It is often assumed that modes of inquiry appropriate for native English speakers are applicable to or appropriate for other linguistic groups, though this may not always be the case (Hunt & Bhopal 2003).

A positive example of where language (and culture) and its interface with mental healthcare is crucial comes from New Zealand, where language and overall customs of many Pacific Islanders – especially the indigenous Māori – are studied and integrated into the overall healthcare environment (Durie 1995). This acknowledgement of indigenous cultures and language and their incorporation into the national language (which ultimately translates into incorporation into the national and clinical psyche of its citizens) has had positive treatment outcomes for clients. It shifts the power distance between CALD and non-CALD people – between systems and clients – thereby creating a better climate for access.
2.6.4 Immigration and Resettlement

Immigration is an important part of the CALD situational journey. Whether immigrants have successful relocations, stressful experiences or never really acculturate to their new environment, the entire process creates a lasting generational “ripple effect”. Immigration is a process of social change, wherein an individual leaves an area for a prolonged stay in – or permanent relocation to – another geographical area (Bhugra 2004a). This may be for the purposes of economic betterment, political upheaval, or educational opportunity. Only in recent years has migratory movement become the focus of scientific enquiry from a mental health perspective.

Immigrants who choose to relocate to another country are often felt to have better health compared to the general population of their host country, prior to leaving their home country (Anikeeva et al. 2010). It may therefore be immigration itself that leads to ill health, given that this process is now well understood to be associated with mental illness in many parts of the world (Bhugra & Arya 2005). The cause and effect of this relationship continues to be a point of debate. The extraordinary stresses related to migration have been blamed for increased rates of certain mental illness among migrant groups (Bhugra & Arya 2005). Any such relocation process involves not only leaving social networks behind, but also potentially experiencing an enduring sense of sadness, alienation and isolation (Bhugra 2004b). Further trauma may be expected in situations of forced migration, which often involve extended periods of living in refugee camps, detention, and imprisonment, chronically living on the margins in society, dietary challenges, as well as financial and housing insecurities.

These factors in combination can result in ongoing vulnerabilities and mental health issues, especially since, on a practical level, mental healthcare in immigrant populations can be complicated by language barriers, culture-related symptom presentation, and discrepancies between what patients and practitioners expect from treatment. Such unique challenges can be seen to
have a marked impact on immigrants’ physical, spiritual and emotional mental health, and overall sense of wellbeing. Indeed, higher rates of schizophrenia have been found in some immigrant groups (Bhugra 2000; Cantor-Grave et al. 2003; Hutchinson & Haasen 2004), and especially in asylum-seekers (Pourgourides 1997; Silove et al. 1998) and refugees (Kivling-Boeden 2002; Lie 2002; Rahman 2003; Silove 2002).

Claassen et al. (2005) conducted research to identify the extent and nature of mental disorders in immigrant groups from three major European countries with high levels of immigrant populations – Germany, Italy and United Kingdom. Despite large-scale immigration in each of the three studied countries, the numbers of relevant research publications varied greatly, with a relatively high level of empirical research in the United Kingdom. Possible reasons for this are a generally stronger culture of mental health service research, and a higher number of researchers who are themselves from immigrant backgrounds in the United Kingdom. Claassen and colleagues (2005) found that overall, the evidence base to guide the development of mental health services for immigrant populations was limited, and that future research with sufficient funding and sound methodological quality should be conducted across European countries.

The ongoing settlement phase of immigration presents unique challenges, for both CALD communities and the supporting services working with them. Relationships within families and communities are put under enormous strain as they attempt to deal with possible past traumatic experiences while adjusting to living in a new culture. Individuals within the family may also be at various stages along the resettlement continuum, which can place even more pressure on family relationships and systems (Codrington, Iqbal & Segal 2011).

Upon resettling in their new host country, immigrants may need to adapt to their newfound freedoms and role changes (Codrington, Iqbal & Segal 2011). These individuals are also often estranged from familiar friends and family members, who may still be in areas of potential conflict. People seeking asylum and refugee status are more likely to find solace among fellow countrymen and
women, with whom they can share their immigration experiences (Australian Red Cross 2013), and this may affect how they, in turn, respond to acculturative demands. Another significant issue is inverted hierarchy, wherein children (who have learned the host country’s language) hold the communicative power over parents (Codrington, Iqbal & Segal 2011).

Motivation to immigrate is, for many, persecution and torture in their home country. Torture and trauma are defined by the World Medical Association in its Tokyo Declaration (1975, p 1) as “deliberate systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason”. Even this definition may be too narrow, given that the acts encompassed by the term “torture” continue to expand over time (Campbell 2007).

Mental health practitioners who have no experience in working with trauma in these newly arrived cultural groups may have anxiety about not being able to help (Codrington, Iqbal & Segal 2011). They may be aware of the injustices already faced by these communities in the CALD individual’s country of origin, in transit, and in Australian detention centres. In refugee work, overwhelming events experienced by the clients have to be recognised (and survived) by not only the client but also the practitioners (Bowles 2006). The inherent complexity of treating this population group means there is a high risk of treatment failure, and furthermore of vicarious traumatisation on the part of the clinician. The result could also be over-diagnosis or pathologising of behaviour which may be normative, given the context.

2.6.5 Acculturation

A traditional definition of acculturation refers to changes in individual experiences resulting from being in contact with other cultures (Graves 1967). Broadly, as applied to individuals, acculturation refers to changes that take place as a result of contact with culturally dissimilar people, groups, and social influences (Gibson 2001). Acculturation is most often studied in individuals
living in countries or regions other than where they were born – that is, among immigrants, refugees, asylum seekers, and sojourners (e.g. international students, sessional farm workers; Berry 2006). It therefore reflects one’s psychological, emotional, financial, social, familial and socio-political connection to a new environment. A successful resettlement is one in which employment, housing, friendships and family cohesion are secured, and an acceptable level of self-esteem and positive regard are achieved within one’s new community. In contrast, a stressful connection to new surroundings is reflected by an absence of these things. An “anxious attachment” to the host country can also occur if the host country is conveying a message of not being welcoming. When the immigrant has had traumatic experiences or was housed for periods of time in detention, such situations can engender long-term psychological insecurities that affect disengagement from the old country and entrance to the host country.

The process of acculturating to unfamiliar psychological, emotional and social situations within a new environment is long-lasting (Minas et al. 2013). How successfully this transition is achieved is based on many factors. According to Mental Health in Multicultural Australia (Minas et al. 2013), the conditions of the social world influence the health and wellbeing of immigrating individuals. A significant amount of research has focused on the predictors of post-migration adaptation, or the ways in which people rearrange their lives and adjust to their new home country (Rudmin 2009; Sam 2006). In previous research, the changes and experiences related to acculturation have typically been studied along three theoretical lines: stress (e.g., Berry 2006), social and cultural learning (e.g., Furnham & Bochner 1982; Masgoret & Ward 2006), and cognitive processes related to acculturation (e.g., Arends-Toth & Van de Vijar 2006; Liebkind 2006).

For many, the process of “sojourning” can lead to high levels of distress (i.e., acculturative stress) which is a major risk factor for mental health difficulties in CALD groups. The experience of acculturative stress is influenced by acculturation attitude, migration status, reasons for migrating, personality,
cognitive functioning, and degree of cultural difference between old and new countries. It may also be influenced by the host country’s attitude and response to immigrants (Minas et al. 2013).

The aforementioned factors contributing to acculturative success are often shaped by the distribution of money, power and resources at personal, local, national and global levels. Health status is therefore not merely the result of individual factors, but rather a complex interrelationship of social and economic factors. Such society-based determinants of mental health include education, employment status, gender, ethnicity and socio-economic class.

On some measures, the health of immigrants is better than the Australian-born population due to the “healthy migrant effect” – namely that healthy people are more likely to meet eligibility criteria and be willing to migrate (WHO 2015). However, this advantage diminishes with increasing time spent living in Australia (Australian Institute of Health & Welfare 2001). Factors associated with the migration and settlement process that may contribute to health issues (and mental health in particular) include low socio-economic status, inability to speak English, lack of recognition of qualifications, discrimination, racism, and social isolation (Australian Institute of Health & Welfare 2001).

The bio-psychiatric model of depression, a disease model which emphasises the roots of the disorder in anatomy, heredity, and the disease processes, is more common in Western societies than elsewhere (Keyes 1985). Conversely, a “situational” model that describes psychological distress in the context of social and interpersonal situations may be a more common explanatory strategy in traditional societies and minority communities (Patel 1995).

A small number of studies in non-Western societies conducted by anthropologists and cross-cultural psychiatrists have examined conceptual models of depressive symptoms (Karasz 2005). In a review of the literature exploring explanatory models for mental illness in sub-Saharan Africa, Patel and his colleagues (1995) found that while the understanding of psychotic
illness closely resembled that of Western nations, conceptual models of neurotic illness differed sharply from Western models. These conditions were commonly regarded as more life circumstances, or life situations. Similar vignette studies conducted by these authors in India (Patel, Pereira & Mann 1998) likewise found that depressive symptoms were viewed as a relatively normal reaction to severe social threats, personal threats and losses. Hence, people from CALD backgrounds may view life stressors associated with acculturation differently to their European counterparts.

The process of immigration can produce a wide range of emotional experiences that affect an individual’s sense of self, family, and culture (Tummala-Narra & Gaw 2000). This can include intense and enduring grief around the loss of significant relationships in their life. Akhtar (1995) coined the term “third individuation” to describe this psychoanalytic process of change, because it is reminiscent of childhood separation and individuation from primary parental or attachment figures. Disruption can relate to loss of familiarity, language, cultural bonds, foods, and cultural customs, which can result in a powerful disintegration of self-concept, identity and feelings about one’s own culture. It can also affect one’s connection to and perception of the host country. A lack of success in acculturating to a new country may lead to acculturative distress.

Acculturative distress refers to the psychological, physiological, emotional and adjustment discomfort that one encounters during the ongoing process of moving from one country to another. Acculturation distress can be influenced and shaped by many factors, such as how the person is immigrating, receptivity of host country, personal and cultural resilience, resources available to the person, and their cultural background. These factors provide a strong foundation to understanding how the immigrant experiences and expresses themselves during constant instability and change.

Many immigrants are forcibly removed from their countries of origin, either by war or ecological disasters. These individuals are considered “at risk” because of their circumstances, and are allowed to resettle in other counties with a safe
status. Australia extends this status to “women at risk”, humanitarian minors, refugees, and asylum seekers. As one colleague of the author has stated, refugees may be seen as trauma victims who physically and psychologically wear the burden of war.

It may be valuable to explore the dimensions of acculturation more deeply, with respect to understanding the plight of those who are forcibly relocated to unfamiliar countries. Such processes, when combined with the trauma associated with the mitigating disasters themselves, have reverberating effects on individuals, communities, and the host country more broadly. At an individual level, high levels of acculturative distress are associated with equivalently high levels of depression and anxiety.

Mähönen and Jasinskaja-Lahti (2012) state there is a need to acknowledge the pre- and post-migration factors that influence ethnic migrants’ post-migration psychological adaptation. They conducted a study in Finland examining the effects of pre-acculturative stress, anticipated socio-cultural difficulties, and anticipated discrimination on ethnic migrants’ (n=153) psychological wellbeing. They also examined how the concordance between these pre- and post-migration factors affects post-migration wellbeing. They found that pre-acculturative stress was the only pre-migration factor directly affecting post-migration psychological adaptation and stress. This latter finding aligned with results from previous research (Bhugra 2004b; Ryan et al. 2006; Tartakovsky 2007). In addition, the results related to the social psychological dimension of acculturation and supported the assumed links between anticipated discrimination and perceived discrimination in the post-migration stage (e.g., Shapiro & Neuberg 2008; Shelton & Richeson 2006).

Mähönen and Jasinskaja-Lahti (2012) state that pre-migration contact with host nationals, as well as accurate information, language training and promotion of self-efficacy, may all help to alleviate pre-acculturative stress. The authors also advocate that in the post-migration phase, societies need to promote positive inter-group relations between newcomers and the national majority group, and
support the development of socio-cultural skills required for immigrants' active participation in society. These skill sets are crucial to successful settlement, as defined by both the migrants and existing host communities.

Nickerson and colleagues (2010) conducted the first study with refugees fleeing the current war in Iraq. Those refugees with family members still living in Iraq reported higher levels of post-traumatic stress disorder and depression symptoms, as well as overall mental health disability. A significant challenge to those who leave family members behind is fear for the future, particularly with regard to the safety of family members left in dangerous settings. This represents a powerful influence in generating ongoing mental health dysfunction in refugees, in spite of secure resettlement (Nickerson et al. 2010).

Many members of CALD communities routinely experience the distress of leaving family in war-torn areas of their home country. The psychosocial anguish that this causes affects their ability to settle comfortably. In professional correspondences with the principal investigator, some CALD clients have discussed how safe they feel in Australia on the one hand, but how guilty they feel on the other. This process leads to survivor's guilt, with many participants never really sharing with family what life in Australia is like for them.

The effects of war on mental health, wellbeing and community participation can be significant and long-lasting. Considering the generally poor availability of mental health services in low-income countries to begin with, brief but efficient interventions are required to enhance the lives of individuals and their families affected by torture, trauma and displacement.

**2.6.6 Intergenerational Complexities**

Individuals or families immigrate for a whole host of reasons, usually to achieve financial security, personal safety, or for betterment of quality of life. The individual, family or group that immigrates may feel a certain pressure to sustain their ethnic or religious identity, and they may seek to participate in a range of groups in the broader society (known as “contact participation”; Berry 1990).
These seeking out behaviours may be conscious or sub-conscious as they work their way through the migration experience and are held and reacted to across generations.

Generational issues for CALD participants were examined in the current study, and it is for this reason that the ABS’ definitions of first, second and third generation Australians are worth noting. The ABS (2011) defines first generation Australians as people living in Australia who were born overseas; this includes Australian citizens, permanent residents and long term temporary residents. The 2011 census shows 5.3 million were first generation Australians (27% of the population; ABS 2011).

First generation Australians would have made the decision to leave their home country – hence they are the “bridge” between the old country and the new. They are responsible for the cultural maintenance of relationships, connection to land, and connection to ancestors and contributions to future generations. Some of the dilemmas that members from this generation face emerge from the desire to stay connected to the old country and maintain cultural elements therefrom, while simultaneously attempting to create spaces within themselves to receive the new country.

Second generation Australians are born in Australia with at least one parent born overseas. There were 4.1 million second generation Australians in 2011 (20% of the Australian population; ABS 2011). The characteristics of second generation Australians often reflect the timing and composition of their parents’ immigration to Australia. Migration patterns to Australia increased significantly in the 1950s and 1960s, so most second generation Australians were born after this period. Waves of migration result in migrants with similar cultural backgrounds arriving in Australia at the same time. Their children also tend to be born around the same time periods (ABS 2006).

Second generation Australians (i.e., those born to first generation immigrants) have some interesting profiles. Of second generation immigrants aged 20 years
or more in 2006, 21% held Bachelor degrees or higher, compared with 24% of the first generation. In every age group, second generation Australians hold Bachelor degrees at a similar or lower level than first generation, but at a higher level than other generations.

Second generation immigrants tend to have responsibility for unconsciously carrying on the legacies and dreams of their immediate and extended family. Sundar (2008) conducted a study with second generation south Asian Canadian youths, exploring how they managed their day-to-day social networks by “browning it up” and “bringing down the brown”. Thus, this population may utilise their ethnicity and South Asian characteristics when needed, rather than their Canadian identity. According to Sundar (2008), this process starts with the youth first assessing each situation, then deciding which identity will help them to achieve the desired outcome, then taking on the identity that is most useful in reaching this goal.

Elley (1993) describes a similar construct in relation to the “multiple identities” of biculturalism or bilingualism, called “hyphenation”. This refers to the process of switching back and forth between roles – both consciously and unconsciously – to take on an identity which is best suited to the situation. Such processes are ever-evolving, so need to be nurtured and internalised as a skill. Those most adept at this process tend to be more successful than those who are not. Indeed, cultural identity switching has been used by many of the principal investigator’s colleagues who are CALD mental health practitioners. They describe sometimes accessing their professional expertise in a given situation, observing that the professional skills would often trump the CALD context or gender issue. When needed, the CALD aspect of their identity is revealed, such as when they are in the company of other CALD professionals. One can see this played out in an American context, with many CALD members of the population hyphenating their two identities (e.g., African Americans, Polish Americans).
The above literature on “hyphenation” challenges our categorical understanding of identity and brings into focus the ways in which identities are mediated by historical and geopolitical realities, as well as social dimensions like race, gender, social class and religion (Elley 1993). The focus on such intersections means identities are situated within and informed by numerous resources, discourses, histories and experiences. Elley (1993) explains that Turkish descendants hyphenate their identity as Turkish-Australian. This hyphenation was described in terms of shared histories, culture, language, religion and shared experiences of growing up in Australia. The second generation Turkish identity is firmly rooted in the Turkish community, but it is also fluid, and can adapt to the broader Australian community. In other words, their “Turkishness” or “Australianness” switches focus, depending on the setting (Elley 1993).

In many circumstances, CALD people may walk a similar tight-rope between their own culture into which they were born and the host culture into which they have been adopted. These psychological navigations require specialist skillsets that are actively and passively acquired, based on their experiences switching identities in response to the situational context. Key to the process is making deliberate, strategic choices about how best to express one’s identity for the purpose of achieving a given goal, which can be access to resources, gaining legitimacy, or attaining a sense of belonging (Sundar 2008).

Intergenerational issues can show up in many ways: the degree of respect of younger members give to older members of their community, the passing down of ceremonial and ritualistic duties, the choice of staying and/or marrying within one’s cultural group, and the maintenance of culturally significant customs. These are but a few of many examples of intergenerational issues that are complicated by immigration-related adaptations. There are reverberating effects that stem from such issues – not only at a family level, but within the wider community, as well.
2.6.7 Examples of CALD Explanatory Models

Explanatory models can be described as self-produced narratives or personal testimonies, used to communicate cultural themes that are important to clients. They allow for the client to discuss the positives and negatives of the said narrative, thereby enabling the clinician and client to construct new understandings and new stories about the client’s health. People from CALD backgrounds are more likely to use narrative-based explanatory models of illness. Arthur Kleinman (1977) stressed that CALD clients may have alternative explanations for illness, which sit outside of what is detailed in the DSM and described according to a biomedical model of health. Explanatory models are therefore influenced by culture, but also gender, country of origin, age, relationship status, and the number of migrations undertaken.

Further to the topic of using self-expression as a tool for managing illness, Beck (1992) equates these verbal expressions of pain and discomfort to forms through which the client produces an autobiography of sorts. Beck (1992) states that these expressions are closely aligned with the individual’s identity, and that they contain information about the client’s concept of self.

Beck (1992) goes on to explain that while individuals’ life narratives and biographies were previously thought to be socially prescribed or constructed, they are now self-produced, bestowing a range of demands on individuals. This shift is described as a by-product of modern society. In years past, personal failures were considered a consequence of fate, God, nature or war, in which the individual had no direct responsibility (Beck 1992). Today, the blame for failed biographies rests solely with the individual. Lemke (2001) states that neo-liberal forms of government have reduced responsibility for social risks, such as unemployment and poverty, such that individuals relate responsibility and morality to economic rationality. Modern Western societies demand this kind of approach to life, which puts the ego of the individual at its centre, requesting this ego to maintain an ongoing association with entrepreneurial and rational personhood. To adhere to these characteristics is to hold an accepted identity and to act out the ideal humanness required by society (Kelly 2006).
In addition, one must be a successful “consumer”, or risk being socially defined as blemished or deficient (Bauman 1998). The learned perspectives and attitudes taken towards oneself become the predominant focus. Identity is a component of the self, nested within it, defined by the meanings and anticipated outcomes of role expectations and social positions (Callero 2003). The “self” comprises many different identities that are drawn on and acted out in different circumstances (Roche 2015). A reflexive human mind manages these multiple identities in an effort to maintain a positive conception of the self and navigate social life. A stable sense of identity and biography are crucially important in the maintenance of a healthy and robust sense of self (Roche 2015).

Other variations of narration are testimonial therapies, which have been successfully adapted to diverse cultural groups. For example, 20 Bosnian refugees in the US underwent six testimonial therapy sessions, and showed a significant reduction in PTSD diagnosis rates, and a significant improvement in post-traumatic symptom severity, depression, and global functioning (Weine et al. 1998). Forty-three Sudanese refugees living in Ugandan refugee settlements also showed significant decreases in the frequency and severity of such symptoms after receiving four sessions of a variation on testimonial therapy, described as narrative exposure therapy (NET; Neuner et al. 2004). The same alleviations to psychological suffering have been attributed to NET and testimonial therapy in studies with Romanian survivors of political repression (Bichescu et al. 2007), asylum seekers, and refugees (Agger et al. 2012; Agger & Jensen 1990; Van Dijk, Schoutropo & Spinhover 2003).

The narration or story-telling approach was further developed for Puerto Rican adolescents using biographical stories of heroic Puerto Ricans. This technique allowed for maladaptive behaviours to be identified when participants compared their narratives to the stories of each hero (Malgady, Rogler & Constantino 1990). What this and other studies show is that psychosocial functioning for those affected by torture and trauma is treated more effectively when individuals are presented with opportunities for self-expression and self-exploration. Being
honoured publicly restores self-esteem and respect to those who feel demoralised, and it mitigates social stigma by promoting acceptance and understanding of the torture survivor’s plight (Puvimanasinghe & Price 2016).

Narration as a form of expressive therapy can take the form of talking, dance, drama and other types of art. To be unable to express a desire or wish is akin to what Durkheim (1951) describes as societal suicide. In the present study, it is theorised that the story-telling approach will resonate with all participants, especially those from CALD backgrounds, as it is through narrative that they express ideas about spirituality, religion, traditional healing, and other topics important to them. Furthermore, it is believed that the CALD participants in this study will find it invigorating and refreshing to have the opportunity to talk about important issues in an open context, where there will hopefully be genuine and heart-felt interest and concern. These ways of communicating are central to all experiences, but CALD individuals in particular may benefit from a narrative approach to the data collection process, as they may otherwise be limited in their access to outlets for self-expression.

2.7 CONCLUSION

Story-telling and narration is one way through which psychological distress resulting from immigration may be reduced. This technique is appropriate for many immigrants who come from environments where there are high levels of conflict, where it may be challenging to give words and voice to what they are feeling. Such individuals may experience acculturative distress without recognising it as such.

Now that the key features of the immigrant experience have been explored in this chapter with particular reference to the importance of spirituality, religion and traditional healing to the CALD immigrant, Chapter 3 will review literature on treatment approaches to address immigrant needs.
Chapter 3. LITERATURE REVIEW: TREATMENT APPROACHES

3.1 INTRODUCTION

This chapter presents a review of literature relevant to clinical treatment approaches, with reference to the mental healthcare needs of CALD populations. The chapter will describe treatment approaches in the Western healthcare model, in international models of health, and in Australian and Queensland mental health services. Finally, transcultural mental health will be described, as will various forms of Indigenous traditional healing and practitioner clinical responses.

3.1.1 CALD Perceptions of Mental Health Services

Many ancient non-Western cultures embrace a holistic approach to health and illness, focusing on the interconnections between mind, body, and spirit (Mark & Lyons 2010). Cultures around the world offer perspectives on the relationship between different forms of healing and illness, and these do not always align with perspectives in mainstream Western culture (Young & Koopsn, 2005). “Holism” is form of treatment approach often associated with culture, and it broadens the traditional medical focus on symptoms and disease to include other health-related domains such as nutrition, psychological and spiritual wellbeing, interpersonal relations and environmental influences (Lowenberg & Davis 1994), with such views complementing a multidimensional view of health (Saylor 2004).

Akutsu, Castillo and Snowden (2007) conducted a study to examine the referral patterns of Chinese, Japanese, Filipino and Korean Americans at ethnic-specific versus mainstream programs in a public mental health system. As predicted, social community-based services – and to a lesser degree, the client’s family and friends – referred the groups to ethnic-specific programs more than other related services. This pattern was most significant for Chinese Americans, followed by Japanese and Filipino Americans, then Korean
Americans. The findings suggest Asian American clients and their social networks may see ethnic-specific programs as more culturally responsive than mainstream services. Further research into referral patterns for specific CALD groups like Asian Americans is warranted, as the literature is sparse and does not provide a clear picture of current referral pathways to ethnic-specific and mainstream programs. Where Asian Americans do turn to ethnic-specific programs, there are reportedly fewer dropouts and better outcomes (Flaskerud & Hu 1994; Lau & Zane 2000; Takeuchi, Sue & Yeh 1995; Yeh, Takeuchi & Sue 1994; Zane et al. 1994).

Non-Western countries may define mental illnesses in culturally specific terms, based on culturally specific contexts. Chhim (2013) describes a peculiarly Cambodian idiom of distress called “bakshbat”. Translated, this literally means “broken courage” and it describes the psychological responses to the severely traumatic events experienced by Cambodian people in past decades. Bakshbat appears to overlap with symptoms of PTSD, anxiety, depression, and dissociative features, but needs to be researched further (Chhim 2013). Bakshbat is described as unique to the Cambodian population because of the complex traumatic and phenomenological experiences endured by those who survived the Khmer Rouge regime from 1975 to 1979 (Chhim 2013). Some Cambodian communities may not have a “Western tradition” of counselling or psychotherapy. Most, if not all, newly arrived ethnic communities will not have trained mental health professionals and if they do, their qualifications may not be recognised in Australia (Bowles 2006).

Other studies with African psychiatric patients in South African found that although most used indigenous names to describe their problems, they also reported their problems were caused by psychosocial factors and a majority reported satisfaction with their Western-based psychiatric treatment (Ensink & Robertson 1999). Nevertheless, there is a small but growing body of literature to show some ethnic groups are more likely than Caucasian Americans to use non-psychiatric sources to treat mental illness. For example, African Americans have more favourable views than Caucasian Americans toward using
alternative therapies or home remedies, which have been used to treat anxiety and depression (Elder, Gillcrist & Minz 1997; Koss-Chioino 2000; Smith & Fahie 1998; Snowden, Libby & Thomas 1997). Latinos have also been found to use alternative or complementary therapies more than Caucasian Americans (Astin 1998; Druss & Rosenheck 2000; Eisenberg et al. 1998; Koss-Chioino 2000). One study found that Latino immigrants are more likely to rely on informal sources of care first before seeking help from formal sources (Cabassa & Zayas 2007).

According to the World Health Organization, 80% of the world’s population use herbal medicine in one form or another (WHO 1993). The resurgence in herbalism has been a worldwide movement. For example, Māori people are among those indigenous populations observably re-engaging with traditional healing methods (Whangapirita 2002). This is in keeping with the aforementioned evidence showing people from CALD backgrounds are more likely to seek spiritual, religious and traditional healing advice from within their own communities, rather than access assistance from a mental health service. The first point of contact for a CALD client is often their Community Elder, which can be a pastor, priest, or spiritual leader. These and other local helpers may facilitate access to community mental health organisations and practitioners.

Community CALD practitioners who work and live within a certain community, may be highly in touch with how constituents prefer to be treated. They may also be more willing to incorporate spirituality, religion and traditional healing into their treatment practices. This is significant, as many community practitioners would never fit comfortably into a government-run organisation or mainstream system’s way of practising, choosing to refer CALD clients to a General Practitioner or local physician for longer term follow-up. Community practitioners may also consider mental health services or more intensive forms of treatment a last resort, given that many CALD people have had negative interactions with healthcare systems over the years.
A study looking at the causal factors for not seeking out treatment for mental health services, found that African Americans typically reported lack of time, fear of being hospitalised, cost of care, and the belief that they should be strong enough to handle the problem themselves as reasons for not seeking help from mental health practitioners (Sussman, Robins & Earl 1987). In contrast, Caucasian Americans reported expense, lack of time, belief that no one could help, and embarrassment about discussing the problem with anyone as their greatest obstacles to seeking care (Sussman, Robins & Earl 1987).

Leavey (2008) conducted a study to examine pastoral care services provided for different groups of faith. In contrast with the mainstream Christian clergy, Imams suggested they were always the first port of call for psychiatric and related problems (Rashid, Copello & Birchwood 2012). Other studies have found that for health-seeking behaviour in the United Kingdom's Muslim community, it was common to consult traditional healers when presented with an ailment (Aslam 1970; Dein & Sembhi 2001; Healey & Aslam 1989).

As with Christian and Jewish clergy members, the traditional roles of Imams are to lead prayers, deliver sermons, conduct religious ceremonies and provide spiritual guidance (Haddad & Lummis 1987). When Muslims have marriage or family discord, they might consult with their Imams, who then advise on specific special prayers, scripture or fasting techniques. In order to help community members with their issues, those religious leaders would be expected to reference and interpret the Qur’an and the Hadith, which are the holy scriptures of Islam (Rashid, Copello & Birchwood 2012). In Islamic faith, traditional healers (i.e., maulanaas, sheikhs) are the mediums through which mental illness is dealt with, as they are considered by the community to be well equipped to drive out the evil spirit (Syed 2003).

There is limited published work available on Muslim healers' perceptions of mental illness; however, one study conducted by Ally and Laher (2008) found that African Muslim healers could make a distinction between a spiritual illness and a mental illness, but that spiritual illnesses also have psychological
manifestations that overlap with mental illness. The healers argued that mental illnesses resulted from childhood trauma or a chemical imbalance, whereas spiritual illnesses were caused by black magic or from jinn.

Studies on help-seeking indicate that African Americans are more likely than Caucasian Americans to see spirituality as important, and are more likely to use it to help treat their depression (Cooper et al. 2001). Further to this, African American and Latino women are found to make greater use of spiritual sources of care and alternative treatments, compared to Caucasian American women (Hwang & Myers 2013).

With ever-increasing fervour, help-seeking from spiritual or religious clergy by distressed individuals appears to be on the increase (Koenig & Futterman 1996). This is particularly evident amongst ethnic and culturally diverse communities, as religious and spiritual clergy play an important role in the provision of mental healthcare across a wide spectrum of the United States populations (Eng & Hatch 1991; Larson et al. 1988; Neighbors et al. 1983; Voss 1996). In a study based on data from the National Survey of Black Americans, for instance, Neighbors and his colleagues (1983) found that ministers were second only to private physicians in the rate at which they were sought for serious personal problems.

The role of clergy in the help-seeking behaviours of ethnic minority populations other than African Americans has not been thoroughly examined (Abe-Kim, Gong & Takeuchi 2004). Researchers in the area have increasingly noted that examination of religious and spiritual variables with respect to health-related matters has largely focused on Judeo-Christian individuals, and in particular, Protestant expressions of faith (Hill & Pargament 2003; Kier & Davenport 2004). There is a need for greater sensitivity in examining variations in these relationships by ethnicity (Seeman, Dubin & Seeman 2003) and cultural characteristics (Hill & Pargament 2003). A study conducted by Sustento-Seneriches (1997) on the help-seeking behaviour of Pilipino Americans, the second largest Asian American population in the United States, found that
approximately 83% of this population is Catholic (Barnes & Bennett 2002). Religion – and help-seeking behaviours related to faith – may therefore be an important dimension of Philippine culture to consider when assessing health-related issues (Abe-Kim, Gong & Takeuchi 2004).

The positive relationship between religion and wellbeing is well documented. Koenig and Futterman (1996) examined 23 studies of the relationship between religiousness and wellbeing among older persons. In 21 studies, more religious individuals had greater wellbeing. Strawbridge, Cohen, Shema and Kaplan (1997) examined the long-term association between frequent religious attendance and mortality over 28 years (n=5,282). Frequent attendees (i.e., those who attended church more than once a week) had a lower mortality rate and were more likely to stop smoking, increase exercising, increase social contacts, and stay married.

Along the same lines of inquiry, Traversa (2012) explored how Catholic and Muslim women in Italy utilise religious experience to construct new meaning about themselves, perceiving it as a liberating force rather than the source of constraint and oppression. Religious belief systems were important sources of community support, and at an individual level, these women were engaged in an internal critique of the traditions and chose to give personal meaning to dominant symbols in their life’s cultural space. In essence, they were using religion as a symbolic resource (Zittoun 2006) in an effort to create alternative feminine identities for themselves and others as a way of achieving empowerment and enhanced self-esteem.

Heyer (2016) writes: “Racial and religious identities are complex, often mired in dynamics of ‘othering’. Such dynamics easily become a means of distancing the pain, fear and rage of intergenerational traumas, thus undermining ways race and religion can be powerful vehicles for the transference and countertransference” (p 434). This emphasises the importance of acknowledging the importance of race (which brings with it ‘cultural difference’) and religion in the approach to treatment.
As Mbiti (1990) said, African traditional religion is community-based. People simply assimilate the religious ideas and practices held or observed by their families and communities. African indigenous religion is handed down from generation to generation within their ethnic group. A qualitative study undertaken by Sacco (1996) revealed that African students perceive their spirituality as a means of embracing the ultimate power of God, their ancestors, justice and an inner awareness of being connected with all of one’s life. These underlying purposes can be attributed to most – if not all – CALD spiritual groups. They come together under the banner of achieving spiritual and religious worship, but find that it gives them so much more.

According to Nortje and colleagues (2016), traditional healers form a major part of the mental health workforce worldwide. Despite this, little systematic examination has been done to examine their effectiveness in treating mental illness or alleviating psychological distress. The authors reviewed existing research related to this topic and found 32 studies across 20 different countries. Overall, the quality of published information on traditional healing was poor, although the authors did report that traditional healing appeared to consistently provide effective psychosocial relief for mild symptomology in common mental illnesses like anxiety and depression (Nortje et al. 2016). However, there was little evidence to suggest that traditional healing can have a more substantial effect on mental health issues, such as those pertaining to primary diagnostic classifications (e.g., mania, bipolar or psychotic disorders; Nortje et al. 2016).

The eclectic and informed clinician is cognisant of the high dropout rate of ethnic minority patients and recognises that the first mandate is patient and family retention in treatment (Lefley, Sandoval & Charles 1998). Persons from culturally diverse backgrounds are often bewildered by the mental health system, since they have different expectations of what will be offered, cannot see the potential benefits of psychotherapy, and feel alienated by institutional settings that they do not understand. As many Western-based clinicians actively oppose the use of traditional healing practices in mental health treatment,
Weiss (1992) has noted that psychiatric patients and their families who utilise folk healing often become more orthodox if mainstream aftercare treatment has failed, thus justifying their concealment of having accessed such services due to clinician disapproval.

Traditional healers are appealing because they share a common perspective with their client and the client’s families. They make use of knowledge, beliefs and practices indigenous to the local culture (WHO 2000). In developing countries, these shared beliefs typically including spiritual and religious models of illness causation, which affect patterns of help-seeking (Bhikha et al. 2012). In cases where more formal psychiatric services or diagnoses are scarce or not affordable, traditional healers are especially well-utilised and provide a potentially valuable source of mental healthcare (Farooqi 2006; Gadit 1998; Makanjuola, Adelekan & Morakinyo 2000).

In addition to populations from developing countries, minority populations in high-income and developed countries continue to use their own traditional healing systems (Nortje et al. 2016). It is worth noting that high rates of traditional healing attendance for mental health problems have been documented in immigrant communities from North America (Beals et al. 2005; Buchwald, Panwala & Hooton 1992; Hartmann & Gone 2012; Padilla et al. 2001; Walls et al., 2006), in Canada (Lin 1983), in Britain (Dein, Alexander & Napier 2008; Furnham, Raja & Khan 2008; Khalifa & Hardie 2005), and in Germany (Assion, Dana & Heinermann 1999).

Nortje and colleagues (2016) report that although the debate regarding the legitimacy and efficacy of traditional healers within mental healthcare is ongoing, many countries acknowledge the potential usefulness of traditional healers for treating various mental health problems and are attempting to incorporate these healers into their systems. This is occurring in Indonesia, South Africa, Bali, Uganda, Papua New Guinea, New Zealand, Canada and the United States of America (Durie 2009; Kurihara et al. 2006; Salan & Maretzki 1983; Sorsdahl, Stein & Flisher 2013).
Bilgrave and Deluty (2002) conducted qualitative research examining the influence of religious beliefs and political ideology on psychotherapeutic orientation and practice. According to the responses of 233 clinical and counselling psychologists, both factors were influential, with that of religious beliefs being more common than political ideology.

### 3.1.2 Western Healthcare Model

Health is the basic unit of functioning for living organisms. In humans, it is the ability of individuals or communities to adapt and self-manage when faced with physical, mental or social challenges (Huber et al. 2011). The World Health Organization (WHO) broadly defines health in its 1948 constitution as “a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity” (WHO 1948). Although this definition was originally seen as controversial, it has progressed even further to include other definitions of health which correlate more with personal satisfaction (Bellieni & Buonocore 2009).

In terms of the Western medical model, treatment efforts usually focus on the elimination of clinical symptoms, and the possibility of functional and social recovery is often not addressed. This mindset arises from selective exposure of clinicians to patients who present to hospitals or clinics with the most severe or acute medical conditions. Such individuals may be less likely to fully recover and function well within society. Hence, it can be postulated that consumers of services transition into “patients” as they present during times of crisis (Cohen & Cohen 1984). This could account for the pessimistic attitude and low expectations of recovery among consumers (Marwaha, Balachandra & Johnson 2009). A recovery model, in contrast to the traditional medical model, emphasises maximising the potential of the individual to live a fulfilling life. This approach provides many more options for intervention, and it challenges some of the pessimistic prognostications of healthcare professionals.
It is important that health professionals, in their interventions with clients, focus on addressing social and economic participation, as well as simply alleviating clinical symptoms. Sometimes, these aspects of client life are left out of the clinical encounter, often relegated to other external non-health services (MHIMA 2014). It is this “sectioning off” of care that is becoming increasingly contentious among healthcare and mental health professionals, as it may lead to fewer front-door presentations and confusion within the medical team as to how to work with the complete person (MHIMA 2014). Such dissection of the individual may also be confronting and confusing to clients of different cultural backgrounds who enter this system for the first time, given that they may be told to access multiple different services to get comprehensive care for a certain ailment (MHIMA 2014).

Central to the Western medical model of healthcare are its individualist views of the body, symptoms and the often transactional relationships between consumer and service provider. In individualist cultures, the person is isolated from relations, history and context. The individual body is presented, adorned and admired with all credit going to the individual who inhabits the body (Helman 2001). In many CALD communities, the body represents the clan, tribe or group. Rarely will there be a public display of the body as it stands to gain a reaction from the entire family, community or group.

Helman (2001) notes that the culture in which we grow up influences how we interpret the changes that occur over time in our bodies and the bodies of other people. In working with clients from CALD backgrounds, the body is defined as the communal mind, body and spirit. This has significant implications for how CALD communities interface with the Western environment, in terms of how they adjust to a dissected paradigm of physicality.

Western healthcare models place an emphasis on being able to concisely describe feelings, symptoms, and medical history. This type of treatment paradigm may exclude some CALD communities, who use a narrative approach to defining their circumstances. Other exclusionary factors may relate to
authoritative perceptions of age (e.g., an older person may have all speaking rights if interacting with a younger person) and gender (e.g., women from many cultural backgrounds would not feel comfortable disagreeing with a man). In many countries, a woman would not even be able to see a male professional without her husband being present.

