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Culture-bound syndromes in Aboriginal Australian populations

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ABSTRACT

Objective: This paper describes the validation of culture-bound syndromes with Urban (N=34) and Rural (N=31) Aboriginal participants. While culture bound syndromes have long been discussed in the international literature (see Cuellar & Paniagua, 2000), published empirical research with Aboriginal Australian populations remains absent. Critically, the secret nature of Aboriginal cultural practices presents additional research challenges which arguably do not impact to the same extent in other Indigenous cultures. The impacts on ensuring culturally and clinically competent assessment in the context of escalating rates of Indigenous suicide and mental health are significant.
Method: Thematic analysis occurred with data generated from three phases of focus groups to address study objectives. The final stage involved a critical analysis of the DSM-IV Outline for Cultural Formulation ("OCF") for the Aboriginal Australian context.
Results: Validation of seven culture bound syndromes with predominant symptom consistency across locations is presented as well as determination of the cultural triggers implicated in the development of culture bound syndromes. Finally, an adaptation of the OCF is proposed to enable clinicians to undertake clinically and culturally valid assessment of Aboriginal clients.
Conclusions: Practitioners are provided with guidance in the identification and formulation of culture-bound syndromes with Aboriginal Australian clients.

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Aboriginal Australian; culture bound; cultural consultants; traditional lore; Indigenous Australian

KEY POINTS

What is already known about this topic:

(1) Anecdotal evidence of the existence of culture bound syndromes has been cited in a small number of papers.
(2) Culture bound syndromes have long been discussed in the international literature.
(3) DSM-IV Outline for Cultural Formulation ("OCF") ensures guidance for practitioners around the formulation of culture bound syndromes.

What this topic adds:

(1) Empirically validates the existence of culture bound syndromes with Aboriginal Australian populations for the first time.
(2) Validates symptom consistency across urban and rural Aboriginal Australian environments.
(3) Provides practitioners with guidance regarding the formulation of assessment with Aboriginal clients experiencing culture bound syndromes.

Introduction

Culture-bound syndromes are defined by the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (DSM-IV) as recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or afflictions, and most have local names. The most recent DSM-5 update criteria to reflect cross-cultural variations in presentations gives more detailed and structured information about cultural concepts of distress, and includes a clinical interview tool to facilitate comprehensive, person-centred assessments.

Whilst a small number of papers (D.A. Vicary & Westerman, 2004; Eastwell, 1982; Westerman, 2003; Reser & Eastwell, 1981; Sheldon, 2001; Westerman, 2010) have referenced cultural issues that can confound valid mental health assessment of Aboriginal people, these papers do not represent empirical research specifically focused on the validation of culture-bound syndromes, but rather represent clinical observations of the authors. The current paper therefore addresses a significant gap by utilising a methodology that enables an evidence-based validation of culture-bound syndromes for Aboriginal people. This distinction is made to encourage further empirical research and replication of the current

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study to other Aboriginal Australian contexts and regions.

The absence of empirical research into the validation of culture-bound syndromes for Aboriginal Australians is concerning, given the escalating rates of suicide and mental health (Australian Bureau of Statistics, 2017; Australian Institute of Health and Welfare, 2016). and the low rates of engagement of Aboriginal clients in mental health services (Huffine, 1989; Hunter, 1989; Westerman, 2010). The long-held concerns with bias in mainstream assessments with Aboriginal clients (Davidson, 1995; Westerman, 2003; Kearins, 1981; Westerman & Kowal, 2002) and the absence of clinical and cultural guidance for practitioners to undertake valid assessments, further contributes to poor treatment outcomes (Westerman, 2010).

Several cultural realities complicate the attainment of a strong body of empirical research into culture-bound syndromes. First, the secret nature of Aboriginal culture means information is effectively "looked after" by certain groups of individuals who have attained either through birthright, or a rite of passage access to certain information. This means that information is not able to be provided to those who have not undergone rites of passage, making research challenging. Additionally, the hierarchical nature of Aboriginal culture as described by Tonkinson (1988) which speaks to different levels of power in Aboriginal communities, means information is only available to those who attain specific cultural status. These cultural issues place complication on the assessment process, heartbreakingly demonstrated by the Fogliani Coronial Inquiry (Fogliani, 2019) into the 13 deaths by suicide of young Indigenous children in the Kimberley. Fogliani found that none of the children had a mental health assessment and that most had died as a result of "system failure" or a lack of access to culturally appropriate services (Fogliani, 2019).

The "cultural compatibility hypothesis", argues that treatment and assessment outcomes are more effective when practitioner and client have compatible racial backgrounds (Dana, 1998, 2000; Sue et al., 1987). Whilst studies have yielded mixed results (Paniagua, 2014; Marsh, 1999), this paper argues that client outcomes are improved via the cultural compatibilities of beliefs, values which lead to a greater capacity for "cultural empathy" as a primary skill. The need to understand the worldview of Aboriginal clients to improve counselling outcomes has been similarly proposed by others (see Seru, 1994; Slattery, 1994; D. Vicary & Andrews, 2001; Westerman, 2010, 2019). It is argued that "cultural compatibility" increases the likelihood that practitioners will be capable of assessing for cultural explanations for a (clinical) disorder. A crucial component of this begins with the (westernized), evidence based, empirical validation of culture-bound syndromes in Aboriginal Australian populations. This places cultural world view into a "relatable" and accessible context for practitioners regardless of cultural background.

The international research (Paniagua, 2000; Cuellar, 2000; Paniagua, 2014) has mostly driven the recognition by the DSM-IV of the existence of syndromes, which are culture-bound as well as the addition of the OCF. However, Australian Aboriginal communities have long recognised culture-bound disorders as being inherent within the culture (Westerman, 2003). This is consistent with a culture in which the spiritual dimension is a dominant aspect of the belief system. The DSM-IV does however deserve criticism on two fronts. First, the separation of these guidelines "compartmentalises" these syndromes as isolated and separate disorders. It is argued these disorders should be incorporated into relevant diagnostic criteria (and effectively within clinical assessment).

Second, the DSM is mono-cultural, meaning questions about its validity for indigenous populations are warranted. However, whilst the empirical evidence of culture-bound syndromes continues to be lacking (in relative terms), the (mainstream) field can continue to argue that there exists an "absence of evidence" regarding the existence of culture-bound disorders (Allen, 1998).

How culture-bound syndromes "present" for Aboriginal Australians

Aboriginal people who present in situations which are foreign (outside of cultural context) are likely to appear more agitated and distressed than normal (Hunter, 1989; O'Connor et al., 2015; Vicary, 2002; Westerman, 2010). The concept of "shame" in the presence of non-Aboriginal authority figures has also been cited as a factor impacting upon clinical presentation of Aboriginal clients (Westerman, 2010). Difficulties with communication also mean Aboriginal people often find it difficult to communicate distress and this impacts on the ability for professionals to question Aboriginal people about their feelings (Hunter, 1993, 1997; D. Vicary & Andrews, 2001; Westerman, 2010).

Culture-bound syndromes and the complexity of culturally valid assessments are explored in the following case scenario. A young lady who had been experiencing disorders of perception and ideation is referred. She reports that she has been experiencing images of her deceased friend, who died by suicide. These

images are mostly visual, but when they "switch" to auditory, her friend is telling her to "join her" (as in "end her life"). The local agencies had known of the client for some time and assumed that disorders of perception such as this were "common" within the Aboriginal culture, that these perceptions reflected the significance of spirituality for Aboriginal people, and that it would be "dealt with" culturally. No one had referenced the community or the client as to whether anything of a cultural nature was triggering these "visits". Whilst the community indicated this was not "normal", assessment should clearly discern at what point this fell outside of the "normal" cultural bounds of grieving and, more importantly, whether there is still a role for cultural intervention. It has become increasingly clear that there is often a role for both clinical and cultural interventions with Aboriginal clients (Westerman, 2003).

