CHAPTER 1

Caduceus and Clipboard

SETTING AND SET

Beyond Australia's northern horizon, submerged by time and rising seas, is another coastline. Somewhere along that slowly shifting shore prehistoric wanderers welcomed the certainty of solid ground — the first footprints of Homo sapiens marked the sand and were washed away. Perhaps slow curious eyes followed them, or furtive, frightened, fluttering glimpses. The ancestors of the ancestors, markers of the land, had entered the rhythm of change, caught in the moods of this land, transformed by it across the centuries and transforming it. Those earliest landfalls, perhaps over 50 000 years ago, may have been off the Kimberley region of Western Australia. To reach the Sunda Shelf, even at the lowest level of the seas, would have required a sea-crossing of some 87 kilometres (Flood 1983). For the survivors of that journey into the unknown there was no return.

THE REGION

Age-scarred and rugged, with colours drained by a relentless sun, the weathered landscape of the Kimberley seems to declare its resistance to change. However, beneath lies a hidden story of geological change. The sandstones and shales of the plateaux testify to ancient forces, while the sediments beneath the sandy country of the west and east Kimberley tell of more recent transformations (Petheram & Kok 1986). The region is vast, even by Australian standards, and remote. It is over 2000 kilometres by road from Perth to Broome in the south-west Kimberley and another 1000 kilometres to Kununurra in the north-east, near the Northern Territory border. Few travellers venture far from the single sealed road, the National Highway, beyond which lies an expanse of nearly half-a-million square kilometres (figure 1.1).