Healthcare in Western countries is based on a systematic “expertise model of care”. In other words, one pays money to an expert to address one’s medical symptoms, after which the patient-expert relationship dissolves, and any intimacy beyond this one-off exchange is rarely achieved (Helman 2001). This process, which relegates one to the role of “patient” – a status denoting “unwellness” – is unique to Western medicine. As such, it may be seen to support a form of social control through power formation, relationship imbalance, social distance and hierarchical structures. There is growing concern over the continued imbalance with one authority, usually the doctor, exercising supreme control over consumer care. As the executive of care, the doctor dispenses care from the top down, thus belonging to a system that mimics corporate behaviour.

International Models of Health. According to a report by the United States Department of Health and Human Services (2001) most minority groups receive a poorer quality of mental healthcare, despite there being a similar prevalence of mental illness across the total population. This, in addition to lower utilisation rates of mental healthcare, indicates that a higher proportion of individuals belonging to an ethnic group have unmet mental health needs (Ton et al. 2005).

The United States of America is a strong supporter of ethno-specific services and ethnic matching (Sue et al. 1991). This typically involves establishing a clinic in a neighbourhood with a predominant ethnic make-up. Matching the ethnic background of provider and client is a key component of this model, as is structuring the clinical milieu to complement the predominant ethnic culture of the client (Ton et al. 2005). Usually this is in the context of community mental health programmes.
New Zealand and the United Kingdom appear to have adopted the same model, which is based on the identification of socio-cultural barriers and areas of racial discrimination for all groups, with a specific focus on certain minority groups where there is a known history of discrimination (de Jong & van Ommeren 2005). In contrast, the Netherlands, Australia and Canada use multicultural models of care to provide culturally sensitive treatment within mainstream mental health services (de Jong & van Ommeren 2005). These countries look at issues of social justice and equity for all groups.

Baarnhielm and colleagues (2005) suggest that the majority of mental health and cultural diversity research in Sweden has focused on immigrants’ health situation and trauma as these relate to one’s receptiveness to the host country. A number of studies in Sweden have focused on the increasing cultural diversity of the population and on the interaction between mental healthcare and cultural groups. There are indications that there may be an underutilisation of mental healthcare services among some immigrant groups. This aligns with the finding by Hjern and colleagues (2001) that instead of accessing these services directly, there is a tendency towards accessing both primary (e.g., General Practitioners) and secondary health services (e.g., emergency room visits).

In 1999, when faced with increasing diversity within the population and the recognition that “language matching” was insufficient, too costly or not possible, Sweden started its first transcultural centre. The centre provided health and medical staff in Stockholm with information, training, consultation and supervision services related to transcultural issues. This step aligned with the views of a leading Swedish health theorist, Nordenfelt (2007) who argued in favour of an updated perspective on health. He postulated that establishing a person as “healthy” does not just entail some objective inspection and measurement; it presupposes an evaluation of the general state of the person. A statement that he or she is healthy does not rely on certain scientific facts regarding the person’s mind or body, but implies a positive evaluation of the person’s physical and mental state.
In line with Nordenfelt’s approach, the Netherlands has begun engaging in a more intercultural approach (de Jong & van Ommeren 2005) or “cultural competency approach” to mental health services, in which clients from different cultural backgrounds are individually catered for. De Jong and van Ommeren (2005) state that they refuse to limit the scope of their work to pure cultural competency, which is heavily advocated for in the United States of America, as this refers only to the skillsets of individual practitioners (i.e., their values, behaviours, attitudes and practices) rather than on multi-layered adaptations to mental health services.

De Jong and van Ommeren (2005) further posit that besides the usual modulation of systematic therapy, it is useful to adapt other forms of existing therapies, and to organise therapeutic groups for immigrants. In particular, this may benefit those women who miss the social and communal aspects of their homeland. There is also a call to incorporate elements of local healing traditions such as vocabulary and metaphors (Hinton et al. 2004; Otto et al. 2003).

Cognitive behavioural therapy can sometimes be combined with Taoist philosophy to treat general anxiety disorders. In addition, programs emphasising Buddhist concepts have been developed that demonstrate psychological benefits, as evaluated by rigorous methods. Mindfulness has only recently entered into the Western psychological discipline as a source of stress relief, evolving from ancient practices in which the individual focuses on affixing their consciousness to the present moment (Katat-Zinn 2003).

3.2 TRANSCULTURAL MENTAL HEALTH

Mental health refers to the psychological or emotional state of someone who is functioning at a satisfactory level (Prince et al. 2007). This definition may also relate to one’s general enjoyment, engagement in life activities and resilience (Patel & Prince 2010). The World Health Organization defines mental health as, “subjective wellbeing, perceived self-efficacy, autonomy, competence,
intergenerational dependence, and self-actualisation of one’s intellectual and emotional potential” (WHO 2001, p 5). These are perceived as important ingredients to the maintenance and achievement of overall wellbeing.

Maintaining good mental health is critical to living a long and healthy existence. Within mental healthcare, there are many areas of professional understanding, service providers and treatment approaches. Work-related health, which affects productivity and self-esteem in the workplace, is managed by specific assistance programs, with input from organisational psychologists and occupational therapists. Strategies for improving the work environment may relate to ergonomics, Feng Shui, lighting, temperature and air quality.

Community prevention and promotion programs also exist to identify families and individuals at risk. Similarly, practitioners from child and youth services aim to address the emotional needs of students who experience acute mental health issues. Individuals may be directed to such services by a range of professional and para-professional groups, including psychologists, life coaches, nurse practitioners, social workers, occupational therapists, activity therapists, psychiatrists, counsellors, clergy members and religious leaders.

Mental health disorders are common, with more than one in three people from most countries meeting criteria for at least one mental health issue at some point in their life (WHO 2000). This proportion is even greater in the United States, in which 46% of the population will qualify for a mental illness at some point in their life (Kessler et al. 2005). According to the World Mental Health Survey Initiative (2005), anxiety disorders are the most common type of mental illness in most countries, followed by mood disorders, then substance abuse and impulse control disorders. In Australia, mental illness is the leading cause of disability, accounting for nearly 30% of the non-fatal burden of disease (Mather, Vos & Stevenson, cited in Queensland Transcultural Mental Health Centre 2005).
Mental illness, according to a mainstream medicalised definition, must have clinical significance. In other words, the emotional or mental symptomatology must be significant enough to affect more than one area of life functioning. This definition, however, does not necessarily align with the transcultural perspective on mental health, which is informed more by the individual's socio-political and socio-anthropological background (Broome 2002). Transcultural mental health refers to a sub-discipline of research and practice within psychiatry that is concerned with relationships between culture, mental health and mental illness (Minas, Sullivan & Minas 2010).

Transcultural mental health is otherwise referred to as global or international health, and in the past has been defined as “tropical medicine” (Patel 2014). Global health has been defined as “an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide” (Koplan et al. 2009, p 1995). Global health or transcultural health stands out in three distinct respects; first, priorities are determined by the burden of disease; second, its driving philosophies are fairness and equity in the distribution of health within and between populations; and third, its scope is worldwide, as it concerns itself with all people globally (Patel 2014). Important in this treatment model is the emphasis on global learning. Thus, while international health was built on the tradition of what those in the developed world could teach those in the developing world, transcultural health emphasises what all countries and communities can learn from each other (Patel 2014).

Transcultural mental health came to prominence in 1956, marking the beginning of a new field of psychiatry (Bains 2005). The existing climate was one in which clinicians saw many war veterans with combat-related symptoms such as post-traumatic stress disorder, or a hyper-vigilant disposition. Their patients were often prisoners of war who had undergone torture and were now struggling to settle back into civilian life. When the war ended, the experiences of these pioneering psychiatrists led them to believe that much of the ill health they encountered related to wider social environments, which might yield to
concerted multidisciplinary action (Mead 1959). There was dawning a new global approach to the world’s mental health issues, and psychiatrists were leading among scientists in occupying the key influential positions.

Central to a transcultural mental health perspective, in relation to clients from CALD backgrounds, is collectivity. Many CALD people come from collectivist cultures, meaning they do not order their lives independently of the family or community around them. The societal expectation is that each individual is part of a unit, with collective responsibility. People from collectivist cultures place an emphasis on the betterment of the clan, family, tribe or village from which they have come. In general, members of collectivist cultures tend to be interdependent, as their identity is infused within the collective and they may have self-concepts that are defined in terms of relationships and social obligations (Wu & Keysar 2007). An example of this would be to call older females “mamma”, or to refer to others in their village or community as “cousin”.

Western measurements of mental health may be incongruent with those expressed by people from CALD backgrounds. In transcultural mental health, cultural explanations or the client’s explanatory model of illness (Kleinman 1977) must be taken into account. The explanatory model is important, given that there are many idioms of distress through which illness symptoms or the need for social support are communicated (e.g., nerves, possessing spirits, somatic complaints, inexplicable misfortune; American Psychiatric Association 1994). Western medicine’s emphasis on the biomedical model of mental health may be very limiting when trying to address the cultural expressions of distress within the context of CALD populations’ varied life and social experiences (Selvamanickam, Gorman & Zgryza 2001).

**Treatment models in indigenous communities.** Australian Aboriginal people who come in contact with mental health services are more likely to receive services which are reactive in nature, such as very basic counselling, advocacy, support or diversionary activities (Atkinson & Bridge 1999; Memmott et al. 2001; Westerman 2002). Research studies involving Aboriginal groups in Australia
and internationally continue to illustrate the negative mental health impacts associated with colonisation (Australian Institute of Health and Welfare 2003).

From an indigenous and holistic perspective, the current dominant biomedical model of health and illness may have a limited view of people and wellbeing, as it fails to consider ideas such as mind, body, spirit and land as essential to wholeness and health (Mark & Lyons 2010). Australian Aboriginals’ concept of health is holistic. Land is central to wellbeing and self-determination, and culturally valid understandings of these issues must shape the provision of Aboriginal services. Ill health is attributed to a loss of connection with ancestral beings who have left their spirits on the land to oversee life. Philosophers like Jung, along with a number of Jung’s contemporaries (such as Petchkovsky) studied and worked with Aboriginal elders (Ngankari) and medicine men. Through observation, they gained insight into the community’s healing connection to the land (Petchkovsky, San Roque & Beskow 2003).

Mental health concerns of Indigenous Australians constitute a major health problems in Australian society, yet there is a paucity of empirical research that specifically addresses the mental health needs of Indigenous people (Collinson & Copolov 2004). At present, the main measures of Indigenous mental health disorders are derived from data on hospitalisation and mortality due to serious mental disorder (Australian Institute of Health and Welfare 2004; DeLeo & Travis 2004). Data from such registers and service collections are not necessarily an accurate indicator of the mental health status of Indigenous people, due to difficulties with identification, attribution, categorisation, and interpretation (Hunter 2002). Nevertheless, the data shows Indigenous people to have a high risk of increased deaths from suicide, a high utilisation rate for mental health services, and a high rate of hospital separations for mental disorders, including a concomitant incidence of alcohol and drug diagnoses (Ende et al. 2005; Roxbee & Wallace 2003).

The same relationship with – and dependence on – the land can be observed in the indigenous communities of South Africa, wherein according to traditional
African cosmology, ancestors and departed spirits are afforded considerable influence in regulating the lives of the living (De Villiers 1984; Schweitzer et al. 2006). Similarly, they are therefore also inherently related to illness and misfortune. Indigenous healers from these communities are consulted in times of illness and may include diviners (Amaggira), herbalists (Amaxwhele) and faith healers (Ensink & Robertson 1996).

Similarly, indigenous communities of North America strongly value concepts of space (i.e., where entities are situated in connection to one another) and place (i.e., the relationships between things; Gone 2008). For the First Peoples of Canada and New Zealand, health is seen as holistic, rather than something that can be isolated from place and the overall universe (Rochford 2004). Healing for CALD and indigenous peoples stems from a person’s relationship with the land and the rest of the community. Financial cost may therefore not be obviously associated with such notions as pain and suffering.

In Māori culture, it is considered common for people to experience occasional auditory or visual hallucinations that feature deceased relatives (Durie 2001; Mark & Lyons 2010; Moon 2003). Māori traditional healers have expertise in this area and draw on their spiritual perceptions to provide guidance and healing as needed. Māori spiritual healers may view ill health as resulting from factors such as “emotional blockages”, unresolved ancestral grievances, curses originating somewhere in the genealogy of the presenting person, and imbalances between the physical and spiritual dimensions (Mark & Lyons 2010).

There is an increased number of Māori people seeking alternative solutions to their health needs (Whangapirita 2002). The use of Ronga Māori is not just an alternative health practice, but also a traditional one, making it far more significant than one that simply meets health needs. A qualitative study involving Māori people from New Zealand found that, regardless of urban or rural status, individuals had limited financial resources and access to mainstream medical facilities (Whangapirita 2002). They also reported relying
on alternative medical interventions as a first, complementary response to illness or injury (Whangapirita 2002).

Cultural concepts, values and beliefs influence health-seeking pathways, and traditional healers play an important role in the management of disease in many cultures. For example, culture-bound syndromes such as Amafufunyana and Ukuthwasa are found in the indigenous Xhosa population of South Africa (Buhrmann 1982; 1984). Here, Western medicine is either not available, viewed with scepticism or used in parallel with traditional treatment methods (Mbanga, Niehaus & Mzamo 2002). Much spiritual or religious thinking reflects a mix of animistic, pantheist, and theistic beliefs. High gods are thought to be present amongst the most primitive of societies, and animistic spirits, totems and other forms of deities are not uncommon in the spiritual or religious lives of higher civilisations (Kliewer & Saultz 2006).

There is a ritual within the Māori community, wherein an infant's placenta is taken at birth and planted in or around the place where the infant was born. The Māori word for land is “whenua”, which means placenta. Culturally, Māori people see all life as being born from the womb of Papatuanuku, under the sea. The lands that appear above water are placentas from her womb. They float, forming islands. It is believed that when a person transitions from this life, they return to the land or placenta from which they came. This practice reinforces the relationship between the newborn child and the land of its birth (Te Akukaramu Charles Royal 2012).

The indigenous communities of America, Australia, South Africa and New Zealand align with a holistic view of life. Durie (2011) states that many indigenous peoples, however, reach conclusions by thinking outwards rather than inwards, so that understanding comes more from observations about the nature of wider relationships than from an analysis of internal structures. This, in fact, is consistent with Western thought. A characteristic of all indigenous peoples is a close and enduring relationship with lands and territories. The Māori worldview endorses an ecological approach to health that accords with indigenous philosophies that incorporate a spiritual dimension (tahawairu). It
recognises the importance of culture to identity, as well as the significance of long-standing connections between people, ancestors, and the natural environment (Durie 2011).

There are very few accounts how indigenous traditional healers work in family therapy (Hajal 1987) or mental health settings (Bush & NiaNia 2012). Yet, indigenous practitioners from different parts of the world often focus on family relationships in their therapeutic practice. Māori communities, as well as other indigenous communities, have long called for traditional healing processes to be used alongside mainstream psychiatric methods of treatment and assessment (Durie 2011). This includes the employment of traditional healers alongside child mental health workers and family therapists who work within indigenous communities. Research is also needed to evaluate the effectiveness of such collaboration, in terms of health outcomes for service users and their families (NiaNia, Bush & Epston 2013). It is expected that close and sincere collaboration between indigenous traditional healers and health practitioners will offer a distressed family healing possibilities that may not be available to them in a conventional child mental health or family therapeutic setting (NiaNia, Bush & Epston 2013). In designing a framework for collaboration between traditional and conventional healers, it is important to consider that many traditional healers practise in private. As described by Cawte (1996), healers in Arnhem Land do not run a clinic, but instead practise their ceremonies anonymously by beaches and billabongs.

The effect of cultural values on perceptions of wellbeing and health outcomes in general is huge, within and across cultures, in multicultural settings, and in institutions established to advance health (The Lancet Commissions 2014). In particular, these values pertain significantly to spirituality, religion and traditional healing.

Spirituality, religion and traditional healing are important factors in human life that help to define one’s relationships with a supernatural force (Corrigan et al. 2003). Engagement in these culturally specific practices may be especially
essential to the wellbeing of refugees and CALD individuals who resettle in Western countries (Guerin, Porembski & Guerin 2006). Traditional healing is often related to religious and spiritual ideations for many CALD individuals, as in times of strife or illness, they may seek divine intervention. The religious leaders or healers within such communities therefore hold a powerful position.

There are many studies that have explored the role of traditional healing practices in mental healthcare. Guerin and colleagues (2006) investigated the mental health outcomes of Somali women, who arrived as refugees in 1992 to an isolated section of New Zealand. Given their refugee status, they were at risk of depression, anxiety and post-traumatic stress. Although there were no specialist mental health services available for refugees, the Somali women retained their cultural identity and contributed to their resilience and wellbeing by engaging in traditional wedding parties and preparations. By gathering regularly together, the women lessened their loneliness and isolation, and were able to commiserate about the struggles associated with their relocation. They were also able to sing and dance, which gave them physical activity and emotional outlets. They prayed and studied the Qur’an, which helped them understand and accept the ways in which war tests the human condition. These women reported improvements in their mental health symptoms, and they did not experience language barriers, problems with travel, or expenses related to seeing someone or for child-minding.

Ovuga and colleagues (1999) posited that traditional and spiritual healers are sought out by a significant portion of CALD people with medical needs. In a Nigerian study, traditional healers, along with general practitioners, were the first to be contacted (Gureje et al. 1995). Within some CALD communities, mental illnesses may be attributed to evil spirits, witchcraft or curses, and it may only be the minority that attribute mental illness to physiological abnormalcies, like high fevers (Ovuga, Boardman & Oluka 1999).

Spirituality, religion and traditional healing practices are internalised and utilised in relationship-type contexts. These relationships are all universal experiences,
and there are many different ways to experience, conceptualise and articulate them. Canda (2006) comments, “of course our biological aspect can go awry or can abuse our physical selves. This can also happen with spirituality and religion. A major theme of spirituality and religion is to connect and to transcend limitations; people can express spirituality in positive and very damaging ways, augmenting and violating individual and collective boundaries” (p 30).

From a cultural and linguistic perspective, spirituality is discussed as a cultural form of expressing distress, through nerves, spells and somatisation. The literature refers also to more pronounced symptoms such as those in culture- or country-bound syndromes, (e.g., “Zar”, “the Evil Eye”, “Brain Fag”, and “Koro”). These thought disorders have a psychosis element to their presentation, but may also be associated with a spiritual or cosmic cause, depending on the diagnostician’s cultural background (American Psychiatric Association 1994). In some cultures, people are thought to be more spiritual if they can communicate with the dead, or see visions or demonic forces. However, in the West, this would be considered a hallucination, and the sufferer considered seriously mentally unwell.

A comprehensive literature review by Balacchino and Drapers (2001) examined the use of spiritual and religious coping strategies in response to life-threatening illnesses. The authors concluded that whilst the onset of illness can make individuals feel out of control when it comes to navigating their lives, spiritual coping strategies can increase their sense of control and self-empowerment, thereby facilitating their adjustment to stress associated with the illness.

In a similar review, Beuscher and Beck (2008) examined the role of spirituality in coping with the early stage of Alzheimer’s disease. The outcomes indicated that people with early-stage Alzheimer’s frequently use prayer and attendance at places of worship as spiritual coping mechanisms. For these people, spirituality plays an important role in improving quality of life and finding meaning while living with Alzheimer’s.
According to Hackney and Sanders (2003) religiosity has a salutary relationship with psychological adjustment, if variations in the types of religiosity are not taken into account. This conclusion was based on a pattern of results, in which institutional religiosity had the weakest correlations with psychological adjustment (and in some cases had negative correlations), while personal religious devotion produced the strongest correlations.

Koenig (2001) in a review of prior studies, found a negative association between religiosity and health, suggesting that religiosity can in fact worsen the effects of certain life stressors. Thus, while religiosity may help individuals cope with problems that result from sources outside of the individual (such as poor health or financial problems) it can, in some instances, worsen their ability to cope with family stressors which may be attributed to personal or spiritual shortcomings.

Shaw and colleagues (2005), in another comprehensive review of the literature, explored the relationship between religion and post-traumatic growth. The authors concluded that in this context, religious beliefs and behaviours may actually help people to recover psychologically from trauma, and may improve their personal growth following a traumatic event. While religious participation appeared to be beneficial, intrinsic aspects of religiosity and spirituality were more closely associated with post-traumatic growth, as these provide one with a sense of meaning and purpose. The social support which accompanies religious groups can also facilitate recovery.

Thuné-Boyle and colleagues (2006) systematically reviewed the potential benefits and harmful effects of religious and spiritual coping, with people diagnosed with cancer. Seven of the 17 studies included for review found that religious coping was significantly associated with improved adjustment to illness. It was felt that religious coping in this instance helped to maintain self-esteem, and provide a sense of meaning, purpose, hope and emotional comfort. This was similarly observed in a literature review of epidemiology and survey research, which focused on the relationship between religiosity and end-of-life mental health outcomes (van Ness & Larson 2002). Here, religious and
spiritual resources were found to help individuals cope with pain during illness, and improve life satisfaction and emotional wellbeing during terminal illness.

Townsend and colleagues (2002) conducted a systematic review to examine the impact of religion on health outcomes, the main mental health outcome of which was depression. The findings in relation to depression came from three randomised trials, which indicated that Islam-based psychotherapy speeded recovery from depression in Muslims. The authors also concluded that religious activity (including attending worship services) was associated with remission of and protection against depression.

A number of studies have explored spirituality and religion in the context of suicide risk. Cotton and colleagues (2006) reviewed studies related to proximal domains of religion and spirituality (such as religious coping and decision making) and their impact on adolescent health. Two of the studies reviewed found a lower suicide risk was associated with personal religious commitment, and religious influence on decision-making, respectively. A more extensive systematic review by Koenig and colleagues (2001) included 68 studies, the majority (83.8%) of which found higher religiosity was associated with a more negative attitude towards suicide and fewer incidences of suicide. In general, both ecological and individual data tend to show the level of religious involvement is inversely related to that area’s suicide rate (Moreira-Almeida, Neto & Koenig 2006).

Rew and Wong (2006) reviewed the literature on religiosity, spirituality and adolescent health. The authors did not draw any conclusions relating to suicide specifically, but found more broadly that 84% of the 43 studies reviewed indicated a positive relationship between religiosity and the health attitudes and behaviours of adolescents. Similarly, Wong and colleagues (2006) found that more religious adolescents had higher levels of self-esteem, although they did not specify how many studies in their review provided evidence to support this link.
DeHaven and colleagues (2004) reviewed the impact of faith-based health programs on various aspects of health, including general mental health and mental illness. Of the two studies for which statistics were reported, both found a significant relationship between faith-based health programs and decreased mental illness symptoms.

A large amount of published literature spanning the past 50 years suggests that many people in developing countries seek out traditional healers for mental health complaints, sometimes in addition to using conventional psychiatric services (Alem et al. 1999; Familiar et al. 2013; Galabuzi et al. 2010; Girma & Tesfaye 2011; Kapur 1979; Khan et al. 2010; Kurihara et al. 2006; Latypov 2010; Makanjuola, Adelekan & Morakinyo 2000; Mbwayo et al. 2013; Razali 2000; Salan & Maretzki 1983; Varghese, Gopal & Thomas 2011; Wig et al. 1980). Remarkably though, the link between religion and health is observed beyond just the psychological domain. Aukst-Margetic and Margetic (2005) concluded, based on a review of the literature, that religious commitment may increase longevity. Data from most of the studies reviewed showed that measures of public religious involvement, such as religious attendance, may be more strongly related to health outcomes than private religiousness. The authors claimed that the relationship between religion and reduced mortality is not conclusive, largely due to the possible confound that healthy people may be more likely than unhealthy people to be involved in public religious activities. They concluded further research is needed to understand why some measures of religiousness are more strongly related to longevity than others.

**Traditional Healers.** Traditional healers form a major part of the global mental health workforce worldwide (Nortje et al. 2016). Despite this, little systematic examination has been done in regard to their effectiveness in treating mental illness or alleviating psychological distress.

A large amount of published literature spanning the past 50 years suggests that many people in developing countries seek out traditional healers for mental
health complaints, sometimes in addition to using conventional psychiatric services (Nortje et al. 2016).

According to Saeed and colleagues (2000), traditional healers manifest a holistic approach that brings together physical, psychological, social and spiritual methods, as well as the charisma of the healer and the confidence they inspire in the local community. The healer may also be adept in using suggestion and altered states of consciousness to mobilise the healing process. The involvement of family and other community members in the healing process is important, as is the ceremonial format of healing sessions and the use of clear instructions to engineer change in the client’s social environment.

Traditional healers may be particularly important to people from CALD backgrounds. Because they are well-respected members of society and come from the client’s own background, many current and historical factors pertinent to the client’s history will require little explanation. It is the principal investigator’s opinion that traditional healing is a long-term cultural strength that has become a protective factor for people of CALD backgrounds. Traditional healers may provide clients with a better understanding of the cause of an illness, whereas practitioners of Western medicine may be useful in ameliorating symptoms. As Suaalii-Sauni and colleagues (2009, p 24) state, “the traditional healing model is perhaps the only model of those raised by participants that might well be perceived as a ‘service delivery’ model”. Similarly, faith healers are more adept at using certain unique treatment strategies than a medical doctor, and can, for example, use powerful methods of suggestion via group support. Families and communities may also be more involved in a client’s treatment (Saeed et al. 2000).

A shaman is a type of traditional healer who learns culturally prescribed ways of communicating with spiritual forces, in order to heal. In many cultures, a person becomes a shaman through a process of initiation in which the initiate is symbolically wounded, dismembered, sickened or killed by envisioned spirits, so that he or she can be reconstructed beyond the ordinary limits of social
conventions as a “wounded healer” (Halifax 1982). Thus, the shaman is able to use the learning from his or her own experiences of crisis and resolution as a pattern for helping others (Canda & Furman 2010).

Canda and Furman (2010) use the example of purification rituals as highly sacred and shared spiritual practices among First Nations peoples of North America (Lyon 1996; Schiff & Pelech 2007). These are used to help people clarify and purify themselves, often in preparation for some ceremony, to gain a greater insight into one’s life purpose and mission, or to gain wisdom and strength to deal with crises.

There is growing body of evidence supporting the use of traditional healing methods among ethnic minority psychiatric patients, but as of 2000, its use remains limited to the United Kingdom (Dein & Sembhi 2001). Dein and Sembhi (2001) used both qualitative and quantitative methodologies to examine traditional healing among 25 South Asian psychiatric patients in the London Borough. They found that 28% had resorted to a traditional healer during their psychiatric treatment. Although the case study was small, the outcomes suggest that South Asian psychiatric clients in Britain do resort to traditional forms of healing in collaboration with Western treatment modalities. Moreover, South Asian patients may use multiple treatments concurrently, even while not always understanding how the treatments work. Traditional healing, once it comes in contact with a Western framework, can therefore become altered.

Traditional healers have sometimes charged clients for their services and in some cases have demanded a very large amount of money (Rashid, Copello & Birchwood 2012). According to Rashid, Copello and Birchwood (2012), not only are such healers financially motivated, but they are also sometimes seen as vindictive, in terms of the means used to acquire their income. Some other healers believe that such behaviour is synonymous with criminal activity, which reflects the extent to which they have distanced themselves socially from the community.
Concerned community members have verbalised how traditional healers in their communities were charging for services, whereas back in the homeland, such services would be dispensed for free. The same participants expressed concern about the increasing incidence of traditional healers seeking financial compensation, positing that this may, over time, make ongoing treatments improbable.

For some, such behaviour adds to the mystique of traditional healing, making it a concept that is controversial at best, in what it brings to the healthcare table. Traditional healing has not typically been endorsed by first world countries, given the emphasis that is placed on evidence to legitimise the efficacy of practices. Historically and even presently, missionaries have played a large part in redirecting developing communities’ cultural traditions and changing these individuals’ worldviews, by introducing their own ideas in the name of religion.

### 3.3 CLINICAL RESPONSE: TRANSCULTURAL MENTAL HEALTH TREATMENT

#### 3.3.1 Australian Mental Health Services

Health services in Australia of course need to respond to the needs of its transcultural community. Figure 3.1 (below) presents demographic information from the 2011 Australian census, specifically with regard to the proportion of the population using Medicare Benefits Scheme (MBS) subsidised mental health-related services.
As evidenced in the above graph, the main age groups using these services are in the 24 to 64 year age range. Compared with Australian-born individuals, those born overseas who speak English at home use fewer mental health services, while this figure is even lower for those who speak a language other than English at home. This disparity between immigrant populations is likely due to acculturation effects – that is, non-English speakers are less acculturated within Australia. The disparity between Australian-born individuals and immigrants more broadly may again speak to acculturation effects, and may also indicate that those born overseas have been exposed to other modes of treatment in their country of origin and find them preferable.

Immigration continues to be the main source of population growth in Australia, and individual health service district demographics will change over time in response to immigration policies, settlement and resettlement trends and global events. Minas (1990) cites a number of issues related to CALD individuals accessing mental health services. Firstly, those with non-English-speaking
backgrounds have reduced access to mental health services compared to the Australian-born (Pirkis et al. 2001), although this does not necessarily reflect a reduced prevalence of mental illness (McDonald & Steel 1997). Indeed, 25% of suicides in Australia have been found to comprise the immigrant population, and 60% of these were from a non-English-speaking background (Minas 1990; Multicultural Mental Health Australia 2008). In addition, CALD patients are over-represented in involuntary admissions, acute inpatient units and diagnoses of psychosis (Stolk, Minas & Klimidis 2008).

Stolk, Minas and Klimidis (2008) conducted research to examine mental health service delivery for CALD clients in Victoria. The CALD communities in the study had lower rates of access to public care, were more prone to acute inpatient settings admissions, and had longer lengths of stay in inpatient settings, compared with their non-CALD counterparts. The authors also found that CALD people were more likely to be given involuntary treatment orders and diagnoses of schizophrenia and psychosis. Women from CALD backgrounds were more likely to have self-medicated during pregnancy, perhaps due to the unavailability of information about such risks. Because of a lack of cultural competency on the part of practitioners, the study also indicated that CALD clients were prone to being over-diagnosed or -pathologised.

Minas (1990) also made the point that in many cultures, there is a strong stigma attached to having a mental disorder (Tseng, Matthews & Elwyn 2004). Since stigma is a socially constructed phenomenon, it is inextricable from cultural frameworks and therefore must be addressed as such (Multicultural Mental Health Australia 2008). This is important to consider when evaluating how mental health services can best cater to CALD clients’ needs.

In 2001, the prevalence of mental health or behavioural issues among those born in Australia (9.8%) was similar to that among people born overseas (9.8%) (Multicultural Health Qld 2003). Over a quarter of a million first generation adult Australians from a CALD background were reported to have some onset of mental health symptomatology within a 12-month period of arrival in Australia.
These difficulties are influenced by social and cultural experiences in the country of origin. Refugees and asylum seekers in particular, have experienced trauma that may affect their mental health (e.g., post-traumatic stress disorder; Multicultural Mental Health Australia 2008). Post-immigration experiences may also play a role, especially given the strong relationship between racial discrimination (which may occur in a new country) and poor mental health – especially depression (Minas 1990; VicHealth 2007).

Within Australia, Victoria, New South Wales (NSW) and Western Australia, transcultural mental health services have been designed, each with its own tailor-made model to address the needs of constituents. The Transcultural Mental Health Centre in NSW adopted a clinical approach, using a large assortment of bicultural mental health clinicians to assess clientele. The Victorian Transcultural Psychiatry Unit is connected to the University of Melbourne and offers research into the area of transcultural mental health as its core contribution, as well as cultural consultation and referral linkages. Western Australia provides psychiatric support to the transcultural community as its main mental health service delivery.

The Australian Capital Territory, South Australia and Tasmania do not have any transcultural mental health services or networks, although they are in the process of discussions with peak bodies. These states do, however, have a few services and ad-hoc funding for specialist services. They have migrant resource centres to provide information and capacity-building to interested parties.

Queensland. Queensland is a highly diverse state. Nearly one in five Queenslanders are born overseas, of whom 44% are from non-English-speaking countries (Queensland Transcultural Mental Health Centre 2005). Immigration is a key source of population growth and Queensland is ranked second among all Australian states and territories, in terms of the total number and percentage of people born overseas from a non-English-speaking country (Multicultural Affairs Qld 2009). However, there are significant fluctuations
regarding net overseas migration\(^1\) over time, mainly due to shifting immigration policy and economic changes.

In 2004, 23% of the Australian population was born overseas and 14% were born in countries where English was not the first language (ABS 2004). The most rapidly growing CALD population groups were those born in China, India and Iraq. The top ten countries of origin for Queensland immigrants between 1991 and 2001 were South Africa, the Philippines, Taiwan, Japan, China, United States of America, Hong Kong, Fiji, Vietnam and India. In 2003 and 2004, most settler arrivals to Queensland came from New Zealand, United Kingdom, South Africa, the Philippines and Sudan.

The Department of Immigration and Multicultural and Indigenous Affairs (DIMIA 2007) reported that in the past 50 years, more than 620,000 refugees and displaced persons have been resettled in Australia. Data from the ABS also confirm that Brisbane and Toowoomba regions have a combined total of 93% of refugee and humanitarian entrants arriving in Queensland, with 13,500 entrants annually reaching Australia. Queensland continues to settle around 10% of the approximately 13,000 refugee and humanitarian annual Australian arrivals annually, of whom most are from Middle Eastern and African countries (ABS 2004).

Given that Queensland has such a diverse population, it is inevitable that the CALD community will make up a significant proportion of the one in five people expected to experience a mental illness in any year (Queensland Transcultural Mental Health Centre 2006). Indeed, in a review by the Queensland Transcultural Mental Health Centre (2005) it was conservatively estimated that well over a quarter of a million Queenslanders from immigrant backgrounds are affected by mental illness. Moreover, religion and belief may be central to a

\(^1\) The Office for Economic and Statistical Research defines net overseas migration as the estimated difference between the number of permanent and long-term arrivals in Australia and the number of people departing Australia on a permanent or long-term basis. This measure is derived primarily from information collected from passengers arriving in, and departing from, Australia.
Another key issue to emerge from the Queensland Transcultural Mental Health Centre’s (2005) review was that people from a CALD background were under-represented in health service utilisation in every district mental health service in Queensland. This finding therefore substantiates the aforementioned research findings from Stolk, Minas and Klimidis (2008) in which CALD individuals had lower rates of access to public care. There was also an evident under-utilisation of interpreters in Queensland public mental health services, with interpreter requirement indicated for 5% of patients born in non-English-speaking countries.

Indigenous health is another area of mental healthcare that requires special attention. Both indigenous and transcultural mental healthcare frameworks value a relationship with the land, spiritual issues and past historical events. Transcultural mental health requires community involvement, including settlement information, understanding of community needs and resources, and explanatory models of care as part of one’s treatment. After twenty years in operation, representatives from the fields of indigenous and transcultural mental health in Queensland are advocating for an integration of both models, in order to build on the strengths of each.

Suicide rates among CALD people are higher than those in the general Australian-born population. Indeed, the rate of suicide in 2016 for CALD people aged 65 and over was 65% and 177% higher, for males and females respectively, compared to Australian-born people in the same age group. The report of the Queensland Mental Health Sentinel Events Review Committee (Queensland Health 2016) investigated 45 deaths involving people with a serious mental illness that occurred during a 28 month period from 1st January 2013 to 30th April 2015. The review found that Indigenous Australians together with people born overseas from non-English-speaking countries made up 20% of all cases reviewed. Furthermore, of the homicides examined during this
period, 42% of offenders were either Indigenous Australians or born overseas from non-English-speaking countries.

The 2016 report by Queensland Health also referenced an earlier report which reviewed fatal mental health sentinel events (Queensland Health 2005) based on data from the period 2002-2003. Of those who were “homicide offenders”, or “people shot by police” during this period, 13% were Indigenous people (compared to 4% in the Queensland population) and 27% were CALD people who spoke a language other than English at home (compared to 7% in the Queensland population) bringing the combined total to 40% for these two groups. The proportion of people from indigenous and CALD background was therefore strikingly higher than that of the Queensland population in the group of homicide offenders and people shot by police. The 2005 report concludes that in several of these cases, the cultural beliefs about mental illness and the failure of mainstream mental health services to draw out details about the nature and severity of the mental health state involved, were crucial in affecting the treatment provided (Queensland Health 2005). The report also notes that Queensland mental health services have at their disposal staff and resources that can be drawn on to assist with treatment for Indigenous and CALD people; however, there was little evidence that these resources had been accessed in these cases.

Indigenous health workers are located in all health services districts within Queensland Health. There is a state-wide Queensland Transcultural Mental Health Service that provides a range of services including access to interpreters, training and cross cultural clinical consultation assessment services. The service had access to over 200 bicultural workers who cover 250 language groups. More effective use of this specialist service may well improve the situation.

Cultural consultation services utilising bilingual mental health consultants are increasingly advocated in the international literature as the preferred model to supplement existing mental health services. Not only is this cost-effective, with
the average bilingual mental health consultant costing 50-75% less than an interpreter, but it also provides a more appropriate response by focusing on the cultural issues in mental health. The Transcultural Clinical Consultation Service responds to requests for assistance from people from approximately 250 different languages and 150 cultural backgrounds per year, and 94% of those who have used the service indicated that the service met their needs and expectations.

One example where the Queensland mainstream healthcare system integrated CALD needs into its services was the EFFORT Refugee Women’s Exercise Program (Mills et al. 2005), which was a collaborative project between a number of non-government organisations and Queensland Health. The aim of the project was to increase physical activity for improved physical and mental health among women of refugee backgrounds. In a similar project, the X-Men Project (2010) was a collaborative project between non-government organisations and Queensland Health, the goal of which was to facilitate wellness within the male refugee population by allowing safe, CALD-inclusive gatherings. The emphasis for this program was on sport, although the ultimate focus was on increasing socialising to reduce isolation and depressive symptoms, and providing better access to nutritional education and physical exercise. Both the EFFORT and X-Men programs aimed to increase mental wellbeing by engaging subjects in natural activities available to them within their own network of resources.

### 3.3.2 Practitioner Clinical Response

There is still some way to go in the discussion about mental health treatment outcomes for transcultural communities (Tham, Klimidis & Minas 1991). Until recently, psychiatric nurses tended only to refer patients to avenues of primary healthcare, especially General Practitioners who speak the same language and are from the same cultural background (Queensland Transcultural Mental Health Centre 2006). This is significant, given that this group sees a majority of CALD clients, and such referral patterns represent an underlying awareness (or
lack thereof) of cultural factors related to help-seeking behaviour of people from CALD backgrounds.

Increasingly, there is a clinical role for cultural consultation services which employ bicultural practitioners to assist with bicultural/bilingual support. Bicultural services are proving to be successful, in light of a shortage of qualified professionals who are able to communicate with clients in their first language (Mitchell, Malak & Small 1998). More research is needed in the area of bicultural and bilingual brokers, to determine the full range of activities being conducted by this group when they engage with clients. This is especially true when the bicultural broker does not have a background in mental health and does not have a professional framework to draw upon (Kirmayer et al. 2003).

