Indigenous Healing Practices in Australia

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ABSTRACT

Indigenous Australian women are among the most disadvantaged women in the world. Over two centuries of colonization have had a damaging impact on perceptions of their gender roles and status as well as many other consequential oppressions. These experiences have affected the social and emotional wellbeing of Indigenous women of all ages, resulting in socio-economic ghettoization, higher suicide rates, psychological distress, illness, and poverty. Generations of women have experienced the forced removal of their children, resulting in complex forms of historical trauma. Despite this, Indigenous women have also maintained strong leadership roles and have kept families and communities intact. In the last few decades, the Australian Indigenous mental health movement has emerged within the context of a broader self-determination movement, restoring and strengthening women's traditional therapeutic practices. This article offers an overview of the social and emotional wellbeing of Indigenous women within neocolonial Australia and explores women's relationship to traditional therapeutic practices. Future directions and key issues for the capacity building of Indigenous women's healing are explored.

KEYWORDS

Indigenous mental health movement; Ngangkari healers; traditional Indigenous healing; two-way healing

Indigenous Healing Practices in Australia

This article uses the term Indigenous and Aboriginal to refer to the traditional custodians of the land, the Aboriginal and Torres Strait Islanders. Australian Indigenous psychology recognizes that social and emotional wellbeing is a dynamic balance between the seven inter-connected domains of the body, mind and emotions, family and kinship, community, culture, country, and spirituality (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014). This holistic understanding of wellbeing describes a concept of the self which is ontologically and epistemologically different from standard individualistic biomedical Western concepts of the self. For example, Indigenous women have experienced their subjectivity as “an extension of the earth” (Moreton-Robinson, 2000, p.21), which is the social and emotional wellbeing domain of country. Moreover, country, in turn, is experienced as a connection to all other domains. Impaired social and emotional wellbeing is recognized to be caused by
“unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage” (Social Health Reference Group, 2004, p. 9).

There is now a broad consensus within Indigenous psychology that Indigenous peoples across the world are impacted by historical trauma, or a cumulative intergenerational socio-psychological trauma caused by the all too often violent experience of colonization (Duran & Duran, 1995; Gone, 2007; Kirmayer, Simpson, & Cargo, 2014). During the mid-1990s, historical trauma was also identified as a soul wound by cross-cultural psychologists (Duran, 2006; Duran & Duran, 1995). Briefly, historical trauma is more complex than classic Western individualistic psychiatric definitions of Post-Traumatic Stress Disorder (PTSD) in terms of duration, social collectivity, and events. Historical trauma is “theorised as a countercolonial explanatory construct” that acknowledges the multiple forms of colonial violence (Gone, 2013, p. 688). Historical trauma has been described as the snowballing of collective experiences and effects of “colonial injury” through “ever-shifting historical sequences of adverse policies and practices by dominant settler societies,” which have cross-generational “legacies of risk and vulnerability” that continue compounding trauma “until ‘healing’ interrupts these deleterious processes” (Kirmayer, Gone, & Moses, 2014, p. 301). It is recognized within Indigenous psychology that the intergenerational impact of colonization continues to have an injurious impact on the social and emotional wellbeing of millions of people across the world.

The important role of traditional therapeutic interventions into the transmission of historical trauma is now recognized. Traditional healing “is widely believed to be the most efficacious way to assist distressed First Nations individuals due to the inherent potency of these traditions achieved through long pre-contact histories of therapeutic refinement” (Gone, 2013, p. 697). Globally, traditional Indigenous healers are creating transformative partnerships with western practitioners, producing innovative disciplinary changes that are part of a wave of Fourth World de-colonization of the psy-complex (Incayawar, Wintrob, Bouchard, & Bartocci, 2009). In Canada, for example, there are blended traditional and western therapeutic practices based on such models as Two-Eyed Seeing (Etuaptmumk), which was developed by Mi’kmaw Elders Albert and Murdena Marshall from the teachings of Chief Charles Labrador of Acadia First Nation in Nova Scotia (Marsh, Cote-Meek, Young, Najavits, & Toulouse, 2016; Roy, Noormohamed, Henderson, & Wilfred, 2015).

