Health, Illness and Behaviour: Warlpiri Men’s Experience in a Central Australian Community

School of Health Sciences
Charles Darwin University

Thesis submitted for the degree of Doctor of Philosophy

Colin Watson

2005
Acknowledgements

The research and subsequent thesis has been accomplished with assistance from the following people and organizations:

Professor Jennifer Watson undertook to supervise this research and readily shared her considerable knowledge in the areas of methodology and the philosophy of interpretation.

Associate Professor John Wakeman encouraged me to undertake this research at doctoral level and acted as to co-supervisor.

Carol Ann Brown whose experience in cross-cultural interaction has been the source of many valuable insights. William Priestley provided considerable local support at Nyirrpi.

Adrian Winwood-Smith granted me access to his considerable collection of anthropological and historical literature. Dr Mary Laughren gave advice on aspects of Warlpiri language and culture.

Bid Rose and Christine Ponter, librarians at Alice Springs Hospital obtained numerous reference materials. Valmai McDonald proof-read the final draft of this thesis.

A scholarship from Territory Health Services and the Royal College of Nursing assisted in the conduct of this research.

And lastly, the men of Nyirrpi who were unfailing in their efforts to lead me to an understanding their lives in health and illness. I hope this thesis reflects the grace, patience and trust with which they embraced this research.
Thesis Declaration

I hereby declare that the work herein, now submitted as a thesis for the degree of Doctor of Philosophy by research is the result of my own investigations, and all references to ideas and work of other researchers have specifically been acknowledged. I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, and is not being currently submitted in candidature for any other degree.

Signed:  

Date:  

Colin Vasey

20/2/06
# Table of Contents

Title Page
Acknowledgements .................................................................................. i
Statement of Authorship ......................................................................... ii
Table of Contents .................................................................................... iii
Table of Figures ....................................................................................... viii
Table of Tables ....................................................................................... ix
Abstract ..................................................................................................... x

## Chapter 1 Introduction

Value of the Study .................................................................................... 3
Clarifying Key Terms ............................................................................... 4
Delimitations of the Study ...................................................................... 4
Limitations of the Study ......................................................................... 5
The Research Setting ............................................................................... 6
  Location ................................................................................................. 6
  Topography .......................................................................................... 6
  From Outstation to Community ......................................................... 8
Introducing The Warlpiri ....................................................................... 8
  A Short History of Contact ............................................................... 8
  Settlement and Change ..................................................................... 12
Conclusion ............................................................................................... 19

## Chapter 2 Language, Hermeneutics and the Practice of Ethnography

Introduction ............................................................................................. 20
Ethnographic Practice ........................................................................... 20
Gadamer, Language and World View ................................................... 22
Relativism ............................................................................................... 26
Linguistic Relativity ............................................................................... 27
Implications for Research .................................................................... 32
Conclusion ............................................................................................... 35

## Chapter 3 Men, Health and Behaviour

Introduction ............................................................................................. 37
Gender and Health ................................................................................. 38
Men’s Health in Australia: an Overview ............................................. 40
Men’s Behaviour in Times of Illness .................................................... 43
Explaining Men’s Illness Behaviour ....................................................... 44
  Biology .................................................................................................. 45
  Role Compatibility Hypothesis ........................................................ 45
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Masculinity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Sex and Gender</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Defining Masculinity</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Male Gender Identity in Warlpiri Society</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Abandonging Masculinity</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Contemporary Practice</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>60</td>
</tr>
<tr>
<td>5</td>
<td>Aboriginal Health in the Northern Territory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Demographics</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>The Health of Aboriginal People in the Northern Territory</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>The Health of Aboriginal People at First Contact</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>The Health of Aboriginal Men at Nyirripi</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Diabetes and Hypertension</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Sexually Transmitted Disease</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Alcohol Related Clinic Presentations</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Men's Use of Clinic Services at Nyirripi</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>71</td>
</tr>
<tr>
<td>6</td>
<td>Methodology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>The Nature of Reality: Ontology</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Knowing and Knowledge: Epistemology</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Towards and Aboriginal Epistemology</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>A Critical Approach to Cross-Cultural Inquiry</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>The Role of the Researcher</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>A Mixed Methodology</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Selecting the Informants</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Talking with Warlpiri Men</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>The Role of Observations</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Analysis and Interpretation</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>The Matter of Rigour</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Researching Cultural Difference</td>
<td>95</td>
</tr>
</tbody>
</table>
Chapter 7  Health and Illness Beliefs in Warlpiri Society

Introduction .......................................................... 100
An Overview of Traditional Warlpiri Medical Beliefs .................... 101
   The Ngangkayi: the Warlpiri Doctor .................................. 101
   The Use of Medicinal Plants ............................................ 102
   Song as Curative ...................................................... 102
Warlpiri Classification of Illness ....................................... 103
A Warlpiri Concept of Health .......................................... 104
The Somatic Experience of Wellness ................................... 110
The Importance of Country, Culture and Community in Well-Being .... 115
Traditional Warlpiri Beliefs ........................................... 118
   Natural Causes of Illness ............................................... 118
   Supernatural Causes of Illness ...................................... 119
      Yarda: The Projection of Illness .................................. 119
      Pirrpirpa-wanga: The Loss of Spirit .............................. 122
      Mirlalypa, Jarupa and Kuuka: The Infliction of Harm .......... 123
Contemporary Warlpiri Beliefs of Illness Causation ................. 127
Discussion ................................................................... 132
Conclusion .................................................................. 135

Chapter 8  Luyurt-ngumani Nyurrur: Worrying About Sickness

Introduction ................................................................ 137
Help Seeking and Illness: an Overview of Relevant Theory .......... 138
The Susceptibility to Illness .......................................... 141
The Signs and Symptoms of Illness ....... .......................... 142
When Help Seeking is Delayed ....................................... 146
Barriers and Enablers ................................................... 148
The Authority to Intervene ............................................ 152
Activities of Daily Living .............................................. 153
Crisis ......................................................................... 155
Discussion ................................................................... 156
Conclusion .................................................................. 160

Chapter 9  Mardarni jana-karna wati-patu: Looking After Young Men

Introduction ................................................................ 162
Seclusion, Segregation and Independence .......................... 163
The Change from Female to Male Guardians ...................... 166
The Absence of Male Elders ........................................ 174
Discussion ................................................................... 177
Chapter 10  

Kurntajarrimi: The Getting of Shame in Warlpiri Society

Introduction ................................................................. 182
The Meaning of Shame .................................................. 182
The Experience of Shame ............................................ 185
The Function of Shame .................................................. 186
The Aboriginal Experience of Shame ............................. 187
Shame and Access to Health Services: Nyirripi Men’s Experiences .................................................. 190
Contagion and Shame .................................................... 191
The Preponderance of Female Staff ................................. 193
Problems with English Language Communication ............ 194
Focused Attention on the Individual ............................... 197
The Importance and Impossibility of Confidentiality .......... 199
The Concept of Jampardiyi ............................................. 201
A Matter of Age .............................................................. 207
Discussion .................................................................. 208
Conclusion ................................................................... 212

Chapter 11  

Language and Communication

Introduction .................................................................. 213
Styles of Conversation .................................................... 213
The Aboriginal use of English ...................................... 214
Interpretation and Understanding in Cross-Cultural Inquiry  .................................................. 215
Semantic Differences .................................................... 223
Conceptual Differences .................................................. 225
Avoidance Speech .......................................................... 227
Secret Speech ................................................................ 228
Underlying Cultural Associations ................................. 228
Word Order and Sentence Structure ............................. 229
Emphasis and Tone ........................................................ 231
Gratuitous Concurrence ............................................... 232
Other Speech Conventions ............................................ 234
Discussion .................................................................. 237
Conclusion ................................................................... 239

Chapter 12  

Homophobia and Homosociality: Explaining Male Health Behaviour

Introduction .................................................................. 240
A Cautionary Note on Language .................................... 240
Homosociality Defined .................................................. 241
Homophobia Defined .................................................... 242
The Link Between Homosociality and Homophobia ................................................................. 244
Homosexuality and Homophobia in Aboriginal Society ....................................................... 246
Male Homosociality in Warlpiri Society ............................................................................. 248
Discussion ........................................................................................................................... 253
Conclusion .......................................................................................................................... 254

Chapter 13  Statement of the Thesis

Introduction .......................................................................................................................... 255
Illness .................................................................................................................................. 255
Manhood ............................................................................................................................. 256
Boundaries .......................................................................................................................... 257
Shame .................................................................................................................................. 258
Behaviour ............................................................................................................................ 260
Conclusion .......................................................................................................................... 260

Chapter 14  Recommendations

Introduction .......................................................................................................................... 261
Recommendation 1 ............................................................................................................. 261
Recommendation 2 ............................................................................................................. 262
Recommendation 3 ............................................................................................................. 263
Recommendation 4 ............................................................................................................. 264
Recommendation 5 ............................................................................................................. 264
Recommendation 6 ............................................................................................................. 265
Recommendation 7 ............................................................................................................. 265
Conclusion .......................................................................................................................... 266

Glossary of Warlpiri Terms ............................................................................................... 267

List of References ................................................................................................................. 271
Table of Figures

1. Figure 1.1 Warlpiri Communities of the Northern Territory ........................................... 7
2. Figure 2.1 Warlpiri Boy at Play .......................................................................................... 34
3. Figure 7.1 Wankaru: Warlpiri Concept of Health................................................................. 108
4. Figure 10.1 Avoidance Relationships and Warlpiri Circumcision Ritual............................... 204
5. Figure 13.1 Male Gender Construction, Shame and Illness Behaviour ................................. 260
Table of Tables

4.1 Life Stages and Associated Events for Males in Warlpiri Society .................. 55
5.1 Body Mass Index in Males >15 years: Nyirrpi 1998 .................................................. 67
5.2 Diabetes: Nyirrpi 1998-2003 .............................................................................. 68
5.3 Hypertension: Nyirrpi 1998-2003 ....................................................................... 68
5.4 Sexually Transmitted Infections in Males 15-45 years: Nyirrpi 2000 .................. 69
5.5 Tobacco Use in Males and Females >15 years: Nyirrpi 2000 ............................. 69
5.6 Alcohol Related Clinic Presentations: January-July 2001 ............................... 70
5.7 Percentage of 15-45 year Age Group Attending Nyirrpi Clinic: March 2001 .......... 71
Abstract

The Warlpiri, an Aboriginal people of Central Australia, like other Aboriginal Australians face considerable health challenges. This research project examined the factors that impede Warlpiri men’s use of health services. It is known that the indicators of poor health status in Aboriginal men are many times greater than that of other Australian men. Despite these health deficits, the utilization of health services and the reporting of illness by Warlpiri men tend to be low.

The research was undertaken at Nyirrpi, a Warlpiri community located in the western deserts of Central Australia. A critical ethnographic methodology that included qualitative and quantitative inquiry was used to conduct this research. Multiple strategies of inquiry including health record analysis, interviews, reflective field diary and observations enabled an understanding of Nyirrpi men’s experience to be developed.

A descriptive analysis of the health status of Nyirrpi men was undertaken using clinic records. This revealed high levels of chronic disease in both men and women. Analysis of clinic attendance revealed markedly lower rates of clinic utilization for men. In-depth semi-structured interviews were used to investigate the knowledge and beliefs about health and illness and health service issues pertinent to Aboriginal men.

The welfare of young Warlpiri men was identified as an area of concern. The path that men take to treatment was examined in order to understand delays in help-seeking. Nyirrpi men universally reported shame as inhibiting access to health services. The causes of this shame are complex and are reported here in detail. Language emerged as a profound factor in the conduct of this research. This has implications well beyond the research arena.

Whilst the behaviors demonstrated by Warlpiri men are similar to those reported by men in the Australian community, generally the mechanisms behind them are different. The concepts of homosociality and homophobia are used to explain these differences.
Chapter 1

Introduction
Chapter 1

Introduction

Any action to improve the health status of men may be undermined by a failure to understand how men experience their gendered existence. The challenge for practitioners and policy makers alike is to recognize and respond to this experience. The many permutations that this experience may take under the influence of variables such as age, race, socio-economic status, political and religious beliefs is equally important. For just as these variables shape not only men's experience, they also influence their experience of health, both its maintenance and its loss.

The research detailed in this thesis was prompted by problems encountered in providing primary health care services to Aboriginal men in a Central Australian community. The problems encountered and the questions that these problems raised were specific to my practice as a remote area nurse.

I have lived in Central Australia for some twenty years. I have worked as a remote area nurse in two Aboriginal communities, Yuendumu and Nyirripi. Warlpiri (alternate spelling Walbri and Walbiri) is the language spoken in both communities and this is the name by which the inhabitants identify themselves. Being a male nurse, much of my practice has been directed at providing health care to Warlpiri men. Early in my association with Warlpiri society I was struck by a paradox; the dominant nature of Warlpiri men's affairs contrasted with an apparent disadvantage in the use of health services. I gradually became aware of patterns of behaviour, especially in help-seeking, which possibly contributed to this disadvantage. These behaviours, often characterized by reticence, subterfuge and at times the complicity of others, suggested that accessing health services for Warlpiri men was fraught with problems.
Warlpiri men carry a burden of ill health comparable to that of women and yet clinical services have long been oriented towards women and children’s health care needs. Historically, health services have focused on maternal and child health. What little focus there was on men’s health was limited to matters of sexual health. These patterns in health service delivery have become entrenched over the years as standards of clinical practice.

This state of affairs has had two effects. Firstly, in a culture where men and women’s affairs are normally kept separate, the focus on maternal and child health effectively excluded men from health services. Secondly, the strong emphasis on men’s sexual health resulted in a narrow clinical focus. The combination of these two factors produced a situation in which men’s health issues were linked explicitly to sexual health and played out in an environment dominated by women and children. The effect for Warlpiri men was a reluctance to be associated with community health clinics, except in situations of dire need.

I suspected that there were other factors limiting Warlpiri men’s access to health services. As well as the historical and service related factors, I suspected that cultural and social factors also influenced Warlpiri men’s health and illness behaviours. My growing awareness of the nature of these problems in my practice corresponded with an emerging popular interest in men’s health issues. The past decade has seen the areas of masculinity and men’s health become the focus of intense academic and research interest. This research has suggested a male health disadvantage and has implicated the gender concept of masculinity as a possible factor in this disadvantage.

The research detailed in this thesis is an attempt to establish if a similar mechanism exists in Warlpiri society. By describing the construction of Warlpiri male gender identity and associated cultural practices an alternate understanding of men’s behaviour can be gained.
The Value of the Study

This research will help improve health service delivery through greater awareness of those factors pivotal to Warlpiri men’s access to health services. This topic has not previously been addressed. The few references made to Aboriginal men’s under-utilization of health services draws on literature pertaining to non-Aboriginal men. While not setting out to study this problem from the perspective of difference, it is unhelpful to assume that culture plays no mediating role in this state of affairs. As such, this study will contribute to existing cross-cultural knowledge.

Remote health service providers in Central Australia have long been aware of the inequitable circumstances surrounding health care and Aboriginal men. Practitioners have only recently promoted men’s health in an attempt at addressing the imbalance between male and female access to health services. Unfortunately, for many Aboriginal men the attitudes and behaviour relating to illness and clinics are entrenched. This study identifies the barriers that remain and suggests service related strategies that can improve Aboriginal men’s health care.

Comparable levels of illness exist between Aboriginal men and women at Nyirripi. Under-utilization of health services compounds the health problems faced by Aboriginal men primarily because conditions are not treated or are not monitored adequately. This contributes to the levels of morbidity and mortality that currently exist in many western desert communities. An understanding of the barriers to health care is pivotal to redressing the present imbalance and essential to improving men’s health.
Clarifying Key Terms

A number of terms are used throughout this thesis. These need clarification for the sake of consistent interpretation by the reader. This research was conducted in a Warlpiri community and I have endeavoured to be specific in attributing material pertaining Warlpiri society. Where necessary, I have identified other language groups by their specific collective names. While I make no claims to generalize these research findings to other Aboriginal communities, I have frequently made use of the term ‘Aboriginal’. This term is problematic in that it fails to account for the considerable diversity within Aboriginal communities across Australia. I have frequently contrasted the term Aboriginal with that of non-Aboriginal, which for the purposes of this research refers to mainstream Australian society. This term also carries the problem of denying diversity.

Given the enormous change that Warlpiri society has undergone post contact, I need to distinguish between the traditional and contemporary contexts. My accounts of traditional or pre-contact Warlpiri society are based on ethnographic and linguistic material. Much of this material was collected following contact. I use the term ‘contemporary’ to refer to the present. I do not use contemporary in its other sense to imply the same (but potentially past) time. My rendering of contemporary Warlpiri society is based largely on my experience and observations.

Delimitations of the Study

This research was undertaken in a cross-cultural setting. Various topics of interest to this inquiry had to be considered in the context of a culture foreign to that of the researcher. These topics were essential to developing an understanding of the research question. I have no training in anthropology and as such these topics pertaining to culture should be read only in context of the research. They in no way represent a complete ethnographic rendering of contemporary Warlpiri life.
Manhood in Warlpiri society is very much a social construction. The process of transforming boys into men is perhaps an ancient tradition, one in which manhood is both achieved and bestowed through the enactment of ceremonial ritual. The rites of passage by which a Warlpiri boy is initiated into adulthood are still practiced today. This aspect of Warlpiri life is both sacred and secret. This study does not reveal details of the ceremonial attainment of adult masculine identity in Warlpiri society.

I have not examined in any detail the broader social, economic, political or historical contexts that have undoubtedly impacted on Aboriginal health status. These have been adequately dealt with elsewhere. This study will only examine those factors that impede access to health services by men at Nyirrpi.

**Limitations of the Study**

My knowledge of Warlpiri culture and community life has exposed me to many ideas, values and customs foreign to my own cultural background. My long association with the study community has given me many invaluable insights fundamental to the development of this research project. These insights influenced the manner in which the research question was framed and in doing so potentially limited the scope of inquiry.

The study was undertaken in one of four Warlpiri communities (see map p. 7). The findings, particularly those relating to culture possibly operate in other Warlpiri communities. Despite a common cultural heritage, no two communities are the same and this should be considered in applying the findings of this research elsewhere. This research makes no claims for other Aboriginal communities in Central Australia.
This research contains significant ethnographic and linguistic content. As stated above I have no expertise in either of these fields, however I have made strenuous efforts to ensure that both the anthropological and linguistic content is accurate.

The Research Setting

Location

Nyirrpi is a Warlpiri community located in the western desert of Central Australia. Warlpiri is spoken by almost three thousand people as a first language. These Warlpiri speakers live in small communities spread over a large area of Central Australia. The main Warlpiri communities are Yuendumu, Willowra, Nyirrpi and Lajamanu, all located north-west of Alice Springs.

The community of Nyirrpi is located 450 kilometres north-west of Alice Springs. The nearest community is Yuendumu, 150 kilometres to the north-east. Nyirrpi is considered a remote community and it is presently home to some 250 people.

Nyirrpi is located close the south-western extent of land traditionally owned by the Warlpiri. Although Nyirrpi is predominantly a Warlpiri community, there are small groups of Pintubi and Kukatja speakers living in the community, linking Nyirrpi with Balgo (Western Australia) and Kintore (Northern Territory).

Topography

The western deserts of Central Australia have an average annual rainfall of less than 250 mm. This rainfall is intermittent. Long periods of drought are separated by occasional heavy falls of rain. Streams are dry for most of the year and surface water is restricted to a few permanent water holes in the surrounding ranges. The average maximum and minimum temperatures are 37° and 21° Celsius in summer and 22° and
5° Celsius in winter. The country surrounding Nyirripi consists of extensive plains of red soils and sand between scattered hills and ranges. The dominant vegetation is spinifex on the sandy plains and rocky ridges, with mulga on the extensive flood-out plains and eucalyptus along the watercourses (Young et al. 1995). An extensive quartzite range 20 kilometers to the south provides a striking backdrop to the community and is dominated by Mount Stanley (Karrku) and Mount Cockburn (Wirniyijarru).

Figure 1.1 Warlpiri Communities of the Northern Territory
From Outstation to Community: the story of Nyirrpi

Nyirrpi has a recent history. The community was established as an outstation of Yuendumu in 1975, when a group of people decided to leave Yuendumu and return to the traditional country of their ancestors. A Pentecostal lay preacher accompanied this exodus. This was the beginning of an association between the community and the Pentecostal Church that has continued to the present time. A small camp was made on Waite Creek at a site known as Nyirrpi. No reliable water could be found and the camp was abandoned. Water was found at Jitilparnta, a short distance to the southwest and a bore was sunk. Jitilparnta is the site of an important soakage belonging to Malujarra jukurrpa (Two Kangaroo Dreaming). People settled at Jitilparnta and the community slowly developed. For many years the community existed as an outstation. Services such as education and health were provided on a visiting basis from Yuendumu.

The outstation was recognized as a minor community in 1983. This enabled funds to be secured for the construction of a school. In 1985, under the Aboriginal Council Association Act, the community was incorporated and a community council formed. Progressive development over the past two decades has consolidated a strong and vibrant community identity.

Introducing the Warlpiri

A Short History of Contact

The first non-Aboriginal exploration of Central Australia was made by Charles Sturt between 1844 and 1846 in an attempt to locate an inland sea. Further exploration of Central Australia began in 1859 when James Chambers and William Finke, successful South Australian pastoralists commissioned John McDouall Stuart to explore northern districts of the colony. Stuart made three expeditions to northern Australia and by 1860 had reached Attack Creek, north of the present day Tennant Creek. Stuart
reported favorably on the suitability of the country for pastoral development (Flannery 1998).

In 1869 with the successful settlement of Palmerston (the present day Darwin), a permanent colonial population was established in the north. In 1870 the South Australian government was successful in its bid to construct the telegraph between Adelaide and Palmerston. Construction was completed in 1872 and was accompanied by the formation of road and stock routes.

The application for pastoral leases and the arrival of stock soon followed. By 1885 much of Central Australia was under application for pastoral lease. The discovery of gemstones and mica at Harts Range and gold in the Arltunga district in the late 1880s brought an influx of prospectors to Central Australia. A general store and hotel were established in 1887 to serve the needs of this new population and land for a township was surveyed. The township of Stuart (the present day Alice Springs) was proclaimed in 1889 (Flannery 1998; Hartwig 1965).

The history of contact in Central Australia tends to be a one sided account describing how Aboriginal people affected the various endeavours of colonial pastoralists and prospectors. Hartwig claims that the ‘inevitable conflict in interest and the vast difference in outlook lead almost everywhere to a period of clash’ (Hartwig 1965 p. 594).

The history of Warlpiri contact with explorers, prospectors, pastoralists and missionaries is well documented (Marcus 2001; Meggitt 1962; Reece 1943; Stead 1985; Steer 1996). Given that this contact is recent, and in the interests of placing recent Warlpiri history in context, I will outline the main events as reported in the literature.
The invasion of Warlpiri territory by non-Aboriginals began in the 1860s. The explorers Gosse, Stuart and Warburton traveled through Warlpiri territory during the late nineteenth century. Warburton's east to west explorations were through the heart of Warlpiri territory. Warburton's journal entry dated 23rd May 1865 records:

Passing through an opening in the range we reached a better traveling country and camped in the afternoon on a high plain with more scrub. South by west we saw three remarkable hills, distant about 25 miles, one table topped, quite flat and scarped all round, the middle one saddled backed and the third wedge shaped and scarped at the point (Warburton 1875, p. 164-5).

The 'three remarkable hills' Warburton (1875) describes were Karrku (Mount Stanley), Wirriwijarru (Mount Cockburn) and Rdhakivi (Mount Campbell) just south of Nyirrpi. Warburton (1875) made only occasional sightings of Aboriginal people in this locale and these meetings were free of conflict.

Between 1880 and 1900 there was considerable expansion of pastoral activities to the north and north west of the Tanami Desert. At the turn of the century, the discovery of gold at The Granites and Tanami brought an influx of miners into Warlpiri territory. By 1909 the gold rush had brought some 500 men into the Tanami Desert. Warlpiri apparently avoided both the Tanami and Granites gold fields following a number of violent disputes with miners (Marcus 2001).

Pastoral settlement at Coniston, Anningie and Napperby on the eastern boundary of Warlpiri territory occurred between 1910 and 1930. Mount Doreen station was taken up in 1932, this being in the heart of Warlpiri territory. Mount Doreen became the home of many Warlpiri who worked both in pastoral and mining enterprises (Marcus 2001).
A severe drought in Central Australia between 1924 and 1928 brought many Warlpiri into close contact with non-Aboriginal people. This contact occasionally ended in violence. In 1928 Warlpiri murdered a prospector near Coniston station. Mounted police made punitive raids on the Warlpiri. Many Warlpiri were killed. To avoid further attack, Warlpiri abandoned their country, dispersing east to Wauchope and Hatches Creek and west to Mount Singleton and the deserts beyond (Tynan 1979).

The Native Affairs Board was established in 1938 with the express purpose of establishing settlements for Aborigines who had become 'detribalized'. In 1941 the Haast Bluff Aboriginal Reserve was established some 300 kilometers west of Alice Springs. Many Warlpiri made their way to Haast Bluff, despite it being outside their traditional territory. In 1946, the Native Affairs Board established the Yuendumu Aboriginal Reserve 300 kilometers north west of Alice Springs. A supply depot, which had earlier been established at Tanami, was moved to Yuendumu. The Native Affairs Board established another reserve for the Warlpiri at Hooker Creek in 1949 on the northern margin of Tanami Desert (Meggitt 1962). Many Warlpiri people were removed from Yuendumu and settled at Hooker Creek. As this settlement was located in Gurindji country, many Warlpiri returned on foot to Yuendumu.

The ration depot at Yuendumu quickly developed into a settlement. The settlement ensured a reliable supply of water, food and some basic services. But settlements also represented the forced or enticed removal of Warlpiri from their traditional country. This meant limited access to traditional foods and sites of religious significance. The notion of 'country', the jukurpa or ancestral sites it contained and the associated ceremonies were integral to Warlpiri self-identity. Removal from one's 'country' was in a sense a removal from 'self'. The loss generated by this dislocation no doubt continues to manifest today.

The Native Affairs Board instigated patrols of the Gibson and Great Sandy Deserts during the 1950s and early 1960s to locate remaining nomadic groups of Aborigines.
These were mostly Pintubi and they were enticed to leave the desert and were settled at Yuendumu and Papunya (Elphinstone 1971).

Settlement and Change: the impact on Warlpiri Men

Traditional Warlpiri life, like that of other nomadic societies was a full time occupation. The Warlpiri neither practiced agriculture nor pastoralism, their existence was entirely dependent upon hunting and foraging activities. Contact with prospectors, pastoralists, missionaries and bureaucrats served to undermine much of the socio-economic basis of Warlpiri life. With settlement and the shift from a nomadic to a sedentary life, most traditional pursuits became redundant. While women’s central role of mother and wife remained intact, the same was not true for Warlpiri men. With settlement many of the bases upon which men founded their identity and status were either removed or made redundant.

The present position of the Warlpiri and many other Central Australian Aboriginal societies has been described as the end product of a shift from a hunter-gatherer economy to a welfare economy located in government settlements and marginal to the capitalist activity of mainstream Australian society (Cataldi 1998). The processes that wrought change in Warlpiri society are far more intricate, these changes manifesting at the very core of Warlpiri society.

The impact of pastoral enterprises on Aboriginal life has a mixed reception in the literature. The charges of forced removal of Aborigines from their land, cheap labour and the various forms of maltreatment are well represented in the literature (Berndt & Berndt 1987; Broome 1982; Marcus 2001).

This history is now undergoing a re-evaluation and while dispossession and exploitation undoubtedly occurred, in some areas the relationship between pastoralists and Aborigines was almost symbiotic in nature. The work practices of the pastoral
enterprise were positively aligned to an evolving Aboriginal masculine identity. Pastoral work involved a range of activities that gave men the scope to develop a variety of skills. This gave men a sense of pride and achievement (McGrath 1987). Many Aboriginal men viewed pastoral work as worthwhile and inhering considerable status. This is reflected in the style of dress preferred by Aboriginal men in many communities today. Despite the disappearance of stock work, particularly for the Warlpiri, the stockman’s mode of attire remains popular. Through pastoral work, associations could be maintained with country and the seasonal nature of this work allowed time to pursue traditional activities.

The Warlpiri response to pastoralism was not without significant social impact. This essentially revolved around the imposed economy of wage and ration. In a study of social change in the Warlpiri living at Mount Doreen station, Adler (1957) highlighted a shift to monogamous nuclear families. This, she suggests was the result of employment, through which individual workers were able to support themselves and their families from their earnings. In this manner individual effort replaced collective effort in the procurement of resources. Whilst this may have been the case, Adler (1957) makes no examination of distribution of resources between kin, a practice emanating directly from the collective identity of the Warlpiri.

Perhaps most importantly Adler (1957) suggests a shift in gender relations. Again she links this change to the employment of Warlpiri men. In the absence of men, women assumed greater social and economic responsibility. This general argument appears elsewhere in the literature:

With increased external influences and labour demands, traditional processes of socialization were being drastically reduced. This had marked repercussions in the sphere of religious practice. While in most areas the authority of men did not extend beyond the ritual place and women’s authority had expanded,
especially in the domestic and socio-economic spheres (Berndt & Berndt 1987, p. 212).

Adler specifically raised the possibility that inheritance could be transferred to the maternal line as a result of a ‘close affiliation and residence with maternal kin’ (Adler 1957 p. 4). Meggitt conceded that ‘the big permanent camps’ that replaced the traditional and smaller residential units had impacted on local organization. However, he described how the Warlpiri adapted to their new circumstances with particular reference to paternal inheritance. Meggitt saw the shift to permanent settlement in terms of altered associations to land. Living in one place meant that conception and birth affiliations to country were greatly diminished. Despite this, Meggitt claims that these affiliations between land and person were invoked at circumcision with ‘all youths at settlements initiated into their father’s lodges’ (Meggitt 1962 p. 74).

Despite three pastoral leases bordering the Yuendumu Reserve, the influence of pastoral involvement on the Warlpiri was minimal. The employment of Warlpiri men was at best seasonal in nature. From the early 1970s Aboriginal employment in the pastoral industry diminished due to a global downturn in commodity prices for livestock products, legislation to pay Aboriginal workers award wage rates and the increasing mechanization of pastoral activities (Smith 2003).

Of far greater significance to Warlpiri society was the evolution of the reserve and settlement. The formation and function of Aboriginal reserves and settlements became vehicles for the federal government assimilation policies. Whatever the aim, the long term outcomes were perhaps not envisaged. Many settlements became enclaves of segregation and poverty. The Warlpiri and other desert dwelling Aborigines in Central Australia used settlements as a base to establish communities with strong identities. These sentiments were shared by Long in his description of Papunya and Haast Bluff settlements, where despite the forced co-habitation of a number of language groups ‘a considerable local patriotism and sense of belonging’ evolved (Long 1970a p. 322).
The move to settlements and the fall of Aboriginal families under the scrutiny of welfare agencies and settlement administration had negative effects on the Aboriginal practice of fathering as indicated by the following statement:

...residence on the settlement or mission, as an inmate of an institution, where he often gets something for nothing, where ration handouts save the need to forage or to work, where his family is catered for, where decisions on many matters are made for him by officials in his best interests (Tatz 1964, p. 270).

There were also differing values and practices concerning fathering. Perhaps the greatest of these concerned the difference between biological and social paternity. Child rearing responsibilities were not limited by biological paternity. A Warlpiri man had responsibility for his brother and sister's children, particularly male children (Meggitt 1962). The predominant non-Aboriginal concept of fatherhood was based on the role of 'breadwinner'. In Warlpiri society the provision of sustenance had never been an exclusive male responsibility and attempts to impose this concept on Warlpiri society met with limited success.

Another area of social organization where change resulted in disharmony was the breakdown of gerontocracy. The power of elder males emanated from their ritual and practical knowledge. Long claimed that conflict arose between younger and older men over the access to women (Long 1970b). Traditionally, older men controlled access to women through arranged marriages based on kinship. Polygamy, especially among older men was common. Increasingly, however younger men challenged the system of arranged marriages confident of the support of non-Aboriginal law. Non-Aboriginal values supported monogamy and the legal system ensured punishment of those men using violence to enforce arranged unions.

Settlement life undermined the economic basis of Warlpiri men's role. The knowledge and skills required to sustain life in a desert environment were not necessary on
settlements. Warlpiri men were initially occupied in the development of settlement infrastructure. Later however, finding jobs to sufficiently occupy men became a problem (Long 1970a; Rowse 1998). An early visitor to Yuendumu noted of Warlpiri men:

...in tribal life, self respect is attained by the accomplishing of prescribed duties and ceremonial ritual, by hunting and the making of weapons which is their method of work (Dean & Carell 1955, p. 114).

Settlement life made the 'method of work' of Warlpiri men all but redundant. The role of men was devalued, as there was nothing of significant worth to replace their previous purposeful existence. Prior to settlement, existence for a man and his family was only ensured through the co-operative effort required to procure nourishment. The effort required to survive in the semi arid environment in which the Warlpiri lived was considerable.

The introduction of rationing had the most far-reaching consequences for the Warlpiri. Rationing required Warlpiri to remain in one place, a style of living not previously possible. The need to hunt and forage was negated by the regular provisioning of rations and hence all the associated activities that had previously occupied men were no longer necessary. The following impression of rationing hints at effects but reveals little understanding of the fundamental forces at play.

Once he had claimed his due he is content to sit down and wait for the repetition of this act, in the meantime he may be whiling his time away with seemingly trivial activities. Significantly this type of self-indulgence has sapped the Walbiri of his interest in providing himself with indigenous foods (Adler 1957, p. 42).
This statement does not fit with the high regard that Warlpiri have for these ‘indigenous foods’ and the effort they still expend in their procurement. It also reflects little understanding of the ecological consequences that living in one place had for the Warlpiri. The rapid depletion of natural resources in the area of residence made dependence on rations absolute.