The CALD client in need of mental healthcare must negotiate not only the challenges of resettlement (which is an ongoing process), but also attitudes toward the mentally ill and mental health systems with which they are not acquainted. Similarly, most mental health professionals do not have knowledge of the CALD client’s language, culture, or attitudes about mental illness (Ekblad, Kohn & Jansson 1998); this should always be the starting point for most clinicians. An open discussion about the client and his or her culture during treatment conveys how important every aspect of the client is to the clinician, and allows for exploration of any cultural transference or cultural countertransference issues (Westermeyer 1993). It grants the client a way of healing within the context of the therapeutic conversation itself. It immediately places the client and clinician in closer contact, lessening the power distance between the two.

Traditional healing is a part of this dialogue, as it is introduced by a CALD community when they immigrate to a new country. Clients who believe in traditional healing practices should have a forum to discuss how issues that brought them to their current treatment would be addressed within their communities. Before any treatment interventions are carried out, a complete socio-cultural history may be taken to include this important information.
Explanatory models – as they pertain to an overarching theory – operate on the premise that everyone has their own way of describing and attributing causation to feelings of illness. A significant difference between the explanatory models of a therapist and patient can lead to tension in their professional relationship. Minas and colleagues (2013) state that mental health service providers often have very different understandings of mental illness from consumers who are from CALD backgrounds. Culturally responsive workers must therefore attempt to understand the illness experience of such consumers, in order that they can determine shared priorities and implement effective intervention. Thus, explanatory models can influence the behaviour of not only the CALD client, but also the treating practitioner (Kleinman 1978). It should be the client’s explanatory model that drives the encounter.

More broadly, clinicians need to become more comfortable with being educated by the client regarding their explanatory model of healing. This will cost the professional an expert or authority role, thus enabling the client to be co-investigator or co-clinician in their own treatment. The clinician also becomes a student in learning about unfamiliar explanations for wellness and treatment regimes.

More research is required to understand the complexities of traditions, faith beliefs and practices, and to document attempts at collaboration (Ae-Ngibise et al. 2010; Ekblad, Kohn & Jansson 1998; Westermeyer 1993). It is likely that better outcomes will result from more co-operation between different paradigms and treatment modalities, and more consideration given to one’s own and other practices. To maintain an indifferent and suspicious distance from unfamiliar cultural practices related to health is counter-productive.

3.4 CONCLUSION

There is a robust body of evidence, generated by diverse disciplinary approaches, which testifies to the burden of a range of emotional and wellbeing
disorders in countries and communities around the world. Transcultural mental health is an area of study, research, and clinical practice that places a priority on improving mental health and achieving equity in health for all people worldwide. The research presented in this chapter highlighted the perspective that CALD clients want a diversity of opinion and practice in their mental healthcare, with a focus on spirituality, religion and traditional healing practices being considered. Internationally, many countries adopt a multicultural or ethnospecific way of providing treatment. Here in Queensland, Australia, the preferred way of treating consumers is client-centred, and based on explanatory methods, and this facilitates care by allowing the consumer to drive the treatment service.

Chapter 4 introduces the theoretical framework for this thesis, and it offers a deeper exploration of why the consumer’s perspective on their treatment and healing is so important to their personal and community wellbeing.
Chapter 4. THEORETICAL FRAMEWORK

4.1 INTRODUCTION

The present study was conducted within an explanatory model framework. Such a framework takes the epistemological position that all human inquiry is a reflective process that humans engage in to better understand their experiences, make sense of significant events within their lives, and reconstruct their worldview. The use of an explanatory model framework is further supported by the philosophical theories of Carl Jung, relating to the “collective unconscious” that is commonly experienced by all human beings. This concept has a significant bearing on how we understand behaviour and perceptions, and it also influences and is influenced by Kleinman’s descriptions of explanatory models, which are so important in the field of transcultural mental healthcare.

Carl Jung was one of the first to write about spirituality and its universality to all mankind, while also taking culture into account. He drew on these elements to explain how people see the world differently and therefore have distinct explanatory models of mental illness. Jung’s work greatly advanced our understanding of the role of culture, spirituality and what he termed “the collective unconscious” in shaping people’s worldviews.

Jungian psychology is very important to transcultural psychiatry, as many of Jung’s studies were the result of cultural encounters with people from widely different cultures around the world. Indeed, it aligns with the principal investigator’s own experience as a mental health clinician working in transcultural mental health in two different countries. Spirituality, religion and traditional healing were observed to be very important to CALD clients. It could be postulated that to not include some consideration of spirituality, religion and traditional healing in the clinical encounter with a CALD client amounts to discrimination. There are many practitioners who feel that their own spirituality
and religion define their very being – that their spirituality and religion are everything to them. Hence, the Jungian explanatory model approach is, in the principal investigator’s view, the most appropriate framework to use for this research study, because it leads to a deeper and more complete understanding of the thesis topic. The philosophical concepts of the Jungian “collective unconscious” and Kleinman’s explanatory model approach are essential elements underpinning the development of effective strategies for transcultural mental healthcare, and provide a sound theoretical framework for this study.

4.2 EXPLANATORY MODELS

Explanatory models may be defined as a set of cultural schemas which explain the onset of emotional un-wellness, highlighting when the onset happened, why it happened, the perceived and natural effects of the illness, and what treatments are appropriate from a cultural point of view (Castillo 1997). Further to this, Castillo (1997) states that mental illness may be seen as a complex system of meaning, which warrants clinical treatment of the client’s subjective experience of their disorder.

Explanatory models explain something about how the individual or community see the world, and how they perceive illnesses and illness-related factors (e.g., symptoms, cures). Explanatory models allow one to understand that symptoms are a reflection of the person’s relationship to themselves, the illness and how they engage with the world around them to alleviate this distress (Jeans et al. 2017). If these curative factors are not immediately available within the consumer’s resources, there may be a deficit within the person’s milieu, which can, long term, lead to anxiety within the person and disconnect from their community and their environment.

Mental health practitioners and consumers often do not have either their cultural backgrounds or their explanatory models of illness in common (Kleinman 1980). The focus on identifying and understanding clients’ abnormalities draws attention away from the more human aspects of sound clinical practice, which
include consultation dynamics, effective history-taking, understanding, empathy, addressing transferential and counter-transferential issues, and building a therapeutic alliance (Kleinman 1980). Bazzano (2017) states that there is something existential which happens when the moment of meeting in therapy or any clinical encounter occurs. The clinical encounter exists in the first place to facilitate a process of individuation for the client; rather than simply bandaging an injury, the clinical encounter may serve as an invitation to both the client and practitioner to leave behind the self for the “no-self” (Bazzano 2017). Immigrants, such as refugees and asylum seekers, are routinely asked to integrate into the culture that (grudgingly) hosts them (Bazzano 2017). They are asked to shed their original identity in exchange for another. The implicit and explicit meta-messaging that this can give off is social conformity to the psychic form of the dominant group (Bazzano 2017). The shift in human discourse from individuation to integration is a setback, a catastrophic loss of those important narratives of agency, autonomy and emancipation that it has taken so long to establish (Bazzano 2017). The subtle seduction betrays an implied attitude of compliance to institutional power, which is the very consciousness that many immigrant refugees and asylum seekers are trying to escape.

This relationship between mental health and culture or religion is referred to in the written works of numerous contemporary health and human philosophers, including Carl Jung, Emile Durkheim, Ed Canda, Harry Minas, Lawrence Kirmayer, Mason Durie, and Arthur Kleinman. The above writers and thinkers have brought to the public's attention the key themes as contextualised by explanatory models and the deeper concepts associated with explanatory models, such as the collective unconscious. These authors caution us to protect the narrative of “belonging”, which is so easily under threat and suspended when one leaves his or her abode to resettle elsewhere. Such sacrifices have implications for one's sense of social identity and group or tribal identity (Bazzano 2017). Clarke (2018) states that this immigrant journey is akin to a spiritual or religious journey, in that the immigrant is asked – or even forced – to detach from their old self and transition to a new way of becoming. The end result may be that the immigrant feels “naked” (Clarke 2018). This undressing
or peeling back of oneself to embrace a new and authentic other reality can be like asking someone to sacrifice their values, assumptions and beliefs. Immigration, like spirituality and religion, can promote an “un-concealment” – a sense of revelation about the position one is asked to take up in a new environment (Jeans et al. 2017). The person is asked to engage with themselves, others and their world, in a profoundly different way.

Many philosophers have based their explanatory theoretical frameworks on an integration of the arts, humanities and social sciences (Neuman 1999). Explanatory models owe their roots to the philosophies of existentialism, epidemiology and anthropology, combined with international perspectives on cultural therapies, tribal issues, and curative factors. Explanatory models do not rely on science to confirm their existence (Neuman 1999). In fact, they have been applied to many disciplines as largely a reaction to the perceived certainty of the scientific realms that claim validity for all groups (Derrida 1976). Explanatory models are concerned with “deconstruction” of the myth that all health should be conceived and carried out in a certain way.

Explanatory models are applied to a studied text to expose the author’s frames of reference, assumptions and ideological foundations, with respect to how Western health is practised (Derrida 1976). Explanatory models therefore encourage us to question current health narratives and traditional concepts of organised health. The overarching goal is to make the social world relatable by revealing the structure of its hidden inner world (Neuman 1999). Thus, explanatory models, like transcultural mental healthcare, frame the world as conceived realities, based on individual experiences which are subject to constant change. From a Jungian perspective, the inner and deeper manifestations of health, and in this case mental health, are explored not so much from surface-level symptomatology but from the ancestral and generational factors that contribute to illness manifestation, for the individual, family, and cultural community at large.
Schizophrenia, for example, has long been defined as a genetically inherited mental illness, which typically afflicts young adults. However, the same definition is not endorsed by many philosophers and anthropologists. Sass (2004) suggests that patients with schizophrenia are vulnerable individuals who become disengaged from our cultural and global frameworks. The disorder is therefore symptomatic of a larger societal problem, rather than existing within the individual or their family. The core features of schizophrenia, if properly understood, show remarkable resemblances to some key aspects of modern society, which is in itself marked by a “wholesale reflexivity”, and associated forms of knee-jerk detachment from common-sense reality (Giddens 1991).

The same can be said of certain anxiety disorders. Once thought to be part of the individual’s genetic make-up, many health practitioners are beginning to re-think anxiety and to see it as an anxious attachment one has to their immediate and existential environment. By way of example, within the process of acculturation, stress gives rise to anxiety with recent studies in this field leading to better understanding of the processes involved – moving from the early concept of a unidimensional process to a more recent bidimensional concept of the processes involved (Berry 1980, Schwartz, Unger, Zamboanga & Szapocznik 2010). Others see anxiety in connection to the foods we eat and the toxicity of the environments we live in, which are full of pollutants our bodies are not able to eliminate. Lastly, the whole issue of substance abuse and drug dependency, when understood in depth, can be described as a person’s active engaging in the altering of their reality, versus being seen in a superficial manner as “getting high” or intoxicated.

Jungian theory places a strong emphasis on understanding the profound role of the unconscious, and its relationship with lived experience. In the years from 1913 to 1917 when Jung was largely ostracised by the psychoanalytic community, he then embarked upon a deep, extensive, and potentially dangerous process of self-analysis that he called a "confrontation with the unconscious" (Jung 1961). Jung emerged from this personal journey with the structures in place for his theories on archetypes, complexes, the collective
unconscious, and the individuation process. These theories, along with his understanding of the symbolism found in dreams and in other creative processes, formed the basis of his clinical approach, which he called analytical psychology. Throughout his long life, Jung continued to develop and broaden his theoretical framework, drawing both on his clinical practice and his study of such wide-ranging subjects as alchemy, Eastern religions, astrology, mythology, and fairy tales.

Jungian thinking can be applied to religious and spiritual symbols and meaning, as they provide not merely consolation but orientation (Sass 2004). They do this by “inducing in the worshipper a certain distinctive set of dispositions (tendencies, capacities, propensities, skills, habits, liabilities, processes) which lend a chronic character to the flow of his activity and the quality of his experience” (Geertz 1973).

Tsivinsky (2016), when discussing a clinical case, stresses the importance of Jung’s concepts as follows:

[Jungian analysis] provides us with valuable tools for discovering the underlying causes of our patients’ symptoms. Exploring the patients’ inner world in Jungian analysis implies working with his symbolic material at individual, cultural and universal levels (p 450).

Heyer (2016) also speaks to the importance of the unconscious by observing that “humans are shaped by culture and ideology to ‘perform’ race, along with being filled with intergenerational traumas that leave a collective imprint on the unconscious” (p 434). Heyer (2016) goes on to state: “those of us who do clinical work live on a terrible cusp of reinforcing what is perceived as healthy, while tugging the covers of concealment off people’s uniqueness so they can be more fully themselves” (p 441).

Abramovitch and Kirmayer (2003) report that Jungian psychology holds a special place within cultural psychiatry, as many of Jung’s theories were formed
on the basis of cultural encounters with people from Africa, India and parts of the Americas. Since cultural psychiatry has its origins in the idioms of distress for people involved with dislocation, Jung’s philosophy tied this dislocation into a wider context. He hypothesised that the physical disruption and transitions experienced by these groups resulted in detachment from history, ancestry, tribe and invariably one’s self or the “collective unconscious”. Jung focused on the religious experiences of his clients, seeing this as an innate pull towards self-actualisation and completeness.

Relevant to the issue of culturally sensitive mental healthcare is the “collective unconscious”, which was described by Jung as the inherited material passed down from one generation to another to be buried in the deepest chambers of our beings (Koss-Chioino 2003). It is the vessel that holds our things unknowingly (Koss-Chioino 2003). Jung once commented, “I define the unconscious as the totality of all psychic phenomena that lack the quality of consciousness” (Jung 1960).

The collective unconscious may also potentially have distorted properties that appear as symptoms of mental or spiritual illness (e.g., schizophrenia; Stephenson 2003). Psychotherapy based on Jungian psychology therefore focuses on analysing the links between a person’s individual consciousness and the deeper underlying psychological structures. Such structures are imprints that humans accumulate over time. They are repositories of all human memory, and are acted out via archetypes (Moacanin 1987).

Archetypes are examples of accumulated information stored in the collective unconscious, which influence our experiences (Moacanin 1987). An archetype is a blueprint of visual and psychic material that is integrated into our life-sustaining worldviews over time (Ross 2001). There are a few archetypes (based on Jung’s work) which are referred to in the current study. The “Mother” archetype, for example, exists in all societies. Mothering has been around as long as humankind, and maternal attributes are therefore universal across cultures. Historical examples include linguistic references to Mother Earth,
4.2.1 Culture and the Explanatory Model

It is stated in the “Framework for Mental Health in Multicultural Australia” that all individuals have ways of understanding and describing their mental health and wellbeing, known as their “explanatory model” (Minas et al. 2013). This encompasses beliefs about the cause, onset, nature and duration of the illness, as well as beliefs about treatment, healing and recovery. An individual’s explanatory model influences their degree of distress and their behaviour in response to distress. It also influences their pattern of seeking help and their engagement and compliance with recommended treatments.

Cultural systems of knowledge, belief and practice provide explanatory models that include ideas about an illness’ causality, course, appropriate treatment and likely outcomes. These explanations may be drawn from particular ideas about what makes up the person and the world, and theories about the processes of illness and healing (Hassan et al. 2015). Explanatory models can have important implications for clients’ coping, help-seeking behaviour, treatment expectations, worries about long-term consequences of illness and stigmatisation (Hassan et al. 2015). Gender, age and marital status are all factors that guide our internal explanatory models and these can influence how, when and why we seek help.

The first studies on explanatory models of illness focus on physical disorders such as leprosy (Weiss et al. 1992) and unexplained chronic fatigue (Lee et al. 2000). More recently, there has been a growing number of studies of explanatory models of schizophrenia (McCabe & Priebe 2004) and depression (Raguram et al. 1996; Yeung et al. 2004).
In terms of how traditional and contemporary explanatory models of illness have been integrated in recent years, Hassan and colleagues (2015) state that within the Syrian community, awareness of mental healthcare has increased, especially in urban settings. Clients in mental health settings were seen to express their distress in bodily terms without invoking supernatural or spiritual explanations. Most Syrians attributed their suffering and mental health issues to loss, violence and daily social and economic pressures (Hassan et al. 2015). However, more context-specific religious or cultural explanations of distress and illness were also common.

Researchers are increasingly questioning the medicalisation of social behaviour and problems, with many calling for such issues to be viewed within a broader context – that is, as social determinants of health, instead of pathologies. It is argued that this pathologising may be a way for dominant groups to maintain control over minority groups by racially profiling them in the medical profession. For example, in a study by Karasz (2005), members of ethnic minority groups were less likely than the dominant white European middle class group to seek professional treatment for depression and other mental health problems. One explanation given was that the former group conceptualises depressive symptoms as social problems or emotional reactions to situations, while the latter is more apt to view depression as a disease requiring professional attention.

Karasz (2005) conducted another study comparing conceptual models of depressive symptoms in two diverse cultural groups in New York City. Thirty-six South Asian (SA) immigrants and 37 European American (EA) individuals were presented with a vignette, written in largely social and moral terms. Suggestions for management and health-seeking in the SA group emphasised self-management and lay referral strategies. The EA group, by contrast, proposed alternative, sometimes contradictory, explanatory models for the depressive symptoms. Their model emphasised biological explanations, ranging from “hormonal imbalance” to “neurological problems”, while the SA group’s model resembled the “situational stress” or “life problem” model.
Other social scientists have also argued that current standards and methods used to measure wellbeing have been generated by Western nations. Negy comments:

_Some social scientists interested in multicultural issues assert that, because much of psychology’s notions about human behaviour were developed based on the behaviour of White Americans and Europeans, psychology’s principles are irrelevant and not applicable to non-White minorities_ (2000, p 447).

There exist culture-specific disorders that exemplify Negy’s (2000) point. West African university students have been described as susceptible to _brain fag_ (“fag” being old slang for fatigue). First described in 1958, a young Nigerian male, tired from too much study, was seen to suddenly lose the ability to read. Sufferers have complained of a burning scalp, blurred vision and even sexual dysfunction. The Canadian psychiatrist who coined the diagnosis speculated that the syndrome was an unconscious rejection of the education system (Nasser 2012).

A Nigerian British psychiatrist, Oyedoji Ayonrinde, has similarly found an American wave of _brain fag_ (Nasser 2012). The phrase was such a household term between 1890 and 1920 that the Chicago Tribune called it “the disease of the century”. Quack cures proliferated around the country: thermal baths, a _brain fag_ pillow, even an electric hairbrush invented at Stanford University (Nasser 2012). “So what’s really going on here?” Nasser (2012) asks. “Is brain fag a universal phenomenon draped in West African garb, or is it a unique condition that only appears when the right cultural circumstances align?” More broadly, it is worth questioning whether diagnoses – especially those pertaining to mental health – are based on true objectivity, or whether they are instead the product of a dominant culture’s point of view.
4.2.2 Culturally Responsive Mental Healthcare

An individual’s explanatory model in a healthcare setting refers to their expression of the details of their illness, which encompasses their beliefs about the cause, onset, nature, and duration of the illness, and curative factors relating to healing, treatment and recovery (MHIMA 2014). Explanatory models will influence the patient’s degree of distress and their behaviour when displaying the distress. It will also influence their pattern of help-seeking for services, and their engagement and compliance with recommended treatments.

As stated earlier, practitioners in healthcare services (and mental health services in particular) will often have different understandings and explanations of mental illness, when compared with CALD clients. Culturally responsive mental health practitioners must seek to understand the illness experience of CALD consumers in order to gain their trust, respect and to enter into a helping and healing relationship (MHIMA 2014). Such is the basis for determining shared priorities, and planning and implementing sensitive and effective treatment interventions and recovery (MHIMA 2014). In delivering culturally responsive care to CALD consumers, practitioners must have a strong sense of how cultural factors interact with a client’s mental health presentation and be prepared to explore this during the assessment and diagnostic phase of care.

Mental health practitioners are trained in using the definitions and formulations outlined in DSM-5 and or the ICD-10. There is evidence, however, that these classifications are based on ethnocentric assumptions, and are not universal to the groups to which they are assigned. The DSM-5 includes broad cultural formulations which can reduce the probability of assessment and diagnostic errors; however, the cultural formulation should serve as a guide for exploring cultural issues as part of the assessment. The cultural formulation can also be used to communicate assessment findings, to reflect on building the therapeutic relationship and to inform treatment planning. The cultural formulation exists to help identify the patient’s cultural factors, such as their religious beliefs, language, identity issues, and coping mechanisms, as well as the historical and present-day challenges faced by the patient’s CALD community. An additional
factor to consider when attempting to achieve culturally responsive care with CALD clients is the potential for language barriers; clinicians should attempt to identify a client’s preferred language, in order to access appropriate interpretation services (Hwang & Myers 2013). In some cultures, interviewing family members may be an appropriate step, but this is not always the case and should be confirmed with the client in a culturally safe manner (Hwang & Myers 2013).

It may be necessary for a healthcare practitioner to explore a range of intervention approaches, in order to pay attention to the client’s expectations around treatment goals. Treatment goals involve a process of negotiation, where differences are acknowledged and commonalities are identified. Some of the negotiation may relate to the use of natural therapies, if this is a part of client’s traditional healing preferences. Receptivity by the mental health professional, regarding their views on what constitutes suitable intervention or treatment, can be based on number of factors including their own cultural and healing experiences (Jacobson & Farah 2012).

The practitioner’s experience of healing pertains to, as Kleinman (1988a) states, the story of what it is like to be a healer, and is as much a part of the healing as the healing itself. According to Kleinman (1988a), many doctors are turning to fiction and essay as a means of conveying the clinician’s inner world, versus turning to each other or the self. The way contemporary practice is being carried out, we know more about the patient than the healer (Kleinman 1988a). This is because we have not found a way to capture the essence of the practitioner experience. Kleinman (1988a) states that if we can get it right from the healer’s point of view, we can thus achieve a higher degree of discrimination in our understanding of what makes care for the chronically ill something which is, at times, such a heartening success and, at others, such a dispiriting failure.

There is no better medical training one can receive than the experience of being “wounded and healed”. To know firsthand about suffering and to be exposed to healing processes in our own life journey – it is this internalised experience that
we call upon when we encounter pain and to facilitate a patient’s healing during the therapeutic process. Kleinman (1988a) provides examples of how good healers who have firsthand experience of illness in their own lives use this knowledge to understand others and create a caring, empathetic atmosphere. It is the lived experience in the collective unconscious that allows this to surface to the conscious level. Kleinman (1988a) states that the personality of the practitioner is just as important as that of the patient in healthcare. Caring for people with chronic suffering is different to what is projected in our society’s dominant technological and economic images of healthcare. Where care is the subject, the relationship between patient and practitioner moves – as it should – to centre stage (Kleinman 1988a).

As people from minority backgrounds come into contact with the host healthcare system, there can be tension due to the client’s inability to convey his or her symptoms. The professional too may not have sufficient knowledge to extrapolate the client’s meaning. Toews (2001) recognised that many CALD communities operate from a perspective that there is always health within each individual and community, although this may not always be recognised by others. Anthony (1993) states that recovery from mental illness is the ultimate vision that should guide how the mental health system functions. He coined the term “personal recovery” to refer to the focus in mainstream mental health services on the deeply personal process of changing one’s attitudes, values, feelings, goals, skills and roles.

Recovery transcends our notion of health, instead involving the development of new meaning and purpose in life, as one moves beyond the catastrophic effects of mental illness. Because of its universality, the challenges imposed by recovery may be said to be built into our DNA (Anthony 1993). Successful recovery is contingent on the consumer, as treating professionals hold only some of the power. The task of the professional is therefore to facilitate recovery; the task of consumers is to recover (Anthony 1993). It is generally acknowledged that most mental health services are currently organised to meet the goal of clinical recovery (Anthony 1993), making the transformation towards
a more personal recovery difficult. Central to mental health recovery is the individual engaging in non-mental health activities, such as sports, clubs, adult education and church (Anthony 1993). There are many pathways to recovery, including choosing not to be involved in the mental health system altogether.

It is the tension between personal and clinical service delivery that is pertinent to the wellbeing of CALD people. Reconciliation in this regard may be facilitated if collaboration between traditional healing mechanisms and Western practices are made possible. It is not that uncommon for people to utilise a variety of different health beliefs in collaboration with Western medicine when searching for optimal treatment, so practitioners should not always consider therapeutic discourse relating to traditional healing as unprofessional. In fact, giving no consideration to the CALD client’s explanatory model can be seen as asking them to abandon everything they know and replace it with the unfamiliar. Such an interaction limits opportunities for engaging in a respectful exchange of ideas, and can instead demoralise people, albeit with good intentions. Clinicians and clients should ideally be interdependently connected, forming a partnership in which both parties consider the other’s experience and worldviews when bringing about individual wellbeing. This is true for clinical practice, as many clinicians and cross-cultural theorists now explicitly acknowledge explanatory models and adapt them into their practice and their own healthcare.

Ethnic groups may differ in their explanatory models, and therefore in their beliefs about illness aetiology, beliefs about suitable treatments, ways of expressing distress (e.g., somatic versus cognitive loading of symptoms), and labels for symptoms (Hwang & Myers 2013). Additionally, an individual’s explanatory model of illness is an example of an “internal” factor that can either facilitate or impede help-seeking and influence treatment outcomes (Kleinman 1987). Such culturally engendered discrepancies may therefore also lead to differences in the likelihood of an individual seeking help from alternative or non-professional services, partially due to the fact that beliefs about the causes of one’s condition may shape one’s attitudes toward, and confidence in, mental health professionals (Kirmayer, Young & Robbins 1994; Kleinman 1980). More
research is required in order to understand explanatory models of illness for ethnic minorities.

The question when treating clients from another culture is: how can we develop and apply mutually respectful and wellness-oriented explanatory models for psychiatric illness? (Kendler 2008). Because causal factors have an impact on psychiatric illness both at the micro and macro levels, within and outside of the individual, and involving processes best understood from biological, psychological, and socio-cultural perspectives, traditional models of science that strive for single, broadly applicable explanatory laws are ill-suited to the transcultural field. Such models are based on the incorrect assumption that psychiatric illnesses can be understood from a single perspective (Kendler 2008). A fundamental implication of this scientific model is that all real causes can be understood from one perspective and one set of laws; indeed, this proves counterproductive in the field of mental health (Kendler 2008). It may instead be worth advocating for a more applicable and appropriate scientific model, which takes into account the other layers of human experience, and which allows for an understanding of the patient’s symptoms in light of their worldview and context (Broome 2002).

Culturally and linguistically diverse people tend to use more narrative-based explanatory models when perceiving and describing mental health and illness. This unveiling of an individual’s explanatory model creates an “appreciation of meaning” that is often bound within a relationship: it belongs to the sick person and their spouse, family, child, friend, caregiver and community (Kleinman 1988b). For this reason, it is usually as much hedged with ambiguities as are those relationships themselves; thus powerful emotions attach to these meanings as do powerful interests (Kleinman 1988b). Symptoms have meanings and embody powerful “truths” which are standardised in a local cultural group as natural or divergent among different social groups. These meanings are taken, internalised and projected onto the world, then called natural or normal as they are found there. Kleinman (1988b) extrapolates that illness soaks up personal and social significance from the world of the sick,
transferring vital information from the person or community’s life experience to the illness experience. This transformation from the personal and social meaning of illness is what gives the explanatory model of illness its potency.

4.3 CONCLUSION

The explanatory model approach is used as the theoretical framework for the research presented in this thesis, and it is supported by the culturally sensitive philosophical work of Carl Jung – in particular, Jung’s theory of the “collective unconscious”. This concept defines universal influences on human perceptions and behaviour. In the current study, the notion of the collective unconscious complements Kleinman’s description of “explanatory models”. Combined, these theories provide the best framework within which to elicit and interpret the study findings, as the responses from study participants were complex, and required consideration of both CALD and non-CALD perspectives on mental healthcare. Based on the literature reported on this chapter, recovery-oriented services for CALD clients should focus on needs pertaining to community and family, and they must account for complex societal issues such as trauma, language, and alternative ways of defining and treating illnesses. In describing the collective unconscious, Jungian theory recognises the innate and intuitive nature of behavioural response patterns that are present in every individual and culture. In the same way, spirituality, religion and traditional healing are common to all societies and cultures, and they may thus be considered essential in understanding pain, suffering and recovery.
Chapter 5. METHODOLOGY

5.1 INTRODUCTION

While general healthcare remains a high priority for all developing nations, the role of transcultural mental health in particular is becoming critical, due to huge numbers of minority immigrant groups (e.g., refugees, asylum seekers, humanitarian minors, women at risk, international students, international employees, etc.) being dislocated from their home countries. How to work with this population and deliver to them an acceptable standard of viable treatment options when they enter into the Western mental health system is becoming more of a challenge. This chapter outlines the methodological approach adopted in the present study. The study was conducted with input from a range of mental health practitioners from diverse cultural, professional and para-professional backgrounds in accordance with ethical approvals that were obtained beforehand (Appendix 1).

In the present study, perspectives obtained from different levels of mental health practitioners, who had either CALD or non-CALD backgrounds, were analysed, with specific respect to how they interfaced with spirituality, religion and traditional healing as protective factors. The participants’ responses also related to how these same factors could be applied to the context of the broader mainstream healthcare system. A qualitative approach was used and interpreted within a post-modern framework. Qualitative designs provided flexibility for exploring how individuals make sense of events and phenomena, the meanings these events or phenomena have, and how people have lived through and coped with them (Willing 2009). Thus, qualitative research is data-driven, whereby findings are developed through a bottom-up process. This is in contrast with a top-down approach, such as in quantitative studies, whereby analyses are driven by pre-supposed hypotheses drawn largely from pre-existing data or theory. Qualitative designs are applied within more naturally occurring settings and are useful for generating greater insight and depth into a single topic (Robson 2008; Willing 2009). A process flow chart depicting the
methodological steps for obtaining qualitative data in the current study is shown in Appendix 2.

5.2 AIMS OF THE RESEARCH

The aim of this study was to investigate how spirituality, religion and traditional healing were perceived by CALD and non-CALD mental health practitioners who worked frequently with CALD individuals. Responses were collected from a diverse cultural group of mental health practitioners. A qualitative methodology was adopted for collecting data. The following specific research questions were addressed:

1. Do mainstream and CALD mental health practitioners (who work with CALD clients) perceive spirituality, religion and traditional healing as important protective factors, within a professional context?

2. How do mainstream and CALD mental health practitioners perceive spirituality, religion and traditional healing as being embedded in a clinical setting?

3. How do CALD-specific factors (e.g., acculturation, immigration) influence practitioners’ perception of spirituality, religion and traditional healing?

4. Do CALD practitioners engage in similar spiritual, religious and traditional healing practices in their home country as in Australia?

5. Do mainstream and CALD mental health practitioners (who work with CALD clients) access spirituality, religion and traditional healing for their own personal mental health and wellbeing?
5.3 RESEARCH DESIGN

Various groups of mental health practitioners, all of whom work with people from CALD backgrounds, were involved in the current study. Community Elders were included to ensure safety and confidentiality, as some CALD individuals may have felt exploited in the past, so by having a valued and trusted member of their community interact with them about engaging in the study, it was hoped that negative reactions could be avoided. Steps for conducting the research are depicted in the Methodology Flow Chart (Appendix 2), while the forms containing the questions put to focus groups discussions are included in Appendix 3.

5.3.1 Setting

The principal investigator’s experience in the multicultural field in Brisbane allowed for key networks to be established. Such connections provided pragmatic avenues to access and work with Community Elders, mental health practitioners and bicultural workers from various CALD backgrounds. Concurrently, support was accessed from professionals in these fields through established networks, if difficult or frustrating situations arose during fieldwork.

5.3.2 Sampling Technique

The Australian city of Brisbane has over 169 different ethnic communities, speaking more than 200 languages in total. A diverse array of religious organisations and sub-groupings also exist. Purposive sampling is often used in qualitative studies as a means of selecting participants. Purposive samples are reasonably small and consist of individual participants who share similar experiences or perspectives to each other (Smith, Flowers & Larkin 2009). In this study, participants were selected from CALD communities within Brisbane, Australia.

Group heterogeneity was specifically targeted, as participant constituents were from a mix of cultural and ethnic backgrounds. Most identified as CALD, with some of this number having been influenced directly or indirectly by immigration issues. All participants shared a knowledge and understanding of working with
clients from CALD backgrounds. The participating mental health practitioners for this research study were engaged on the basis of long-term relationships with eight well-known organisations that work primarily with CALD clients.

5.3.3 Informal Reference Group

Working collaboratively with community groups over the years led to the establishment of a culturally safe “informal reference group”. The informal reference group’s core function was to assist in the development of research questions and to ensure that focus groups were conducted in a culturally sensitive manner. As recommended in previous research, this group contributed to discussion of issues requiring deep examination, and also ensured that each stage of the research was conducted in an open, respectful manner, with consideration given to a diverse range of community members (Temple & Moran 2006; Tinkler 2004). Participants in the group provided advice about the construction of the research questions, in terms of how specific and sensitive the language was to CALD populations. Also the informal reference group were consulted on conduct of focus groups whereby anonymity and confidentiality were maintained in a culturally appropriate and sensitive way. This group suggested the use of pseudonyms which is consistent with what Crow and Wiles (2008) advocate.

The process for receiving feedback from the informal reference group began with the focus group and research questions being developed by the principal investigator, in consultation with Griffith University supervisors. The questions were then submitted to 25 colleagues (i.e., the constituents of the informal reference group) who all work in the mental health wellbeing area, in roles such as community leaders, spiritual leaders, religious leaders, traditional healers, non-government workers, government workers, community workers, settlement workers and bicultural workers (the latter group of whom contributed advice only, rather than being participants in the study). Feedback about the questions mainly related to the order of items, question phrasing, word choice, and use of certain language to gain full understanding of participants’ responses within focus group discussion.
The informal reference group suggested that questions be kept brief and concise due to language comprehension difficulties inherently elicited in many English words. It was also noted by these colleagues that many of the CALD communities may not have equivalent words, language or understanding of many mental health issues and that definitions of such issues may be called something different. Similarly, although all participants had a high level of English literacy, many CALD participants – and Community Elders in particular – interacted frequently with their community, oftentimes switching back and forth between their native language and English.

It was decided, after reviewing some of the input from consultation with these 25 colleagues, that the number of questions for Community Elders would be reduced. As well as addressing the above linguistic constraints, this step was put in place because the Community Elders were asked to respond, not based on their own personal views, but on the views of their community. The provision of fewer questions therefore allowed them more time to adequately reflect on the questions from a collective perspective. Indeed, many members belonging to the CALD groups of which Community Elders were leaders had been through traumatic experiences; this layer of complexity added further justification for the provision of fewer questions to this participant group.

The consultation process with the informal reference group, which involved the 25 colleagues from different professional backgrounds, ensured the focus group questions for study were appropriate. Furthermore, this process assisted with integrating the “CALD voice” into every aspect of this research project, as CALD communities were constantly engaged in making amendments to questions. Again and again, feedback was reviewed and amendments made, until it was deemed that all involved parties were satisfied with constructed questions. The cross-cultural diversity of community members provided the opportunity for greater representation and prevented a gatekeeper or sole voice contributing to the construction of the research methodology.
On the issue of de-identification, the informal reference group was consulted on the best way to conduct focus groups whereby anonymity and confidentiality were maintained in a culturally appropriate and sensitive manner. Each participant encouraged the use of pseudonyms, and it was decided that names that referenced plants, fruits, vegetables and animals would be ideal, as they are non-threatening, inoffensive, and easily incorporated into “ice breaker” introductions. Crow and Wiles (2008) suggest that a common method researchers use to preserve anonymity and confidentiality is by using pseudonyms for participants and locations. The principal investigator is aware that these types of pseudonyms are currently being used within the community wellbeing sector when CALD community groups gather for professional activity.

5.3.4 Advisory Group
A second group – hereafter referred to as the “advisory group” – consisted of three experienced bi-cultural mental health practitioners, who were consulted for questions or issues that arose during in-depth analyses of research data. Feedback from the advisory group served as an additional “lens” through which a better understanding of complex thematic material could be achieved.

Originally, five bicultural mental health clinicians were outreached, although only three were included in the final advisory group. This group was accessed to discuss any findings from the focus groups which required an additional level of examination than what was carried out within the main research team. The advisory group was distinct from the informal reference group of 25 colleagues who assisted with wording of the research questions submitted to focus groups; nor were they participants in the formal research study itself. The advisory group consisted of practitioners who were familiar and frequently worked with cross-cultural mental health. They were all from a CALD background. The group constituents each signed consent forms before participating.

Members of the advisory group were individually asked how they understood a particular statement put forward by one of the focus group members. The statement in question was read out aloud to them in a de-identified manner. The
The principal investigator received feedback from the informal reference group on how to carry out the focus groups in an ethically sensitive manner. These groups suggested using innocuous pseudonyms, such as names of plants, animals and colours. These were carefully chosen with consideration given to the cultural groups concerned: the intention was not to offend, but rather to empower, while at the same time “icebreaking”, and encouraging conversation. For example, the pseudonym “horse” may be associated with strength and might, while “cat” may be associated, just as positively, with cuteness and affection. Participants were observed to respond positively to their chosen pseudonym. The main purpose of using pseudonyms was so that all recorded data from discussion groups were de-identified. These pseudonyms were written on stickers and attached to participants’ clothing for the duration of focus group discussion.
Potential participants were not interviewed by the principal researcher in advance of focus group discussions. Participants were recruited by their discipline senior or community leader (see 5.5.1), and the principal researcher did not know who was going to attend any one focus group discussion. With further respect to anonymity, it may be noted that, although participants included their real name on consent forms, these forms were collected as a group at the end of each focus group, and so the principal researcher generally did not identify participants by their non-pseudonym names (unless, unintentionally, the participant was already known to the principal researcher).

All participants were handed an informed consent form and participant information sheet (Appendix 4) at the initial meeting. The form outlined the purpose of the research project and the nature of their involvement, so that each participant was able to make an informed decision as to whether they would participate or not. If anyone showed signs of reticence to read and sign a form, they were taken aside, and the details of research project (and the option to withdraw) were explained further. Reticence was also assumed to potentially reflect limited written comprehension of the language. It was ensured that participants received enough information verbally on the project and how their participation would contribute to the research. In one case, a Community Elder had to be respectfully excluded, as he could not understand the consent form. The principal researcher left the room while participants read the consent form and information sheet, in order to give them adequate time and space to reflect on the requirements of the study. Upon returning, the principal researcher addressed any questions the participants had.

Briefly, it may be observed that the research questions included in the participant information sheet are different to those listed in Section 5.2 of this chapter. Specifically, the core content of the questions is the same, but the language used to convey each question is altered between the thesis and information sheet versions. When developing the participant information sheet, consideration was given to the different levels of English literacy that participants were expected to have. The questions on the information sheet
were therefore worded in such a way that they were intended to be non-academic and accessible to all participants, whether from a CALD background or not. This was important because it enabled participants to be able to give informed consent to participate. To encourage their participation and to assist with travelling expenses, the Community Elders were financially compensated for their time. They were also told they could expect feedback on preliminary findings.