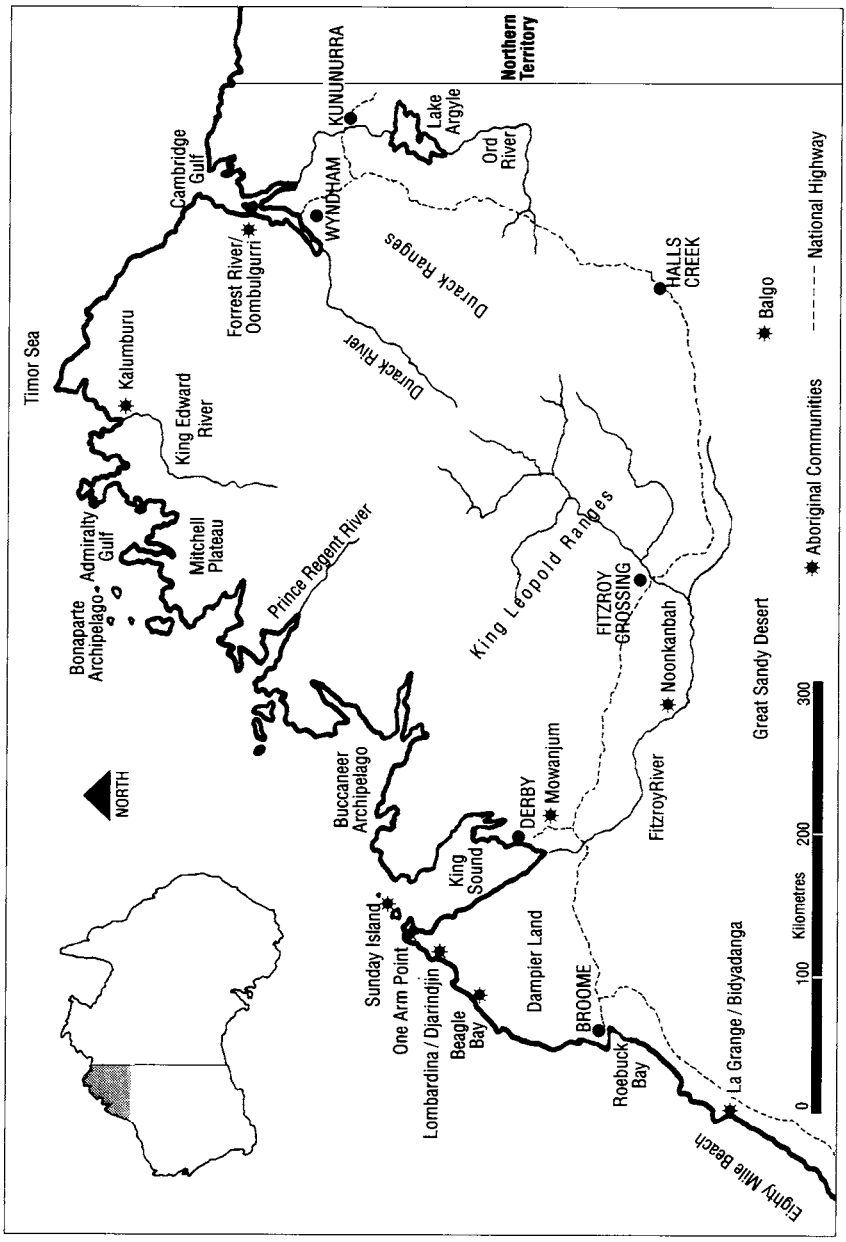

Figure 1.1 *Map of the Kimberley region, Western Australia*

The coastline of the Kimberley region is divided by the mangrove-lined waters of King Sound. Draining the Fitzroy River, low mud-islands emerge and disappear in its 10-metre brown tides. From the entrance to the Sound at the tip of the Dampier Land peninsula, the Indian Ocean pulses over gentle bays and wide tidal beaches, which give way southwards to the dazzling, uninterrupted shoreline of Eighty Mile Beach, where the Great Sandy Desert confronts the sea. North from King Sound the spectacular Buccaneer and Bonaparte archipelagoes stand as rocky sentinels before a tortuous shoreline. Here the sea surges through narrow channels to hidden inlets. The coast is wild, beautiful and deserted.

To the east, rising to some 800 metres, the deeply etched sandstone and basalt Kimberley plateau spreads over almost a third of the region. From the air the gently rolling, weathered hills seem barren through most of the year — the radiated heat trapped in a dull, stifling haze. At ground level, spinifex, grass and scattered gum-trees appear like the scrawny vestiges of some former epoch, struggling between rock and stone; struggling perhaps, but also wonderfully adapted. Following the monsoonal deluges of the 'wet' (December to March), these surfaces explode into a profusion of life. Swollen rivers carve deeper through tortuous gorges, whose shadows shelter hidden subtropical realms. Towards the ocean to the west and north sharp escarpments, cut deeply by tidal inlets, border the plateau. To the south and east the massif gives way through the rugged King Leopold and Durack ranges (the former containing Mount Ord, at 930 m the highest point in the Kimberley) to the savannas and grassland plains of the Fitzroy and Ord river basins.

These fertile corridors attracted and guided European pastoralists, who have in turn transformed the land. They initially arrived in the 1860s, and by the First World War there were some 700 000 cattle and 300 000 sheep in the Kimberley (Petheram & Kok 1986). Over-stocking and inadequate attention to pasture management rapidly resulted in soft riverbanks crumbling under-hoof, in deep gullies sweeping away the fragile topsoil during the summer floods. From a wild torrent swelling to the horizon across the floodplains during the 'wet', the Fitzroy contracts to a chain of long, silent waterholes, flood-strewn debris high in the river gums attesting to the river's moods. Away from the muted green corridors of the watercourse, the plain is grass, spinifex, dust and endless ranks of anthills raised to the sky.

South from the Fitzroy the transition is less abrupt. The monsoons that deliver up to 1500 mm of rainfall in one season to the north-west of the plateau are far less generous or predictable moving inland. South of Halls Creek annual falls of less than 400 mm mark the southern limits of the cattle industry. Increasingly arid, the unyielding plain and stunted growth hide contrasts. Temperatures can fall below freezing during the cloudless, sparkling nights of the dry season, rising to the high thirties during the shimmering heat of the day. In the wake of heavy rains, the mesa-studded plains of the south-east are unable to drain the saturated land. Rivers suddenly fill and bodies of water materialise. Barren of even their usual sparse cover, dead trees disappearing to the horizon tell of these lakes' pulsations. Further to the south and east begin the sandhills of the Great Sandy Desert carving across the base of the Kimberley to the ocean.