On presentation, the young girl acknowledges "seeing and hearing things that no one else can see and hear". In accordance with the DSM-IV this is one of the primary criteria (hallucinations) to warrant a diagnosis of psychosis. In formulating any diagnoses, however, this presentation needs to be considered within an Aboriginal context in which spiritual and cultural concepts are often normalised and "culture-bound". Given that culture-bound syndromes share symptoms in common with clinical disorders, such as psychoses or schizophrenia, the obvious question is: "When is something considered 'normal' culturally (or culture-bound) and when does it become a clinical disorder (psychosis and/or schizophrenia)?" Getting this right dictates intervention: cultural; clinical, or both?

Of note to this scenario is that Aboriginal people have the highest rates of psychotic illness of any group in Australia (Sartorius et al., 1986) experiencing psychotic illness at 1.8 times that of non-Aboriginal people, and are hospitalised at 2.4 times the rate (Australian Institute of Health and Welfare, 2016). Such presentations are also known to occur amongst other Indigenous cultures worldwide and there is a similar and necessary focus on understanding the distinction between perceptual disturbances of a cultural versus clinical nature (refer to Paniagua, 2000).

The need to understand culture-bound syndromes

Kleinman et al.'s (1978) seminal work identified how illness and treatment are "culturally shaped" where patients' cultural beliefs and practices influence their construction of illness.

Sheldon (2001) argues that there are a number of sensitive topics within the assessment process that clearly impact upon client presentation. These include bereavement, the breaking of taboos, ceremonial business, sexuality, fertility and domestic habits. Whilst the extent of "taboo" and "stigma" around mental health has been widely discussed across cultures (Paniagua, 2000; Cuellar, 2000; Paniagua, 2014), it is not known the extent that the extreme "secretness" of Aboriginal culture is consistent with other cultures. What is known, is that little research has focused on how these differences manifest within mental health presentations.

Whilst, the OCF in the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994) is an important starting point for culturally valid assessments, a number of issues have been raised as problematic (Aggarwal et al., 2013). First, practitioners require high levels of cultural competence to operationalise this model (when engaging clients, during questioning regarding symptomatology and when taking client/family history), and across a significant number of culture-bound syndromes. Second, the absence of Aboriginal Australian contribution to this cultural formulation clearly limits its applicability to this context.

The present provides an initial validation of culture-bound syndromes within Aboriginal populations in Western Australia from Urban and Rural locations.

Methodology

Participants

65 participants were involved in the study (refer to Table 1). Of those 65 participants, some (N = 14) worked directly in health-related Aboriginal organisations. The remainder (N = 51) were identified as having recognised cultural knowledge and expertise (N = 51). All were adults aged 18 and above with the mean age 35 years with some (N = 13) being recognised "Elders".

Table 1. Description of participants involved in the determination of culture-bound syndromes.

	Gender	
Group	Male	Female
Rural	4	5
Rural	5	6
Rural	6	5
Urban	5	5
Urban	7	7
Urban	5	5
Total	32 (49%)	33 (51%)

Data collection & procedure

Participants were recruited via a snowball method using the authors existing community networks. Participants were selected based upon having their birth/tribal/language group origin in the region in which the study was held to ensure the culturally specific and informed nature of participants.

One of the largest obstacles to empirical research with Aboriginal people lies in the significant within group cultural heterogeneity (Dion et al., 1998; Westerman, 2003; Vicary, 2002; Westerman, 2010). This issue has been addressed by recruiting from two distinct samples of Aboriginal people. including a group representative of *Rural*, groups in the Pilbara region and *Urban*, or Perth based Aboriginal participants. Attempts were made to involve equal numbers of males (N = 32) and females (N = 33) and ensure equal representation from Rural (N = 31) and Urban (34) populations.

Dividing the sample by Urban/Rural split, provided an opportunity to explore differences between these groups in (a) culture-bound syndromes; (b) the manifestation of culture-bound syndromes, and (c) triggers to culture-bound syndromes. A description of the sample is provided at Table 1.

Consultation

Stage One involved community consultation within the Pilbara and Perth regions. Elders were consulted to obtain permission for the research to be conducted, consistent with accepted cultural protocols (see Westerman, 2003). Aboriginal organisations were then approached for a similar rationale and cultural endorsement and to ensure the research was supported.

Steering committee and ethics

Two local steering committees were developed in the Pilbara and Perth regions to ensure the cultural and ethical appropriateness of the study. This also ensured ongoing cultural safety of research through acting as an ongoing feedback loop. The study was also approved by the Curtin University Human Research Ethics Committee (approval number HR 170/99).

To gain an in-depth understanding of culture-bound syndromes, a qualitative focus group methodology was adopted. The Steering Committees were strong supporters of the use of focus groups as they felt it enabled a more "informal, narrative" approach which has been demonstrated as effective with Aboriginal groups (see Westerman, 2003).

Due to the sensitivity of topics focus groups were held separately for males and females. Participants were also allocated to groups based on the need to be respectful of cultural issues. This occurred by seeking permission from participants for their names to be placed on a central list to query potential participants regarding the existence of any avoidance relationships. In those instances, (N = 6), participants were reallocated to another group.

Questions developed for the focus groups were open-ended, non-directive and lacking in

1. Do people agree culture-bound syndromes exist in Aboriginal communities today? (Participants were provided with a definition and examples of culture bound syndromes). This included:
    a. Culture bound syndromes are things that are often considered 'normal' in Aboriginal communities but when viewed from whitefella world might be considered to be mental illness. and so mob can be misdiagnosed. Examples would be having spiritual visits of those who have passed on; sorry cutting during grieving time.
2. From these cultures bound syndromes that have been discussed, what are the sorts of signs or symptoms that tell you that they are experiencing (INSERT culture bound syndrome name from those identified)? What are the sorts of behaviours that tell you that this is culture bound? What would result in people (from mainstream) getting these things 'mixed up' or confused? What would help them to figure out whether (insert culture bound syndrome identified) was cultural or not?
3. What are some of the cultural reasons or triggers that people are aware of that have caused Aboriginal people to become unwell mentally?

Figure 1. Focus group questions for developing information regarding culture-bound disorders in Urban and Rural Aboriginal sample.

suggestibility to address *acquiescence* (the tendency to agree rather than disagree when in doubt) and *providing socially acceptable responses to questions* (Kline, 2000). These broad questions can be found at Figure 1.

As the main researcher is Aboriginal, the focus groups were delivered in a mix of Standard Australian English and Aboriginal English (see Eades, 2013) which ensured language compatibility between the researcher and participants.

The number of focus groups was dependent upon whether *theoretical saturation* was achieved which is described in the Results section.

Procedure

Prior to the commencement of each focus group, participants were provided with an informed consent form that also gathered basic demographic information (age, gender, location). The contents were read out prior to the commencement of groups; given some participants had limited literacy. Some chose to sign forms, whilst others indicated their verbal agreement and understanding of the information contained in the form.

The main researcher facilitated all of the focus groups, using a standard process using the focus group questions contained at Figure 1 and following this standard format:

1. Posing a question to the group;
2. Ensuring all participants offered an opinion to gain group consensus;
3. Provision of a summary at the end of discussion to:
   (a) ensure correct interpretation of ideas and outcomes;
   (b) offer participants the opportunity to add to discussion; and
   (c) ensure agreement.