Traditional healing is a holistic, community building spiritual practice that this article will explore in more depth in relation to the traditional therapeutic practices of Indigenous women. There is a broad consensus across Indigenous psychology that traditional healers and Indigenous health workers in general
are far better equipped to deal with psychological and emotional distress and should be included with non-Indigenous professionals providing services. The role of the traditional healer and therapist was defined in a 1979 Australian Commonwealth government inquiry into Aboriginal health as “an amalgam of the roles of doctor, spiritual adviser and psychiatrist in Western society” (Parliament of the Commonwealth of Australia, 1979, n.p.). This comprehensive inquiry recommended that Aboriginal traditional healers and therapists be involved in the development and delivery of health care services (Parliament of the Commonwealth of Australia, 1979). This policy recommendation can be said to be expressed in Principle 7 of the 2014 West Australian Mental Health Act, which states that mental health services must provide Aboriginal and Torres Strait Islander people with access to Elders and traditional healers during assessment, treatment, and care (Mental Health Commission, 2015).

**Women's Social and Emotional Wellbeing**

Since colonization, Indigenous women have been forced to conform to White ethnocentric patriarchal gender norms, which silenced, pathologized, and criminalized the strength of Indigenous women’s childrearing, relationships, culture, and spirituality. Colonization and the prolonged cultural genocide that resulted can be argued to be a gendered form of oppression. Indigenous females were subjected to forms of oppression that were different from the forms of oppression that Indigenous males experienced (Dudgeon, 2008; Haebich, 2014). The *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families* (BTH, 1997) examined the history, policies, and psychological impacts on the Stolen Generations. As a comprehensive document about the colonial abduction and abuse of Indigenous children, it is incomparable internationally. The report repeatedly discussed evidence that girls were targeted for both removals and abuse. For example, the majority of children who were stolen from mothers were female, and female children who were taken by the state from their families were abused more often than male children (BTH, 1997; Jacobs, 2005). Girl children were targeted for removals such that by 1921, 81% of children removed were female. By 1939, girls were still being singled out for state abduction (BTH, 1997). As the historian Haebich (2014) observes, women and girls were “targeted for special treatment.” The 1905 Western Australia Aborigines Act targeted women: “[i]n contrast to ‘half-caste’ men, the women remained subject to the provisions of the 1905 Act for life. There were also gendered differences in removals to most institutions, with more women and girls sent in and detained indefinitely” (Haebich, 2014). The institutionalized mass abduction of girl children was, in part, driven by the desire to provide White settlers with domestic servants (BTH, 1997). According to the BTH (1997) report, “The
Aborigines Protection Act 1886 and its regulations provided that at the age of 13 years ‘half-caste’ boys were to be apprenticed or sent to work on farms and girls were to work as servants” (p. 51). Trapped in dormitories and then small homes all too often dominated by White racist misogynists, many girls endured chronic levels of abuse (BTH, 1997).

Indigenous women suffered the multitude of racist oppressions imposed on colonized people that resulted in forms of social disadvantage such as lack of employment and educational opportunities, chronic ill health, and poverty (Fredericks, Adams, & Angus, 2010). Racist discrimination has been identified as a significant social determinant of health (Clark, Anderson, Clark, & Williams, 1999; Krieger, 2000). Layered on top of this multilayered oppression is that the erosion of status and cultural knowledge has diminished abilities to negotiate for native title and land rights (Berndt & Berndt, 1980). Finally, the colonial commodification and control of Aboriginal women’s sexuality was also wounding (Dudgeon, in press).

Indigenous Australian women’s social and emotional wellbeing is currently in crisis. Today, Indigenous women endure chronic levels of ill health typical of third world communities. At the same time, their access to adequate health care is often thwarted by the numerous barriers of institutional racism that, despite a plethora of government and non-government reconciliation programs and interventions, remain entrenched (Burns et al., 2013). Life expectancy for Indigenous females improved less than men’s between 2010 and 2012 (.8 for males and .1 for females, respectively), while a gap of around 10 years still exists between non-Indigenous and Indigenous peoples’ life expectancy (Department of the Prime Minister and Cabinet, 2016). Indigenous women also reported higher levels of distress (Kelly, Dudgeon, Gee, & Glaskin, 2009). Indigenous females in the 20–24 age group have the highest rates of completed suicide, which is more than five times higher than non-Indigenous females in the same age group. Indigenous women are being incarcerated at higher rates (Kelly et al., 2009), and more incarcerated females than males suffer from mental health conditions (73% of males compared to 83% of females) and Post-Traumatic Stress Disorder (PTSD) (12% of men compared with 32% of women) (Indig, McEntyre, Page, & Ross, 2010).