GUIDING FRAMES

From the 1980s the Kimberley has been home to roughly equal numbers of Aborigines and non-Aborigines. While living in the same space, they are in many ways in different worlds. This is reflected in the region's economies. That of the dominant culture is based on growth, including: mining (gold, iron, zinc, silver, lead, diamonds, marble; with known deposits of uranium, copper-platinum, and bauxite); marine resources (particularly pearling); cattle (over 90 leases averaging 350 hectares, two-thirds of which are owned by corporations from outside the region); agriculture (small-scale horticulture focused about Kununurra); tourism (now bringing perhaps over 200 000 visitors a year); and government services (Aborigines, in this sense, being a resource).

The Aboriginal economy, save for a small urban subgroup, is primarily domestic, static, and based on welfare. Thus, there are glaring disparities in disposable income and in credit (other than internal 'credit', most Aborigines of the Kimberley are functionally excluded from the credit resources of the wider society). Aborigines of the region are economically poor — and often powerless.

Contemporary powerlessness — its roots and history; its manifestations and articulation; its consequences and perpetuation — threads through and links the sections of this study. The focus of this study is the Aborigines of the Kimberley; but it does not pretend

to speak for them, or to present an 'Aboriginal view'. It is a non-Aboriginal perspective. There have been many studies with such a perspective before, and more will follow. However, while the field of Aboriginal studies has historically discounted Aboriginal opinions, that situation has changed, with the development of a powerful Aboriginal voice producing its own constructions of 'Aboriginality' and of non-Aboriginal cultures. Hopefully, works such as this one and others by Aboriginal writers will stimulate a dialectical process of mutual exploration and understanding.

There are serious problems in generalising from one region of Aboriginal Australia to another, in particular from remote Australia to urban populations. This work is based on a particular region that, itself, contains enormous diversity: its findings may not be relevant to the unique circumstances of other regions and populations. On the other hand, they may. The study demonstrates that patterns of Aboriginal ill-health in the Kimberley are powerfully influenced by social factors that are embedded in the particular history of the region. This is true for mental health generally — a point frequently missed by psychiatrists constrained by their metropolitan professional identity:

> Tearing the subject from history, rendering him a passive actor, a judgmental dope, out of touch with the real rhythms and reasons of his behaviour, is the production of each psychiatrist experiencing and rationally reacting to, therein constituting, the professionally organised domain of psychiatry. (Robillard 1987 : xvi)

This work proceeds from the premise that the analysis of health demands a knowledge of the historical forces defining its social context. The following chapters trace an outline for this task. Chapter 2 presents an overview of forces affecting Aborigines in the region since the arrival of Europeans and Chapter 3 sketches the development of health services in the region. While these sections are quite detailed, as LeVine has commented regarding cross-cultural variation in psychosocial adaptation: 'a full understanding necessarily requires both historical reconstructions and the analysis of current function' (1982 : 164).

Disciplinary divergences

I have trained and worked predominantly in clinical psychiatry, and my orientation is informed by that exposure. Soon after arriving in

the Kimberley in March 1987, I found that my ascribed professional identity substantially determined the attitudes and expectations, not only of Aborigines, but of workers from other disciplines. In a situation not unique to researchers in remote Australia, the tension between psychiatry and the social sciences has long allowed only an uneasy rapprochement: 'the relationship between sociology and psychiatry often takes the form of a superficial acceptance of the ideas of the one by the other, or the acceptance of the authority of the one by the other' (Doerner 1981 : 2).

Psychiatry is in a particularly sensitive position in that it deals with issues that overlap the fields of interest of the social sciences. As a subdiscipline within medicine it is frequently construed as reflecting the supposedly narrow positivist perspectives of the physical and natural sciences, inappropriate for the study of systems of meaning. However, as a discipline that engages its subjects on the level of emotions and feelings, psychiatry of necessity *is* concerned with systems of meaning and with intersubjectivity. While the ascendancy of biological theories and the 'medical model' of mental illness is transforming both research and practice in general psychiatry, the cross-cultural subdiscipline is in the opposite direction — from foregrounding biology to emphasising cultural explanations.