Objectives

Focus groups occurred over three stages, with the same participants and addressed the four study objectives. The first stage addressed the first study objective to validate the existence of culture-bound syndromes. The second stage addressed the second study objective to determine factors known to trigger and maintain culture-bound syndromes. The final stage addressed the third study objective, that being, to determine if culture-bound syndromes (as identified in Stage two) had symptom variation in their presentation across Urban and Rural Aboriginal groups.

The final study objective involved the main researcher (a practicing Aboriginal psychologist with fifteen years clinical experience) undertaking a broad clinical and cultural review of the DSM-IV OCF for the Aboriginal Australian context (refer to Attachment A). This was undertaken by using the thematic data gathered from the three phases of the focus groups, in combination with the main researcher's subject matter expertise.

Results

A thematic analysis was conducted on focus group raw data to identify common themes in each group as described by Braun and Clarke (2006). To ensure that the researcher was not "giving voice" to the data, themes were only reported when participants agreed by consensus. In addition, group discussion continued until *theoretical saturation* was achieved, meaning that no new information was forthcoming. This procedure provides a greater degree of confidence in the external validity and integrity of the data (see Westerman, 2003).

Cultural security of information

In line with accepted cultural security of research (see Westerman, 2003) information from focus groups was checked for accuracy and whether information could form part of the study. This additional "check" by the main researcher ensured information was "culturally secure" to be publicly accessible.

Culture-bound syndromes in Aboriginal Australian populations

As can be seen in Figure 2, based on Stage 1 focus group discussion and thematic analysis of raw data, seven (7) culture-bound syndromes were identified. There were only slight differences in local names used to describe what were essentially the same syndromes (e.g., "grieving time" versus "Sorry Time"; "being sung" versus "being cursed" as noted in Figure 2). The only difference between Rural and Urban samples was that the Rural sample reported sorry cutting was still often part of the cultural grief process, whereas the Urban sample indicated this was less common and becoming less so. However, both groups had knowledge of these syndromes including the use of this as a grief process. There were no specifically identified gender differences observed in describing the syndromes noted.

Culture Bound Syndrome Name	*Rural name/description*	*Urban Name/Description*
Being "sung", cursed or having the "bone" pointed	Singing Pointing the bone	Being sung Being cursed
Longing for Country	Sick for country Crying for country	Longing for country Sick for country
Wrong Way Relationships	Wrong way	Wrong way
"Sorry Time"	Sorry Time Funeral time	Funeral time
Pathological grief and hysteria	Sorry grief	Grieving time
Self-harmful behaviours and pain tolerance	Sorry cutting	Sorry cuts
Spiritual visits (or psychosis)	Visits	Visits

Figure 2. Culture-bound syndromes in Aboriginal Australian populations.

Manifestation of culture-bound syndromes in Aboriginal Australian populations

Stage two of the focus groups focused on determining the symptom-based manifestation of the established pool of culture-bound syndromes. The information provided is based upon a thematic analysis of focus group data as described in the Results (refer to Braun & Clarke, 2006).

Being "sung", cursed or having the "bone" pointed

Participants spoke of non-physical retribution for wrong-doing (payback) interchangeably referred to as "being sung" or "cursed" which involved conjuring (or calling/ ceremonial singing for) spirits to inhabit the person's psyche and for bad mental, physical, or spiritual health to result. The manifestation was wide-ranging and had been known by participants to take the form of psychosomatic complaints, with "physical" blindness, depression, and sadness amongst the most common. The holistic nature to wellness in Aboriginal populations means that culture-bound syndromes can manifest at any of these levels – mentally, physically, spiritually, or culturally. Being sung has been a key concern amongst practitioners working with Aboriginal clients for some time (see Westerman, 2003). It is also a concept that is interestingly consistent amongst many other Indigenous cultures worldwide (see Cuellar & Paniagua, 2000). Participants concerns centred on the misdiagnosis of "being sung" as it could often manifest as a "*command hallucination*" – refer to section on "Spiritual visits versus psychosis".

It should be noted that in instances of being sung, participants noted the existence of a "hierarchy" of punishment dependent upon the hierarchical position of the individual. This means that there are general punishments for cultural wrongdoing for Aboriginal people who have not gone through a rite of passage. However, in instances in which the transgression involves those who had been through a rite of passage or ceremony, a very distinct set of ceremonies were enacted. Wrongdoing by lore men could therefore only be resolved by lore men themselves as a very distinct (and secret) cultural process.

Longing for country

Participants spoke of the strong relationship between Aboriginal people and their traditional lands or "country" which was often related to mental unwellness.

Participants linked this with the spiritual disconnection Aboriginal people experience when removed from traditional land. Examples were cited from direct experiences in which short-term removal from traditional land had led primarily to symptoms of depression. Whether this removal was through choice, through necessity (i.e., health or mental health-related needs requiring long hospital stays) or circumstance (i.e., incarceration; "being on the run" from payback or lore) didn't appear to make a difference to the end result. It was agreed that absence or periods of disconnection from land could have an adverse effect on many levels of functioning.

Individuals away from their country (place of birth/ Dreaming) for extended periods of time will experience episodes of unwellness (conforms with DSM-IV Major Depression) due to their weakened spiritual link with country (Westerman, 2003). Effects include

1. Physical ill health, including weakness, nausea, general "sickness" and somatic complaints;
2. Spiritual ill health;
3. Cognitive disorientation, dissociative fugue; and
4. Cultural "ill health" including identity confusion, disorientation, acculturative stress.

The importance of Country might partially explain the profound effect prison has on many Aboriginal people and the high rate of Aboriginal deaths in custody compared to Western figures (Biles et al., 1989; Westerman, 2010).

Appropriate intervention included returning to country to reconnect with land, culture, and spirit. Participants spoke of knowing when they needed to return home and this was often precipitated by feelings of sadness, despondency, moodiness, frequent crying, wanting to be alone and arguing with loved ones for no apparent reason. Participants described going home as feeling like "a rejuvenation".

Wrong way relationships

Participants spoke of "wrong way" skin relationships in the development of mental ill health, which is further detailed in the section titled 'skin and avoidance relationships'. "Skin" determines who can marry but unfortunately, assimilation and removal of Aboriginal people from their families and cultures of origin, has resulted in skin groups and avoidance relationships becomingly increasingly confused. The result is that Aboriginal people have married or fell in love with someone who was "wrong way" or not of the correct skin group for them. In instances when this had occurred a range of ongoing issues which included bouts of depression and suicidal behaviours was reported and resulted in the community shunning not only the relationships but often the product of these relationship (children born to these relationships were considered *wrong way kids*).

Participants cited examples in which such crises of identity had triggered ongoing identity confusion and poor mental health outcomes.

In instances where Aboriginal mental health clients present to services, questions should always be asked about whether skin relationships operate in the community. Extensive cultural mapping of a client's cultural connections and kinship also ensures these cultural realties are understood and not misinterpreted (see Westerman, 2003).