Due to the complex forms of ill-health caused by entrenched poverty, Indigenous women gave birth to low-birth-weight babies twice as often as non-Indigenous women between 1991 and 2008 (Lowell, Kildea, Liddle, Cox, & Paterson, 2015). Indigenous scholar Fredericks draws the connection between health status and cultural strength: “[i]f Aboriginal and Torres Strait Islander women continue to have their sense of identity marginalized and eroded, they will continue to have the poorest health of any group of women in Australian society” (Fredericks, Adams, & Angus, 2010, p. 7).
The Emergence of Gender as a Distal Social Determinate

Restoring Indigenous women’s social and emotional wellbeing and re-empowering them through strength-based, culturally safe, healing practices is an urgent priority. However, while there has been substantial research into social and emotional wellbeing (Dudgeon, Milroy, & Walker, 2014; Gee et al., 2014) and Indigenous engagement with the Australian healthcare system in the last decade, specific clinical data on Aboriginal women’s social and emotional wellbeing and their negotiation of the mental healthcare system is scarce (Burns et al., 2013). A wide-ranging and comprehensive literature review of research between 1970 and 2015 revealed a paucity of research in this area (Bradley, Dunn, Lowell, & Nagel, 2015). For example, De Donatis’ (2011) analysis of Indigenous etiologies of mental illness in an ethnographic exploration of north-east, Arnhem Land Yolnu “remains the only in depth investigation found of Indigenous Australian mental health and illness concepts. However, no attempt was made to explicate distinctions (if any) between male and female experiences of mental health or illness” (Bradley et al., 2015, p. 3). As it is recognized that healing should address the needs of specific groups, such as women, “[i]t seems prudent to consider that approaches have options that are specific to different age groups, gender and location. Healing practices should also specifically target a range of groups such as women, men, youth, Elders, incarcerated, gays, lesbians and the homeless” (Feeney, 2009, p. 17). However, evidence about Indigenous women’s social and emotional wellbeing has yet to be systematically evaluated (Bradley et al., 2015).

An analysis of gender as a distal social determinate for Indigenous women’s social and emotional wellbeing is a recent developing area of inquiry within Indigenous psychology (Halseth, 2013). Evaluations of the transformative or restorative benefits of traditional women’s healing for Indigenous women is also limited (Gone, 2013; Newton, Day, Gillies, & Fernandez, 2015; Waldram, 2013). A comprehensive review of evidence-based evaluation measures for assessing social and emotional wellbeing (SEWB) found that “[o]nly one measure, the SEWB module, has been specifically designed to capture the culturally specific understandings of SEWB in the Indigenous population” (Newton et al., 2015, p.46), but there is no mention of gender in the measure. In order to address the research gap on Indigenous women and girls’ social and emotional wellbeing, it is necessary to design a culturally appropriate measure in consultation with communities, one that is strength based and illuminates gendered resilience. Adapting existing western clinical measures is fraught with issues of systemic ethnocentrism (Drew et al., 2010) and risks “misdiagnosis when they focus on symptoms that are not necessarily considered abnormal within minority cultures (Dingwall & Cairney, 2010) or when questions are framed in formats that are unlikely to survey culturally relevant presentations” (Newton et al., 2015, p. 46).
Additionally, minimal research has been conducted to examine women’s traditional therapeutic practices. In a systematic analysis of the re-emergence of traditional healing and the building of partnerships between western and traditional healing practices, Suggit (2008) identifies three questions: “How currently widespread are Indigenous healing practices? […] How effective are these Indigenous approaches at addressing mental health conditions? […] How does, or might, Indigenous healing work within, alongside or in partnership with western psy disciplines to treat mental health patients?” (p. 34). As Suggit notes, “due to the current paucity of research in this complex multidisciplinary area these questions cannot be answered with any degree of confidence” (p. 34).