5.5 PARTICIPANTS

5.5.1 Recruitment
A total of 29 practitioners from community and Queensland Health services were recruited for the study. The practitioners were recruited through community organisations (see Appendix 5 for details) via the organisations’ managers and discipline seniors. Each of these managers and discipline seniors was first briefed by the principal investigator about the details of the research project, and were given a participant information sheet and recruitment form (see Appendix 4). These documents outlined the scope, nature and participant requirements for focus group discussions. Subsequently, the principal investigator organised a venue for each focus group and communicated this information to the managers and discipline seniors, who contacted practitioners they thought would be potential participants (from their own professional networks), informed them of the focus group details, and provided them with the recruitment form and participant information sheet. The principal investigator therefore had no prior knowledge of who would attend the session until the day and time of the session.

A total of five Community Elders from various communities in Brisbane were also recruited for this study. The Elders were from African, Australian, Sudanese, Eastern European and Samoan backgrounds. They were recruited via a well-known community leader representative, who interacts frequently with community leaders from other sectors within Brisbane. This representative was approached by the principal investigator with information about the study, in
order that they might assist with recruitment. The representative was then briefed about the research project in more detail, and provided with recruitment forms and participant information sheets to disseminate among other community leaders and groups. Following this recruitment process, the community leader representative and research team had no further contact with each other regarding the other aspects of the study.

**5.5.2 Participant Characteristics**

As stated, the study included groups of five Community Elders and 29 mental health practitioners from various areas of the community and government workforces. Details of the forms given to participants in the study are included in Appendix 4. The principal researcher (who conducted all focus groups) initially did not know the names of attendees. Once introductions were made, each participant was assigned a pseudonym and given a consent form, in accordance with the approved ethical standards.

After consent forms were returned, the names of participants were known only to the principal researcher. Participants were not told the names of other participants and they were advised not to tell other participants their name. The selection process for participant recruitment was impartial, in that the principal researcher did not know in advance who was going to attend the focus groups. That said, some participants may have been acquainted with each other or the principal researcher beforehand.

Thirty-four people participated in the study. The professional backgrounds and demographic information for participants are summarised in Figure 5.2 and Table 5.1, below (see Appendix 6 for full demographic details of focus group participants). Specific information about the characteristics of the different practitioner groups is provided in Section 5.5.4.
Figure 5.1. Professional backgrounds of study participants.

![Diagram showing professional backgrounds of study participants.]

Table 5.1. Demographic information of study participants.

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Religion</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Elders (n=5)</td>
<td>4 female</td>
<td>4 Christian</td>
<td>5 CALD</td>
</tr>
<tr>
<td></td>
<td>1 male</td>
<td>1 Buddhist</td>
<td></td>
</tr>
<tr>
<td>Community practitioners (n=10)</td>
<td>8 female</td>
<td>10 Muslim</td>
<td>8 CALD</td>
</tr>
<tr>
<td></td>
<td>2 male</td>
<td></td>
<td>2 Non-CALD</td>
</tr>
<tr>
<td>Community mental health practitioners (n=4)</td>
<td>4 female</td>
<td>3 Christian</td>
<td>4 CALD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Spiritual/non-religious</td>
<td></td>
</tr>
<tr>
<td>CALD Queensland Health mental health practitioners (n=7)</td>
<td>3 female</td>
<td>7 Christian</td>
<td>7 CALD</td>
</tr>
<tr>
<td></td>
<td>4 male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland Health mainstream mental health practitioners (n=8)</td>
<td>6 female</td>
<td>2 Christian</td>
<td>8 Non-CALD</td>
</tr>
<tr>
<td></td>
<td>2 male</td>
<td>6 Non-disclosed</td>
<td></td>
</tr>
</tbody>
</table>
The community mental health practitioner group comprised 1 social worker, 1 psychologist, 1 occupational therapist, and 1 traditional healer. The CALD Queensland Health practitioner group comprised 3 occupational therapists, 2 social workers, and 2 psychologists. The mainstream Queensland Health practitioner group comprised 4 social workers and 4 psychologists.

The Community Elder and community practitioner groups did not all have credentials which were formally recognised within Australia, although all were high-level professionals in their countries of origin. Their previous professional roles were in the areas of law, politics and public decision-making. Upon arriving in Australia, they retained the skills acquired from professional experiences abroad, and they engaged in new roles to lead and develop their cultural communities.

Of the 34 participants, 24 were CALD and 10 were non-CALD. As shown in Table 5.1, the gender breakdown of the 34 participants was 23 female and 11 male. The majority of participants were 31-50 years old. The breakdown in terms of religious affiliation across all focus groups is shown below in Figure 5.2.

**Figure 5.2. Religious affiliations of focus group participants.**
The religious make-up of participants across the nine focus groups is somewhat similar to those in the ABS figures from the 2011 census (Figure 5.3). According to these statistics, 61.1% of the Australian population was Christian, with the next largest groups being “No religion” at 22.3% and “Not stated” at 8.6%. Increasing migration from South East Asia, India and the Middle East in recent years has resulted in an increasing percentage of non-Christians in the general Australian population.

Figure 5.3. Religious affiliations in Australian population.

5.5.3 Rationale for Diversity of Practitioner Perspectives
The diversity of participants’ backgrounds contributed to the breadth and depth of research findings. Professionally, participants were un-credential community practitioners and Community Elders, or credentialed community and government mental health practitioners. Further diversity was achieved with inclusion of both CALD and non-CALD participants in focus groups.
Although there has been an improvement in the education of health professionals as to the cultural aspects of psychiatric assessment and treatment in recent years, mental health professionals are generally ill-prepared for working sensitively and effectively with clients who come from CALD backgrounds (Tham, Klimidis & Minas 1991). Though many practitioners come into contact with CALD clients, either via their work environment or through curiosity or genuine desire to want to work with all people, it may nonetheless be a struggle for clinicians to feel comfortable with knowing the best way to treat such clients. There are many factors to consider when working with people from CALD backgrounds, but one critical factor is understanding the client’s explanatory model for their illness, and to hold this dynamic in a “deterministic way” for their client and for themselves (Pease & Fook 1999). If the client can express their own explanatory model, they have an opportunity to be heard in the context of their own culture, which gives them a place at the table of service delivery and treatment possibilities.

An important dimension to the services offered by CALD practitioners who participated in this research study is that they have bicultural identity. The term “bicultural” suggests the attribute of having lived across two or more cultures – either through speaking other languages, immigration to one or multiple countries, or indirectly acquiring this bicultural knowledge from a family or community of immigrants (e.g., having first or second generation immigrant status).

Much of the focus group discussion, as well as the manner in which the discussion was held, was expected to be influenced by participants’ language and culture. With respect to language, it was expected that participants may sometimes answer questions indirectly, thus requiring some degree of interpretation as to the exact meaning. Such was hypothesised on the basis of either difficulties with English as a second language, or pragmatic discourse choices in the context of communicating with a person representing authority. The principal investigator and facilitator of discussion in the focus group had
many years of experience in transcultural mental healthcare, which equipped her well to discern participants’ indirect responses and linguistic nuances.

This consideration also relates to the importance of having CALD-focused researchers with experience and skills in empathising with participants’ background and drawing out their responses effectively in discussion groups. It is only within such a communicative context that the CALD community can be given a “voice”. Importantly, the current study required an understanding of both the “language” of CALD clients and communities and the “language” of the mental healthcare system.

5.5.4 Practitioner groups

Community Elders. The term “Community Elder” refers to someone in a respected position of authority or stature within a particular community. They are usually male, older in age, with credentials not acknowledged in Australia, and they belong to the community of which they are a leader. Community Elders are selected by the community based on certain attributes, such as cultural knowledge, wisdom more broadly, a desire to service others, and influence within their community. In terms of the topics for the current research project, they are also perceived as knowing about cultural curative methods and the status of their community’s health and wellbeing. The role of Elder can involve ceremonial investiture of some kind – they are expected to mentor, share their experiences and create a bond and oneness within their community, and at times they may act as the spiritual representative.

Community Elders are often the first point of contact for community members suffering emotional deregulatory issues. They may be seen as sympathetic to clients’ causes of distress and may also be able to offer helpful suggestions as to potential treatments and referrals. Many Community Elders, due to their age and experience, have been affected by trauma from war, cultural and national upheaval, or detention issues. They may have experienced similar things to their community members, and yet have survived such events with their dignity and honour intact; this contributes to the community’s faith in them as advisors.
**Community Practitioners.** Community practitioners were individuals who may or may not have had formal credentials that are acknowledged in Australia. Many of them worked as professionals in their country of origin, in the areas of social work, psychology, nursing, psychiatry, counselling and other helping professions. However, these individuals were not able to have their qualifications recognised in Australia due to linguistic constraints, educational system disparities, or time and financial costs.

Community practitioners in the current study engaged in a supportive community framework, thus allowing them to work with clients and access community networks. In their role, they may have operated community-specific programs or created programs based on individual, family or community needs. All lived and worked within their communities and were therefore aware of the stressors within those environments. Many had experienced refugee, migration and resettlement issues, as well as discrimination, language barriers, educational challenges, and work difficulties. As with the Community Elders, they may have experienced events similar to those experienced by other members of their community. While Community Elders are normally the first point of contact, community practitioners would be next in line for community consultation.

**Community Mental Health Practitioners.** Community mental health practitioners were those who went through educational institutions to obtain a degree, and who are regulated by professional and legal bodies (e.g., Australian Association of Social Work, Australian Psychological Association). These practitioners tended to practise from a cross-cultural perspective and may also have had other roles within their community, such as spiritual and religious leader, mediator or traditional healer. They typically lived and worked within their communities and they identified with the challenges experienced by CALD people. Community mental health practitioners were seen to operate from a social justice framework with an emphasis on fairness, right and wrong in their socio-cultural community treatment approach. According to the participants themselves, they could never see themselves working comfortably within a
government organisation, as bureaucracy creates additional work that takes away from client and community involvement.

CALD Queensland Health Mental Health Practitioners. Culturally and linguistically diverse Queensland Health mental health practitioners were accredited social workers, psychologists and occupational therapists, working for Queensland Health. Ethnically, they were second generation Australians from a CALD background, and therefore had to negotiate between this world and their professional world. They were affected by migration issues, either directly or inter-generationally, and this group had the youngest average age.

Being from a CALD background, they may instinctively treat CALD clients with a high level of sensitivity. However, they also have to work within a government system that is concerned about managing risk, which keeps clients at somewhat of a social distance. They also work within a system that is based on the Western paradigm of mental healthcare treatment.

Queensland Health Mainstream Mental Health Practitioners. Queensland Health mainstream mental health practitioners were all government employees, dealing with mental health issues and disorders that required specialist training. The group comprised social workers, psychologists and occupational therapists. Participants belonging to this group had the most professional experience. On average, they were in their early 40s, and they were all Anglo-Australian.

As these practitioners work for the government, their services come under the control of corporate governance procedures, arising from concerns about litigation bodies (e.g., Australian Association of Social Workers). Although these practitioners come imbued with all the empathetic attributes of the aforementioned practitioners, the nature of working within such a sector is that it is challenging to keep services “client-centred”. There is a significant amount of legal and professional pressure to adhere to risk management measures and standardised procedures for providing treatment.
5.6 DATA COLLECTION

Semi-structured focus groups were used to collect data for the research study. A focus group methodology was chosen as it allowed mental health issues – some of the topics in which may have been challenging or sensitive – to be examined from a range of perspectives. It also meant that participants could think about the rationale for using spirituality, religion and traditional healing as factors for consideration, and then engage in dialogue about the integration of these issues into mental healthcare more broadly. Use of focus groups provided opportunities for research to be conducted from both individual and collectivist perspectives.

The focus group is commonly used in the social sciences and marketing – group discussion produces data and insights that would less accessible without the interaction found in a group setting (Lindlof & Taylor 2002). The focus group approach allows the interviewer to gain feedback on people’s views on the topics under investigation in an efficient manner, to study people in a more natural conversational situation than in a 1 on 1 interview and to gain insight into group patterns of interaction (Marshall & Rossman 1999).

In particular, this technique is considered highly beneficial when working with CALD clients, because CALD people, due to their collectivist frameworks, may rarely distinguish between themselves and others. Given the collectivist nature of CALD communities, focus groups can be naturally engaging, and therefore effective in obtaining valuable data.

The focus groups were conducted in large meeting rooms, with rooms set up so that participants could be seated and easily see one another and the principal investigator. The principal investigator conducted each of the focus groups according to the following procedure: (1) Disseminate consent forms and information sheets to participants as they arrive, and allow time for participants to read and generate any questions; (2) Address any questions asked by the participants; (3) Begin discussion with introduction of the general research aims and topics for discussion; (4) Begin formal discussion procedure, using focus
group questions (in Appendix 3) as prompts; (5) Encourage question-asking between participants. A break for food and drinks was provided midway through the focus group. During the semi-structured focus group discussions, personal reflection and feedback regarding spirituality, religion and traditional healing (and their roles in mental healthcare for CALD individuals) were invited from practitioners and Community Elders.

People from CALD backgrounds may tend to resonate with informal group meetings, as they regularly congregate within such settings. Generally speaking, food, drink and personal communication may combine to create a “space” where meaningful interaction happens. Community Elders wanted to have both formal and informal elements (e.g., pre-discussion chat, music, food, drink, socialising, small chat, breaking for formal meal and discussion). It was postulated that CALD and non-CALD mental health practitioners would desire a gathering that was more formal (to show its importance and seriousness), but in the informal setting they appeared relaxed, particularly after they had had some time to become acclimatised.

5.7 DATA ANALYSIS

The process of analysis was based on the same process described by Smith, Flowers and Larkin (2009). In order to develop a close relationship with the data, the first phase of the analysis began with the principal investigator reading and re-reading an individual transcript a number of times, while also listening to the original recording. Initial thoughts and comments relating to aspects of a transcript were noted in the left-hand margin. The second phase of analysis involved noting emerging themes in the right-hand margin, and key words from the transcript were used to illustrate these. The third phase of the analysis involved producing a chronological list of all the emerging themes. Each individual theme was then physically laid out on a large surface and those that appeared related to one another were clustered together. An initial attempt was made to label these clusters in some way, and many of these clusters began to form super-ordinate themes. The clusters were then entered into a table and
through this process theme names were developed which more closely reflected the terms and language used by participants.

These phases of analysis were then repeated for each subsequent transcript and focus group. Simultaneously, any new themes emerging from a subsequent transcript were looked for in a previous transcript. Once all focus group transcripts were analysed, the tables or lists for each transcript were then compared with one another in order to explore overall themes, sub-themes, relationships and connections across the themes. This process led to the development of major themes and sub-themes, which characterised the key thematic content across all transcripts.

To be classified as a super-ordinate theme, the theme had to recur in some form throughout each of the topics discussed during each of the focus group discussions. A master list was developed, in which themes merged with one another to form superordinate themes. Theme names were developed through using words or interview extracts which appeared to most closely capture the essence of the theme.

As a means of quality and credibility checking, samples of the data analysis were discussed between all members of the research team throughout the analysis phase of the research. Such samples included the analysis table for each focus group and the master lists of major super-ordinate and sub-themes across all focus group transcripts. Where there appeared to be any instance of disparity, these were fully discussed and revisions made accordingly. In addition, throughout the data collection and analysis stages, interpretations and reflections were noted and discussed with all members of the supervisory team. All information discussed was de-identified.

The analysis of qualitative data focused on a comparison of responses by mental health practitioner groups, CALD versus non-CALD practitioners, community versus government practitioners, and individual versus community responses.
Thematic content analysis provided the framework for emerging themes. This allowed the principal investigator and five bicultural advisory group clinicians (i.e., the advisory group; see 5.4.4) to uncover richer meaning within the qualitative data, for an ultimately deeper exploration of the research findings. Open coding was used to discover, name and categorise phenomena, and assist in developing categories in terms of their properties and dimensions. The aim was to uncover as many potentially relevant categories as possible and to interpret the positive and negative reasoning behind the answers to questions. Inductive and deductive reasoning were applied when analysing outcomes, as all researchers involved made assertions, inferences and interpretations regarding the themes and question responses provided by participants in all phases of focus groups.

5.8 CONCLUSION

This chapter has outlined the methodological steps for the current study, all of which were decided between the principal investigator and the Griffith University supervisory team. The focus group findings themselves were also discussed between all members of the research team, and input was sought from an additional “advisory group”, composed of other mental health clinicians working with CALD clients. Focus group questions were generated on the basis of experience in the relevant field, and of feedback from an “informal reference group”, the constituents of which were professionals and para-professionals with a CALD background. The sensitive topics for discussion, as well as the inclusion of minority group participants, demanded a qualitative research design with a high level of methodological rigour. Adherence to these elements in the ways described above has resulted in findings obtained from a range of mental health practitioners that point the way to more effective mental healthcare within CALD communities.
Chapter 6. RESULTS

6.1 INTRODUCTION AND OVERVIEW

This chapter presents findings from a qualitative research study wherein nine semi-structured focus group discussions were undertaken. Focus group participants were all mental health practitioners, and included Community Elders, Queensland Health mainstream mental health practitioners, CALD Queensland Health mental health practitioners, and practitioners from the community. The different perspectives offered by these participants provided a rich and diverse set of responses relating to the importance of spirituality, religion and traditional healing in treating CALD clients’ mental health. It was acknowledged that these themes were important in transcultural mental healthcare, and ways to define, acknowledge and implement them were discussed and analysed.

The findings from this study emerged from responses to twelve questions asked of practitioners and eight questions asked of Community Elders. Responses were distilled into three salient themes – spirituality, religion and traditional healing. These three themes were discussed as effective protective factors in transcultural mental healthcare. Aside from defining the aforementioned themes and their emergent sub-themes, topics also related to continuity of practice and degree of utilisation of the themes in mental healthcare.

Results indicated that people from CALD backgrounds acknowledge spirituality, religion and traditional healing as important protective factors in their provision of mental healthcare services. A comparison of responses between focus group participants revealed similarities and differences in perspective, and provided a depth and consistency in how research questions were addressed.

As mentioned, spirituality was an important theme during focus group discussion, as was the emergent sub-theme of “Shared understanding and individuality”. All focus groups appeared comfortable talking about spirituality and showed a commonality of understanding. Religion was a more controversial
theme, from which the sub-themes “Emotional response”, “Community as collective”, “Religion and identity”, “Rules, structure, rituals and hierarchy”, “Negative aspects of religion”, “Acculturation”, and “Intergenerational complexities” emerged. The theme of traditional healing was associated with sub-themes, “Western paradigms”, “Economics”, “Treatments” and “CALD construct”.

6.2 RESULTS

The findings from this study will be addressed in terms of the themes that emerged from responses to the key questions of spirituality, religion and traditional healing. As most CALD people identified spirituality, religion and traditional healing as essential aspects of their lives, issues of continuity of practice are also addressed below. Results emerging from discussion of mental health issues are thereafter reported.

6.2.1 Definition of Spirituality

Spirituality was the first topic discussed, and it evolved as a main theme in all nine focus groups. Participants from each focus group were asked to define spirituality. There was an overwhelmingly high degree of uniformity in these definitions across all nine of the focus groups. Spirituality was understood as a personal and private connection with a higher power, or any cosmic attachment which gives meaning to life and supports a sense of being that ultimately transcends the physical world.

Spirituality was also described as manifesting a number of significant attributes, such as having universality, providing a sense of wellbeing, and giving meaning to life. It was referred to in terms of a connection to some higher power or spirit, or an interconnectedness of human consciousness. There was a consensus that spirituality provides humans with an important framework for understanding the world around them, as exemplified in the quote below:
Pecan: “To me, spirituality is aligning yourself with a power greater than yourself. I think spirituality is inherent in every person and it guides your life in your moral code of behaviour and your everyday way of being. It affects your integrity and hopefully it motivates you to want to be a better person to help others and to be as kind and as loving as possible” (Focus Group [FG] 9, p2).

There was slight variation in how Community Elders and CALD practitioners defined spirituality, as they saw spirituality as having an important connection to one’s country, and to the land, nature, animals and water therein. Most importantly, spirituality provides an important ancestral connection to the Elders and to those that have come before us, as indicated below.

Snow Pea: “Spirituality is something that is about your family and it’s about your ancestors, but it’s about your connection to your people and to the land, to the water; we have family fish that protect us and they work. Our ancestors come to talk to us because the spirits are still alive” (FG8, p2).

The overall tone in which spirituality was discussed within all the focus groups was easy, light, joyful and spontaneous. This topic promoted the fluid flow of ideas and conversation, with participants appearing eager to express themselves.

6.2.2 Spirituality Sub-themes
Two salient sub-themes emerged from the topic of spirituality: “Shared understanding” and “Individualism”. There was a shared understanding in how participants associated with this topic, although spirituality was also individualistic in how it was practised.
Spirituality: Sub-theme 1 – Shared Understanding. Participants from the community practitioner group talked about their shared understanding of spirituality from a conscious-raising perspective.

**Cucumber:** “For me [spirituality is] thoughts linked with consciousness. When you believe in something it can make you feel happy or not happy … All [are] linked to each other – your thoughts, your emotions, your consciousness” (FG1, p2).

The Community Elders, on the other hand, identified their shared understanding of spirituality as something connected to the spaces, places and people around them. They emphasised the importance of interconnected relationships between these elements which, over time, become sacred. The Community Elders believed definitively that there is a spirit world, and within the spirit world are sacred objects which should be revered, and which are a part of all humans, whether they actively acknowledge them as such or not. As one participant expressed,

**Fox:** “Spirituality is a broad word – a connection with the spirits” (FG2, p4).
Culturally and linguistically diverse Queensland Health mental health practitioners talked about a shared understanding of spirituality from a contemplative reflective position, with more of a self-focus.

Beans: “I think it’s about connection, whether it’s with other people or something greater like a higher power. I think it is an internal process and it’s something you really don’t think about” (FG3, p2).

The Queensland Health mainstream mental health practitioners talked about their shared understanding of spirituality from a “meaning” perspective, as if it adds purpose to one’s life. They identified what they call the “Big Ticket Items” in terms of where we all sit within the wider universe, and talked about the more macro-existential questions, such as, “Who am I?”, “Where do I belong?”, and “Why did this happen to me?”. These are the logical, rational and important dynamic questions we, as human beings, keep returning back to in our quest and search for meaning.

Lettuce: “It could be related to experience and practices that allow a person access to, or experience of, what they define as their spirituality. It’s answering a lot of life’s bigger questions” (FG5, p2).

Community mental health practitioners discussed commonalities around all human beings manifesting a similar connection to each other, suggesting we are inescapably bound. Spirituality was closely associated with identity and linked to belief, faith, and a deeply entrenched connection to the universe and world around us. They talked a lot about relationships, behaviours, and customs as being important features which contribute to becoming a more humanitarian and “better” person.

Spirituality: Sub-theme 2 – Individualism. Individualism was another sub-theme to emerge across all nine focus groups when defining spirituality. There was a consensus that spirituality is perceived uniquely between individuals. Within
each focus group, Individualism itself was discussed from slightly different vantage points. For example, Queensland Health mainstream mental health practitioners talked about how it encompassed personal, political and social ideologies that place the person and their belief structure at the centre of the particular encounter. Individualism operates from the premise that what the individual wants and needs is the most desirable outcome.

**Shallot:** “I guess when I’m thinking about spirituality, [it] is an aspect of ourselves or an aspect of our existence that is somehow unknown or difficult to pin down and understand fully in the ways we might understand abstract things like thoughts and feelings. Spirituality is even more difficult to understand [than] those things ... [It’s] very much an individual thing” (FG8, p2).

In contrast, CALD Queensland Health mental health practitioners talked about individualism from more of a personal-relational perspective, which focused more on humans’ connectedness with broader social constructs, such as church, community, land, and ecology. For them, relationships with ancestral beliefs and family also informed stories about spirit origins. The CALD Queensland Health mental health practitioners discussed intergenerational issues in more depth than any other group, and talked from lived experience in a very humble and reflective tone. Although some of the group were Australian-born, they all nevertheless had a CALD background, and thus appeared to identify strongly with this topic. In particular, they spoke more quietly and gently than the non-CALD mainstream mental health practitioners.

Community mental health practitioners discussed individualism more from a humanistic, philosophical and ethical position. Spirituality was described as innate – as part and parcel of this ongoing human endeavour to “be a better person”. By this way of thinking, the individual has a certain responsibility towards others, so a great emphasis is placed on empathy towards others and the universe. These practitioners communicated their feelings in an elegant, creative and emotionally intelligent manner. Spirituality was seen to be
relationship-bound, owning its connection to wider and greater elements within the universal sphere.

Community Elders described individualism from a strong cultural and relational perspective. Relationships of all kinds make up the spiritual interconnectedness to the past and present, thus forming the basis of these individual yet collective historical connections. Community Elders saw individualism as contextualised by the greater society, with each of us having an inherent responsibility to both partake in and sustain the collective. The group recognised the importance of gratitude and duty towards mankind, and sacrifice of one for the betterment of all. They appeared to have a sense of social justice to hold these as universal truths; indeed, this aligns well with a community development model of thinking. It was as if they saw their personage in relation to spirituality as having an unspoken social contract – to look outside of themselves and contribute only to the extent that it benefits the “collective good”. Beyond that though, they also believed that our own identities may be informed by a better understanding of the role we individually play in human evolution. The Community Elders were most vocal and emotional when they talked about spirituality and individualism from a relationship perspective.

Community practitioners identified with individualism in a similar way as the Community Elders. To them, spirituality from an individual framework can be best understood from as a motivational or action-orientated place. It is about doing as a way of being. One has to take action to show how one feels about the rest of the community. It is therefore not enough simply to speak about sacrifice. One community practitioner spoke as follows:

Tomato: “I believe that each human being is divided into two different segments – the lower self which is the animal self (worldly desires) and the upper self [which] is spirituality” (FG1, p2).

Summary: Spirituality. The above findings were interpreted as indicating there was shared understanding of how spirituality was defined and described across
all nine focus groups. Within each individual focus group, there were “shadows” or smaller thought patterns. For the community practitioners, these were related to consciousness-raising. For the Community Elders, there was a significant focus on the broader connection to nature, and sacred sites within time and place. For the CALD Queensland Health mental health practitioners, spirituality related to self-focus and orientation, in terms of one’s higher power. For Queensland Health mainstream mental health practitioners, there was a shared understanding about life’s major existential questions of self-examination. Finally, community mental health practitioners saw spirituality as a gateway to social and civic duty, with an overall aim of guiding people to become better humanitarians.

The CALD Queensland Health practitioners perceived spirituality from an inward perspective, according to where one sits on a relational scale with oneself, family, friends, community and the greater world. On the other hand, the mainstream Queensland Health mental health practitioners talked about their shared understanding from an intellectual, articulate concrete questioning point of view, namely by asking the “Big Ticket” queries of “Who am I?” and “Why am I here?”

Queensland Health mainstream practitioners were very clear and concise about individualism as it relates to their spirituality. They were happy to divulge their connection to this content, presumably because individualism is a subject with which they are very familiar, given it owes its origins to Western thought and is a “prized possession” in such society. They spoke about individualism from the perspective that it imposes a narrative on every aspect of one’s life, and that so much of the Western identity is steeped in this conscious, subconscious, unconscious state of mind. It is as if spirituality was a sacred entity unto itself. Individualism allows practitioners (and all Western-minded people more broadly) to unpack experiences and explore all kinds of other freedoms and inalienable rights. It is sown into the Western political, spiritual and moral landscape and influences most decision-making processes therein.
Spirituality and its sub-themes appeared very comfortable for participants to discuss. This topic was felt to resonate with participants because of its universal nature and accessibility. It also allows for a wide range of perspectives and it is up to the individual where they would place themselves on the continuum, in terms of the strength of their personal beliefs around faith, higher powers, and sacred objects. Spirituality therefore needs no more approval or sanction beyond what the individual brings to the table. To date, spirituality remains a topic of conversation which can be discussed without evoking controversy or negative emotional response. Religion, on the other hand, proved to be a topic that was more controversial than expected.

6.2.3 Definition of Religion

Religion was defined by participants as something that provides a set of values around how people should behave – a formalised and structured system around spiritual beliefs. More broadly, they also described it as a way of life, a concept in which people have faith, and a belief that is shared between members of the one community. A number of powerful sub-themes emerged when focus groups discussed religion. The topic and overall discussion appeared less comfortable than spirituality.

Community Elders and community practitioners defined religion as integral to relationships within one’s community. To them it was a salient part of identity.

Celery: “[Religion is a] guide to life, how to treat your parents, how to treat your wife, your friends, how you do your job, how to be sincere; all of it is a way of life” (FG1, p3).

Most of the Community Elders could not speak about religion without referring to spirituality as the basic tenet of any religious practice. Spirituality and religion were used interchangeably by this group, potentially because of their non-English-speaking backgrounds, but also because of how they conceptualised both themes similarly.
Queensland Health mainstream mental health practitioners instead focused on the structural and ritual aspects of religion:

Chilli: “[Religion is] the formalisation and structures put around spiritual belief systems. So how it’s operationalised in a day-to-day [context], not from an individual [perspective], but from a societal level… It provides a structure around it, provides the rules, provides the institutions that go with it… Perhaps it’s more about societal response to spirituality rather than an individual one” (FG7, p4).

6.2.4 Religion Sub-themes
Religion was a far more contentious subject for discussion and it gave rise to more sub-themes than spirituality.

Figure 6.2 Religion sub-themes.

Religion: Sub-theme 1 – Emotional Response. As mentioned, religion was more controversial than spirituality. Most of the focus group participants described religion as an uncomfortable topic, acknowledging it is heavily laced with rules, structures, rituals and hierarchal systems which overshadow the spiritual or sacred dimensions of the practice. This topic seemed to ignite opinions on political and social issues within the groups, such as religion being directly
responsible for wars and subjugating certain groups of people. It was also described as a self-serving institution. Focus groups were more emotive and resolute when discussing religion.

Religion: Sub-theme 2 – Community as Collective. Religion was also seen as manifesting an attribute of community collective. This is particularly important because it relates to who will carry out the functional aspects of the religious duties. All focus group participants agreed that religion is inherently associated with community, membership in which allows one to come together with other individuals to gather, practise beliefs and be considered a collective. This group formation is integral to religions’ genesis and functioning. This is exemplified in the response given by one Queensland Health mainstream mental health practitioner:

**Shallot:** “In contrast to the concept of spirituality, I see religion as more of an organised sort of formal and co-defined practice, so that religion would have to be shared [in terms of] practices, ... beliefs, ways of doing things, ways of understanding things” (FG8, p5).

Religion: Sub-theme 3 – Religion and Identity. Community practitioners and Community Elders identified religion as a matter of singular importance to their psychological, physical, spiritual and humanistic make-up. The significance that they place on religious identity is paramount, as they make no differentiation between themselves and their religious and spiritual practices. If anything, these two groups place their religious beliefs above any other attribute or value. One of the community practitioners commented:

**Pumpkin:** “Religion is a concept that one has put their faith in – whether it be one or many Gods or a being that gives you a sense of worth and purpose in life. And [it] also helps guide ... how to act as a human being and gives you a purpose [at] the end as well” (FG1, p4).
The CALD practitioners expressed their feeling of immersion in religious (and spiritual) issues, which they see as the only way to really live and make a contribution as humans. They reportedly fully engaged in religious activities and saw religion as their “life lens”. At the same time, this group of CALD Queensland Health government employees were less explicit about the relationship between religion and identity, compared with Community Elders and community practitioners. They accepted that religion was an instrumental part of their existence but didn’t explore it as fully as the other CALD participant groups. Queensland Health mainstream mental health practitioners, in sharp contrast with all other groups, did not have such any such connection and in no way saw their identity as attached to religion. If anything, there was a significant social distance observed between these practitioners and the overall theme of religion.

Religion: Sub-theme 4 – Rules, Structure, Rituals and Hierarchy. Most of the participants – especially the Queensland Health mainstream mental health practitioners – focused on religion as structure. This was seen as a salient feature of religion, given the by-laws and formalities by which it defines itself. Such elements are usually written down as part of a formal document, and are understood and explained by a hierarchical committee. It was felt that rules, structure, rituals and hierarchy are part of religions’ organisational mission statement and are the things which distinguish them from other groups. These features are important for attracting membership. As stated by one CALD Queensland Health mental health practitioner:

Beans: “I guess my general thought about religion is that it’s an organised institution. It’s a formalised system and organisation… There are generally dos and don’ts, or accepted ways of doing things” (FG3, p2).

Religion: Sub-theme 5 – Negative Aspects of Religion. Queensland Health mainstream mental health practitioners seemed to adopt the worldview that religion was something which in years past attempted to serve the masses, but
which more recently has not served humanity well and is deserving of suspicion. This group was the most vocal about the religion’s negative aspects, stating that both historically and currently, it is at the heart of many global conflicts. This group emphasised the relationship between religion and politics, saying that the long-term consequences of religion have been negative, and that it has not benefited humankind universally. This is exemplified in the quote below:

**Cabbage:** “Something I struggle with most about religious organisations [is] that kind of contradictory nature in terms of what often comes about – someone saying they held strong Christian values or whatever, then go[ing] and do[ing] the complete opposite of what that is, the values” (FG5, p7).

The subordination of women and exclusion of different minority groups intrinsic to many religious faiths was also at the heart of their argument. Indeed, this participant group appeared very passionate about these topics when they were brought into discussion, with many female members of the participant group nodding and shaking their heads when others were referring to the subjugation of women. Religion to Queensland Health mainstream mental health practitioners was therefore thought of as “taking away freedoms” and stifling self-expression, rather than enriching people’s lives. One of the practitioners emphatically stated:

**Beetroot:** “I’ve got a lot of friends now who are ministers’ wives in various churches and there have been times where I have really had to bite my tongue about what they’ve seen as their role. You know, I can’t take on a leadership role in the church because that’s not a role for women’, and I go, ‘hello, you’re intelligent! You have all these qualities!’” (FG5, p8).

In keeping with this discussion, the other participants mentioned how religions have caused devastation throughout the world and throughout human
existence, but it was discussed in more matter-of-fact and less angry tone than
the Queensland Health mainstream practitioners. One reason for this could be
that religion is a value so deeply entrenched within CALD communities that they
are reluctant to express dissatisfaction around it. For many communities having
undergone cultural upheaval, this is the only thing they had to cling to, so
expressing any type of strong rejection of it is to enter into a large historical
betrayal.

Religion: Sub-theme 6 – Acculturation. Acculturation has really impacted on
how religion is practised for all CALD participants, especially for the Community
Elders and the community mental health practitioners. Each of these groups
talked about the personal price they have had to pay, with the Community
Elders in particular expressing that for them collectively, the cost had been very
high. They talked about how things had changed for them between their country
of origin and Australia, and the negative experiences they have had to endure
as a result of being exposed to more freedom. The Elders provided many
examples, usually negative, from their communities, referring consistently to the
ongoing toll this has taken on them personally. It was obvious during their
retelling that they were emotionally affected, and even though many reported
incidents happened some time ago, they were able to access their raw
emotions as if it had happened to them yesterday. Because this group
appeared so affected by acculturation, a lot of time was spent on the issue
during a post-discussion debrief. One Community Elder passionately described
the changes in religious practice in his CALD community’s country of origin,
versus in Australia:

Fox: “Our people came from where the war affected their church
and they defended it to make it strong. And then when they come to
the first world and [experience] the freedom of worship… When they
get here, the way they worship – the way they do things – is
different, is also challenging communities here in Australia” (FG 2,
p20).
The group of CALD Queensland Health mental health practitioners discussed being impacted by acculturation as it related to their family. As second generation Australians, growing up they observed what their parents, aunts and uncles had to go through to resettle in a different country. The group talked about how their family did not have access to familiar things needed for worship and the lingering effects this had on them.

Queensland Health mainstream mental health practitioners who did not have a CALD background acknowledged that their religious practices have changed as well, and that they were affected by acculturation but for slightly different reasons than CALD practitioners. These practitioners experienced what might be referred to as a “reverse acculturation effect”, as they were affected indirectly by being the passive recipient of others’ experiences. Queensland Health mainstream mental health practitioners discussed in detail how through personal travel and working with clients of many cultural backgrounds, their own personal and professional lives have been enriched. These practitioners talked about how interacting with “the other” made them reflect on their own values and religious journey.

**Chili:** “You don’t get to reflect on [your own culture] in the same way as you might reflect on someone else[s] because you notice the differences in other people and other groups … Being part of the dominant [culture], you don’t reflect on what is that about. Our culture, or my culture, my spirituality, my religion, whatever – it’s more around I’m noticing the differences in theirs. I think it’s only once you’re into their category that you start to examine your own and make that explicit. I think that personal healing is something that is done by other groups” (FG7, p11).

Coming from a dominant culture does not lend itself to this kind of thoughtful contemplation. It is not until one encounters a different culture that it becomes noticeable. A big shift that takes place around acculturation is that it forces one out of their comfort zone and thrusts one into unknown territories. It forces both
the host recipient and the newly arrived individual to reflect on or even renegotiate how their own familiar practices are viewed. Thus, exposure to different cultural groups creates awareness and growth for all. A new paradigm shift takes place which creates another way to engage with and integrate some elements from both parties.

All of the above sub-themes yield very powerful reactions which are felt both individually and communally. Acculturation stress may be a major part of settling in another country and its effects transcend generations. In addition, resettlement creates a change that has enduring effects in terms of accessing and practising spirituality, religion and traditional healing.

The Community Elders were the most vocal and stirred up about how immigration has changed the fundamentals of their communities’ religious and spiritual practices. Community mental health practitioners were the next most vocal group of all the groups, indicating they had also paid a high price in relocating. The group of CALD practitioners also stated that their practices have been affected by acculturation and immigration, but for the better, overall. They reported having more freedom to choose, which many of the practitioners found liberating. Professionals from both community and government settings may be better equipped to access resources from their host country, thus potentially easing resettlement more so for these groups.

Community Elders thought of religion as a gravitational pull towards that which embodies and represents who you are, or who your family or community culture is. Prior to the Community Elders relocating to Australia, many of their communities adopted practices that were handed down from forebear to forebear without question, so there was an absence of questioning traditions. Since coming to Australia, there has had to be a focus on maintaining their traditions, made more difficult by the fact that many of the spiritual resources needed may not be located here in Australia.
The community that appeared most comfortable with religion and least affected across all religious sub-themes was composed of community practitioners. These individuals felt that their religion was everything. They tended not to break religion down into categories or classifications the way other groups did; nor did they focus on ethnicity or any kind of racial aspects of identity. Religion and spirituality took precedence as the most important things to them in life.

Some discussion emerged around how CALD and mainstream Queensland Health mental health practitioners engaged with acculturation. Both of these groups felt that acculturation played a major role in the lives of their extended families. Acculturation in relation to intergenerational issues surfaced for a number of practitioners who were second generation Australians. These participants described their families’ decisions to relocate to Australia, and how this affected them and their extended family – both in Australia and in their country of origin.

Religion: Sub-theme 7 – Intergenerational Complexities. As with acculturation, intergenerational issues surfaced as significant issues for both mainstream and CALD Queensland Health mental health practitioners. These focus groups reflected upon their religious experience in an intergenerational way, with reference to how they and their children were affected. Although the mainstream practitioners had no direct immigration experience themselves, they were able to reflect upon this discussion and talk from the experience of others, whether this be professional clients, friends who have travelled or immigrated to other countries, the lay community, or other members of the focus group. On the topic of religion, one of the Queensland Health mainstream mental health practitioners stated:

**Mushroom:** “I think it’s almost like [religion has] got a dirty reputation. I just think about some of my struggles with my children, thinking about their spirituality and for me, I grew up in the religious tradition quite strongly, and I know a lot of what shapes me, my
values and spirituality comes from that but I don’t offer it to my children. I don’t want my children to be part of that” (FG7, p7).