Food became the ultimate vehicle of assimilation policies with the introduction of communal feeding throughout Central Australian Aboriginal settlements from the late 1950s. The practice of communal feeding reflected almost no appreciation of the economic and social role of food and socially specific consumption practices in Aboriginal society. The social significance of food and the consequences of communal feeding are described by Rowse:

...food is not merely feed because its passage from hand to hand daily enacts and signifies domestic structures of relatedness. Communal feeding implied official willingness to disassemble the domestic group (Rowse 1998, p. 174).

The contemporary dietary staples of the meat-based stew, damper, tea and sugar suggest that rationing and communal feeding were not without long lasting effect.

A culture of welfare has caused dependency and engendered a lack of pride and motivation in many Aboriginal men and ultimately contributed to what Davis refers as the ‘failure of Aboriginal men’ (Davis 1992, p. 38). Recognition of the dominant influence of women in the maintenance of the family is reflected in their access to income via welfare payments. The nurturing role of women is the key to this access to resources. In this manner the status of motherhood has been transformed and has become a source of status. As the domestic economy became based on the welfare payments, substantial control of that economy resided with women. Women’s role as mothers and housekeepers were supported in a way that did not apply to men.
Pearson has likened welfare to a form of social poison. He argues that access to cash has undermined the social regulatory principle of reciprocity. Most significantly he identifies alcohol as the prime item of men’s expenditure (Pearson 2000).

However, Folds disavows this notion of dependency in his assessment of the Pintubi and welfare. He claims that for the Pintubi, welfare is regarded as the rightful debt owed them by the state as payment for a way of life that is no longer possible. Of the Pintubi and welfare, Folds makes the following observation:

They are shaping representations of themselves in their relationship with government in ways that fit their own view of the world and serve their own purposes (Folds 2001, p. 41).

While it is possible that some Aboriginal recipients of welfare do not denigrate this state of affairs there is no denying however that Aboriginal men are left with much free time and access to income. Employment within communities is limited. The ties to family, community and country are sufficiently strong that very few Aboriginal men are able to seek employment outside their immediate area of residence. Men’s aspirations to autonomy from the demands of family are now possible through their access to cash income (Martin 1995). Rowse claims that many Aboriginal men are able to finance their homosocial activities, particularly alcohol consumption and gambling, from the welfare payments they receive as well as money procured from female relatives (Rowse 2002).

Aboriginal religious life is to a large extent the domain of men. However, even this aspect of men’s lives was open to interference and restriction by various imposed non-Aboriginal religions. At Nyirrpi, the Pentecostal Church was rigorous in prohibiting ceremonial activity, including the initiation of young men. Only with the political sophistication of the community has the church been marginalized, making possible a degree of cultural revivalism.
Conclusion

Warlpiri contact history is recent in comparison to other Central Australian Aboriginal societies. The shift from a nomadic hunter-gatherer to a settled and dependent existence has occurred within living memory. This shift has involved considerable social change. The role of Warlpiri men has altered. To a great degree Warlpiri men have been disempowered. Their authority has been challenged in almost all spheres of life in which they traditionally held central positions. Their roles as fathers, teachers, providers, hunters and religious leaders have all been impacted by settlement. The process of culture change has diminished the self-esteem of many Aboriginal men, a fact reflected in the rates of alcohol abuse, domestic violence, imprisonment and youth suicide.

These dramatic changes in social circumstances have been accompanied by deterioration in health status. Warlpiri men carry a considerable burden of illness and yet they are under represented in the clinic utilization rates. This research attempts to uncover the concepts that health and illness have for Warlpiri men today and the factors that determine their use of primary health care services.
Chapter 2

Language, Hermeneutics and the Practice of Ethnography
Chapter 2

Language, Hermeneutics and the Practice of Ethnography

*He gave man speech, and speech created thought,*  
*Which is the measure of the universe.*

*Shelley*  
*Prometheus Unbound*

**Introduction**

Language and the semantic analysis of language play a central role in the ethnoscientific paradigm. Our task as social scientists can be seen as discovering how language allows us to know another culture. Other than the problems related to translation, there seems to be scant attention given to the philosophical, methodological and analytical implications of language in the conduct of cross-cultural research.

The following is an examination of Hans-Georg Gadamer’s (1900-2002) statements regarding language and worldview. It is also an examination of the principle of linguistic relativity, a set of ideas concerning the relationship between language and thought. I will compare these ideas with Gadamerian hermeneutics and demonstrate how linguistic relativity can strengthen hermeneutic analysis.

**The Practice of Ethnography**

Understanding is the goal of most qualitative research. Qualitative methods should provide sufficient descriptive information that the phenomenon under study can be comprehended. In ethnography there is a belief that all human behaviour can be understood within the context that it occurs.
The writers of ethnography are generally alien to the culture they are studying. In ethnography we attempt to render the ‘insider’s’ (emic) view of a culture from the perspective of the ‘outsider’ (etic). Research undertaken from the emic perspective discerns knowledge from the informant’s view of reality. Understanding behaviour can only be accomplished when the researcher comprehends the behaviour according to the perceptions and interpretations of those engaged in that behaviour. In the emic approach, the language of the culture is examined and the organizing social frameworks uncovered. Importantly, the emic approach describes the cultural perception of reality from the viewpoint of the insider. It requires that the researcher intensively enter the informant’s world recognizing the values, meanings and beliefs of that world (Omery 1988).

The etic approach to ethnography involves organizing the research according to the theoretical perspectives of ethnographic practice, in effect the outsider’s perspective. Inherent in this approach is a belief that the researcher is best suited to determine the final descriptive account of the culture under study. As such, more importance is placed on the informant’s observed behaviour as opposed to their cognitive state.

Exclusive adherence to either the emic or etic approach will be at the expense of valuable data. Most ethnographers adopt an approach that combines both perspectives, thus giving a more complete account of the phenomenon under study (Werner & Schoepfle 1987).

A central concern in ethnography is the control of ethnocentrism. The cultural baggage that the ethnographer brings to the inquiry is considered a powerful influence in the interpretation of research findings. This cultural baggage must be monitored for its influence on all analytical insights. The ethnographer must remain alert to the informant’s organization of cultural knowledge.
There is however no such control exercised in the hermeneutic process. The interpretive paradigm positively values the researcher’s subjective involvement. As researchers we experience and interpret reality through pre-understandings or biases, which are so fundamental to our being they cannot be temporarily suspended or ignored. In interpretive studies the researcher acknowledges their viewpoint and its potential influence in the synthesis of meaning. The fusion of the informant and the researcher’s horizons must then tolerate a degree of ethnocentrism.

Hans-Georg Gadamer: Language and World View

Gadamer discussed in detail the notion of language as the horizon of hermeneutic ontology. He stated that ‘whoever has language has the world’ (Gadamer 1975, p. 453). In his writing on language, Gadamer quotes extensively from the work of Wilhelm von Humboldt (1767-1835), the German statesman and philologist. Humboldt was the first to suggest the relative nature of language by claiming that every language could be regarded as a particular view of the world. He equated language and thought exactly in a hypothesis now known as the Weltanschauung (worldview) hypothesis. Humboldt believed thought to be impossible without language and that language had spontaneously evolved of its own accord. This view entailed recognition of the part played by the subject in understanding the world, presumably both the perception and conceptualization of the world. This included the notion of mental power, a biological endowment that enabled the differentiation of both the sound and structure of whole languages (Gadamer 1975).

Gadamer (1975) claimed that potential deficiencies in linguistic understanding are the very thing that makes hermeneutic understanding possible. He was specific in his claim that it is not the learning of a foreign language but the use of that language in conversation that is important. This use invokes what Gadamer (1975) called the traditionary content of language, the cultural and historical meanings of speech acts. However, knowledge of tradition may not be readily accessible to those who have not
‘lived’ in a particular language. The ability to converse in a foreign language does not automatically acculturate the second language speaker. Acculturation is a life long process that can only be partially achieved through language.

The interchange of language and worldview that occurs in conversation can produce a new standpoint from which to experience and understand the world. From the perspective of social research we are interested in developing a standpoint that is inclusive of the ‘other’s’ worldview. However, the hermeneutic approach does not seem to provide the tools for completely uncovering the truth behind this standpoint because it essentially undervalues the interdependence of language and worldview. Perhaps this has arisen because so much of the hermeneutic tradition is embedded in textual interpretation.

There are considerable differences between the translation and interpretation of text and that of living speech. There is a greater range of interpretive possibilities in living speech, precisely because the information we receive in conversation is not limited to speech: we see, feel, hear, smell and intuit information from multiple sources. This suggests a difference between the ‘other’s’ textual world and their lived world. The ‘other’s’ lived world is far more complex because the interpreter can experience it directly. In this way, the importance of language in perceiving and conceptualizing this complex first hand experience of the ‘other’s’ lived world becomes apparent.

By investigating the structures and categories of the ‘other’s’ language, insight can be gained into the conceptual world in which speakers of that other language live. It is this understanding which can lead to a new standpoint from which to examine the nature of both our own and the ‘other’s’ world.
Gadamer approached the topic of language and worldview with caution. He stated that:

...if every language is a view of the world, it is not so primarily because it is a particular type of language (in the way that linguists view language) but because of what is said or handed down in this language (Gadamer 1975, p. 441).

Gadamer claimed that language is not the primary source of worldview, thereby implicating other agents. These are the things handed down in language, the historical and cultural aspects of a linguistic tradition. Gadamer did not totally discount the role of language in the formation of worldview. To explore this notion further we need to examine what Gadamer meant by the term worldview. Gadamer claimed:

To have a world means to have an orientation toward it. To have an orientation toward the world, however, means to keep oneself so free from what one encounters of the world that one can present it to oneself as it is. This capacity is at once to have a world and to have a language (Gadamer 1975, p. 443).

For Gadamer, both ‘world’ and ‘language’ are transpersonal matters with language made to fit the world. Language is therefore ordered to the world rather than to our subjectivity. This peculiar objectivity of language reveals things as they are in reality and not as they seem in our subjective experience. This places language in a universal linguistic ontology, or more simply a reality based in language that is both universal but also relative to all people.

The variation in worldview encompassed by different linguistic traditions must surely hinder the understanding of traditions relative to a particular language. Understanding cannot be universally realized in the interpreter’s language alone. We are, for the most
part unaware of what our insight cannot illuminate in language because we lack the linguistic skills to enable further insight.

For Gadamer, the fact that human experience of the world is verbal in nature broadens the analytical possibilities of the hermeneutic experience. Gadamer, however, did not believe that the verbal world in which we live to be a barrier to understanding, but rather one that allows knowledge of ‘being-in-itself’. He defined ‘being-in-itself’ as not only what an object is in its substance and essence, but also what it can be as a result of becoming known. This allows infinite manipulation of items in our perceptual field and as Gadamer claimed, ‘embraces everything in which our insight can be enlarged and deepened’ (Gadamer 1975, p. 447).

Gadamer suggested that there is a relative quality to language when he states that those brought up in a particular linguistic and cultural tradition viewed the world in a different way from those who belong to other traditions. He also believed that the historical ‘worlds’ that succeed one another through the course of time to be different. He implied that information is transmitted culturally and linguistically through history. Gadamer states:

...it was always a human, i.e.; verbally constituted-world that presents itself to us. As verbally constituted, every such world is of itself always open to every possible insight and hence every expansion of its own world picture, and accordingly available to others (Gadamer 1975, p. 447).

However, I believe that our linguistically constituted worldviews pose significant barriers to the achievement of understanding. These barriers arise because the very notion of ‘being-in-itself’ ascribed to the objects of our world is different not only for each linguistic community but every individual as well. That the human experience of the world is verbal does not imply that a ‘world-in-itself’ is being objectified. As we have seen, what ‘exists-in-itself’ is independent of one’s own willing and imagining.
In becoming known, an object is placed at one's disposal in the sense that one can reckon with it and use it for one's own purposes (Gadamer 1975).

This implies a certain degree of subjective variation in the comprehension of objects that make up the world. This is a significant barrier to understanding and only with attention to linguistic detail can these barriers be breached. The extent that this feature pervades language and the worldviews they constitute is a matter for comparative linguistics and beyond the scope of this research project. However, the feature is significant enough to warrant attention, above and beyond that of mere translation.

Because every person belongs to a language, a common horizon of understanding becomes possible. We gain access to the world to which we belong through language. This participation in language as a medium of our experience of the world is the basis of the hermeneutic experience. The method appropriate to achieve the hermeneutic is one that places the interpreter in an attitude of receptivity, open to the experience of an event or phenomenon.

But do different languages entail different experience and how might this difference impact upon achieving a common horizon of understanding? Whilst many features of language are universal, in many instances meanings are relative to a particular language. The notion of relativity is therefore important in cross-linguistic and cross-cultural qualitative research.

Relativism

Within the human sciences, the interpretivist paradigm recognizes that all people see the world in a different way and that meaning is context dependent. Interpretivism is more concerned with subjective meanings than objective facts. Interpretivism entails a subjective, relativist view of the world (Peile & McCoat 1997). Inherent in the relativist stance is the denial of certain kinds of universal truths, an assumption that the
world has no intrinsic characteristics. There are many possible interpretations of the world because there are no absolute truths.

The Greek sophist Protagoras, was one of the first to propose the idea of relativism by claiming there was great individual variation in perceptual knowledge (Honderich 1995). It is impossible to understand or communicate without employing either a language or some conceptual scheme. The relativist position is that the conception of knowledge and its conveyance as truth in language is dependent upon the scheme in which it is set.

Foley defines the relativist perspective as:

...knowledge that is obtained through culturally mediated conceptual schemes, i.e. historically situated, contingent frameworks of meaning and understanding. These are made up of folk and scientific theories, linguistic and cultural categories and social practices we acquire as a result of the trajectory of our life experience situated in a particular culture, language, space and time. These schemes may be relative to that life trajectory and not shared with others of a different history (Foley 1997, p. 169).

I will now examine how experience placed within the context of culture and language can lead to variation in conceptual schemes.

**Linguistic Relativity**

The German philosopher, Johann Herder (1744-1803) was the first to consider the variation between languages. He believed cultures belonging to different times and places could not be evaluated by universal standards. Herder claimed that language not only provided naming devices but also entailed a whole way of seeing the world.
Herder believed that the content of thought and the language that expressed thought could not be separated (Mautner 1997).

Wilhelm von Humboldt further explored the link between language and thinking. In a treatise entitled *Linguistic Variability and Intellectual Development*, Humboldt proposed that language encompassed *Weltanschauung* or worldview. His ideas anticipated the formulation of linguistic relativity when he claimed:

Each tongue draws a circle about the people to whom it belongs, and it is possible to leave this circle only by simultaneously entering that of another people. Learning a foreign language ought hence to be the conquest of a new standpoint in the previously prevailing cosmic attitude of the individual. In fact...every language contains the entire fabric of concepts and the conceptual approach of a portion of humanity. But this achievement is not complete, because one always carries over into a foreign tongue to greater or lesser degree one's own cosmic viewpoint, indeed one's own personal linguistic pattern (Humboldt quoted in Duranti 1997, p. 62).

This suggests that language is a powerful instrument that discloses the world by providing categories of thought. But these very same linguistic-based thought categories constrain the possibilities of knowing because they invariably encompass different viewpoints.

Linguistic relativity emerged from the German intellectual tradition of the eighteenth and nineteenth century. Immanuel Kant (1724-1804) whose philosophical writings overshadowed much of German intellectual endeavour of the eighteenth and nineteenth centuries, claimed that knowledge of an independent world was obtained by employing mental categories. Kant believed that knowledge of the world was never direct and because it was mediated by these mental categories our knowledge was limited to appearances (Mautner 1997).
Philosophers such as Hermann Cohen (1842-1918) and Ernst Cassirer (1874-1945) refined Kant's ideas. Reality was assumed to be both pre-given and unorganized and could only be made coherent by the application of mental categories to experience. These mental categories emerge from differences in culture and language. They are thus relative to the language and culture and cause contrasting experience for people from different linguistic and cultural backgrounds. Whilst experience is universal to human existence, it is very much inscribed in the linguistic and cultural categories of the community in which it occurs (Foley 1997).

Franz Boas (1858-1942), the noted anthropologist influenced by the writings of Herder and Humboldt, introduced relativism to the study of culture. Boas believed that the differences seen across cultures were the result of historical, social and geographic conditions and that all populations had complete and equally developed cultures. Boas believed these unique conditions denied the possibility of universal laws governing all cultures (Foley 1997). Edward Sapir (1884-1939), a student of Boas further developed this idea of cultural relativity by studying many of the Native American languages. Sapir was trained in anthropology and linguistics and his comprehensive theoretical view of language stressed the psychological foundations of linguistic knowledge. Sapir believed that language could be studied to reveal the unconscious categorization inherent in the worldview of every speaker's language.

Writing in 1929 Sapir claimed that:

Human beings do not live in the objective world alone, nor alone in the world of social activity as ordinarily understood, but are very much at the mercy of the particular language that has become the medium of expression for their society...the 'real world' is to a large extent unconsciously built upon the language habits of the group. No two languages are sufficiently similar to be considered as representing the same social reality. The worlds in which different societies live are distinct worlds, not merely the same world with
different labels attached. We see and hear and otherwise experience very largely as we do because the language habits of our community predispose certain choices of interpretation (Sapir 1949, p. 69).

These ideas were taken up and further developed by Sapir’s student Benjamin Whorf (1897-1941). Whorf followed Boas in claiming that linguistic categories were essentially classificatory in nature and that thought (the cognitive understanding of the world) was linguistically mediated. These concepts were set out in the following statement in which Whorf stated that:

We dissect nature along lines laid down by our native languages...we cut up nature, organize it into concepts and ascribe significance as we do, largely because we are party to an agreement to organize in this way, an agreement that holds throughout our speech community and is codified in the patterns of our language (Whorf 1956, p. 213-14)

Whorf made a very explicit formulation of linguistic relativity in which he claimed that people who speak different languages perceive and think about the world quite differently. Whorf believed that:

...users of markedly different grammars are pointed by the grammars toward different types of observations and different evaluations of externally similar acts of observation and hence are not equivalent as observers but must arrive at somewhat different views of the world (Whorf quoted in Foley 1997, p. 201-2).

Whorf implied that as individuals, our perceptual abilities are basically the same but our perceptual choices and how we process these perceptions are different. How we make meaning from these perceptions differs as a function of the particular language in which conceptualization takes place. Whorf believed that it was not thought that varied in language but the conceptual processing. Linguistic relativity is therefore concerned
with the conceptual and experiential ramifications of a person’s linguistic resources (Lee 1991).

Boas, Sapir and Whorf all died within five years of each other. The Second World War effectively terminated the further development of the Boasian tradition within anthropology and linguistics. In the two decades following the Second World War linguistic relativity was reformulated as a hypothesis. Unfortunately the research surrounding the testing of this hypothesis was both disappointing and inconclusive. However, over the last two decades linguistic relativity has been re-examined. Michael Silverstein (1948-) reformulated linguistic relativity within the context of the Boasian tradition of anthropological linguistics. Silverstein’s analysis takes a hermeneutic approach by viewing linguistic relativity as a guiding framework in which the interaction between linguistic form and wider cultural practices could be investigated (Foley 1997). Silverstein argued that language analysis is restricted because of the tendency to reduce all meaning to reference. Silverstein claimed that attending to the contextual properties of grammatical categories gave a more rounded reflection on language (Foley 1997).

This suggests a shift in which the linguistic influence on cognition is seen as relating not only to the formal systematic structures of language but to the cultural conventions and individual styles of use within a language. The relationship between language and thought is considered reciprocal; the kind of language we use is also influenced by the way that we see the world. The language used by members of a particular social group represents a very subtle and selective view of the world. This view of the world in turn supports certain kinds of observations and interpretations while restricting others. Hence meaning resides not in the words alone, but the social and cultural contexts of their use and interpretation.
Implications for Research

By attributing to language a universal disclosing power, Gadamer denied that communication across linguistic divides is problematic. Both parties in any conversation bring their language and worldviews to conversation. Gadamer stated that in linguistic communication, the world is disclosed. He further stated that 'reaching understanding in language places the subject matter before those communicating' and that understanding is the result of a negotiation of some pre-agreed meaning (Gadamer 1975, p. 446). This negotiation of meaning excludes everything that has not been agreed upon. What is not agreed upon is that which is different. This difference is generated by the interplay of language and conceptualization.

Whorf believed that a multi-language investigation of cognition could illuminate the nature of reality of different language speakers. This could be achieved by bringing together the range of meanings abstracted conceptually from perceptions across language groups. Whorf stressed the importance of attending to the way meaning is calibrated between people and the processes of logic in language. Whorf stated:

We handle even our plain English with much greater effect if we direct it from the vantage point of a multilingual awareness...and to restrict thinking to patterns of mere English is to lose a power of thought, which once lost can never be regained (Whorf 1956, p. 224).

The importance of negotiating the agreement of meaning is essential to successful communication. Whorf (1956) believed this negotiation could only be achieved with conscious attention to the linguistic processes that organize our experiential interface with the rest of the world. In this manner communicable meanings could be generated. Interestingly, Whorf stressed that it was not essential to be able to speak another language for this to occur, it was sufficient to be aware of the principles people use in
making meaning and to be able to reflect on these principles. This process of reflexive interpretation is the mechanism of calibration that Whorf claimed could increase understanding between languages (Whorf 1956).

It is this attention to the structure and meaning inherent in each language that encapsulates the importance of linguistic relativity, not only as a philosophical contribution to the science of linguistics, but also relevant to the way in which research is conducted across cultural and linguistic divides. Linguistic relativity provides an alternative conceptual stance from which to examine thinking over and above its manifestation by speakers of a particular language.

I see many points of agreement between Gadamerian hermeneutics and linguistic relativity. I believe that both approaches are not only compatible but also complementary. Multilingual awareness has the capacity to increase cross-cultural understanding by engendering respect for the ‘other’s’ logic and worldview.

Multilingual awareness has other methodological considerations. Ethnographers speak about reducing semantic accent. Semantic accent is described as the use of the informant’s language to which meanings are applied from the researcher’s culture (Spradley 1979). Semantic accent can be avoided by concentrating on the meanings of terms in the informant’s language (Spradley 1979). Detailed exploration of the informant’s meanings, through multistage translation techniques can control semantic accent.

The following is an example of how the investigation of language can be applied to the analysis of qualitative data.

The photograph below depicts a child at play. Non-Aboriginal people, when asked to describe the photograph might reply: ‘A boy is standing’ or ‘A child standing’. There is greater flexibility in Warlpiri responses, which might include ‘Kurdu ka walyangka
*karrimi* (child is ground on standing), ‘Walyangka ka kurdu karrimi’ (ground on is child standing) or ‘Karrimi ka kurdu walyangka’ (standing is child ground on).

Figure 2.1 Warlpiri Boy at Play (photograph from author’s collection)

This would seem a similar interpretation of both content and meaning. Or is it? By juxtaposing the subjects of the English and Warlpiri versions, we can learn something about how different languages categorize the world into elements. Warlpiri speakers invariably fail to name the sex of the child, despite this being readily observable. The term *kurdu* is applied to all children, from infants to adolescents. Names exist to indicate specific ages in children of either sex, however these seem to be used in specific social circumstances and not everyday use. If we examine the structure of
both sentences, other subtle differences are revealed. These differences point to a conceptual variation between the two language systems. The English sentence consists of a subject, ‘the boy’, and the predicate, what is said about the subject, in this case ‘standing on the ground’. The English sentence suggests objects separated in space with little emphasis placed on how these objects relate to one another. Perhaps this is because in the English sentence one of the objects, ‘the boy’ has developed a focus as the subject of the sentence.

In the Warlpiri sentence, the subject is less definite because ‘child’ and ‘ground’ are not prefixed with ‘the’, for which there is no Warlpiri equivalent. The locative case ngka, meaning ‘on’ or ‘at’, indicates the spatial relationship between the ground and the act of standing (Laughren et al. 1996). The ‘ground-on-ness’ implicit in the term walyangka says something about both the child and the act of standing. The Warlpiri version can be seen as reflecting a holistic view of the world in which objects are both named and related. It is this relatedness, the very threads by which objects are connected to one another and the world at large that assumes a prominence in Warlpiri language and worldview.

Conclusion

In this research, analysis and interpretation will focus on the cultural and linguistic categories. This mode of investigation will be conducted essentially on two distinct levels. Firstly, I will examine all Warlpiri language concepts that emerge from the interviews. This examination will uncover both the meaning and the social implications of these concepts. Secondly, as these interviews were conducted in English, I will examine the linguistic and conceptual issues inherent in the Aboriginal use of English.

The ideas posed by linguistic relativity support and strengthen hermeneutic analysis. By attending to the detail of linguistic structure and terminology we can extend the
limits of our inquiries and thereby produce a deeper understanding from our interpretive endeavour.
Chapter 3

Men, Health and Behavior
Chapter 3

Men, Health and Behaviour

For behaviour, men learn it, as they take diseases one of another.

Francis Bacon
-Advancement of Learning-

Introduction

Men’s health, as an area of clinical interest and academic inquiry, is a recent phenomenon, one that corresponds with an evolving public and policy discourse about men, gender and health. The concept of men’s health will by its very nature mean different things to different people. It is dependent upon the context of men’s lives and the many variables that contribute to men’s experience of both health and illness.

Those people who provide health services to men also help to define men’s health. A diverse range of clinical services targeted specifically at men, from specialist clinics for erectile dysfunction to health screening in general practice, are likely to come under the banner of men’s health. Similarly, the range of debate and inquiry in men’s issues from the popular press to academic and biomedical journals is now considerable and wide ranging.

The tendency to limit men’s health to mere disease associations is to restrict the view of the concept. Men’s health encompasses not only issues of health and illness but also those things that impact on well-being. Men’s health essentially concerns two interacting elements. Central to the notion of health is the body and how it functions in both a physical and psychological sense. Also relevant is the environment in which the body exists. Environmental influences on the body are likely to be broad. As such, the
literature on men's health is vast, confusing and at times contradictory. In this chapter I will confine my examination to three interrelated concepts: gender, health and behaviour. In doing so, I hope to explain gendered differentials in both health and behaviour.

*Gender and Health*

Gender assumes a central position in social life. Gender is a 'multidimensional category of personhood encompassing a distinct pattern of social and cultural difference' (Roscoe 1994 p. 341). These categories of gender 'draw on perceptions of anatomical and physiological difference between bodies' but these perceptions are 'always mediated by cultural meanings' (Roscoe 1994 p. 341). Gender manifests across nearly all human endeavour and organization. The outcome is inevitably one of difference. Reflected in this difference are practices that are said to disadvantage men in some aspects of their health. This disadvantage is most commonly represented as increased exposure to risk. The enactment of gender across a wide range of situations produces elements of risk that are complex, insidious and which operate on many levels (Sharpe & Paul-Heppner 1991). The predominance of men in heavy industry is often associated with a greater risk of occupational injury. If we examine the normative expressions of gender that are associated, perhaps stereotypically, with men who work in heavy industry, other more subtle risks emerge. These may be related to a whole range of behaviours and attitudes such as diet, exercise and alcohol consumption, all having some potential impact on health.

Male and female differentials in morbidity and mortality are thought to result in part from the effects of biology but overwhelmingly as a consequence of gender roles (Harrison 1978). Much has been written about the influence of male gender role on health and illness related behaviours. Brannon identified four traits that he believed central to notions of masculinity (Brannon 1976). Included in these was the need to be seen as different to women, to be superior to others as well as self reliant and
independent (Brannon 1976). Forrester claims that the defining characteristics of masculine behaviour included an orientation towards achievement, assertiveness, autonomy, dominance, endurance and strength. The enactment of these behaviours excludes or diminishes health maintenance behaviour, which is viewed as inappropriate to masculine identity (Forrester 1986).

Social trends undoubtedly impact on gender roles. However, it may be the case that broad social and cultural change has made some aspects of masculine gender role redundant. There can be little doubt that gender roles change and evolve through time, but given the rapid nature of social change in the past century there is now considerable disparity between the stereotype and reality. The stereotype of the male as breadwinner is no longer appropriate in a time of labor market trends characterized by unemployment and increased female participation in the workforce. Problems arise when gender norms remain socially and culturally embedded but their enactment is either redundant or simply not possible. This sets up a degree of tension between gender role and reality. This is the basic argument behind the theory of gender role strain, upon which much of the male health disadvantage literature is predicated (Courtenay 2000; Good et al. 1989; Moynihan 1998; Sharpe & Paul-Heppner 1991).

The term health behaviour needs some qualification. This term is used often in its broadest sense to encompass both health and illness. These are mutually exclusive by definition. Unfortunately this distinction is not often made in the literature. The health promotion literature distinguishes between preventive and promoting behaviours. The wearing of sunscreen might be seen as preventive behaviour. A health promoting behaviour is any of those actions such as exercise, or dietary or alcohol moderation (Hawe et al. 1995). Illness behaviour concerns specifically behavioural and psychological reactions to illness. In many instances the term health is inclusive of illness. This research is concerned primarily with behaviours and attitudes surrounding illness. As such my working definition of illness related behaviour specifically refers to those curative endeavours in times of illness.
The current debate on gender differentials in health has highlighted the apparent disadvantages faced by men. For every age group, illness, injury and death are greater for men. In terms of health, males are disadvantaged from birth until death, the so-called cradle-to-the-grave disadvantage. Let us now examine the nature of this disadvantage in relation to Australian men.

**Men’s Health in Australia: an Overview**

By far the greatest source of information on men’s health lies in sex difference research. Much of the research on men’s health examines the differentials between men and women’s health. The prevalence of disease and death are compared and contrasted to illustrate the increased morbidity and mortality faced by men.

The sex ratio at birth in Australia is 106 males to 100 females, however this numerical advantage is negated by higher perinatal mortality and congenital defect in males (House of Representatives Standing Committee on Family and Community Affairs 1997). The life expectancy for Australian men is 75.4 years, some six years less than that of women. Australian men die from nearly all non-gender specific causes at higher rates than women (Mathers 1995).

Body mass index, a ratio of weight and height is used to determine overweight and obese classifications. Comparing the results of the 2001 National Health Survey with previous surveys, the proportions of adults classified as overweight or obese has increased considerably. For males, those classified as overweight or obese has risen gradually from 46% in 1990 to 52% in 1995 and finally 58% in 2001. A slightly larger increase was recorded for females. Increases in overweight and obese classifications were recorded across all age groups for both males and females (Australian Bureau of Statistics 2002).
Australian men have greater mortality from cardiovascular disease. The mortality from ischaemic heart disease for Australian men has been estimated at twice that for females (Mathers 1995).

The picture for neoplastic disease shows a similar pattern. In the 2001 National Health Survey, 1.6% of the population was listed as having a neoplasm, the majority of which were malignant. More males than females reported malignant neoplasm for most types of cancers excluding those that were sex specific (Australian Bureau of Statistics 2002). Neoplastic disease is most prevalent in the elderly, with 3% of females and 8% of males 65 years and older reporting cancer (Australian Bureau of Statistics 2002).

The issue of youth suicide and accidental death has attracted considerable public attention in the past decade. If we examine the sex differentials for all age groups, the death rate for males from suicide and accidents greatly exceeds that of females. In 1996 the rate of male suicide was estimated as being 4.4 times greater than that of females. While more women than men attempted suicide, more men were successful (Mathers 1995). The problems of adolescence are well known, but males and females experience these problems very differently. Boys are encouraged to participate in the ‘rough and tumble’ of the adult male world. They are expected to cope with the adjustments to adulthood without admitting to the problems they might encounter. These patterns of behaviour may become entrenched in later life.

Violence in our society is strongly linked to male behaviours and attitudes. Males perpetuate 91% of homicides, 90% of assaults and nearly all sexual assaults and robberies in Australia (Egger 1995). Huggins suggests that male violence may be a marker for other negative issues such as depression, substance abuse and suicide and possibly reflects the authoritative and combative aspect of male gender role (Huggins 1996).
Males engage in more risk behaviours than females in both work and recreational pursuits. Men are expected to be daring, constantly pushing the limits in most activities, especially those that are physically challenging. In 1996, the death rate from injury in young Australian males was four times that of young women. The hospitalization rate from injury in young males was three time that of young women (National Health and Medical Research Council: Injury Prevention Programs Working Party 1996).

Risk-taking is directly linked to the gaining of life experience. Peake argues that adolescent binge drinking may be an important and necessary vehicle for adolescent growth (Peake 1994). And yet recently published data on alcohol-related road injuries revealed that between 1990-1997, over 70% of serious alcohol-related road injuries were male and that over 50% of these occurred in the 15-24 year age group (National Drug Research Institute 2003). For young Australian men, the mix of alcohol and driving appears a dangerous aspect of adolescent growth, particularly when both alcohol and the motor vehicle have become so embedded in the realization and expression of dominant modes of masculine identity (Vick 2003; Walker 1999).

Employment can affect health in a number of ways. Generally males, are employed in areas that are physically hazardous. This demographic is changing as women increasingly find employment in heavy industry. Exposure to a wide variety of occupational hazards such as chemicals and noise are likely to have negative impacts on morbidity (Sabo & Gordon 1995). There are multiple psychosocial and economic effects of employment on health. These are determined by job characteristics, family situation and attitudes to employment. There is also the effect of unemployment and retirement upon men's health. Where traditional masculine roles dictate that men lead active, productive lives and provide for their families, unemployment and retirement have significant implications for men's psychological and physical well-being.
Men's Behaviour in Times of Illness

Men’s experience of illness is characterized by two related behaviours. These are reduced illness reporting and delayed help-seeking. These contribute to an overall under-utilization of health services.

Denial of symptoms is frequently reported as a characteristic of male illness behaviour. The phenomenon of denial appears in specific clinical conditions; including substance abuse, particularly alcoholism (Grant 1997), cardiac conditions (Folks et al. 1988) sexual health (Manhart et al. 2000) and psychological health (Wisch et al. 1995). Given the diversity of these conditions and the contexts within which they occur there is likely to be considerable variation in the rationale for denying symptoms.

Delay in seeking treatment is partly associated with under reporting of symptoms. However these are two distinct phenomena. Foregoing or delaying care in illness is associated with prolonged morbidity, increased severity of illness and consequent mortality (Weissman et al. 1991).

