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Conceptualising Anangu Pitjantjatjara Yankunytjatjara mental health beliefs

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ABSTRACT

Objectives: Very little is known about how Anangu Pitjantjatjara Yankunytjatjara describe and explain mental health from their own perspectives without resorting to Western frameworks. This study used a social contextual research approach to describe how Anangu talk about behaviours that are called "mental illness" in Western contexts, their explanations about the contexts they believe shape these behaviours, and how Anangu support people who exhibit them.

Method: Seven senior Anangu were repeat interviewed between 1–2 hours by an Anangu researcher for a combined total time of 31 hours in a "yarning" conversational approach. Interviews were analysed using a thematic analysis approach to explore the contextual features giving rise to mental health behaviours.

Results: Results indicated that in the Anangu Pitjantjatjara Yankunytjatjara Lands there are complex interactions between fundamental ancient beliefs of cultural processes and the changing Western influences since colonisation, and examples are given of each of these. The same looking Western behaviours of "mental health" could arise from alternative traditional contexts.

Conclusions: This research fills a gap and adds to the very small amount of Anangu mental health literature by providing an extensive overview of the mental health behaviours from the perspectives of Anangu themselves. It also shows how there can be gaps in research done without Indigenous researchers onboard.

KEY POINTS

What is already known about this topic:

(1) Indigenous descriptions and explanations for the behaviours of 'mental health' differ from western versions.
(2) Previous research has usually not involved Indigenous researchers.
(3) Previous research often does not let Indigenous peoples provide context for their descriptions and explanations.

What this topic adds:

(1) Anangu elders added rich contexts to their descriptions and explanations for the behaviours of 'mental health' rather than generalizations.
(2) Having an Anangu researcher vastly improved the details given compared to a previous research study that did not.
(3) Anangu elders kept western and Anangu contexts separate even with behaviours that superficially looked the same.

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Australian Aboriginal mental health; Anangu; naming mental health behaviours; traditional interventions; ngangkari

How do Indigenous people conceptualise mental health?

Around the world, Indigenous peoples are increasingly shifting away from Western conceptualisations of mental health and towards more relevant and appropriate concepts that align with their own worldviews (Gone & Alcántara, 2007; Hatala, 2008; Kirmayer et al., 2003; Ryan et al., 2019; Taitimu et al., 2018). Indigenous Australians are now also using empirical evidence to also support their own worldview (Dudgeon, Milroy, et al., 2014; Dudgeon et al., 2000; Gee et al., 2014; Grieves, 2009; Vicary & Bishop, 2005; Vicary & Westerman, 2004; Westerman, 2021).

According to Indigenous Australians, health should be viewed holistically (Lock & Cooperative Research Centre for Aboriginal Health, 2007) to encompass spirituality, social relationships, connection to culture, land and Country. These domains foster a sense of wellness of body and mind, and an absence leads to states of illness (Dudgeon, Walker, et al., 2014; Gee et al., 2014; Grieves, 2009; Vicary & Bishop, 2005; Vicary & Westerman, 2004; Ypinazar et al., 2007). Mental health for Indigenous Australians has therefore moved away

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from the individualised, biomedical pathologizing associated with the *Diagnostic and Statistical Manual of Mental Health Disorders* (5th ed.; DSM-5; APA, 2013), towards an emphasis on social relationships and community well-being (Dudgeon et al., 2000; Gee et al., 2014; Togni, 2017; Vicary & Westerman, 2004).

Despite the effort to shift away from the DSM-5 conceptualisations, much of the theory and practice is still arranged through a Western lens and perspectives privileging Indigenous Australians versions of the behaviours labelled as "mental health" issues are mostly absent (Bennet-Levy et al., 2014; Laliberte et al., 2010). This is partly because not much is known about how Indigenous Australian perceive or talk about the behaviours currently labelled as mental health and illness.

Globally, some studies have explored how Indigenous and other non-Western communities talk about mental health behaviours without the DSM-5 labels and promote their own interpretations and contexts for them (Niania et al., 2017; Ryan et al., 2019; Taitimu et al., 2018). Taitimu et al. (2018), for example, demonstrated significant diversity in Māori explanations for hallucinations and delusions. The behaviours were described as normal and not concerning, and some even considered them a spiritual gift to hear voices of ancestors in this context (cf. Niania et al., 2017). For others, hallucinations and delusions were attributed to current substance misuse and historical trauma resulting from colonisation, cultural imperialism and/or trauma indicative of breaching cultural protocol (Taitimu et al., 2018). Consequently, participants explained the need for the treatment to consider both cultural and clinical elements and were much more context-dependent than the DSM attempts.

Ryan et al. (2019) research with a Somali community in New Zealand established similar findings, as the origins of mental health behaviours commonly observed in psychotic disorders, which this Somali group described as "going crazy" and "talking nonsense" (p. 143), were diverse in nature and *tied firmly to specific life contexts* by their Somali participants rather than being generalised and abstract like the DSM-5 categories attempt to be (APA, 2013). The observed behaviours were explained instead as involving spirituality and building a new identity in an unfamiliar environment away from their home country, but these were limited to specific life contexts and could not be generalised to align with Western notions of "anxiety" or "depression".

In Australia, Westerman (2021) considered "culture bound syndromes" in a range of mental health behaviours. The author noted, for example, that in specific contexts, self-harm was a customary cultural response to certain life experiences. Moreover, they found that different types of social relationships carried different social responses. For example, the cultural term described as "wrong way relationships" (a forbidden marriage) not only socially rejects those two individuals, but the children of those relationships also carry the social stigma to the next generation, creating the possibility for mental health behaviours to emerge from social exclusion and identity crisis over generations (Westerman, 2021, p. 25).

Vicary and Westerman (2004) also explored cultural explanations for some of the mental health behaviours that are found in the DSM-5. According to the DSM-5 (APA, 2013), behaviours such as prolonged sadness are understood as undesirable cognitive-emotional states caused by the underlying mental disorder/disease of depression. However, Vicary and Westerman (2004) argued those similar behaviours (e.g., prolonged sadness) can be contextualised as consequences of varying external events such as disconnection from Country and culture, or loss of a loved one (Guerin, 2017). Therefore, many Western and Indigenous Australian perspectives on the causes and meaning of certain mental health behaviours are fundamentally different (Vicary & Westerman, 2004).