The CALD Queensland Health mental health practitioners talked about religion and intergenerational issues from two different perspectives. Firstly, there were two practitioners who were born in Australia to immigrant parents. They felt that their parents’ and grandparents’ relocation to Australia had something to do with inter-country and intra-country conflicts. In the parents’ home countries, there was no questioning of religious and spiritual practices, as the priority was safety and avoiding persecution. Upon arriving to Australia, resources were in short supply for the newly arrived, as the host country was unaware of or unconcerned with the needs of its immigrating communities. Thus, there may not have been sacred places for the families to worship, such as temples or certain places in nature. Instead, they needed to worship at someone else’s home.

The second intergenerational aspect of religion for CALD Queensland Health mental health practitioners was that when they grew up, they realised the sacrifices their parents and other relatives had made – what they had gained and lost by immigrating to Australia. The participants were then able to reflect on their own current religious and spiritual development and growth. They talked about the questioning – sparked by maturity – of what they valued and held true, versus what they had simply grown up believing. They talked about how important this phase of one’s life is; it allows you, the individual, to have control over your religious destiny and to take responsibility for your religious life, rather than blindly following doctrine.

The CALD Queensland Health mental health practitioners appeared to be comparing their experiences to those of their parents and other relations, reflecting on how lucky they were to grow and mature though questioning – something their parents may not have experienced. There was a joyful tone to this conversation, although underneath and sporadically appearing throughout were notes of remorse for the lost opportunities of their older generations.
**Summary: Religion.** There was a shared understanding across all nine focus groups in terms of how religion may be defined. Nevertheless, religion was a highly contentious issue for most of the focus groups, but for different reasons. Community Elders felt they paid a high price for their religious beliefs by undergoing the immigration experience. They were required to sacrifice important parts of their culture and faith that are essential to who they are as human and spiritual beings. The Community Elders described how people in this country talk about valuing freedom and encouraging people to express themselves, but that when one does, they are treated badly. Many Community Elders felt conflicted about their immigration, with some even saying that knowing what they know now, they would not have done it again if they had had the choice. They stated that the price they and their community have had to pay makes them ambivalent in relation to the benefits achieved.

The CALD Queensland Health practitioners talked about religion from two different vantage points. One group discussed the intergenerational effects of immigration on themselves and their families who were persecuted in their country of origin. Such effects persist even now. The second discussion point for these practitioners related to the immigrant’s inner conflict stemming from, on the one hand, separating from family, birthplace and familiarity, and, on the other hand, newfound freedom in seeking new truths.

Queensland Health mainstream mental health practitioners spoke the most negatively about religion of all participant groups. Initially, they appeared uncomfortable with the topic, stating it is usually discussed more so in private, here in Australia. Subsequently, they described how religion has created turmoil in the world, citing contemporary global problems within the Middle East, the Catholic Church and beyond. They also gave many examples of religion’s role in colonisation.

It felt as if these mainstream practitioners were quite concerned about how they would be perceived by others, and that they did not want to come across in
such a public forum as being insensitive. The discussion and material were therefore approached with a degree of caution. It may be that the group was outside of their comfort zone, because they were conversing about topics for which they could not control, and which they were more used to discussing in private.

6.2.5 Definition of Traditional Healing

The definition to emerge across all of the focus groups was that traditional healing is a CALD construct, or at least is informed by cultural communities. It was seen to be heavily influenced by ancestral wisdom and aspects of individuals’ cultural identity. Traditional healing practices were not seen to be endorsed by Western systems or paradigms, and were rather described as methods of healing communicated via older generations or collective cultural understanding.

**Pecan:** “Traditional healing [knowledge] in cultural settings [is] … passed down from one select group of people to the next select group of people in the next generation, and those people are often revered and respected and their methods are held in high regard by the rest of the culture” (FG9, p6).

All of the CALD practitioners in this study – and the Community Elders in particular – agreed wholeheartedly that traditional healing and Western medicalised interventions both have equally valid roles, and that traditional healing is derived from ancient wisdom, which may yet change over time and be sensitive to such things as immigration and relocation.

**Cashew:** “I think of traditional healing as ancient wisdom which may change over time, but … I think particular modern healthcare now is actually drawing a lot on some of that ancient wisdom, and I think that is a definite trend” (FG9, p6).
Queensland Health mainstream mental health practitioners did not appear to connect or resonate as easily with this topic, stating that traditional healing was a way to heal something which medicine cannot heal, or a treatment of some kind that is not necessarily scientific. One practitioner from this group stated that traditional healing informs us on “how to make sense of the world”, as distinct from medicalised interventions.

**Beans:** “I guess [traditional healing is] treatment of some kind that there isn’t necessarily scientific evidence for, and is not performed by … someone from a medical or scientific background” (FG3, p3).

The Community Elders were the only group who offered a balanced approach to traditional healing; while they value it, they also negatively perceive the associated high costs that are increasingly demanded for such services in their communities. Some healers thereby seem to be exploiting the community as a means of making money, rather than conducting their practices with the purer objective of healing the person or community.

**Cat:** “When you believe a traditional healer, they have so much influence in what you can do, whether bad or good” (FG2, p14).

There was not an entirely shared understanding of traditional healing between participant groups. Community Elders, community practitioners and community mental health practitioners were able to talk about the subject easily, identifying with the topic more readily. The Queensland Health mainstream mental health practitioners appeared to struggle with the topic of traditional healing, frequently asking the discussion facilitator, “Is this what you mean?” and offering suggestions of home remedies as examples. Initially, they even appeared anxious, self-conscious and “out of their depth” when trying to connect to the topic, although with time they became comfortable listening to and following the lead of CALD practitioners in how they discussed traditional healing.
Both CALD and mainstream Queensland Health mental health practitioners talked about this theme from a rational point of view, although the CALD group did appear to grasp an understanding of the topic more easily. They did not struggle with content, but they did intellectualise and rationalise their thoughts and views in the same way as the mainstream government practitioners did.

Some traditional healing methods only apply to specific places and countries, as practices are affected by access to healing properties. Many will try to substitute, but acknowledge it may not be the same. All of the CALD practitioners reported that traditional healing had great value in their community and were eager to recount examples of when traditional healing was used with positive outcomes.

**Onion:** “[My mother] tried [for] 10 to 15 years to have children. She went to a witch doctor who did some massage on her tummy. [It] is now scientifically known what that was, but she resorted to spiritual healing or traditional healing back then and as a result I was born, so she believes in that. But now that she has come here to Australia she would never resort to that now; she knows that was just a cultural thing and you can actually explain that by science” (FG1, p7).

**Lettuce:** “I think there are some traditional methods of healing that people use which they consider magical and they actually have a historical proven effect in their lives. To me it doesn’t necessarily have to have a supernatural component” (FG5, p9).

Community Elders defined traditional healing as behaviours or beliefs that have been passed between generations and within clans, tribes or communities. They expanded on how these sometimes symbolic objects (e.g., significant places, animals, colours, customs) are of uppermost importance, equating them with other natural activities such as eating and breathing. The Community Elders felt that everything they did in life was in some way “governed” by
traditional practice, whether it be dance, food, water, language, clothing or relationships. Everything can be traced back to some type of spiritual, religious or traditional practice within all communities.

The Community Elders were proud in their pronouncements that traditional healing has been in their communities since the beginning of man, and that the traditions have not changed significantly with the passage of time. They alluded to changes in traditional healing being most profoundly affected during acculturation, reporting that staying in their culture of origin means they maintain those elements in their purest form. The Community Elders then appeared sombre in discussing how changes to many of their practices have been “thrust upon them”, since relocating to Australia. They talked about the “upsets” in their lives and how their communities have been affected by war and turmoil; these devastating events were not of their choosing but ecological issues they have had to endure. Immigration appeared to be a topic which evoked feelings of loss and remorse for the Community Elders. More than any other group, they discussed how affected they were by changes to their community’s traditional healing practices and what this meant to them, personally. They mourned the loss of these practices, and they all emotively defined traditional healing as very closely aligned with their individual, collective and community personage – their place in time and space. One Elder proudly stated:

Cat: “I would explain [traditional healing] as going back to the roots of connections with our ancestors, so we look at the things within our culture, and that culture is something that we have inherited from our parents and where we come from… Traditional healing is [the use of] those things that are part of who we are, in terms of the culture, the background, and using those strengths within that to help us to get to a place where we will feel better about ourselves or feel better about whatever it is we are going through” (FG2, p10).
The CALD Queensland Health mental health practitioners and community mental health practitioners were in agreement with the Community Elders in feeling that traditional healing owes its relevance to historical significance. These practitioners added the valuable point that traditional healing could also have superstitious elements, which are passed between people or communities. They acknowledged there is no scientific basis, but its enduring legacies for those within the CALD communities, who continue to use it, testify to how wonderfully it works.

Community practitioners talked about traditional healing with more ease than any of the other groups. They saw it as something that is part and parcel part of their identity, again, connecting it to their religious practices.

**Celery:** “So traditional healing according to our prophet tradition … is a way to heal something which medicine cannot heal” (FG1, p6).

Queensland Health mainstream mental health practitioners attached more emotional dissonance to traditional healing. They also requested clarification frequently and needed more prompting than other groups. These practitioners appeared uncomfortable, based somewhat on their concise and succinct discussion of the topic. To Queensland Health mainstream mental health practitioners, traditional healing referred to the healing of people through magical or supernatural elements. They rationally and factually discussed traditional healing as needing historical validation to be credible, noting that it is not something prescribed by medical practitioners, and that it is not controlled under the auspices of healthcare, *per se*. Traditional healing, according to the group, is grounded on holistic beliefs and understandings, which are to be accepted without explanation. Faith can therefore be seen as an essential aspect of traditional healing practice. This point and the negative connotations therein are alluded to in the comment:

**Lettuce:** “Anything that hasn’t had health control is probably considered a traditional healing” (FG5, p9).
6.2.6 Traditional Healing Sub-themes

Traditional healing was discussed in relation to four main sub-themes: its relationship with Western paradigms, pertinence to CALD people, treatments, and economic aspects.

Figure 6.3. Traditional healing sub-themes.

Traditional Healing: Sub-theme 1 – Western Paradigms. Traditional healing was discussed as a practice that is not endorsed in Western paradigms of mental healthcare. Queensland Health mainstream mental health practitioners were adamant that spirituality, religion and traditional healing did not adhere to a Western medical framework, and they focused on the struggle to acknowledge these elements’ importance. As previously described, they were most vocal about the scientific nature of current healthcare practices, reporting that until alternative ways of caring can fit into this modality, traditional healing has a long way to go to be considered a serious paradigm.

Queensland Health mainstream mental health practitioners reported certain impediments to integrating traditional healing into a Western healthcare system, including time pressure, management pressure, language barriers, and a lack of
access to resources, interpreters and bicultural workers. At an attitudinal level, they attributed difficulties to reduced clinician comfort, familiarity and knowledge about traditional healing. The practitioner group described an under-valuing of these practices in the current scientific and rational frameworks in which they work.

This view was somewhat different to how community practitioners, Community Elders, CALD Queensland Health practitioners and community mental health practitioners perceived the situation. While these groups acknowledged the challenges of integrating such themes into Western medicine, they discussed the possibility of it with much more hopefulness; they were positive about the potential for these elements of intervention to be brought into care.

Traditional Healing: Sub-theme 2 – CALD Construct. The value of traditional healing is questioned in Western mental healthcare, as it is seen as a CALD issue and is attached to and embedded within cultural minority population groups only. It was perceived as a CALD construct by all of the CALD practitioners and Queensland Health mainstream mental health practitioners as well, but for different underlying reasons. This topic appeared harder for Queensland Health mainstream mental health practitioners to identify with, largely because it is not a prominent part of their worldview.

To the group of non-CALD mainstream practitioners, traditional healing was described as an “other” – as something that non-Westerners engaged in and which they did not play a part. Even further to this, they also appeared not to connect with having any form of “culture”, again seeing it as something owned by others, but not themselves.

The closest this group could come to identification with the topic of traditional healing was to discuss old wives' tales, such as the remediating effects of chicken soup made by one’s mother. Interestingly, home remedies like this could be classified as an example of traditional healing, but perception-wise, it appeared too difficult for the participants to understand that in this context.
Chilli: “I suppose that’s hard … to differentiate [traditional healing practices] from old wives’ remedies – you know, those sort[s] of ones which were treatments and were quite valid 100 years ago. They’ve just been passed down and they might still have medicinal properties but they haven’t been pre-packaged and put into a pill, if you know what I mean” (FG7, p8).

All of the CALD practitioners perceived traditional healing as associated with third-world living, but they saw this as a positive attribute. Since the practices tend to remain within their respective communities, they are relatively untouched by Western or other outside influences. If this was not the case, they felt that the practices would change and lose many of their unique properties, due to newfound access to resources.

Traditional healing is therefore perceived to be culture-based, owing its origins, purity and healing properties to each cultural community’s safeguarding. The strong relationship seen to exist between culture and traditional healing is exemplified in the comment below, made by one Community Elder:

Cat: “[Traditional healing is] about using those traditional things: it could be the trees, the tea, throwing the bones, speaking to ancestors… But it often is about the leader themselves being the centre of that healing, or possessing those aspects to be able to heal, whereas in the Western world, we go and doctors learn to become healers” (FG2, p11).

Traditional Healing: Sub-theme 3 – Treatments. Another theme which emerged was treatments, which involved all three elements of spirituality, religion and traditional healing. Service design and delivery were unexpected topics that spontaneously occurred in conversation as an aspect of both Western medicine and traditional healing. Most of the practitioners across all nine focus groups
made a connection with the topic, as it really resonated with their everyday professional experiences.

The CALD practitioners discussed how treatment delivery for CALD clients aligns with the philosophy of relational care, which refers to the catering to others' needs, in a spiritual or religious manner. According to the Community Elders, diagnosis and treatment are conducted in CALD communities by someone considered an expert in that context. Relationships between community members and each other, their higher power, and their physical (or otherwise) location for sacred healing practices play a significant role in treatment, as indicated below:

**Rabbit:** “Our master has had diabetes all of this life. About ten years ago, he was supposed to have his leg amputated; he got gangrene. He refused to let the doctors take his leg because with only one leg [he] can't walk around. Ten years later he still has both his legs. He is nearly blind now, but the power of prayer got him there” (FG2, p11).

All CALD practitioners appeared to really understand both treatment paradigms, as they were able to make verbal connections and give examples of integrated treatments for infertility, pregnancy, breastfeeding and caesarean births. There was a parallel drawn between how services are delivered in both Western mainstream treatment traditional healing. In both systems, an important ingredient is engagement and client-centred care. There are similarities in approach between the familiar Western mainstream framework and traditional healing frameworks, such as the administration of assessments, followed by an official diagnosis by a significant person (e.g., shaman, imam, witchdoctor, spiritual leader or priest). In some cases, a specific location is deemed to be where the healing should take place (e.g., temple, mosque, church, forest) and a treatment regime or methodology is administered (e.g., herbs, tree leaves, plants, touching, certain prayers, holy water). An important person or relation is often present or involved as part of the overall healing framework (e.g., family,
spouse, child). An example of what traditional healing might look like in practice is described in the quote below.

**Okra:** “Whenever you’re upset, whenever you’re distressed, physically unwell, you pray about it. You always pray and talk to God. Sometimes the priest will, without necessarily doing the whole sacrament, the priest with anoint you with holy water and draw a cross on you with oil. And we have had the anointing of the sick – that sacrament was performed in our house a couple of times. The priest comes to the house and does it. It’s a sacrament not done in the church” (FG4, p3).

The similarities between the two systems is worth noting, as it allows traditional healing practices to sit alongside mainstream practices within a familiar, deliverable healthcare framework.

The Community Elders were much more forward than other groups in acknowledging how traditional healing has served many communities for hundreds of thousands of years. The Elders did not feel there was a lot of deviation from traditional practices and treatments to the way in which the mainstream system treats people. The community mental health practitioners echoed this sentiment by stating that the natural medicines were superior to Western healthcare treatment.

**Pecan:** “Ultimately, healing comes from the person, not what you give that person to heal, so you can stimulate that person’s healing energy, then that person is able to heal. But what you give that person needs to stimulate healing within them, and sometimes it’s touch, words, prayer, herbs, nutrients” (FG9, p6).

The Community Elders commented that they saw their traditional healing practices as easily integrated with Western medicine. Since many of these CALD communities pre-date Western civilisation in general (and Australia in
particular), their treatments were perceived as superior because they have been
around longer, their effectiveness is understood by the community, and their
use is highly valued. The Elders did, however, also describe some negative
examples of longstanding healing practices, and the impact this has had on
their communities.

Traditional Healing: Sub-theme 4 – Economics. The negative examples of
traditional healing treatments were provided in large part by Community Elders,
who felt that monetary incentives were creeping into the gestalt of healing
practitioners, thereby taking precedence over the services they provide. The
Community Elders attributed this interest in funds to Western ideology, with its
glorification of success, capitalism, and the individual as opposed to the group.
They expressed concern about industrialisation and Western influence further
corrupting many of their traditional values and practices.

Horse: “[Religious institutions] make so much profit; they take
advantage of [religious] people… You cannot build 20-something
churches in a small city, in a city [where] they [also] need hospital[s],
they need schools, or they have old people to help” (FG2, p17).

The Community Elders also attributed the observed economic framework for
traditional healing practices to immigration, noting that in their country of origin,
healers stand to be ridiculed for such behaviour. It appeared that the
Community Elders felt this to be a deliberate practice on the part of the wider
mainstream systems to undermine their culture, and to keep their communities
from really evolving to their full potential. Although this was never stated
explicitly, it was implied very strongly.

Community mental health practitioners also expressed they were worried about
the financial costs associated with traditional healing, suggesting that practices
will be “watered down” to accommodate Western notions of monetary
incentivising and big business. What becomes important is not the healing but
the money-making, so corners may be cut in the interests of increased clientele
and monetary gain. In many CALD countries, healers lived off the land or were reliant upon the goodwill offerings of the communities they serviced.

**Summary: Traditional Healing.** All of the participating groups saw traditional healing as a CALD construct, but with different connotations attached. The CALD groups owned the uniqueness of these healing properties across a wide array of cultural groups. They were proud to have ownership of this ancient wisdom and ancestral legacy. Traditions were seen as something that are slow to change, and may therefore be the curative antithesis of the chaos elicited in our rapidly changing Western world. The CALD practitioners appeared “proud” that traditional healing had longevity and involved intergenerational movement of knowledge. They commented that even if the practices were forced to change, they would still be in forms that were recognisable to their community.

**6.2.7 Continuity of Practice in Home Country and Australia**

When asked about spirituality, religion and traditional healing, all participants – CALD and non-CALD participants alike – agreed that they were important in their country of origin. This was especially emphasised by the Community Elder participant group, as exemplified below:

**Cat:** “They are [important]. What people believe – what people practise – is how they live their lives, so it is super, super important, I think… For people in my country of origin, you can’t separate those things from your normal day-to-day life… I mean that’s who we are, that’s what people believe, that’s what they practice. You can’t take them away from all of that” (FG2, p13).

During the focus groups, participants were asked if they engaged in spiritual practices in their country of origin, what those spiritual practices were and whether they still engage in spiritual practices. Below is a response from one of the community practitioners:
Spinach: “Just the usual for Muslims: going to the Mosque, praying, praying at home, fasting, sharing the fast with the family and praying together to be blessed and be accepted” (FG1, p3).

Some community practitioners took the position that they practise spirituality and religion in everything they do. It is how they live their lives; their beliefs and practices transcend time and definition.

Celery: “From the day I was born I practised Islam every day, wherever I was. I’m still practising. We start the day, we open the door and go out. There are special words we say, when we go to sleep… [It’s in] every aspect of my life. Constantly practising… For me, without it – maybe I can’t survive” (FG1, p4-5).

The Queensland Health mainstream mental health practitioners were generally less inclined to partake in as much religious and spiritual practices. One participant from the group stated that they were only really engaged in such activities when attending church on holidays such as Christmas and Easter. In terms of traditional healing practices, the group as a whole openly acknowledged that they did not, and could not, resonate with the notion of engaging in such activities. One participant defined the practices as:

Beetroot: “Anything that you don’t need an MMBS behind your name to be able to do… There are people who do have certain letters who still do traditional healing, but [I] guess it’s not a Western medical practice” (FG5, p9).

In stark contrast, all of the CALD participants stated that they do participate in traditional healing practices currently. For some, there were slight variations between how they practise now and how they practised in their country of origin:
Cat: “I think the definitions have not changed for me but the practices might have altered a bit, because I don’t believe that things are static” (FG2, p19).

The community mental health practitioners were vehement in putting their views forward about why traditional healing should be integrated into mental healthcare. It may be noted that there was a prominent traditional healer who participated in one of the focus groups and who was well-known to the other participants in that group; this may have had some bearing as to why these participants were strongly engaged with this topic. One of the members stated:

Pecan: “I engaged in traditional healing practices in my country of origin, particularly the indigenous forms of natural medicine. I practise traditional healing here, but it’s Western herbal medicine or Western treatment, so yes, it’s traditional healing but from a different tradition” (FG9, p9).

6.2.8 Change in Definitions of Spirituality, Religion and Traditional Healing

Each focus group was asked to identify if there had been changes in how they define spirituality, religion and traditional healing over time. The majority of participants stated that their definitions had not changed, but the practices had altered a little as a result of coming in contact with so many cultural groups, either personally, professionally, through travel, or from general life experience. As one participant stated,

Okra: “Yes, [my understanding has] grown. It’s definitely grown just from life experience, and I think you are challenged with it from when you are a kid at school that you’re different to other people” (FG4, p4).

Hence, while the definitions of the key themes have not changed for these participants, their own understanding of them has grown and been enhanced.
The CALD practitioners said their growth was prompted by technological advances in Western medicine, and everyday access to others’ perspectives and knowledge since coming to Australia.

The Queensland Health mainstream practitioners, when reflecting on whether or not there were changes in how they defined spirituality, religion and traditional healing, proved very emotionally articulate and insightful. One participant responded:

**Cabbage:** “I think for me they have [changed]. I’ve done a lot of growing since I’ve moved to Australia and engaged with people that I might not have otherwise engaged with if I was living back at home” (FG5, p12).

Community mental health practitioners also felt the same, stating that they had experienced much growth by virtue of relocating:

**Pecan:** “I think [my definitions of the themes] definitely have changed since coming to Australia. I feel that each of those aspects – spirituality, religion and traditional healing – have all been enhanced, all been multiplied by knowledge in each of those areas” (FG9, p10).

### 6.2.9 Focus Group Understanding of Mental Health

When all of the focus groups were asked to define mental health, as a collective they described it as having several aspects. Mental health is the state of one's mind; it is the state of one’s thoughts and how they affect one’s body and overall sense of wellbeing. All of the participants defined mental health in this same way, with only slight variations as indicated below:

**Zucchini (CALD QHealth):** “Health of the mind” (FG5, p14).
Pecan (Community MH practitioner): “Mental being, mind, healthy mind: that’s mental health for me – having a happy, healthy mind and a healthy and happy life” (FG9, p13).

Beans (CALD QHealth): “Mental health is how our mind and thoughts are and how they affect our body. I think it’s like integrated wellness” (FG3, p4).

Okra (Community practitioner): “It’s around emotional wellbeing. It’s around feeling” (FG4, p4).

Mental health may also be seen as closely related to spirituality. One focus group in particular defined it in such terms. These participants all collectively had a religious upbringing, so spirituality and religion featured prominently in their worldviews.

Carrot: “[Mental health is a] balance between mental, physical and spiritual [components]. If a person is spiritually high they can be calm and non-judgemental, not jumping. If [the mental, physical and spiritual components are] out of balance, [they affect] each other.” (FG1, p11)

6.2.10 Protective and Risk Factors in Personal Mental Health

The question of whether spirituality, religion and traditional healing assisted mental health practitioners in staying mentally healthy was put to each focus group. Overwhelmingly, the majority of practitioners stated that they accessed some aspect of spirituality, religion and traditional healing as a way of managing their own mental health and wellbeing. The CALD practitioners stated that they access all three, while the Queensland Health mainstream mental health practitioners mainly accessed some form of spirituality or religion, suggesting ultimately that it is a combination of both medical and traditional treatments that may produce the best outcomes. When asked whether the three elements positively affected their mental wellbeing, one of the CALD group stated:
Beans: “Yeah I think they do. I can’t really separate spirituality and religion so I would say both obviously help. [In terms of] traditional healing, I think I am a practical person… I would do it, but I would also do other things as well so I think it’s a combination that help[s] with mental health” (FG3, p4).

Another Queensland Health mainstream mental health practitioner expressed a similar sentiment, by stating:

Chilli: “Yeah, I would say it has to. I can’t see how it can’t. You can’t completely take that stuff away and say, ‘I’ll have nothing to do with that’, so therefore it has to impact on your own mental health. I think it impacts [in] a positive way” (FG7, p19).

Some of the CALD Queensland Health mental health practitioners stated:

Eggplant: “Yes, definitely for me – particularly spirituality. That’s what I identify most with, and [having] regular opportunities to reflect on my purpose in life, how to make a difference, [personally] and with all social workers. It’s the profession, isn’t it?” (FG5, p15).

Okra: “Yes, because when I’m distressed, when I’m upset, I turn to these things for comfort. I turn to these things for hope to persevere, to be patient, to be tolerant of things, people that cause me stress. It helps me to feel safe and secure; [it’s] something to rely on” (FG4, p6).

The community mental health practitioners were perhaps the most emphatic about using all three key themes in their mental healthcare.

Pecan: “I think it definitely influences your mental health – spirituality, religion as well as traditional healing – because when you
are down, that’s what you hold [onto] to give you hope and strength and the wisdom of knowing that this will pass and that things can get better again” (FG9, p14).

6.2.11 Usefulness in Mental Healthcare
Finally, each focus group was asked if they thought spirituality, religion and traditional healing would be useful in mental healthcare. The question resonated positively with each group. They came to a consensus that there is a place for all three themes to be integrated in mental healthcare – that if it helps clients to heal and cope, then it should be considered. As everyone is different, it may not suit every person, and thus it may only be appropriate if clients indicate interest.

A number of CALD mental health practitioners indicated that they already ask about these themes with some of their clients. Several practitioners expressed the view that it is probably one of the most under-utilised tools that we have in mental healthcare. The CALD practitioners were the most passionate about wanting these themes enacted in all forms of mental healthcare, both in government and non-government spheres. Some CALD practitioners made such bold statements as:

Cashew: “I can’t see how you can do mental healthcare without it” (FG9, p15).

Peanut: “If we ignore the elephant in the room, which is spirituality, religion and traditional healing, we discriminate against the client in our mental health [treatment] in that moment, because [they are part of] the innate ability and knowledge of the client” (FG9, p16).

Pecan: “I think it’s important for practitioners not to skirt around [these topics] – just to be direct and ask the person about their beliefs. Ask the person about their spirituality” (FG9, p17).
**Walnut:** “You can’t possibly be an effective mental health clinician if you are not open-minded and curious” (FG8, p15).

As articulated above, some participants put forward the view that if practitioners engage with clients around this issue, better outcomes will be achieved. Although Queensland Health mainstream mental health practitioners were willing to see some of the themes integrated into mental healthcare, they advocated for a more sensible and realistic approach, saying that even though spirituality, religion and traditional healing are very important, they need to be carefully enmeshed with the biomedical model. This, at the best of times, is hard to do. Spirituality, religion and traditional healing are not objectively positive themes, and indeed they can be injurious where people cause societal harm in their names.

### 6.3 CONCLUSION

This chapter has outlined focus group findings for the current study, presented in the context of three main themes and accompanying sub-themes. Spirituality was accepted by all participants as innate to humankind, and personal and individualistic in nature. Religion, on the other hand, was more contentious, with different groups of participants expressing opposing views – some endorsing it and others expressing negative views. Some participants did not see their spirituality and religion as separate, but rather as integral parts of a complete whole that defined their very being. The strict rules and controlling hierarchy, which are inherent features of religion, were seen as negative attributes by some participants. Many also blamed religion for starting wars and eliciting other harmful outcomes.

Traditional healing was not as widely accepted by the Queensland Health mainstream mental health practitioners during the focus group discussions, although all of the CALD Practitioners saw it as important to them. Many CALD
participants, since migrating to Australia, now use a combination of traditional healing and Western medical interventions.

The majority view was that all three themes – spirituality, religion and traditional healing – were important in mental healthcare, and to not consider the client’s views on these matters during the clinical encounter may amount to discrimination. Interestingly, participants put forward a number of suggestions for achieving improved outcomes in transcultural mental healthcare. They advised that practitioners should approach the clinical encounter with an openness to exploring the client’s attitudes to spirituality, religion and traditional healing, and that they should also adopt the mindset of being an equal to the client, rather than being the expert. The participants also highlighted the value of improved training for practitioners to better address the needs of CALD clients. How the above findings relate to previous research and theoretical frameworks will be addressed in Chapter 7.
Chapter 7. DISCUSSION

7.1 INTRODUCTION

The overarching purpose of the current study was to explore spirituality, religion and traditional healing as influential factors in mental healthcare for CALD individuals. These topic areas were explored during nine focus groups, in which there were a range of professional and para-professional mental health practitioners from government and non-government sectors participating. The data provided a multi-dimensional and intergenerational understanding of how spirituality, religion and traditional healing are differently perceived according to professional status and socio-cultural and community context. This diversity was considered important, given that CALD people – and therefore CALD clients of the aforementioned participant groups – inherently associate these themes with mental healthcare. For the purposes of this study, mental health practitioners were redefined to include Community Elders, community practitioners and other non-credentialed para-professionals who come into direct contact with CALD communities.

Within this chapter, a description of transcultural mental health will first be provided, as this was the treatment framework within which the research was conducted. Key findings from the study will then be outlined, before they are discussed in more detail and with reference to existing literature. The comparisons provide noteworthy parallels and points of difference, as identified by focus group members. The study findings are also discussed in this chapter with respect to the contributions made to knowledge, theory, and clinical practice, with comments provided as to where further research is justified to fill in potential gaps.

7.2 TRANSCULTURAL MENTAL HEALTH

A transcultural mental health model of care is an international, interdisciplinary treatment framework, in which the focus is on the social and cultural determinants of psychopathology and the psychosocial treatments of a wide
range of mental and behavioural issues in individuals, families and communities. This framework is especially geared towards understanding the mental health of immigrants, refugees, indigenous peoples and ethno-cultural minorities. The global aim of transcultural mental health is to facilitate widespread access to mental healthcare services for CALD people, by providing information and access to culturally appropriate mental health resources. This is accomplished by identifying mental health services and developing and managing programs to meet those specific identified needs (Prince et al. 2007).

Within a transcultural mental health framework, one is encouraged to reflect upon the relationship between clinical and cultural care, as it impacts on health, immigration and other intake and settlement issues. Increasing levels of migration around the world mean that acculturation is a core issue in many societies, with political, economic, health, spiritual, religious, educational and psychological dimensions. Transcultural mental health helps us to understand these orientations with respect to individuals’ pre- and post-migration backgrounds. Evidently, not all immigrants have the same experiences; nor do they achieve the same degree of success in their personal lives, or in their communities (Minas et al. 2013). Immigration, settlement and the resultant variety in cultural “masks” can lead to mis-labelling, distortion, or even misdiagnosis of many psychiatric conditions. Such outcomes may be avoided if practitioners approach mental healthcare in CALD clients with a transcultural lens.

In this study, transcultural mental health was well-positioned to help explore contemporary and historic factors, and how they affect the interplay between diasporic identities. More broadly, transcultural mental health is concerned with understanding different explanatory models of illness which exist in the worldviews of non-Western peoples. In the current study, this was underpinned by an explanatory model with a Jungian-based framework, which provided a foundation on which to explore spirituality, religion and traditional healing and, in conjunction with the literature review, informed the development of this study’s research questions.
This is the first qualitatively designed study set in a transcultural mental healthcare framework that was conceived and developed with input from the CALD community. The results pertain specifically to Queensland, and the healthcare system therein, and in this way it is also uniquely situated to provide insights about this specific client population. The diversity of participants, with respect to their professional and cultural backgrounds, is fundamental to the design of the present study, and the outcome of including such a varied range of practitioner voices is that it provided a complexity and depth in the responses elicited.

7.3 KEY FINDINGS

The key findings from this study are summarised below:

1. All focus groups viewed spirituality as meaningful, and as a positive mental health factor.

2. Both mainstream and CALD mental health practitioners were open to utilising spirituality in the clinical context.

3. Religion was perceived differently by participants, depending on their backgrounds. Mainstream mental health practitioners were less inclined than CALD participants to perceive religion as an important protective factor in a professional context.

4. Mainstream practitioners were somewhat open to utilising religion in the clinical context, although their more negative perception of religion may mean that they introduce negative perceptions of religion into the clinical encounter. CALD participants identified positively with religion in a clinical setting – particularly with regard to the sense of community it can engender for clients.
5. The responses regarding religious beliefs given by CALD participants were influenced by factors associated with their CALD status, such as acculturation, immigration and intergenerational complexities. They also discussed the bi-cultural nature of their identities.

6. Traditional healing was collectively perceived by participants as a set of culturally specific and long-lasting practices. Mainstream mental health practitioners did not appear to entirely understand or resonate with traditional healing as a protective factor, while CALD participants embraced the use of such practices wholeheartedly.

7. Mainstream mental health practitioners were hesitant to use traditional healing practices in a clinical setting, because such practices are not scientifically based. CALD participants, on the other hand, went so far as to state that to not include them in the treatment paradigm when dealing with transcultural clients is discriminatory.

8. As a subset of the CALD cohort, Community Elders perceived traditional healing as positive, although they also spoke negatively of the practice of demanding financial compensation for traditional healing services.

9. CALD participants engaged in spirituality, religion and traditional healing in both their country of origin and in Australia. Their definitions of such practices had not changed, but the mode of practice had sometimes been adapted, where necessary.

10. All participants engaged in spirituality, religion and traditional healing to some degree, in maintaining their own mental health and wellbeing.

### 7.4 SPIRITUALITY

All focus group participants viewed spirituality as something which gives meaning to life and which facilitates a sense of being. It was described as transcending the physical world and connecting with a higher power. The
spiritual elements of mental illness are, at best, overlooked, and, at worst, dismissed as irrelevant and or misunderstood (Maxwell 2001). The healing potential for the individual and their networks to access more meaningful recovery may therefore be relatively unexplored. Spiritual and religious pursuits take many forms, from active adherence to specific tenets of a particular faith, to the quiet serenity of adhering to a contemplative life. Until recently, there was not an effective way of measuring these themes and how important they are in the wellbeing of people from diverse backgrounds. It is in this spirit of exploration and respectful intellectual inquiry that the issue was researched in the present study.

Kliwer and Saultz (2006) assert that all people are inherently spiritual – that each person has a spiritual component that is a part of their essential personhood. In some religious faiths, spirituality is viewed as a way of life, which in combination with religion, defines a person’s very being. Livingston (1989) states that the human experience may be studied from a biological perspective, or a social political perspective, or from the perspective that we possess an aesthetic sensibility. If we are to understand human life in its totality, spirituality needs to be considered, since it influences every aspect of our daily lives.

In this study, spirituality was easy to connect with and have a shared understanding of, as it pertains to everyone’s own personhood. It can account for many different displays of human behaviour, from mindfulness activities, to exercising belief, to psychotic illnesses. This commonality of understanding of spirituality makes it a less confrontational topic than religion, largely due to the individualised accountability associated with it.

The personal nature of spirituality may present it as particularly familiar to the Queensland Health mainstream mental health practitioners, who aligned most with the precepts of the individualised Western medical mental healthcare model. Spirituality, more than either of the other key themes, was discussed without much filter by this participant group. The Community Elders, on the
other hand, were focused on the collective functioning of their communities, and were less familiar with the concept of spirituality as an individual choice. They said that the individual sometimes has to take priority (especially when there are mental health or wellbeing concerns), but once those issues are resolved, the expectation is that the individual will shift back into an interdependent relationship with the community and once more focus on protecting the interests of the whole group.

Neither spirituality nor religion were acknowledged as particularly familiar topics of open conversation for many Australians, which may create barriers of access for CALD clients presenting for mental health services. In the current study, spirituality appeared easiest for all participants to discuss, but this was less so for Queensland Health mainstream mental health practitioners. The CALD practitioners engaged in a hearty and long-lasting discussion on the topic, highlighting their openness to allow both spirituality and religion into the clinical encounter. Their non-CALD government counterparts, on the other hand, by virtue of their cultural conditioning, were reluctant to do the same.

As stated above though, Queensland Health mainstream mental health practitioners in the current study expressed that they did feel comfortable talking about spirituality. Of the three main themes which were discussed during focus groups, they were somewhat open to utilising both spirituality and religion in the clinical context, in order to inform a deeper understanding of the client’s psychological processes.

Many of the CALD focus group participants arrived in Australia as either refugees or asylum seekers, and they carried with them a burden of psychological stress. Some participants even originated from countries wherein there is active conflict and intertribal turmoil, and it is from these situations that they fled to Australia for safety. The community practitioners and Community Elders in particular may have experienced prolonged detention, subjugation, food shortages and housing insecurities. Some of the participants described feeling an increased sense of responsibly to ensure that others within or outside
of their community never have to experience such events. They value the freedom being here in Australia affords them.

With this freedom comes protection – both physical and psychological – from environmental and ecological attack. As well as engendering personal physical safety, this protection nourishes independent thought, decision-making and overall cultural safety (Whangapirita 2002). In one sense, individualism is attractive to CALD people, as it is something of a lens for evaluating oneself apart from external or communal influences. This may benefit psychological recovery on an individual level, but the larger collective threat is that communities can begin to lose some of their practice identity. Community Elders, other leaders, and parents in the current study described intergenerational conflicts, with younger community members disobeying cultural authority. Behaviours which do not conform to the culture’s rules or norms may include intermarrying with other groups, postponing marriage, divorcing, and having children out of wedlock. Further, younger community members may refuse to practise spiritual, religious or traditional healing in the same way as their parentage, which further breaks down the family and community connection. Many of the Community Elders describe their child-rearing practices as one of many practices that is becoming more unrecognisable over time.

To many, spirituality as a concept emphasises the relationship between humans and their environment. As health is directly related to caring relationships, Canda and Furman (2010) articulated it simply as being at the heart of helping – that spirituality sits at the heart of empathy and care, and that it initiates a call to service. The call to service is a call to action.

The CALD Queensland Health mental health practitioners and community mental health practitioners discussed the important role of spirituality, both in their personal and professional lives. These two groups took on more of a social fairness perspective, using spirituality to mediate their interactions with other people. They perceived spirituality as an internal process – as a foundational
component of their self-awareness and human understanding. They also identified another important dimension of spirituality – that it helps us understand our own suffering and gives us hope. Given that this is also a major tenet of a Western mental healthcare approach, the CALD participants felt that a key benefit of accessing spirituality (as well as religion) is that it helps us navigate our way through these complicated emotions and arrive at a place of peace. Spirituality and religion may help us cope with those things that do not otherwise make sense, such as war, trauma and pain.