The combined effect of under reporting symptoms and delays in seeking help diminish men’s uptake of health services. This is the most common trend reported in men’s health literature (Addis & Mahalik 2003; Buckley & Lower 2002; Hibbard & Pope 1983; Mechanic 1978; Tudiver & Talbot 1999). This trend has been demonstrated to exist across age (Jacomb et al. 1997) and racial and ethnic backgrounds (Thouez et al. 1990). In Australia fewer men attend medical services and those that attend, do so less frequently than women. Recent data indicate that males attend their doctors at a rate of 5.1 visits per annum compared to 6.2 visits per annum for females. Under the age of 15 years more male patients were seen but that this trend was reversed progressively after the age of 15 years (Australian Institute of Health and Welfare 2003).
Explaining Men’s Illness Behaviour

Describing and explaining men’s illness behaviours is complex, prone to oversimplification and generalization. A number of theories attempt to explain gender differences in illness and associated behaviours. As these theories are based on gender role, it may be useful to distinguish between gender identity and gender role. Nanda defines gender identity as:

…the private experience of gender role: the experience of one’s sameness, unity and the persistence of one’s individuality as male, female or androgynous, expressed in self awareness (Nanda, 1994, p. 395-396).

This is contrasted with gender role, which is the outward expression of ‘self’ as either male, female or androgynous. The public presentation of gender role is demonstrated by:

…dress, verbal and non-verbal communication; economic and family roles…the sexual feelings one has and the persons to whom such feeling are directed…the experiencing of one’s body, as it is defined as masculine or feminine in any particular society (Nanda, 1994, p. 395-396).

Gender identity and gender role are distinct and co-existent concepts. While gender identity and gender role are closely aligned, variation between the private experience and the public expression of gender is possible.

This research is conducted around the concept of gender role. In either an Aboriginal or non-Aboriginal context, the behaviour, attitudes and beliefs associated with gender identity manifest in ways that make direct and indirect inquiry possible.
Biology

The anatomical and physiological difference between male and female defines and delineates sex from gender. Biology impacts on behaviour in an indirect manner. Women have a greater exposure to the health care system through the need for both obstetric and gynecological care (Franks et al. 1996).

Role Compatibility Hypothesis

The female gender role is more compatible with the adoption of the sick role than is the male gender role. Female gender norms that include a greater propensity for expression and help-seeking are seen as conducive to sick role behaviour in women. Conversely, male gender norms such as stoicism and self-reliance are likely to inhibit illness recognition and help-seeking behaviour in men (Marcus & Siegel 1982). Women’s prime responsibility for family health increases the salience of health matters, particularly the identification of signs and symptoms of illness (Franks et al. 1996).

Fixed Role Hypothesis

The respective gender roles have fixed role obligations and these have varying degrees of compatibility with the adoption of sick role behaviours. Acknowledgement and action in times of illness requires the temporary deferral of these fixed role obligations. Men face greater occupational and financial responsibilities that make the sick role less accessible (Marcus & Siegel 1982). This hypothesis would be vigorously contested in the current climate with increased female participation in the workforce and the inherent assumption that the role of wife and mother is a less important fixed role obligation than that of ‘breadwinner’.
Partly in response to such criticism, Gove (1984) developed the Nurturant Role Hypothesis to explain gender differentials in illness behaviour. He proposed that the nurturing obligations that characterize female gender role contribute to increased levels of morbidity in women due partly to the incessant demands of this role. This built on previous work of Hibbard and Pope (1983) who demonstrated a causal relationship between female gender role and symptom reporting. This study also supported aspects of the fixed role hypothesis with female symptom reporting decreasing as role responsibilities increased.

**Role Strain Hypothesis**

The role strain hypothesis is based on the assumption that rigid adherence to the male gender role is potentially dysfunctional (Eisler et al. 1988; Harrison 1978). O’Neil defines male gender role strain as a ‘psychological state in which gender roles have negative consequences or impact on the individual or on others’ (O’Neil 1990, p. 25). These negative consequences result from rigid gender roles causing personal restriction and devaluation or violation of others. Male gender role strain contains four essential characteristics; the competition for success and power, limited displays of emotion, diminished intimacy between men and a degree of conflict between family and employment (O’Neil 1981; O’Neil et al. 1995). These characteristics result from socialization patterns that produce unrealistic and contradictory expectations of male behaviour culminating in a desire to avoid anything that might be perceived as feminine in either attitudes or behaviour.

The role strain hypothesis has infused most of the literature on masculinity and health for the past decade. The concept of male gender role strain remains the subject of considerable research interest. Male gender role stresses characteristics of strength, endurance, and silence. Help-seeking is seen as the antithesis of these characteristics. This is particularly evident in the area of psychological health. Good et al. (1989) demonstrated that aspects of male gender role, specifically restricted displays of
emotion, adversely impacted on men’s ability to seek help for psychological problems. Many men believe that complaining of illness or displaying any health concerns are a threat to their masculine identity. There is perhaps greater social acceptability for women to acknowledge and act on symptoms (Hibbard & Pope 1983; Verbrugge 1985). Australian research in the area of male gender role strain has suggested a ‘shift towards the feminine’ with age (Theodore & Llody 2000) implying that acknowledgement of symptoms and help-seeking is less detrimental to gender role in the elderly.

Conclusion

The title of this chapter contains the three interacting elements of interest to this research project. Men, or more specifically male gender role, its impact on ideas about both health and illness, and associated behavioural responses to illness, form the core of this research endeavour.

The above description is a broad sweep across the literature. It gives a general impression of differentials in health status between Australian men and women, patterns that are repeated in other industrialized societies.

Behaviour and health are inextricably linked on many levels. Whilst the links between certain behaviours such as cigarette smoking, excess alcohol consumption and morbidity no doubt exist, it is the behavioural responses to morbidity that characterizes much of the concern and interest in men’s health research.

It is impossible to attempt any research on men’s health without making reference to the concept of masculinity, if only because so much of the literature is predicated upon this very concept. However, the concept is problematic to the point where many writers now refer to the plural, masculinities, pointing to the inordinate variability in the enactment of male identity across cultures.
The disjunction between the images and discourses on masculinity and men and male behaviours denies potential variables such as race, economic status and sexual orientation. It could also be the case that masculinity as a concept does not exist in all societies and that the qualities, identities and means of evaluation of male adult status exist in other forms.

In the following chapter I will examine in detail the concept of masculinity as depicted in the recent literature. Problems become evident when applying the concept of masculinity to Warlpiri society. Some indication of this problem can be seen in the absence of any equivalent linguistic term in Warlpiri society. However, it is only in the explication of the experience of Warlpiri males, particularly the gradations of identity and status that define their existence, that the redundancy of the term masculinity in a Warlpiri context becomes evident.
Chapter 4

Masculinity
Chapter 4

Masculinity

*It may well be the best-kept secret of the literature on masculinity that we have an extremely ill defined idea of what we are talking about.*

*Clatterbaugh*

*-Men and Masculinities-

**Introduction**

The literature on non-Aboriginal men’s health identifies masculinity as a key determinant of men’s attitudes and behaviours towards health and illness (Forrester 1986; Franks et al. 1996; Hibbard & Pope 1983).

Masculinity is an amorphous concept and hence difficult to define. I suggest that masculinity is many things to many people and that it might only be possible to discuss it in relative terms. In the Warlpiri worldview the term masculinity is meaningless. The Warlpiri have a markedly different schema for conferring and evaluating adult male status.

In this chapter, I will attempt to explore what it means to be an adult male in two different societies. I hope to explain why, for the purposes of this research, masculinity is a highly inappropriate concept and as such is not employed in the process of this research. Instead, I will use culturally sympathetic parameters to explore and define adult male status in Warlpiri society. As these matters are culturally sensitive, I will only describe them in the broadest sense.
Sex and Gender

It is important to distinguish between sex and gender as these terms are often used to imply the same meaning. Sex refers to the biological state of being male or female as indicated by anatomical and physiological features. Gender is the behavioural and attitudinal expression of sex as dictated by social and cultural norms (DeLorey 2003; Pryzgoda & Chrisler 2000). The distinction here is between bodies (sex) and gender (person), one emerging from biology, the other from society.

The terms sex and gender are however problematic. Sex as a biological category would seem fairly unambiguous. However the category of intersex, where male or female classification cannot be made, throws into doubt the notion of binary sex categories (Fausto-Sterling 2000). The problem with gender lies not so much in definition but rather in the matter of genesis, specifically separating the effects of biology from environment in the formation of gender identities.

The origin of sex-based differences in behaviour has been the subject of considerable scientific inquiry and debate. A gendered existence means to think, feel and act in a specific manner. Whether this is innate or learned has given rise to two distinct paradigms, one embedded in biological determinism, the other in social construction.

The biological theory proposes that respective gender characteristics are innate in each person, a product of their genes and hormones (Buchbinder 1994). Of these hormones, perhaps none has received as much attention as testosterone in the quest for linking behaviour and biology. Testosterone has been studied in relation to aggression, competitiveness and dominant behaviour in men (Pease 2002). While this remains a contentious issue, it has been demonstrated that testosterone can both affect and respond to behaviour (Mazur & Booth 1998). This suggests that the effect of testosterone on the brain occurs in the presence of environmental influences.
The matter of biology is essential in the development of gender identity. Genitals represent the first and most significant sign of impending gender assignment. Anatomical features not only determine the sex of a child, they also determine how people behave towards that child. The sex assignment that occurs at birth is in effect the beginning of gender development. In this manner gender identity is formed, a combination of biology and later exhortations regarding the behaviour considered appropriate to that biology (Harris 1995). The expectations regarding gender are culture specific and they are markers of affective, cognitive and behavioural conduct.

The idea of gender role had its origins in the work of Parsons and Bales (1956) who researched socialization processes within the family. Parsons and Bales (1956) proposed the idea of instrumental and expressive behaviours as primary social functions. Instrumental behaviours were those most associated with males and included competition and rational action. Expressive behaviours aligned with females and included nurturing and creative activities. While Parsons and Bales (1956) believed instrumental and expressive behaviours to be complimentary, they were gender specific and socially prescribed. According to Parsons and Bales (1956) after an initial maternal alignment boys were at some stage required to:

...proceed farther and more radically on the path away from expressive primacy toward instrumental primacy (Parsons & Bales 1956, p. 99).

Parsons and Bales (1956) believed this shift in alignment was achieved through social learning. In effect, behaviour was shaped by rewards and punishments, through exposure to specific 'models' and the imitation of these models by the child. This gender socialization was not exclusive to the family but was perpetuated by other social agencies.

The debate over the respective roles of biology and environment in determining human behaviour has a long history. Many scientists are now suggesting that the separation of
nature and nurture is a false dichotomy (Lorenzen 2001; Rutter 1997). The human genome is revealing the complex ways in which genes both respond to and determine human actions (Ridley 2003). Richard Mulcaster wrote some four centuries ago that ‘nature makes the boy toward, nurture sees him forward’ (Harris 1998, p. 4). This statement has much to offer the current debate. Gender differences should perhaps be understood as emerging from complex and variable interactions of both biology and environment.

Gender theory suggests that behaviour is based on performance, one that is socially prescribed. As such, masculinity and femininity become an act rather than an essence, one in which the role is well set out for the players. It has been suggested that male gender role requires men to be non communicative, competitive, inexpressive and to evaluate life success in terms of external achievements rather than personal and interpersonal fulfillment (Harrison 1978). The application of these stereotypical behaviours and attitudes has drawn considerable criticism.

The theory of gender roles suggests an unchanging model of gender, one imbued with a power imbalance in favour of males and one that does not account for individual variation or deviation from norms (Connell 2000; Pease 2002). This form of biological determinism is criticized by Connell who considers masculinity aligned to male bodies but not determined by male biology (Connell 2000). He suggests that masculine qualities are not exclusively assigned to the male sex and that femininity and masculinity are co-existent features in gender identity (Connell 2000).

The issue of sex and gender becomes further complicated when we examine the Warlpiri language for equivalent terms. The Warlpiri word karnta (woman, wife female) and wirriya (boy, male) are polysemous terms in that they have multiple meanings and applications. The use of these terms to denote biological sex is only applied to animals. For people, the Warlpiri replace biological categories with gendered terms. The shift from biological to gendered conceptions is a reflection of
how objects in the natural world are classified by Warlpiri. The biological state of being either female or male is one of the apparent ‘truths’ we attribute to many living things. That Warlpiri do not conceptualize biological sex in this manner is not to suggest that it does not exist as an entity, but rather that it is conceptualized in an alternate manner. This brings us back to the conjunction of language and worldview. The Warlpiri use of gendered terms such as wati (man) connotes both sex and gender as does its English language equivalent. The term wati implies both male sex and the socio-cultural markers required for the status of an adult male in Warlpiri society.

The primacy of gendered terminology in the Warlpiri language demonstrates the idea behind linguistic relativity. Differing ways of viewing the world and classifying objects are revealed through language. In the Warlpiri language, the concept of sex is implied in gendered terminology as it is in English. Sex is also implied by the ‘skin names’ that form the basis of Warlpiri kinship. These names are divided into two groups, one male and the other female. These terms are only used in reference to people and while they primarily denote social identity they also imply sex classification. So what does this mean? Simply that sex and gender are recognized in Warlpiri worldview but that the words used to indicate these classifications are less definitive and carry alternate associations.

**Defining Masculinity**

There are real difficulties in defining masculinity. These problems of definition stem from the complex nature of masculinity that is at once multi-faceted, ambiguous and culturally variant. While the Australian Oxford Dictionary (1998) defines masculinity not surprisingly as ‘the state or fact of being masculine’, some indication of the essence of masculinity is suggested by ‘the characteristics or qualities of men’. It is these qualities and characteristics that pose the challenge of pinpointing a definition for this concept. The following statement suggests the nature of this challenge:
...a man is much more than just flesh and blood, he is an object full of social significance and meaning' (Edley & Wetherell 1995, p.37).

There is an argument that consideration of masculinity as a single entity is no longer a valid endeavour. The term masculinity suggests men are one homogenous group and as such characteristics and experiences related to race, class, sexuality, age and religion become diminished. The diversity of men’s lives is in effect subsumed by the dominant and common denominator of gender. A number of writers now refer to masculinity in the plural (Beynon 2002; Connell 1987; Courtenay 2000; Pease 1999). By considering masculinity in the plural we are more inclusive of the diversity of men’s existence.

Connell (1995) believes that masculinity is essentially the application of gender to specific cultural contexts. His definition of masculinity indicates the importance of gender to the concept:

Masculinity, to the extent that the term can be briefly defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender and the effects of these practices in bodily experience, personality and culture (Connell 1995, p. 71).

Connell (1995) hints at the problematic nature of attempting a definition of masculinity. This suggests that the concept is ambiguous in meaning and prone to change. It may be that there can never be a single definition of masculinity given the plural, changing and historically informed elements likely to contribute to any definition (Whitehead & Barrett 2001).
Male Gender Identity in Warlpiri Society

Mervyn Meggitt’s ethnography of Warlpiri society includes detailed accounts of male initiation rituals. The fieldwork on which these accounts are based was conducted between 1953 and 1960. The process of attaining adult male status was a life long journey for Warlpiri men. Meggitt (1924-2004) lists the various life stages and associated events that Warlpiri males passed through in the achievement of adult male status. The following list remains as originally recorded by Meggitt, however I have substituted contemporary spelling of the Warlpiri terms. I have also added synonyms for those Warlpiri terms listed. The classifications are unchanged. The ages listed for each event are approximations.

Table 4.1 Life Stages and Associated Events for Males in Warlpiri Society
(Hale 1995; Meggitt 1962; Swartz 1998)

<table>
<thead>
<tr>
<th>Approximate Age</th>
<th>Warlpiri Term</th>
<th>Life Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 years</td>
<td><em>Wita</em></td>
<td>Infancy</td>
</tr>
<tr>
<td>3-12 years</td>
<td><em>Murruku, Wirriya, Pupu</em></td>
<td>Boyhood (pre-puberty)</td>
</tr>
<tr>
<td>12-14 years</td>
<td><em>Purunyungu</em></td>
<td>Seclusion prior to circumcision</td>
</tr>
<tr>
<td>12-14 years</td>
<td><em>Marlulu</em></td>
<td>On tour prior to circumcision</td>
</tr>
<tr>
<td>12-14 years</td>
<td><em>Jakuru, Pupu-wangu</em></td>
<td>Circumcised</td>
</tr>
<tr>
<td>14-16 years</td>
<td><em>Marliyarr</em></td>
<td>Advanced initiate</td>
</tr>
<tr>
<td>16-18 years</td>
<td><em>Para-parnta</em></td>
<td>Sub-incised</td>
</tr>
<tr>
<td>18-25 years</td>
<td><em>Yampirriwarnu</em></td>
<td>Bachelor</td>
</tr>
<tr>
<td>25 years and onwards</td>
<td><em>Yupukarra</em></td>
<td>Married</td>
</tr>
<tr>
<td>40 years and onwards</td>
<td><em>Ngarrka</em></td>
<td>Mature man, fully initiated</td>
</tr>
<tr>
<td>60 years and onwards</td>
<td><em>Purlka</em></td>
<td>Old man</td>
</tr>
</tbody>
</table>

According to Meggitt, the initiatory process did not end until middle age when a man was considered to be fully cognizant of all Warlpiri ritual (Meggitt 1962). However, as
the following definition indicates, Warlpiri male gender role involved more than ritual knowledge. Meggitt gives the following definition of penultimate male status:

The term ngarga (ngarrka) connotes a complete social man, one who may join in all Warlpiri rituals, is married, has children and can fulfill all the obligations and exercise all the skills needed of a good citizen (Meggitt 1966, p. 106).

Despite this holistic definition, ritual remained undeniably a central tenet of male gender identity in Warlpiri society. Ritual involvement began with circumcision and continued throughout a man’s life. Myers makes the point for the Pintubi, southern neighbours of the Warlpiri that ‘ritual is the activity more than any other that defines men as men’ (Myers 1986, p. 225).

The basis of all ritual, including that of male initiation, is to be found in the stories of ancestral beings. These jukurrpa or dreamtime stories detail how these rituals were introduced to the Warlpiri, but give no indication why they were practiced (Meggitt 1966).

Despite the long path to ritual knowledge and the achievement of ngarrka status, circumcision was by far the defining event in the transition from boy to man. The literature on initiation practices points to two distinct integrative functions, one psychological, the other, social. Gutwirth argues that initiation is a reaction to the existence of two sexes and that circumcision marks the sexual differentiation in socialization (Gutwirth 1969).

Van Gennep describes the significance of circumcision as such:

...cutting off the foreskin is exactly equivalent to pulling out a tooth (or any other mutilation). The mutilated individual is removed from the common mass of humanity by a rite of separation that automatically incorporates him into a

56
defined group; since the operation leaves ineradicable traces, the incorporation is permanent (Van Gennep 1960, p.71-72).

According to Meggitt, the Warlpiri equate circumcision with the death of the boy. The *jukurrpa* story detailing the introduction of circumcision into Warlpiri society describes the death of the ancestral initiate from his injuries (Meggitt 1966). Whilst circumcision continues to signify the death of the boy, it also heralds his re-birth as a man. My observations of this ritual lead me to the conclusion that the circumcision ceremony concerns both death and resurrection. The ‘death’ of the boy is indicated by his separation from the family and is accompanied by the wailing of female kin. However circumcision is equally about the boy’s rebirth as a young man, something that can only be accomplished by men. The significance of blood in these ceremonies is possibly linked to this re-birthing process (Hansen 1953). While women give birth to and nurture boys, it is only through the intervention of men that boys are transformed into men. Berndt suggests that removal of the foreskin symbolizes the final severing of the novice’s connection to his mother and withdrawal from his former association with women (Berndt & Berndt 1988).

Male gender identity in Warlpiri society is explicitly linked with ritual. Circumcision is the ultimate mark of adult male status. There appears to be far less emphasis on enactment for the validation of status. Masculinity is not a concept employed in Warlpiri society to either confer or evaluate identity in adult males. In its place stands ritual, the performance of ceremony instrumental in the construction of Warlpiri male gender identity. As such, masculinity is a concept of limited value in this research, but one that is almost impossible to avoid when making comparisons between Aboriginal and non-Aboriginal society.
Abandoning Masculinity

Applying masculinity to the context of Warlpiri life became problematic. Inquiries framed in complex and culturally sensitive concepts such as manhood and masculinity posed methodological challenges. This approach to the research question drew considerable criticism for being irrelevant, for potentially portraying Warlpiri men negatively and being far too sensitive for a non-Aboriginal researcher to investigate.

The problem of investigating Warlpiri masculinity was resolved in an unexpected manner. I was invited to join a hunting expedition with a family group at Nyirrpi. The purpose of the trip was to collect yarla (bush potato), a prized food that was in season at the time. Digging for yarla, being essentially a gathering activity (although one which entailed considerable effort) I had assumed was woman’s work. The gendered division of labour in hunter-gatherer society indicated well-demarcated lines of responsibility in terms of men and women’s work. I was therefore quite surprised to observe the men digging alongside their wives. I asked about this and was told that anybody could dig for yarla. This pragmatic approach was about the imperative to obtain food and although some food and gender restrictions applied, the emphasis was one of co-operation rather than strict division.

This incident caused me to question my ideas about what constituted men’s business and women’s business. The two spheres were obviously complementary, in effect a binary system of mutual effort that had previously ensured survival in a harsh environment. I realized that on many occasions I had heard various things described or categorized as either men’s business or woman’s business. This categorization effectively encapsulates gender differentiation in Warlpiri society.

For the purpose of this research, inquiry will be framed with reference to the ceremonial and secular aspects of men’s lives. The interaction of men and their
community within the constraints of culture assume greater importance, while the stereotypes associated with enactment and validation become less significant.

**Contemporary Practices**

Ritual remains an important facet in Warlpiri male lives. It continues to mark the transformation from boyhood to manhood and remains almost universally applied. Perhaps indicative of the changes that have beset these ceremonies are the terminologies in use today. The terms for seclusion and 'on tour' are no longer in use. Seclusion is now only practiced immediately prior to and following circumcision. Initiates rarely visit ceremonial sites beyond the immediate vicinity of their communities.

The male initiation ceremonies as described by Meggitt and Hansen bear little resemblance to those performed today (Hansen 1953; Meggitt 1962). While there has no doubt been great change in the manner in which these ceremonies are conducted, what remains unchanged is the almost universal desire that they continue to be practiced. The fact that Warlpiri parents welcome their son's circumcision suggests the fundamental importance of these ceremonies in establishing male gender identity. However, it needs to be stated that the importance of these ceremonies is not limited to gender identity, but social identity as well. As Gutwirth (1969) attests, these ceremonies are both psychologically and socially integrative. And Myers claims initiation for the Pintubi was:

\[\text{...directed at the making of individual men, at the same time the ceremony symbolically constitutes the society as a structure of reproduction (Myers 1986, p. 228).}\]

Changes at the constitutive level are reflected in broader gender changes that have overtaken Warlpiri men. Altered masculine roles in contemporary Warlpiri society
have significantly reduced the social capital of men. Traditional female roles have largely remained intact post contact. Caring for children and maintaining the family unit are still core activities in a Warlpiri women’s life. Men however, have seen a far greater change in their social existence. The change from a nomadic to a sedentary lifestyle, from a life made meaningful by the daily activities of survival to one of inactivity induced by dependence on social security payments has been profound in its consequences. These consequences are reflected in the health statistics of Aboriginal men.

Conclusion

The state of being male or female is biologically determined. The state of being masculine or feminine is less definitively attributable, but is most likely socially determined. In this chapter I have attempted to examine and differentiate masculine identity formation and enactment in both a non-Aboriginal and a Warlpiri context. In doing so, the central concept of masculinity is revealed as being problematic as it can’t be readily applied to the Warlpiri context. There is far greater emphasis on construction and less on subsequent enactment in Warlpiri society. For Warlpiri men, there are few if any requirements for repeated validation of gender status.

The parameters of adult male gender identity in Warlpiri society are determined by ritual. As such, masculinity becomes a meaningless construct, particularly for the purpose of this research. There can be no universal definition of the term masculinity because this essentially denies the diverse expression of gender. Abandoning the term masculinity does not imply that we discard gender entirely. In fact, the Warlpiri language is rich in gendered terminology. The challenge will be in relinquishing my concepts of gender and to allow corresponding Warlpiri concepts to infuse my interpretive endeavours.
Chapter 5

Aboriginal Health in the Northern Territory
Chapter 5

Aboriginal Health in the Northern Territory

*He who has health has hope, he who has hope has everything.*

*Unknown

*Arabian Proverb*

Introduction

In this chapter I will examine the health status of Aboriginal people in the Northern Territory. I will include historical records in order to glean some impression of Aboriginal health status in Central Australia at the time of first contact. And I will describe the health status of Nyirrpi men at the time this research was undertaken.

Demographics

The population of the Northern Territory in December 2000 was estimated at 196,300 persons. Experimental projections suggest an Aboriginal population of some 51,876 people. The Aboriginal population comprised 26% of the Northern Territory population. Nationally, the Aboriginal population comprises 2% of the Australian population (Australian Bureau of Statistics 2001).

The Health of Aboriginal People in the Northern Territory

Whilst there have been significant improvements in infant mortality rates over the past three decades there has been little change in life expectancy due to continued high adult mortality rates. Nevertheless, 81% of all infant deaths in 2000 were Aboriginal. In the same year, half the 910 deaths registered in the Northern Territory were of Aboriginal
persons. The death rate for Aboriginal people in the Northern Territory is three times that of other Australians and is worse than that for indigenous people in other developed countries (Territory Health Services 2001).

While expectation of life has improved for Aboriginal people in the Northern Territory over the past decade it continues to lag behind that of the non-Aboriginal population. Life expectancy for Aboriginal men in the Northern Territory was estimated in 1999 at 60.3 years compared to 76.6 years of non-Aboriginal Australian men. For Aboriginal women life expectancy was estimated at 66.4 years compared to 83.1 years for non-Aboriginal women in the Northern Territory (Territory Health Services 2001).

Hospitalization rates for Aboriginal people in the Northern Territory are three times that of non-Aboriginal people. The conditions for which Aboriginal people require hospital treatment included circulatory disease, respiratory and genito-urinary infections and endocrine disease (Territory Health Services 2001). The Aboriginal mortality rate from the so-called ‘diseases of lifestyle’ has not decreased over the past three decades. The current epidemic of diseases such as diabetes, hypertension, renal and cardiovascular disease may an increase in Aboriginal mortality at some future point (Condon et al. 2004b).

These statistics give a fairly bleak impression of Aboriginal health in the Northern Territory. But has this always been the case? An examination of historical documents in part answers this question.

The Health of Aboriginal People at First Contact-Central Western Deserts

The decline in health of Aboriginal Australians since colonization is well documented (Edwards & Madden 2001; Elphinstone 1971; Saggars & Gray 1991). It is assumed that Aboriginal people enjoyed far greater health and well-being prior to European contact but what do we know of the health of Aboriginal Australians pre-contact?
Extensive palaeo-biological research has revealed major categories of disease among Aboriginal Australians, including stress, osteoarthritis, fractures, congenital malformations, neoplasm and treponemal infection. In particular, desert dwelling Aboriginals showed signs of biological stress that are thought to be related to environmental factors such as famine and nutritional deficiencies. Desert dwellers were found to have the highest rates of bone infections attributed to endemic treponematosis (Webb 1995). These treponemal infections were well documented in the first years of frontier contact in both Central and Northern Australia.

Writing in 1932 in his capacity as Chief Medical Inspector and Chief Protector of the Aborigines of the Northern Territory, Herbert Basedow wrote:

A good deal has been written about the customs, cults, traditions and somatic characteristics of the Australian Aboriginal, little space has been devoted to the consideration of his existence as a subject of medical interest. Comparatively little has been published in a comprehensive sense pertaining to the manifestation of disease and its multifarious symptoms and effects among the autochthonous people of Australia prior to pollution of their racial purity by foreign invasion (Basedow 1932, p. 177).

Indeed, attempting to construct a sense of Aboriginal health status at the time of contact is difficult. The literature prior 1932 is sparse. This needs to be seen within the historical context within which contact occurred, the time and duration of contact and the paucity of appropriately qualified people in frontier environments able to undertake such medical research.

Basedow categorized the common presenting complaints of Aboriginal patients as being chest and throat complaints, abdominal disorders, venereal disease, traumatic injuries and conditions of the eye. Information was gathered from a wide variety of sources, which Basedow termed semi-official and charitable. This included police
troopers, postmasters and pastoralists. Basedow ascribed no scientific value to this information; nevertheless it is the first record of Aboriginal illness post-contact (Basedow 1932).

There are a few medical reports from the first expeditions into the central western deserts that give some account of Aboriginal health. The earliest of these was published in 1938 in the Journal of Tropical Medicine and Hygiene. An expedition to The Granites, a gold mine some 600 kilometers north west of Alice Springs had been undertaken in 1936 with the express purpose of assessing the health and welfare of Warlpiri people living at The Granites. Despite the isolation, concern had previously been raised about the impact of mining activities on Aboriginal people. The labour provided by Aboriginal men and the domestic and sexual servitude of Aboriginal women at The Granites lead the anthropologist Olive Pink to comment:

I see a warden has been sent to protect the mining rights…but what about the rights of our black fellow humans…I am sure they are not being protected (Marcus 2001, p. 180).

This expedition was primarily medical, collecting anthropometric data and conducting dental and physical examinations. The most striking feature of the expedition report was the high levels of treponemal infections. These infections were known by the term yaws, an infectious disease affecting skin and bone. While the disease was caused by a subspecies of the organism responsible for syphilis (Treponema pallidum), yaws is not transmitted sexually. Couper Black and Cleland asserted that:

...syphilis may be ruled out on being prevalent among the Aborigines now or at any time in the past (Couper Black & Cleland 1938, p. 78).
Surprisingly there was little trachoma reported. Trachoma is a chronic blinding eye disease now hyper-endemic in many Central Australian communities. The dental health of those Warlpiri examined was described as “remarkably good” (Couper Black & Cleland 1938, p. 80).

A slightly different assessment was made six years later when a mission patrol reported adversely on those people encountered on an expedition through Warlpiri territory. Despite the absence of medical personnel, accurate descriptions of the clinical features of yaws were given. The encounter with a group of thirty-four people was described as:

...what a tragic sight they presented. I did my best to treat their maladies. First, a boy with a burn on his arm, three or four inches by one inch and more on his chest and leg. Another boy whose legs were like broomsticks...his left knee being set at about forty five degrees and will not straighten. Then came a woman whose head looked as if it had been split open, but the wound was sealed with clay. Next was girl I suspected of venereal disease with pus in her private parts (Reece 1943 p. 8).

A medical report from an expedition to the Lake McKay region (the western boundary of Warlpiri territory) in 1957 describes the Aboriginal people encountered there as:

...shy and unsophisticated people who presented no difficulties when examined. Most of them were well built and some of them were outstandingly good physical specimens. They were of average stature of the semi desert native; all were well nourished and their babies were fat. Palpebral conjunctiva and oral mucosal coloring was good in all cases. No case of yaws was seen (Hargrave 1957, p. 15).
Given what little information is available, the varying sources and quality of this information, it is difficult to generate a reliable and comprehensive impression of the health status of Aboriginal people of the central western deserts at the time of contact. Many of these historical documents are very much a product of the times in which they were written and must be read as such.

The Health of Aboriginal Men at Nyirripi

The following data were gleaned from analysis of opportunistic screening undertaken at Nyirripi. All men identified as residents of Nyirripi were screened annually between the years 1997 and 2001. The format for screening used during this period was based on healthy adult screening. This systematic, clinic based approach yields high opportunistic coverage and as such is a valid estimate of the prevalence of clinical conditions.

Data collected included personal and family medical history, immunization status, height and weight, blood pressure, blood sugar level, urinalysis, examination for trachoma and assessment of visual acuity. This physical assessment was completed by genital examination and the collection of blood and urine specimens for syphilis, human immunodeficiency virus, gonorrhoea and chlamydia screening. Adult male screening is commenced at 15 years of age. These results are for all Nyirripi men, 15 years and greater.

Body Mass Index

Body mass index (BMI) is the ratio based on weight and height. It is a mathematical formula that correlates to body fat and is used to determine if a person is at an unhealthy weight given their height. Body mass index is a convenient way to assess weight but does have limitations. It does not account for skeletal composition or muscul arity. Those with thickset builds may have a high body mass index in the
absence of excess body fat. Nevertheless, body mass estimation has become the most common technique for assessing body fat.

Table 5.1 Body Mass Index: Nyirrpi Males >15 years 2000

<table>
<thead>
<tr>
<th></th>
<th>Normal BMI 18.5-25</th>
<th>Overweight BMI 25-30</th>
<th>Obese BMI &gt; 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males &gt;15 years Nyirrpi 2000</td>
<td>14</td>
<td>13</td>
<td>16</td>
</tr>
</tbody>
</table>

*(a) Total population Nyirrpi males >15 years (43).*

In the above table, 67% of the adult male population of Nyirrpi can be described as being either overweight or obese. This is significant, given the potential to develop conditions such as diabetes, hypertension, cardiovascular disease and dyslipidemia. Many of these conditions already exist in this population of men. Results from the 1994 National Aboriginal and Torres Strait Islander Survey estimated obesity in Aboriginal males at 25% (Australian Bureau of Statistics 1996). This survey was based on self-reported assessments and is possibly an under-estimate of obesity.

**Diabetes and Hypertension**

Perhaps partly as a consequence of the high levels of overweight and obesity, diabetes and hypertension feature prominently in both men and women at Nyirrpi. Diabetes in particular is a significant cause of excess morbidity and mortality in Aboriginal Australians. In diabetes mellitus, high levels of blood glucose cause damage and eventual failure of various organs. The development of diabetes and the progression to complications such as cardiovascular disease and renal failure is largely preventable (Couzos et al. 2003).
Table 5.2 Diabetes: Nyirrpi 1998-2003

|          | 1998 |  | 2003 |  
|----------|------|---|------|---
| Male     | 8    |  | Male |   
| Female   | 10   |  | 12   |  
|          | 22   |  |      |   

Table 5.3 Hypertension: Nyirrpi 1998-2003

|          | 1998 |  | 2003 |  
|----------|------|---|------|---
| Male     | 7    |  | Male |   
| Female   | 10   |  | 13   |  
|          | 15   |  |      |   

(a) Male population > 15 years Nyirrpi 1998 (43), 2003 (52)
(b) Female population > 15 years Nyirrpi 1998 (51), 2003 (69)

These figures are based on clinical records. The increase in case numbers for both conditions over the 5-year period reflects the development of new disease and the pre-existence of disease in new Nyirrpi residents. This suggests the value of annual screening procedures for detecting undiagnosed disease.