Transformative healing journeys initiated by traditional spiritual healing practices are significantly different from the kind of clinical psychopharmaceutical interventions made by the prescription of SSRI medications or Western cognitive-behavioral therapy. Moreover, the expectation that women’s traditional healing practices conform to White scientific measurements in order to justify funding can be understood as culturally inappropriate and a potential form of institutionalized racism.

Indigenous-led research that recognizes the gendered dimension of prolonged cultural oppression and the gendered impacts on social and emotional wellbeing is only beginning to emerge within mainstream academic research and is urgently needed so that evidence based mental health policies can be strategically designed to include the specific needs of Indigenous women and girls. This research would build on existing Indigenous led practices and recognize the importance of self-determination as a principle of healing for Indigenous women.

In what follows, a critical history of traditional healing practices is offered. It should be noted that traditional healers are known by several language names (Clarke, 2008): for example, the western desert name is Ngangkari (Elkin, 1993; Goddard, 1992; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council Aboriginal Corporation, 2003; Schulze, 1891); in northeast Arnhem Land, they are called Marrnggitj (Cawte, 1996; Elkin, 1993; Reid, 1983); and in the area colonized around Sydney, they are called Garraaji (Tench, 1996). Here, the focus is on women Ngangkari healers. In recent times, a community-based renaissance of women’s traditional healing has risen up from within communities with the partnership of the Indigenous health movement. The strength of this re-emergence of women’s traditional therapeutic practices, (although rarely subjected to clinical evaluation) testifies to the continuation of strong cultural practices.

**Indigenous Women’s Traditional Healing and the Dreaming**

For over 2000 generations our people have stood on this land. As women we had our own special relationship with the land. Whilst we had the same status as
men, we still remained sacred and separate. We had rights as individuals. We were able to exercise well-defined rights of ownership of the inherited regions of our tribal territories. Inheritance was through the mother’s side. We were recognised as being economically productive. Our work was valued because of our role as mothers and food gatherers. Women’s labour provided consistent food for the whole group.

We had our own magic. We had our own religion. We had our own rituals. We had our own ceremonies and corroborees. All to which men had no access. (NSW Women’s Coordination Unit 1991, NSW Aboriginal Women’s Conference 1990 Report, NSW Women’s Coordination Unit, Haymarket, p. 8 as cited in Thomas & Selfe, 1993, p. 167)

Although the Australian Parliament recommended that traditional healers be consulted in the design of mental health services in a 1979 report, noting that Australia was lagging behind internationally, it is only quite recently that traditional healers are practicing with psychiatrists and psychologists. Increasingly Indigenous psychological theory and practice is being guided by traditional epistemologies or ways of knowing. Cherokee sociologist Eva Marie Garroutte (2003) describes this as “Radical Indigenism,” research that reflects the whole of community goals and capabilities of Indigenous peoples and “follows the path laid down in the models of inquiry traditional to their tribal community” (p. 144). Recovering traditional epistemologies and using them to decolonize existing neocolonial psychology through, for example, the use of spiritual healing is an emerging decolonizing practice within Australia. According to Dudgeon and Walker (2015), “Some Indigenous Australian people have their own spiritual healers, or Ngangkaris, who have nurtured the physical, emotional, and social wellbeing of Indigenous people across 350,000 square miles of the remote western desert of Australia for thousands of years” (p. 290). Moreover, “Ngangkari focus on both physical pain relief and mental wellbeing, putting the spirit ‘in the right place’ or restoring the spiritual balance of someone who is not well through massage, coaxing, and using special powerful sacred tools” (Dudgeon & Walker, 2015, p. 290). The spirit has been called the ngarlu or lian by Indigenous healer Joe Roe (Yap & Yu, 2016). In order to begin to understand Indigenous healing practices, it is vital to acknowledge the influence of the Dreaming or Aboriginal spirituality, which is the foundation of not only all traditional healing practices, but the source of cultural lore and practices and holistic connections to country.