While this study demonstrated that there was a commonality of defining and understanding spirituality in the broader sense, there were also variations in the way different groups pursued their spirituality. This needs to be taken into account by mental health practitioners if it is to be integrated into mental health treatment. Some may perceive spirituality and religion as indivisible, with the combination of the two contributing to their very identity. Many from an indigenous culture may perceive it in terms of one’s relationship with ancestors and the natural environment. Others still may only be aware of the concept of spirituality, without adopting it seriously into the individual worldview.

Community Elders had similar views to indigenous peoples about the relational aspect of spirituality and how it forges deeper connections between an individual and themselves, other people, their community, the land, animals and natural environment. This is in accordance with the findings of Durie (2011), who found similar perceptions exist for indigenous Māori peoples.

As noted, religion and spirituality were often used interchangeably throughout the study, especially when the Community Elders and community practitioners were discussing both topics. This suggests that those individuals and communities which score high in their spirituality or religiosity have difficulty differentiating the two. During focus group discussion, all CALD practitioners stated that they practised spirituality, religion and traditional healing, and considered all three very important. This was reportedly the case both when they were residing in their countries of origin and now, in Australia. In addition,
the same practitioners indicated that any changes in how they practised, understood and defined their spirituality and religion resulted from the acculturation process, as they were limited in how easily they could access the resources required for religious activity.

These findings align with the literature, in which religion and spirituality are described as complex, multifaceted, overlapping terms (Ingersoll 1994; Kilpatrick & Holland 1990; Maidment 2006; Tangenberg 2005). While conceptualisations of spirituality may be blurred by those of religion, the unique attractiveness of spirituality is “that it is not contained by a theological wall or any specific ideological system or framework”; nor is it “considered an equivalent with religion, religiosity, or theology” (Cowley & Derezotes, cited in Bhagwan 2002, p 2). Spirituality refers more to a human search for purpose and meaning in life experiences, which may or may not involve expression in a formal religious institution (Sheridan et al. 1994).

During focus group discussion, Queensland Health mainstream mental health practitioners passively concurred with many of the sentiments of the other participants, which was interpreted as a genuine self-reflection into how they interfaced with these themes. They appeared to listen attentively and learn, while the CALD mental healthcare professionals held the floor. Still, their relative silence makes it difficult to discern their true feelings and the degree to which their input was influenced by group pressure. Indeed, their hesitation in engaging with the topics completely might reflect a saving of face among their peers. The significance of this in relation to transitioning spirituality, religion and traditional healing into a mental healthcare setting is that perhaps non-CALD mainstream practitioners may decide to act out of peer pressure, as opposed to a genuinely held view and heartfelt desire to carry the themes into their clinical approach.

The CALD mental health practitioners embraced the complex fusion of spirituality and religion, and were prepared to bring them into the clinical experience. Spiritual and religious topics tap into existential issues and
transcendental values (Siporin 1985). These, in turn, bring strength to many in despair, particularly when existential and spiritual concerns interlink themselves with psychosocial problems (Carmody 1991; Grotter 2001). Thus, spirituality has been incorporated into psychological treatment pertaining to the areas of child and sexual abuse (Valentine & Feinauer 1993), anxiety and suicidal ideation (Bugental & Bugental 1984; Fournier 1990), HIV/AIDS (Dunbar et al. 1998; Greif & Porembski 1988), physical disability (Aguilar 1997), substance abuse (Albers 1999; Carroll 1999), terminal illness (Nakashima 2003) and other forms of traumatic exposure. An examination of the different dimensions of spirituality and religiosity would allow for a more informed characterisation of these multidimensional constructs, as an important next step in furthering such research.

It is worth noting that several authors have highlighted the disconnect between religion and spirituality (Hill et al. 2000; Sheldrake 1992; Zinnbauer, Pargament & Scott 1999). Religion has become increasingly contentious in contemporary society, defined by constructs such as denominations, theological belief systems, and major world traditions (Wuff 1997). As a result, religion has come to represent participation in some theological system, while spirituality represents one’s deeper understanding with a purer spiritual force. Importantly, the two need not be mutually exclusive, although they are often perceived as such by the general population (Zinnbauer et al. 1997; Zinnbauer, Pargament & Scott 1999).

7.4.1 Summary: Spirituality

This study has shown that in order to understand the importance of spirituality, one must understand the similarities and differences in how CALD and non-CALD people perceive it. For CALD communities, spirituality may play a vital role in all aspects of human relationships, and individualism, as a Western concept, may not be as readily adopted. Many CALD people come from collectivist societies where increased social distance is not supported and hence their understanding of “individualism” is limited. The notion of individual freedom may be seen as countering benefits to the tribe or group, which indeed
would not be encouraged or considered sustainable. Westerners, on the other hand, may instead perceive individualism as a highly valued commodity.

7.5 RELIGION

Collectively, participants in this research study saw religion as the framework in which the rules, roles, structure and organisational by-laws are contained that allow for membership into a group with shared philosophies and practices. Because religion is based on communal ideas, it is particularly important for CALD people who come from a tribal background, wherein interdependence is encouraged. For these people, religion is an internalised, inherited way of being, which is fundamental to their identity and concept of self. In contrast, the non-CALD mainstream practitioners in the current study were of an individualist frame of mind, where the needs of the person – as opposed to the collective – are prioritised. This consciousness has evolved from Western social constructs that historically originate from European countries. Putting in place a “bridge” between these two approaches will lead to better outcomes, as is the goal in the field of transcultural mental healthcare.

Similar to participants in this research study, Corrigan and colleagues (2003) define religion as an institutionalised doctrine, containing prescribed beliefs, practices and forms of expression. It is a formal institution, in which its members overtly participate (Cascio 1998). Unlike spirituality, religiosity in itself does not necessitate a personal encounter with transcendence.

7.5.1 Negative Aspects

Some participants in the current study posited that religion does not, in fact, align well at all with the above reference to facilitating transcendence, given its historical involvement in human activity which advocates to the contrary. In particular, the Queensland Health mainstream practitioners highlighted the subjugation of indigenous communities, women and ethnic minorities as examples of acts performed in the name of religion. Specific incidents that were cited as justification by the practitioner group included the sexual abuse
allegations in the Catholic Church, Jihadist activity in the name of Islam extremism, violence inflicted on first peoples of colonised countries, and the systematic oppression of females by a ruling patriarchy. Historically too, the Roman and British empires used religion to coerce, subjugate and conquer. Thus, for the Queensland Health mainstream mental health practitioners, religion as a topic conjured up many unfavourable associations. Indeed, such things cannot be argued to benefit the health, welfare and fostering of the human spirit.

Based on the response by this particular practitioner group, it would appear that integration of religion into transcultural mental healthcare may be difficult, as the negative projections are inevitably brought into the clinical encounter between themselves and the client. Specific triggers associated with the topic may be worth noting in the current study: all CALD participants originated from countries where colonial repression had its hand. This may be one of the reasons why the Queensland Health mainstream mental health practitioners reacted strongly, possibly because their forebears would, in many cases, have been the perpetrators of said repression. This may therefore ignite feelings of historical trauma, eliciting some degree of defensiveness against religion, in whose name the colonisation was perpetrated.

Interestingly, CALD practitioners, whose communities would have been victim to the colonisation, were more accepting of religion, both for themselves and as integrated into healthcare practice. They appeared to have internalised spirituality and religion as positive avenues of psychological relief. According to the Jungian philosophical approach, they took a negative experience, situated in the “collective unconscious” of society, and recreated it as positive. The same is seen in religious belief more broadly. For example in Christianity, Christ is, in the “collective unconscious”, the wounded hero figure. Christians identify with his wounds when they are faced with trials and tribulations. The same wounded hero prototype enacted with other spiritual and religious heroes such as Mohammad, Buddha, Abraham and Moses. All of these icons were called into suffering for the sake of a greater good.
From a more practical perspective, religion and spirituality may support mental health (Leavey, Dura Villa & King 2012). Indeed, involvement in any community, including a religious one, can provide a framework for positively oriented behaviour. Oman and Thoresen (2002) describe some of the pathways through which religion can causally influence mental health, referring to the use of social supports, positive health behaviours, and effective coping strategies (e.g., prayer and meditation). According to the authors though, benefits may only be seen if such activities are explored free of compounding forms of negativity or trauma.

At a deeper level, the difference in response to religion between CALD and non-CALD participants may also relate to their identities. In community-based cultures, people simply assimilate the religious ideas and practices observed by their families and communities. For example, African indigenous religion is thought of as inherited from one’s previous generations (Mbiti 1990). Via this generational transmission, African perceptions of spirituality are guided by nurture, so that they ultimately perceive it as embracing God as an ultimate power, reverence for ancestors, and an inner awareness of being connected with all of one’s life (Sacco 1996).

All of the CALD participants identified spirituality and religion as core elements of their identity, with ethnicity and cultural background also important in defining their worldview. The community practitioners, who most fervently aligned with this perspective, saw themselves as steeped in a tradition that takes precedence over ethnicity and defines every aspect of their lives – how they eat, how they worship and their interpersonal relationships. All of their daily activities are aligned with their spiritual and religious traditions.

Queensland Health mainstream mental health practitioners, on the other hand, viewed religion as only a small part of their identity – a part that is well thought out and carefully internalised. The divergence in participants’ relationship with religion is supported by Canda and Furman (2010), who describe the varying
degrees to which one can identify with spirituality and religion. At one end of the spectrum, one may be spiritual but not religious, whereas on the other, one may see spirituality as their whole life.

Some studies have found that aspects of religion and spirituality – often referred to in the psychiatric literature as “religiosity” – may actually worsen the course of psychiatric illness and undermine recovery (Brewerton 1994; Getz, Fleck & Strakowski 2001). According to this conclusion, intense participation in religious and spiritual activities may ignite delusions and other forms of psychosis that should be targeted for treatment.

Yet, despite the potential for negative impacts, many social scientists have advocated that spirituality and religion may provide “alternative treatment approaches” that help people deal with their mental health disabilities (Hill et al. 2000, p 55). Moreover, they may furnish safe and supportive communities where the person can flourish. Some of the literature reports that people can experience a spiritual or religious emergency or “crisis of faith” as is borne out in certain segments of the Christian and Islamic communities. Walker (2018) emphasizes this point by highlighting how important “spiritual fitness” is in helping when a crisis of faith presents itself in soldiers suffering from post traumatic stress disorder (PTSD). Starnino and Sullivan (2016) in the same vein state – “For many who experience serious mental illness, spirituality and religion can be common vehicles that provide a sense of coherence and meaning to life. However in the presence of early trauma, spiritual beliefs may be enhanced or destroyed, or never develop.” As such, there is reason to be cautious of pathologising communities’ responses to stressful socio-cultural occurrences. Traumatic events such as war, forced immigration, resettlement and acculturation to new environments can create these situations which intensify the fragility of an individual’s worldview.

7.5.2 Acculturation

Acculturation takes place at both individual and population levels when two or more cultural groups come into continuous contact (Berry 1990; Redfield, Linton
One of the groups – usually the one which has immigrated – may feel pressured to sustain their ethnic or religious identity (known as “cultural maintenance”), or seek out a range of groups in the broader society (known as “contact participation”; Berry 1990). This process of acculturation demands important adjustments that have a permanent impact on a person’s identity (Goodenow & Espin 1993).

Two CALD participants who took part in the current study described the ongoing effects of immigration on themselves and their extended family. They talked at length about the experience of being second generation Australian and inheriting a “bi-cultural identity”. This is not uncommon, and emerges when one tries to maintain ties to a culture of origin, while simultaneously adhering to the norms of the majority culture (Lu 2001). The literature defines bicultural identity as the bridging together of two cultures. It is considered advantageous to the individual, as it enables one to gain the best from both worlds (Centrie 2000; James 2003). Bi-culturality often disappears over time, due to exposure to shifting environmental demands (Farver, Bhadha & Narang 2002; Handa 2003).

In some cases, researchers have referred to the bicultural identity as a “hyphenated identity”, as certain culturally-specific behaviours are utilised by the individual at different times (Elley 1993). An example from the research study was when the CALD Queensland Health mental health practitioners appeared to fluctuate – according to the topic of conversation or how they wanted to present to the rest of the group – between emphasising their professional and CALD identities. Biculturalism or a hyphenated identity is something CALD people access regularly on an unconscious level. According to what the environment or situation requires, certain dimensions of their identity take centre-stage over other parts of the “self”, which in turn play a lesser role in that particular moment.

7.5.3 Immigration

Community Elders emphasised the important role of immigration in their carrying out of religious practices. With immigration comes some degree of
acculturative distress, which is a complex social, cultural and psychological process of adapting to a different society (Sundquist et al. 2000). Those participants in the current study who did relocate to another country may have done so out of desperation, and may have been seeking asylum or refugee status. As is the case with many who fit this description, they may have experienced living isolated from their familiar communities (Australian Red Cross 2013). Frequently, fear is at the heart of the claim for asylum, whether in response to violence, state persecution, alienation or religious persecution. As they wait for their immigration status to be resolved, many refugees live in a state of poverty, and may face further difficulties during this period, relating to food and housing insecurities, ongoing work, language barriers and employment challenges (Australian Red Cross 2013).

Integral to the immigration process is the ongoing resettlement phase and the role of cultural factors therein. Immigrants and CALD support services face unique and challenging circumstances. Relationships within families and communities may be put under enormous strain when individuals attempt to deal with past traumatic experiences while simultaneously adjusting to a new culture. Different members of an immigrant family may be at different stages along the resettlement “spectrum”, and this mismatch in can place even more pressure on relationships and systems (Codrington, Iqbal & Segal 2011).

As indicated above, Community Elders were the most vocal and sorrowful in discussing ongoing immigration and resettlement difficulties. One Community Elder spoke with tears in his eyes about how he felt like a “trouble-shooter” in his community, stating that his role as Elder had shifted, so that now he was chronically putting out fires between his community and the wider Australian community. He detailed one event in which police were called in response to his African community congregating in large numbers, before and after a church service. With much anguish, he described how humiliated he and his people felt as the police arrived and moved them along. He seemed ashamed at having “lost face” in his community, as a result of not being able to effectively deal with
the situation as it played out in front of all. Despite his high status within the community, he was relatively helpless in this new context.

This recount is consistent with the literature on how immigration, while offering new opportunities and freedoms, may also lead to role changes and relationship breakdowns, both in a family and community context. Males, for example, may lose their former status in the family as the breadwinner, and single-parent households may emerge from a father's death in war, or separation (Codrington, Iqbal & Segal 2011). Another stress factor includes estrangement from extended family and community supports for child-rearing, which may then lead to the formation of an inverted hierarchy wherein English-speaking children hold the power over oftentimes depressed, traumatised parents (Codrington, Iqbal & Segal 2011).

In response to the above resettlement difficulties, people seeking asylum and refugee status are more likely to find solace and containment among fellow countrymen and women with whom they can share their experiences about the sea journey and period of detention (Australian Red Cross 2013). The motivation to immigrate is, for many, persecution and torture in their home country. Indeed, this was the case for many of the Community Elders and community practitioners from the current study. They adopted prominent roles as a way of building resilience and “paying it forward”, thus finding catharsis in actively bringing together members of the community and advocating publicly for the group's needs.

Similarly, the same CALD participants recognised that collectivism was a feature of their (and many other) non-Western societies. In such societies, it is the family and the group itself that serve as the protective factor, while in Western society the government asserts itself as protective factor. This issue has an important bearing on the acculturative process, as CALD individuals bring a collectivist worldview with them when they immigrate, and this may not naturally enmesh itself organically into the host country's medical system.
Mental health practitioners who have no experience of working with newly arrived cultural groups may have anxiety about not being able to help (Codrington, Iqbal & Segal 2011). They may be aware of – without knowing how to address – the many injustices already faced by these communities, either in their country of origin, during flight, or even in Australia. Research by Bronstein, Montgomery and Dobrowolski (2012) highlights how a higher incidence of pre-immigration traumatic events was associated with greater post-traumatic stress disorder symptomology in many male adolescent asylum seekers from Afghanistan. Similarly, children from Afghanistan are more likely to have grown up in an environment of conflict and violence (Rashid 2008).

In refugee work, overwhelming events in the external reality of the clients have to be recognised (and survived) by not only the client, but the practitioners as well (Bowles 2006). These clinicians work with clients who have complex levels of trauma, which are often accompanied by more complicated psycho-social cultural issues (Codrington, Iqbal & Segal 2011). Vicarious traumatisation is therefore a very real possibility for both the client and practitioner, with the broader result being over-diagnosis or pathologising of behaviour which may be normative, given the context.

### 7.5.4 Intergenerational Complexities

Intergenerational and acculturation issues play a significant role in the psychological and emotional make-up of the immigrant. Culturally and linguistically diverse practitioners who participated in this study were either first or second generation immigrants, and each of these groups experienced both stressors and privileges as a result. For example, the Community Elders described how they relocated to Australia, bringing their children and as many of their family members with them as they could. They detailed the challenges of giving up all that was familiar. For a number of this group, this involved death of or permanent separation from family members.

The CALD Queensland Health mental health practitioners who participated in this study, were also intergenerationally influenced by immigration. Many
expressed that they had benefited from certain freedoms afforded to them by growing up in Australia. They said that unlike their parents, they had access to choice and growth; they had options around how they wanted to practise religion, spirituality and traditional healing. This was in contrast with their parents’ experiences. Although these participants were second generation Australians, they were fundamentally aware and appreciative of the huge sacrifice made by their parents and extended family when relocating to Australia for personal or cultural safety reasons. It appeared that these participants felt indebted to their parents and community for making such a big concession for their benefit. These individual participants appeared affected by acculturation in a different way than other groups. It was as if they internalised their parents’ sacrifice as a motivation in life; the debt of gratitude was so immense that they could not let parents or extended family down.

Psychologically speaking, people’s desire to find relationship stability may lead to them immigrating around the same time in their lives, and within a few years of starting a family. This may stem from an unconscious desire to recreate one’s culture or sub-culture. The Freudian impulse to procreate is associated with a strong desire to replicate a communal identity. Jung describes this with reference to the collective unconscious process of creativity engaged in by all humans. Jung saw procreation and human affiliation as reflective of a collective expression of their innateness. For example, there appears to be a strong need for immigrants to recreate a family situation here in Australia after being separated from family in their country of origin.

7.5.5 Identity
As previously described, many of the CALD practitioners in this study were born in Australia to immigrant parents, and they may therefore live and function “bi-culturally” or “bi-ethnically”. This in itself is an evolving process of acquiring multiple identities, which requires an awareness of how to navigate two worlds – the CALD world and the mainstream world. These complex identity negotiations were observed during focus group discussion when CALD Queensland Health mental health practitioners would transition back and forth between their own
cultural understanding of a topic and a Western perspective. Interestingly, the CALD practitioners also appeared to vacillate between their professional and gender identities when answering questions. Other paternal and maternal role identities emerged during discussion, particularly when this related to intergenerational issues.

The application of “multiple identities” is referred to by Sundar (2008) as “browning it up”. In other words, the South Asian adolescents in his study would emphasise behaviours consistent with South Asian characteristics. Alternatively, the youth would “bring down the brown”, or exhibit behaviours and attributes considered to be more Canadian (Sundar 2008). In the same study, the author observed that second generation South Asian-Canadian youth managed identity challenges by invoking these strategies to reach or achieve particular objectives.

Sundar (2008) described the process that was undertaken by the bicultural participants in his study. The youth assessed each situation, decided which identity would help them achieve the desired outcome, and finally executed the identity that was most useful in reaching that goal. The salient feature was to actively negotiate different aspects of the environment and make deliberate, strategic choices about how best to express their identities in a way that is beneficial. The positive outcome may be access to resources, emotional or psychological attainment, or gaining legitimacy or a sense of belonging (Sundar 2008).

The aforementioned findings by Sundar (2008) are consistent with observations from the current study, as all CALD practitioners appeared to engage in these processes on an unconscious level, thereby accessing those parts of themselves that best represented them in a particular situation, or otherwise obtained the most desired results. It appeared that the more identity options available to the CALD participants (e.g., education, professional skills, current job title), the more they engaged in this process. What this takes, however, is a lot of psychic functioning and at the end of it all, CALD people can feel over-
taxed, as a lot of mental effort is spent on achieving what, at times, amounts to small positive gains.

Community Elders identified this hyphenated process within their role and with the youths in their community. Specifically, they described the role reversal that occurs when younger members of the community acculturate at a faster rate than their parents. By acquiring English and knowledge of Australian customs so quickly, they appear to “outgrow” their parents, who may feel they have lost parental control and must rely on their children to teach them how to navigate their way through society. Within the school systems, the youth may learn they can question authority, and from their Australian peers, that they can accuse parents of child abuse if they administer the same forms of discipline as were normal in their home countries.

These intergenerational rebellions create challenges in parents’ relationships, reportedly contributing to a potential increase in rates of marital breakdown and family ruptures. A number of the Elders voiced how such rebellion by the youth in the community is happening at an accelerated rate post-immigration, and that in their countries of origin, this would not take place without the permission of the family or of the Elders or other tribal leaders within the community.

All CALD mental health practitioners engaged in religious practices, both in their country of origin and in Australia. However, during discussion, they admitted their religious practices had changed. This was presumed to result from having married into other cultures or faiths, or from having greater exposure to different cultures, which in turn elicited self-reflection about their own views. The CALD mental health practitioners were reportedly grateful for the opportunities that living in Australia afforded them – here, they were free of persecution and had safety and security – but still, a deep longing for their own homeland remained. The ongoing grief associated with this separation, and the desire to be close to one’s ancestors, is always going to feature in the emotional response to their relocation. The participants summarised the immigration experience and its after-effects as a “mixed blessing”. This provides justification for why spiritual
and religious issues lie within the realm of transcultural mental health, as they raise such profound identity issues that could not be truly understood outside such a context.

The majority of CALD practitioners who participated in this study felt that even though they still practise their religious and spiritual beliefs in Australia, a lack of access to certain tools, places and objects of worship limit full participation in these familiar practices. The Community Elders appeared the most passionate about this issue. One Elder admitted that a battle for his community, on almost a daily basis, is to come to terms with the fact that so many objects or locations that are considered sacred are not available to them here in Australia. Other members from this group, while reiterating their gratitude to the opportunities provided in Australia, mourned the cultural rituals and relationships which are central to their sense of wellbeing and self-concept, but which are not readily available to them now.

The Community Elders appeared to have some shame attached to this topic, as they referred to this being yet another identity shift that ethnic communities are asked to make upon immigrating. For them, the issue of hyphenated or bicultural issues manifested conflicted feelings, which drain emotional, physical and psychological energy from the person and their network. This process can often lead to negative psychological consequences for the individual and reduced community cohesion more broadly. The Community Elders stated that their community members feel vulnerable to misrepresentations, so expend significant mental energy attempting to connect, control and contain important information entering and leaving the community about themselves.

Healthcare systems are just beginning to acknowledge the effect of culture on personal and social meanings of illness and distress. These meanings can give the practitioner or healing professional a glimpse into the private inner world of personal experience (Kleinman 1988b). Thus, listening to the client’s narrative is of utmost importance, as it contains within itself some idea of how the client understands their own symptoms and illness. This is of course relevant for all
people, but particularly for those from CALD backgrounds. It also manifests the “rights and wrongs” of the past which are still embedded into our environment and collective thinking, and this type of intellectual tracing of the past and present can allow for a more meaningful expression of how a person experiences the world.

7.5.6 Summary: Religion

Religion turned out to be a relatively uncomfortable, complicated topic for focus group discussion with practitioners. Although there was some agreement on the definition, participant groups diverged over its functionality and purpose. Queensland Health mainstream mental health practitioners related religion to historical events perpetrated in its name. This may be why such topics are so complicated for them to bring into the clinical encounter. Culturally and linguistically diverse participants, in contrast, identified positively with the topic. This may be because their immigrant or CALD status means they congregate within communities of the same cultural background, and the same community interaction is an essential element of religion.

The CALD Queensland Health mental health practitioners were influenced intergenerationally by religion, and employed personas and identities to manage these demands. The Community Elders also described identity costs to themselves and their individual communities in relation to the youth, male-female role reversals, diffusion of their eldership role and overall access to spiritual, religious and traditional healing practices.

The range of possible religious affiliations and views makes religion an important issue to consider in transcultural mental healthcare, while taking account of the sub-themes that emerged from this study. In summary, religion is an important part of identity formation for immigrants and CALD people and is highly influenced by acculturation, which imposes long-term generational effects.
7.6 TRADITIONAL HEALING

Traditional healing, as defined in this study, allows CALD people to hold the space and claim ownership of something non-CALD people cannot. The practices involved have always been controlled by CALD people. We have created, refined and evolved them to accommodate the needs of CALD people. Such processes are in keeping with the “collective unconscious” notion of rebirthing; we reconfigure ourselves and project those representations into the land, sea or sky. Traditional healing has been left untouched by societal forces imposed by a dominant culture, and the practices therefore gain significance because they are pure, special, and unappropriated by those outside of the relevant culture.

7.6.1 CALD Construct

Traditional healing was collectively understood by participants as a set of practices that are culture-specific and long-lasting, dating back to pre-historic times in some cultural groups. It was acknowledged that many forms of traditional healing have been around as long as mankind itself, and they all have a deep connection with cultural ancestry. Traditional healing is associated with its own explanatory model of medicine, developed and administered by and for each cultural community.

This is demonstrated in a culturally powerful way by members of the Māori community, as tradition dictates that a newborn’s placenta should be taken soon after birth and planted in or around the place where they were born. This practice reinforces the relationship between the newborn Māori child and the land, as it is assumed that when one transitions from this life to the next, one returns to the land which created them (Te Akukaramu Charles Royal 2012).

Divergent views on traditional healing were expressed by those oriented to the Western mental health model, as opposed to all other CALD mental health practitioners. The former group did not appear to resonate with traditional healing practices because they are not scientifically based, whereas CALD participants embraced them wholeheartedly, going so far as to state that to not
include it in the treatment paradigm when dealing with transcultural clients is discriminatory.

One potential reason for such disparity between Queensland Health mainstream and CALD mental health practitioners is that the two groups view culture very differently. Mainstream practitioners referred to their own culture as a set of behavioural characteristics manifested by Australians. These behaviours included “being low key”, abbreviating sentences and words, acting like a “larrikin”, enjoying work-life balance, and appreciating certain music. They rarely brought up their own ethnic ancestry unless prompted or asked directly.

In contrast, CALD mental health practitioners talked about their cultures in detail, describing the community constituents, how long the community had been settled in Australia, the size of the community, and circumstances surrounding their settlement. They delved even deeper, when prompted, about challenges faced by the community, conflicts in their country of origin, ongoing tensions with neighbouring countries, and the results of these factors in terms of immigration patterns. This type of narrative or explanatory model of identity is routine for CALD people, especially if interest is expressed by the listener. This is not the case for non-CALD mainstream practitioners, and it is this discrepancy which may have led to some of the perceived resistance in embracing cultural issues within the clinical and treatment context. Awareness of one’s cultural identity (and the effect thereupon of one’s CALD or non-CALD status) may impact on how practitioners interact with CALD clients, and it may therefore be worth integrating into education and training programs developed for mental health professionals in this area.

According to responses from the focus group discussion, all CALD mental health practitioners who spoke of engaging in traditional healing methods prior to coming to Australia acknowledged that they still do. Even those who were born in Australia admitted unequivocally to engaging in traditional healing methods. This pattern of response from the current study indicates that
traditional healing for many CALD mental health practitioners is ingrained in their cultural identity and worldview.

Again however, there was a disparity noted between CALD and mainstream practitioners born in Australia. Initially, they did not appear to resonate at all with the topic, and asked repeatedly for clarification about what was meant by “traditional healing”. The CALD mental health practitioners needed no such affirmation, and understood the term immediately. After listening to the discussion about how traditional healing is defined and exemplified, the Queensland Health mainstream mental health practitioners admitted to using some of these practices. However, they also reportedly felt they needed further education about it, in order to understand it fully and rethink how they have been perceiving it. This is significant for future research studies, as it may take combined discussions of both CALD and non-CALD mental health practitioners to move the broader consciousness into an area of understanding that would allow for the development of improved treatment paradigms in mental healthcare.

The CALD Queensland Health mental health practitioners described engaging in traditional healing practices as a way of engaging with family and maintaining close contact with that part of their cultural grouping. This second generation CALD participant group presented themselves as living between two worlds – the world of the Western scientific thinker, and the world of the bicultural, bilingual professional. They appeared excited to have the opportunity to discuss and present their cultural methodologies. In professional practice, they may be forced to choose which of numerous methodologies to use, or whether to use a mix of traditional and Western approaches. The “multiple identities” exhibited by the group may be a consequence of their inheriting a parental legacy of appreciating their cultural background, or missing their home country. These second generation Australian focus group participants were the only CALD Queensland Health mental health practitioners who repeatedly referred to their parents.
7.6.2 Economics

In describing themselves and their traditional health practices, CALD people often use an autobiographical narrative style to discuss experience (Kleinman 1988b). The Community Elders were passionate about the purest elements of the traditional healing experience when it was being lived out in its natural habitat. The Elders spoke of these practices as ancient, and they were proud of their historical connection. Traditional healing was highly endorsed by the Community Elders; however, they did acknowledge the existence of some bad examples, such as when traditional healers adopt a Westernised model of service delivery and demand financial compensation.

Rashid, Copello and Birchwood (2012) similarly report that healers have come under attack for charging clients in return for their services. In some cases, large sums of money were requested for treatment. It was argued that helping a client through altruism was a virtuous quality. Rashid, Copello and Birchwood (2012) went on to state that not only were such healers portrayed as being financially motivated, but also vindictive in the means used to acquire their fortune. In the current study, some of the Community Elders, who themselves are healers, believed that such behaviour was synonymous with criminal activity. Indeed, it may add a layer of distrust to the healing practices, as perceived by the broader community. The Community Elders worried about losing traditional healing, and lamented the potential for another cultural displacement experience for them and their communities.

These types of ongoing narratives highlight a certain preoccupation for CALD communities with loss more generally, including the loss of place, self-representation and control. The metaphor of self-fragmentation – of the self as broken, with pieces missing – is a familiar story in these accounts (Furman 2005). Agosin (1999) highlights in her research story that she feels she became a poet and storyteller in order to participate more fully in inventing her history, and in doing so, she unintentionally engaged in a process of reinventing herself. This is in keeping with Jingian thinking. Many authors who have studied this issue write that survival of the self lies in one’s ability to compose stories and
narratives of the self. Oftentimes, CALD people, especially those who have experienced traumatic relocations, may discuss themselves and their healing narrative to align with stories about who they were and who they are becoming. This too is in line with Jungian theories. This process is important as it allows for a space in which personal self-actualising can be promoted. All CALD mental health practitioners in the current study gave examples of ancient traditional healing methods in which they engaged. It is through this engagement that they maintain a connection to themselves and their culture. They reiterated that European history is quite young, but that many of the cultures and histories they come from long predate European existence.

7.6.3 Western Paradigms
As described earlier, the CALD mental health practitioners in this study accepted traditional healing as valid, while Queensland Health mainstream mental health practitioners were hesitant to do so, because it is not supported by scientific research. Scientific thinking informs the framework for Western clinical practice, with research efficacy mandatory in order to substantiate clinical treatment practices. In comparison, substantiation of traditional healing for CALD mental health practitioners was based on the methods' longevity, and anecdotal historical evidence of successful remediation. Indigenous communities were given as living examples of cultural viability and cultural safety when they interact with Western frameworks (Durie 2011).

It was evident from this study that the context in which transcultural mental health is practised is a biomedical model, and even though Queensland Health mainstream mental health practitioners could appreciate the importance of spirituality, religion and traditional healing to CALD consumers, it was difficult to integrate the three approaches into a tangible mental healthcare approach. One mainstream practitioner commented that they were disciplined for addressing issues of spirituality, religion and traditional healing when treating a transcultural client, which justifies the reason for concern among professionals in the government sector. There appears to be an ideological clash in this regard. Transcultural views on spirituality, religion and traditional healing should be
taken into account, and any attempt at integrating these key themes into the prevailing biomedical mental healthcare system needs to be carefully carried out.

7.6.4 Treatments Using Traditional Healing

Participants in the current study – particularly those coming from a CALD background – highlighted the importance of traditional healing in their communities. Rashid, Copello and Birchwood (2012) found that the Muslim population in the United Kingdom sought spiritual advice from traditional faith healers for psychiatric and other related problems. The authors stated that the important role that religious and traditional faith healing beliefs have on perceptions of mental illness and substance misuse warrants further investigation.

Traditional healing is intimately associated with one’s religion, history, social relationships, cosmology and land, and it may therefore also influence one’s culturally specific beliefs about illness and suffering. For example, the Zulu people of South Africa believe in sorcery as a common cause of mental illness, usually enacted by someone who bears a grudge against another person (Crawford & Lipsedge 2004). Elsewhere, witches and other forms of demonic beings are thought to exist in the spiritual realm and inflict harm against others. Some traditional healing methods involve the input of cultural ancestors, who are considered responsible for protecting and supporting their living relatives, and who, alternatively, can inflict illness as punishment (Crawford & Lipsedge 2004).

Outside of the Western medical context, traditional healers are often consulted by people in case of misfortune or persistent illness. Most illnesses are regarded as a lack of harmony between a person and their environment. Traditional healers will identify the cause of the imbalance and prescribe treatments in the way of herbs, baths or rituals to restore equilibrium to the person or family in question (Crawford & Lipsedge 2004). Oftentimes it could be that families or traditional healers prefer that culturally specific phenomena are
used in explanatory models for psychiatric illness, since this may be associated with less stigma than a formal diagnosis of, for example, schizophrenia (Niehaus et al. 2004).

A study by Rashid, Copello and Birchwood (2012) revealed the importance of faith healing practices, which was widely recommended to clients experiencing symptoms of psychosis. Here, the healers were believed to be powerful mediums that helped in the treatment process. Healers told stories of how clients with serious physical and mental problems recovered by just praying and having belief in Allah that the illness would be removed. Other studies in this area have shown that those who practise their faith have decreased levels of depression and anxiety, and increased life satisfaction and wellbeing (Koenig 1997). Moreover, they are found to adapt better to the rigours of personal loss, physical illness and disability (Koenig 1997). Thus, it is important for mental health workers to take into account the power of faith healing, without branding such individuals as religiously deluded. As it stands, this is not necessarily the case, as according to findings by DeSousa (2007), mental health patients felt as if they could not talk about their religious beliefs out of fear of being negatively labelled and involuntarily hospitalised. Community Elders in the current study also voiced similar fears, stating that members of their communities were reluctant to discuss their spiritual or religious beliefs when faced with mental health issues, as they feared being misunderstood or stigmatised in a non-empowering way.

Another source of conflict between traditional and Western methods of healing is the client’s religious attributions – that is, that they believe ailments to exist because Allah or God has willed it (Rashid, Copello & Birchwood 2012). Hamdy (2009) argued that among Western observers, faith in the divine will has often been interpreted as passivity, inaction and anti-science, a common assumption being that religion acts as a constraint against the presumed benefits of science and technology, or that it constitutes resistance against Western technoscience.
Tied in with this incompatibility was the religiosity gap between service users and mental health workers, as identified in the earlier referenced study by Rashid, Copello and Birchwood (2012). One of the healers in this study argued that making referrals to faith healers could bridge this gap. Cultural awareness programmes should involve collaboration with faith-based physicians, especially given that Padela and colleagues (2008) showed having a spiritual dimension adds to the physicians’ work. This could be another way to bridge the religiosity gap, as they can inform service users and family members about how both Western and traditional forms of healing can work alongside one another for the benefit of the client (Rashid, Copello & Birchwood 2012).

7.6.5 Summary: Traditional Healing

This study found that traditional healing was seen by most of the participants as specifically engaged in by CALD communities. The Queensland Health mainstream mental health practitioners did not see themselves as having a culture in the same way as CALD practitioners. This is significant as it provides some insight into their self-representation, as divergent from that of CALD people. Culturally and linguistically diverse people may have formed their identity on the basis of culturally specific struggles and differences, and they are thus able to highlight and easily access hallmarks of their culture. Consciously and unconsciously, CALD individuals could perceive the challenges faced by their culture. This appeared absent from the Queensland Health mainstream mental health practitioners’ perspectives. Such divergent world schemas need to be better understood within the clinical context, as it could be the key to integrating traditional healing views within transcultural mental healthcare.

An important issue to emerge from this research was that traditional healing allowed CALD mental health practitioners to facilitate an important dialogue with CALD clients. Greater benefits can be achieved in this field by allowing CALD mental health practitioners, across government and non-government sectors, to educate, train and mentor their mainstream mental health practitioner counterparts in implementing treatment paradigms that are specific to themselves and their community. As an increasing number of CALD consumers
enter the mental healthcare system, this type of community knowledge will become more important.

The combination of cultural and professional competencies that CALD mental health practitioners possess means they are in a unique, influential position. This group may therefore be able to provide important insights into why integrating spirituality, religion and traditional healing into mainstream mental healthcare is challenging. On the other hand, practitioners from Western countries would have had all of their education, training, supervision as well as personal contact in the Western healthcare model. This system would be all that they know, making it the dominant one in their lives.

Importantly, the CALD mental health presence and the introduction of different explanatory models for treatment could be seen as threatening the dominant medical cultural narrative with which mainstream mental health practitioners are familiar. The Western healthcare system has been the primary framework through which all treatment has been delivered, and to introduce an “invisible hand” that guides and challenges that perceived reality may be too confronting for mainstream practitioners to digest all at once. At the same time, the questioning of a dominant authority may evoke unconscious anxiety in these clinicians, of which some was subtly brought to the surface during focus group discussion. This should be considered in future research, and conversations around such topics as were discussed in the current study should be conducted in mixed groups.

Because of the cultural divide between how CALD and mainstream practitioners saw traditional healing, it is likely that until this difference is understood more fully, tensions will exist between the two and implementation of tangible solutions will be hindered. There are recent hints of change however, as Western and non-Western societies are becoming increasingly interactive and thus exposing each other to unique perspectives. It seems there may be a growing call to integrate both as an ideal treatment option.
7.7 CONTINUITY OF PRACTICE IN HOME COUNTRY AND AUSTRALIA

CALD mental health practitioners showed a strong predilection to follow the same traditional healing practices in Australia as in their country of origin, although in some cases, this was combined with Western medicine. Community Elders stated that their practices had changed slightly since coming to Australia, since things that they considered sacred such as trees, the ocean, land and foods were no longer available, so that they were forced to find substitutes. It is projected that younger members and later generations of these communities will be inclined to place more reliance on Western medicine, thereby placing at risk future dependence on traditional healing practices.

Community practitioners were born into their spiritual, religious and traditional healing practices, and felt that traditional healing was a way for them to heal when other medicine does not have an answer. All tended to see traditional healing as related to ancient curative objects and practices which their community defines as sacred, healing, and good for the body, mind and spiritual soul.