"Sorry time"

The passing of loved ones places considerable obligation on relatives to return home to "pay respects" or attend "Sorry Time"- which is a period of mourning. This involves all relatives deemed as important meeting on the traditional lands of the deceased for a period of communal mourning and often necessitates waiting for up to several weeks for relatives to travel to pay respects. Sorry Time has distinct rituals and can differ across Aboriginal groups. For example, in some communities they will walk away in blankets; in others they will be confined (spiritually) to parts of the community until the deceased person's spirit has gone back to their "dreaming" and reborn in an infant form. For Aboriginal people, these rituals are crucial to the "reincarnation" of the "deceased" who is then "reborn" following the full application of all rituals unique to the individual communities. What was consistent in the focus groups is that the first name of the deceased is no longer used, and a culturally sanctioned name is used instead following their passing. The rationale for this is that you "call the person's spirit back" if you used their name. Those who share the same name of the deceased are then no longer referred to by that name but given a different culturally sanctioned name. Another consistent grief ritual is in the non-use of photos and other images of the deceased for a period of time determined by the community and this is also for fear of "disturbing the deceased person's spirit". Unresolved grief is a significant issue in Aboriginal communities in which mortality rates are considerable. The need to resolve grief culturally *and* clinically is therefore essential for practitioners to fully understand when working with Aboriginal clients. The

absence from Sorry Time and grieving time holds important ramifications for poor mental health outcomes for Aboriginal people.

Absence from sorry time

Participants agreed that absences from Sorry Time, particularly those who have a close relationship with the deceased or being an important cultural person; were always noticed. Participants spoke of individuals not attending Sorry Time coming into "bad luck" (through spiritual means) or being "growled" by relatives for not paying their respects. Additionally, individuals who did not come home to pay respects, would experience feelings of distress that would typically increase in intensity. This included instances of catatonic and clinical forms of depression as well as "spiritual visits that were of a troubling or distressing nature" (refer to section on 'Spiritual visits versus psychosis').

Appropriate interventions included returning home to country to pay respects, or in some instances, sending a family member as a representative to Sorry Time. It is important this representative clearly articulates who they are representing.

Pathological grief and hysteria

Participants agreed Sorry Time is a process that encourages the outward and intense expression of grief by loved ones for the deceased. This can appear as hysterical and histrionic. Participants spoke of intense and prolonged periods of "wailing" by (mostly) female Elders and described a ritual of "sorry cutting" (refer to this section below) and the cutting of one's hair, as common expressions of grief. Sorry cutting often involves hitting oneself with rocks, sticks etcetera (further addressed in self-harmful behaviours in the next section). Participants agreed that the open and intense expressions of sorrow enabled resolution of grief to occur within the context of whole of community support and respect.

These rituals exist as displays of respect for the deceased. However, Sorry Time was considerably more ritualistic in the remote sample and, involved specific people related to the deceased and often separation of genders. For example, practices such as "women's wailing circles" (the author's term, not the traditional term) in which predominantly women would wail in distress for the deceased as part of a community ritual.

Participants also agreed that time was not a consideration in the expression of grief. It is not uncommon for relatives (immediate and distant) to cry at the mention of a deceased person who may have passed away years previously. Other common behaviours cited include the bowing of heads at the mention of a deceased person and as already noted the first names of the deceased are often not used. Instead the person is provided with a different cultural name or referred to in a "second hand" manner. For example, "You remember that old man who used to live next door" instead of directly naming the deceased.

It was considered vital to have an extensive cultural map (as described by Westerman, 2003) for Aboriginal clients for two reasons. First, to ensure specific cultural rituals are undertaken in instances in which clients have had relatives pass away when they are away from their traditional country or place of dreaming. It may be that clinicians will need to either facilitate return to country for grieving and Sorry Time or, in instances where clients cannot return home, that aspects of grieving can be assisted (e.g., bringing a part of the "spiritual country" such as culturally sanctioned "dirt" or "country"; spinifex, sand or whatever is specific to the area for the person grieving, etc.) and second, that clinicians are able to determine "what" needs to be done and facilitate any of these processes if possible to address aspects of the grief reaction clinically (and culturally).

Self-harmful behaviours, pain & conflict resolution

Participants spoke of several culturally sanctioned activities and behaviours which from a "mainstream" perspective would appear representative of self-harmful behaviours but were rites of passage or ceremony. There were three primary examples noted:

1. sorry cutting for grief;
2. tribal, lore markings; and
3. physical payback.

First, "cutting" or hurting oneself as an expression of grief during Sorry Time, still occurs in significant parts of the Pilbara and was one of the few rare differences between the Urban and Rural focus groups. Whilst both groups were aware of sorry cutting, the Urban groups indicated this occurred less in their region compared to the Rural groups. The manifestation was, however, consistent across groups when it did occur. In the Rural region, for example, participants spoke more of culturally related individuals either hitting themselves with a rock (predominantly) to the head but sometimes other parts of the (mostly

upper) body or areas that represented limited physical risk of death to the individual. By "culturally appropriate" participants explained that this was dependent upon the relationship with the deceased and not "random" in that the behaviours were "controlled" and ritualistic (i.e., specific cutting behaviours; specific individuals and specific to funeral or Sorry Time only). This cutting behaviour can often break skin but not always. In the Urban groups there was a similar discussion around sorry cutting and agreement that this was also specific to cultural grieving and Sorry Time rituals in those instances in which it was known to occur. In addition, there was agreement that there exists a culturally accepted threshold for when the "sorry cutting" became of concern to the community and this was when the behaviour was outside of the confines of collective grieving such as "Sorry Time" or funeral time (words were used interchangeably in both locations). Other themes that participants felt differentiated "sorry cutting" from self-harm was that it did not occur in isolation of others unlike self-harm. Finally, that the individual would not engage in cutting behaviour deemed to be "risky" to self.

Another cultural ceremonial process which could often be confused for self-harmful behaviour was associated with tribal markings or cuts that occur during lore time (young men's rite of passage) and is demonstrative of the initiation process. Participants indicated this was generally confined to the chest and upper body area. Given that there were no recognised "lore" people in the group and due to the secret nature of "lore" discussions, further detail was not provided or asked of the group consistent with cultural safety.

Third, and finally, the payback process as already described can involve some form of physical punishment which from observations outside of the culture, could be considered as harmful rather than restorative. For example, it can involve spearing in the leg, upper thighs or e.g., hitting with nulla nullas or other fighting sticks. This process however, must be sanctioned culturally by recognised Elders and not carried out in an arbitrary or random manner by individuals.

Participants felt these cultural practices often presented as significant challenges clinically in separating self-harm (individually initiated) from culturally sanctioned (collectively initiated) behaviours on a number of dimensions. First is that the physical signs or cuts may be confused clinically for a deliberate act of self-harm. The cultural appropriateness of these behaviours being reliant upon practitioners being able to gauge from their (often non-Indigenous) worldview and beliefs but also from the clinical (mono-cultural) diagnostic information available to them.

Participants noted several differentiating factors. For example, participants noted that the cutting of skin either by one's own hands, can be a process of resolving some form of pain. The ritual of sorry cutting has as its *intention* to *release or resolve* pain rather than *create pain*. The cutting of skin through Sorry Time is to resolve the pain of loss, and to also demonstrate respect for the deceased. The payback process represents a process of resolving conflict and group (or collective) harmony is restored. This ensures that the spirit maintains cultural "balance" and is not disrupted through the pain of unresolved, internal conflict. Finally, the cutting of skin in the initiation of young Aboriginal men is representative dually of the conflict that exists when boys become men and of the status, they have now attained through the lore process.

However, in terms of syndromes, which are culture-bound, there is significant potential for such behaviours to be observed as intentions to harm oneself. Being able to determine the difference between behaviours which represented deliberate self-harm as opposed to those which represented a culturally appropriate expression of grief, rite of passage or problem resolution process was considered of primary importance by participants.