The social and emotional wellbeing framework recognizes the connection between mental health and spirituality, and spirituality is understood to be central to holistic Indigenous mental health (McEwan et al., 2009). As Grieves (2009) indicates, “Aboriginal wellbeing relies on a belief system, that philosophical basis of ontologies and epistemologies known as Spirituality” (p. 42). This spiritual epistemology is connected to the land: “women retain bodies of knowledge pertaining to the spiritual landscape” (Langton, 1997,
p. 96) and “Indigenous women perceive the world as organic and populated by spirits which connect places and people” (Moreton-Robinson, 2000, p. 18).

Commonly thought of by settler culture as only a prelapsarian creation myth in which various spiritual beings create and initiate the earth, humans, and their fellow animals, the Dreaming is not about static or lost origins, but about a continuous becoming—a self-aware life-force that exceeds time and space, the boundaries between life and death, and builds thought (San Roque, 2006). The Dreaming is a process of spiritual becoming, an always already past, present, and future “everywhen” (Stanner, 1990, p. 225). In other words, the Dreaming is a complex generative force, or Tjukurpa as the Anangu people describe it, a living, sacred intelligence that flows through both humans and non-humans and is continually communicating and listening. The radical connectivity of the Dreaming as a living force means that everything is in communication with everything across space and time, in life and death. There is, in this sense, no fundamental ontological difference between human and country; both are part of the Dreaming and in dialogue with each other through this shared receptivity.

The Dreaming is recognized through ceremony, song, and art, through cultural practices that are a celebration of a dynamic, transformative, living force, and an honoring of cultural law through narratives. A complex interconnected web of narratives about relations between people and country is also central to the Dreaming and holds people in place and in relations to each other and country. The Dreaming unites the different Indigenous nations across Australia, and there are many different names for it. For example, the Aranada call it Altjiringa, the Altjidja people, the Djugar, the Karadjeri people call the Dreaming the Bugari, the Ungarinyin name it the Unggud, the Wiradjeri call this force the Maratal, and the Yawuru people, the Bugarrigarra (Elkin, 1993, Yap & Yu, 2016).

A central part of the renaissance of Indigenous spiritual healing is a reconnection to country through the stories of the Dreaming. As Préaud (2009) comments [in regard to the Yiriman project in the Kimberley that takes young people out into country], it is a healing spiritual process that “gradually builds the young people as country themselves” (p. 9). This process of becoming country performs a deep healing transformation at the ontological level. As Yuin Elder Guboo Ted Thomas put it, “The elders guard the Law and the Law guards the people. This is the Law that comes from the mountain. The mountain teaches the dreaming” (Alli & Guboo, 2003).

**Minyma Ngangkari: Traditional Women Healers**

In recent times, traditional women healers are leading a renaissance of cultural healing. The historically recent emergence of an Indigenous mental
health movement is intimately caught up in official recognition and support of Ngangkari healers within communities across Australia. Like the Indigenous mental health movement as a whole, the Ngangkari are focused on a restorative, holistic decolonization of people’s social and emotional wellbeing and the energizing of sustainable autonomous Indigenous designed and led healing practices for communities. Simply put, Ngangkari healers work with the spirit or *karanpa* by using a psychic medicinal tool called a *mapanpa*, which removes bad spirits or *mamu* from the body, returns a lost *karanpa* to the body, or strengthens the spirit. In effect, healing restores the vitality of the spirit. Ngangkari women healers usually focus on women’s health issues, which is a practice that is aligned with traditional gendered healing practices where women healers treat women and men treat other men. Much of this healing is spiritual. By realigning a displaced spirit or *karunpa*, Ngangkari healers can cure depression and other forms of mental illness. Often, this is done by sending out the spirit of the Ngangkari healer to communicate with other spirits. According to Veronica Perrurle Dobson, an Arrernte woman:

> [t]he healer cures the sick person by getting the sick person’s spirit and placing it back into their body, making them well again. A child loses their spirit when someone frightens them when they are sleeping. It’s the same for an adult, especially older people. (Dobson, 2007, p. 11)

Moreover, women healers also conduct healing ceremonies, which connect people back into communities restoring their social and emotional wellbeing (Bell, 1982; Grieves, 2009). Scholars have argued that women play a dominant role in healing ceremonies (Berndt, 1982; Reid, 1983) and also conduct conflict resolution ceremonies, which are focused on healing communities (Slattery, 1987).