A major differentiating factor between CALD groups in the current study was that the Community Elders had only recently immigrated to Australia; thus, they were still feeling the effects of settlement and country estrangement. This group contained participants who potentially had to flee from their native land, having little input in terms of where they ultimately would end up. As all CALD groups were highly spiritual and religious, their spiritual and religious practices would certainly have been coloured and affected by these tumultuous events.

It emerged in the study that all CALD practitioners were directly exposed to spirituality growing up. This was in direct contrast to the Queensland Health mainstream mental health practitioners, many of whom did not grow up with positive messaging about spirituality and appeared to have continued to rely on
this frame of reference. A number of the latter group adapted their own spiritual practices to accommodate their lifestyle views.

As stated, CALD participants reportedly engaged in spiritual, religious and traditional healing practices in their country of origin, as well as in Australia. Moreover, their definitions of these practices had not changed since relocating to Australia, but the mode of practice had, to some degree. This is a significant finding, as in a clinical encounter, a CALD client’s views on the above themes may similarly still be very much the same as when they first immigrated to Australia. Only with time and the effects of acculturation will one’s perspective change to become more closely aligned with the prevailing views in Australia.

Being exposed to so many different cultures, views, and other ways of interpreting and practising spirituality, religion and traditional healing has assisted some of the practitioner participants with their own personal growth. In addition, diversity in the clients that practitioners frequently work with, and hearing their explanatory models for mental illness during these encounters, creates a space for the practitioner and the client to both explore the other’s perspective.

Community Elders spoke about how challenging immigration and acculturative distress had been to their communities. Community practitioners, on the other hand, reported no change to the way they practised spirituality, religion and traditional healing since relocating to Australia. This was an interesting finding to emerge from this study. According to Bhagwan (2009), regular attendance at religious activities may be linked to high levels of orthodoxy or other religious beliefs, which he defined as attending a place of worship or engaging in meaningful spiritual and religious activities at least twice a week. Community practitioners described engaging in meaningful religious activity on a daily basis.

The rest of the CALD practitioners reported a high level of ongoing active participation in an organised religious or spiritual group, which accords with the
finding by Bhagwan (2009). All of the CALD mental health practitioners who participated in the study scored highly on issues involving spirituality, religion and traditional healing, in terms of how they incorporate these themes into both their personal and professional lives. The themes therefore appear quite integral to who they are as people.

Queensland Health mainstream mental health practitioners described a very different experience growing up, having been reared in households where spirituality and religion were not a featured part of their experience. This, coupled with the Australian mindset of not talking about one’s spiritual or religious views openly, could be an impediment to Queensland Health mainstream mental health practitioners feeling comfortable meeting with these issues in a therapeutic or professional milieu. High levels of spirituality can sometimes translate into high levels of support for the use of spiritual interventions and support for their appropriateness in social work or other forms of practice, whereas the opposite is also the case (Bhagwan 2009). Spirituality was found to be important to the mainstream group of practitioners, but only from a historical vantage point, as all of them are residing in their country of origin. Members of the participant group were looking back on their childhood experiences and comparing them to their children’s, in terms of spiritual and religious activities. They brought up examples like Bar Mitzvahs, weddings and the cultural ceremonies that take people from one developmental stage to another. Again, the mainstream group was rational in discussing their memories of childhood spiritual and religious involvement, and indeed most appeared to have no significant emotional connection with the topic.

7.8 SPIRITUALITY, RELIGION AND TRADITIONAL HEALING IN PERSONAL MENTAL HEALTH

When asked if they engaged in spirituality, religion and traditional healing as a way of maintaining their own mental health wellbeing, all participants
emphatically said that they did. This response may be due to mixed fertilisation of the focus groups, as both mainstream and CALD Queensland Health mental health practitioners were included in the same focus group discussion, and the mainstream practitioners appeared to take their cues from their CALD counterparts over the course of the conversation. Group dynamics emerging from the study strongly advocate for mixed focus groups discussion as a way to shift conversations into unfamiliar terrains, in a non-confrontational way. The fact that this was one of the last questions asked, and this group had the opportunity to process and work through other questions, may have meant that their consciousness was shifted to one that was more emphatically accepting of the key themes discussed.

Mental health was understood similarly across all groups, but community practitioners and community mental health practitioners also connected this definition with the mind, body and spirit. This was especially the case for the community practitioners, who were born into their spiritual, religious and traditional healing orientations, and whose psychological make-up is therefore deeply embedded in these themes. This participant group talked about the physical and spiritual dimension to their understanding, stating that the body was divided into two selves – a higher and lower self, or the physical and spiritual.

More broadly, the finding that CALD participants’ definitions of spirituality, religion and traditional healing have not changed since relocating to Australia, suggests that mental health practitioners who participated in this study were relatively highly involved in these three activities. This calls for mental health practitioners to be aware of CALD clients’ (and their own) behaviours and perceptions during the clinical encounter, so that a space of helpfulness and full participation in the clinical encounter can be achieved for the client.
7.9 IMPLICATIONS OF FINDINGS

7.9.1 Application of Spirituality, Religion and Traditional Healing to Transcultural Mental Healthcare

Mental health was defined by participants as a maintenance of wellbeing and an absence of illness, through the caretaking of one's spiritual, emotional, and physical needs. Mental health was seen by all as an important ingredient in overall health. Queensland – and therefore its healthcare workforce and clientele – is becoming increasingly culturally diverse, which is reflected in the finding that most mental health practitioners in this study overwhelmingly engaged in spirituality, religion and traditional healing in order to maintain their own emotional wellbeing and mental health.

The uniformity with which the participants expressed these views was seen to contrast with how the discussion began; Queensland Health mainstream mental health practitioners in particular initially expressed trepidation about discussing these topics, though by the end appeared more accepting. This group was still reluctant to integrate traditional healing into their practice, but reportedly saw value in doing the same with spirituality and religion. One of the practitioners who had initially shown reluctance commented “How can I not?”, when asked at the end whether she engaged in spirituality, religion and traditional healing as a way of maintaining her own wellbeing.

All of the mental health practitioners felt there was a space for spirituality and religion to be integrated into mental healthcare. One community mental health practitioner went as far as to state that if the clinician does not, it is akin to harming clients, given the oath to do what is in the best interest of the client. The consensus was that if clients wanted it, services should find a way to action this. The CALD Queensland Health mental health practitioners and community mental health practitioners strongly advocated for the client to hold the clinical space and for service providers to honour their wishes, as opposed to asking clients to conform to the system.
The Queensland Health mainstream mental health practitioner group raised objections to the integration of traditional healing, as they felt it was too complicated a topic to be considered. One of the group commented that it would be impossible to learn all the traditional healing practices, as this would be a major burden on a healthcare system that is already under pressure due to reduced staff resources, data management requirements and workload obligations. These concerns about the treatment constraints imposed upon them by the system are reasonable, but if the argument is unpacked further, there may also be a hidden dynamic in operation around this particular issue, which relates to how CALD people appreciate, approach, and are influenced by culture in a medical and dominant socio-political system that operationalises culture differently. In Australia, one is obligated to strongly consider the practice mindset of the community in which one lives. As Australians jokingly will tell you, they do not have culture, although perhaps this joke is internalised more than is recognised.

On the other hand, the CALD Queensland Health mental health practitioners, like all other CALD practitioners, were serious about incorporating traditional healing (as well as spirituality and religion) into transcultural mental healthcare. They appeared optimistic and hopeful that the system could be reconfigured to accommodate all three key themes. In order for these benefits to be realised however, management leaders within the Western healthcare system need to adjust their thinking, and practitioners need specific training to equip them to deal with CALD clients. In particular, this training should engender an openness to exploring the client’s views on spirituality, religion and traditional healing, by learning from the client and seeing the clinical encounter as a partnership arrangement.

Overall, participants felt that the themes of spirituality and religion should be integrated into transcultural mental healthcare. Positive suggestions for facilitating this process also came from focus group discussion, including putting some reference to the themes on intake forms, and making the themes a part of the assessment process. This latter suggestion is important as it allows
practitioners to be reminded of their importance and clients to feel affirmed and responded to. These responses offered by study participants speak to the need for greater acceptance by healthcare management bodies, and improved training of mental health practitioners, to better equip them to deliver mental healthcare services to transcultural clients.

Spirituality proved to be a good beginning to the conversation in the current study, and its ease and non-threatening nature makes it a potential entry point into discussion about how all three key themes might be integrated into mental healthcare. Religion and traditional healing were harder concepts to engage with, as both have personal and professional challenges attached. Still, as mental health practitioners took a professional oath to provide client-centred services and treatment, they are obligated to go where the client wants to take them.

Australia has experienced significant increases in the number of immigrants coming from non-English-speaking countries between 2001 and 2011. For example, immigrants from India have increased by 200,000 people and immigrants from China have increased by 176,200 (ABS 2012). The number of languages spoken in Australia has increased from 160 in 1996, to over 200 in 2011 (ABS 2012). This means that cultural beliefs about mental illness will affect how these immigrant groups seek help, and whether or not they will have access to appropriate services. Understanding mental illness as a health problem that requires medical attention is a Western driven concept that can seem strange or even threatening to some people from CALD backgrounds. To understand and respond to the needs of the culturally diverse, mental health practitioners who are interfacing with these communities need to know their own traditional healing beliefs, who their CALD communities are, and how to engage with these communities in a collaborative partnership to deliver effective mental health services. The self-reflective element of this process is important for gaining insight into one’s own biases and availability to the client.
One valued assumption in a Western-based model is the belief in a common rationality, whereby persons who deviate from this rationality may be defined as unwell (O’Connor & Vandenberg 2005). This is a particularly important area, as the mental health field has a long history of considering religious and other forms of experiences as pathological or lacking in some way (O’Connor & Vandenberg 2005). Some would go so far as to equate those who engage in such practices as primitive, uneducated, or less civilised.

An area for further research and conversation is how collaboration might be brought about between religion and science, both of which are essential for the wellbeing and treatment of CALD clients. During such debate, it is important to be aware of the potential conflict between the two disciplines, such as the overlaps between psychosis symptoms in Western medicine and, as an example, possession of jinn in Islamic thought (Rashid, Copello & Birchwood 2012). As Western systems are infused more with scientific thinking and research, intersections between rational and non-factual understandings needs to be processed, with some consensus reached. Cox (1996) argues that collaboration occurs when explanatory models of faith healers include an awareness of the complex nature of mental disorders, and those of psychotherapists include a respect for the theological insights of spiritual leaders. The results from the current study indicate that this may be an effective standard for clinical practice, as sought by a range of mental health personnel working in the transcultural mental healthcare field.

### 7.9.2 Implications for Mental Health Practice

One of the key implications for practice to emerge from the current study is that spirituality, religion and traditional healing are issues that are central to the CALD identity. As the mental health workforce and the clients they treat are becoming more culturally diverse, it is imperative to know about the different treatment options and to make them available within the Australian context. Spirituality, religion and traditional healing are attractive and appealing to both the workforce and consumers, as they share a common grounding, in terms of the knowledge, beliefs, and practices indigenous to the local culture (WHO
This is supported by Nortje, Obadeji, Gureje and Seedat (2016) who analysed studies from the past 50 years and concluded that many people in developing countries seek out traditional healers and spiritual methods of healing for mental health complaints, and they will often utilise other conventional psychiatric treatment services in collaboration (e.g., Alem et al. 1999; Familiar et al. 2013; Galabuzi et al. 2010; Girma & Tesfaye 2011; Kapur 1979; Khan et al. 2010; Kurihara et al. 2006; Latypov 2010; Makanjuola, Adelekan & Morakinyo 2000; Mbwayo et al. 2013; Razali 2000; Salan & Maretzki 1983; Varghese, Gopal & Thomas 2011; Wig et al. 1980).

Despite their widespread use, little is known about the effectiveness of spirituality, religion and traditional healing in treating mental health issues, and this has never been systematically reviewed (Nortje et al. 2016). Spirituality, religion and traditional healing methodologies keep communities engaged with the more natural elements of life and more organic elements of their culture. By interfacing with these pure and unchanged systems, the community is afforded an opportunity to engage in healing that is from the earth, by the earth and ultimately resultant in important psychosocial, spiritual and religious benefits for those who seek it out. To engage with these resources is cost-effective, as they require only what is found in the clients’ natural environment, with reasonable facsimile found in others, as well. For example, one common spiritual way of enhancing wellbeing is to spend time in nature. Exposing oneself to nature and fresh air, through walking or just taking time out, is a commonly used way to heal. The natural environment is where a lot of traditional, spiritual and religious activities take place, but it is also obviously familiar to other non-CALD individuals.

Healthcare practitioners are even known by the principal investigator to meet with their clients within such environments, based on the belief that this will lead to a more positive experience than meeting with clients in sterile office situations. These practitioners acknowledge the benefits obtained by both themselves and the client, from sitting in nature and discussing stressful life events, as many life stressors are made insignificant when sitting amongst the
divine, located within nature. In addition, many CALD communities have felt discriminated against by medical establishments, so to work with these clients in spaces they see as natural and safe may provide them with a sense of security, as nature is perceived as more reliable than many man-made institutions.

7.9.3 Implications for Mental Health Policy

The literature on explanatory models, attitudes and beliefs concerning help-seeking and mental health services for CALD clients is sparse, fragmented and based on small-scale studies of very few immigrant communities (Minas et al. 2013). A better understanding of social and psychological determinants of mental health and mental illness in CALD communities, and of their perceptions of treatment services, should include reference to the perspective of the client, family members and identified support workers, as an important precursor to the development of effective policy and treatment services, mental health promotion, and illness prevention services. Findings in the research for this thesis are in agreement with the literature in this regard and clearly demonstrate the importance that the CALD community attaches to spirituality, religion and traditional healing and that they want their own perspective on these issues to be taken into account in the clinical encounter. The research findings also show a disconnect between Mainstream practitioners in particular and the views of CALD clients, in that the practitioners felt that they were too busy to take these factors into account, were inadequately trained for this and that the religious landscape was too diverse and complex. An important conclusion to be drawn from the findings in this research is that the mental health delivery system needs to be restructured in order to provide effective mental health service delivery to CALD clients.

The mental health of immigrants is almost always negatively affected by migration experience (Latypov 2010), pre-migration trauma (Csordas 1988), long-term detention and incarceration (Krippner 2012; Mehl-Madrona 2009; Omonzejele 2008), restriction of access to family and friends (Seligman 1995), human rights violations, exposure to threats of different kinds (Howard &
Thornicroft 2006) and fear for family and friends that are left behind. These are all social determinants of mental health for this population group (Kowalski & Mrdjenovich 2013).

Several psychosocial factors have also been found to be associated with increased risk of mental health disorders among immigrants. They include limited English proficiency and limited access to learning (Campion & Bhugra 1997), separated cultural identity (Salem et al. 2009), lack of real opportunity for effective use of occupational skills (Hewson et al. 2014), trauma exposure prior to immigrating, and the many stresses associated with resettlement and adjustment to a new host country (Barry 2006).

To understand the determinants of mental health, psychological rates of primary and secondary symptomology need to be better researched and understood. Similarly, more information is needed on protective factors such as engaging in spiritual and religious beliefs and practices, access to English classes, higher levels of social support, and higher self-efficacy (National Institute for Clinical Excellence 2014; Reeves, Kuper & Hodges 2008).

A key goal of mental health policy, practice and research is to develop improved ways of accessing effective health promotion, illness prevention, early intervention, treatment and psychosocial supportive services for immigrants (MacLaren 2009). As there is an emerging body of knowledge about people from CALD backgrounds, produced by practitioners from CALD backgrounds, important factors for consideration when developing improved healthcare paradigms will likely surface more and more in the clinical literature as time goes on.

7.9.4 Implications for Research
Currently in Australia, there is an absence of population-based mental health data concerning immigrant and refugee populations, which is in itself a great inequality in mental health. The dearth of information about the mental health status of such a large proportion of the population, and the possible deficits in
how our mental healthcare system caters to them, is a serious shortfall. Only through bringing these inequalities to light can strategies be developed to address the needs of disenfranchised groups and reduce inequalities in mental health status and services. As it stands, some proposed actions by the healthcare system are framed as recommendations, although they are not directed at specific organisations or agencies. The intent of the recommendations that have been made is to suggest strategies that will contribute to the development of an inclusive culture for all Australians.

CALD practitioners in the present study expressed how excited, joyful, and honoured they felt in being able to have a forum where they could discuss and elaborate on in detail some of their culturally held values, beliefs and treatments that had been handed down from generation to generation in their communities. They talked about how affirming it felt to their own mental health and professional wellbeing to be given an opportunity to discuss cultural activities that were important to them. To have an audience of practitioners who stood side by side with them in the work environment, and to have these people listen to personal practices that were a meaningful part of their identity and personal make-up – this was described as spiritually transformative. Such were the observed benefits of the current study to those participants involved, and this is perhaps another rationale for developing future studies with a similar methodological focus.

At the beginning of focus groups, mainstream participants were generally hesitant about connecting with religion and traditional healing topics. The mixed nature of the focus groups, however, provided a safe space for them to hear the perspectives of CALD participants, who were observed to be much more open about the same topics. By listening to others’ experiences and asking questions, they appeared better able to engage with the main factors during discussion, and even communicated an inclination to apply the topics to their personal and professional lives. The discussion facilitator was encouraging and supportive, thanking each participant for sharing, and also reiterating that to express one’s views in any group context is difficult, and any perspectives given
would be kept confidential, highly valued and respected. The facilitator stressed that there were no right or wrong answers during the discussion. There was also a brief conversation around making oneself vulnerable and available to discuss these very sensitive issues. At the end of each session, participants were again informed that they could have access to the discussion facilitator (and principal investigator) or a different private clinician, to discuss any content raised within the group. These processes, along with refreshments being served, created a stress-free milieu, engendering more active and engaging participation for all involved. The use of mixed focus groups, and the creation of a “safe space” for discussion, were therefore seen as positive aspects of the research design for this study, and it is recommended that such a design be implemented in future related research.

7.9.5 Implications for Clinical Services
Since spirituality, religion and traditional healing have been shown in the current study to be very important to CALD people, practitioners working with the CALD population should be aware of this and address these issues in clinical practice. This is supported by the research literature, particularly in regard to spirituality and religion. As many immigrants have come from war zones and have experienced terrible suffering, the importance of these protective factors is greatly increased in their situation.

Immigration and resettlement issues are therefore important mitigating factors influencing the degree to which CALD people engage with spirituality, religion and traditional healing. Moving forward, CALD clients should be consulted by service providers and given the opportunity to describe their settlement experience in Australia, taking into account forced relocation, detention, and other pre-immigration issues. Open dialogue around issues of spirituality, religion and traditional healing, how the client interfaces with these themes, and the nature of their supportive networks should be explored by mental health practitioners in the clinical encounter. These themes can open up a whole new treatment paradigm and advance the formation of more inclusive healthcare practices.
Finally, many CALD communities are first exposed to Western mental healthcare services after arriving in Australia, and the practitioners to which they are introduced are not from their own cultural background. Spirituality, religion and traditional healing, which are universal in nature as shown by this and other research studies, provide a platform for the mainstream mental health practitioners and CALD clients to meet, establish a mutual understanding and collaborate on improved mental health treatment outcomes.

One of the key obstacles for progress in transcultural mental healthcare is clearly outlined in a report prepared by MHIMA (2014) for the National Mental Health Commission. It is stated that data by CALD variables are not available in any sort of locally or nationally consistent basis, as they are not recorded as part of any reportable datasets. This is a key issue that needs to be resolved. If nationally reportable mental health data are inclusive of CALD data variables, or at least if the ABS were to use the recommended core set and supporting indicators for CALD data collection, that would be the first step to developing a useable profile of the needs and issues for CALD mental health consumers nationally.

Organisational and management inertia may slow the implementation of CALD-effective mental healthcare paradigms in the mainstream mental healthcare system. This issue can be addressed with ongoing advocacy and supportive dialogue on holistic care for all consumer groups.

7.10 LIMITATIONS AND FUTURE DIRECTIONS

The current study was not conducted on a long-term longitudinal scale. The sample size in this qualitative study was also only relatively small, and to make findings generalisable, a larger sample size would be preferable. The study also only focused on participants in Brisbane, Australia; hence, a larger study spread across other states would provide expanded scope and even more generalised findings. It would be interesting to compare the findings from this study with other studies from within Australia and the international arena.
Participants for this study needed to have a high level of spoken and written English proficiency, as funds were not available to access interpreters. This meant they may not have been reflective of their larger community, as they may have had a relatively high level of linguistic acculturation to the host country. In addition, the participants were likely to be highly acculturated and well versed in Australian health expectations, with access to financial resources. Hence, some degree of selection bias may have influenced the results obtained. That said, language interpretation services may not have resulted in entirely representative data either, given the potential for interpreters to miss important nuances in the communication exchange. Language interpretation would also have inhibited the flow of discussion for other participants. Hence, while the choice to include only those participants who were proficient in the English language may have introduced selection bias, the alternative choice to include non-English-speaking participants would probably also have posed a risk to the integrity of the study results. That said, future research may extend the focus of this study to non-English participants, to see if findings are replicated.

Given that different cultures were involved in this study, homogeneity was not achieved regarding any one specific cultural group. This may have limited the generalisability of results to specific sub-sets of the population, although the diversity of voices was considered a positive aspect of the study, since it allowed for a range of complex perspectives to be heard. All study participants were homogeneous in having had direct contact with people with mental health difficulties, and they were all placed in a position of responsibility to assist them with access or treatment. The majority of participants were from a CALD background and had been influenced and affected in some way by immigration and resettlement issues.

The impact of gender, religious affiliation, age and professional status were not analysed in any detail in the study, but suggestions emerged from this results that adherents to different religions may be significantly influenced in their views on the subject of the study, as a function of the particular religion that they
follow. Variability of people’s views within the realms of spirituality and traditional healing practices are also worthy of closer investigation in future research.

A further issue is that foreign accents and foreign names can also create certain transferential and counter-transferential representations. These factors may be under-recognised, and acknowledged only as a language or dialect difference, or as a barrier to effective treatment. On a deeper level though, linguistic difference can evoke value-laden unconscious judgments that reflect transferential images such as low intelligence, poor education level, and linguistic inferiority or superiority (Nagai 2009; Stocker 2017). Future research may seek to address whether clinicians from varying ethnic and professional backgrounds perceive foreign accents and other dialect differences as barriers to mental health treatment. This topic was not included explicitly in the research questions asked in the present study, but it may be considered an area of inquiry worthy of further investigation. Stocker (2017), for example, found that individuals’ credibility was affected by the presence of a foreign accent. It may be that this is a barrier for clinicians working with CALD clients who have dialectical differences.

7.10.1 Challenges for Consideration in Future Research with CALD Populations

When conducting sensitive research with vulnerable populations, the research method needs to be rigorous and flexible, in order that the target population’s diverse range of vulnerabilities, needs and experiences are catered for in a manner that accurately and safely captures participants’ perspectives (Elam & Fenton 2003; Liamputtong 2007). The challenge for this current study, therefore, was to find a methodological approach that addressed these challenges while yielding valid data that answered each research question (Gifford et al. 2006).

It is well established that a qualitative approach to research provides a deeper understanding of the phenomena being studied. It is particularly important when
exploring sensitive topics such as spirituality, religion and traditional healing with diverse populations perceived as vulnerable (Ager 2000; Gifford et al. 2006; Liamputtong 2007; 2013). Using a qualitative methodological approach expanded the scope of the research (Sandelowski 2000) and strengthened the quality and rigour of the research findings (Ager 2000; Creswell 1994; Creswell & Plano-Clark 2007; Moffatt et al. 2006; Östlund et al. 2011; Polit & Beck 2012). This simultaneously helped to offset potential weaknesses or biases that can otherwise occur when a single method approach is used in isolation for researching sensitive topics in any vulnerable population (Ager 2000; Creswell 1994; Creswell & Plano-Clark 2007; Moffatt et al. 2006; Östlund et al. 2011; Polit & Beck 2012). In the present study, many of the participants were immigrants to Australia, having left countries that were in a state of war. As individuals who had therefore experienced extreme trauma, they are vulnerable to psychological crises (Starnino & Sullivan 2016). Many of the CALD participants were refugees, and so they may be considered 'vulnerable' persons, regardless of the practitioner status they obtained in Australia (MHIMA 2014). Qualitative inquiry therefore provided an opportunity to compare, contrast, and validate findings, by enabling the exploration of the research questions from a number of different levels and perspectives.

Active participation of the target group population throughout the research process, from conceptualisation of the research issues through to the planning and development of the research method, was fundamental to the success of this research. The questions themselves emerged from many years of formal and informal discussions with practitioners and community members, all of which provided the principal investigator with skills in effectively establishing trust with participants, even when targeting sensitive issues among marginalised, vulnerable populations (Brondani, Moniri & Kerston 2012; Marcus et al. 2004; Marsden 2002). Such was essential for the success of the current study, as some participants came from a refugee or asylum seeker background and may therefore have had some mistrust for government services, host country populations, mental health systems or research institutions (Gifford et al. 2006; Hynes 2003; Liamputtong 2007). The community-inclusive nature of
the methodology adopted for this research also elicited a sense of safety between participants and the research project, while at the same time providing valuable contextualised insight into communities’ socio-cultural normative beliefs on the research topics (Lantz et al. 2006).

The research questions were addressed with input from mental health practitioners and para-professionals from a wide spread of cultural and ethnic backgrounds (both CALD and non-CALD). The organisations from which participants were drawn for the focus group discussions were well distributed across CALD and mainstream mental health backgrounds. Participants chose of their own free will to take part in the research study and to that extent, participant involvement was randomised, with the principal investigator unaware of who was attending each focus group until they arrived. This, as well as other methodological considerations, contributed to the current study’s research validity.

Vicarious trauma is defined by Herman (1992) as a way of describing how healthcare therapists can be affected psychologically by the mental health presentations of the client. The ways in which a clinician’s own cultural experiences interact with the client’s cultural experiences are not fully recognised and understood, as it is easy for the all-powerful clinician to misunderstand or under-identify a client’s reactions and project them on to the vulnerable client (Nagai 2009). Within healthcare in general – and mental healthcare in particular – the phenomenon of “vicarious trauma” is well-known. In other words, by bearing witness to the trauma experienced by a client, the treating practitioner may themselves be affected. Immigration alone can be a traumatising experience, but in addition, some participants in the present study spoke of other traumatic events they lived through before leaving their war-torn home countries. While this was not the focus of the present thesis, it is worth future researchers considering their own susceptibility to vicarious trauma. Those individuals conducting studies with CALD participants may be exposed to accounts of traumatic events, and thus vicarious trauma is a very real possibility.
The nature of the current study required a high degree of consultation with professionals from the relevant sector. Multiple levels of gate-keeping needed to be overcome, in order to access community leaders, Community Elders and other stakeholders (Black et al. 2011). There are ongoing tensions between non-government and government organisations regarding who works best with CALD communities. This is complicated further by the diverse range of individual and community cultural belief systems and explanatory models of mental health, within a health system that advocates a bio-medical scientific model of care.

Another issue involved in the study was that transcultural mental healthcare can raise issues of overcompensation for its workforce, in relation to how clients are to be treated. It has its own treatment framework that guides how CALD people should be treated, and this can be seen as protectionist or exclusive. From a distance, it can appear to be too flexible and foreign compared to mainstream mental health services, within which practitioners are reluctant to explore other models or treatment modalities. In addition, cultural transference and counter-transference can occur within mental health systems whereby individuals or even entire communities are assessed and diagnosed unfairly. These same individuals or communities can also unconsciously contribute to being interacted with in a disempowering fashion, or they can unconsciously assist in being responded to in a maternal fashion (Napier & Whitaker 1978).

Finally, as the mental healthcare system is the only one available to treat CALD consumers with complex immigration and settlement histories, it would be worth re-examining how we – as clinicians and members of society more generally – view such individuals. It may be more appropriate to treat them as contextualised by their experiences, as “veterans of war” rather than simply sufferers of mental illness.
7.11 CONCLUSION

The great importance of spirituality, religion and traditional healing to participants in this study – in particular, those from a CALD background – clearly demonstrates why these protective factors should be incorporated into the practice of transcultural mental healthcare. Results indicate that practitioners should be culturally sensitive when treating clients from a CALD background. The study results also attest to the appropriateness of the theoretical framework used. The Jungian concept of the “collective unconscious” has a significant bearing on human behaviour, as does Kleinman’s theory of the explanatory model.

Spirituality, religion and traditional healing have been shown in the current study to be important, as they are manifestations of the collective unconscious. As previously stated, every culture on Earth has some reference to spirituality, religion and traditional healing. These are universals that have been consistent over time in the human experience. The participants in this study verified the importance of these themes to their own wellbeing and client groups. Overwhelmingly, the mental health practitioners, even those who were reluctant, agreed by the end that these factors are important to mental health. Sub-themes pertaining to spirituality, religion and traditional healing, such as individualism, intergenerational legacy, identity, community and collectivity emerged in the study as relevant to human relationships.

Spirituality and religion were reported by participants to lead to better understanding and contextualise pain and suffering. On a deeper level, spirituality, religion and traditional healing initiate us into transformational dialogue around how we may be “better”, as human beings. This was exemplified when CALD and mainstream mental health practitioners acknowledged how changed they were by virtue of being exposed to different cultures. Such exposure helped them develop a greater understanding of the CALD and human issues involved. More generally, the findings from this study point to the need for mental healthcare providers to consider spirituality, religion and traditional healing when treating CALD clients, in order to produce
improved outcomes that align with a transcultural approach to service provision.
References


Ae-Ngibise, K, Cooper, S, Adiibokah, E, Akpalu, B, Lund, C & Doku, V 2010, ‘Whether you like it or not people with mental problems are going to go to them: A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana’, International Review of Psychiatry, vol. 22, no. 6, pp. 558-657.


Agosin, M 1999, Passion, memory and identity. UNM Press.


Australian Bureau of Statistics 2011, *Cultural and linguistic characteristics of people using mental health services and prescription medications*, cat. no. 4329.0.00.001, Commonwealth of Australia, Canberra.


Bowles, R 2006, ‘Supervising bicultural counsellors in their work with traumatised refugees: Interface considerations of difference, Psychotherapy in Australia, vol. 12, no. 3.


Cashwell, CS, Young, JS, Fulton, CL, Willis, BT, Giordano, A, Daniel, LW & Welch, M 2013, ‘Clinical behaviors for addressing religious/spiritual issues: Do we practice what we preach?’ *Counselling and Values*, vol. 58, pp. 45-58.


DeLeo, D & Travis, H 2004, Suicide in Queensland 1999-2004: Mortality rates and related data, Griffith University, Brisbane.


Department of Immigration Multicultural and Indigenous Affairs 2007, Migrating as a refugee or humanitarian entrant, Commonwealth of Australia, Canberra.


Durkheim, E 1951, *Suicide: A Study of Sociology*, Free Press, US.


Falgoust, N 2006, *A curriculum for building religious and spiritual cultural competency in mental healthcare*, California State University, US.


Fournier, R 1990, ‘Social work, spirituality and suicide: An odd mix or a natural blend?’ *Social Thought*, vol. 16, no. 3, pp. 27-35.


Fukuyama, M & Sevig, T 1999, *Integrating spirituality into multicultural counseling*, Sage, US.


Ghorbani, N, Watson, PJ, Zarehi, J & Shamohammadi, K 2010, ‘Muslim extrinsic cultural religious orientation and identity: Relationships with social and


Gone, JP 2008, ‘So I can be like a Whiteman: The cultural psychology of space and place in American Indian mental health’, *Culture & Psychology*, vol. 14, no. 3, pp. 370-398.


Haas, P 2012, Pharisectomy: How to joyfully remove your inner Pharasee and other religiously transmitted diseases, MO: Influence Resources, Springfield, US.


Haddad, YY & Lummis, AT 1987, Islamic values in the United States: A comparative study, Oxford University Press, US.


Hamdy, SF 2009, ‘Islam, fatalism, and medical intervention: Lessons from Egypt on the cultivation of Forbearance (Sabr) and reliance on God (Tawakkul)’, *Anthropological Quarterly*, vol. 82, pp. 173-196.


Harman, W & Institute of Noetic Sciences 1988, *Global mind change: The promise of the last years of the twentieth century*, Knowledge Systems, US.


Herman, J 1992, *Trauma and recovery*, Basic Books, UK.


Heyer, G 2016, ‘Race, religion and a cat in the clinical hour’, *Journal of Analytical Psychology*, vol. 61, no. 4, pp. 434-449.


Hodges, C 2012, Fresh air: Trading stale spiritual obligation for a life-altering, energizing, experience-it-everyday relationship with God, Tyndale Publishers, Carol Stream, US.


Hughes, P, Thompson, C, Provor, R & Bouma, G 1995, Believe It or Not: Australian Spirituality and the Churches in the 90s, Christian Research Association, Melbourne.


Jung, C 1960, *The structure and dynamics of the psyche: Collected works (vol. 8)*, Bellingen Foundation, US.


Kiehl, E 2016, "'You were not born here, so you are classless, you are free!" Social class and cultural complex in analysis', Journal of Analytical Psychology, vol. 61, no. 4, pp. 465-480.


Kleinman, A 1980, Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry, University of California Press, Berkeley, US.


Leavey, G, Dura-Vila, G & King, M 2012, 'Finding common ground: The boundaries and interconnections between faith-based organisations and mental health services', *Mental Health, Religion and Culture*, vol. 15, no. 4, pp. 349-362.


Levin 2002, God, faith, and health: Exploring the spirituality-healing connection, John Wiley & Sons, Hoboken, US.


Mental Health in Multicultural Australia (MHIMA) 2004, Framework for the implementation of the National Mental Health Plan 2003-2008 in multicultural Australia, National Multicultural Mental Health Policy Development Steering Group, Canberra.


Moll, R 2014, What your body knows about God: How we are designed to connect, serve, and thrive, InterVarsity Press, Downers Grove, US.


Multicultural Mental Health Australia, 2008, Stepping out of the shadows: Reducing stigma in multicultural communities training package (Community Trainer Manual), NSW Health, Sydney, NSW.


Neighbors, HW, Jackson, JS, Bowman, PJ & Gurin, G 1983, ‘Stress, coping, and black mental health: Preliminary findings from a national study’, *Prevention in Human Services*, vol. 2, pp. 5-29.


Robson, C 2008, Real World Research (2nd ed), Blackwell Publishing.


Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group Executive Committee, 2010, *Spirituality and mental health*, Royal College of Psychiatrists, UK.


Sacco, T 1996, ‘Spirituality and social work students in their first year of study at a South African university’, *Journal of Social Development in Africa*, vol. 11, pp. 43-56.

Salan, R & Maretzki, T 1983, ‘Mental health services and traditional healing in Indonesia: Are the roles compatible?’ *Culture, Medicine, and Psychiatry*, vol. 7, pp. 377-412.


Scott, SK, Sheperis, DS, Simmons, RT, Rush-Wilson, T & Milo, LA 2016, ‘Faith as a cultural variable: Implications for counsellor training’, *Counseling and Values*, vol. 61, no. 2, pp. 192-205.


models of mental health service delivery in New Zealand', *Pacific Health Dialog*, vol. 15, no. 1, pp. 18-27.

Sue, DW & Sue, D 1990, *Counselling the culturally different: Theory and practice*, Wiley-Interscience, US.

Sue, DW & Sue, D 2003 *Counselling the culturally diverse: Theory and practice*, John Wiley & Sons, Canada.


Psychiatry: Models of Mental Health Services in Multicultural Societies, vol. 42, no. 3, pp. 491-504.


University of Pennsylvania 2003, ‘New Penn/Gallup poll measures “spirituality state of the union”’, Penn Today, 4 March,


Willing, C 2009, Introducing Qualitative Research in Psychology, City University, London, UK.


APPENDIX 1.

ETHICAL CLEARANCE
Dear Mrs Mitchell-Macaulay

HREC Reference number: HREC/13/QPAH/300
Project Title: Exploring Spirituality, Religion and Traditional Healing as Protective factors in Transcultural Mental Health Care

Thank you for submitting the above research protocol to the Metro South Human Research Ethics Committee for ethical and scientific review. This protocol was first considered by the Human Research Ethics Committee (HREC) at the meeting held on 4 June 2013.

You are reminded that this letter constitutes ethical approval only. You must not commence this research protocol at a site until separate authorisation from the Metro South Chief Executive or Delegate of that site has been obtained.

A copy of this approval must be submitted to the Research Governance Office/f/Delegate of the relevant institution with a completed Site Specific Assessment (SSA) Form for authorisation from the Chief Executive or Delegate to conduct this research at the Princess Alexandra Hospital.

I am pleased to advise that the HREC has granted approval of this research protocol. The documents reviewed and approved include:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover letter</td>
<td></td>
<td>12 May 2013</td>
</tr>
<tr>
<td>NEAF Application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to comments to Griffith University HREC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter of Support - WAQ</td>
<td>14 March 2013</td>
<td></td>
</tr>
<tr>
<td>Letter of Support - QACC</td>
<td>4 May 2013</td>
<td></td>
</tr>
<tr>
<td>Letter of Support - Multicultural Centre for Mental Health and Well-being</td>
<td>16 April 2013</td>
<td></td>
</tr>
<tr>
<td>Letter of Support – Executive Director, Addiction and Mental Health Services</td>
<td>21 August 2013</td>
<td></td>
</tr>
<tr>
<td>Recruitment information sheet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Information Sheet – Focus Group discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus Group Demographic Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent Form – Focus Group Discussion – Mental Health Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent form – Focus Group Discussion – Community Elders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus Group Questions – Mental Health Practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus Group Guiding Questions – Community Elders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email communication in response to HREC comments</td>
<td>6 October 2013</td>
<td></td>
</tr>
</tbody>
</table>
Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the protocol in the specified format, including unforeseen events that might affect continued ethical acceptability of the protocol. Serious Adverse Events must be notified to the HREC as soon as possible. In addition the investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of the event.

2. Amendments to the research protocol which may affect the ongoing ethical acceptability of a protocol must be submitted to the HREC for review. Amendments should accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study. Hard copies of the cover letter and all relevant updated documents, with tracked changes, must also be submitted to the HREC office as per standard HREC SOP. (Further advice on submitting amendments is available at http://www.health.qld.gov.au/ohtm/documents/researcher_userguide.pdf

3. Amendments to the research protocol which only affect the ongoing site acceptability of the protocol are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Officer.

4. Proposed amendments to the research protocol which may affect both the ethical acceptability and site suitability of the protocol must be submitted firstly to the HREC for review and, once HREC approval has been granted, then submitted to the Research Governance Officer.

5. Amendments which do not affect either the ethical acceptability or site acceptability of the protocol (e.g. typographical errors) should be submitted electronically (track changes) and in hard copy (final clean copy) to the HREC Coordinator. These should include a cover letter from the Principal Investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.

6. The HREC will be notified, giving reasons, if the protocol is discontinued at a site before the expected date of completion.

7. The Principal Investigator will provide at least, an annual report to the HREC on the anniversary of the approval and at completion of the study in the specified format.

8. If you require an extension for your study, please submit a request for an extension in writing outlining the reasons. Note: One of the criteria for granting an extension is the compliance with the approval’s conditions including submission of progress reports.