Despite this, or as a consequence, with growth into a similar domain of interest, particularly in the limited field within Australia, differences are accentuated in defining 'territory'. This is frequently articulated in terms of emic versus etic distinctions. Derived from linguistics and extended to cultural research, emic approaches (from 'phonemic') explain observed behaviour using constructs from within the culture, whereas etic approaches (from 'phonetic') utilise external criteria imposed by the researcher in an attempt to generate universal categories (Davidson 1977). In contrasting these orientations, Berry (1980) indicated that an emic approach: studies behaviour from within the system; examines only one culture; uncovers structure; and generates criteria relative to internal characteristics. By contrast, an etic approach: studies behaviour from a position outside the system; examines many cultures, comparing them; imposes structure; and generates criteria considered absolute or universal. However, Jahoda (1977) has pointed out that any cultural system is composed of overlapping and interlocking systems at different levels. He questioned whether an analysis is possible within one system without reference to another, and whether a researcher (who

generally is not and cannot become a member of the system under study) can provide an analysis from 'inside the system'.

In the field of Aboriginal studies Biernoff has opposed the emic approaches of anthropology to the etic analyses of psychiatry in the interpretation of 'aberrant' Aboriginal behaviour. Acknowledging that 'identifiable symptoms and aberrant behaviour do occur and are recognised as abnormal by both Aborigines and psychiatrists' (Biernoff 1982 : 149), he suggested that 'it is but a small step from explaining psychopathology in cultural terms, to describing culture in psychopathological terms' (ibid : 150).

While the trend to pathologise culture is not unique to psychiatry, in that discipline it arises primarily in settings with limited cross-cultural exposure. In the fields of cross-cultural psychiatry and psychology there is intense and active debate on these issues. The emic–etic distinction is clearly of major concern; cross-cultural psychiatry contrasts these orientations as ethnopsychiatry versus comparative psychiatry (Lipsedge 1989). While the corpus of psychiatric writing on Aborigines is limited, there are examples of both approaches. One may compare the etic analysis of 'voodoo death' by Eastwell (1982) and the 'fear of sorcery syndrome' by Reser and Eastwell (1981), to the emic analysis of the 'Groote Island syndrome' by Cawte (1984). Spiro provided a salutary caveat: 'that cultural frames make emic, or intra-cultural, sense does not imply, however, that they are immune from valid cross-cultural, or etic, judgement, let alone that they are the primary, if not the exclusive, determinants of what social actors think and feel or how they behave' (1984 : 329).

Psychiatry clearly brings certain biases to the cross-cultural situation. Kleinman (1987) has repeatedly drawn attention to the ethnomedico-centricism of the discipline and the particular problems of cross-cultural instruments, indicating, for example, that the approach to the diagnosis of depression exemplified by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM–III and its scion DSM–IIIR) minimises emic aspects (Kleinman & Good 1985). This is necessarily the case; for, as classificatory tools to guide treatment by comparison of like constellations of symptoms and behaviours, such nosologies rest on an etic foundation. As taxonomies, diagnostic systems are culturally determined, identifying clinical conditions that are themselves culturally constituted and embedded in a social context: 'a medical

and psychiatric diagnostic system is a cultural object that constitutes abstract clinical entities based on distinctive symbolic conventions' (Fabrega 1987 : 392).

With many conditions but few clearly defined causes and even fewer confirmatory tests, psychiatric praxis rests on such labelling, indeed: 'underlying all of its powers, institutions and technologies — has been one sustaining psychiatric act: diagnosis' (Reich 1981 : 62). Within the field there are both pragmatic and magical functions of such labels. It is the latter, the transmutation of description to disorder, the confusion of 'things with the names we give them' (Biller 1976 : 5) that causes friction between psychiatry and the other social sciences. Instruments such as DSM-III, which have come to signify for psychiatry's detractors the profession's inflexibility, do not adequately take into account the culturally constituted idioms of distress that inform, for example, possession states (Obeyesekere 1970) and sickness behaviour (Nichter 1981) in non-European contexts, or the social role of sickness among Aborigines (Nathan & Japanangka 1983). In tradition-oriented Aboriginal Australia this includes the use of the projective mechanisms of sorcery (Reid 1983) and ritual (Kaberry 1973 [1939]) in dealing with stress and danger. However, in pointing out psychiatry's potential for pathologising culture, Biernoff has not considered that a significant proportion of clinical work in exotic situations is the identification and treatment of organic disorders, all too easily ascribed to cultural factors (Hunter & Allan 1986). Denying or minimising disorder or disease in a cross-cultural context is disarmingly easy and dangerous. There is no simple solution, one strives for an openness to the cultural dimensions of human existence while retaining clinical vigilance.