Sexually Transmitted Disease

The pattern of sexually transmitted disease in Nyirrpi males is similar to that for the Northern Territory (Territory Health Services 2001). Gonorrhoea and chlamydia were the most common infections. Whilst the numbers of these infections do not appear to be great, when considered cumulatively, almost half the men in this age group suffered a sexually transmitted disease within a 12 month period. These figures highlight the importance of screening as both an annual and opportunistic clinical activity in Central Australian Aboriginal communities.
Table 5.4 Sexually Transmitted Infections in Males 15-45 years: Nyirripi 2000

<table>
<thead>
<tr>
<th>Sexually Transmitted Infections in Males 15-45 years: Nyirripi 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

Tobacco Use

The prevalence of tobacco use by Aboriginal Australians is greater than other Australians (Ivers 2001). Tobacco is used by about half the adult males in Nyirripi. These results correspond to those for Aboriginal adults in the Northern Territory for which the prevalence of tobacco use is estimated between 45% and 59% (Australian Bureau of Statistics 1996; Territory Health Services 2001; Watson et al. 1988). This is twice the rate for non-Aboriginal Australians. Older men used chewing tobacco almost exclusively. The patterns of tobacco use vary considerably between men and women. The rate of cigarette smoking in women was about half that of men and it occurred predominantly in younger women. The recent appearance of cigarette smoking in this age group may suggest a future trend towards greater tobacco use in young Aboriginal women.

Table 5.5 Tobacco Use in Male and Females >15 years: Nyirripi 2000

<table>
<thead>
<tr>
<th>Tobacco Use in Males and Females &gt;15 years: Nyirripi 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Smoking</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>49%</td>
</tr>
</tbody>
</table>

The greatest difference in tobacco use concerns chewing tobacco. Tobacco is mixed with the ash of the umbrella bush (*acacia ligulata*); this potentiates the release of nicotine. The tobacco is either held in the mouth or behind the ear. Both mechanisms allow a continuous absorption of nicotine. Chewing tobacco carries with it a higher
risk of developing oral cancer (Ivers 2001). This is reflected in the mortality rate for oropharyngeal cancer in Northern Territory Aboriginal people, which exceeds that for the Australian population (Condon, Barnes, Cunningham & Armstrong 2004a).

The harm to health of tobacco use is well documented. Unfortunately the long latency period for tobacco related health problems combined with the immediacy of conditions such as diabetes, hypertension and renal insufficiency has overshadowed tobacco use as a public health issue in Aboriginal communities.

Alcohol Related Clinic Presentations

The hazardous use of alcohol plays a significant role in the morbidity and mortality of Aboriginal Australians (Saggers & Gray 1991). Aboriginal people who consume alcohol are more likely to do so at hazardous levels. Research suggests that of Aboriginal male drinkers, over 20% consume alcohol in high-risk levels (daily consumption greater than 75 mls per day). This compares with an estimated 8% of non-Aboriginal male drinkers being in the high-risk category (Edwards & Madden 2001).

Table 5.6 Alcohol Related Clinic Presentations: January-July 2001

<table>
<thead>
<tr>
<th></th>
<th>0-14 years</th>
<th>15-45 years</th>
<th>&gt; 45 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>44</td>
</tr>
</tbody>
</table>

Table 5.6 details alcohol related clinic presentations at Nyirrpi clinic for a 6-month period in 2001. The 44 presentations in the 15-45 year age group come from 11 individuals. Of these 11 individuals, 9 were presentations for acute alcohol withdrawal. Female presentations in the 15-45 year age group were for the treatment of injuries sustained in episodes of alcohol related violence.
The care of Aboriginal people in acute alcohol withdrawal is complicated by the fact that these people are likely to have other medical conditions. Intoxication and acute alcohol withdrawal presents a significant clinical challenge to the remote area practitioner.

**Men's Use of Clinic Services at Nyirrpi**

Despite a significant burden of disease, Nyirrpi men are not equally represented in health service utilization data. Nyirrpi men are under represented in clinic presentations, a pattern of service use that they share with many other male populations. When health service utilization is poor morbidity is compounded through poor treatment compliance and the unmonitored progress of disease.

**Table 5.7 Percentage of 15-45 Year Age Group Attending Nyirrpi Clinic: March 2001**

| Percentage of 15-45 Year Age Group Attending Nyirrpi Clinic: March 2001 |
|-----------------------------|-----------------------------|
| **Male** | **Female** |
| Attend | Non Attend | Attend | Non Attend |
| 29% | 71% | 73% | 27% |

**Conclusion**

The health status of Aboriginal men compares poorly with that of other Australian men. This trend is evident at Nyirrpi. Coupled with demonstrable health deficits is an under-utilization of health care services. These issues were daily realities in my practice at Nyirrpi and are the basis of this research project. As we have seen, similar patterns of health service utilization have been reported in non-Aboriginal men. Prior to looking at the results of this inquiry, I will explain the methods and underlying principles by which this research was conducted.
Chapter 6

Methodology
Chapter 6

Methodology

What sets us against one another is not our aims...but our methods, which are the fruit of our varied reasoning.

Antoine de Saint-Exupery  
-Wind, Sand and Stars-

Introduction

All scientific inquiry is based upon some form of research methodology. In the human sciences, methodology is taken to be a discipline that provides the procedures by which to generate knowledge. These procedures are justified by means of philosophical arguments. This chapter will set forth the philosophical arguments upon which the methodology for this research project is based.

The research project will explore the meaning of social beliefs and action in a culture foreign to that of the researcher. It is not ethnography in terms of generating a holistic representation of the culture of interest. It is, however, an ethnography, which will focus on specific actions central to the illness behaviours of Warlpiri men.

The manner in which a research problem is posed, particularly the reason for undertaking the research, will inevitably be reflected in the methodology selected. An ethnography framed within a context of critical inquiry becomes more than an exploration of culture. The inquiry process and the resultant knowledge provide a potential catalyst to change unjust and irrational social practices. A critical ethnography is therefore considered the most appropriate methodology for this research project.
The Nature of Reality: Ontology

Ontology concerns the nature of existence and the structure of reality. The ontological question of reality and being is critical to the way in which research is formulated and conducted.

If we consider ontology in the light of relativism, where an object is said to exist only in relation to another object, reality is then possible in the form of multiple cognitive constructions. These are socially and experientially based and are both local and specific in their nature. The form and content that a conception of reality takes will depend on the person who holds them (Guba 1990). Reality does not exist unless there is a 'knower' to create the reality. The world is imbued with meaning only when engaged by conscious beings (Crotty 1998).

As reality is constructed from a human perspective, people are at the centre of social inquiry. Therefore, multiple realities exist because human experience can be interpreted in many ways using a variety of symbol and language systems. Any focus on human realities must take into account not only the object but also the relation it bears to the experiencing person. The facts of the world and the facts of human consciousness coincide in this focus. For reality to be intelligible it must be linked closely to human thought, which is expressed predominantly in language.

For the relativist there is no independent reality, only that which is created individually and collectively by the human mind. Realities are unique to both individuals and groups and reality is dependent on the human mind for its existence. Reality exists as a set of holistic and meaningful constructions. These constructions conflict both within and between people (Guba 1990). This suggests that the concept of reality has a dynamic nature, one that is intertwined with both time and place.
Knowing and Knowledge: Epistemology

Both epistemology and ontology pose questions that determine the nature of research. An epistemology is a way of understanding and explaining how we know what we know. Epistemology is the theory of knowledge and as such is embedded in both the theory and methodology of all social research. In the constructivist paradigm, knowledge is seen as a creation of the human mind and not some accidental discovery.

Epistemologically, the constructivist paradigm takes a subjective position (Guba 1990). As we have already stated, reality exists in the minds of individuals, therefore subjective interaction will be the only process that can uncover these meanings. This suggests that during the process of inquiry, the researcher and informant become closely aligned. Guba (1990) is specific when he states that the two are fused into a single unit and that the product of the inquiry is a creation emerging from their interaction. Accordingly, knowledge must in part be based on consensus.

As we have already established, there are multiple realities, so it follows that multiples of knowledge can exist. This is knowledge that is locally and politically grounded and emerges not only from the meaning of words but also from the natural context within which they are embedded (Greene 1990). This then, suggests that interpretation plays a significant role in methodology.

Towards an Aboriginal Epistemology

Do the nature of knowledge and the cognitive processes that produce knowledge vary between cultures? And if so, what are the implications for research undertaken across cultures? It is worth considering these questions, as I believe their impact on the practice of qualitative research to be profound.
There is no equivalent Warlpiri language word for the concept of knowledge. There are however numerous words describing various aspects of knowledge. *Pinarri* denotes a person who is wise or knowledgeable. Similarly *pina-wangu* denotes ignorance, *pina-virarntu* to teach and *pina-pina-jarrimi* to learn. All these terms describe states of being, namely the presence, absence or transfer of knowledge between individuals. English language fares little better at defining knowledge. In both languages the concept of knowledge is implicit in the state of knowing, or imparting or acquiring information and experience. In the Warlpiri language all the words associated with knowledge are person centered.

Christie (1993) believes that Aboriginal and non-Aboriginal thinking differ on a number of levels. He describes non-Aboriginal thinking as being atomistic, in which all things can be reduced to their constituent parts, and objective, with reality experienced through perceptions and interpreted through intelligence. Christie (1993) claims that an extensive Aboriginal naming system defines the possibilities of reality and thereby negates the need for an atomistic approach. An object could be referred to by a variety of names, dependent on the context and the person’s relation to the object. Christie (1993) claims that in Yolngu society, the universe can be structured in multiple ways. I believe that this approach to reality and the cognitive processes that define reality are very similar to the Warlpiri. Their language is based on an extensive naming system with little evidence of reductionist thinking and the language is both context and person specific.

In all scientific systems, knowledge is based on a framework of metaphor. This is no different for Aboriginal science where the metaphoric basis of worldview is celebrated in the *jukurrpa* (‘the Dreaming’ of central desert societies). *Jukurrpa* is a pervasive worldview that reaches into language, social life and the sacred realm of Aboriginal people. The Aboriginal worldview is primarily a religious one, based on belief. This contrasts with the non-Aboriginal worldview, which is a secular one, based on proof.
The whole notion of proof as the basis of knowledge is not as firmly entrenched in Aboriginal society.

Aboriginal knowledge has in the past been viewed as fallacy based on ignorance (Burridge 1973). Burridge claims that the concern for proof generates conflict between Aboriginal and non-Aboriginal belief systems. This is a point worth considering in research. There is the risk that when proof of truth is viewed as the ultimate research outcome, Aboriginal culture may be undermined as Aboriginal belief systems may be seen as lacking proof of truth. And yet the considerable ecological knowledge of many Aboriginal people, a knowledge based on a long tradition of observation, would appear to be both scientific and entailing proof of truth.

Indigenous knowledge constitutes a wealth of information covering all spheres of life such as spirituality, the environment, culture, governance and social affairs. Indigenous knowledge is said to be cumulative, developing slowly over time. It is based firmly on experience and is passed from each generation through a well-developed tradition of narrative. Christie (1991) claims that Aboriginal science is made of knowledge production, which has evolved to allow human beings to fit into, rather than exist outside of, ecology. Indigenous knowledge is specific to a community and is linked to the spiritual and cultural practices of that community.

De Graaf (1984) states that there are two domains of knowledge within central desert societies. There is the essential knowledge of life, that which is related specifically to survival. This knowledge is lodged within the myths and song cycles of the Jukurrpa. Overlying this fixed system of knowledge is information pertaining to social and ecological change. These two domains are linked by the power of interpretation. This interpretation is limited to recognized variables and a known range of variation.

In Aboriginal society, knowledge is privately owned. Some individuals have access to important and powerful information. Access to this information is made on the basis of
religious and political authority. This contrasts sharply with non-Aboriginal society, where most information is considered public and freely available.

So how might these epistemological differences be implicated in research across cultures? Christie (1993) states that the questions we ask always encompass all the criteria we require to understand a reply. This is a significant statement. It suggests that non-Aboriginal knowledge of Aborigines may be inherently flawed because of the epistemological considerations associated with representation. The process of both translation and interpretation distorts experience and worldview to a point where it does not accurately reflect reality. This is perhaps an extreme view, but the transfer of knowledge between cultures will always entail some loss of meaning. Christie (1993) believes that we can overcome this by developing an understanding of alternative views of reality. This can broaden our ways of knowing and increase our chances of arriving at absolute truths. However, Attwood and Arnold (1992) do not see this as a problem and argue that critical inquiry will at best produce approximate truth claims. While these may be different, they are no less valid, because of their potential to generate new insights.

**A Critical Approach to Cross-Cultural Inquiry**

The critical ethnographic methodology is heavily influenced by critical social science. It is therefore important to distinguish between the numerous definitions and applications of critical thought and practice, as not all will apply to this project.

As Kurfiss (1988) states, critical thinking is a rational response to a question that cannot be answered definitively and for which all the relevant information may not be available. Critical thinking is an exploration of a phenomenon where all relevant information is considered, all assumptions are open to question and divergent views are sought. The outcome of critical thinking is a conclusion that can be justified. This
definition is perhaps very broad and could be applied to any number of research methodologies within the human sciences.

There appears to be some debate as to the relevance of critical theory to the practice of critical ethnography. Thomas claims that critical ethnography is not related to critical theory as proposed by the Frankfurt Institute for Social Research (Thomas 1993). However others claim that critical ethnography does in fact rely heavily on critical theory (Fontana & Frey 1994).

Critical theorists seek to understand human experience as a means to change the world. Research influenced by critical theory will concern social justice and human experience as the means of bringing about social change. In critical theory, knowledge is seen as being socially produced and is equated with power. Critical theorists share other assumptions common to naturalistic inquiry, such as, the informer is the person with knowledge and all knowledge is qualitative in nature.

Critical social science involves an interpretation of the social world in which we live. Through this interpretation, oppression becomes apparent in a way that empowers people to change their lives. These interpretations must reveal how social order functions and demonstrate the inherent disadvantage within social structures. Critical social science is an endeavour to explain social life in general or some particular instance of it, in a way that is scientific, critical, practical and non-idealistic. It is scientific as it provides comprehensive explanations subject to public evidence and it is critical because it offers a sustained negative evaluation of social order on the basis of explicit and rationally supported criteria. Empowerment and social change are the hallmarks of critical theory (DePoy & Gitlin 1994).

Critical social science must be practical as it stimulates those people at its centre to transform their social existence in specific ways. This is achieved by fostering the knowledge that serves as the basis for such a transformation. However, ideas are not
the sole determinants of behaviour and emancipation does not automatically emerge from enlightenment (Fay 1987).

Critical ethnography is a style of analysis and discourse embedded within traditional ethnography. Critical and traditional ethnographies share several fundamental characteristics. Both rely on qualitative interpretation of data, core rules of ethnographic method and analysis and an adherence to symbolic interactionist theory.

There are important characteristics that distinguish these two approaches to ethnography. Street differentiates between the two approaches by stating:

...an ethnography framed within the context of critical inquiry is predisposed to rationally analyze and change unjust and irrational social activity...and is distinguished from ethnography which have no transformative agenda and whose purpose is to describe and interpret cultural realities (Street 1992, p. 12).

This is perhaps the defining characteristic of critical ethnography and is emphasized by Thomas when he states that traditional ethnography describes what is, where as critical ethnography asks what could be (Thomas 1993). This point is expanded by Agar (1986) who states that traditional ethnography being purely interpretive can give only one possible reading of the culture studied.

Critical ethnography is based on an explicit framework in which knowledge, by modifying consciousness and prompting action may be used to effect social change. Critical ethnography is simultaneously hermeneutic and emancipatory. Emancipation in this context means altering constraining modes of thinking and acting (Thomas 1993).

By employing a critical ethnographic approach to this research I do not expect to effect either behavioural or cultural change, but rather gain some understanding of the key
issues that can be used to change policy and practice. Practitioners must have sufficient understanding in order to accommodate the cultural and behavioural barriers to Aboriginal men’s health care.

The Role of the Researcher

Values are central to the research process, but are viewed very differently by the major social science paradigms. In constructivist thought, the values of both the researcher and participant are celebrated. All inquiry is seen as being value laden. The values and visions of human action and interaction always precede a search for descriptions, theories and narratives, and the research process is ultimately driven by anticipated outcomes (Cherryholmes 1992). Limiting the influence of the investigator’s values in the research process is both difficult and unhelpful. By stating ones values and pre-understandings their effect on the research process and outcomes can in part be controlled.

The interpretive method is enhanced only when these pre-understandings are brought into consciousness. An awareness of prior understandings is essential for the phenomenon under study to be brought into focus without contamination from the interpreter’s perspective. Having lived in Warlpiri communities for the past twenty years I have developed some understanding of the issues confronting Warlpiri men. I commenced this research with the following understandings of Warlpiri male life:

1. In Warlpiri society adult male status is constructed and confirmed only through ritual practice.

2. Altered male roles in contemporary Aboriginal society have significantly reduced the social capital of men. The consequences of alterations in roles are reflected in the health statistics of Aboriginal men.
3. Illness concepts in Warlpiri society largely emanate from the realm of the supernatural and these beliefs continue to operate in Warlpiri society.

4. Shame is a significant emotion in Aboriginal society and may be implicated in the non-reporting of illness.

5. Health service provision in Aboriginal communities is gender biased.

6. Illness and health related behaviour in non-Aboriginal men is linked to notions of appropriate masculine conduct.

Only by attending to the researcher’s prior knowledge can the phenomenon under study have any chance of being revealed. As data is processed through the interpreter’s frame of reference, potential meanings emerge based on the interpreter’s prior knowledge. The pre-understandings listed above played a significant part in determining lines of inquiry for this research. As such, I am aware of their potential to constrain the inquiry process. Heidegger’s advice that the ‘first, last and constant task’ in interpretation is to allow ‘the object to take over’ was the only means by which the constraints of my pre-conceptions could be overcome (Heidegger 1973, p. 153).

A Mixed Methodology

There has been a trend in social sciences to view the traditionally opposed paradigms of qualitative and quantitative research not as dichotomous but rather as a spectrum of inquiry (Creswell 1994; DePoy & Gitlin 1994; Tashakkori & Teddie 1998). Many issues pertinent to human sciences cannot be answered by measurement alone, quantitative techniques in many instances are not able to fully capture the human experience. This has made possible the combining of research design and methods, a style of inquiry well suited to health and human service research.
Mixed method studies are those that combine elements of qualitative and quantitative design in the study of a single research topic. The combination of research methods strengthens the inquiry by uncovering different facets of the issue being investigated (Creswell 1994). This enables the limitations of each to be transcended and can make possible a range of new insights.

A mixed methodology allows the researcher to address research issues from both a numerical and narrative point of view. Employing an exclusively quantitative research design in social science research limits the inference to the issue under consideration. The results are one-dimensional and while they might suggest further inquiry, any additional insights will only emerge through a different research design. The realm of qualitative inquiry is one in which the researcher is able to gain some insight into the complexities of human experience.

This research does not fully integrate both methodological designs but rather uses a sequential approach. A sequential approach is one in which the investigator uses qualitative methods to follow up on quantitative results to explain, elaborate and interpret findings. The inquiry methods in this research project are conducted within a dominant paradigm but embedded within it is a smaller component of research drawn from an alternate paradigm (Creswell 1994). This type of research is by no means unique as demonstrated by the long history of including simple descriptive statistics in ethnographic research (DePoy & Gitlin 1994).

In this research the qualitative and quantitative components are sequential. Investigation and analysis of a distinctly quantitative nature was used to confirm the nature and degree of the research topic. In this manner, suspicions that Nyirrpi men under utilized health services were confirmed. Secondly, quantitative data were used to establish some impression of the health status of Nyirrpi men. This suggested that the poor utilization of primary health services by these men was indeed significant and worthy of further investigation. Investigating the factors that impact on men's use of
health services could only be undertaken using a qualitative design, using primarily information gained from interviews and observations to understand the experience of Warlpiri men.

Selecting the Informants

Twenty men were interviewed for this research project. The process for sampling informants for interview could best be described as being both random and stratified by age. It was recognized that while Warlpiri society has altered dramatically since contact, age, particularly that of men, was and remains an important indicator of status. Age therefore becomes an important factor in the experiences, values and behaviours of men and to capture any generational differences it was important to sample across age groups.

I chose to divide the adult male population into three groups. The first group chosen were the community elders who are generally men 65 years and older. Accurate dates of birth for these men were not available as they were born prior to contact with non-Aboriginal Australians. These were men who had either experienced traditional nomadic lifestyles or could recount first contact stories. Unfortunately, there were very few men in this group. The second group I considered were men who had come into adulthood in the 1950s and 1960s, at a time when Warlpiri culture was relatively intact and the effects of culture change were less pronounced. Men from this age group dominated the sample. And lastly, the younger men who had only ever known community life and who were perhaps more accustomed to non-Aboriginal cultural norms than their elders.

The rationale behind this method of sampling arose from the different clinic-related behaviours that characterized each age group. I was well aware of these differences from observations made over many years. Essentially, young men’s behaviour was characterized by reluctance and considerable unease. Middle-aged men were generally
more confident but could also be prone to unease in the clinic setting. This contrasted
with the behaviour of male elders, who displayed no such reluctance. These senior
men were comfortable and confident in the clinic setting. By including men from each
of these groups I hoped to gain some understanding of age dependent differences in
illness behaviour.

The twenty interviews represented just fewer than fifty percent of the adult male
population of Nyirrpi. The literature suggests sampling until saturation occurs.
Saturation is said to be an indicator of rigour and occurs when sufficient information
has been gained to understand the phenomena under study. Precisely, it is that point at
which new information fails to emerge from the data (DePoy & Gitlin 1994). In cross-
cultural research saturation is perhaps a poor indicator of rigour. It is possible to miss
vital pieces of information by adhering to the notion of saturation. I would suggest that
in cross-cultural and cross-linguistic research that saturation perhaps never occurs.

While saturation may appear to occur at some point there is always the potential for
new insights. I was beginning to get a sense that I had reached saturation by about my
fourteenth interview. During the fifteenth interview, the term *jampardiyi* was
mentioned for the first time. This was a significant piece of information and gave rise
to numerous insights about the manifestations of cultural traditions on Warlpiri men’s
contemporary experience. There were other insights that I gained as my data collection
drew to a close. This probably reflects my own growing understanding of the issues I
had been investigating.

Death and mourning are ever-present features of remote Aboriginal community life.
These two issues determined how the research was conducted, the sample size and
importantly, sample composition. The sampling process became opportunistic as
interview schedules were disrupted on a number of occasions by the death of
community members or related people from neighboring communities. In such
circumstances the criteria for inclusion became one of kinship, choosing those who were both available and not in mourning.

Initial data collection represented baseline information upon which to tease out lines of further inquiry. The process of inquiry was iterative. Each interview was transcribed in the field by the researcher. In effect the process of transcription became a form of preliminary analysis. Reflection on the data as they were gathered informed the lines of inquiry of subsequent interviews. This enabled a gradual piecing together of the key points of investigation.

**Talking with Warlpiri Men**

The interviews were conducted in a private setting, one that removed both the interviewer and informant from any possible distractions. Men in Nyirrpi were aware of the research project. Those selected for interview were approached and invited to take part. In these initial discussions men were given only a brief description of the research project. This was done in order to set the limits of the inquiry. All men invited to participate agreed to do so.

Men were interviewed without an interpreter. This was the request of those men interviewed. Most middle-aged men who form the majority of the sample possessed good English language skills. In their opinion the use of an interpreter was both unnecessary and demeaning. There was also the issue of privacy, with most of the men stating their preference to talk ‘face to face’. This was a fortunate turn reflected in the level of intimate detail in which many of the men were prepared to speak.

Interviewing young men who by nature tend to be reticent and have poor English language skills was problematic. The use of an interpreter in these instances proved unsuccessful. In the presence of a senior male, younger men displayed considerable
deference. This made young men extremely hesitant and despite the interview being conducted in Warlpiri, responses were limited to monosyllables.

The interviews in this research project took the form of guided conversations. This was the approach I felt appropriate to my aim of achieving some understanding of Warlpiri men’s experience. I have been conversing with Warlpiri men for some eighteen years and felt I should apply communication styles that I was most familiar with as opposed to imposing some rigid system of inquiry with numerous rules and restrictions.

There was however one major fault to my interview style. This problem related directly to my work. Being a sole practitioner in a busy clinic, I had fine-honed an interview style to quickly gather the information I required to make a diagnosis. Unfortunately, this rapid-fire technique of information extraction did not transfer well to the qualitative interview. It proved exceedingly difficult to discard these habits and adopt a new interviewing style.

The introduction of the research project to informants was problematic. I was aware that much of what passed as informed consent is in fact based on misunderstanding. Because the research concerned Warlpiri men, I was keen that men understood that this research was an inquiry into Warlpiri men’s health issues and not related in any way to men’s ceremonial life. The process for gaining informed consent therefore required a detailed explanation of the issues I was interested in researching. In a number of cases I felt that this detailed explanation influenced the responses I later received. Grbich (1999) claims that disturbance of the setting by the researcher diminishes rigour but I felt my options in this situation to be limited. When I attempted to modify this introduction, men commented that they felt unprepared for the interview. I reverted to a full introduction as I was not prepared to jeopardize the consent being fully informed, particularly relating to the demarcations of this research.
The technique of inquiry required considerable adjustment. Questioning was often only appropriate and meaningful when framed in terms of local or even personal experience. A formal inquiry about the post-initiation care of young men might elicit little response but asking men to recount their own experiences was likely to produce a far more detailed account.

Data collection was not limited to formal interviews. The collection of information became an activity that continued well after the completion of formal interviews.

**The Role of Observations**

Observations divorced from their social and cultural context are meaningless. The true meaning, motivation and outcomes of observed behaviours can often be hidden, particularly in a cross-cultural context. They are hidden because of their apparent normality. Observations at best give superficial meaning to any given social situation. The observer does not appreciate the true meaning because observations are made from the cultural and social view of the observer. As the goal is to understand something of the complex and meaningful experiences of others, understanding can only occur when viewed from the perspective of those who live the experience. Schwandt succinctly makes the point as to why this perspective is so important when he states:

...particular actors, in particular places at particular times, fashion meaning out of events and phenomena through prolonged, complex processes of social interaction involving history, language and action (Schwandt 1994, p. 118).

The uncovering of additional information from observations can be purely accidental. Often the perspectives from which observations are made predetermine the interpretation and hence the true meaning may not be recognized. Observations of behaviour and beliefs that appear strange gain our attention precisely because of their difference from our cultural standpoint. We are more likely to dismiss those
observations that concur with our cultural experience because in their similarity they hold no intrinsic value.

The following anecdote illustrates how apparent similarity can predetermine interpretation:

At Nyirrpi, the community garage is located opposite the community store. The garage is a place where men congregate, sometimes to work on their cars, sometimes to just sit and talk. This was one of many scenes from community life of which I was aware through my observations over the years. I had never given much thought to this congregation of men, it seemed a normal phenomena from my cultural perspective. I assumed, as in non-Aboriginal society, that garages were ‘male places’ either from a practical or social perspective. My assumptions were completely incorrect however. While men used the facilities of the garage to work on their cars, the prime reason that men gathered there was unrelated to any notion of a ‘male place’. It was primarily related to the concept of *jampardy* or avoidance. Essentially men gathered opposite the store so they could observe who entered and departed, their observations determining when they had ‘room’ to enter the store themselves.

This anecdote illustrates two important points. Firstly, while long held assumptions were incorrect, the tacit knowledge inherent in them readily lent itself to the correction of these false assumptions. A researcher lacking this tacit knowledge may have failed to grasp the significance of this insight. And secondly, it raises questions about the validity of other assumptions and the truth of impressions upon which they are based. In qualitative research, data are mediated through a human instrument. Interpretation is the synthesis of meaning that emerges from the dynamic interchange between the informant and researcher. Data are processed through the researcher’s unique frame of reference. Some interpretive studies attempt to retain a sense of objectivity about the subjective meanings of others by deliberate bracketing of the researcher’s beliefs and
understanding of the phenomenon under study. The claim here is that subjective reality can be studied objectively.

Another view is that this bracketing or putting aside the researcher’s beliefs and understandings is very difficult to achieve, that the researcher’s frame of reference invariably shapes the interpretive outcomes. Philosophers such as Gadamer and Heidegger doubt that researchers are able to bracket their assumptions to the point that they have no impact upon the process of interpretation. They argue that all people experience, perceive and interpret reality through a veil of pre-conceptions that are a fundamental and irrepresible part of being. The interpretive viewpoint and its influence in the synthesis of meaning should be acknowledged and explicitly stated in research methodology. As Gadamer stated:

For it is necessary to keep one’s gaze fixed on the thing throughout all the distractions that the interpreter will constantly experience in the process and which will originate in himself [sic] (Gadamer 1975, p. 267).

All our actions emanate from a particular cultural standpoint. We cannot escape this standpoint nor can we negate its impact on our research endeavours because it is so ingrained in our being we become oblivious to its various manifestations. In this research my observations extended well beyond the field placement to include the entirety of my life in Warlpiri communities. These cumulative observations shaped my understandings. These, as I have previously stated, were an inherent component of the research design. Observations made during the course of fieldwork were nearly always overshadowed by previous experiences. For this reason I have limited my use of observations.
Analysis and Interpretation

The first stage of analysis involved quantitative data. Simple descriptive statistics were used to establish the nature of the research problem. These statistics in the form of frequency rates were able to give an impression of the health status of Nyirrpi men at the time of the study. Most importantly these statistics demonstrate the underutilization of clinical services by men at Nyirrpi.

The data collection and analysis can best be described as iterative. This process has been described as an interactive and interpretive process consisting of three stages: preliminary analysis, thematic analysis and coding (Grbich 1999). The transcription of interviews allowed time for reflection on data as they were collected. This allowed me to identify gaps in the data, emerging themes and problems with my interview technique.

A theme list provided the framework upon which to base my inquiries. The iterative approach allowed me to 'flesh out' the overall structure of my inquiries. I had to be mindful however to balance this construction and to keep my inquiries within certain limits. This was a technique I found very useful as it allowed me to constantly build on my understanding. As each interview was transcribed I was able to reflect upon its content and as new questions arose, they were taken forward into subsequent interviews.

The search for meaning in the information took on a number of layers. I transcribed the interviews immediately they were completed. I did this for a number of reasons. I chose to transcribe myself, as I was accustomed to linguistic and conceptual idiosyncrasies that may not have been apparent to others. Through the process of transcription I was able to immerse myself totally in the data thus becoming familiar with the overall content.
Once all the interviews were transcribed they were examined for recurrent themes. These had emerged early. Each transcription was divided into categories. These categories generally corresponded with the areas of research interest and lines of inquiry. Each category was then subdivided on the basis of content. The aim was to reduce each category to its constituent components. This produced in some instances another four tiers of information.

This process had three important functions. Firstly, gaps in the information became rapidly self-evident. Secondly, partial meanings were uncovered and thirdly inconsistencies in the data were revealed. These all suggested further inquiry and while there were few inconsistencies in the data there were considerable gaps in the information. This was largely due to the nature of the research topic. Most gaps concerned matters of kinship, a topic of considerable complexity of which I had only rudimentary understanding. The missing information was gained in part through the anthropological and linguistic literature. But ultimately, it was only through numerous return trips to the field that the missing information could be gained.

During the period of field placement I kept a journal of my experiences. This became an invaluable tool for setting down thoughts on a whole range of issues. In particular, it became a record of evolving ideas that were to be the genesis for new lines of inquiry. It was also a critical account of my skills in the research arena. As questions arose, either during transcription or analysis, they were placed in field journals for later explanation or clarification. This also proved a good strategy for identifying missing information.

The process of writing the results was combined with discussion. This seemed a logical manner in which to present the findings. Much of my understanding of the data was either facilitated or validated by my past experience and observations of Warlpiri life. Capturing the word of the informant is only part of the process of comprehension. The informant’s voice should be augmented by the ‘unarticulated contextual
understanding' of the inquirer (Altheide & Johnson 1994). To present the results in a 'stand alone' manner would have diminished their ultimate meaning. The combining of results with discussion is useful, especially where findings require interpretation to make them more meaningful.

The Matter of Rigour

Reliability and validity have a long history as the central concepts in evaluating empirical research. These concepts of evaluation have been challenged as appropriate for judging rigour in qualitative research. Many alternate criteria for evaluating qualitative research have been proposed with little consensus evident.

Janesick decries what she calls 'the constant obsession with the trinity of validity, reliability and generalizability' and believes this preoccupation causes the researchers to lose sight of understanding by separating experience from knowing (Janesick 1994, p. 216-17). This is an important point, for no matter how we evaluate qualitative research, the core issue of rigour will always be based on the relationship between the research findings and the subject of research. The measures I employed to obtain a 'good fit' between the results and reality involved triangulation, cross member checks, verification of specific findings in literature and extensive use of informant quotes.

Triangulation is a process where different kinds of data or methods or researchers are used to reveal different aspects of empirical reality. Triangulation is said to help reduce errors by using multiple methods so that different types of data provide cross data validity checks (Creswell 1994).

The term triangulation comes from the science of navigation where location is determined by taking a bearing from different positions. Mixed methods add rigour primarily because of the opportunity for data triangulation (Borkan 2004). In qualitative inquiry, data may either be collected by different methods or read from
different positions in order to arrive at a singular truth (Grbich 1999). In this research project, data from three distinct sources has been used. Quantitative data derived from screening yielded simple descriptive statistics that were used to illustrate the status of men’s health in Nyirrpi and health risk behaviours.

Descriptive statistics were also used to define the nature of the research problem, namely poor utilization of health services by Nyirrpi men. While simple descriptive statistics were useful in defining the nature of the research problem they did not in any way contribute to an understanding of the underlying dynamics of behaviour. The quest to understand the experience of Nyirrpi men with regard to health and illness could only be achieved using the tools of words and not numbers. By using a variety of data collection techniques, a holistic impression of the research problem was constructed from multiple explanatory insights (Knafl & Breitmayer 1991).