9. Any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes (WHO / ICMJE 2009 definition) should be registered, including early phase and late stage clinical trials (phases I-III) in patients or healthy volunteers (WHO Recommendation / ICMJE policy). If in doubt, registration is recommended. All studies must be registered prior to the study’s inception, i.e. prospectively.
http://www.anzctr.org.au/

This HREC approval is valid for three years from the date of this letter.

Should you have any queries about the HREC’s consideration of your protocol please contact the Metro South HREC Office on 07 3443 8049.

Please note that the Metro South HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice. Attached is the HREC Composition (Attachment I).
The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the following websites:

Once authorisation to conduct the research has been granted, please complete the Commencement Form (Attached) and return to the Metro South Human Research Ethics Committee.

The Metro South HREC wishes you every success in your research.

Yours sincerely,

[Signature]

Professor Maher Gandhi
Chair
Metro South Hospital and Health Service
Human Research Ethics Committee (EC00167)
Centres for Health Research
Princess Alexandra Hospital
Dear Professor Chenoweth,

I write further to the additional information provided in relation to the provisional approval granted to your application for ethical clearance for your project ""Exploring spirituality, religion, and traditional healing as protective factors in transcultural mental health care."" (GU Ref No: HSL/13/13/HREC).

The additional information was considered by Office for Research.

This is to confirm that this response has addressed the comments and concerns of the HREC.

Consequently, you are authorised to immediately commence this research on this basis.

The standard conditions of approval attached to our previous correspondence about this protocol continue to apply.

Regards

Dr Kristie Westerlaken
Policy Officer
Office for Research
Bray Centre, Nathan Campus
Griffith University
ph: +61 (0)7 373 58043
fax: +61 (07) 373 57994
email: k.westerlaken@griffith.edu.au
web: 

Cc:

Researchers are reminded that the Griffith University Code for the Responsible Conduct of Research provides guidance to researchers in areas such as conflict of interest, authorship, storage of data, & the training of research students. You can find further information, resources and a link to the University's Code by visiting http://policies.griffith.edu.au/pdf/Code%20for%20the%20Responsible%20Conduct%20of%20Research.pdf

PRIVILEGED, PRIVATE AND CONFIDENTIAL

This email and any files transmitted with it are intended solely for the use of the addressee(s) and may contain information which is confidential or privileged. If you receive this email and you are not the addressee(s) [or responsible for delivery of the email to the addressee(s)], please disregard the contents of the email, delete the email and notify the author immediately.
SSA AUTHORIZATION
PRINCESS ALEXANDRA HOSPITAL
METRO SOUTH HOSPITAL AND HEALTH SERVICE

HREC Reference number: HREC/13/QPAH/300
SSA reference number: SSA/13/QPAH/317
Project title: Exploring spirituality, religion and traditional healing as protective factors in transcultural mental health care.

Dear Mrs Mitchell-Macaulay,

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the Princess Alexandra Hospital.

On the recommendation of the Human Research Ethics Committee approval is granted for your project to proceed.

The following conditions apply to this research proposal. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval.

1. Problems and SAEs: The Research Governance Office must be informed of any problems that arise during the course of the study which may have ethical implications. Where serious adverse events (SAEs) are encountered, the events must be notified as soon as possible.


2. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project are to be submitted to the HREC for review. A copy of the HREC approval/rejection letter must be submitted to the RGO.

3. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted to the research governance office.

4. Proposed amendments to the research protocol or conduct of the research which may affect both the ongoing ethical acceptability of the project and the site acceptability of the project are to be submitted firstly to the HREC for review and then to the research governance office after a HREC decision is made.

If this research involves the recruitment of patients from the Metro South Hospital and Health Service (MSHHS), it is my responsibility to remind you of your ongoing duty of care for all people recruited into projects or clinical trials whilst public patients. All conditions and requirements regarding confidentiality of public information and patient privacy apply. You are required to comply at all times with any application requirements of Australian and Queensland Laws including the Health Services Act, the Privacy Act.

Enquiries to: Central for Health Research
Research Governance
Phone: (07) 3443 8050
Fax: (07) 3443 8003
Our Ref: HREC/13/QPAH/300 – SSA/13/QPAH/317
E-mail: RMH.Research@health.qld.gov.au

Mrs Deborah Mitchell-Macaulay
8 Harlequin St
Sunnybank Hills QLD 4109
Public Health Act (2005) and other relevant legislation, ethics obligations and guidelines which may be applicable to the MSHHS from time to time including, without limitation, any requirement in respect of the maintenance, preservation or destruction of patient records.

When the study involves patient contact, it is your responsibility as the principal investigator to notify the relevant consultant and request their approval.

We wish you every success in undertaking this research.

Yours sincerely,

Professor Ken Ho
Chair, Centres for Health Research
METRO SOUTH HEALTH

CC/ Geoffrey Lau
Director Of Therapies Programming
QH Metro South Mental Health District
APPENDIX 2.

METHODOLOGY PROCESS
FLOW CHARTS
STAGE I – Engagement with Community Elders

Researcher presents project to Community Leader Representative

Community Leader Representative presented research project to range of Community Elders from different cultural backgrounds

The Community Leader Representative informed each Community Elder of the time and place where a Focus Group for this research project would be conducted

On the day of the Focus Group meeting the principal investigator had no idea who was attending – on arrival, cultural meeting and greeting took place with food and drink provided

Consent Forms, Demographic Forms and Participant Information Forms were handed out, completed and collected

Researcher presented the research project to Community Elders who then discussed the research project which was voice recorded and later transcribed
STAGE II – Engagement of all Mental Health Practitioners

Researcher approached Managers of Community Organisations and Allied Health Discipline Seniors for Social Workers, Psychologists, and Occupational Therapists of Queensland Health mental health services directly and followed up with a letter requesting that they participate in the research project.

Each Manager and Discipline Senior of community and government organisations were briefed about the project – they then discussed with their staff.

The Discipline Seniors and Managers were given details of when and where Focus Groups would take place – researcher had no idea who would present on the day that Focus Group were scheduled to take place.

On the day, Researcher gave an overview of the research project to Mental Health Practitioners who showed up – each participant was issued with a deidentified Consent Form, Demographic Form and Participant Information Sheet.

After the forms were filled out and collected, the discussion was commenced with voice recording throughout and later transcribed.
STAGE III - Advisory Group

The Advisory Group consisted of 3 bi-cultural mental health clinicians who were not in any other way associated with the research project.

Researcher met with each member of the Advisory Group to give them an overview of the research project and explain how the Advisory Group would function and left them with a Participant Information Form and a Consent Form which they subsequently signed and returned to Researcher.

Researcher met with each member of the Advisory Group individually as needed to workshop a particular theme that came up during the analysis phase of data collection – this only occurred after consulting with Griffith University Supervisory Staff. Each theme was read out loud to the advisor member who vocalised their thoughts or reflections.

Feedback from members of the Advisory Group was then discussed with Griffith University Supervisory Staff and integrated into the analysis.
APPENDIX 3.

FOCUS GROUP QUESTIONS
Focus Group Guiding Questions – Community Elders.

There are 2 groups of participants with corresponding focus group guiding questions.

Community Elders

1. How does your community define spirituality?
2. How does your community define religion?
3. How does your community define traditional healing?
4. How important are these beliefs/practices in your country of origin?
5. Do you think these definitions of spirituality/religion/traditional healing have changed since coming to Australia? If so, how have they changed?
6. Can you provide an example of how it has changed?
7. Do you feel that this change has affected your community’s sense of wellbeing? If so, how?
8. Do spirituality, religion and traditional healing help people in your community with their mental health? If yes, why? If no, why not?

Note:- This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student of Griffith University as part of her PhD candidature.

Focus group participants are asked to respect the privacy of other participants.
Focus Group Guiding Questions - Mental Health Practitioners.

There are 2 groups of participants with corresponding focus group guiding questions.

Mental Health Practitioners

1. How do you define spirituality?
2. Did you engage in spiritual practices in your country of origin? If yes, what where they? If no, do you engage in spiritual practices now?
3. How do you define religion?
4. Did you engage in religious practices in your country of origin? If yes, what where they? If no, do you engage in religious practices now?
5. How do you define traditional healing?
6. Did you engage in traditional healing practices in your country of origin? If yes, what where they? If no, do you engage in traditional healing practices now?
7. Do you think these definitions of spirituality/religion/traditional healing have changed since coming to Australia? If so, how have they changed?
8. Can you provide an example of how it has changed?
9. How important are these beliefs/practices in your country of origin?
10. How do you define mental health?
11. Do spirituality, religion and traditional healing help you with your own mental health? If yes, why? If no, why not?
12. Do you think that Spirituality, Religion and Traditional Healing can be useful in Mental Health Care?

Note: This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student of Griffith University as part of her PhD candidature.

Focus group participants are asked to respect the privacy of other participants.
APPENDIX 4.

FORMS GIVEN TO FOCUS GROUP PARTICIPANTS
Recruitment Information Sheet

School of Human Services and Social Work, Griffith University.

“Exploring Spirituality, Religion, and Traditional Healing as Protective Factors in Transcultural Mental Health Care”

Who is Conducting the Research?

Student Researcher: Mrs. Deb Mitchell-Macaulay (Mo: 0401-296-317
Email: deb.mitchell-macaulay@griffith.edu.au)
Supervisors: Professor, Lesley Chenoweth (Ph: 07-3382-1005
Email: l.chenoweth@griffith.edu.au)
Associate Professor Lynne Briggs (Ph: 07 5552-7466 Email: l briggs@griffith.edu.au)

Why is the research being conducted?

This project is exploring Spirituality, Religion and Traditional Healing as protective factor resources that people from culturally and linguistically diverse (CALD) backgrounds access when they encounter mental health upset or distress.

The project is being conducted as part of a PhD thesis in Social Work. It is hoped that the results will assist communities and mental health providers to more effectively assist people from culturally and linguistically diverse backgrounds when they are experiencing emotional problems or mental distress.

The expected benefits of the research.

It is expected that the insights gained from this research will equip Mental Health Practitioners to provide better mental health service delivery specifically tailored to the needs of CALD clients in ways that are sensitive to the needs of the culture of the client in each case.

What you will be asked to do?

A community leader or the manager of your organisation will invite you to participate in the project by attending a semi structured focus group discussion examining spirituality, religion and traditional healing as protective factors in transcultural mental health care. In order to protect your privacy, you can choose to meet with the Student Researcher individually or with another participant.

Risks to you?

Risks associated with participation in this project are minimal. However, thinking about issues of well being, culture or spiritual or religious affiliation for some can be very painful and difficult. Talking about these experiences can be upsetting. You will have the choice to stop or ask for a break at any time during the facilitated discussion. You are free to ask questions or debrief with a qualified clinician at any time. Your participation is completely voluntary and you are under no obligation to take part in this project.

Note: This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student undertaking a PhD with Griffith University.

As a participant in the Focus group you are asked to respect the privacy of others.
Focus Group Demographic Form.

Topic: Exploring Spirituality, Religion & Traditional Healing as protective factors in transcultural mental health care.

Student Researcher: Deb Mitchell-Macaulay

What is the study about?
The aim of this study is to investigate whether or not spirituality, religion and traditional healing are being utilised as protective factors within culturally and linguistically diverse (CALD) communities when faced with struggles or challenging mental health conditions. The implications for CALD communities and mental health practitioners will be discussed.

The aims of the research
This study is being explored from a research and practice perspective. It seeks to understand the perspectives of people from different cultural groups as well as mental health practitioners working alongside them. It will adopt a qualitative methods approach to data gathering. This exploratory study wants to add to the body of knowledge in understanding:

1. How important spiritual, religious and traditional healing issues are in the life of culturally and linguistically diverse elders, mental health practitioners and consumers when faced with emotional distress.

2. Whether spirituality, religion and traditional healing are seen as protective factors and are they accessed during times of distress.

3. Differences in how communities and mental health practitioners access spirituality, religion and traditional healing.

4. If culturally and linguistically diverse communities and mental health practitioners utilise spirituality, religion and traditional healing as protective factors and if so, are they accessed in the same way?

5. A newer dimension to the explanatory model framework.

6. Insight into creation of more assessment tools in working with clients of difference.

Note: This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student of Griffith University as part of her PhD candidature.

Focus group participants are asked to respect the privacy of other participants.
Focus Group Demographic Form.

**Topic:** Exploring Spirituality, Religion & Traditional Healing as protective factors in transcultural mental health care.

Completing this Information Sheet will only take 15 minutes of your time and will be kept confidential. You do not have to answer any questions you are not comfortable answering. Thank you for your participation!

### SECTION 1: PERSONAL DETAILS

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your age?</td>
<td>.......... Years</td>
</tr>
<tr>
<td>2. What is your Gender (please circle)</td>
<td>Male/Female</td>
</tr>
<tr>
<td>3. What country were you born in?</td>
<td></td>
</tr>
<tr>
<td>4. What is your preferred language?</td>
<td></td>
</tr>
<tr>
<td>5. How many languages do you speak?</td>
<td></td>
</tr>
<tr>
<td>6. Are you employed full-time? (please circle)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Please choose an option which relates to you (please circle)</td>
<td>Part-time/Casual/Unemployed/Student/Home duties/Volunteer work</td>
</tr>
<tr>
<td>7. What is your current role/occupation?</td>
<td></td>
</tr>
<tr>
<td>8. How long have you lived in Australia?</td>
<td>.......... Years .......... Months</td>
</tr>
<tr>
<td>9. How many countries have you lived in before coming to Australia?</td>
<td></td>
</tr>
<tr>
<td>10. What is your ethnicity or cultural background?</td>
<td></td>
</tr>
<tr>
<td>11. Do you have links to your culture in the community you currently live in? (please circle)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>12. Are you considered a leader in your community? (please circle)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>13. Are you considered a religious leader in your community? (please circle)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>14. Are you considered a spiritual leader in your community? (please circle)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>15. Are you considered a traditional healer in your community? (please circle)</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Participant Information Sheet – Focus Group Discussion

School of Human Services and Social Work

“Exploring Spirituality, Religion, and Traditional Healing as Protective Factors in Transcultural Mental Health Care”

Who is Conducting the Research?

Student Researcher: Mrs. Deb Mitchell Macaulay (Mo: 0401-296-317  Email: deb.mitchell-macaulay@griffith.edu.au)
Supervisors: Professor. Lesley Chenoweth (Ph: 07-3382-1005 Email: l.chenowenth@griffith.edu.au) Logan Campus.
Professor Lynne Briggs (Ph: 07 5552-7466 Email: l briggs@griffith.edu.au), Gold Coast Campus.

Why is the research being conducted?

This research project is exploring Spirituality, Religion and Traditional Healing as protective factor resources that people from culturally and linguistically diverse backgrounds access when they encounter mental health upset or distress.

Overall aim of the project is to Explore: -

1. How important spiritual, religious and traditional healing issues are in the life of CALD elders and mental health practitioners when faced with emotional distress.

2. Whether spirituality, religion and traditional healing are seen as protective factors and are they accessed during times of distress.

3. Differences in how communities and mental health practitioners access spirituality, religion and traditional healing.

4. If CALD elders and mental health practitioners utilise spirituality, religion and traditional healing as protective factors and if so, are they accessed in the same way by both groups.

5. A newer dimension to the explanatory model framework

6. Insight into creation of more assessment tools in working with clients of difference.
**Why is the research being conducted?**

The project has been approved by Griffith University Human Research Ethics Committee and is being conducted as part of a PhD thesis in the Department of Social Work and Human Services under the close supervision of Drs. Chenoweth and Briggs. It is hoped that this research will add to current body of transcultural and cross cultural literature and will assist clinicians and practitioners to work more effectively with people coming from culturally and linguistically diverse backgrounds who are experiencing emotional or mental distress.

**The expected benefits of the research.**

Participants will have an opportunity to share attitudes, responses, values and beliefs related to their own views about mental health care, which will contribute to the advancement of mental health care procedures and interventions. It is expected that the insights gained from this research will equip Mental Health Practitioners to provide better mental health service delivery specifically tailored to the needs of CALD clients in ways that are sensitive to the needs of the culture of the client in each case.

**What you will be asked to do?**

Potential Participants will be provided with a Recruitment Information Sheet through a community leader or manager of your organisation to inform you about the research project and the semi-structured discussion focus groups that will be used in the research project as the means of data collection so that you may make a considered decision as to whether you are interested and willing to attend a semi-structured focus group discussion examining spirituality, religion and traditional healing as protective factors in transcultural mental health care. Two discussion focus groups will be used in the research study for gathering information - a group comprised of community Elders and a second group composed of Mental Health Practitioners. Deidentified data will then be submitted to an Advisory group to assist with analysis and interpretation.

You will be given a global view of the project should you accept the invitation. You will be given:-

- Participant Information Sheet;
- Consent Form;
- Focus Group Demographic Information Form.
Once these forms have been completed and collected, the researcher will guide a semi structured focus group discussion regarding questions pertaining to themes, and topics relevant to research study. The presentation and focus group discussion should take no more than 1½ to 2 hours. The researcher will remain at the facility in the event someone has additional questions of concern.

All participants will be instructed on where they can go for support.

We ask that you respect the privacy and confidentiality of other participants.

The study outcomes will be analysed by the Student Researcher in collaboration with her supervisory team of Drs. Chenoweth and Briggs; additional findings of interest will be explored in an in-depth discussion and analysis with an Advisory Group of 5 qualified bicultural mental health practitioners who will assist with cultural understanding and interpretation of more complex aspects of the data.

Who do we want to speak to?

We want to speak to bicultural community Elders from culturally and linguistically diverse (CALD) backgrounds - men and women who are over 50 years of age, have migrated to Brisbane and are familiar with mental health issues and service delivery either from personal experience or through knowledge within their community.

We also want to speak to both bicultural and non-bicultural Mental Health Practitioners from CALD and non-CALD backgrounds who work with CALD clients and are 21 years of age or older and who may be either government or non-government workers.

Risks to you?

Risks associated with participation in this research project are minimal. However, thinking about issues of well being, culture or spiritual or religious affiliation for some can be very painful and difficult. Talking about these experiences can be upsetting. You will have the choice to stop or ask for a break at any time during the research discussion. You are free to ask questions or debrief with a qualified clinician at any time. If you require support during or after the delivery sessions, it is recommended that you contact Margaret Wells (credited mental health nurse and clinical family therapist) Mo: 0487-960-912 to discuss your concerns.

Your participation is completely voluntary and you are under no obligation to take part in this research project. Non-participation will not involve any penalty, affect any services that you may be provided with or result in adverse consequences. If you choose to
participate, you may stop participating at any time without having to explain why.

A participant may withdraw from the discussion group at any time and if you decide to do so, the information you have provided up to that point will not be included in the data collected from the study and will be destroyed.

**Your Confidentiality will be respected.**

If you agree to participate in this research, you will be asked to only sign a Consent Form and provide limited personal details in the Demographic Form. Your name and personal details on the Consent Form and Demographic Form will be held in secure storage at Griffith University and accessible only by the Student Researcher and her two professorial supervisors. In order to further protect your privacy you can choose to meet with Student Researcher individually or with another participant.

The information you provide will not be reviewed by anyone other than the researcher listed on this information sheet. The data collected from this research will not be recorded or reported in a way in which you could personally be identified and all participants in discussion groups will be issued with an alias which will be used through this process so that participant's anonymity and confidentiality will be maintained in the reporting of results.

The semi-structured focus group discussions will be voice recorded and a note taker will be present. All voice recordings will be erased once the information has been transcribed.

The information collected is confidential and will not be disclosed to third parties. All information will be kept under lock and key and your anonymity will at all times be protected and safeguarded. For further information consult the University's Privacy Plan at - [http://www.griffith.edu.au/privacy-plan](http://www.griffith.edu.au/privacy-plan) or Ph: 07 - 37354375.

Feedback regarding Research outcomes will be provided to anyone who is part of the participating organisations regardless of whether they are participants in the research study or not. They can access information by contacting the Researcher directly. The Researcher will organise feedback visits to participating organizations.

**Do you have any further Questions?**

If you have any questions relating to the research, then please contact Drs. Lesley Chenoweth or Lynne Briggs on the numbers provided.
Do you have concerns about how this research is being conducted? If you have any complaints or concerns regarding your participation in this research project, please contact:-

The Manager, Research Ethics, Office for Research
Bray Centre, Nathan Campus, Griffith University
Telephone: 07 37354375 Email: research.ethnics@griffith.edu.au

The study has been approved by Metro South HREC which can be contacted if you have any further questions:-

HREC Coordinator
07 3443 8049
PAH_Ethics_Research@health.qld.gov.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact the HREC Coordinator at the phone number or email address provided below:-

HREC Coordinator
07 3443 8049
PAH_Ethics_Research@health.qld.gov.au

Note: This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student undertaking a PhD with Griffith University.

As a participant in the Focus group you are asked to respect the privacy of others.
Title of Thesis: "Exploring Spirituality, Religion and Traditional Healing as Protective Factors in Transcultural Mental Health Care"

By signing below I, acknowledge having read the Participant Information Sheet and understand that:-

- The research is investigating the protective factors for community elders from culturally and linguistically diverse backgrounds that have knowledge of mental health treatment services.
- I have read and understand the Demographic questions I am being asked.
- I am being asked to take part in a semi structured focus group discussion with the Student Researcher facilitating a discussion about spirituality, religion and traditional healing in mental health care.
- I understand that the semi-structured focus group will be voice recorded and transcribed by a note taker – all voice recordings will be erased after being transcribed.
- I understand that I can refuse to participate or terminate my participation at any time.
- With the exception of the Demographic & Consent Forms, I am not required to provide names, specific times and specific dates of events and or any other information that can be identified. All information that I provide will be kept confidential.
- In order to protect my privacy I can choose to meet with Student Researcher individually or with another participant group.
- I am assured that all information given in this consent form is strictly confidential and that there will be no other identifying information asked of me except in the Focus Group Demographic Form and this information will be kept in secure storage for a period of time and then destroyed.
- I understand in exceptional circumstances the Student Researcher may have to disclose information to Professors Chenoveth and Briggs or the Manager of Research Ethics on 3735-4375 (or research-ethics@griffith.edu.au) including if there is any potential harm to myself.
- No information will be released to others without the written consent of myself.
- The data will be kept at all times and in a locked filing cabinet in the Student Researchers office at Griffith University for a period of 5 years before being destroyed.
- I understand that some of the data from the focused discussion group in deidentified form may be discussed with an Advisory Group.

I have read and/or had explained to me the Participation Information Sheet and the Consent form. I agree to participate in this study and give my consent freely. I understand that the research project will be carried out as described in the Information Statement, a copy of which I have kept. I realise that if I decide to participate, it is my decision, and I also realise that I can withdraw from the research project at any time, before the focus group starts and that I do not have to explain why. I have had all questions answered to my satisfaction.

__________________________ (Please print)
Name

__________________________
Signature

__________________________
Date

Privacy Statement.

The conduct of this research involves the collection, access and/or use of your personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to
meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However your anonymity will at all times be safeguarded. For further information consult the University’s Privacy Plan at http://www.griffith.edu.au/privacy-plan or telephone (07) 3735 4375.

Note:- This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student of Griffith University as part of her PhD candidature.

Outcomes of the study will be disseminated every three months by revisiting organisations and providing updates regarding research findings.

Information about where I can receive support will be provided.

Focus group participants are asked to respect the privacy of other participants.

If you require support during or after the delivery sessions, it is recommended that you contact Margaret Wells (credentialed mental health nurse and clinical family therapist) Mo: 0487-960-912 to discuss your concerns.
Title of Thesis: “Exploring Spirituality, Religion and Traditional Healing as Protective Factors in Transcultural Mental Health Care”

By signing below I, acknowledge having read the Participant Information Sheet and understand that:

- The research is investigating the protective factors for mental health practitioners from culturally and linguistically diverse and non-cultural backgrounds that have knowledge of mental health treatment services.
- I have read and understand the demographic questions I am being asked.
- I am being asked to take part in a semi-structured focus group discussion with a student researcher facilitating a discussion about spirituality, religion and traditional healing in mental health care.
- I understand that the semi-structured focus group will be voice recorded and transcribed by a note taker – all voice recordings will be erased after being transcribed.
- I understand that I can refuse to participate or terminate my participation at any time.
- With the exception of the Demographic & Consent Forms, I am not required to provide names, specific times and specific dates of events and or any other information that can be identified. All information that I provide will be kept confidential.
- In order to protect my privacy or if I am uncomfortable meeting in my workplace environment, I can choose to meet with Student Researcher individually or with another participant group.
- I am assured that all information given in this consent form is strictly confidential and that there will be no other identifying information asked of me except in the Focus Group Demographic Form and this information will be kept in secure storage for a period of time and then destroyed.
- I understand in exceptional circumstances the Student Researcher may have to disclose information to Professors Chenoweth and Briggs or the Manager of Research Ethics on 3735-4375 (or research.ethics@griffith.edu.au) including if there is any potential harm to myself.
- No information will be released to others without the written consent of myself.
- The data will be kept at all times and in a locked filing cabinet in the Student Researchers office at Griffith University for a period of 5 years before being destroyed.
- I understand that some of the data from the focused discussion group in deidentified form may be discussed with an Advisory Group.

I have read and/or had explained to me the Participation Information Sheet and the Consent form. I agree to participate in this study and give my consent freely. I understand that the research project will be carried out as described in the Information Statement, a copy of which I have kept. I realise that if I decide to participate, it is my decision, and I also realise that I can withdraw from the research project at any time, before focus group starts and that I do not have to explain why. I have had all questions answered to my satisfaction.

__________________________________________ (Please print)
Name

__________________________________________
Signature

__________________________________________
Date
Privacy Statement:

The conduct of this research involves the collection, access and/or use of your personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the University’s Privacy Plan at [http://www.griffith.edu.au/privacy-plan](http://www.griffith.edu.au/privacy-plan) or telephone (07) 3735 4375.

Note: This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student of Griffith University as part of her PhD candidature.

Outcomes of the study will be disseminated every three months by revisiting organisations and providing updates regarding study findings.

Information about where you can receive support will be provided.

Focus group participants are asked to respect the privacy of other participants.

If you require support during or after the delivery sessions, it is recommended that you contact Margaret Wells (NURSE: mental health nurse and clinical family therapist) Mo: 0487-960-912 to discuss your concerns.
Title of Thesis: “Exploring Spirituality, Religion and Traditional Healing as Protective Factors in Transcultural Mental Health Care”

By signing below I, acknowledge having read the Participant Information Sheet and understand that:

- The research is investigating the protective factors for community elders and mental health practitioners from culturally and linguistically diverse and non-cultural backgrounds that have knowledge of mental health treatment services.
- I am being asked to take part in an Advisory Group discussion with other qualified bicultural Mental Health Practitioners and the Student Researcher in facilitating the discussion and analysis of themes and content from the study of the role of spirituality, religion and traditional healing in mental health care.
- I understand that I can refuse to participate or terminate my participation at any time.
- I am assured that all information rendered, will be strictly confidential.
- I understand in exceptional circumstances the Student Researcher may have to disclose information to Professors Chenoweth and Briggs or the Manager of Research Ethics on (07) 3735-4375 (or research-ethics@griffith.edu.au) including if there is any potential harm to myself.
- No information will be released to others without the written consent of myself.
- The data will be kept at all times and in a locked filing cabinet in the Student Researcher’s office at Griffith University for a period of 5 years before being destroyed.

I have read and/or had explained to me the Participation Information Sheet and the Consent form. I agree to participate in this study in an advisory capacity. I understand that the research project will be carried out as described in the Information Statement, a copy of which I have kept. I realise that if I decide to participate, it is my decision, and I also realise that I can withdraw from the research project at any time, before advisory group discussion starts and that I do not have to explain why. I have had all questions answered to my satisfaction.

__________________________________________________ (Please print)
Name

__________________________________________________ ________________________ (Please print)
Signature Date

Privacy Statement

The conduct of this research involves the collection, access and/or use of your personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at http://www.griffith.edu.au/privacy-plan or telephone (07) 3735 4375.

Note:- This research is being conducted by Deb Mitchell-Macaulay in her capacity as a student of Griffith University as part of her PhD candidature.

Information about where you can receive support will be provided.

Advisory group participants are asked to respect the privacy of other participants.

Advisory group participants will be provided with feedback in relation to the questions work-shopped, every 3 months.
TO WHOM IT MAY CONCERN

This letter is to confirm that World Wellness Group has been approached by Ms Deb Mitchell-Macaulay in relation to her studies. She has requested our involvement with a structured focus group discussion as part of her research. World Wellness Group will facilitate access to our staff team of practitioners (13 staff) for the focus group.

We support her research in principle and World Wellness Group is pleased to participate in a focus group discussion on the research topic.

Yours faithfully

[Signature]

Marina Chand
Director
on behalf of World Wellness Group

25 February 2013
14th March 2013,

To Whom It May Concern;

This letter is to confirm that The Islamic Women’s Association of Queensland has been approached by Ms Deb Mitchell Macaulay in relation to her studies. She has requested our involvement with a structured focus group discussion as part of her research. The Islamic Women’s Association of Queensland will facilitate access to our staff team of practitioners for the focus group.

We support her research in principle and we are pleased to participate in a focus group discussion on the research topic.

Kind Regards,

[Redacted]

Galila Abdel-Salam

Director
4/5/2013

To Whom it May Concern

This letter is to confirm that Queensland African Community Council Inc. (QACC) has been contacted by Ms Deb Mitchell-Macaulay in relation to her studies. She has requested our involvement with a focus group discussion as part of her research.

We fully support her research in principle and QACC is pleased to participate in a focus group discussion on the research topic.

If you have any questions regarding our involvement, please contact me on 0411 330 382 or email qacc@qacc.com.au

Your sincerely,

[Signature]

Sharon Orapeleng
President
On behalf of Queensland African Communities Council Inc.
16th April 2013

TO WHOM IT MAY CONCERN

This letter is to confirm that Multicultural Centre for Mental Health and Well Being Inc. – Harmony Place has been approached by Ms Deb Mitchell-Macaulay in relation to her studies. She has requested our involvement with a structured focus group discussion as part of her research. Harmony Place will facilitate access to our monthly Staff Meeting where 16 staff will meet for the focus group.

We support Ms Mitchell-Macaulay’s research in principle and we are pleased to participate in a focus group discussion on the research topic.

Should you have any questions in relation to this letter don’t hesitate to contact me.

Yours faithfully

[Redacted]

Annabelle Allimant
Manager
APPENDIX 6.

DEMOGRAPHIC INFORMATION
## DEMOGRAPHIC INFORMATION SUMMARY - Focus Group Discussions 1 to 9.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (yr)</th>
<th>Gender</th>
<th>Country of Birth</th>
<th>Preferred Language</th>
<th>How Many Languages Spoken</th>
<th>Employed Full Time</th>
<th>Current Occupation</th>
<th>How Many Other Countries Lived In</th>
<th>Length in Years:</th>
<th>Extent of Cultural Background</th>
<th>Links to Your Cultural Community</th>
<th>T Leader in Your Community</th>
<th>T Considered a Religious Leader in Your Community</th>
<th>T Spiritual Leader in Your Community</th>
<th>T Educational in Your Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tornton</td>
<td>49</td>
<td>M</td>
<td>Zimbabwe</td>
<td>English</td>
<td>3</td>
<td>Full time</td>
<td>HI Coordinator</td>
<td>13.8</td>
<td>2 Indian</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Sally</td>
<td>53</td>
<td>M</td>
<td>Yemen</td>
<td>Turkish</td>
<td>4</td>
<td>Full time</td>
<td>Coordinator</td>
<td>18.0</td>
<td>2 Turkish</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Diana</td>
<td>31</td>
<td>F</td>
<td>Philippines</td>
<td>English</td>
<td>1 Parttime</td>
<td>Disability Manager</td>
<td>31.0</td>
<td>1 Filipino</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Peas</td>
<td>21</td>
<td>F</td>
<td>New Zealand</td>
<td>English</td>
<td>1 Full time</td>
<td>Senior Advisor</td>
<td>5.0</td>
<td>1 European</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Sarah</td>
<td>45</td>
<td>F</td>
<td>Egypt</td>
<td>Arabic</td>
<td>2 Full time</td>
<td>Manager</td>
<td>13.2</td>
<td>3 Arab</td>
<td>Y</td>
<td>Y,N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Alex</td>
<td>44</td>
<td>F</td>
<td>Bosnia</td>
<td>Bosnian</td>
<td>4 Parttime</td>
<td>Coordinator</td>
<td>18.0</td>
<td>0 Bosnian</td>
<td>Y</td>
<td>Y,N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Pamela</td>
<td>31</td>
<td>F</td>
<td>Bosnia</td>
<td>English</td>
<td>3 Parttime</td>
<td>Coordinator</td>
<td>19.0</td>
<td>2 Bosnian</td>
<td>Y</td>
<td>Y,N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Asma</td>
<td>35</td>
<td>F</td>
<td>Egypt</td>
<td>Arabic &amp; English</td>
<td>3 Parttime</td>
<td>Coordinator</td>
<td>6.0</td>
<td>2 Muslim</td>
<td>Y</td>
<td>Y,N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Camila</td>
<td>40</td>
<td>F</td>
<td>Egypt</td>
<td>Arabic</td>
<td>2 Full time</td>
<td>Director</td>
<td>31.0</td>
<td>2 Arab</td>
<td>Y</td>
<td>Y,N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Gael</td>
<td>31</td>
<td>F</td>
<td>Australia</td>
<td>English</td>
<td>2 Casual</td>
<td>Coordinator</td>
<td>31.0</td>
<td>0 Lebanese</td>
<td>Y</td>
<td>Y,N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>40.3</td>
<td>3M:4F</td>
<td></td>
<td></td>
<td>2.0</td>
<td></td>
<td></td>
<td>19.6</td>
<td>1.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>38.5</td>
<td>F:97%</td>
<td></td>
<td></td>
<td>2.0</td>
<td></td>
<td></td>
<td>18.3</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion Group 2: Elderly, 5th April 2014**

- **Rabbit**: 56 | M | Australia | English | 1 | Time / Volunteer | Marketing Director | 56 | 0 | Australian | Y | Y | N | N | N | N
- **Home**: 40 | F | Romania | English | 4 | Full time | Manager | 39 | 2 | Romanian | Y | Y | N | N | N | N
- **Cat**: 35 | F | Botswana | English | 2 | Full time | Mental Health | 14 | 2 | Motswana | Y | Y | N | N | N | N
- **Fox**: 45 | M | Sudan | Moro | 2 | Unemployed | Manager | 31 | 4 | Moro | Y | Y | Y | Y

**Average**: 43.0 | 3M:2F  | 2.0 |                    |                  | 23.0                     |                    |                  | 18.3                       | 3.0                        |                            |                            |                            |                            |                            |

**Discussion Group 3: 10th May 2014**

- **Beans**: 39 | F | Australia | English | 1 | Parttime | Occupational Therapist | 32 | 0 | Indian | Y | N | N | N | N | N
- **Average**: 53.0 | 3F  | 1.0 |                    |                  | 31.0                     |                    |                  | 31.0                       | 3.0                        |                            |                            |                            |                            |                            |

**Discussion Group 4: 10th May 2014**

- **Beru**: 39 | F | Australia | English | 2 | Full time | Occupational Therapist | 28.4 | 0 | Egyptian | Y | N | N | N | N | N
- **Average**: 36.0 | 3F  | 2.0 |                    |                  | 28.4                     |                    |                  | 24.4                       | 0.0                        |                            |                            |                            |                            |                            |

**Discussion Group 5: 12th May 2014**

- **Juzeli**: 32 | M | Romania | Romania | 2 | Full time | Health Coordinator | 16 | 1 | Romanian | Y | Y | Y | Y | N | N
- **Jenkins**: 42 | F | New Zealand | English | 1 | Full time | Social Worker | 8.25 | 1 | European | N | N | N | N | N | N
- **Leitner**: 43 | F | Austria | English | 1 | Parttime | Clinical Specialist | 43 | 0 | Australian | Y | N | N | N | N | N
- **Bestem**: 41 | F | Australia | English | 1.5 | Full time | Social worker - mental health | 5 | 9 | Caucasian | Y | N | N | N | N | N
- **Eggplant**: 35 | F | Australia | English | 1 | Parttime | Social worker | 31 | 1 | Anglo | Y | N | N | N | N | N

**Average**: 38.0 | 3M:4F  | 2.0 |                    |                  | 25.1                     |                    |                  | 24.5                       | 1.0                        |                            |                            |                            |                            |                            |

**Discussion Group 6: Elderly, 23rd May 2014**

- **Koala**: 67 | M | Samoa | Samoan & English | 2 | Unemployed | Pastor | 6.75 | 2 | Samoan | Y | Y | Y | Y | Y | Y
- **Average**: 67.0 | 3M  | 2.0 |                    |                  | 6.75                     |                    |                  | 6.75                       | 2.0                        |                            |                            |                            |                            |                            |

**Discussion Group 7: Mental Health Practitioners 23rd May 2014**

- **Chili**: 46 | M | New Zealand | English | 1 | Full time | Social Worker | 24.5 | 1 | Pakistani | Y | N | N | N | N | N
- **Mushroom**: 49 | F | Australia | English | 1 | Parttime | Social Worker | 49 | 0 | Irish | Y | N | N | N | N | N

**Average**: 47.5 | 3M:3F  | 2.0 |                    |                  | 38.5                     |                    |                  | 38.5                       | 0.5                        |                            |                            |                            |                            |                            |

**Discussion Group 8: Mental Health Practitioners 24th June 2014**

- **Ellesbeens**: 37 | M | Romania | Romanian | 2 | Full time | Clinical Psychologist | 6.8 | 1 | Romanian | Y | N | N | N | N | N
- **Boshem**: 41 | M | New Zealand | English | 4 | Full time | Occupational Therapist | 7.2 | 1 | Tahitian - French | Y | Y | Y | Y | Y | Y
- **Locket**: 32 | F | Sweden | English | 2 | Parttime | Student | 12.2 | 2 | Swedish | N | N | N | N | N | N
- **Wright**: 35 | M | Australia | English | 1 | Parttime | Occupational Therapist | 35 | 0 | Australian | Y | N | N | N | N | N
- **Reid**: 39 | F | Australia | English | 1 | Full time | Clinical Psychologist | 35 | 0 | Australian | Y | N | N | N | N | N

**Average**: 35.0 | 3M:3F  | 2.0 |                    |                  | 19.7                     |                    |                  | 17.1                       | 0.7                        |                            |                            |                            |                            |                            |

**Discussion Group 9: WING 30th July 2014**

- **Cawth**: 48 | F | United Kingdom | English | 2 | Full time | Manager | 35 | 2 | Dutch | Y | Y | N | N | N | N
- **Almond**: 35 | F | India | English | 4 | Parttime | Occupational Therapist | 10.5 | 1 | Indian | N | N | N | N | N | N
- **Pescar**: 41 | F | South Africa | English | 2 | Full time | Community Educator | 19 | 1 | South African | Y | N | N | N | N | N
- **Peanut**: 44 | F | South Africa | English | 2.5 | Full time | Psychologist | 18 | 1 | South African | Y | N | N | N | N | N

**Average**: 47.5 | 4F  | 2.6 |                    |                  | 20.4                     |                    |                  | 18.0                       | 1.6                        |                            |                            |                            |                            |                            |