Anangu Pitjantjatjara Yankunytjatjara literature

Within the context of the Anangu Pitjantjatjara Yankunytjatjara Lands (APY lands) in northern South Australia, there is a scarcity of literature exploring how Anangu talk about the "mental health" behaviours in the absence of Western conceptualisations. Although some have contributed by working alongside Anangu Elders to develop useful cross-cultural mental health resources, the contexts for how mental health behaviours arise is missing (Osborne, 2013; Togni, 2017). Panzironi (2013) offered a review into mental health behaviours observed in Anangu settings and the approaches *ngangkari* (traditional healers) use to support people that exhibit those behaviours. Although studies like these highlight the need for greater mental health literacy, more research is needed to address the gaps in literature and consider how Anangu provide their own explanations for the mental health behaviours they see in their community and approaches they use to support individuals.

In one of the few Anangu research studies, Brown et al. (2012) explored depression in Anangu men through intimate experiences of their life history. In direct opposition to the biomedical model of the DSM-5 (APA, 2013), participants talked about

"depression" as a grievance to the spirit primarily caused by the colonising effects that led to breakdowns of Aboriginal cultural structures, marginalisation in society, denial of customs and traditions, loss of connection to country, and sustained economic disadvantage. Participants in the research of Brown et al. (2012) explained that a buffer to their illness was having a sense of *kanyini* or connectedness to others in their community and growing their spiritually, but that these buffers were frequently disrupted. Participants reported that cultural practices to grow and maintain spirituality had decreased due to impacts of colonisation and that social relationships had changed due to a breakdown of kinship structures (Brown et al., 2012). Many stated that the services of *ngangkari* was superior to Western models of mental health care in the appropriate cultural context. Some participants explained that Western problems needed Western interventions and cultural problems need cultural interventions (Brown et al., 2012).

An alternative way of thinking about mental health: a social contextual approach

Contrary to the individualised and biomedical way that the DSM-5 conceptualises mental health (APA, 2013), Guerin (2001, 2016, 2017, 2020) has argued that looking "inside" the individual needs to be replaced with observations of historical, social, cultural and other material contexts. Further, Guerin (2017) explained how the pathways to mental health behaviours are shaped by these external settings. This fits well with most Indigenous conceptions and others who have argued along similar lines indicating that mental health behaviours are consequences of the interplay between past historical events and policies, recurrent economic instability, ongoing poor social situations, loss of cultural structures, and limited opportunity in life (Hunter, 2007, 2013, 2019; Hunter & Milroy, 2006).

The social contextual approach (Guerin, 2016) proposes that in order to grasp a better understanding of mental health behaviours, attempts at exploring hidden contexts are needed, such as how societal and community structures shape behaviour (Guerin et al., 2024). So, the social contextual approach aligns well with how Indigenous Australians themselves view their social emotional wellbeing which is largely influenced externally by their social relationships with family and community and the historical, economic and social factors that continue to shape their mental health (Fromene et al., 2014; Gee et al., 2014; Guerin, 2016, 2022).

This has a lot in common both with other recent Social and Emotional Wellbeing approaches but without the internalisation commonly used in explaining what occurs (Dudgeon, Bray, et al., 2023; Dudgeon, Carlin et al., 2023), and recent approaches to using narrative and yarning in treatments (Bessarab & Ng'andu, 2010; Geia et al., 2013; Lapsley et al., 2002; Wilson, 2008). It is beyond the scope of this paper to review this material, but there are close links which should be pursued.

Using such a social contextual approach, for example, Fromene and Guerin (2014) interviewed five Indigenous Australian participants (non-An angu) with a diagnosis of borderline personality disorder [BPD] (APA, 2013). Participants reported that the "symptoms" or behaviours of BPD, such as "patterns of instability in interpersonal relationships, self-image, and affects, and marked impulsivity" (APA, 2013, p. 645), were shaped by their unfortunate life circumstances, including a complex history of individually targeted and systemic racism, most of which they could trace to the long-term effects of colonisation. Many of the participants complained of unfair treatment from government agencies, particularly regarding child removals, and many indicated that historical events, such as being displaced from Country and removed from cultural practices, had negatively shaped identities of Aboriginal people. As a result, the BPD behaviours that are observed can be better explained as reasonable responses to the external historical, social, economic, political and opportunity contexts impacting on the individual – what they describe as "holistic" environments.

Guerin and Guerin (2012) explored important social contexts during their research in the APY Lands with Anangu. This was research was conducted over a long period of time, during which the researcher talked informally to community members. However, like so much of the extant research, this research was primarily carried out by non-Anangu with some Anangu advisors. They found that government interference and changing policies were key life contexts that shaped the mental health behaviours observed. These observed behaviours superficially resembled many DSM-V (APA, 2013) behaviours but arose from different contexts, meaning that they should be understood and treated differently from the biomedical models. For example, participants in this study told of "mental health" behaviours arising from family issues, but the family issues were almost always about familial conflicts caused by government interference. However, despite finding out much from the APY Lands, these (non-Indigenous)

researchers did not report the richness suggested earlier with which other Indigenous peoples have talked about such behaviours. It is likely, therefore, that Anangu researchers would be needed to find out more, which was one aim of this research.

Therefore, the social contextual perspective appears to align well with how Indigenous Australians themselves include spirituality, strong and clearly defined social and community relationships, culture, land and Country, as facets of "mental health" behaviour causation (Gee et al., 2014). But this alignment might be shown even stronger if the research was conducted by Anangu, so the present research had an Anangu researcher (the first author) explore how Anangu talk and think, to allow for a thorough exploration of their own contexts.

Research questions

The central research questions of the study that were explored were:

- how do Anangu talk about the behaviours that are labelled as mental illness and provide explanations about the contexts they believe these behaviours arise from, when conversing with an Anangu researcher?
- how do Anangu support people who exhibit these behaviours?

Method

Ethical approval

Ethics approval was granted by an Aboriginal specialist reviewer as part of the University of South Australia Human Research Ethics Committee (204528), partners in the South Australian Aboriginal Health Research Accord (Morey, 2017), and signed and informed consent was obtained by all participants. There were many ethical issues raised which were solved through talking with the community and two Anangu mentors of the first author, and through the Ethics process. Some of these are outlined below.