The following example demonstrates how different methods can reveal alternate views of an object under consideration and in the process confirm the overall authenticity of data. Quantitative data derived from screening had revealed that there were high rates of sexually transmitted disease amongst Nyirrpi men. Other than the public health implications, these statistics revealed no other information about the significance of these diseases in the lives of Nyirrpi men. Interview data revealed the role of shame in men’s poor utilization of health services. That this shame was overwhelmingly related to the stigma of sexually transmitted disease was information that assumed some significance given the rates of disease in Nyirrpi. These findings were confirmed by my observations. The circuitous route that men often took to gain treatment, their reticence to discuss symptoms, and their general unease suggested that this shame was deeply ingrained.

For information that could not be supported by observations or anecdotal evidence, repeated checking of verbal information was required. This process of validating proffered information was a means of paying due respect to the value of the
information given. This was well understood by Aboriginal informants who were more than happy to elaborate and confirm my initial interpretations.

Devitt states that attempts to establish rigour with Aboriginal informants can be misconstrued as rudeness (Devitt & McMaster 1998). Information is passed from Aboriginal informant to non-Aboriginal inquirer in good faith and the need to check this information is therefore seen as both redundant and insulting. This is a simplistic view. Meaning is a precious commodity, dependent upon the vagaries of linguistic and conceptual differences between informant and inquirer. This is especially well known to Aboriginal people. They experience first hand the burden of failed communication and appreciate the tenuous nature of communicating in a language, which at best, is second in a linguistic repertoire.

Face validity or member checks were used to improve rigour by presenting interpretations to research participants. The iterative method of data collection takes the form of a continuous member check. Interpretations from one interview are used to inform the next. This constant process of validation is essential for highlighting inconsistencies in the data and misinterpretations by the researcher.

In this research project both culture and language became pivotal points of inquiry. Developing an understanding of emerging concepts required frequent reference to anthropological and linguistic literature. This literature assumed considerable importance in terms of both investigation and verification. An example of this process involves the Warlpiri word *pirlarli*. This word was used during an interview and not being familiar with the word I asked for its meaning. *Pirlarli* means friend, a fairly unambiguous meaning. Later, I checked this meaning in the Warlpiri language dictionaries and found the explanation correct but incomplete. *Pirlarli* are assigned to accompany initiates during their seclusion. I then referred to the anthropological literature and discovered that these ceremonial friends in later life were implicated in avoidance. I then confirmed this information with men at Nyirrpi. This process of
cross checking interview data with linguistic and anthropological literature was essential to developing an understanding of Warlpiri concepts.

I regarded the use of Warlpiri language words in the course of interviews as significant linguistic clues. While the interviews were conducted in English, Warlpiri language words were frequently used during the course of interviews. Commonly, the use of these words was in association with concepts for which there were no English language equivalent. Most often these words were significant for their semantic content as illustrated by the above example.

The greatest danger to the interpretation of information was the Aboriginal use of English. Sentence construction, word order and emphasis became crucial to understanding. I would suggest that our disregard of these is a common feature of our communications with Aboriginal people. We assume, quite incorrectly, that when speaking across cultures in English, each party is equal in their linguistic competence. This is rarely so and communication is affected accordingly. There is a distinct power differential between Aboriginal and non-Aboriginal speakers of English. This power differential is nearly always disadvantageous to Aboriginal speakers of English. For Warlpiri, English language is at best a second language, with many older Warlpiri speaking other Central Australian languages such as Pintubi, Luritja, Anmatyere and Kukatja.

Research and Cultural Difference

Research conducted at the point where health and culture intersect inevitably raises issues of difference. Thomas states that researchers of Aboriginal health are challenged by the ‘confusing and ambiguous politics of the representation of Indigenous peoples as equal but different’(Thomas 2004 p. 136). It is important to dissemble these issues as they pose considerable challenges for both the conduct of research and the provision of health services.
This research is infused with the theme of difference. My intent in exploring cultural difference is to uncover insights that might shed light on Warlpiri men’s under-utilization of health services. By examining the pitfalls in researching cultural difference it may be possible to avoid misrepresentation.

Hollinsworth diminishes the importance of cultural difference when he cautions against research and academic writing that starkly contrasts traditional Aboriginal society with mainstream Australian society. While acknowledging the useful insights that such comparisons can yield, Hollinsworth claims that contrasting different societies can lead to ‘crude and misleading constructions’ (Hollinsworth 1992 p. 1). Others are more explicit in their opposition to researching difference. Goldberg (1993) makes the claim that the description of difference is never neutral, that comparisons are essentially value judgements that infer notions of inferiority and superiority.

As a variable in health research, culture has assumed considerable importance because cultural difference is thought to effect health status, health related behaviour and receptivity to health information (Lambert & Sevak 1996). An appreciation of cultural difference and how it manifests in beliefs and behaviour is important to cross-cultural understanding. By identifying culture as an important variable in health and exploring difference, it may be possible to find solutions to problems encountered in cross-cultural health care. This assumption however has been challenged on the grounds that culture provides malleable boundaries for behaviour and beliefs and as such people are not necessarily constrained by culture. Ahmad acknowledges the explanatory role of cultural difference but claims that culture must be considered in context, ‘as flexible and contested, interacting with, shaping and shaped by other social and structural contexts of people’s lives’ (Ahmad 1996 p. 215).

By adhering to an essentialist notion of culture, researchers can inadvertently present culture as a liability. Perceived problems or difficulties are invariably linked to differences in beliefs and behaviours. Thomas takes the opposite view when he decr...
the practice of social scientists to concentrate only on the beneficial applications of their research and to keep discussion of any negative implications to a minimum (Thomas 2004 p. 2). This is partly related to Brady's claim that culture and difference have been elevated rather than contested in Aboriginal health research. The politics of difference has lead to considerable sensitivity in Aboriginal health matters. This sensitivity has given rise to a degree of uncertainty in Aboriginal affairs, due in part to 'prevarication in decision-making and policy formulation' (Brady 2004 p. 126).

Ahmad (1996) acknowledges the importance of equipping health service providers with the necessary tools for cultural understanding. However he argues that placing an emphasis on cultural difference to explain inequalities has conflicting outcomes. In this manner culture can appear to be both the cause and solution to these inequalities. This is something that Brady alludes to in relation to Aboriginal alcohol abuse. Research into the Aboriginal experience of alcohol consumption has revealed how cultural and social factors play a dominant role in maintaining high levels of alcohol consumption. She specifically identifies the high value placed on individual autonomy and a reluctance to confront individuals about their consumption of alcohol and subsequent social problems (Brady 2004 p. 127). In contrast, programs targeting alcohol abuse and domestic violence in Aboriginal communities identify the same kinship relations and social structures in Aboriginal communities as points of intervention.

All cultures change over time. In Warlpiri society considerable change has seen greater individual autonomy and less severe consequences for non-conformity. Where social and structural change has occurred there may be disparity between cultural beliefs and behaviour. Ahmad states that this makes 'the notion of some unitary culture and a linear link between cultural beliefs and behaviour problematic' (Ahmad 1996 p. 210). Ahmad claims that the complexities of cultural change makes the task of describing norms or predicting behaviour on the basis of cultural knowledge almost an
impossible task. While there is possibly some truth in this claim, cultural knowledge is imbued with considerable explanatory power and as such is a valuable resource. The utility of research that considers health in the context of culture rests on the translation of research findings into practical recommendations for service provision. Mere knowledge of Aboriginal cultural beliefs is not sufficient in itself. The knowledge emanating from research of this nature must be linked to policy and integrated with practice. However, culturally sensitive approaches in the areas of health and health service provision may fail if issues such as racism and socio-economic inequity are not also considered. These and other variables are as likely to effect health behaviour as is culture.

The claim by Francis that to 'cite culture is merely to divert attention away from the real objects of concern' is valid (Francis 1993 p. 193). The focus on culture can shift inquiry and action from structural and social inequalities. However, cultural differences do exist and as such are relevant to the study of health in cross-cultural settings. Trudgen (2000 p. 137) views cultural difference as a cost, one that is borne by Aboriginal people on a daily basis with profound effects on quality of life. To deny or diminish the consequences of cultural difference in health care settings serves no obvious purpose and has the potential to compromise care.

This research concerns health services delivered in a cross-cultural setting. Through the process of description, difference emerges as a dominant theme. It is not my intention to denigrate Warlpiri social and cultural practices. Difference should be positively regarded and not viewed as a potential problem but rather another aspect of human expression that health service providers must endeavour to accommodate. The challenge of cultural representation is to avoid introducing stereotypes and portraying people as victims of their social or cultural circumstances while at the same time giving an accurate and honest account of the culture under investigation.
Conclusion

This research employed a sequential mixed methodology combining both quantitative and qualitative data. As this research was conducted within the context of another culture, ethnography emerged as the appropriate methodology. Ethnography was indicated because this research involved concepts foreign to my own cultural background. Traditional ethnography is descriptive. While this research entailed considerable description in the endeavour to achieve understanding there was considerable emphasis on altering the disadvantageous state of affairs that presently describe men's health care at Nyirrpi. As such, ethnographic methods were combined with a critical approach. A linguistic approach to the interpretation of data was employed to enhance comprehension.
Chapter 7

Health and Illness Beliefs in Warlpiri Society
Chapter 7

Health and Illness Beliefs in Warlpiri Society

He who knows much believes little.

Unknown
-Italian Proverb-

Introduction

The human condition in every sense of the word is imperfect. We are by our very nature imperfect beings; our existence is both defined and delimited in part by our physicality. The biological and psychological equilibrium we might equate with well-being are transient qualities. Our susceptibility to illness is one of the common traits of humanity. Existence itself is determined by an inordinate combination of factors, many of which are beyond the control of the individual. Whilst we share this most basic feature of nature, we do not share the beliefs and associated practices attached to the concepts of health and illness.

This chapter examines the beliefs and practices the Warlpiri ascribe to matters of wellness and illness. I will draw on both the literature and informants' responses in detailing these beliefs. Traditional healing practices have diminished, no doubt hastened by the availability of introduced health care. Traditional beliefs however remain both valid and intact. That these beliefs remain entrenched is a testament to the power of the narrative in contemporary Warlpiri culture. Some understanding of how the Warlpiri conceptualize wellness and illness and incorporate traditional ideas with contemporary practice is essential if practitioners are to provide services of optimal quality.
An Overview of Traditional Warlpiri Medical Practice

Traditional Warlpiri medical practice is divided into two categories, those conducted by the *ngangkayi*, the traditional healer and those conducted by people themselves. Both categories are mediated by well-defined beliefs systems and practical knowledge.

The *Ngangkayi*: the Warlpiri Doctor

The Warlpiri doctor or *ngangkayi* is an interpreter of illness within a given social setting. Elkin (1994) described Aboriginal healers as men of high degree. Cawte (1974), who made a detailed study of Warlpiri healers, suggests that exemplary character was not necessarily a requisite for the position of healer. In the minds of many Warlpiri, sickness is largely attributable to a social cause. Cawte (1974) makes the point that the occurrence of sickness and the fear that possible sickness can instill were exploited to induce conformity to authority and to achieve social cohesion.

For Cawte and Kidson (1964), the Warlpiri system of medical belief existed partly as an externalized social conscience. Rarely is the threat of illness sufficient to moderate behaviour in contemporary Warlpiri society. And yet, as an explanatory system of illness, the social cause as diagnosed by the *ngangkayi* is as valid for the Warlpiri as any other.

The *ngangkayi* possesses a spirit, the *maparnpa*, which is the chief mechanism through which he can practice his healing art. The *maparnpa* is inherited from a male relative or comes to the person in a dream (Cawte & Kidson 1964). *Maparnpa* are described as small translucent beings that live inside the *ngangkayi*’s body, usually attached to the ‘strings’ (vessels) of the brain. The *ngangkayi* rubs his body vigorously in order to extract the *maparnpa*, where upon it is cast out in search of a diagnosis. My observations of *ngangkayi* practice confirm the action of rubbing of the chest in an emphatic fashion, presumably to invoke this diagnostic faculty. Once the *maparnpa*...
has uncovered the source of the sickness it will return to the ngangkavi’s body and inform him. Maparnpa may be applied directly to the patient’s body, being used to plug holes where yarda (projected objects) have been extracted or may be inserted to kill other agents of sickness such as snakes and scorpions (Cawte 1974).

The Medicinal Use of Plants

All cultures practice the art of herbal medicine. The Warlpiri are no exception, using an extensive range of plants for medicinal purposes. These have been well documented (Aboriginal Communities of the Northern Territory of Australia 1988; Latz 1995).

Knowledge about these plants, their collection and preparation, is secular; however these tasks ultimately fall to women. In many instances the ritual of collecting plant specimens was associated with traditional ownership of country, so access to medicinal plants might be restricted. There is also a seasonal component to plant use, some bioactive ingredients being available only during certain seasons. Knowledge about medicinal plants has been retained, most children at Nyirrpi being able to identify plants and describe their use. However, this information only survives through a strong tradition of narrative, as the use of medicinal plants is now rare. The ease of availability and the perceived efficacy of non-Aboriginal medicine have all but eliminated this form of traditional self-care.

Song as Curative

Very little has been recorded on this aspect of Warlpiri medical practice. Cawte comments that while song is considered to have healing attributes in many traditional societies the Warlpiri doctor did not provide his patients with ‘interminable comforting songs’ (Cawte 1974, p. 82).
I dispute this claim as I have heard on many occasions the incantations that accompany treatment by the *ngangkayi*. Song is very much a part of the therapeutic repertoire of the *ngangkayi*. The singing of healing songs remains a significant part of Warlpiri medical practice.

Song also has the power to cause harm. Meggitt alludes to this power when discussing the danger associated with the singing of ceremonial songs. He describes the care with which men sing certain ceremonial songs and the harm that may result if overhead by the uninitiated (Meggitt 1962).

*Yawalyu* are decorative designs and ceremonies controlled by women. The function of *yawalyu* seems to be an extension of the female role, having both procreative and curative elements (Munn 1986a). Munn (1986a) claims that both the ancestral designs painted onto the body and the songs associated with these designs were used as a curative amongst women. Songs were sung during labour to facilitate safe delivery and prevent haemorrhage (Nathan & Leichleitner 1983). Unfortunately, these are rarely practiced today and only amongst senior Warlpiri women. The singing of healing songs is often accompanied by the application of fat and ochre, which is believed to make the skin cool and smooth. While *yawalyu* is considered strictly within the domain of female practice it could be applied to men and children in episodes of illness. In this manner, the sacred becomes secular. Illness posed such a threat that women’s religious life could be revealed and shared with the broader community.

**Warlpiri Classification of Illness**

Warlpiri appear to classify illness by one of three categories. Illness is categorized by identifying a body part or product, a symptom or a specific illness. Warlpiri frequently name a body part as the source of illness. A body product such as sputum or pus may be identified as the source of discomfort although there seems to be recognition that
these products are indicative of some other problem. Occasionally, a body part and symptom are combined to indicate the illness such as *miyalu murra-murra* to indicate abdominal pain.

**A Warlpiri Concept of Health**

Before examining the meaning that health might have in Warlpiri society, it may be beneficial to take a historical overview of health and health systems in order to gain some perspective on the origins of our respective systems. Medical beliefs in western culture are based predominantly on science and scientific method. Both modern medicine and public health while based in contemporary science have their origins in far older cultures.

Warlpiri medical beliefs appear to share elements with two distinct and ancient belief systems. The first, animism, is considered the basis of human religion and is believed to have originated in the Paleolithic age. Animism concerns the belief that all objects in the world contain spirits. Animistic deities are immortalized in mythology as the creators of the natural world, concepts very similar to Aboriginal mythology. Animism remains a feature of many indigenous cultures (George & Davis 1998; Helman 1986).

The second system of belief gave rise to healing practice in ancient Greece. The basic principles of Unani concern the composition of the body. This was believed to consist of four basic elements, earth, air, water and fire. Each of these elements could have different temperaments, hot, cold, wet and dry. The body consisted of simple and compound organs, which were nourished by the humors of blood, yellow and black bile and phlegm. These humors were assigned temperaments. Health was said to exist when the humors and temperaments within the body were in balance. Some elements of Unani practice appear in the Ayurvedic practice of the Indian subcontinent although this is said to predate that of the Greek practitioners (George & Davis 1998; Helman 1986).
Warlpiri medical beliefs contain elements related to both systems with temperament and spirit featuring prominently. Whilst there does not seem to be any specific belief concerning humors, the importance of hot and cold properties within the body and in external objects are central to Warlpiri medical beliefs. The idea of balance, which appears in humoral beliefs, is also one shared by the Warlpiri, although with greater emphasis on balance between the body and the environment. Equally, the central notion of life force or spirit is well represented in Warlpiri conceptions of well-being. That these beliefs feature prominently in the medical systems of neighboring cultures raises the question of contact and the possible export of belief systems through ancient trade routes.

Can we assume that the English language word health has any meaning for Warlpiri people? My investigation and analysis of this question was undertaken at the level of language, both English and Warlpiri, as these are the languages we use to negotiate meaning and engage in communication. The reality is that most communication conducted between Warlpiri and non-Aboriginal people is in English. So there remains significant doubt as to the convergence of semantic intent when Aboriginal and non-Aboriginal people discuss abstract concepts such as health.

There have been numerous attempts at defining what health might mean to Aboriginal people. The National Aboriginal Health Strategy Working Party in 1989 described health from an Aboriginal perspective as being:

...not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life (National Aboriginal Health Strategy Working Party 1989, p. x).
Some of these elements are highlighted in the Warlpiri conception of wellness as depicted in the motif below (see p. 108). We are brought back time and again to language, searching for words which might have similar meanings in English and Warlpiri. In terms of health, no such equivalent expression exists in Warlpiri language. But does this mean that a similar concept does not exist in Warlpiri cognition? Again we find the answers to this question in language. Laughren (1984) has indicated the multiple uses and meanings of Warlpiri anatomical terms. She states that these not only have core meanings, but also a number of other applications including physiology and symbolism. These terms may also be used to denote both physical and psychic qualities as well as abstract concepts.

An example might be found in the Warlpiri word milpa (eye). Other than its pure anatomical use, milpa can be used to denote physiology, milpa-parnta (blind) a behaviour, milpa-jararla (deceitful) and as a symbol milpa-narrarra (in the shape of an eye) (Swartz 1998). A number of terms exist to describe certain ‘looking’ behaviours and yet there is no Warlpiri word for sight, the essential function of the eye. That this term does not exist does not mean that the concept is missing from Warlpiri cognition. The word nyanyi (see) is distinct from the sense of sight. The prime physiological function of the eye is inherent in the term and therefore the concept of sight is invoked with the use of Warlpiri words associated with the eye (Laughren 1984).

There are two Warlpiri words that should be considered for their semantic content in relation to the concept of health. The first is ngurrju, meaning good or well. This term is often used for greeting another person, ngurrju-mayi, (are you well?). This term seems to be the only one used in reference to personal well-being.

The Warlpiri word, wankaru meaning life, alive or whole is perhaps closer to our notion of health. The association between life and wholeness suggests an inclusive and far-reaching concept. But there is also an essential difference, for the Warlpiri notion of wellness as holistic concerns the collective of which the individual is but one part.
And this interpretation is not limited to the social aspects of human existence but includes the individual as part of a greater scheme. Individual wellness is connected to the greater order of life, the earth and all it contains. Munn eloquently explains this:

The most central acts of creative autonomy and potency occur within the male cult where the individual constructs or renews ancestral objects and may play the role of his own ancestors in dramatic performance. Through these operations in which he becomes almost 'ancestor-like' he can contribute in certain ceremonies to the reconstitution, or life maintenance of the people, flora and fauna of the countryside...that is to the maintenance of the country itself (Munn 1986b, p. 78)

There are cross-linguistic clues to how the Warlpiri perceive and integrate non-Aboriginal words and concepts. If we examine how Warlpiri use the English word health, we see that it is most often used in association with provision of a service. Health is used as a reference point for objects, such as people, buildings, motor vehicles, in fact anything that is related to the provision of the health service. This seems to imply that the word health is not used in any personal sense to evaluate and describe well-being.

Nevertheless, the concept of health does exist in Warlpiri thinking, and it may even share similarities with the much-criticized World Health Organization (WHO) definition of health, which lists physical, mental and social components of well-being (World Health Organization 1946). The definition also qualifies that the mere absence of disease and infirmity do not equate with health. Brady makes the observation that health as outlined in the WHO definition is an ideal state and one that may be difficult to achieve in reality (Brady 1996). There have been other criticisms of the WHO definition, that the terminology is too broad, that the definition is open ended and that is does not provide specific tools with which to measure health. These criticisms may
well be justified, but the definition is worth considering because its components can be used as a baseline upon which to think about Aboriginal concepts of well-being.

Aboriginal Health Workers at Yuendumu designed the motif depicted below. It represents a Warlpiri view of health. It has adorned the entrance to Yuendumu Clinic for many years and is a powerful reminder of the alternate Warlpiri concepts of health, illness and healing.

Figure 7.1 *Wankaru*: A Warlpiri Concept of Health

![Diagram of Wankaru: A Warlpiri Concept of Health]

**Wankaru: a Warlpiri Concept of Health**

Shelter represented by the windbreak and fire embodies the sense of belonging to place, people and practice important to the Warlpiri sense of self.

Traditional diet represented by food gathering utensils. ‘Bush food’ is regarded as most appropriate for Warlpiri people.

Physical activity through hunting and gathering activities contributed to health. The ability to walk great distances in search of sustenance was essential to survival.

Water gathered at permanent and ephemeral sites was critical to survival in a semi-arid environment.
The Warlpiri specifically equate wellness with the absence of illness. Given that we have already established no parallel Warlpiri word for health, it is interesting to note that a word for sickness exists. *Nyurnu* (to be sick) includes all forms of illness classification. The term *nyurnu-warli-warli-wangu* (the absence of sickness) is used to indicate the well-being of an individual. Here the Warlpiri definition of health is directly opposite to that of the WHO definition. For the Warlpiri, the emphasis appears to be on the avoidance of disease and the steps ones takes to ensure sickness is kept at a distance. Prevention takes on a greater prominence and is achieved by correct behaviour, the maintenance of correct kin relationships, the fulfillment of obligations and participation in ceremonies. A fully acculturated and socialized person is therefore likely to be a well person. This suggests the importance of exemplary conduct as a means of avoiding sickness. This mode of thinking no doubt contributed to the maintenance of social order. Disease or indeed any misfortune is attributed to a cause and the cause is always related to the afflicted individual or a close relative and shortcomings in their behaviour.

The following anecdote illustrates how the Warlpiri concept of well-being extends beyond individuals to encapsulate both conduct and country:

In 1998, I accompanied a group of Nyirrpi people on a trip to a place called Labbi Labbi, an almost mythical site of permanent water on the Western Australian border. Labbi Labbi, a rock hole located north of Lake McKay, is located in country jointly claimed by the Warlpiri, Pintubi and Kukatja. The purpose of the trip was to make a documentary about the Pintubi contact with Donald Thomson (1901-1970). Thompson was an anthropologist who mounted a number of expeditions into the western desert in the late 1950s in order to locate and study the remaining desert dwelling Aboriginals.

The trip to Labbi Labbi took many days. Most of the Aboriginal people in our party had traditional affiliations with the land but had not previously visited this
country. There were no roads or tracks. As we made our way painstakingly across the plains, fires were constantly set in the spinifex. Fire is a traditional land management practice of Central Australian Aboriginal people. Through the setting of fires, people were signaling their presence to mirlitypa, ancestral guardians of country. They were also demonstrating that although they had been absent for many years, they were now conducting themselves with complete propriety. This behaviour was an endeavour to avoid misfortune and to ensure the welfare of people who were far from home.

The Somatic Experience of Wellness

Before I discuss the informant’s beliefs regarding illness, I need to distinguish the semantic differences that exist between the terms well-being and health. These terms are clearly distinguished in the health literature. The terms used by Warlpiri to discuss personal health perhaps have a closer association with well-being.

The experience of physical, psychological and social well-being is both subjective and relative. An individual’s assessment of well-being is related to their personal circumstances. An Aboriginal person with multiple chronic disease diagnoses may make claims to wellness. These claims are made in relation to the circumstances of that person’s life, particularly those circumstances valued by the person. In my experience, it is common for Aboriginal patients to deny any ill effects from their physical ailments, some of which might be asymptomatic. They may claim to feel no ill effects from conditions, particularly those of a chronic nature. This brings into question the subjective experience of illness. Does a raised blood pressure or blood sugar bring about somatic changes that can be detected and attributed to a particular illness? Or do these chronic illnesses manifest in a silent and consequential order? Or is it that the human body makes progressive adjustments to chronic illness so that perception of symptoms is diminished?
Subjective well-being comprises three components: cognition, life satisfaction and affect (Eckersley et al. 2001). It differs from the concept of health in that it does not make any reference to the presence or absence of illness. This then suggests that for some individuals the subjective feeling of well-being is entirely congruous with the presence of disease. The subjective experience of well-being is often associated with happiness and is correlated with control, optimism, self esteem and social support (Eckersley et al. 2001). For the Warlpiri, the social aspects of community, country and culture resonate with considerable importance.

The Warlpiri never consider the physical experience of wellness in isolation. The physical state of the body is always related to something else, usually an activity or place. The simple inquiry, Ngurrju-mayi (are you good?) is likely to receive a response in the affirmative, Yuwai, ngurrju-ka-nyina (yes, I am sitting good!). The relationship of the body to place, in this instance the ground, appears central in Warlpiri thinking. Similarly, the onset of illness is frequently associated with place, the appearance of signs and symptoms being linked not to the body, but to the place they first appeared.

Munn (1986a) in a detailed analysis of Warlpiri religion, notes the central feature of ancestral body transformation into geographical features. She makes the claim that the close association of body and earth in Warlpiri thinking is in effect a form of religious thought. For the Warlpiri, bodily experience is never considered as a freestanding, independent entity. It is always considered in context, being firmly situated in both time and place. I believe that this approach reflects patterns of thinking in which greater emphasis is placed on the relatedness of outwardly independent phenomena.

Laughren (1984) states that the Warlpiri word palka (body) is defined in relation to the non-body such as the ground, thus giving it an unambiguous spatial delimitation. In this manner, the body is realized as a discrete entity, separate to surrounding objects, but nevertheless connected to the environment at a cognitive level.
The Warlpiri appear to assess body function in a fundamental manner. The most basic of body functions are used to gauge well-being. Relatives requesting information about their ailing next of kin, particularly those gravely ill, confine their inquiries to the person's level of activity. Their inquiries will be framed with reference to the person's level of function, if the person is awake, if they can walk or talk. These are perhaps ways Aboriginal people make an assessment of well-being in the technical world of contemporary health care. Warlpiri people are sadly well experienced with the technology of intensive care units and have a rudimentary understanding of its function. And yet the reference points they use to evaluate a person's state of functioning are far more basic.

These basic evaluations are used at a community level and while they give crude information about functioning, these can be very misleading evaluations. Because requirements for functioning are minimal, evaluations may underestimate the degree of illness. The distance between minimal functioning and crisis is not great. It has been my experience that a common reaction in situations of sudden calamitous decline is one of incredulity by those close to the person. Statements regarding the person's state of health prior to collapse are nearly always related to their activity level.

The perception and regulation of body temperature is an important component of correct body function and is often referred to in episodes of illness. A normal functioning body must be both cool and dry. These qualities are inextricably linked to the pirlirrpa (spirit), which is responsible for the regulation of body temperature. The loss of pirlirrpa is experienced as coldness, not surprising perhaps given that the Warlpiri equate pirlirrpa with life force. The importance and validity that Warlpiri people ascribe to the concept of pirlirrpa is evident in the practice of mothers placing their hands over their infants' heads during episodes of coughing or sneezing. This practice is to prevent the dislodgment of the pirlirrpa from the body. The Warlpiri practice of waking someone from sleep by gentle stoking of the eyelids has a similar
rationale. Warlpiri believe that to startle someone, as in sudden waking, is to cause shock and potential dislodgment of the *pirlirrpa*.

The concept of wind, as both an environmental artifact and as breath, is inherent in the Warlpiri conception of spirit. *Warlpa* (wind) is important to the correct functioning of the body. The *pirlirrpa* is responsible for breathing, its own respirations stimulating the lungs and allowing the transfer of wind through the body. This is an essential mechanism by which the body is kept cool.

Animism, one of humankind’s oldest belief systems, comes from the Latin word *anima*, meaning breath or soul (Peile 1997). Air moving through the body keeps the *pirlirrpa* strong and the free flow of air around the body is essential for this to occur. It is therefore not uncommon to find people sleeping out-of-doors, even in the coldest months when they are unwell. Conversely, the hot dry winds so typical of the summer months are avoided as they can cause the *pirlirrpa* to overheat and become weak. Similar beliefs are reported amongst the Kukatja, western neighbors of the Warlpiri (Peile 1997).

The Warlpiri consider the property of heat as being dangerous to well-being. Fever, especially in children is almost always regarded as a serious sign of illness and acted upon by parents. The most common vehicle for sorcery, the *yarda*, is considered to be a very hot object. Its power to induce sickness comes directly from the heat it generates. Once extracted from the body, the *yarda* must be disposed of by either burial or immersion in water, these methods considered the only safe way to counter the danger of these objects.

The Warlpiri seem to adhere in part to the ideas of hot and cold in disease causation, but do not appear to take these beliefs further as in some other cultures, by imbuing hot and cold qualities to various substances for use in therapy.
It was noted that one of the central beliefs concerning *piirlirpa* and the reaction to fright is well reported in literature on humoral theory. As in Warlpiri belief, any fright results in a dissociation of the spirit that then abandons the body. Severe psychic shock alters the body's metabolism and the functioning of the central nervous system in general (Bannerman et al. 1983). For the Warlpiri, mere dislodgment of the *piirlirpa* within the body is sufficient to cause illness. Whilst the cause of this is not related to temperature, the manifestation of *piirlirpa-wangu* or spirit loss as we will see, results in loss of heat from the body and eventual illness.

Sleep disturbance is of considerable importance in Warlpiri society. In non-Aboriginal society, sleep disturbance may be a sign of physical or psychological distress and is usually reported as a secondary feature of some other condition. A person suffering anxiety might be expected to report sleep problems amongst other symptoms. For the Warlpiri, sleep disturbance is of primary concern and its cause is often only a secondary consideration. The primacy of sleep disturbance as a symptom is revealed in the following comment:

'We ask the family what is wrong with you, if you got a pain in the chest or in the stomach or headache or couldn't sleep.'

Piele (1997) suggests that for the Kukatja, sleep is of considerable importance, from both a physiological and religious perspective. Sleep and the act of dreaming is the vehicle through which the Kukatja connect with the spirit world. Tonkinson (1970) makes mention of this in his study of the Mardudjara people of the western desert. He reports dreaming as the mechanism by which people maintain contact with their country, its totemic beings and ancestral spirits. This concept is one shared by the Warlpiri:

'...*piirlirpa*...well you don’t know you dreaming, that’s the way you talk...you good sleep...well *piirlirpa* gone...dreaming, looking out...somewhere walk
around. Nothing in camp...dreaming”. “Hey you mob been stop that way, long way”. Too late...he sit down nothing now...his pirlirrpa that way now, outside.'

As this statement suggests, Warlpiri concerns about sleep may extend beyond mere sleep disturbance. The nocturnal journeys of a person’s spirit during sleep may entail some danger if the spirit is unable to reconnect with the body before waking. As we will see, the disassociation of spirit and body has considerable implication for well-being in Warlpiri belief.

The Importance of Country, Culture and Community in Well-Being

An attachment to country, cultural practices and a sense of community are often associated with well-being by Warlpiri. The importance of ‘being in country’ seems to stem from a multitude of factors. Firstly we need to define what is meant by the term ‘country’. Ownership of country is passed from a father to his offspring. People today are well aware of ‘their country’, of the jukurrpa or Dreaming associated with it and yet may never have visited that country.

People living in communities such as Nyirrpi will largely have no formal ties with the land on which they are living. For example the area of land where Nyirrpi is sited is known as Jitilparnta and is traditionally ‘owned’ by one family. And yet all people who live in Nyirrpi today undoubtedly feel a connection to both the community and surrounding country. It is where they are ‘at home in the world’, the familiarity of people, place and practice fostering this sense of belonging.

Many Warlpiri men spoke about the severance of this connection in terms of homesickness. One man spoke about his elderly father’s longing to return home:
‘...because he wants to be in his country where he knows everyone. Because in
town (Alice Springs) it is different, there is a lot of stuff...he does not feel at
home.’

Connection to people, especially the maintenance of harmonious social relations is
essential to the Warlpiri sense of well-being. People are central to a Warlpiri person’s
sense of identity. This identity has its roots in the obligations and responsibilities
dictated by kinship. When relationships are fractured through conflict or if people are
absent from a person’s life, either through illness, substance abuse or death, people feel
a degree of vulnerability and a loss of identity.

One man described his attempts at self-harm following a community dispute as
resulting not from the dispute itself, but from the fact that he had ‘no family’. Other
than his frail and aged mother, this man had no immediate family members who could
‘jump in’ to support him in his dispute. To him, the absence of family was keenly felt
as his social identity became less secure when forced to deal with the conflict alone.

An informant related a story about the death of a young man, which further illustrates
the importance of good interpersonal relationships and the presence of family. The
young man who died in Alice Springs from an alcohol related illness had lost most of
his family. His only living relative was an elder sister. His refusal to seek treatment
was linked to the absence of relatives, people who could not only encourage treatment
but who would ‘look after’ him. The idea of adults needing to be ‘looked after’ seems
anomalous until we consider what the term means for Warlpiri. The notion of ‘looking
after’ is not limited simply to aspects of physical care, but includes the spiritual, social
and cultural elements inherent in Warlpiri relationships. The Warlpiri concept of
‘looking after’ is well illustrated by the following account:

‘I think that is the main thing you know, you have to have older brothers. Even
older brother has to respect younger brothers. We lucky...we got large family,
“ah we should tell him off”. We worry about ourselves. And we got only a few old men looking after us. We lucky as a group...if I go to town, well I got my brother.’