Traditional women healers in the central desert of Australia, specifically the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women’s Council, have led the revival of Ngangkari healing in Australia. The NPY Women’s Council emerged from within the Pitjantjatjara land rights movement during the late 1970s, when women formed a women’s only group that now represents a population of 6,000 covering 350,000 square kilometres. The Ngangkari program began in 1998, and, in 2000, over fifty Ngangkari healers met at the sacred rock of Uluru and resolved to strengthen their work by forming alliances with the mainstream health system (Woods et al., 2000). It was the NPY Women’s Council who published their stories in *Ngangkari Work Anangu Way* (NPY Women’s Council, 2003). Anangu is a central desert word for Indigenous people. In 2013, they released *Traditional healers of Central Australia: Ngangkari*.

Partnerships between traditional healers are rebuilding communities. The Congress and Society of Aboriginal and Torres Strait Islander
Medicine Men and Women are aligned with the Aboriginal and Torres Strait Islander Public Health Journal, an Indigenous Public Health Organisation from the Australian state of New South Wales. The aims of the Congress of Aboriginal and Torres Strait Islander Medicine Men and Women (2012) are to:

- Bring awareness to the wider public of the roles of the Aboriginal and Torres Strait Islander Medicine Men and Women;
- Assist the Aboriginal and Torres Strait Islander Medicine Men and Women in lobbying Federal, State, and Territory governments for greater recognition and the implementation of policies governing the delivery of traditional Indigenous Australian healing method;
- Add to the existing body of knowledge on Aboriginal and Torres Strait Islander Medicine Men and Women both literature and from an Aboriginal and Torres Strait Islander perspective;
- Assist in promoting awareness of the role of the Aboriginal and Torres Strait Islander Medicine Men and Women in regards to dealing with Aboriginal and Torres Strait Islander public health issues;
- Research ways to inform health professionals and health services of the role and service delivery and effectiveness of treatments delivered by the Aboriginal and Torres Strait Islander Medicine Men and Women; and
- Provide an online platform with which to promote the Australian Aboriginal and Torres Strait Islander Medicine Men and Women.

Significantly, “building access to cultural healers and cultural healing” is identified as the first of the key elements for implementing the Gayaa Dhuwi (Proud Spirit) Declaration” (Dudgeon, Calma, Brideson, & Holland, 2016, p.7). The Gayaa Dhuwi (Proud Spirit) Declaration is supported by world leaders in Indigenous mental health by the National Aboriginal and Torres Strait Islander Leadership in Mental Health and began with the development of the Wharerata Declaration in 2010 (NATSILMH, 2015; Sones et al., 2010). The Wharerata Group of Indigenous mental health leaders are from Canada, the US, Australia, Samoa, and New Zealand (Dudgeon, Darlaston-Jones, & Bray, 2017). The Gayaa Dhuwi (Proud Spirit) Declaration is focused on closing the mental health gap for

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\text{m}ental \text{ health and related conditions have been estimated to account for as much as 22\% of the health gap measured in Disability Life Adjusted Years (12\% to mental health conditions, 4\% to suicide, and 6\% to alcohol and substance abuse) (Vos, Barker, Stanley, & Lopez, 2007). (Dudgeon et al., 2016, p. 2)}
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The Gendered Reality of Indigenous Australian Women

Anthropologists such as Berndt (1970) proposed that traditional Aboriginal culture was “two sexed”, and elsewhere, it has been argued that gender roles are “essentially interdependent and complimentary” (Bell & Ditton, 1980,
Women were independent of men economically, but both contributed to the family. Women had a role in religious activities in matters pertaining to women’s business and to the whole group in certain rituals and ceremonies. Men and women knew the range of behavior that was expected of them and permitted to them as men and women. There was no uncertainty as gender roles were defined in mythology and upheld by the group. The two distinct halves of female and male gender worlds were interdependent, in order to uphold the structure and life of the whole group.