Recruitment

Participants were recruited using a purposive sampling strategy, following discussions between the first author (a full Anangu man) and the two Anangu mentors about the people who could contribute most to this research. This researcher was also then guided by the mentors in determining whether it would be best to approach those persons together, or with just one of the mentors making first contact. This was decided by the mentors according to proper Anangu protocol. For example, with some Elders it would be inappropriate for a younger man to make the initial contact and another party needed to approach the person first (Bishop et al., 2006); for other Elders, this was not necessary. The inclusion criteria were that the participants had to identify as Pitjantjatjara and/or Yankunytjatjara and have lived all their lifetime in the APY lands. Each participant was provided a gift card following each interview.

Participants

Participants were seven senior Anangu men and women (see Table 1 for demographics) who had spent the majority of their life in the APY lands. At the time of the research, five of the participants were currently living in the APY lands and two were living in Tarndanyangga (Adelaide) supporting a family member who had relocated for prioritised health care. To maintain anonymity, participants are referred as P1 to P7. Seven participants were sufficient for this study as it entailed in depth repeated interviews which explored the contexts for behaviours without trying to generalise beyond this (Guerin et al., 2018; Morse, 2000).

Data collection

Semi-structured, repeat conversational approach interviews were used to allow participants to talk freely over time about the contexts for the behaviours and the "treatments" (Guerin et al., 2018). The participants determined the direction, length, number and topics

Table 1. Participant demographics and interview details.

Participant	Sex	Age	Number of Interviews	Total Time
P1	Male	60+	3	5h23m
P2	Female	50+	3	4h07m
P3	Female	60+	4	5h12m
P4	Male	50+	3	3h32m
P5	Female	50+	3	4h48m
P6	Female	60+	3	5h00m
P7	Female	50+	3	3h30m
			Total Time	30h52m

Table 2. Some behaviours from the DSM-5 descriptions along with the Pitjantjatjara translations.

English	Pitjantjatjara
Anxiety, appear anxious or fearful	Ngulu-ngulu, nyakunytja ngulu-ngulu
Appear odd or eccentric	Kawa-kawa, mawalpa-mawalpa
Being reckless	Liri waru, kata waru, waru-waru
Crying spells	Titutjara ulanyi, Rawa ulanyi
Delusions	Katangka kulini kutjupa-kutjupa
Detachment from social relationships	Kutju nyinapai
Disorganised thinking	Putu tjukaruru kulini
Distrust and suspiciousness of others' motives	Anangu kutjupa tjuta ngukani
Disturbance of eating, or eating-related behaviours	Mai ngalkunytja wiya titutjara nyinanyi
Dysfunctional beliefs	Kulintja kutjupa, tjukurpa malikitja tjuta kulini
Excessive emotionality	Mirpanaripai, kanany-kananypa, anangitja
Excessive fear and anxiety	Ngulunytju pulka
Hallucinations	Kutjupa-kutjupa nyanganyi
Hallucinations or delusions	Kutjupa-kutjupa nyanganyi munta katangka kulini kutjupa-kutjupa
Impulsivity	Putu uri wiya nyinanyi
Increased alcohol and drug use	Wama pulka tjikini, drugs pampuni
Intermittent explosive anger	Liri waru, pikati-pikati
Intrusive and unwanted thoughts	Kulintja kura, katangka kulini kutjupa-kutjupa
Panic attacks	Kututu wala
Recurrent and persistent thoughts	Rawangku palunyatu-palunyatu kulini
Sad mood, sadness	Tjituru-tjituru
Sleeping troubles	Rawa kunkunpa ngaripai titutjara, putu kunkunarinyi
Spending less time with friends and family	Rawa kutju nyinapai, kumpira nyinanyi ananguku ngulu

of the conversations. Conversations were conducted in the Pitjantjatjara language employing a "yarning style", an appropriate method for this population (Bishop et al., 2006). If needed, participants were prompted with behaviours of interests but offered the opportunity for participants to add other topics as these behaviours were only the starting point (Table 2 shows some of the behaviour prompts used if needed along with their Pitjantjatjara translations).

The interviews were conducted sporadically over a three-month period between June and September 2022 by the first author. Many external factors challenged interview scheduling, including two of the participants losing close family members and entering Sorry Camps (a temporary camp away from original dwellings to allow individuals and families to grieve the recent loss of a loved one). These two participants both graciously offered to continue with the interviews later. Four of the participants were uncontactable for a period while they attended an important Women's Law and Culture gathering held by Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) in the APY lands. Therefore, a mixture of face-to-face conversations, phone calls, and Zoom video calls were used during the interviews. The first author met with six of the participant three times for approximately 2 hours per interview and met with one of the participants four times (see Table 1 for interview durations per participant).

During the conversations, the participants were asked to talk about the sorts of "mental health" behaviours found in the DSM-5 (APA, 2013) but not in the context of Western mental illness or disease. Rather, participants were encouraged to talk about them as "troubling behaviours" which they had observed, how and when they occur, the terms used for them, the contexts in which they occur, the diversity not considered in the Western models, and how the community or Anangu people view these. In addition, participants were encouraged to talk about how Anangu themselves provide support to people who show those behaviours. The idea was not to have participants pressured to provide "their" version of *Western terms*, but instead allow them to provide their own contexts and terms for *observed troubling behaviours* among Anangu (cf. Ryan et al., 2019).

Data analysis

As the first author was fluent in Pitjantjatjara, the thematic analysis (Braun & Clarke, 2021) was undertaken by them listening to the audio of each interview (with permission) a number of times. This allowed the researcher to consider volume, rate of speech and intonation which are important communicative features of spoken Pitjantjatjara language. Key comments were translated into English by this researcher for the purpose of inclusion in this paper and checked by the Aboriginal mentors.

Both researchers developed themes directly from the data on the basis of shared meaning (Braun & Clarke, 2021). These were focused on the social contextual aspects of behaviour (Guerin, 2016), to explore the potential social, economic, historical, cultural and opportunity contexts that may shape the emergence of "mental health" behaviours.

Results

Overview

Through several yarning conversations, explanations of mental health behaviours were explored through an Anangu lens. Participants clearly described a dichotomy between traditional and western contexts which led to "mental health" behaviours. Each had some similar looking behaviours but were due to either "cultural violations" or to issues of colonisation and western imposition. This dichotomy has implications for differential treatment as will be shown. Table 3 provides a list of the behaviours which were talked about by participants, whether in an Anangu or western context.