The absence of senior men is referred to here possibly in terms of guidance on matters of Warlpiri Law, which the latter no doubt provided. But the fact that this informant had many ‘brothers’ (both actual and classificatory) was considered fortunate as the ‘brothers’ could chastise and look out for one another.

Strong family relationships were requisite to this ability to ‘look after’ as was further described:

‘Yeah but now I am grown up and I’m in my thirties...you know and um, I’ve seen a lot of young fellas passing away younger. I’m different because my family love me and when I was young I had my family beside me the whole time. And my family still worries about me and I am closer to them.’

When asked if Warlpiri families were strong one informant replied:

‘No, they are not and you have got to have a strong family pushing you. I think ‘specially man’s way you’ve got to have a strong brother and strong uncles.’

Aspects of religious life and Warlpiri Law were mentioned by one informant as being both strong and important to a sense of well-being. The majority of men however expressed concern about the non-adherence to these rules of Warlpiri life and pondered how these changes might manifest in people’s lives.
Traditional Warlpiri Illness Beliefs

In Australia, mainstream health services have long been imposed on Aboriginal society, in effect diminishing and sidelining traditional Aboriginal medical systems. Despite this, much of these systems have remained intact in part because of a strong tradition of oral transmission of both knowledge and experience.

At the time of contact, the Warlpiri had a well-established medical philosophy and practice. The treatment of common ailments was and remains the shared knowledge of the community. Cawte and Kidson (1964) reported that this knowledge, especially the location and preparation of medicinal plants, resided with the senior women. This still seems to be the case today, and although traditional treatments are used less frequently, they are still considered effective by many Warlpiri.

Traditional Warlpiri beliefs concerning the cause of illness are strongly characterized by malevolence. The ill will of both human and supernatural agents directed at Warlpiri were most frequently reported in my interviews with Nyirrpi men. I will now discuss the emergent themes concerning the aetiology of illness and death in Warlpiri society.

Natural Causes of Illness

This category of disease classification is dominated by environmental causes. Central to these are causes associated with the weather. Extremes of temperature are implicated. ‘Strong sun’ is considered responsible for many complaints ranging from headaches to meningitis. The conditions caused by ‘strong sun’ pertain mainly to the head. It is not uncommon during the summer months to see people protecting their heads with wet clothing. Likewise, infants have their heads covered from direct sunlight, as they are considered vulnerable to this type of illness.
Equally, cold weather is associated with various respiratory complaints. Warlpiri often complain ‘pirriyarlku-karlpimi’, to indicate the suffering induced by cold weather. Wind, which at Nyirrpi often blows from the east is said to bring with it troubles from neighboring communities.

Whilst these environmental causes can be guarded against there is also a sense of inevitability that accompanies these beliefs. The manifestation of illness is as much about chance as personal responsibility. Supernatural causes however place greater emphasis on the individual and their social culpability.

**Supernatural Causes of Illness**

Supernatural causes place the origin of disease outside the ordinary operation of cause and effect. For the Warlpiri there are two broad mechanisms through which illness is induced, that of malevolent agents and acts perpetrated but not directly observed.

**Yarda: The Projection of Illness**

Cawte claimed that sickness caused by evil entities was far exceeded by human malevolence. This was achieved by incantation and the projection of objects, notably the **yarda**. The **yarda** is a small blade usually made from mulga wood 3-6 cms long and incised with markings to indicate the time between projection and onset of symptoms. Other projected objects include **pirli** (stones), **ngapa**, (water) and **yalyu** (blood). These objects are ‘sung’ into the body of the victim by another person. This form of interpersonal activity undertaken by aggrieved individuals creates a climate of insecurity, fear, suspicion and revenge. According to Cawte and Kidson (1964), the source of these projected objects could usually be identified and were rarely attributed to people other than Warlpiri.
Belief in projected objects remains strong. *Yarda* are still removed by the *ngangkayi* today. Belief surrounding *yarda* have changed however. Most commonly these are now attributed to people other than the Warlpiri and in many instances the victim may be accidental. *Yarda* are considered very dangerous objects and are usually only handled by the *ngangkayi*.

*Yarda* was most commonly mentioned when discussing Warlpiri beliefs regarding the cause of illness. Most commonly men spoke of *yarda* being ‘sung’ into the body from a great distance. There was considerable difference of opinion regarding the perpetrators of *yarda*-induced harm. Most men blamed neighboring communities, particularly the Anmatyere and Alyawarra who are considered especially knowledgeable in these matters. Such malevolent behaviour was less likely from the Warlpiri’s close neighbors, the Pintubi and Luritja. Some men believed that it was entirely possible for Warlpiri to ‘sing’ *yarda* into fellow Warlpiri, but this was unlikely to occur within a community. A number of men spoke with suspicion of the activities of Warlpiri living at Willowra and Lajamanu, believing their fellow Warlpiri had both the intent and knowledge to inflict harm with *yarda*.

Men attributed the acquisition of *yarda* to a number of causes. Animosity between men was most commonly reported, this arising from marital infidelity. Acquisition of *yarda* could be accidental. Men frequently mentioned this when discussing their own experiences with *yarda*. A widespread belief was that *yarda* were invisible during projection and hence unavoidable. Standing between the intended victim and the perpetrator was frequently mentioned as the cause of accidental acquisition of *yarda*. The wearing of clean clothes was said to attract *yarda* and could also lead to accidental acquisition.

Men believed there were few initial signs or symptoms associated with *yarda*. Entry of the *yarda* into the body most often went unnoticed. Men believed that people acquired *yarda* when visiting other communities and that symptoms would not appear until they
had returned to their own community. The first symptoms were said to include weakness, numbness, swelling and pain. If these symptoms were ignored fever and rigors might herald the appearance of far more serious symptoms:

‘If somebody do put yarda inside your body or inside your brain you feel funny, makes you laugh, laugh for no reason. And you don’t know what you doing…make you mad.’

Most men were confident that yarda was not fatal as long as the ngangkayi was consulted. The removal of yarda by the ngangkayi was not considered a difficult procedure and was universally believed to restore health and well-being. The process of extracting yarda is well described in the literature (Cawte & Kidson 1964) and corresponds with observations made by myself. The consultation involves a brief history taking to elicit the nature and source of the complaint. The examination involves considerable palpation to uncover the location of the offending yarda. This is followed by vigorous manipulation to bring the yarda to a point where it can be sucked from the body. The yarda is then dramatically expelled from the mouth of the ngangkayi, often accompanied by blood and mucous.

Men expressed concern about the availability of skilled traditional practitioners to treat yapa-kurlangu nyurnu (Aboriginal sickness). It was acknowledged that non-Aboriginal medical science was ineffectual in the management of these conditions.

Yarda is not the only means by which illness can be inflicted. Men spoke of pirli (small stones) and warua (snake) being projected into the body by those wishing to inflict harm. Other mechanisms for inflicting illness include the drawing of body organs in the sand, pointing kangaroo bones and ‘singing’ human hair. The terms pointing, singing and boning are used variously to refer to the act of projecting illness.
Pirlirrpa-wangu: The Loss of Spirit

*Pirlirrpa* is described alternately as spirit, life force and the seat of emotions. The concept of *pirlirrpa* is more than an essential component for the functioning of a healthy body, it is necessary for life itself. Without *pirlirrpa* life cannot exist. The men of Nyirrpi described features of *pirlirrpa* that suggested its function as both a life force and the genesis of human emotion.

*Pirlirrpa* was described as a fragile entity, adversely affected by social disharmony. The most common mechanism through which *pirlirrpa* is lost was said to be the startle reflex. In particular, waking suddenly from a deep sleep, loud sounds such as shouting or any situation causing fright was likely to cause the *pirlirrpa* be dislodged or to take flight from the body.

‘The person goes to sleep and that pirlirrpa go to sleep. If something happened...when you get a fright, well pirlirrpa goes away...jump out.’

When dislodged, the *pirlirrpa* leaves its usual location in the abdominal cavity to become wedged in the upper back or the shoulder. This dislodging causes the *pirlirrpa* to become ‘cramped’ causing pain to the person. This situation is readily diagnosed by the *ngangkayi*, the *pirlirrpa* is extracted, ‘straightened out’ and returned to its correct location in the body.

Once the *pirlirrpa* becomes separated from the body however, it slowly withers to the point where it ceases to exist. This is accompanied by a slow physical deterioration and eventual death in the person from which the *pirlirrpa* took flight. Most men stated that if diagnosed early the *pirlirrpa* could be located by the *ngangkayi*. The *pirlirrpa* was said to take refuge in a nearby bush or tree. The *pirlirrpa* is considered invisible to all except the *ngangkayi*, however was audible when dislodged from the body, often heard crying at night. This was always considered a precursor to illness.
Two other mechanisms for spirit loss were mentioned. Any surgical procedure where the body is incised may lead to *pirlirrpa-wangu*. If the person undergoing surgery is extremely anxious, the *pirlirrpa* might take flight once the surgical incision is made. This was considered a grave problem for people undergoing surgical procedures in regional medical centers. A person returning to their community following surgery in a state of *pirlirrpa-wangu* was unlikely to recover. It was believed that the *ngangkayi* might be able to ‘sing up’ the *pirlirrpa* and return it to the body, but most likely the *ngangkayi* would have to travel to the place where the surgery was performed in order to locate the *pirlirrpa*.

Deliberate interference with a person’s *pirlirrpa* was also mentioned. During times of ceremony, *wamurlu*, the plant and animal down used as body decoration could be ‘sung’. When applied to the body, the effect was said to ‘pull down’ the *pirlirrpa* causing illness. This was done in retaliation for men’s sexual indiscretions. It was also reported that elders had the ability to capture and hide a person’s *pirlirrpa*. This was considered especially serious, as it was unlikely that the *ngangkayi* could successfully intervene in such a situation.

The loss of *pirlirrpa* from the body is believed to cause a decline in body temperature and weakness. Other symptoms were said to include vomiting, slowed breathing, joint and bone pain, diarrhoea, weight loss and anorexia.

*Mirlalypa, Jarnpa and Kunku: The Infliction of Harm*

*Mirlalypa* is defined as a:

...spirit being able to give *purlapas* (ceremonies) to people in dreams. They are the guardian spirit associated with each Aboriginal person (Swartz 1998, p. 80).
Cawte and Kidson (1964) record that *mirlalypa* was the spirit twin that accompanied every Warlpiri person throughout life. *Mirlalypa* were described as moral beings that enforced respect for sacred objects. They were thought capable of inflicting punishment, usually in the form of a bite from a mythical snake. This punishment was never severe and usually manifested as pain that resolved once the victim realized their transgression.

*Mirlalypa* are still recognized by the Warlpiri. They are no longer seen as spirit twins living in close proximity to Warlpiri but are associated with country that Warlpiri now visit infrequently. They are believed capable of inflicting punishment in the form of sickness but are said to be ‘quiet’, and not life threatening.

The attribute of benevolence was one that resonated from the interview data. *Mirlalypa* were variously described as ‘friend’, ‘protection’, ‘safety’ and ‘bodyguard’. It is believed that *mirlalypa* protect people whilst they are ‘in country’ (away from the community, in the bush). *Mirlalypa* could guide people to water and food or protect them from the evil doings of *kuuku*. Most informants believed that *mirlalypa* were now only found ‘in country’ (country traditionally owned by Warlpiri families):

‘My country is *Kunajararravi*, well there is a lot of *mirlalypa* hanging around there. I can go anytime, I can sleep (there) by myself because I am from that country. I just talk, “ah it is me, I’m Jungarayi”. All they do is watch me, that is all.’

Given their guardianship role for country, *mirlalypa* can inflict harm on any person who transgresses while visiting country. The rules for visiting country involve making appropriate introductions to *mirlalypa*. This involves calling out your name, your relationship to the country and the purpose of your visit. Failure to do this would incur the displeasure of *mirlalypa*. One informant advised:
'Don’t pick up a rock or stick or anything...they’ll make you sick or sing you or something.'

It is generally believed that *mirlalypa* would not cause a person’s death. The punishment is never severe and usually resolves once the person realizes their wrongdoing and makes appropriate amends. Punishment could include pain, dizziness, madness and blindness. It was generally believed these were inflicted either by *yarda* or ‘singing’ the *pirlirrpa*:

‘*Mirlalypa* can make you sick with *yarda*. Poison one. Sing ‘im that *yarda*. Make ‘im no good one.’

It was generally agreed that illness caused by *mirlalypa* was amenable to the interventions of the *ngangkayi*. If the offence was regarded as one of omission and a breach of protocol it could be readily rectified by negotiation. This negotiation, conducted on behalf of the victim took place between *mirlalypa* and the traditional owner of the country where the offence took place. Such a negotiation would involve the same steps of introduction, detailing links to country, the purpose of the visit and the reason for the transgression (such as the need for firewood or food). It was suggested that these things were known by *mirlalypa*, the identity and intent being deduced from the footprints left by the intruder. For the illness to be removed correct protocols had to be observed.

The punishment of transgressions while ‘in country’ can equally apply to *kirda* (traditional owners). The fear of punishment seems a social mechanism for the equitable access to resources.

‘One old fella, my grandfather Japaljari, he went to his country and then he got this gold. It was gold, then he brought it back here and showed it around,
showed it to karnta (women), “ah I found it at Kunajarrayi”...that mirlalypa came and made him blind.”

Non-Aboriginal medical science attributed this old man's blindness to diabetic retinopathy. This diagnosis made little sense to either the old man or his relatives. In essence it was a diagnosis made within a cultural and social void, as it did not connect with the social reality of his life. There was little logical connection between the ‘sugar sickness’ he had suffered for many years and his inability to see. His revelation of objects to women was considered a more likely cause.

Another form of sorcery practiced is yirrarni, the carving of a person’s likeness on a tree. People today speak of ‘putting a person’s name in a tree’ as a vehicle for inflicting illness. Another form of sorcery was achieved by poisoning. For this, mawunya (poison), in the form of a special stone imported into Warlpiri country is added to food or articles of clothing to inflict sickness.

Jarnpa and kuuku were separate entities that today are considered by many to be synonymous. This change in understanding is most likely a direct result of cultural change. Cawte and Kidson (1964) described jarnpa as mortal avengers, senior Warlpiri men who were appointed to the position of jarnpa for the express purposes of judicial incantation and execution. The role of jarnpa was intended to ensure adherence to ceremonial practices as dictated by Warlpiri Law. Whilst today there is an uneasy and limited recognition of Aboriginal Law by the Australian legal system there is certainly no tolerance for the socially sanctioned executions as practiced by jarnpa. As such these positions have disappeared.

Kuuku are supernatural beings capable of inflicting deadly harm to people, especially those whose behaviour has been less than socially acceptable. Kuuku are nocturnal entities and their presence may be indicated by the appearance of a black feather or broken twig overnight. The kuuku’s intent may only be the procurement of food,
nevertheless people are mindful of venturing far from their homes, especially at night. *Kuuku* was described as *yapa-piya* (like human) and decorated with *wamurlu* (plant or animal down).

*Kuuku* are agents for direct supernatural intervention. *Kuuku* might ‘sing’ a person with *yarda*, but the usual mechanism for inflicting death was described as such:

‘*Kuuku* comes in the night, they slit your throat, put grass...spinifex grass in your throat and they can seal it up by singing your throat and no one will know it. You wake up...they give you time, you know...might be one day. Well you wake up and might be something trips you up, trips you over and you go and pick a fight with your brother. And your brother says, “ah I don’t want to fight with you”, and you still want to punch him. And eventually you punch him and as soon as your brother pushes you, well that’s it...you’re finished.’

The story of spinifex grass in the throat was repeated on many occasions. The common theme in all these accounts concerned sudden death in the absence of any physical signs. These beliefs were often used to explain male mortality, particularly when apparently healthy young men died suddenly without any obvious cause. Most men were aware of the consequences of risk taking behaviour and could readily identify any number of behaviours likely to contribute to illness and early death in men. Whilst these behaviours were recognized they were rarely attributed as cause. One could argue that this is a form of denial, but again I think that the power of traditional beliefs lies in their explanatory value. They are the reference points on which individuals base their response in times of illness and death.

**Contemporary Warlpiri Beliefs of Illness Causation**

However, not all men believed illness to be exclusively caused by the malevolence of supernatural beings. There was certainly awareness that lifestyle and behaviour
changes were causing illness amongst Warlpiri men. When asked about the implications of *yapa nyurru* (Aboriginal sickness) one man responded:

‘I think it is *yapa* making a mistake, like drinking *pama* (wine).’

The Warlpiri informants I spoke with were well aware of the health crisis confronting their community. Men were able to name the major disease entities new to Warlpiri experience. Men saw a distinct link between the changes in their lifestyle and the illnesses they now suffer.

Informants cited changes in two key lifestyle areas as instrumental in altered patterns of health. Changes in diet, specifically the change from ‘bush foods’ to store foods was cited by nearly all informants. There was an overwhelming belief that bush foods made Warlpiri people strong. There was no explanation why store foods were inappropriate for Warlpiri people. However the suitability of bush food to Warlpiri people was revealed in the men’s accounts of their grandparent’s lives. All men agreed that their grandparents were healthy and readily listed the foods that not only sustained them, but also enabled them to thrive in a semi arid environment.

‘They were healthy because they lived in the bush. They had a good life, good living.’

Despite the common belief as to the unsuitability of store foods for Warlpiri people, these very foods are now dietary staples. One man described the attraction of new food as such:

‘We just see something that tastes better and we can’t stop. Like with grog, tastes better. We don’t say, ‘ah that’s rubbish’, we just keep on.’
There was awareness that these altered circumstances of Warlpiri life had been imposed. That dramatic changes were wrought on Warlpiri life with the transition from nomadic existence to that of community life is unquestioned. So too, are the effects of dietary changes on health in the minds of many Warlpiri men:

‘...because kardiya (non-Aboriginal) brought different sorts of things, sugar, tea leaf...any kind of foods.’

The second area of lifestyle change commented on by men concerned physical activity. Men spoke with pride about the great distances their forebears were able to walk. It was recognized that this need to travel was directly linked to survival:

‘They used to walk, camp one night, soakage to soakage. They travel a lot.’

Implicit in these discussions was the recognition that the physical activity of walking great distances was beneficial to health. Men linked the inactivity of sedentary living with contemporary health problems. When asked the reasons for ill-health one man stated:

‘Some people, you know I watch some people and they don’t walk around too much.’

The enforced change to community life meant the need to walk to ensure survival was no longer necessary. The complexity of changes wrought in lifestyle is hinted at when one man describes the reasons why people can no longer walk the great distances his ancestors once did:

‘...nah, because sugar been stop them. Because sugar been go in their wanarri (leg) and cigarettes and tobacco. In old days, tobacco, janyungu (native tobacco, taken for its central nervous system stimulating effect), they used to
get ‘im from pirl (hill), they really good for him. They could walk a long way.’

The new foods on which Warlpiri people rapidly became dependent were likened to poison. Sugar was viewed as physically disabling and chewing tobacco regarded as an inferior stimulant.

One man detailed the travels of his parents:

‘Well they didn’t have sweet stuff, sugar and grog and smoke. My mother was showing me. They used to walk from Vaughan Springs right up to Haast Bluff, they used to walk up with my father and mother. All the family group, they went to Haast Bluff, yeah foot walk. Through Newhaven, yapa used to live there, Warlpiri. Well they used to go to Haast Bluff for ration, after one year or three year they moved back. Right back foot walk. Living on bush tucker.’

Men spoke about the devastating effects of alcohol. Many men cited alcohol as the cause of death in young men. Whilst other substances were mentioned, alcohol featured strongly in the men’s responses. Alcohol was seen as the cause of both mortality and morbidity in Warlpiri men primarily through motor vehicle accidents and acts of violence. Many men viewed alcohol as a poison, one which slowly destroyed body organs. Other men saw the problems wrought by alcohol as arising not from the substance itself but from the manner in which it was consumed. Men used terms such as ‘one side drinker’ and ‘hard for grog’ when referring to people who choose to drink alone. The act of not sharing alcohol was considered dangerous and likely to result in illness. The mechanisms through which this occurred were unclear, perhaps the solitary drinker consumes more alcohol but more likely this behaviour was contrary to the reciprocity which characterizes most Warlpiri social conventions.
Again the sense of imposition was evident in the men’s responses:

‘whitefella came and bring the grog and that is why people get sick.’

Memories of life without alcohol have been passed on in families. These stories form part of an overall narrative about pre-contact life. These stories have both immediacy and validity given that these are the first hand experiences of community elders. The connection between alcohol use and grief was made by a number of men. In some instances family disputes might prompt people to drink. One informant stated that concern and respect could be elicited from relatives by excessive drinking. However, the loss of multiple family members was a tragedy from which few could recover. For the survivors, the only solace to be found was in alcohol.

The Warlpiri concept of ‘looking after country’ is equally applied to people. This implies not only land management practices, but also the cultural obligations associated with sacred sites, practices that indelibly link people to land. Similarly, in a human sense this term also implies more than physical care. The obligations and responsibilities that exist between people determine social identity. This is an important point and one that was inferred on a number of occasions. For Warlpiri people, their relationships with other Warlpiri, both within and outside the family defines not only who they are, but how they behave as social beings. The unrelenting loss of ‘significant others’ undermines the foundations of this social identity and perhaps prompts survivors to seek the oblivion found in alcohol.

One informant mentioned the notion that illness could be passed on in families. This hereditary explanation was an interesting observation given the pattern of chronic disease within some families. Another informant stated that environmental factors were important in the genesis of disease. These related exclusively to the misuse of infrastructure, such as the inappropriate use of toilet facilities and other issues related to repair and maintenance of buildings.
Discussion

Warlpiri people generally consider their healing systems to be incompatible with non-Aboriginal medical practice. That traditional Aboriginal healing modalities have never been comprehensively incorporated with non-Aboriginal clinic services indicates this essential incompatibility. As one man stated:

‘Yeah, needle makes you better. Or we might think, “ah this ngangkayi man has got to make me better”. We think two way.’

This ‘two way thinking’ suggests a dichotomy in both thought and practice concerning illness and health care. This situation is in part a consequence of history. The exposure to non-Aboriginal medicine appears in many of the records of early contact between the Warlpiri and non-Aboriginal people with various accounts of the ailments encountered and treated (Adler 1957; Cleland 1928; Reece 1943). Warlpiri people display a degree of pragmatism by utilizing both systems of health care. This apparent accommodation of differing medical philosophies suggests nothing more than a desire for comprehensive treatment.

In most regions of Australia, traditional Aboriginal systems of healing have been irrevocably lost. In Central and Northern Australia there is a declining interest in traditional medicinal lore. This perceived ambivalence has prompted research to investigate the bioactive components of medicinal plants and record the methods of collection, preparation and application (Aboriginal Communities of the Northern Territory of Australia 1988; Latz 1995). Equally, the future existence of Aboriginal healers is in doubt (Cawte & Kidson 1964; Elkin 1994). The practice of traditional medicine, like other aspects of Aboriginal culture has declined in the face an imposed and alien culture.
In this chapter I have shown that while Warlpiri healing practice may have diminished, beliefs systems regarding illness remain intact. Beliefs are only visible when they manifest in behaviour. For the practitioner, different illness beliefs are largely invisible and as such represent hidden obstacles that can confound health care.

Nathan and Leichleitner comment on the combination of traditional and contemporary medicine in Central Australia by suggesting that ‘the marrying of these beliefs has led...to dishonest, confused and manipulative approaches to health care’ (Nathan & Leichleitner 1983 p. 70). There are two problems with this statement. Firstly, I would suggest that the combination of belief systems in contemporary health care is something that rarely occurs because practitioners have little knowledge of Aboriginal belief systems. I suspect that many practitioners fail to appreciate how entrenched these beliefs remain in Aboriginal thinking. Secondly, Nathan and Leichleitner's assertion that the combining of belief systems is both dishonest and manipulative reflects an ignorance of the complex nature of contemporary health care in remote Aboriginal communities. The following anecdote reveals some of the issues and challenges posed by divergent belief systems:

A small boy was brought to the clinic. The boy’s father was a ngangkayi and well regarded for his ability to heal. The boy had become ‘miserable’ during the afternoon and had refused his evening meal, preferring to sleep.

On examination, I found the boy to have a high fever and elevated pulse. Other vital signs were normal, however the child was drowsy and a little irritable. I consulted the doctor. He advised immediate hospitalization so that meningitis could be excluded.

I discussed the child’s condition and plans for his hospitalization with his parents. On hearing this news, the mother picked up her son and carried him from the clinic stating; ‘father will fix him’. I advised the doctor of this
development. The doctor requested that I notify the Police so that the child could be located and returned to the clinic. This course of action was not pursued.

The child was duly returned to the clinic. The father stated that he had removed dirty water and a small stone from the child’s body and that the child would now recover. A discussion of illness framed with reference to foreign objects ensured. The danger posed by dirty water and stones was explored and hospital based treatment was discussed within the context of these beliefs. The parents consented to their son’s hospitalization. The diagnosis of meningitis was confirmed, the boy was treated and he made a full recovery.

This anecdote highlights the importance of acknowledging alternate beliefs, no matter how alien they may seem. For the practitioner, acknowledgement of such beliefs may appear detrimental to individual well-being. In such instances, the practitioner is responsible for the clear communication of information and where possible, interactions should support and incorporate Aboriginal beliefs.

Beliefs can be seen as reflecting a view of reality. Warlpiri people with diabetes and hypertension are well able to repeat the lifestyle messages they have received regarding their illness management. And yet enactment of these messages can fail, perhaps not because they have been misunderstood but because they relate poorly to Warlpiri reality. Morgan et al. (1997) claim that Aboriginal people have a preference for concrete knowledge that they can relate to the immediate context of their lives.

Bain (1992) makes an astute observation when claiming that Aboriginal people rarely venture far from what they can access directly through the senses, whereas non-Aboriginal abstractions often break that link. This suggests the importance of how we, as non-Aboriginal health professionals present information to our Aboriginal clients. This becomes readily apparent if we attempt to link the cause of disease to treatment.
Aboriginal people may be less amenable to treatments they feel are not related to their illness. This implies the importance of the social and cultural context in which diagnosis and treatment is explained. While it is important that people receive information, the challenge lies in the language we choose to impart this information. The challenge is to balance an understanding of disease with appropriate cultural reference points. The communication of non-Aboriginal medical concepts takes considerable skill and the line between comprehensibility and condescension is a fine one.

Conclusion

Culture is the weave through which the world is both experienced and interpreted. As such, culture determines how illness and health are socially organized in any given society. Understanding specific systems of belief and practice is essential for successful cross-cultural practice. In Central Australia, health care in Aboriginal communities is dominated by non-Aboriginal systems of belief and practice. And yet, traditional Aboriginal beliefs concerning health and illness remain very much intact, valid and embodied in contemporary life. As these beliefs and associated practices are invoked they undoubtedly impact on behaviour, eliciting responses often unintelligible to non-Aboriginal practitioners. The potential for conflict when divergent medical systems come into contact is considerable and the consequences of this conflict are largely borne by Aboriginal people.

For non-Aboriginal practitioners, understanding traditional illness beliefs is best realized through the phenomenological and social meanings with which they are inscribed. Warlpiri medical knowledge can be seen as part of the broader Warlpiri cosmology. This knowledge can only be considered in reference to broader societal structures. Given that these beliefs have now been so effectively overshadowed by non-Aboriginal medical science both their existence and importance can go unrecognized by non-Aboriginal practitioners.
This account of Warlpiri medical beliefs reminds the non-Aboriginal practitioner that divergent world-views exist and manifests in the lives of both client and the service provider. Failure to account for these beliefs can compromise the care given in a cross-cultural setting.
Chapter 8

_Luyurr-ngumani Nyurnu: Worrying About Sickness_
Chapter 8

_Luyurr-ngumani nyurru_: Worrying About Sickness

_Sickness is felt, but health not at all._

_Thomas Fuller_

_-_Gnomologia-

Introduction

In times of crisis, help-seeking is a sign of constructive coping and self-enhancement. There is enormous diversity in people’s response to health crises. The factors influencing the decision to seek help can be complex. The core components of help-seeking are the event that prompts action, the person experiencing the crisis and their social networks. Within each of these components there are a myriad of variables all likely to contribute to the dynamic nature of decision making.

Decisions regarding help-seeking can result in one of three possible outcomes. Those decisions are to seek help, delay help or to decline help. The consequences of delaying treatment are rarely positive. At best, the presenting condition, due to its advanced state can require aggressive and prolonged medical treatment. At worst, given the realities of remote area life, delays in treatment can be potentially fatal.

This chapter represents an attempt to examine the path Warlpiri men take to treatment and to identify significant points in the decision making process which might result in delayed treatment. The path to treatment is likely to vary for each person. Decisions regarding illness and the seeking of help involve thinking and behaviour. There is an enormous body of literature spanning the human sciences with numerous theories and explanatory models developed to account for health and illness behaviours. It is not
my intention to embark on a detailed review of this literature, but rather to attempt to extract some common themes that may be of use in my analysis of help-seeking in Nyirrpi men.

**Help-Seeking and Illness: An Overview of Relevant Theory**

The literature details a shift from early theories that depicted decision-making as a static and one-dimensional process with set psychological and behavioural components to later models of a multi-dimensional, dynamic and inherently social phenomena.

Perhaps the earliest and most well known attempt at analyzing health behaviours was made by Hochbaum, Kegels and Rosenstock who in 1952 developed the Health Belief Model. This model was devised to systematically explain and predict preventive health behaviour. The Health Belief Model is based on the idea that behaviour is dependent upon the value of a certain outcome and the likelihood that such an outcome can be achieved by taking certain actions (Diefenbach & Leventhal 1996). These ideas were applied to the health domain. In the Health Belief Model there are two central tenets, the first concerns the impetus to take a health action and the second concerns the preferred path of action. The impetus to act is determined by one’s perceived susceptibility to an illness and the likely severity of that illness. The path to action is determined by the expected benefits of the particular action but only when these outweigh the practical and psychological barriers to action (Kirk-Sanchez 1999; Wedding 2001)

In Social Learning Theory, Rotter developed the notion of personal control and its role in decision-making (Rotter 1954). In this theory, learning is viewed as a manifestation of reinforcement that result in the development of beliefs regarding the influence of one's actions on outcomes. Rotter proposed that there are two classes of belief concerning both action and outcome (Rotter 1954). The first is characterized by the belief that one had control over one's actions and therefore control over outcomes. The
The second system is characterized by beliefs that outcomes result from actions over which a person has little control. These ideas about control are applied to health behaviour. The Health Locus of Control scale was developed to measure beliefs that a person's health is determined either by their own behaviour or by forces outside their control (Wallston & Wallston 1978).

A concept similar to locus of control is that of self-efficacy. This principle refers to a person's beliefs about their ability to produce levels of performance sufficient to influence events in their life (Bandura 1994). The confidence in one's abilities to overcome problems and meet challenges is fundamental to how people think, feel, and behave. Whilst not explicitly stated, self-efficacy is based on a sense of control with successful problem solving enhanced by a belief in one's ability to overcome challenges.

Ideas concerning control appear in other behavioural theories. In the Theory of Planned Behaviour, the performance of a specific behaviour is a joint function of intention and perceived control over behaviour (Ajzen 1991). Intentions are the motivating forces behind behaviour. They are subject to conscious control and are dependent upon both resources and opportunities. These factors determine the degree of control that can be exerted over behaviour. Ajzen (1991) proposed that one's ideas about the prospects of success were of greater importance to outcomes than the actual ability to solve problems.

A more recent trend in the research on decision-making has seen a shift from behavioural to sociological phenomena. The shift in focus from individual choice to socially constructed patterns of decision making emerged in part through the sheer variety of cross-national studies of health and illness. Rational action frameworks were deemed inadequate because they failed to fully account for the features of social life and their place in decision-making (Pescosolido 1992). While acknowledging core cognitive processes, the sociological shift was both event and network centered.
Decisions were represented as a series of moves beginning at the point of problem recognition through to action. Importantly, the process was seen as one involving actors embedded within social networks, making decisions not in isolation but in negotiation with others. The concept of social networks implies other variables such as beliefs, values and practice. Whilst these characteristics are individually held, they are in part socially determined (Pescosolido 1992).

No single theory achieves a perfect fit with reality. This is evident in the ongoing development and refining of key theories. The contexts of health, illness and behaviour are broad and varied. The frame of reference for any theory is dependent upon the unit of analysis. The number of theoretical constructs and their inherent variables suggest the application of the most appropriate theory or theories to the unit of analysis.

An overall criticism of many theoretical frameworks is that of cultural bias, that they are not necessarily applicable across all societies (McAllister & Farquhar 1992; Poss 2001). Another criticism is that some theoretical constructs are positively correlated to certain political systems. In those societies characterized by collective or repressive political regimes an external locus of control may become an adaptive feature of life.

Theoretical frameworks are defined and potentially limited by the field of humanities from which they emanate. Psychological models such as the Health Belief Model have been criticized for failing to account for variables such as social norms and economic factors. These are valid criticisms and within the literature there are numerous examples of synthesis, combining or adapting models in an attempt to achieve a closer fit between theory and reality (Poss 2001).

The Nyirrpi data on help-seeking has been analyzed from the perspective of the individual, their internal world of beliefs, values and motivations and their external world of social relationships. Theories and models are useful tools for understanding
complex relationships between variables. Every effort should be made therefore to match as closely as possible the model being proposed to the reality under investigation. Whilst there is much merit in this approach, it is important to remember that the model is only a tool and that the prime focus should remain on the reality being investigated.

The salient constructs to emerge from the literature are those of perceived susceptibility to illness, the interpretation of signs and symptoms, a confidence in the ability to resolve problems and the threats posed by treatment. These align closely with the information provided by Nyirrpi men.

The Susceptibility to Sickness

Susceptibility is a construct of the Health Belief Model and is defined as the subjective interpretation of the risk of contracting an illness. This construct relates the concept of risk against the likelihood of a specified behaviour. In the context of this research, susceptibility is related specifically to help-seeking and is only considered briefly here as illness typologies have been considered in detail previously.