According to Dudgeon and colleagues (2014), “Women’s roles in traditional contexts, how these were disrupted during colonization, and the misrepresentations of these roles have become important issues” (p. 29). This issue flows through to therapeutic practice and theory. The two-gendered approach to life has remained in the cultural realities of Indigenous people across the country. Most of the language groups across Australia have women’s camps, where women gather in a place over a number of days to discuss their business and resolve issues. Men stay in the background, bringing provisions when needed, but do not enter the women’s domains at these times. Recognition is made that there is men’s business and women’s business. This two-gendered perspective needs to inform psychological interventions in order to offer a culturally safe approach to therapy. This perspective will inform the employment of Indigenous staff, whereby males and females are selected for certain roles. In healing programs, there might be times for women’s involvement only.

The National Empowerment Project

The National Empowerment Project (NEP) is a comprehensive Indigenous-designed, -led, and -delivered empowerment program that aims to restore resilience in communities across the nation in order to prevent suicide, self-harm, and psychological distress. Led by Pat Dudgeon, the project began as a response to the high suicide rate in the Kimberley region. The National Empowerment Project is holistic, strength-based, culturally appropriate, responsive to geographical context and designed to build up the capacity of people to strengthen their communities by addressing the social determinants that impair social, cultural, and emotional wellbeing. Using ongoing participatory action research to assess progress, the National Empowerment Project is continually responsive to the needs of the communities. The National Empowerment Project is guided by six protocols: human rights and social justice; community ownership; community capacity building; resilience focused; building empowerment and partnerships; and respect for local knowledge (Dudgeon et al., 2014). An Aboriginal and Torres Strait Islander knowledge framework also guides the generation of all knowledge from the
project. This knowledge framework is a community-based approach, a holistic perspective, recognizes Aboriginal and Torres Strait Islander diversity, self-determination, and the history of colonization (Dudgeon et al., 2014).

Significantly, the National Empowerment Project acknowledges the importance of traditional two-gendered therapeutic empowerment and employs male and female co-researchers where possible. When the cultural, social, and emotional wellbeing program was developed, it also included men’s and women’s groups or camps. This two-gendered approach is also in response to community feedback. According to Karunda community feedback in 2013 about “[p]referred cultural, social and emotional wellbeing empowerment and healing programs,” it was recorded that what is preferred is “gender based so that programs are offered in a culturally appropriate way” (Dudgeon et al., 2014, p. 13). The guide for Indigenous facilitators also recognizes that gender differences are important. This recognition of the continuing existence of traditional gender boundaries within communities is a vital part of building strength within communities and acknowledging women’s authority.

**Conclusion**

The Indigenous mental health movement in Australia is a historically recent movement based on the principle of self-determination. This article provided an overview of the impact of colonization on the social and emotional wellbeing of Indigenous women in order to highlight the extent of the crisis facing the movement. The emergence of women’s traditional therapeutic practices is a promising sign, which indicates the enduring strength of Indigenous healing. However, it should be noted that the focus on traditional therapeutic practices in this article is not meant to invalidate two-way healing in urban or other settings. This critical history of Indigenous women’s healing practices is limited because an analysis of gender as a distal social determinant for women’s social and emotional wellbeing is an emerging area of inquiry within Indigenous psychology (Halseth, 2013). Further, there is limited data on Indigenous women’s social and emotional wellbeing (Bradley et al., 2015), and evaluations of the transformative or restorative benefits of traditional women’s healing for Indigenous women are scarce (Gone, 2013; Newton et al., 2015; Waldram, 2013). Suggested future research directions include the Indigenous design of culturally appropriate measures for understanding the impact of various determinants on women’s social and emotional wellbeing. As Fredericks (2007) writes in the conclusion of her essay on Indigenous women’s health: “[i]t is Aboriginal women who understand what has happened from the position of being, of having lived the experiences, having heard the stories, having seen and felt the pain as Aboriginal women” (p.20). The emergence of Indigenous women’s therapeutic practices as
distinctly gendered practices would speak to and with these all too often suppressed experiences, stories, and suffering.

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