The findings are therefore summarised in two main sections: (1) "mental health" behaviours arising from Anangu cultural contexts, and (2) "mental health" behaviours arising from contemporary or "Westernised" contexts that are observed in Anangu. Within each section will be given the results for the behaviours, the contexts for those behaviours, and comments from the participants about healing, treatment and support.

To help the reader get a nuanced or contextual understanding of the observed behaviours discussed by participants, a glossary of some Pitjantjatjara words and their variations relevant to the Results is given in Appendix 1. As mentioned earlier with respect to Table 2, both the observed behaviours and the glossary words need to be viewed in their full contexts as described by participants and not just as generalised verbal synonyms for Western terms like "depression" or "anxiety" (cf. Ryan et al., 2019).

Anangu cultural pathways to 'mental health' behaviours

For cultural sensitivity and Anangu seeking to maintain the secrecy of particular cultural practices, we avoid describing in great detail the different types of "cultural violations" that lead to the Anangu mental health behaviours commonly observed (those *not* reported to Guerin & Guerin, 2012). Within the Anangu population, these nuanced issues are well understood and are treated by the appropriate community members as will be shown.

Observed 'mental health' behaviours arising from Anangu cultural contexts

Participants described a small number of observed behaviours that may constitute the "spiritual health" issues which usually require *ngangkari* intervention in order to improve the individual's wellbeing, shown in Table 4. These behaviours were related to the *kurunpa*, and consisted of several variations such as *kurunpa upa*, or *kurunpa ini* which can be explained as behaviours consistent with low mood, sadness, loss of motivation, anxiety and being easily startled. Many details were given which cannot be repeated here but the variations and their contexts are well known among Anangu.

Participants also spoke of Anangu talking about cultural matters which were not appropriate. They reported unusual "thinking" and talking about "cultural" matters that are considered outside the boundaries of culture or what is considered totally prohibited within the context. Participant 7 recalled a conversation they had with a family member and the individual describing things they had experienced

Table 3. Pitjantjatjara Yankunytjatjara words used throughout this research paper (cf. Goddard, 1996.).

Pitjantjatjara Yankunytjatjara term	English translation
Anangu Pitjantjatjara Yankunytjatjara Lands	Refers to a group of geographically defined "very remote" communities in the far north-west of South Australia.
Anangu	"Person". People living in the APY lands refer to themselves as Anangu.
Ngangkari	Traditional healer
Ara irititja	Old ways, stories from long ago
Tjukurpa	Dreaming, Law
Karangki	Crazy, mad
Ukiri	Marijuana, cannabis
Kurunpa	Spirit
Kurunpa upa	Weak spirit
Kurunpa ini	Loose spirit
Mamu	Evil spirit, Devil
Rama	Mad, crazy, insane
Rama-rama	Irresponsible, silly, absent-minded
Ingkata	Pastor
Piranpa	White person or westernised concept
Pilunpa	Quiet
Paluru	Pronoun, (he, she, it) third person singular
Kanyini	Having or connectedness

Table 4. Participant observations of common "mental health" or "troubling" behaviours.

- Explosive anger
- Anger (threatening)
- Screaming and swearing
- Walking around talking/laughing to themself
- "Kunyu" - daydream
- Watarkurinyi – memory problems
- Watarkurinyi – absent minded
- Pilunpa – not talking
- Pilunpa – expressionless
- Not walking through community but around it
- Staying inside the house all day
- Body language (pupa-pupa ankupai – hunched over walking)
- Munupina – not thinking straight, zoning out
- Out of context talk
- Sleeping all day
- Doing outrageous things – flashing, disrobing in public
- Moodiness
- Impulsive
- Ngukani – not trusting others
- Ngukani – suspicious of other's motives
- Nightmares
- Yelling at night in the room
- Alcohol and substance abuse
- Social withdrawal (Kutju nyinanyi)
- Mawal-mawalpa (inconsiderate)
- Rama (crazy, mad, insane)
- Rama-rama (irresponsible, silly)
- Karangki (mad)
- Thinking a lot
- Constant worry (Kulintja pulka)
- Hearing voices (mamu – evil spirit or devil related)
- Hearing voices (general)

recently. Participant 7 commented that this individual had confused some traditional Anangu concepts with contemporary modern life. Participant 7 explained that this type of behaviour is abnormal and is a sign that the individual's thinking has changed.

> *We were sitting there just talking, and this young woman was talking about these strange things. I told her no, no. Don't talk like that. Why you talking like that about sacred stuff like that. But she kept going on about it and trying to convince me. That's when you know when they mixing up things like that. Means their thinking has changed. - P7*

Anangu cultural contexts giving rise to 'mental health' behaviours

Figure 1 shows the general traditional pathways leading to the above behaviours, which typically are about going against a cultural belief or practice, whether intentional or not, which leads to a "dislocated spirit", which leads to the observed behaviours and then culturally appropriate treatments.

Participant 4 outlined an example of what would be considered in the Anangu cultural pathway.

> *That person would have gone to the wrong area - a woman's or man's area and then later on felt sick. That's why they stop eating from upset stomach and then stay home for I don't know how many days, but a long time. That's when the family take them to see* ngangkari *to put the* kurunpa *back in place. - P4*

Anangu cultural 'treatments'

All participants spoke of spirituality as being central to the wellbeing of the individual in an Anangu sense. When an individual is well, their spirit is in balance. On the other hand, when illness occurs which is obviously not physical, there are symptoms participants spoke of that would qualify the behaviour as a "spiritual health" issue rather than "mental health". Participants did not frame their explanations of various behaviours as being either mental or spiritual in origin but viewed mental and spiritual concerns as integrated. Therefore, participants rejected Western medical terminology and "labelling" as there is no general term for "mental health" in the very rich and precise Pitjantjatjara language, and these must not be glossed over.

Participant 6 explained the process of an Anangu "spiritual" health behaviour. This participant is a *ngangkari* who plays an active role in treating spiritual health issues both individually in an Anangu community context and also professionally alongside Western medicine. She stated that the development of these behaviours is characterised by the dislocation of the *kurunpa* and the *ngangkari* would need to find where the problem was coming from in the body or mind of the individual and remove that harmful object.