Most of the men interviewed in this research believed they were susceptible to yapakurlangu nyurmu (Aboriginal illness). The dual model of illness causation that exists in Warlpiri society gives rise to multiple foci of risk. Nyirrpi men mostly considered themselves vulnerable to illness generated by malevolent and supernatural beings. Men believed that there was little that one could do to avoid this form of illness, but with the correct diagnosis and prompt treatment by the ngangkayi, well-being could generally be restored. There was a distinct association between illness and social control, with illness being considered both a punishment and a deterrent.

With those diseases classified as kardiya-kurlangu (belonging to non-Aboriginal people), susceptibility was directly attributed to lifestyle choices. Alcohol, tobacco and
poor nutrition were readily identified as factors that increased a person’s susceptibility to developing a chronic disease such as diabetes or hypertension. There was recognition that the shift from a nomadic to a sedentary lifestyle carried with it risks for all Warlpiri people and as such everyone was at risk of illness. This sense of inevitability is revealed in the following statement:

‘...just since the whitefella came in...we have wrong food, we don't look after ourselves, we have sugar problems, with blood pressure with myself and other people round here.’

In the Warlpiri context, the issue becomes one of both susceptibility and attribution. Explanations of illness can emerge from one of two belief systems. The differentiation between attribution and susceptibility is significant in that it highlights the differences in thinking about illness states. This manifests in decisions as to what treatments to pursue. The treatment modalities for Aboriginal and non-Aboriginal illness schemes are generally considered mutually exclusive, however it is not uncommon that both are utilized for the one illness episode. This is a pragmatic approach to treatment in which the therapeutic options are maximized.

The Signs and Symptoms of Illness

Understanding how people interpret signs and symptoms of illness is critical to understanding their subsequent decision-making regarding treatment seeking. Symptoms are those perceived changes within the body and are central to the illness appraisal process. Symptoms manifest as altered biological and psychosocial functions, sensation or cognition (University of California School of Nursing Symptom Management Group 1994). Symptoms are subjective, being sensations that are directly and individually experienced. Culture, gender, experience and belief impact on a person’s perception of bodily sensations (Teel et al. 1997). Conversely, signs are those observable physical phenomena, commonly associated with a given illness and taken to
indicate its presence. Signs are objective as they can be sensed by others (Miller & Keane 1983).

A number of models have been proposed to describe the process of symptom interpretation. These models share similar constructs. The process of interpretation begins with an awareness of physical or psychological disturbance. This disturbance is assessed in relation to illness prototypes developed through previous experience of symptoms and other illness-related knowledge. A judgment is made as to the severity of the symptoms by matching symptom information against existing illness templates. The outcome of this judgment is variable and dependent upon familiarity and possible causes of the symptom (Bishop 1987; Bishop & Converse 1986; Cacioppo et al. 1989; Teel et al. 1997). Muscle pain might be a familiar symptom and possibly disregarded if associated with physical exertion. However muscle pain associated with fever might be assessed differently and further investigated.

In episodes of illness, symptom interpretation is at the core of help-seeking decisions and as such there are likely to be a great many factors influencing decisions. The issue of symptom familiarity is pertinent. In conditions of a chronic nature, past experience of symptoms leads to knowledge about severity and self-management, which no doubt feature in the help-seeking decisions. However, the interpretation of symptoms and selection of behaviours are dependent upon cognitive processes and not explained by the stimulus alone. Intra and inter-personal factors and their many determinants are equally central to outcomes. For instance, an association between symptom perception, mood and introspection has been frequently reported (Ferguson & Ahles 1998; Gijsbers van Wijk et al. 1999; Kolk et al. 2003). It is probable however, that many of these contextual variables are particular to the episode and not universal features of the illness experience.

Nyirrpi informants were asked about the indicators of illness that would prompt them to seek treatment. Men almost exclusively spoke about signs, specifically the
indicators of illness in others that would cause alarm. This objectification of the illness experience was perhaps in part a feature of the narrative style of relaying information. The signs that were reported were linked to a cause, they were rarely considered a singular entity and were frequently explained by the manner in which they occurred. The most commonly reported sign was weight loss. Weight loss was believed a sign that the sufferer was the perpetrator of sorcery:

‘...he will lose his weight and people will think, “Ah he is the killer”.’

The idea of culpability as a cause of illness emerged from a number of accounts of people dying at the hands of others. Blame was apportioned in these instances and if the perpetrator could not be punished then his next of kin became the target of retribution. This ‘pay back’ punishment might occur through formal retribution or may occur supernaturally.

The concern with homicide as a cause of illness was repeated in a number of discussions:

‘...mainly after grog...when they kill, they might feel funny or get skinny. That’s the problem now, all those skinny people...that dead body can easy kill you back.’

The informant goes on to explain how the threat of illness plays a significant role in moderating behaviour and hence social control:

‘...yeah...because I didn’t kill anybody...I got a good life.’

Weakness was widely reported as worthy of concern. Weakness was most commonly associated with bleeding and anorexia, both conditions frequently attributed to supernatural causes.
Signs and symptoms that might be regarded as acute, such as bleeding, pain and respiratory difficulties were not mentioned in the interviews. When these were introduced by me, they were recognized as being potentially serious and would warrant immediate intervention:

'...ah bleeding, you better go hurry up...see doctor.'

This apparent inconsistency in reporting only signs of a minor nature possibly relates to the familiarity with signs and symptoms associated with chronic conditions. Pain, bleeding and respiratory distress might only be expected in a crisis situation and therefore not commonly seen. In a community where there are high levels of chronic illness, the appearance of weakness, anorexia and weight loss in a person is probably a familiar occurrence and therefore readily recalled by informants.

Any unusual behaviour was also considered noteworthy, such out-of-character behaviour was said to have its genesis in supernatural events. Altered activity associated with illness was also worthy of concern. Men identified a preference for sleep and reluctance to leave one's campfire as indicators of sickness. In effect, signs of illness represent any deviation from normal. The signs reported by Nyirrpi men generally match the body insignia identified by Saltonstall (1993) as indicators of illness in others. She includes skin color and change, either in appearance or activity as the signs that indicate illness in others.

Nyirrpi men generally reported signs that were of a minor or chronic nature but the context in which they occurred was central to their description. The attribution of cause then becomes central to the course of action taken. Illness is mostly explained by traditional beliefs. Biomedical explanations remain poorly understood and yet medicine remains the prime focus of health services. This dichotomy between belief and practice is fundamental to the failure of primary health care services to move beyond a mere curative role.
When Help-seeking is Delayed

Help or care seeking is defined as any action prompted by a perceived health threat and a perceived inability to cope with life stressors (Cameron et al. 1995). Early explanatory models equated help-seeking with a single decision either to seek or refuse help.

A decision to delay seeking help in illness is not uncommon particularly among Nyirripi men. The reasons for delayed treatment are complex and most likely particular to each episode. The impact of shame on men’s access to health services is considerable. The decision to delay or decline treatment could arise from any of a number of reasons associated with the shame complex or other unrelated factors. These decisions need to be considered in light of the barriers that prevent help-seeking.

Safer et al. (1979) identify three stages of delay in seeking medical help. In the first stage there is a delay in appraisal or the perception of the symptom. This is linked to sensory aspects of the symptoms, their familiarity and the meaning attached to them. In the second stage, delay is associated with the potential paths to treatment and the meaning they have for the sufferer. In the third stage, the decision to seek help is taken in light of the cost and benefits of treatment.

The idea of potential benefit outweighing cost is revealed in the following statement in which avoiding the consequences of delayed treatment becomes the benefit:

‘...the main thing, I ah really doesn’t want to get more worse, I want to do it quick.’

Unfortunately, recognition of these consequences does not necessarily translate into action. The costs commonly cited in the literature are financial and transport issues (McCarthy 1999; Shaw et al. 1999; Spector 1996). These issues are not relevant at
Nyirrpi but nevertheless there are significant potential costs for men in clinic attendance and these, as we shall see in chapter 10 set up effective barriers to help-seeking.

In terms of yapa-kurlangu nyurnu, or Aboriginal sickness, most Nyirrpi men expressed a sense of inevitability with illness the consequence of past deeds or the deeds of others. While supernatural influences were considered unavoidable there was no impression of helplessness because the threat is counterbalanced by specific and powerful treatments to which people could avail themselves. The rapid and almost endemic spread of chronic disease within many Aboriginal communities has undermined the cultural validity of traditional modes of treatment. When traditional treatments are ineffectual, a person may be resigned to their fate believing their case is untreatable.

In a sense this two-way approach to thinking about disease causation can prolong the time taken to receive treatment as illustrated by the following anecdote:

A nineteen-year-old man presented with a three-week history of fever and migrating joint pain. On examination he was found to have a cardiac murmur. An electrocardiogram demonstrated first-degree heart block. A diagnosis of acute rheumatic carditis was made and the young man was evacuated to hospital. On investigating the three-week delay in seeking treatment, I was informed that the young man had initially consulted his father who was a well-respected ngangkayi. A yarda had been removed from his knee and he reported some relief from this treatment. Unfortunately his symptoms returned and the joint pain became so debilitating that he finally sort clinic-based treatment.

In this situation, treatment for a potentially life-threatening illness was postponed in the belief that the cause was yapa-kurlangu or supernatural. The issue here is not the superiority of one medical system over another but rather the misattribution of cause.
In situations as these, there is little that practitioners can do until a clinical presentation is made. However, misattribution can continue to occur after a diagnosis has been established as illustrated by the following anecdote:

A middle-aged man was referred to hospital following several episodes of abdominal pain and vomiting. The diagnosis of cholecystitis (inflammation of the gallbladder) was confirmed. Investigations revealed marked cholelithiasis (gallstones) and surgery was recommended. The man declined all treatment and returned to Nyirrpi. His refusal of treatment stemmed from a fear of surgical procedures. The man was aware that the gallstones were causing his symptoms. These were viewed not as biochemical concretions, but as objects that had been projected into his body by someone wishing him harm. During the recurrent episodes of cholecystitis the man sought treatment from both the ngangkayi and the local health clinic. The eventual removal of these stones by surgery was seen not as a failure of traditional medicine but rather a confirmation of traditional illness beliefs.

An examination of help-seeking behaviour that fails to consider illness beliefs, human agency, structural conditions, timing and event sequence is unlikely to comprehend the dynamic nature of the thoughts and actions that propel a person to treatment.

**Barriers and Enablers**

A barrier to health care is the perception of any tangible or psychological cost of an action, a cost that at some point must be weighed against the expected benefit or outcome of that action (Wills & DePaulo 1991).

Shame is by far the greatest barrier to treatment for Nyirrpi men. This more than anything else influenced men’s ability to seek help. Shame is central to men’s access to and utilization of health services and as such is examined separately. Other barriers
were reported, including fractured social support, interpersonal conflict, substance abuse, competing interests and alternate priorities. Men did not view treatment regimes with which they were familiar as deterrents to treatment.

The visibility of help-seeking at Nyirrpi was a significant barrier because it declared to others the possibility of a health problem. This causes embarrassment and provokes feelings of inferiority, inadequacy and dependency. In this manner, help-seeking itself becomes a barrier. The act of attending the clinic becomes enmeshed in issues of privacy as illustrated by the following comment:

‘Well sometimes when you start walking to the clinic from the house, well people look at you and sort of make fun of you or laugh at you.’

This situation stems from the close association between men’s health and sexual health. This was the most frequently reported source of shame for men in their interactions with the clinic at Nyirrpi.

As imposed structures, clinics are often portrayed as gendered spaces. Typically, clinics are staffed by women and the clientele are predominantly women and children. Men at Nyirrpi contested this portrayal. While claiming their right to use clinic services, they acknowledged that sharing clinic space with women and children carried a number of risks. These risks are often sufficient to hinder access to health services.

Other transitory cultural barriers to help-seeking are worth noting. During important community events clinic attendance is restricted. Notable amongst these are funerals and ceremonies. Attending the clinic during a funeral is considered poor etiquette. The self-inflicted injuries that accompany mourning rituals are generally left untreated. As an outward display of grief male kin lacerate their thighs, female kin their scalps. Traditionally these wounds were left untreated, often being packed with ash to prolong
healing and promote scarring. Whilst these practices still occur, the prohibition on medical intervention has been relaxed somewhat.

During times of ceremonial activity there are very rigid restrictions on movement within the community. These are absolute for women and children and while men generally have some freedom in their movement they also tend to abide by these restrictions. The following anecdote reveals how ceremonial precedence can lead to significant delays in seeking medical help:

A number of boys had been sequestered in a bush camp west of the community prior to their initiation ceremony. On the morning of their initiation a group of men marched through the community dancing and singing as they went. Women and children fled to the east. This banishment marked the commencement of ceremonies and the distancing of women and children from the secrecy of men’s ceremonies. The day was hot and there was little water and food available to the women and children due to the haste in which they had departed the community. Late in the evening, after the completion of the ceremonies, the women and children were allowed to return to the community. An infant was brought to the clinic. The infant was gravely unwell and was evacuated to hospital where acute bronchiolitis and dehydration was diagnosed. The family stated that the infant had been unwell all day. They were reluctant to leave the encampment to seek medical care. To do so would have been viewed as a grave transgression, one that could have put both the child and mother at considerable risk of harm.

In this anecdote the risk posed by illness was assessed in relation to the harm likely to result from cultural transgression. It illustrates how the possible benefits of seeking treatment are outweighed by the threat or cost that treatment might entail.
Previous health service utilization models have described enabling in terms of factors or qualities that generate the capacity to make use of available health resources (Thouez et al. 1990). Actualization variables include client perceptions regarding the quality of care and their relationship with health care providers. Whilst these are important in any clinical setting, the most significant enablers for Warlpiri people come from their next of kin. For the Warlpiri, enablers are those persons who have the authority to pass comment on what are essentially the personal affairs of another person.

The influence of family in the decision-making process cannot be underestimated. Families are responsible for encouraging appropriate illness behaviours. This is achieved by speaking quietly and gently encouraging behaviour in a certain direction. It is not uncommon for the extended family to be involved in this process and it is a strong-willed individual who can resist the entreaties of massed kin.

Being embedded in social networks allows the negotiation of meanings. This provides the mechanism through which individuals understand and experience difficulties. The effect is to shift the emphasis from individual choice to that of socially constructed patterns of decision-making (Pescosolido 1992).

Families were seen as being important for both the guidance and support they could offer. But when family influence is lacking, people are left to their own devices and they, as one informant stated:

‘...just want to do things on their own.’

They are, in effect outside the scrutiny that the family offers and hence the support that is crucial in time of illness is not forthcoming. This compounds the vulnerability of those people who through social disharmony or death have fractured family lives.
The pivotal role that significant kin play in interpersonal intervention is often described as ‘looking after’. This intervention might take the form of encouragement as indicated by the following statement:

‘...yeah if he was sick, very sick, he would come to the clinic, but only if there was a friend who could come with him. A best friend to come to the clinic with him. Like encouraging one another and that. And if the nurse says, “take your trousers off”, those mates will wait outside. At least he knows his friends are waiting for him. That would help him inside and encourage him.’

In this instance, the act of ‘giving courage’ might be enough to enable an appropriate response. Persistent resistance might warrant a more direct form of intervention, this however is only available from certain kin.

The Authority to Intervene

The authority to intervene on another person's behalf is determined and limited by kinship. The relationships that apply to Warlpiri men are listed in detail in the following chapter. For Warlpiri men there is the added security offered by their yarlpurru. The concept of yarlpurru is one referred to fondly by Warlpiri men and refers to that class of men who were initiated at the same time. A man's yarlpurru remains a life long friend and is someone who can be called upon to provide assistance and who should at the very least be supportive and encouraging in times of illness.

Those people who have responsibility for others are expected to exercise that responsibility in terms of encouraging appropriate illness behaviour. This, however, may extend only as far as encouraging the person to see the ngangkayi and may not include clinic-based services.
Those people with responsibilities for young men are often not present, they may live elsewhere, they may be incapacitated by their own poor health or substance abuse problems or may be deceased. This factor alone contributes to the vulnerability of many young men. Young men are granted a degree of independence and often live separately from their parents. As a result, young men may lack the support and guidance of significant others. These factors are crucial to the welfare of young men. The impact is twofold. Firstly, when there is a lack of direct supervision, the delay between onset of illness and presentation for treatment can be lengthy. Secondly, and perhaps of greater significance to young Warlpiri men, is the cultural void in which they find themselves.

While there is recognition that lifestyles have altered greatly, there is also awareness that certain aspects of Warlpiri life have been surrendered all too readily:

‘They still talk about old days, but they don’t own nothing…they just forget about it. Like those young fellas living in Nyirrpi…they got no Law: nothing’!

That young men are considered to be living a life without Law is equally a reflection on those responsible for their education and socialization as young Warlpiri adults. When cultural and social instruction is absent it is all too readily replaced by the ubiquitous cultural imports to which young Aboriginal men are now exposed.

Activities of Daily Living

The very public nature of community life makes the concealment of signs and symptoms difficult. While symptoms may be concealed, signs of illness are hidden with less success. Life at Nyirrpi is one lived mostly out-of-doors and as such is open to public scrutiny. So entrenched is this a feature of community life that a person’s absence from public view gives rise to speculation and concern. Family and friends generally respect a person’s decision to decline or delay treatment but only as long as

153
that person is able to carry out activities of daily living. Incapacitation places a burden on others. In such instances the decision to seek help may be made by others.

The ability to perform activities of daily living can be a pivotal point on the path to treatment. The effort needed to meet activities of daily living in a Warlpiri community can be minimal, requiring only a basic level of functional independence. This basic level of functioning can mask the severity of the signs of illness. The minimal demands required to function independently in a Warlpiri community, the ever-present support of extended family and kin networks ensure that physically compromised persons meet the daily living requirements even if only in a rudimentary sense. The descent from this level of minimal functioning to crisis can therefore be both sudden and unexpected. The outcomes of these crisis situations are likely to be adverse given the reality of remote area life, the level of local health resources and the distance to major medical centers. The following anecdote illustrates the inadequacy of using activities of daily living as an indicator of wellness:

A man of senior years had gradually relinquished the activities that had marked his desert existence. At first there was reluctance and then a refusal to join his brothers in hunting expeditions. Despite concern about apparent lethargy, he continued to care for himself, even managing a daily walk to the store for food. He lived with his extended family, who assisted with washing clothes and cooking food. The man collapsed and was brought to the clinic in an unconscious state. Appropriate resuscitation treatment was given and the man was evacuated to hospital. The man was diagnosed with a cerebral hemorrhage. He died five days after his admission to hospital. Family members reported that the man had been coughing blood for a few days prior his collapse. They had suggested that the man visit the clinic but had not pressed the issue. The man claimed that he was well and because he ‘walking around’ no further action was taken.
It is not uncommon for people to describe the concealment of symptoms in terms of secrecy and while the rationale for 'hiding sickness' was varied, responsibility for such behaviour rested firmly with the afflicted individual. For the Warlpiri, this notion of hiding was most commonly associated with sexual infections:

‘See somebody could loose his hair, and he doesn’t want to come through that door (seek clinic treatment), that’s why they get shamed. When people wear that thing, the hankies.’

This statement refers to an attempt to hide alopecia, a sign of syphilis, by the wearing of a bandana. This sign was one well known to Nyirrpi men and the act of wearing a bandana itself was enough to give rise to suspicion of illness. This anecdote also highlights the part that an event plays in decision-making. The characteristics of some clinical conditions are imbued with such sensitivity that considerable efforts are made to conceal their outward manifestation.

Whether symptoms are deliberately concealed or independence and function takes precedence over signs of illness, the ultimate effect is one of delay.

Crisis

The health resources in remote communities are basic and are not well suited to the management of medical emergencies. Health infrastructure and human resources are appropriate to a primary health care focus and as such emergency care is rudimentary. The transfer of patients from remote locations to an acute care setting is marked in hours. This represents the final delay in treatment, one that may result in an adverse outcome.
Discussion

In this chapter various theoretical constructs have been employed to examine the path taken to treatment by Nyirrpi men. Every theoretical model in social science faces the challenge of maintaining its explanatory power across various cultural contexts. There are however far more fundamental concerns which need to be addressed. These concern the relevance of culture, specifically the differences in belief and practice and their impact on the experience of health and illness (Ahmad 1996; Lambert & Sevak 1996).

An overt focus on culture can divert attention from other important issues. Issues such as social inequality, poverty and racism may not feature in traditional ethnographic research. I do not wish to downplay the importance of these social determinants by excluding them in this research. My justification for doing so is two-fold. Firstly, the social determinants of health are broad and previously well researched (Altman & Nieuwenhuysen 1979; Marmot & Wilkinson 1999). Secondly, inequality is perpetuated by ignorance. Awareness of cultural practice enables appropriate interventions. People selectively draw on elements of their culture to help them explain and manage the situations they face. Making sense of foreign disease concepts is often only achieved by reference to the ideas, beliefs and values that constitute a particular cultural heritage.

The prime value of ethnographic research is in the generation of knowledge from the perspective of someone embedded within a specified culture or society. Is greater understanding and improved communication enough to effect change? Participatory methodologies are valued for the potential empowerment that accompanies knowledge generation. Knowledge generation alone is no longer seen as sufficient rationale for ‘outsider’ research. While information on health status has been well documented, the experience of illness, the cognitive processes and behavioural responses have been inadequately described. By examining values, beliefs, customs and aspects of lifestyle,
insights can be gained into the illness experience. If we are to understand another's experience of illness it will only be through those facets of life that are implicated in the loss of health.

There is a danger that the ethnographic approach can use culture as the pretext for examining difference instead of shared experience. By emphasizing difference, there is a risk of highlighting those customs and beliefs associated with negative aspects of culture and society. In this manner people can be portrayed as victims of their cultural heritage. It is not my intent to do so here, however in some instances there might appear to be little difference between description and denigration.

Culture is only part of the decision making process. The demographic factors of age, sex and marital status are worthy of consideration. With age, many of the structural barriers particularly those relating to shame, diminish in importance. Gender offers some advantage to women in that their exposure to clinical services through child health provides greater opportunity for treatment. Through this exposure, the clinical encounter becomes normative. This is not so for men, whose exposure to clinical services tend to be episodic and for whom the clinical encounter is not normative. Marriage offers considerable benefits to men in terms of their help-seeking and subsequent care during illness. Women are held accountable for the health and welfare of their children and husbands. Women will often report illness on behalf of their husbands. Such reports are often accompanied by a request that consultation and care be delivered outside the confines of the clinic.

When people have two systems of belief about the causes of illness, they have a choice, not only in explanation but also in treatment. Illness attributed to a non-medical cause may or may not be treated by traditional means. If medical care is sought at a later point, the issue of delay might then become a relevant issue. An obvious solution to this problem is to reduce the distance between traditional and biomedical modes of care. There is nothing new in this approach. The employment of Indigenous healers to
work in clinics and research into medicinal plants are two areas where the synthesis of traditional and contemporary treatments has been attempted in the past.

However, it should be stated that areas of incompatibility between the two systems of practice do exist and these differences need to be managed in a manner that does not diminish the validity of either system. The following anecdote highlights potential points of conflict between the two systems of care and how they were managed:

A man and child were brought to the clinic. Their car had struck a tree and as neither was wearing seatbelts both had been ejected through the windscreen. While I was attending the child, relatives of the injured man summoned the *ngangkayi* to the clinic. The *ngangkayi* arrived and proceeded to examine the injured man, an examination that involved vigorous manipulation of the head and neck and compression of the chest. Given the man’s potential for chest, spinal and head injuries this treatment was potentially dangerous. On discovering this situation and despite considerable alarm, I quietly asked the *ngangkayi* his opinion as to the extent of the injuries. This was enough to halt the examination by the *ngangkayi*, he was happy to give his opinion and I was then able to take over the injured man’s care.

This anecdote also raises the issue of cultural safety. As practitioners we aim for the ideal of culturally safe practice. Unsafe cultural practice diminishes and demeans the cultural identity and potentially the well-being of individuals in the health care setting. The emphasis is always placed on the actions of the practitioner. But does the culture of those we care for adversely impact upon our practice? At what point does ‘culture’ become unsafe? The practitioner is often faced with the choice of either ensuring clinical or cultural safety. One often excludes the other and either can place the practitioner and patient at risk.
The signs and symptoms cited by Nyirrpi men as prompting help-seeking could be considered minor and chronic in nature. This inconsistency might be explained in terms of familiarity. Nyirrpi men reported those signs and symptoms of which they had direct experience through observation. There may also be a cultural basis for this inconsistency. Well-being in Warlpiri society is associated with vigor and strength and the appearance of signs and symptoms such as weakness and weight loss are most closely associated with the loss of well-being.

There are other idiosyncratic factors such as the ability to endure discomfort and pain. This is no more obvious than in the number of older Aboriginal people who suffer from trichiasis. An end stage complication of trachoma, trichiasis results from the buckling of the upper eyelid, which brings the eyelashes into direct contact with the cornea. This is one of the mechanisms in which the cornea is irreversibly damaged. It is rare for elderly Aboriginal people to complain of this condition despite the severe discomfort it brings. The ability to endure this discomfort does not augur well for medical intervention that could prevent the progression to blindness.

The ability to endure discomfort might be unrelated to the non-reporting of trichiasis. Other factors come into play, such as access issues related to frailty, or a fear of treatment that entails its own discomfort. Perhaps the symptom has becomes itself normative, being considered part of the ageing process. With trachoma being endemic in many Central Australian communities, the trajectory of disease progression suggests that trichiasis is likely to be found in many elderly Aboriginal people. In the absence of self-reported symptoms, there are few other clues that might alert practitioners to the existence of this potentially blinding condition.

Men’s help-seeking is strongly associated with sexual health. Men associate their help-seeking with such conditions and believe that others do as well. One strategy some men have adopted to diffuse speculation about the nature of their clinic visit is to publicly announce the reason for the clinic visit. This ‘re-labeling’ shifts the emphasis
from sexual health to other more mundane matters. The effectiveness of this strategy is not known.

This suggests a point of possible intervention. Reducing the association between men’s health and sexual health seems essential if the shame that accompanies men’s clinic experiences is to be reduced. The longstanding public health emphasis on the sexual health of Aboriginal men has contributed to these entrenched notions. Obviously Aboriginal men are treated for all manner of clinical conditions, however the public face of Aboriginal men’s health has become firmly associated with sexual health. This in part explains the reluctance, especially among many young Aboriginal men, to make use of clinic services.

Promoting a holistic approach to well men’s screening will eventually effect a change in the way both men and women conceptualize men’s health. This may help to reduce the perceived stigma that currently surrounds Warlpiri men and health services.

Help-seeking is likely to occur when the act of seeking help occurs in private (Shapiro 1978). Complete privacy in treatment is the only means by which men can overcome the crippling effects of shame associated with clinic attendance. Given the sensitivity surrounding men’s health and sexual health, anonymity becomes an issue of utmost importance.

**Conclusion**

Engagement with the biomedical health system means in large part surrendering control. Whilst health care is based upon empathy and negotiation, there is by necessity a loss of personal power in health encounters. In terms of self-efficacy, a person’s ability to influence what happens to them becomes limited as others are invested with the power to make decisions concerning their health and welfare. This is perhaps a universal feature of all health encounters. However, who surrenders the
most? When non-Aboriginal people engage with a health system, it is one to which they are acculturated. The value and belief systems are familiar and the procedures and treatments are a logical consequence of the illness episode. For Aboriginal people there is less familiarity as well as a degree of discordance with the logic of many treatments.

Some of these issues can be negated by the manner in which services are provided. The way in which people receive help can preserve their sense of autonomy and augment their motivation to help themselves. Clients who are offered a choice of treatment or input into a plan of care benefit more from help than those who have help imposed or have no choice in the type of help they receive. This suggests the importance of negotiated care. The issue of choice, whether it is between treatments or systems of care, is crucial as it gives the client some degree of control over the decisions concerning their welfare. There is very little benefit to be gained from styles of care that are either imposed or offer the client no input. The opportunity of choice imparts an opportunity for control and this must ultimately contribute to the success of treatment.
Chapter 9

Mardarni-jana-karna wati-pattu: Looking After Young Men
Chapter 9

Mardarni kana-jarna wati-patu: Looking After Young Men

Youth, what man's age is like to be, doth show, we may
our ends by beginnings know

John Denham
-On Prudence-

Introduction

In this chapter I will examine the unique experience of young Warlpiri men in the years between their initiation into adulthood and marriage. I propose that this is a time of considerable risk for many young men. The confluence of emerging gender identity, sexuality, independence and minimal supervision can place young men at risk.

Prior to circumcision, the influence of and control by female kin in a boy's life is almost absolute. Female kin are the prime guardians of Warlpiri children. For boys however, this changes dramatically after circumcision with the relationship between the young man and his female kin becoming distant and circumspect. Of most significance however is the transfer of care of young men from women to men. Male elders have traditionally acted as guardians and mentors to young men. Societal change and its impact on Warlpiri men have had adverse consequences for the quality of this guardianship.

I will examine the various processes of social transition that young men undergo and attempt to extract the defining elements as they currently operate. I hope to reveal how altered social structures in Warlpiri society leave many young men vulnerable.
Seclusion, Segregation and Independence

The passage of Warlpiri boys into the sacred and secret realm of adulthood has three features worthy of examination. One of these features is referred to in the anthropological literature, the other emerged from the Nyirrpi data and the final is an observation. These features are interrelated and they result in a unique set of circumstances that can ultimately predispose young Warlpiri men to risk. Prior to his circumcision, a boy is removed from secular life and secluded in a bush camp some distance from the community. Seclusion is a preliminary stage in the ritual cycle in which the boy is prepared for the ceremonial journey he is about to undertake. Meggitt details the significance of circumcision in Warlpiri society:

Circumcision with its accompanying ceremonies, firmly and unequivocally establishes a youth’s status in Warlpiri society. Should he fail to pass through these rites, he may not enter his father’s lodge, he may not participate in religious ceremonies, he cannot acquire a marriage line, he cannot legitimately obtain a wife; in short he cannot become a social person (Meggitt 1962, p. 309).

Whilst circumcision ceremonies herald physical development, far greater emphasis is placed on the social development of the young man through his ceremonial involvement. So fundamental is the function of circumcision ceremonies in Warlpiri society that they continue to be uniformly practiced.

Following his circumcision, the boy remains secluded. In some instances the seclusion might take the form of a journey to neighboring communities. This was once a feature of circumcision ceremonies, what Meggitt (1966) referred to as the ‘grand tour’. Accompanied by guardians, the novice was instructed in the flora, fauna and topography of the country and the totemic significance of various localities. One such tour was described in terms of the places visited:
'I was with my other yarlpurru (co-initiate), we stopped together. I went straight away to Walungurru, stayed there a couple of weeks and then went to Tjukurla and then to Warakurna. Finished up there and then came back here.'

The act of ‘finishing up’ does not refer to an arrival at a final destination but the formal conclusion to ceremonial activities. When the young man returns to community life he is not fully integrated back into the life he once knew. Men reported that they were expected to live separately to their families. In this form of segregation young men were encouraged to live with their yarlpurru in the jangkayi, the unmarried men’s camp. According to Meggitt the separation from family occurred gradually:

Once boys are circumcised, they spend less time in their parent’s camps and more in the bachelor’s camps, by the time they are aged 16 to 18 years they rarely sleep or eat with their parents (Meggitt 1962, p. 80).

However, Nyirrpi men reported a far more abrupt process of separation:

‘...we didn’t live with mother and father, we used to live by ourselves. Like when I came out from the bush, that’s all. I went to my father’s place and mother...“No! you’re not coming here”.’

This seemingly harsh treatment is in part related to the meaning of circumcision, which is symbolic of death. The act of circumcision ‘kills’ the boy. Through religious instruction the boy is remade in the form of a man. This transformation is heralded by the possession of ritual knowledge. The need to protect this knowledge explains the subsequent segregation of young men. By excluding women and children from the social sphere of young men, their access to this knowledge is effectively blocked.

The imperative to retain sacred knowledge within the male domain is one of the cornerstones of male homosocial networks in Warlpiri society. A young man might
live with male kin or his co-initiates and while his parents continue to provide material support, his contact with them was only fleeting. He has effectively left the world of children and is now firmly ensconced in the world of men as the following statement indicates:

‘Yeah...lived separate with uncles. They told me, “just go to your father for food and go back”. Can’t stop with my mother and father. Stop with my uncles.’

The majority of men I spoke to reported living with other young men in the jangkayi, the camp of unmarried men. This institution remains a feature of contemporary community life with dwellings dedicated for the use of young men and unmarried older men. Regardless of a young man’s living circumstances, segregation from family brought considerable independence as well as a decrease in the level of parental supervision. The following anecdote illustrates how independence at a young age is inherited with a degree of vulnerability:

A 14-year-old youth was living with other young men in the bachelor’s camp. His parents were separated and did not play an active part in his life. The young man had lived with his grandmother for many years, but she rarely saw him now that he lived in the bachelor’s camp. The young man rarely left the bachelor’s camp and he always looked unkempt. He always wore the same clothes, in particular a hooded coat, with the hood always covering his head. This gave rise to suspicions that something was amiss and these concerns were eventually brought to the attention of clinic staff. The young man was asked to come to the clinic. He was uncommunicative and denied any problems. During the course of the examination he was asked to lower the hood of his coat so his ears could be examined. He sadly shook his head and with downcast eyes mumbled, “wijini” (sore). Examination revealed an extensive
scalp infection to which the hood had become firmly adhered. The lesions were soaked, the hood removed and the infection treated with antibiotics.

This anecdote reveals an apparent lack of advocacy resulting in a considerable delay in treatment. This situation resulted in part from the young man's living circumstances, particularly the lack of direct and immediate supervision that can accompany life in the jangkayi. This does not imply that the other men living in the jangkayi were negligent. They simply did not have the ability to enforce treatment. He had no elder brothers, his father and uncles were absent and his grandmother was restricted in her access, given his residence in the jangkayi. It would have been most improper for her to approach the bachelor's camp and so her supervision and influence were limited.

The circumcision ceremony marks the withdrawal of boys from the world of women and children and their gradual alignment with the world of men. Part of that realignment involves a transfer of responsibility for young men's welfare from their female to male kin. This is a crucial feature of the incorporation of young men into adulthood.