Spiritual visits (or psychosis)

Participants cited numerous examples of misdiagnoses occurring with Aboriginal people regarding psychosis being confused with grief processes or being sung as already discussed. The result is Aboriginal people have learnt not to admit to visits from loved ones for fear that a diagnosis of mental illness will result.

Participants spoke of examples of Aboriginal people experiencing "visits" from loved ones following their passing as a normal aspect of grieving. From a purely symptom-based perspective there are clear similarities with clinical disorders like psychoses or schizophrenia but there are also some clear distinctions. It is crucial to treatment efficacy that assessment is both clinically and culturally rigorous and valid. In relation to this, the group discussed triggers to, and manifestation of, being sung and how this *differs* from clinical forms of psychoses or schizophrenia. This is broken down broadly into the two major constructs of hallucinations and delusions (below).

Hallucinations or spiritual visits

Participants noted that spiritual visits were predominantly visual. However that instances were cited in which visits impacted at all sensory and perceptual

levels including auditory, or tactile (kinaesthetic) forms. Notably when hallucinations were auditory, participants indicated it was common for multiple voices to be heard and for these voices to manifest as "running commentary".

Participants further agreed that in instances of being sung, triggered by cultural wrongdoing, there was *often little distress or agitation*, concomitant with the experience but this appeared specific to those Aboriginal people who have undertaken rite of passage or "lore" and therefore have access to specific cultural "treatments" accessible only by lore men for lore men. The detail of which are not available due to cultural security of this information. This fits with the concept of "punishment" for wrongdoing (such as being sung) being perceived differently based on shared and unique values and beliefs. That belief being that should wrongdoing occur, it needs to be resolved through payback or natural justice. The lack of distress associated with the experience is, presumably a result of a belief that this will be "worked through" as a clearly understood and respected cultural process. This is different to most forms of psychoses in which agitation and distress is so overwhelming that the compulsion to comply with voices (auditory hallucinations) is significant. This distinction, would then provide a strong argument for the decreased likelihood of violent behaviour and harm to others. It is also consistent with the way being sung occurs. Universally, participants saw this as consistently resulting in "harm" to self as opposed to others.

Participants also noted that with cultural grieving, spiritual visits should also be comforting to the individual. However, this is often dependent upon whether the grief is concluded culturally. In instances where something has been "missed" in the grieving process, visits could take on a troubling or distressing form. There are numerous grief rituals that differ from tribe to tribe and which represent Sorry Time and practitioners therefore should ensure that they are aware of local customs. Some examples include the cutting of one's hair as a sign of respect for the deceased; the cutting of the hair of the deceased by a close relative; smoking ceremonies; sorry cutting as already described. If specific tribal rituals are not fully concluded spiritual visits will often become troubling. However, participants were clear that when visits were troubling or distressing, practitioners needed to understand specific rituals and then assess what had been "missed" in this grief process. An example provided was that it is important as part of grieving process that a piece of hair is cut from the deceased at the time of death. If people were away from Sorry Time when a close relative had passed away ensuring they had a piece of the deceased person's hair may be an important treatment intervention. At all times any cultural intervention should occur in consultation with close family relatives. The treatment "outcome" that would be monitored would then be that the visits were no longer troubling or impairing individual function.

Two final aspects that were agreed to by participants in terms of distinguishing spiritual visits and psychoses were that consistently there was a separation of "self" from the "entity" – for example, – "I am being sung by, or I am being visited by". In many cases of psychoses the individual *becomes* entwined or indistinguishable from the entity – for example, "I am god, I am the devil" and so forth.

Finally, participants noted the *content* of hallucinations are consistently of a cultural nature – visually it may be spirits being seen or when voices are heard these will be from "cultural beings" or take on a consistently cultural form. It follows that if the disorder is culture-bound it will consistently manifest itself culturally.

Delusions or "culturally appropriate"

Participants were concerned that the beliefs associated with "being sung" or spiritual visits could also classify as "delusions" or false beliefs. Participants agreed that to distinguish "delusions" from culturally appropriate beliefs, the community context was critical. Participants did note, that when Aboriginal people have a belief that may seem "delusional" (from a mainstream perspective) this is always specific to the experience and does not generalise out to all experiences. For example, if they are reporting visits from a deceased relative, they will not report "visits" or "perceptual disturbance" occurring outside of this context.

Triggers for culture-bound syndromes

The third stage of the focus group discussion centred upon the cultural factors that were seen to either trigger or maintain culture-bound syndromes. Discussion centred upon the secret nature of Aboriginal culture which often made assessment significantly more complex for clinicians attempting to extract information of clinical value. Those factors that were considered critical for clinicians to be able to work in a more culturally inclusive manner in relation to assessment were discussed. Thematic analysis derived the following key themes from the focus groups' raw data:

How "cultural" are you?

A significant barrier to the assessment of culture-bound syndromes is the "determination" of cultural identity. Specifically, participants spoke of the fact that "culture" was often equated with skin colour or whether you were from a "traditional" (remote) community. Participants agreed cultural identity needed to be explored through culturally competent interview processes and extensive cultural mapping rather than making often erroneous assumptions based on external factors such as skin colour and geographical origin.

Men's versus women's business

Participants spoke of the separation between genders as being consistent across Aboriginal groups. Gender is a "subculture". It is accepted that private discussions, and most daily interactions in communities, was within same-sex alignments. Therapeutic interactions should ideally occur with clinicians of the same sex as the Aboriginal client. Where a clinician of the same sex as the client is not available, practitioners should engage an appropriate cultural consultant to minimise the impact of gender differences. Client presentation can be impacted by interviews being conducted by a clinician of a different gender (see Westerman, 2003). This is consistent with the cultural compatibility hypothesis already noted – being, the less the differences between (Aboriginal) client and clinician, the fewer the assessment errors (Davidson, 1995; Kearins, 1981).

The hierarchical nature of Aboriginal culture

Participants spoke of levels of "power" that exist in communities and that this often-made access to information "not possible" by those not at a level of equal "power" to their (Aboriginal) client. For example, Elders, healers (Maban, Ngunkarri) and lore men have different types of "power" in decision-making and in access to and ownership of knowledge that is kept safe or sacred on behalf of Aboriginal people. This information is only shared with those equally positioned within the hierarchy or who have similar "power".

Traditional lore

Participants were able to have limited discussion about traditional lore, in a manner that ensured cultural safety of information. Anything culturally "unsafe" was not recorded or reported. Simply put, the initiation or rite of passage for Aboriginal men is known as lore. During ceremony or initiation, young men are instructed with traditional lore teachings. The taboo nature of men's lore business means that the detail of lore should never be the focus of questioning or intervention and certainly not part of published research. It is clear, that questioning about the detail of "lore" by clinicians and those who are not initiated is culturally unsafe for the practitioner and client. It is advised that a process of informed cultural consent is undertaken as described by Westerman (2010) to ensure that culturally safe questioning occurs in these instances.

Skin and avoidance relationships

Participants spoke about the complexity of skin groups and the need to understand this as a core construct. There are layers to the construction of skin groups which offer layers of complexity however, the broad explanation of skin groups was discussed as follows:

"When an Aboriginal child is born, they are assigned to a 'skin group'. Ordinarily, the mother's skin group determines this skin name. Skin groups determine how relationships are constructed and conducted within the person's community. As children grow, they are taught to relate to people based on their skin. Skin determines who they can marry, who they are able to speak to, speak about, be near, make fun of and so on. In line with this, Aboriginal people often talk of marrying people who are 'straight (skin)', or "right way" for them. Alternatively, an individual who is from a skin group in which traditional marriage, communication or close proximity cannot occur is referred to as 'wrong way' or a 'wrong way relationship'. This is about the skin group classification".