> *The spirit has been dislocated, which it is not in a state of balance. Therefore, we take them to see* ngangkari *to put the spirit back in place. Sometimes they maybe went to the wrong area or did the wrong thing and we got to find a way to put the spirit back in place for them to go back to being normal. – P6*

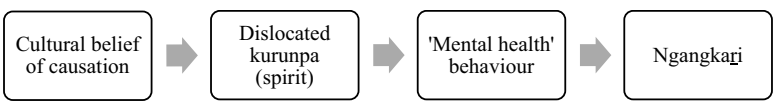

Figure 1. Explanation of Anangu mental health pathways and treatment.

Another participant (P3) also discussed the role of *ngangkari* in ensuring the spirit is realigned back to its natural state.

> *This is when the spirit is out of place, that person will sit there quiet, not engaging with anyone, feeling quite unattached from something. That's when they need to go see a* ngangkari *to put their spirit back. They have the main power to fix this sort of thing*. Ngangkari *are the one that know. – P3*

Contemporary or 'Westernised' contexts leading to Anangu 'mental health' behaviours

All participants explained that "Westernised" versions of mental health behaviours were more common in their remote communities and are observed and attended to more frequently (see Table 3). Overall, the direct cultural violations are not as common as similar-looking Western influenced behaviours as the community is generally well-managed in a traditional way.

Observed 'mental health' behaviours arising from Westernized contexts

Participants identified many behaviours which they commonly observed in their communities. The most common responses according to participants were: (1) disconnection from community, (2) confused thinking, and (3) anger and hostility.

Descriptions of disconnection

Participants described a range of behaviours whereby individuals were seen to be "disconnected" emotionally, spiritually and relationally from other members in the community (Table 3). This took on a range of different forms such as wandering around community without much engagement with other community members, emotionless interaction with community, and isolating from others.

All participants explained that wandering and pacing around the community was seen as a mental health behaviour commonly observed. Moreover, all participants described that observing their body language and the way the person walks around community is sign that they need support. Participant 3 expressed that it is typical of a person suffering from a particular type of mental illness to pace and wander around community.

> *We see that person wandering around all day. Up and down, up and down the community. Doing the same thing, over and over. Just walking around with no plan really. She may be going a bit* karangki *(mad) by just doing the same thing all the time. – P3*

Another participant (P6) added that pacing and wandering was common, but also explained in a highly nuanced way that generally their body language would illustrate whether they are suffering from mental health.

> *You see that person and he or she they just walked around in a hunched over position. Their shoulders aren't upright, they are just walking around hunched over carrying a lot of stuff, their problems. Sometimes we see them other people and they walk around confident and upright and they walk around with a strong upper body. But some of these people they walk around all day in hunched over with nothing to do. – P6*

Participants described a lack of emotional expression as an indicator of an individual suffering from mental health (Table 3). Participants described that they would become aware of this in the communities once they began to observe a sudden shift in the individual's mannerisms and expressions.

Participant 7 described that an individual would begin to change how they interacted with other community members, and this typically resulted in isolating and not showing any emotional expressions during their interactions.

> *That person would just be sitting their* pilunpa *(quiet). Not talking, not showing anything on their face. No laughing, not joining in on the conversation. When we ask them question, they'll just one-word response and there's no more joy in their face anymore. Just looking sad. – P7*

Participant 5 indicated that even though the individual would be around people, listening to conversation, they would be startled at the request to engage in conversation, this participant described this as a "zoned-out" behaviour.

> *He would be just sitting down, not talking to anymore and not laughing or joining in on conversation like everyone else. And when we say something to him, he would be like shocked and startled. It's like he is zoned-out and not joining in on conversation nowadays. – P5*

Participants described isolation and social withdrawal as a common "mental health" behaviour Participant 1 observed isolation in the context of rarely engaging with others in the community. They explained that isolating at home is a common behaviour and that by not engaging and for the most part being alone this perpetuates the cycle and reinforces their feelings of worthlessness.

> *They usually just stay home all day and night, not coming out to see anything in the community. They*

might just stay in the one place at their house, thinking, thinking all day and night. No job, just sitting there in the house maybe thinking they no good and stay like that for a while, feeling no good. – P1

Likewise Participant 2 added that some individuals feel "shame" to come out and speak because of how they think others viewed them in the past from past problems they have had with other community members.

> *We don't see some of them people out in the community. They just stay at home and sit there one place all the time. Sometimes they have problem with other people, whatever problem and then they are shame, so they don't come out much in community. They had problem and still think that problem with that person is still there so they stay away thinking to themself. – P2*

Confused thinking

Participants spoke of confused thinking and behaviours consistent with "psychosis" behaviours being commonly observed in community contexts. There were a number of these behaviours present, particularly speaking on topics that were considered to not fit their cultural and social context, changing topics frequently, and speaking very slowly.

Participant 5 described the behaviour of witnessing a young adult family member screaming and shouting in the room late at night. They described the individual as yelling at someone or something and being controlled by this being. This participant explained this behaviour is commonly observed in communities but was extremely rare to their knowledge when she was growing up. They attribute this type of behaviour as possibly being "caused" by cannabis addiction.

> *They scream at night in their room. Start yelling really loudly and maybe fighting this person in their room. We go to check their room and no one is there with them. We get really worried because no one in the room with them. They are by themselves. This happen a lot these days, maybe 'ukiri' but I can't remember ever seeing this happening back in the day. - P5*

Similarly, Participant 6 added that confused thinking and "out of cultural context" talk is expressed more commonly in communities these days compared to when they were growing up in the APY lands. They explained that this younger female person was speaking very quickly, in muddled-up sentences, and changed topics frequently. The participant spoke of being worried for this individual and not encountering many behaviours like that before. Although the participant explained that people make up funny stories in the appropriate context which may seem outrageous which have a similar pattern to the one the young female was displaying, the participant reinforced that they could tell this was an action affected by "mental health". She explained that she knew this young female personally and understood she was in a toxic domestic violence relationship whereby she was controlled in every aspect of her life and therefore the participant explained that potentially it was stress related.