METHODOLOGIES

The sign proclaimed plainly and simply: 'No doctors allowed'. There was no easy explanation of this perplexing message for the eminent American researchers who had travelled to Balgo, one of the most remote Aboriginal communities in the Kimberley. The specificity was unavoidable: not whites (or *gudiyas*), or miners, or politicians, or bureaucrats — but doctors. This prohibition challenged the expectations of 'privileged access' that presumed an interculturally shared valuation of doctors as caring and appreciated.

In that community, Aborigines clearly did not resonate with that professionally self-serving construction.

The sign was on the door of the art centre, one of a few conspicuously intact buildings surrounded by gutted, tumbling dwellings and ramshackle windbreaks. Nearby, my international colleagues saw Aboriginal Australians and their dogs retreating from the early afternoon heat and dust. By any definition the residents of this isolated ex-mission settlement were, and remain, in terms of money and resources, poor. Judging from the arid countryside and the state of disrepair in the community, there appeared little likelihood of changing that economic situation — unless, perhaps, through painting.

Gugadja (Kukatja) artists had first adopted non-traditional media in the late 1970s. By 1986 Balgo art was being exhibited at the Art Gallery of Western Australia and further afield. Entrepreneurs soon 'discovered' this untapped resource and were quick to take advantage of artists who were unaware of the 'value' of their productions in the metropolitan markets of the south. Thus, the connection to the sign. At the time of our visit the government clinic staff had been withdrawn owing to vandalism and perceived 'threats', continuing services being provided through the Royal Flying Doctor Service. Our Aboriginal informants explained that doctors, flown out at a time of great need for brief clinics, had been unavailable on several occasions for consultation. Instead, we were told, they had been seeking out artworks and purchasing them at bargain prices.

Episodes of such professional confrontation were rare during the course of my research in the Kimberley. When they did occur, however, they were reminders that the work I was engaged in was socially and historically located. A non-Aboriginal, urban, economically privileged professional, I was engaged in the immediately asymmetric process of Aboriginal health research. Indeed, in the course of medical work it is impossible to discard the expectations and behaviours that constitute one's professional identity. To the extent that one wishes to minimise the distorting effects of such ascribed or enacted attributes, one must acknowledge and question their impact on communication and interpretation.

RESEARCH: PATHS AND MAZES

Fieldwork for this study took place between March 1987 and November 1989. While the planning stage reflected my medical

background and psychiatric training, the orientation gradually changed to accommodate unforeseen circumstances. Such divergences resulted from the logistics of fieldwork and were a consequence of dialectical reformations based on emerging material. No rigid research protocol existed.

The most important shift in focus occurred at the outset. This study was initially conceived as an emic analysis of suicide within a discrete Aboriginal population, but I soon realised the problems inherent in such an endeavour. Additionally, to more accurately delineate the dimensions of Kimberley Aboriginal suicide, a review of death certificates was undertaken. While suicide emerged, as expected, it was found to be embedded in and eclipsed by dramatic regionwide increases in Aboriginal mortality from a variety of non-natural causes. At the same time that the mortality review was under way, I was attempting to become familiar with the Aboriginal history of the region. I quickly recognised that this task was essential to understanding the results of the mortality study. Emerging from this preliminary experience was a sociohistorical orientation that became the unifying frame for all subsequent work, including the large random sample survey that was conducted during the last eighteen months in the region. In the following chapters I will describe in detail the methodologies used in the various sections of this study. Given what has been said thus far regarding the non-linearity of this research, a brief overview is here provided which will allow the reader to follow the path taken, including some of the digressions.

Research proposals often bear scant resemblance to subsequent fieldwork. I arrived in Broome with a proposal submitted the year before to the New South Wales Institute of Psychiatry entitled: 'Psychiatric morbidity and the emergence of suicide in a remote Aboriginal population'. With hindsight, that proposal reflected a naive optimism, the aim being:

> To generate a psychiatric morbidity profile of an Aboriginal population in a remote area of Australia, components of which were surveyed using short stay techniques twenty years previously, with particular attention to depression; suicide and suicide-equivalent behaviour; the psychosocial antecedents of this; and the cultural and subcultural interpretations of these behaviours.

This agenda rapidly gave way to practical considerations. A period of 'being there' and becoming known was a necessary