Skin groups determine avoidance relationships, and this has significant impact on engagement in services and behavioural presentation. Formal meetings that require representation from family members will often be compromised. A voidance relationships often means that certain family members will not be able to participate and will not offer explanations as to why due to "shame" (Westerman, 2010).

External attribution beliefs

Participants viewed the Aboriginal belief system as being significantly different. The causes of mental health concerns were often determined as due to external reasons, or sources, such as: (a) payback, including "intergenerational payback"; (b) being sung; and (c) wrong way "skin" relationships. In instances in which individuals were in mental health distress, community would often seek external causality (e.g., he

was sung; he was married "wrong way"), rather than an internally driven individual choice.

Interestingly, if a proximal cultural trigger could not be readily identified, secondary (distal) causes, such as "intergenerational payback" or "inherited mental illness" would be ascribed as causal.

A cultural formulation model

The final stage involved the main researcher clinically appraising the existing DSM-IV OCF against data gathered from this study. There are four domains to clinically and culturally competent assessment based upon study themes including; (a) cultural competence of practitioner; (b) individual (client) connection with culture; (c) cultural nuances or context, and (d) community validation of individual beliefs. This model is provided at Attachment A.

Discussion

This paper provides an initial empirical validation of the existence of "culture-bound" syndromes for Aboriginal Australian populations, their manifestations, and triggers.

Whilst this is an important starting point to understanding the role culture plays in the onset and course of mental ill health, it also has significant treatment implications. It follows that intervention should necessarily flow from the origins of the disorder. Simply put – cultural cause, cultural treatment. For example, in the case of cultural grief, it follows that if this is unresolved it can also manifest clinically.

Differentiating cultural syndromes from clinical disorders: A major outcome has been to determine some of the distinguishing characteristics between clinical and cultural disorders. Firstly, in relation to "sorry cutting" individuals appear disconnected from pain. Differential pain tolerance has been noted in several cultures worldwide in which rites of passage which outwardly appear painful are clearly not experienced as such. For example, the Hindu festival of Thaipusam in which participants engage in various acts of devotion and control over their senses – including piercing the skin, tongue, or cheeks.

It is therefore worth considering whether dissociation is at play here; and whether dissociation is a practiced cultural phenomenon.

Sorry cutting is essentially about releasing pain, not creating pain. However, to engage in these rituals in a way that ensures that pain is *released* rather than *felt* there must arguably be a dissociative element involved.

This is consistent, with self-harm in that there is also a dissociative element to it. The dissociation enables the self-harm to not be felt as painful. This point is significant, as it makes the ability to clinically separate cultural sorry cutting from self-harm difficult without the clinician being able to determine the "triggers" and cultural context to these behaviours.

It is very clear that sorry cutting is vastly different and distinct from self-harm. It is the role of clinicians to be clear about what has triggered the behaviour (external, collective cultural grief resolution as opposed to internal resolution of psychological pain) and that the individual's report matches the community context (i.e., similar idioms of distress used to describe the behaviour; the same language and terms used to describe the behaviour; it fits with cultural grief protocols and within the context of Sorry Time, sanctioned within the community etc).

Psychoses, schizophrenia or being sung/spiritual visits: A further study outcome was in the exploration of the normalcy of the spiritual dimension (e.g., seeing, hearing, feeling spirits of the deceased) within Aboriginal culture. Of importance is that this manifestation means that two of the diagnostic criteria out of five for the diagnosis of schizophrenia is met. This includes hallucinations and delusions which are both evident in cultural spiritual visits within the culture-bound phenomena of being sung and grief reactions.

The culture-bound syndrome of "being sung" appears similar to "black magic" of Central Zaire in South Africa (Tseng et al., 2004) and would manifest in a way that increases the likelihood of clinical diagnosis and intervention. It is a common in those who are sung or cursed to believe that their thoughts can be controlled by an external source, consistent with the *command hallucination passivity experience*. This was of great concern to participants given the established relationship between command hallucinations and violent behaviour which increased the likelihood that anti-psychotic medications (clinical intervention) would be used as the sole treatment (Tseng et al., 2004).

The study resulted in several outcomes in assisting to distinguish between the spiritual visits and hallucinations. as well as distinguishing characteristics between delusions and culturally appropriate beliefs.

It is essential the clinician determines a sense of community norms, idioms of distress, dialect used, the manifestation of disorder as an initial stage to community mapping of cultural kinship ties, connections, hierarchy of the individual and any skin groups/ relationship that are evident and which dictate behaviours within discrete communities. The clinical

assessment is then guided by this. Does the individual use words to describe what is occurring in a way consistent with the community? Has there been a trigger (i.e., a death; cultural wrongdoing, etc.) that can account for the individual's beliefs?

Culture-bound syndromes are a complicated issue. The secret nature of Aboriginal culture also limits the average clinician's capability to be able to work at a culturally and clinically safe level with Aboriginal clients. It is essential that clinicians engage in cultural supervision, with a clinically and culturally informed mental health practitioner who is ideally "culturally vouched" for.

Study Strengths and Limitations: The study strengths lie in the use of a focus group format which has provided an informality to the study and enabled the gathering of highly complex cultural information. The use of theoretical saturation is also a significant strength which has provided some confidence in the generalizability of the study outcomes. The exploration of within group cultural differences via participants being from two considerably different locations and tribal groupings is a further study strength. This addresses concerns regarding the diversity of Aboriginal culture and the associated inability to develop valid outcomes that are capable of being relevant across culturally disparate regions.

There are of course, several limitations of this study. First, it is the first empirical study which has specifically looked at culture-bound syndromes within Aboriginal populations. It has also been undertaken with Aboriginal Australian populations in Western Australia in Urban and Rural locations and has not been extended beyond this cohort.

Second, the study was confined to Aboriginal Australian populations and was not inclusive of Torres Strait populations. Third, whilst the study did not find gender differences in the culture-bound syndromes identified outside of lore men who have "been sung". The secret nature of "lore" precludes the exploration of "lore" culture-bound syndromes.

Finally, the review of the OCF whilst important, has not been tested clinically with Aboriginal clients by practitioners who ultimately need to determine its utility as noted by Lewis-Fernández and Díaz (2002) and more recently by Aggarwal et al. (2013).

In conclusion, the consistency with which individuals speak of, and know of these disorders strongly supports the fact that it is possible that they also exist in other Aboriginal tribal groups. It is vital to better mental health outcomes for Aboriginal people that this study is replicated and particularly in other states. The rationale being that there is now a strong case to be made for the universal existence of culture-bound syndromes amongst Aboriginal Australians based upon outcomes of this study.