> *One young woman, she came up to me and was telling me story about this thing that had a spirit. I was laughing at the start, thinking no way, they don't have spirits like us. Then she told me that yes, they do and how she had this vision and dream about it. She was really adamant that it happened. Then she changed the subject and told me something else about leaving something at my house but she didn't leave them things there for me, I didn't see them there. She was telling me all these stories about all different things and I never had that before from anyone. Her partner was always stressing her out and making her life hard, so maybe it was all the stress. - P6*

Participant 3 described the experience of a close family member she had witnessed. The participant spoke of this young adult experiencing visions after engaging in a violent situation where they had seriously injured another individual and fled. Following the fleeing, the young person had for the first time in their life experienced visions of people seeking retribution for his wrongdoing.

> *He had a big fight with this person and that person was seriously injured. He then ran away to the bush and stayed there. He was worrying he did something bad, so he wanted to go out bush for a bit and he went to a homeland. He was there by himself and he told me that he started having these visions and seeing and hearing things of people trying to come and get him for what he did. - P3*

Anger and hostility

All participants commented that anger, hostility, impulsivity and being irritable were common features of an individual suffering from mental health in the community. Participants described that anger could be prolonged over months, even years and individuals could stay trapped in this constant feeling of anger and hostile outbursts ranging from money issues (Centrelink problems), housing arrangements in community, employment issues, feelings of inadequacy and deep seeded feelings of worthiness among others.

Participant 6 describes the frequent outbursts of a community member that they observe. They explain

that usually these outbursts are related to issues arising from money and the lack thereof.

> *They look like really angry person but he isn't really. He always shouting, screaming and looking angry because he got no money. Money is big problem. He walks around looking angry but there are other problems there too. Sometimes he might feel no good because his family didn't give him money back or something like that. - P6*

Participant 1 explained that living in overcrowded housing situations can be a cause of frustration, stressful at times and impact on general wellbeing:

"You know that young person might be doing something there, cooking that meal and they walk outside or walk away for a moment, come back and somebody took over the meal area without asking them. He might get really angry because, you know maybe too many people there and he was cooking there first and they did it without asking him. But then this can happen a lot with a lot of people there". - P1

The contemporary or 'Westernized' contexts giving rise to Anangu 'mental health' behaviours

One participant (P6) believed that since the 1980s there has been a shift in the lifestyle of many people who became situated at a more central location, with a greater expectancy to engage with Western practices such as the capitalist market economy, and who were also introduced to substances such as alcohol and illicit drugs.

> *It was the start back then about 1980s; communities began to be developed and we became more stationed at one place. We had to start working and making money so less time to live culture way. Then there was also the alcohol, drugs and cigarettes that became more available around this time too. We started to do different things. Learning all new types of things but also living Anangu way so sometimes it was tough and sometimes easy but a lot of time we still trying to hold on to our culture and we still got it. – P6*

Participant 2 believed that this process has been gradual since the 1980s and 1990s. Similarly, they described a changing interaction with cultural practices. The participant explained that despite still having a strong culture, the emergence of balancing their traditional life with a changing world has delivered challenges.

> *Around this time maybe since the 1980s or 1990s maybe, there was a change. We still had language, we still had* Tjukurpa *and we still got them things strong today too, but we also had to come together into one community and start living two ways, by working and making money to live. Sometimes this was challenging because, some things in the* piranpa *(white) world was hard to understand. They do things differently and we had to live that way too, working for money to buy things and all that. It was a change. – P2*

Furthermore, all participants explained that the current "mental health" behaviours observed in communities need to be treated with a mixture of both Anangu and Western practices. Participant 4 described this process as engaging a *ngangkari*, attending the clinic or a hospital or reconnecting on country with family members.

> *Today, there needs to be two ways with some mental health problems. Sometimes* ngangkari *can't fix the problem. Sometimes they might need help like needle from clinic. We got to be working two ways on this sort of stuff. Sometimes we got to take them out bush too and be together learning the old ways too. Following* ara irititja *(old Anangu ways) and being together* ngurangka *(on our homelands). – P4*

Participants described the contexts shaping the behaviours they commonly observe as mental health issues. Participants explained that these behaviours described as symptomatic of mental health issues were different from the behaviours associated with cultural contexts. As opposed to the previous cultural belief pathway outlined in Figure 1, participants described the pathway for non-cultural mental health behaviours in Figure 2 outlined below.

Participants described a range of contexts for the new "Western" mental health behaviours observed. Many were responses of cumulative difficult life stressors and worries, such as financial stressors, witnessing adverse events such as domestic violence, and weakening of support structures, but they also remarked on the context of drug availability addiction, and lack of appropriate things to do in community.

Worry and stress

All participants spoke of worry and stress being pervasive in the lives of Anangu people. Participants spoke of prolonged worry and stress impacting on mood giving rise to long stints of "mental health" symptoms

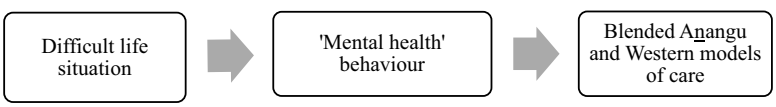

Figure 2. Description of contemporary "mental health" pathways and treatment as told by Anangu.

such as: sadness and demotivation, worrying which interferes with their daily life by not engaging with the community and staying isolated at home. Feeling hopeless and helpless, having low self-esteem, feeling inadequate or worthless, irritability, hostility and aggression.

Participant 7 provided an anecdote of a close family member as this individual experienced low mood lasting months and isolation from family and community due to their family being wrongfully accused of a matter.

> *She was really sad for a long time. She didn't come out and see many people, just hide away in the room and tried to forget the things. There was a big problem with her family when they were drinking and other people were blaming her for this thing when she wasn't even there. So, she was worrying a lot about how other people was talking about it. It was really stressing her out. So, she just stayed home and just didn't come out for a long time. - P7*

Furthermore, Participant 1 added that finances are source of many irritability, hostile and anger issues in the community. Participant 1 spoke of the many times that individuals feel inadequate about not having money to provide the basic essentials for their family.

> *Sometimes it's really hard. People might see some of these fellas and think they angry person, but they got to understand where that anger coming from. You know lotta' problem with money. They try really hard to give their children good things but when they can't they get angry and people blame them which makes them angrier. So, sometimes we just got to see it's more than just being angry, there's sometimes feeling no good with themselves. - P1*

Participant 3 explained that losing important people affects a person as they are important to the social relationships particularly to the family. Therefore, this brings on intense worry and stress, particularly grief.