ATTACHMENT A: The Aboriginal Mental Health Cultural Formulation Model, adapted from the DSM-IV Outline for Cultural Formulation (American Psychiatric Association, 1994)

Practitioner factors

1. Minimum standards of cultural competency (as determined by the Aboriginal Mental Health Cultural Competency Profile (CCP: Westerman, 2003);
2. Practitioner must examine potential for racial bias/prejudice in self;
3. Explore the need to address the impact of ethnicity, gender, age, hierarchy, and lore issues relevant to client (see point 2);
4. Determine if any of these factors impact on client presentation, cultural validity of assessment, engagement, and cultural safety of information;
5. Ensure a process of informed cultural consent as described by Westerman (2010) in instances in which there are gender and/or hierarchy differences between client and practitioner;
6. Explore the need to address the impact of cultural differences during assessment and testing via:
   (a) Assessment across environments. Use ethnographic triangulation of data sources to ensure accuracy of client presentation and test results;
   (b) Is there evidence of symptom variation for major disorders (see Westerman, 2003);
   (c) Can the symptoms be interpreted differently based on cultural differences in how symptoms manifest themselves? See Westerman (2003);
   (d) Minimise the impact of cultural differences via the use of cultural consultants as described by (Westerman, 2003; Westerman, 2010);
7. Role of Aboriginal English (see Eades, 2013) in questioning style, culture in interpreting assessment questions;
   (a) Allowing for cultural differences during testing via;
   (b) Culture-reduced (low inference) or unique tests;
   (c) Modify testing ("testing the limits") as described by Carlson and Wiedl (1978) dynamic assessment and triangulation of test results);

(d) Qualitative interpretation of test items based upon cultural learning differences as described by Kearins (1981);
(e) Culture-specific report identifying elements of bias throughout.

Individual client factors

1. Assess status in community and whether there exist hierarchical differences between client and clinician that need to be addressed, i.e., lore man, elder, healer, etc.
2. Obtain sense of normal and differential functioning. Does the client have forms of perceptual disturbances which are culture specific as described?;
3. When undertaking a Mental Status Exam consider differences in how time is ascribed in Aboriginal contexts and whether a lack of orientation to time, place and space is reflective of cultural differences;
4. Assess the belief system – using the Acculturation Scale for Aboriginal Australians (see Westerman, 2003);
5. The description of the illness is clinically and culturally convincing and consistent including:
   (a) The client uses language which is specific to their culture of origin to describe the illness (e.g., being sung; sorry cutting; having bad or good spirit and language ("idiom of distress") consistent with and specific to their community dialect);
   (b) If client is experiencing visits, they perceive themselves as being separate to the entity;
   (c) Do the beliefs (delusions) cause distress? Explore whether any lack of distress is tied in with cultural norms regarding presentation;
   (d) Client's perception of the cause of the problem. Does the client see the behaviour as being culturally related or triggered? Assess how this manifests itself – culturally? Spiritually? Mentally? Physically? Treatment must address all areas affected;
6. Spiritual connectedness to land, country and dreaming which is able to be articulated by the client as part of individual beliefs and cultural obligations;
7. Does the client see the illness as requiring:
   (a) a cultural solution;
   (b) mainstream intervention;
   (c) mix of mainstream and cultural interventions;
   (d) mainstream interventions adapted to treat cultural illnesses.

Cultural nuances

The practitioner is referred to this article as a method of determining the unique Aboriginal Australian culture-bound syndromes, their manifestation and their triggers as described.

1. An overriding aspect of this aspect of assessment is to determine whether the client's description of the disorder is consistent with how their community, place of dreaming, birth have knowledge of these types of syndromes. This requires that the practitioner is able to assess at the level of individual belief first (stage 2 of assessment) in order to provide this context;
2. This provides context, but also validates the manifestation of the disorder where possible. The description provided by the client must match the community's view of the disorder (including aetiology, onset, same language; same words used to describe the syndrome; same manifestation; and validation of the client's cultural connection, integration in culture, shares the community beliefs. This extends to validating the client's hierarchy if necessary (i.e., if they state that they are a "lore" man, the community needs to validate that – refer to Community aspect of assessment).

The below specifically provides cultural nuance to spiritual visits and being sung as one of the most common culture-bound syndromes to provide an example of problem formulation:

Hallucinations

1. Culture-bound spiritual visits (perceptual disturbances) do not have an end point. Intervention is not focused on eliminating the visits;[1]
2. Culture-bound spiritual visits should not be experienced as troubling to the individual. Culture-bound visits should be experienced as comforting particularly if related to grief experiences;
3. If spiritual visits of deceased loves ones are not comforting in their nature, this suggests cultural grief processes have not been enacted. The focus is on the visits being comforting, not stopping the visits. Clinically, it can be viewed in a similar manner as addressing the degree of impairment the client is reporting;

4. Visits will be gender specific and need to be considered within that particular context.

Delusions

1. The beliefs (delusions) attached to the spiritual visits are consistent with cultural practices (e.g., visits occurring to eldest son) which is specific to the client's community context;
2. The beliefs (delusion) do not extend beyond the particular event;
3. The context of the belief (delusion) differs;
4. Thought sharing, passivity phenomena, possession by outside forces, "thinking backwards", tangentiality, loose associations, word salad need to be viewed within the context of the cultural differences between client and practitioner as described by Westerman (2003), and whether these behaviours are a result of the expression of cultural differences;
5. The culture views the delusion as a delusion;
6. Variability in language, style of emotional expression, body language and eye contact should be considered differently and extent of cultural difference between client and practitioner explored as a possible reason for these differences;
7. Catatonic behaviour is more common in mainstream cultures, but can occur when one has been "sung" or cursed.

Community factors

1. Abhorrent behaviours are often appropriate and sanctioned by the community norms or context of behaviours. A process of cultural mapping should be undertaken using the Acculturation Scale for Aboriginal Australians (Westerman, 2003) to determine this;
2. Does the community see the behaviour as normal? Note whether the community has access to key decision-makers specific to the client's specific presenting issue (i.e., Elders, lore men, traditional healers);
3. The community, Elders, lore men, traditional healers, key stakeholders can relate the behaviours to a culturally relevant experience including:
   (a) An experience of grief;
   (b) Retribution or cultural wrongdoing;
   (c) Removal from land, place of dreaming for extended periods;
   (d) Failure to resolve grief culturally;
   (e) Traumatic event (cultural transgression, family distress);
4. Role of historical, cultural, political and social factors as triggers and capacity to heal from ongoing trauma as a direct result of assimilation policies;
5. Severity of problem in relation to cultural norms;
6. Cultural factors related to psychosocial environment and levels of functioning.

Conclude with a formulation which incorporates practitioner, individual, cultural and community factors and their impact upon assessment and diagnosis.

Notes

1. This is not the case with the culture-bound illness of "being sung" in which the focus of any cultural treatment is the cessation of the manifestation of being sung. This includes the cessation of command hallucinations or spiritual visits or other alterations to one's perceptions. This is what distinguishes being sung from psychosis from being sung – compliance with command hallucinations does not result in the voice ceasing – it does when an individual has been sung.

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The authors have no interests to disclose in relation to this project.

References

Aggarwal, N. K., Nicasio, A. V., DeSilva, R., Boiler, M., Lewis-Fernández, R. (2013). Barriers to implementing the DSM-5 cultural formulation interview: A qualitative study. *Culture, Medicine, and Psychiatry*, *37*(3), 505–533. https://doi.org/10.1007/s11013-013-9325-z

Allen, J. (1998). Personality assessment with American Indians and Alaska natives: Instrument considerations and service delivery style. *Journal of Personality Assessment*, *70*(1), 17–42. https://doi.org/10.1207/s15327752jpa7001_2

American Psychiatric Association. (1994). *The diagnostic and statistical manual - fourth edition (DSM-IV)*.

Australian Bureau of Statistics. (2017). *Life Tables for Aboriginal and Torres Strait Islander Australians, 2015-2017. 3303.0: Causes of death*.

Australian Institute of Health and Welfare. (2016). *Australia's health*. AIHW. Australia's health series no. 15. Cat. no. AUS 199.