> *There's a lot of worry because we losing a lot of old people to and they important people for the family. And people really worry when they lose them people because they have been such a big part of our life, and when they lose that person people really miss them for long time and so they might stay one place and heal from that too. - P3*

Substance misuse

All participants spoke of substance use particularly alcohol and cannabis (*ukiri*) and the heavy ongoing use as factors contributing that contribute to mental health behaviours commonly observed. Participants explained that alcohol and cannabis may be used to suppress their emotions and escape their feelings however, inversely, they are viewed as substances that could give rise to mental health in the community.

Participant 1 describes alcohol and cannabis as a mechanism for people to escape their worries.

"Young people these days, they drinking and smoking ukiri *because they got worries. Worrying for family, no money, no job, not much else to do and because people worrying a lot, sometimes alcohol and* ukiri *can make them forget for a while". - P1*

On the other hand, Participant 5 explained that alcohol and particularly ongoing heavy cannabis use can bring about mental health behaviours.

"You know I've seen some young people grow up here, and they start smoking that ukiri *and then you see some go a bit silly, talking silly way and doing silly things, walking around laughing to themself and that type of thing. That's not them. They not really crazy, that's the* ukiri*". - P5*

'No program' in community

Six of the participants explained that there is a scarcity of activities available for the young people and young adults to do in community. Likewise, Participant 6 explained that after finishing school, there were no clear pathway to gaining employment and not enough programs on offer in communities leaving very limited options.

"When a lot of the people finish school, there's no real next step. What they gonna' do when they finish. No real jobs and no program for people in community to be part of. That's why probably a lot of young people do other things because no program for them. We got to make program to get them out doing things in community. Helping make things and doing fun stuff too maybe to stop from thinking about things. There's got to be more of that". - P6

Participant 3 explains the big picture government perspective and funding related issues in amongst this.

> *The government they come, sit down, but don't really listen. We tell them we need more things for our people to do in community, more funding for programs to run. Funding for a lot of different things but funding for people that got mental health problems too because without program, what else people in community going to do and where they going to get help in community. - P3*

Participant 4 added that more investment needs to be made to get people more active in a range of activities in the community.

"We need to see more things in community, going out hunting and being on country for young people learning old ways, being active, keeping together this is good for young people to do. There needs to be more things in

community, not everyone wants to work at the school or building, picking up rubbish, people got to have other things to do. And doing activities out bush is a good thing too for people". - P4

Anangu views on western 'treatments'

Participants illustrated the need for mental health care to be a priority in their remote communities. They acknowledge that due to the recent new contexts for mental health behaviours, bicultural methods need to be implemented with equal recognition for Anangu and Western medical staff. This section outlines their common responses of (1) better facilities and respite centres, (2) on-Country care and (3) blended approaches to care.

Facilities and respite

Four participants recognised that currently there are limited opportunities for mental health treatment with both Anangu and *piranpa* (Western) collaboration and facilities where Anangu suffering from distressing circumstances can professionally have their needs addressed.

Participant 3 explained the need for a respite facility for an acutely distressed individual to have their needs attended to via means of different therapies and therapeutic activities in their remote community.

> *Me and* paluru *(name withheld for privacy reasons) went to Adelaide and seen this place where the* piranpa *were working with people that had mental health. They were doing all different types of things with them people. They were painting, meditation, music stuff, sitting down talking quietly. And it was their own space to feel comfortable and talk to someone that could understand them. That's what I was thinking that they should do that here in these communities in the APY lands. - P3*

Participant 1 added that spaces like this ensure that individuals feel appreciated, and the support mechanisms are put in place around them via family, community and professionals.

> *A place like a centre can really help someone, they can be supported by their family to go there and their family won't feel worried anymore that they just walking around with no help. They can go there have a cup of tea and plan for what they want, sit down and do what they want, any activity and work through how they thinking both with Anangu and* piranpa. *- P1*

On-country care

All participants indicated that being on Country is integral to an individual's mental health. Being on Country regularly and connecting with the many contextual elements doing that entails was viewed as a useful practice for mental health prevention, positive mental health maintenance and mental health intervention.

Participant 4 described that being on Country is embedded in many positive aspects. They explained that elements of connecting with your *Tjukurpa*, connecting socially and continuing to grow an individual's spirituality in this process.

> *We got to take the people suffering with the [mental health] problems out bush on Country. A lot of the time they stay one place in community and do not get out much. We got to have program where we take them out bush and their families can tell them story about their family or go with all the other men or other women and camp out bush* pilunpa *(quiet), talk and they'll feel comfortable to tell us how they are feeling. - P4*

Participant 6 emphasised the positive relational aspects with your close family members, friends and extended kin are nourishing aspects of being out bush.

> *Sitting around talking and laughing with your family, telling stories, funny stories, all together around the fire is good for Anangu to be doing that. You start to see people smiling and coming together because then they aren't worried about all the problems in community or in the city. - P6*

Participant 1 added that being on Country is also like being with your family and everything in it is your family too.

> *That tree that is our family, that bird it's got its own name and it's our family, that sandhill, that rock, every single one of those animals we see out there in the bush they are family in the Pitjantjatjara Yankunytjatjara lands, this is all our family. We got to take them people suffering out to the bush to be with their family too. - P1*

However, Participant 1 commented that getting out on Country often presents a challenge as there are issues related to suitability of vehicles, price of fuel and spare tyres.

> *Today it's hard to get out [on Country] all the time because not everyone owns a Toyota. There's a lot of smaller cars like [holden] commodores and only small cheaper cars. Plus, not everyone got money to pay for fuel and no spare tyres. So that makes it hard to get out to homelands which are something like 30, 40, maybe 50 kilometres away from communities. - P1*

Blended approaches

Participants explained that contemporary mental health care requires two-way approaches particularly for the Westernised pathway mental health behaviours. The Western mental health behaviours were explained as having no clear origin therefore it was

hard to determine how to treat the behaviours. However, participants describe that it was essential to have a two-way approach for support.

As a *ngangkari*, Participant 4 described an anecdote of in the past dealing with a serious mental health issue combining both Anangu practice and Western medicine.