Biles, D., McDonald, D., & Fleming, J. (1989). Royal commission into aboriginal deaths in custody. *Australian Deaths in Custody 1980-1988*, *7*, 65–132.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Carlson, J. S., & Wiedl, K. H. (1978). Use of testing-the-limits procedures in the assessment of intellectual capabilities in

children with learning difficulties. *American Journal of Mental Deficiencies*, *92*(2), 234–236.

Cuellar, I. (2000). Acculturation and mental health: Ecological transactional relations of adjustment. In I. Cuéllar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health* (p. 45–62). Academic Press.

Cuellar, I., & Paniagua, F. A. (2000). *Handbook of multicultural mental health*. Academic Press.

Dana, R. H. (1998). Cultural identity assessment of culturally diverse groups: 1997. *Journal of Personality Assessment*, *70* (1), 1–16. https://doi.org/10.1207/s15327752jpa7001_1

Dana, R. H. (2000). Culture and methodology in personality assessment. In I. P. Cuellar & F.A (Eds.), *Handbook of multicultural mental health* (pp. 98–120). Academic Press.

Davidson, G. R. (1995). Cognitive assessment of Indigenous Australians. *Australian Psychologist*, *30*(1), 30–34. https://doi.org/10.1080/00050069508259601

Dion, R., Gotowiec, A., & Beiser, M. (1998). Depression and conduct disorder in native and non-native children. *Journal of American Academic Child and Adolescent Psychiatry*, *37*(7), 736–742. https://doi.org/10.1097/00004583-199807000-00013

Eades, D. (2013). Aboriginal English [online]. In D. Eades, *Aboriginal ways of using English*. Aboriginal Studies Press.

Eastwell, H. (1982). Overview: Australian Aborigines. *Transcultural Psychiatric Research Review*, *19*, 221–247. https://doi.org/10.1177/136346158201900401

Fogliani, R. V. C. (2019). *Inquest into the deaths of 13 children and young persons in the Kimberley region, State Coroner's Office, Western Australia, Perth*. https://www.coronerscourt.wa.gov.au/_files/inquest-2019/13-Children-and-Young-Persons-in-the-Kimberley-Region-Finding.pdf

Huffine, C. (1989). Social and cultural risk factors for youth suicide. In L. D. M. Linnoila (Ed.), *Report of the secretary's task force on youth suicide* (pp. 56-70). Department of Health and Human Services.

Hunter, E. (1989). Changing Aboriginal mortality patterns in the Kimberley regions of Western Australia. 1957-1980: The impact of death from external causes. *Aboriginal Health Information Bulletin*, *11*, 27–32.

Hunter, E. (1993). Aboriginal mental health awareness: An overview, Part II. *Aboriginal And Islander Health Worker Journal*, *17*(1), 8–10.

Hunter, E. (1997). Double talk: Changing and conflicting constructions of indigenous mental health. *Australian & New Zealand Journal of Psychiatry*, *31*(6), 820–827. https://doi.org/10.3109/00048679709065507

Kearins, J. M. (1981). Visual spatial memory in Australian Aboriginal children of the desert regions. *Cognitive Psychology*, *13*(3), 434–460. https://doi.org/10.1016/0010-0285(81)90017-7

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care: Clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine*, *88*(2), 251–258. https://doi.org/10.7326/0003-4819-88-2-251

Kline, P. (2000). *A psychometrics primer*. Free Association Books.

Lewis-Fernández, R., & Díaz, N. (2002). The cultural formulation: A method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly*, *73*, 271–295. https://doi.org/10.1023/A:1020412000183

Marsh, A. M. (1999). *African American community mental health center service utilization: A test of the cultural compatibility hypothesis* [Doctor of Psychology (PsyD), dissertation]. Old Dominion University. https://digitalcommons.odu.edu/psychology_etds/212

O'Connor, J., Chur-Hansen, A., & Turnbull, D. (2015). Professional skills and personal characteristics for psychologists working in an urban Australian context with indigenous clients. *Australian Psychologist*, *6*, 464. https://doi.org/10.1111/ap.12125

Paniagua, F. A. (2000). Culture-bound syndromes, cultural variation, and psychopathology. In I. P. Cuellar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health* (pp. 142–170). Academic Press.

Paniagua, F. A. (2014). *Multicultural Aspects of Counseling and Psychotherapy Series 4: Assessing and treating culturally diverse clients: A practical guide*. SAGE Publications, Inc. https://doi.org/10.4135/9781506335728.

Reser, J. P., & Eastwell, H. D. (1981). Labelling and cultural expectations and the shaping of a sorcery syndrome in Aboriginal Australia. *Journal of Nervous Disorders*, *169*(5), 303–310. https://doi.org/10.1097/00005053-198105000-00007

Sartorius, N., Jablensky, A., Korten, A., Ernberg, G., Anker, M., Cooper, J., & Day, R. (1986). Early manifestations and first-contact incidence of schizophrenia in different cultures: A preliminary report on the initial evaluation phase of the WHO Collaborative Study on Determinants of Outcome of Severe Mental Disorders. *Psychological Medicine, 16*(4), 909–928. https://doi.org/10.1017/S0033291700011910

Seru, G. (1994). Mental health issues for Elders with a focus on Grannies. *Aboriginal And Islander Health Worker Journal*, *18* (13–16).

Sheldon, M. (2001). Psychiatric assessment in remote Aboriginal communities. *Australian and New Zealand Journal of Psychiatry*, *35*(4), 435–442. https://doi.org/10.1046/j.1440-1614.2001.00920.x

Slattery, G. (1994). Transcultural therapy with aboriginal families: Working with the belief system. *Australian & New Zealand Journal of Therapy*, *8*(2), 61–70. https://doi.org/10.1002/j.1467-8438.1987.tb01204.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P. B., Smith, E. J.,& Vasquez-Nuttall, E. (1987). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, *10*(2), 45–52. https://doi.org/10.1177/0011000082102008

Tonkinson, R. (1988). Egalitarianism and inequality in a Western desert culture. *Anthropological Forum,5*(4): 545–58. doi:10.1080/00664677.1988.9967387

Tseng, W., Matthews, D., & Elwyn, T. S. (2004). *Cultural competence in forensic mental health. A guide for psychiatrists, psychologists, and attorneys*. Brunner-Routledge.

Vicary, D., & Andrews, H. (2001). A model of therapeutic intervention with indigenous Australians. *Australian and New Zealand Journal of Public Health*, *25*(4), 349–351. https://doi.org/10.1111/j.1467-842X.2001.tb00592.x

Vicary, D. A. (2002). *Engagement and intervention for non-aboriginal therapists working with Western Australian Aboriginal People* [Unpublished PhD thesis]. Curtin University.

Vicary, D. A., & Westerman, T. G. (2004). That's just the way he is. *Australian e-Journal for the Advancement of Mental Health*, *3*(3), 103–112. https://doi.org/10.5172/jamh.3.3.103

Westerman, T. G. (2003). *Development of an inventory to assess the moderating effects of cultural resilience with Aboriginal youth at risk of depression, anxiety and suicidal behaviours* [Doctor of Philosophy]. Curtin University.

Westerman, T. G. (2010). Engaging Australian Aboriginal youth in mental health services. *Australian Psychologist*, *45*(3), 212–222. https://doi.org/10.1080/00050060903451790

Westerman, T. G. (2019, April 19). Sick heart of a generation. *The Australian*.

Westerman, T. G., & Kowal, E. (2002). *Mental health outcome measures for Indigenous Australians: A review of current practice in culturally valid assessment processes*. Co-operative Research Centre for Aboriginal and Tropical Health.