> *Many times, I've had to help* piranpa *with the [mental health] issues. We got to be working together, sometimes I will come in and help with the problem, sit down and talk and sometimes the* piranpa *will do it* piranpa *way. But we got to make sure that Anangu and* piranpa *way together help that person get better from that problem. - P4*

However, Participant 6 described that due to the lack of Anangu cultural framework in dealing with the emergence of these newer mental health behaviours, *piranpa* and Anangu collaboration is essential in the treatment of mental health behaviours.

> *This isn't Anangu way, it's the new way of living so we got to do it both ways. Understand from the* piranpa *side and work together to help. Anangu got to be there helping too, get* ngangkari *to come in and be there to help with the* piranpa *if problems are there. - P6*

Participant 4 explained that when serious conditions present such as hearing voices these a require deliberate and immediate action. The content of the voices was interesting to note. They described that some voices can be distressing. Voices telling the individual to do harmful things is considered something of the *mamu*, whereas hearing family members voice does not cause the individual any distress. Consequently, when an individual experiences voice hearing with the *mamu* interpretations, the individual's family would help the person seek help in a range of ways such as *ngangkari*, Western medicine and seeing an *ingkata*, as many Anangu are devout Christians.

> *Sometimes people hear voices and they are somethings tell the person to do bad things to themselves which makes the person scared. And we see them. They shut down and look really scared and start getting really worried. These voices are like a* mamu *telling the person to do bad things. That's why we take them to the clinic and see* piranpa *doctor, or sometimes go to see* ngangkari *and we take some people also to go see* ingkata *in the community with the other family members to pray for this person to get rid of the* mamu *in their head. - P4*

Discussion

This research presents Anangu voices, and their discourses of the observed mental health behaviours, the contexts of development, and the treatment and support mechanisms used when dealing with these related issues. By using the social contextual approach (Guerin, 2017) this study increases the understanding of the unique factors combining the individual, community, political, opportunity, economic and cultural contexts which influences mental health behaviours especially in remote Aboriginal communities.

Like all research, this research had to be limited in various ways, which requires more research to elucidate further contextual nuances. Only one Indigenous group was talked to, there were fewer males, and the participants were senior community members from an older generation. While we believe that the observed behaviours would be similar even if this group had been expanded, the observed contexts and treatments might include far more, especially from younger community members. All these need to be followed up and in many more communities. Contextual research does not make claims to generalities (Guerin et al., 2024).

One of the strengths of this research was having an Anangu researcher. This greatly enlarged what was found out about traditional or cultural views on the "mental health" behaviours and directly showed the limitations of most previous research that did not have Indigenous researchers (cf. Guerin & Guerin, 2012). Comparing these two research examples shows the limitation of the first well. While little detail of the cultural contexts leading to the "mental health" behaviours was able to be presented directly in this paper for cultural sensitivity, the earlier similar research (Guerin & Guerin, 2012) did not find out about many of these.

These points about limitations and strengths make a general point clear, that contextual research is more difficult, time-consuming, and intensive, but that it finds out much more. A lot of time and consultation is needed to engage in these sorts of research and to conduct the research. We leave here the open question of whether spending so much time and effort on a limited focus of people and results is more or less useful than using less intense methodologies across many more people and groups (Guerin et al., 2024).

Contextual research also means that we do not get the common generalised conclusions found in psychology using other methods, although the accuracy of highly generalised results over large groups can be questioned. We found that getting the nuances of behaviours and their contexts elicited through more contextual methods, rather than producing generalisations, was more helpful in thinking about treatments. We leave another open question here as to which approach is more correct or more useful.

The key findings from this research suggests that Anangu mental health beliefs are continually being shaped and adapting alongside wider societal changes which are impacting on their ways of being. Consistent with findings from other Indigenous mental health literature (Dudgeon, Walker, et al., 2014; Gee et al., 2014; Vicary & Westerman, 2004), traditional Anangu markers of "mental illness" were seen to be derived from the balance or unbalance of their "*kurunpa*". Anangu framed their explanations of various behaviours in non-contemporary contexts as being spiritual in origin but viewed mental and spiritual concerns as integrated. Therefore, Anangu rejected Western medical terminology and "labelling" as there is no general term for "mental health" in the very rich and precise Pitjantjatjara language.

The findings from this study provide support for the views of Guerin (2017), Guerin and Guerin (2012), and Hunter (2007, 2013, 2019), who have argued that issues related to "mental health" occur from external events. In Indigenous Australian populations, "mental health" issues are largely consequences of the complex interplay between traumatising past historical events and policies, recurrent economic instability, ongoing poor social situations such as housing instability and overcrowded housing, loss of cultural structures, limited opportunity contexts. The "mental health" behaviours were also seen to arise from family issues, but these were almost always of conflicts within families caused by government interference. Therefore, mental health behaviours can be considered as non-pathological protests against difficult life situations and oppressive policies and practices rather than pathologizing normal human conditions.

For Anangu, complexities are ever present in the contemporary context, as largely colonising effects and persistent expectation to integrate their ways of being to include both Anangu and "Western" epistemologies. Our findings are also consistent with the Brown et al. (2012) study by confirming the contexts that give rise to mental health behaviours explicitly, alcohol and substance misuse, a sense of hopelessness, worry and stress and shifting cultural ways of being. Furthermore, this study also confirmed the role of *ngangkari* who assume an integral role in treatment particularly by being the primary mechanism of support in the traditional Anangu context and supporting Western medicine in contemporary contexts (Brown et al., 2012; Panzironi, 2013).

Implications

This study has provided increased knowledge and understanding of "mental health" beliefs directly from the perspective of Indigenous Australian Elders. This contextually more nuanced understanding may support more appropriate responses to mental health needs by professionals and combined with evidence from other studies (Brown et al., 2012; Dudgeon, Walker, et al., 2014; Vicary & Westerman, 2004) is informing ongoing work on the development of "blended" or alternative, more culturally situated approaches to prevention and care. Importantly, this research reinforces the value of including local knowledges, individuals and groups with nuanced understanding of the community and culture in primary roles of research when researching cross-culturally.

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No potential conflict of interest was reported by the author(s).

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Data availability statement

Due to the nature of the research and due to ethical concerns, supporting data is not available. Reasonable requests for more information will be considered.

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