**The Change from Female to Male Guardians**

In Warlpiri society, the passage from boyhood into young adulthood brings considerable change in social relationships. The most striking of these changes concerns the care of young men. Once a boy has been circumcised his welfare becomes the responsibility of men. This responsibility is well defined and shared amongst senior male relatives. This responsibility seems to apply during the period from initiation until the young man takes a wife in marriage, where upon the prime responsibility shifts to the wife. This transfer of care is re-enforced by strict rules of association that impel young men to keep company exclusively with their age-mates and older men.
It is possible that this shift in care stems from a concern regarding the revelation of secret and sacred information that the young men have become privy to during their initiation. The prohibition on keeping company with children and women was reported as being extremely strict by many men. They reported constant scrutiny as young men and severe punishment of any breaches of this protocol.

The shift in care is well illustrated by the following statement:

‘They would say, ‘go and see the father’. Because men’s business is separate...so mother wouldn’t know. Well mother would know but wouldn’t say to the nurse because it would make the sick person shamed inside. And that would make him worse and force him away from the clinic more. It is really up to the father or grandfather or brother or cousins you know. They would talk to the sick person.’

In this statement we are introduced to some of the male kin charged with the responsibility for young men. I will examine these relationships through both the anthropological literature and the interview data. My inquiries were framed exclusively in reference to illness and the relationships are listed in order of degree of responsibility.

The brother-in-law or ngumparna has the ultimate responsibility for the care of young men. This seems to be limited to the circumcision and sub-incision rituals during which the brother-in-law has a prominent role in ensuring the welfare of the young man. However, as the following statement reveals, this relationship can extend well beyond the context of ritual:

‘Yes brother-in-law...we see them first, otherwise they might get wild and do something crazy. His sister’s husband, and both of them, ah sister would ask younger brother, “ah talk to my husband and you two work it out together”.'
They might go into a room together, away from other family members and talk about his problems. No one should interfere with them...he can take him to the clinic and come back and pick him up later. That is the way.'

This responsibility is symbolized by the *purdurru*, the hair string belt given to the young man by the brother-in-law during the circumcision ceremony. The *purdurru* symbolizes the respect and remembrance expected of the young man for all that was done on his behalf by the brother-in-law. The young man is expected to be independent to a degree whilst being overseen by his brother-in-law. This responsibility has significant implications for the confidentiality of medical information as the brother-in-law may often act as an intermediary between the young man and the health service.

'...he might go inside his room, too shamed to come out and only come out at night. Well brother-in-law would be the only one allowed to talk to him...the brother-in-law comes first.'

That the intermediary role of the brother-in-law effectively represents a breach of confidentiality was of little consequence to Nyirrpi men. This relationship is so entwined in the obligation between the father, son and the brother-in-law that privacy becomes an issue of little importance.

Elder brothers or *papardi* also assume the role of guardian and overseer. Nyirrpi men considered elder brothers to be the 'first choice' in this hierarchy of care. Perhaps this stemmed from the elder brothers considerable ceremonial obligation towards their younger sibling, an obligation that according to Meggitt (1962) formed the basis of a 'fraternal solidarity'. Elder brothers were responsible for watching their younger sibling and ensuring they associated with the correct people. They were responsible for punishing any deviations from these protocols:
In everyday life, the elder brother continues to look to the youth’s discipline, an obligation that the father is usually keen to avoid (Meggitt 1962, p. 131).

It was generally expected that brothers maintain a good relationship and that younger brothers yield to an elder brother’s will. Where interpersonal relationships are poor between brothers, a man may call upon other relatives to fulfill this role. Male cousins most frequently assume this role. A mother was expected to pursue her concerns about a son through his elder brothers and not to approach the young man directly. In times of illness, the elder brother has a pivotal role in ensuring the young man’s welfare. If the young man is reluctant to seek help and there is sufficient concern from his relatives, the elder brother would be expected to intervene as indicated by the following comment:

‘If that man (brother) sees him sick and he says, “ah you want me to take you to the hospital”. And the man agrees with him and he takes him to the hospital and gets a check.’

The role that a brother takes in such a situation is to a degree coercive, but always supportive. Warlpiri people will often refer to such support as ‘company’. This support is vital for clients but may be problematic for practitioners, particularly when the support person is included in examination procedures.

Male cousins or wankili are often referred to by the term ‘cousin brother’ and include the sons of both the maternal uncle and paternal aunt. These ‘cousin brothers’ assume the same status as elder brothers, although their role appears to be described almost exclusively in terms of support rather than guidance or punishment. This is most likely due to their similarity in age. Wankili can be called upon to assist young men in the absence of elder brothers or where the relationship between brothers is not sound. The tone of the relationship between cousins is indicated in the following statement:
‘Yeah sometimes my uncle or cousin you know. I got my cousin, he come around and talk to me. “Ah something is wrong with me”. Just tell me, “don’t get frightened, just go to hospital, have a checkup, get medicine”. Just tell me like that...just encourage. That’s more important...you might get more serious.’

Uncles or *ngamirni* are the brothers of the young man’s mother. The father’s brothers are called father, so in effect uncles can only come from the mother’s family. Uncles were said to be the ‘second choice’ in the hierarchy of care of young men. The relationship was described by Meggitt as such:

A man takes a deep interest in his close sister’s son, and the affection he feels for his sister clearly extends to her children (Meggitt 1962, p. 138).

The relationship is further consolidated by the uncle’s involvement in his nephew’s circumcision. The uncle’s influence is indicated by the following statement:

‘...or just get older brothers or uncles. And that way he will listen to the uncles and older brothers...he’ll listen to his uncles.’

As this statement indicates there is an expectation the young man will follow the advice of his male elders. This expectation is a component of the respect that should exist between young men and their seniors. This regard can be mutual as revealed in the following statement:

‘...like I was worried about my uncle, that first time he jumped on the plane, I told him, ‘please uncle, don’t run away from hospital, you have that operation please. If you run away, I will never help you’. Maybe he been listen to me see, like I’m his nephew again see.’
When the father is deceased it appears that uncles have an elevated level of responsibility. One man described himself as the “number one boss” for his nephews whose father was deceased.

The role the father or *kirdana* plays in his son’s welfare appears to be less direct. Meggitt (1962) was explicit in stating that the father was responsible for his son’s welfare including procuring the services of the *ngangkayi* if his son fell ill. However, Nyirrpi men spoke of the father’s role in terms of explanation:

‘...father can explain it, ‘you have to go to hospital to get fixed up’. If he (son) says no, talk to his brother.’

As this statement suggests there would seem no obligation for a young man to heed his father’s advice or demands. I have observed on many occasions the behaviour of fathers when their adult sons become unwell. They are usually present but appear to play little part in deliberations. The role of intermediary usually falls to either the uncle or an elder brother who take on the central role of family spokesperson liaising between the client and health staff.

The role of grandfathers (paternal grandfather or *warringiyi* and maternal grandfather or *jamirdi*) does not extend beyond that of support. The paternal grandfather instigates his grandson’s circumcision. Following circumcision this relationship while affectionate is tempered by recognition of the grandfather’s religious authority. A young man’s religious domain is inherited from his *warringiyi*, this becomes another bond they share (Meggitt 1962). The role of the *jamirdi*, the maternal grandfather is less obvious. He has little direct involvement in the boy’s ceremonial life, other than teaching on matters of kinship and behaviour (Meggitt 1962). I am unsure how altered these roles are today as grandfathers did not figure prominently in my interviews with Nyirrpi men. Their roles appeared to be limited to the provision of advice.

171
Once a young man is married a degree of responsibility for his health and welfare falls to the wife. Many men believed it was their wife’s responsibility to act as an intermediary between themselves and the health service.

‘Until you got a wife and raise your family and you got a wife to look after you.’

This statement illustrates the dynamic and individual position of wives. I have observed on many occasions wives being held accountable for situations that had befallen their husbands, more often than not situations in which the wives had no control or involvement.

Not all men agreed with these sentiments and expressed the view that as men they were responsible for their own well-being:

‘Ah don’t worry about him (telling elder brother). It is my problem…see I been get man…it is my problem. You gotta talk to the person who is sick.’

There appears to be one exception to this gendered system of welfare however. Many of the men I spoke to at Nyirrpi mentioned the role that grandmothers played in their lives. These men accorded their grandmothers considerable respect. This regard appears to emanate from the grandmother’s pivotal role in circumcision ceremonies. Grandmothers assume the role of kurdungurlu or ceremonial worker for their grandson’s circumcision. This role is reflected in the following statement:

‘You can only take notice of your grandmother…because she is the one who put you through all the business.’

Many of these relationships have a reciprocal nature in that they involve the notion of indebtedness which links people in quite complex ways. The concept of respect is also
linked to this notion of indebtedness but seems to imply mutual concern rather than an esteemed regard. A young man was expected to act in a respectful manner towards those involved in ‘making him a man’.

‘Grandmother is right you see because she is there all the time. See grandmother is the same one, even when you get initiated, grandmother will come and talk to you when you come out of bush camp that’s all. Not the mothers, only the grandmother can come and talk to you. Like when you are a new initiated man, grandmother can tell you again, “no don’t, you have to be ngurrju (good) now”.’

The influence attributed to grandmothers was described in terms of behaviour, ensuring that young men behave in an appropriate manner, offering direction and support. The importance of the grandmother’s role is further indicated by the following comment:

‘...nah the men there but she has more power, she didn’t want you to get into any trouble...“you got to stay away from young women”...mother can’t tell you...she gets shamed because you are a young man. You’re a young man so it is up to the grandmother to give orders and that. That is yapa (Aboriginal) culture.’

Implicit in the grandmother’s influence was a sense of personal responsibility:

‘I think she is the boss, once you’re a man you gotta look after yourself, but you got grandmother, she’s the one gotta try and help.’

When practitioners fail to appreciate not only the change in status of young men, but also the significance of the shift in responsibility for care, they are essentially placing young men at risk. This most commonly occurs when practitioners refer to female kin instead of males in reference to the young men in their care. In essence, this represents
a denial of his adult status. It is likely to cause embarrassment for next of kin and shame for the young man. It is important for culturally safe practice that only those persons appropriate to the young man are involved in his care. Unfortunately, this aspect of kin relationships is dynamic and may not always follow expected kinship pathways. Men suggested it was highly appropriate to ask young men if they wanted support in the clinical setting:

'well, if he is having problems with English, you can mention it to him, "ah we will get your father or brother". You can say like that to him.'

Interpersonal issues such as privacy, personal support and respect are no doubt universal. The application of kinship to these issues can result in situations that appear both strange and contradictory to non-Aboriginal thinking. To give up one’s right to privacy in order to receive treatment is unfortunate but also pragmatic. However, involving male kin in a young man’s care may not always be possible. Many factors including increased mobility, death, alcohol abuse or simply the abrogation of responsibility, reduces the influence of male elders and can further place young men at risk.

The Absence of Male Elders

Brady (1991) suggests that petrol sniffing in Aboriginal youth has resulted from an increase in the social distance between mature adults and younger people, which she attributes to the widespread influence of non-Indigenous culture. This she says is indicative of a generation gap in which all the focus is on young adults. Unfortunately the equation is not so one-sided with Aboriginal adults equally complicit in the distance between generations.

Brady (2002) suggests that traditionally, late adolescence was the time when ‘one surrendered to rigorous training and expectations of adult life’, a process that
‘inculcates both autonomy and compassion for others’. As we have seen, this process occurs in early adolescence for Warlpiri boys and while autonomy is definitely an outcome of separation, traditionally a network of senior male kin provided the education, discipline and protection necessary to guide young men into adulthood.

The responsibilities of senior Warlpiri men in the development of young men is revealed in the observations of Meggitt:

Boys derive much of their knowledge of kinship organization from the patient teaching of their mother’s fathers; they learn hunting and fighting techniques as much from uncles and brothers-in-law as from fathers and elder brothers. The sister’s husband, the mother’s mother’s brother and the classificatory sister’s son take a larger part in disciplining a youth than do his father or brother (Meggitt 1962, p. 82).

Meggitt’s observations were made in the early 1950s. Warlpiri society is greatly changed today and while the kinship system has survived it has not been without change in the dynamics of relationships. One such change is evident in the central role that elder brothers now have in disciplining their junior male siblings. The most significant change in kin relationships is the quality and quantity of care now available to young men. Quite simply young men are vulnerable because those men who have a responsibility for their welfare are often not present in their lives. Explaining this absence is difficult, some of the causes are visible, others less tangible. The life expectancy of Aboriginal men is 21 years less than that for non-Aboriginal men. The median age at death for Aboriginal men in the Northern Territory is 45 years (Australian Bureau of Statistics 2003). These trends are well reflected in the population distribution of Nyirrpi.

The effect of high mortality rates is revealed in the following statement. When asked who might care for him if he became ill, one man replied:
‘...ah might be my uncle might come...but I got no uncle.’

When asked where his uncles were he replied, ‘nothing...all finished’ (deceased). High Aboriginal male mortality creates a considerable void for surviving male kin. Absence might result from factors such as outside attractions and the means to access them. Such attractions constantly draw men away from their communities. The effect is an overall reduction in the number of senior men who are available to mentor young men. Such absences manifest in other more destructive ways:

‘Well in some ways for Warlpiri men, if they loose their mother or father or uncle or auntie, there is nobody to look after them. Or even their grandmother or grandfather...well, I’ll go and live in town. I can’t go back to Nyirripi, there is nobody to look after me. Like people my own age...they will just live in town and live on grog all the time.’

Again we are brought back to the concept of being ‘looked after’. This has less to do with the material aid and support that one could expect from being part of a family and more to do with simply being part of a family and the sense of identity that this imparts. The absence of kin is considered unnatural, against the order of social organization. The Warlpiri word yapunta-yapunta describes the state of being without a family. This word and its synonyms carry negative connotations such as outcast, destitution and abandonment. Meggitt (1962) describes Warlpiri kinship as a structure that ‘can extend indefinitely in time and space’. The existence of both actual and classificatory kin sets up a wide-ranging network of relatedness in which it is possible for the self to become indistinguishable from the group.

Brady (1992) has argued that this shared identity is outwardly manifested in the form of solidarity. And yet many remote Aboriginal communities are made up of close-knit family groupings held together by a thin veneer of community identity. Fractures in community cohesion almost always occur between these family groupings. Warlpiri
society was not traditionally based on a sense of community but one of family, a notion that persists and remains at the heart of contemporary Warlpiri politics. It is not surprising then that the sense of relatedness, particularly amongst kin, features strongly in Warlpiri thought. The term warlalja denotes ownership and kin; these separate but interconnected meanings give some indication of the centrality of family to individual identity.

So how might the absence of close kin impact on the lives of those left behind? One informant, in commenting on the death of a young man made explicit reference to the absence of male elders:

‘He didn’t have his brothers or anyone supporting him...and you see a lot of people like that. You know why? From family reasons...brothers, he hasn’t any leaders to show him the way, show him the right way. You know it is a bit sad because I don’t think all his brothers did show him the right way.’

In this way young men are caught up in a cycle of vulnerability. In the absence of senior men, others become involved by default in the welfare of young men. Most often these are female kin. This may alienate the young men who consider their affairs beyond the concern of women.

Discussion

The death rate for Aboriginal males increases sharply from early adulthood (Phillips 2002). This suggests that young Warlpiri men are potentially a group at risk. In contemporary Warlpiri society, this risk is amplified by a unique set of cultural and social factors. Examining the mechanics by which these factors operate in the lives of young Warlpiri men should in no way be seen as a criticism of the contemporary social processes. As these factors are a feature of Warlpiri life, the potential impact on the welfare of young men is real and as such the mechanisms are worthy of examination.
This inquiry has three potential outcomes. The first is to highlight the issue of Aboriginal youth at risk, a demographic group of previous low clinical concern. The second is to gain some understanding of the lives of young men and the forces that impact on their welfare. The third is to identify how health staff can enable young men's help-seeking in times of illness.

The shift from female to male care during adolescence could be considered a risky social manoeuvre. The independence granted young men, their separation from family coupled with the diminished influence of senior female kin, can make them vulnerable in times of illness. In the past, an extensive network of senior male kin provided a safety net, one that protected and guided young men towards adulthood. The fabric of that safety net has now unraveled to a point where the supervision of young Warlpiri men can no longer be guaranteed.

A recent and compensatory trend has seen many young men return to live with their families following initiation. This trend is protective only in that young men are living in close proximity to family members. The power relationships within the family are altered considerably, particularly between mother and son. Their relationship post circumcision is circumspect with the son under no obligation to heed his mother's advice and her ability to impel him towards treatment is dramatically curtailed.

In Central Australian Aboriginal communities adult health screening is presently commenced at 15 years of age. Gaining access to this age group can be difficult. Age is partly a factor, with the perception amongst both practitioner and client that there are few pressing health concerns in this age group. In this manner, they become less of a priority in terms of screening endeavour. And yet this is the very group in which high reservoirs of sexually transmitted infection are found. Screening in this age group may be the only contact with the health service in a given 12-month period. An evaluation of preventive health screening in two Aboriginal communities found that those at greatest risk of not receiving preventive screening were young men and the elderly.
(Ivers 1998). Ivers (1998) suggested that while clinic attendance in young men was poor, they were more likely to participate in mass screening activities. This suggests that screening may be the most appropriate way for young men to access health services.

There is considerable value in this idea because in this type of clinical encounter the focus of attention is shifted from the individual to the group. How practical is this approach however? Mass screening is heavily resource-dependent and places additional strain on health services. Ivers (1998) found that in those young people who attended clinics it was rare for them to receive opportunistic screening.

Any clinic attendance is an opportunity to receive preventive as well as curative interventions. The challenge therefore is to promote opportunistic screening. This involves a change in the culture of remote area nursing practice, shifting the emphasis from the specifics of a presenting complaint to evaluating the whole person in relation to their past and future health requirements. This approach can be as simple as checking a person’s immunization status as part of their examination and offering opportunistic vaccination. Or it can be as complex as conducting a well adult screen.

Practitioners can enable help-seeking amongst young Warlpiri men in a number of ways. Understanding the manner in which help-seeking might occur and encouraging existing social support mechanisms are areas in which practitioners can have considerable impact on reducing barriers to care for young men. The homosocial networks of young men are mutually protective and to a degree self-supporting. These are culturally prescribed features of the yarlpurru (co-initiate) and pirlalyi (friend) relationship. It is important that the supportive and protective aspects of these relationships are identified and encouraged by practitioners.

These behaviours are a common occurrence, even when a young man is seeking treatment for a sexually transmitted infection. The contradiction between
confidentiality and group presentation can be explained in terms of empowerment. While the presence of others may impart confidence, the underlying mechanism is one of shifting attention from the individual to the group. This is an important coping mechanism crucial to help-seeking behaviours in young men. It is essential that this mode of presentation is recognized by practitioners and not only supported but encouraged. However, the characteristics of these behaviours may cause them to be misinterpreted by practitioners. Typically, a group of young men may present when the chance of encountering others is minimal. The reason for presentation may not be directly stated and communication styles may range from reticence to good-humored banter. The practitioner might misinterpret this behaviour as time wasting or malingering and dismiss the young men thereby missing the opportunity to treat.

The issue of role models for male youth is one that resonates within the broader Australian community. Mentoring programs targeting youth who lack significant male role models are seen as one possible solution (Light 1999; Spry 1999). Such programs presume the availability of appropriate mentors. And yet it is the availability of Aboriginal male elders that is at the center of this problem at Nyirrpi. The issue of availability is linked to the broader social circumstances in which Aboriginal men now find themselves.

Aboriginal men have been denied their role as decision makers and community leaders. Patrol officers, settlement superintendents and various imposed bureaucracies have usurped these roles over the years. This is evident in the ongoing debate over the place of customary Aboriginal law within the wider Australian legal system. By failing to recognize traditional punishment under Australian law the Aboriginal jural system is diminished. The process of colonization has affected Aboriginal women also but their primary roles are by and large unaltered. Not so for Aboriginal men however, who have been gradually pushed to the periphery of community life. Any solution lies in the empowerment of Aboriginal men and their engagement with their community.
Aboriginal men are central to the process for only they can step forward and reclaim what has been taken from them.

**Conclusion**

Young men at Nyirrpi represent a group of the population at risk. This risk results from the confluence of culture and change. The transfer of responsibility for young men from women to men at circumcision remains a feature of contemporary Warlpiri society. However the effects of social change have diminished the quality of this care. This vulnerability is linked directly to the levels of supervision available to young men following their circumcision. The absence of chronic disease in this age group can mean they are afforded little clinical priority. The provision of health services to young Warlpiri adults should account for the social circumstances that define their lives and in so doing achieve a more comprehensive level of care.
Chapter 10

*Kurta-jarrimi*: The Getting of Shame in Warlpiri Society
Chapter 10

*Kurnta-jarrimi*: The Getting of Shame in Warlpiri Society

*Here shame dissuades him, there his fear prevails*

*Ovid*
- *Metamorphoses*

Introduction

Shame emerged as a recurring theme in the interviews with Nyirripi men concerning their help-seeking behaviour. This chapter will examine the concept of shame from both a cultural and linguistic perspective, highlight the central role it plays in Warlpiri social life and demonstrate how it influences behaviour.

Shame is a powerful physiological, psychological and social phenomenon. It is a social emotion that occurs both within and between people. Shame influences individual actions, is evoked in interpersonal relations and thus plays a significant role in social interaction and regulation.

Prior to analyzing the data on shame I will consider the meaning, function and experience of shame. Behavioural, social and psychological scientists have considered the impact of shame on human experience. The following represents some of the themes as they appear in the literature.

The Meaning of Shame

The word shame has its origins in the Old English word *sceamus*, the Germanic word *shamo* and the Indo-European word *skem*, all meaning to hide or cover. In a number of
European languages, shame has both positive and negative meaning. In Greek, *aiskhynē* conveys the negative content of disgrace and dishonor, while *aidos* the more positive content of modesty and bashfulness (Neilson 1934).

The concept of shame in English language has both a narrow and negative focus with associations of disgrace and disturbance of the psyche. The meaning inherent in shame is dependent on the society in which it is being considered. Traditional societies such as the Warlpiri have elevated the shame concept to a level of pre-eminence in order to regulate social relationships and control behaviour. Shame in Warlpiri society is the master emotion because of its centrality to both religious dogma and secular social controls. In essence, it forms the social glue balancing autonomy and communal endeavour. This is no better represented than in the extensive Warlpiri shame lexicon, which includes a vast number of expressions for behaviour, emotion and thinking associated with shame (Swartz 1998).

The literature reveals two perspectives for the defining of shame. The sociological view considers shame the primary means of regulating relationships and to a lesser degree controlling behaviour. The threat of shame acts as an incentive to behave in an acceptable manner. These incentives are both powerful and negative and include such emotions as humiliation, mortification, disgrace and anxiety. Scheff and Retzinger (1997) describe shame as the premier social emotion. They consider shame to be a large family of emotions including many cognates and variants such as embarrassment and shyness which are elicited in response to rejection, failure or inadequacy, both real and imagined. These emotions when experienced are perceived as a threat to social bonds.

The psychological view of shame suggests the discrepancy between the ‘ideal self’ and the ‘actual self’ and is summarized by Lazare as:
...both an emotional and cognitive state in which experiences are caused by the perception that oneself or one’s presentation to others is less than one had thought or hoped (Lazare 1992, p. 228).

Both the social and psychological elements are fundamental to shame. The shame mechanism is dependent upon the interaction of an ideal self-identity and others. Group identification and adherence to shared ideals contribute to strong social bonds. By embracing a shared ideal, ‘the self’ actively constructs an identity. Failure to achieve or maintain an ideal is recognized by ‘the self’ as failure. Others recognize this failure especially when ideals are shared. In the eyes of ‘the other’ we find a mirror with which to view our shortcomings. In shame, we see ourselves as others see us (Thrane 1979). Shame is total in that it concerns not only valued ideals but also identity and as such it strikes at the heart of personhood.

It is perhaps worth making a distinction between shame and guilt, terms that are often used interchangeably. Guilt and shame often arise in the same circumstances and both share the function of social control. There the similarities end. Guilt evolved as a self-monitoring system to motivate help-giving and avoid harming or exploiting others (Gilbert et al. 1994). The intense feeling associated with these states requires resolution. Resolution of shame comes about through acceptance following reformation of the character. With guilt there is the suggestion of debt with resolution being made through restitution, punishment or forgiveness. In guilt the focus is on the act and hence the sense of self remains relatively intact. The ‘self-other’ comparisons made in shame invoke strong feelings of inferiority (Thrane 1979).

The experience of shame has been described as global, possibly because it involves the core of a person’s identity. This suggests multiple behavioural and psychological manifestations of shame, some of which I will now attempt to document.
The Experience of Shame

The experience of shame includes behavioural, physiological, cognitive and affective components. There are problems establishing the experience of shame because narrative accounts may be unreliable. Many people may find it difficult to discuss their shame experiences in detail given the intensity of the associated emotions. Scheff and Retzinger (1997) suggest that narrative accounts of shame may be exaggerated, misnamed or unacknowledged. They are possibly correct, however I believe the difficulty people might have in recounting their experience of shame is limited only to the social context in which it occurred, the situation that stimulated the shame response. Recounting the emotional, physical and behavioural consequences are possibly less threatening than the stimulus itself. Scheff and Retzinger's contention that shame might indeed be misnamed is worth considering however, given the alternate use of shame and shy by Warlpiri informants (Scheff & Retzinger, 1997).

Shame usually relates to a state in which a prior event highlights some deficiency in the self. The physiological response may include blushing, sweating, feeling faint and an increase in heart rate. On a cognitive level there is the realization that one has been deficient, particularly in the eyes of others. This generates negative thoughts about 'the self'. This low self-esteem dampens the mood with affective responses that can range from sadness to depression. There is an overwhelming sense of exposure, in which one's failings are 'writ large for all the world to see' (Lazare 1992, p. 229). This, says Lazare, causes the very essence of 'the self' to feel at odds with the world (Lazare, 1992). The outward manifestations of the shame response are revealed in certain behaviours. Gaze-aversion, decreased vocal tone and body movement, passivity and speech difficulties may afflict the shamed person. So intense may the response be, that the person takes flight thereby avoiding or removing the shame stimulus (Gilbert et al. 1994).
The Function of Shame

Shame functions to help direct behaviour within and between persons so that social harmony is maintained. The primary motive of human behaviour is to secure important social bonds. These bonds are essential to both individual and group survival and have dynamic and interacting components that make the mechanism of shame possible.

All social bonds are characterized by the interaction between 'self' and 'other' in terms of separateness and togetherness. There is a constant tension in achieving a balance between these two extremes. Tension between togetherness and separateness is a fundamental dilemma in all relationships. Too much closeness or too much distance can jeopardize social bonds. In shame, the bond with others can't be denied. Shame serves the social order by restoring balance. Shame plays a vital role in social cohesion by regulating social distance. The shame response signals a threat thereby allowing the appropriate adjustments to be made and balance to be restored (Retzinger 1996).

To control behaviour requires a strong identification of the individual with the group. Implicit in this identification is a commitment to uphold shared and valued ideals concerning conduct. Shame supports our ideals by constantly illuminating our shortcomings (Lindsay-Hartz 1984).

Freud related shame to his concept of ego ideal. Ego ideal was a synthesis of internalized cultural values, idealized parental representations and moral precepts. Freud saw shame as a defense against exhibitionistic and sexual drives rather than an interpersonal subjective experience (Gilbert et al. 1994).

If emotion is in part linguistically constituted we need to be careful not to assume that what we refer to as shame in English is a universal emotion. Emotions are profoundly culture specific in the sense that two languages are unlikely to classify emotions in
exactly the same manner (Parker 1996). It is possible that the universal but complex human experience of shame is imperfectly captured by a singular English language word.

The Aboriginal Experience of Shame

Whilst shame is universally a human experience, there are cultural variations in the way in which it manifests between different groups of people (Duncan 1986; Harkins 1996; Retzinger 1996). As shame has emerged as a major determinant of help-seeking behaviour in Nyirrpi men, it is worthy of further examination within an Aboriginal context.

While the human repertoire of emotions is universal, we need to consider these concepts within their respective linguistic and socio-cultural contexts. Harkins (1996) examined in detail the linguistic and cultural differences in the concept of shame. She demonstrated significant differences in the cultural and semantic content of Maori and Australian Aboriginal concepts of shame. Such differences can be identified in the emotion words of a particular language. Inherent in the meanings of these words is a wider set of cultural concepts and the behavioural responses with which they are associated.

Shame has been extensively described in two Central Australian languages. The Arrrente word *apure* is defined:

...shyness, embarrassment, unsure of the right way to behave. People might have this feeling after doing something wrong or it may stop them from doing something wrong or they may have this feeling when they do not know someone or are not sure about the right way to behave. Putting yourself forward, standing out from the group, especially if you are not the senior person in the group, will cause this feeling. Respect for certain relatives is
demonstrated by avoidance (*nyurrpe*). People may feel *apure* if they accidentally break the rules (Henderson & Dobson 1994, p. 198).

Henderson and Dobson (1994) describe the behaviour which accompanies *apure* as averting one’s gaze, a reluctance to speak or speaking indirectly or simply moving away from the person or situation which is perceived to be causing *apure*.

In the Pitjantjatjara/Yankunytjatjara language the word *kunta* can denote either the respectful attitude of one person towards another or the state of embarrassment (Goddard 1992). In this sense shame is felt as discomfort arising from any situation where the person’s sense of self is both exposed and observed. Being in the wrong place or making a mistake are possible causes for a person feeling shame. For the Pintubi, shame (also *kunta*) carries connotations of embarrassment, shyness, and respect. Myers describes how shame is used to ensure social control in Pintubi society (Myers 1986). Shame is used to evaluate the totality of ‘self’ in relation to positively valued qualities. In this manner, shame balances the demands for relatedness to others and for personal autonomy. Personal autonomy is negatively valued in those societies where group cohesion is essential for survival.

Duncan (1986) identifies two areas in which shame is pre-eminent in Australian Aboriginal society. These are the taboo on contact between certain kin and the system of respect-based etiquette. In both these areas of social regulation shame is the mechanism through which behaviour is controlled.

Shame in a Warlpiri sense appears to arise from violation of some social norm, such as being in an inappropriate place or social situation, failing to show proper respect or reticence in social interactions. Failure to perform ritual or customary duties and to neglect kinship obligations can also generate shame. The shame state is associated with feelings of embarrassment and inadequacy (Hale 1995; Swartz 1998). A person
guilty of such crimes of omission will often be described as ‘useless’; this is no reflection on their ability but rather a comment on perceived shortcomings.

Warlpiri people use the words shame and shy in the same context. There seems to be considerable variation in the somatic response of these two emotions. This suggests that shyness and shame are points along a continuum of emotional response with the defining elements being the stimulus and the reaction. Certainly the behavioural manifestations appear to range from reticence through to mortification. Two Warlpiri words are given for shy. The term, *jukuru* means unwilling, morose, apathetic. There seems to be little ‘semantic fit’ between the English language word shy and the Warlpiri word *jukuru*, other than vague associations with the behavioural components of shyness. The Warlpiri word, *muurlpa* meaning caution in the company of others is perhaps closer to non-Aboriginal notions of shyness. Inherent in the meaning of *muurlpa* is the social stimulus and the behavioural response that characterizes shyness.

Shyness in a Warlpiri context is likened to mild embarrassment or bashfulness and appears to be applied in a number of social situations. Any situation where a person becomes the focus of attention, either for positive or negative reasons, is likely to provoke reticence. And as the Warlpiri word *muurlpa* suggests, social reticence in the presence of others demonstrates both respect and a capacity for shame. This is an important point as it suggests that for Warlpiri speakers of English, shame and shyness are one concept, the difference being the degree of reaction and the social context in which the emotion occurs.

On a behavioural level, shame and shyness share many similarities. Averting one’s gaze by lowering the head, keeping social contact to a minimum and lowering the voice are seen in both shame and shy responses. It was difficult to form any impression of how Warlpiri people experience shame at an emotional level. Warlpiri men likened the somatic manifestation of shame to being uncomfortable:
‘I think he gets upset and he does not want to go in (the clinic) when he feels shamed like that.’

The relationship between this unease and clinic attendance was emphasized in the following statement:

‘...he gets dizzy and he does not want to come back next time he gets sick into this hospital.’

Removing oneself from community life is a shame behaviour in Warlpiri society. Sobriety is often accompanied by shame for deeds committed whilst inebriated. For those concerned, a self-imposed exile is the most common way of coping with the shame associated with their inebriated behaviour. This exile behaviour is well understood by others and rarely is the person confronted about their behaviour. To do so would illicit extreme mortification and could provoke a violent response. Scheff and Retzinger (1997) have proposed that women and men respond to shaming in different ways. Women react to shaming with further shame, whilst men react with anger. In Warlpiri society, highlighting another person’s shame is considered provocative in the extreme. Shame unacknowledged is by no means shame unrecognized.

Shame and Access to Health Services: Nyirrpi Men’s Experience

The purpose of conducting this research was to investigate issues relating to access and utilization of health services by Nyirrpi men. Men interviewed were universal in their responses regarding what they felt were the barriers to accessing clinical services. All men interviewed spoke of the shame associated with health clinics. Shame was reported as the prime cause for their limited utilization of clinical services.
Shame can have many sources. The following were reported as sources of shame:

**Contagion and Shame**

For most men in Nyirrpi, attending the clinic was tantamount to admitting they were suffering a sexually transmitted disease. For these men, merely being present in the clinic represented a breach of confidentiality. Nyirrpi men equate men’s health with sexual health. In my discussions with men about their health, men automatically assumed I was speaking about sexually transmitted disease. This mode of thinking is well entrenched and represents a significant barrier to Aboriginal men’s health care.

Shame seems to be derived not so much from the stigma associated with a specific disease but with the manner in which the disease is contracted. In the minds of most adults at Nyirrpi, episodic drinking of alcohol is associated with indiscriminate sexual activity. Therefore any man who consumes alcohol in this manner is assumed to have engaged in such behaviour. These liaisons can be both extramarital and prohibited by kinship, a significant cause of the shame that men experience. If a man who drinks alcohol has the need to attend the community clinic his guilt is proven in the eyes of all onlookers regardless of the nature of his illness.

‘When they come from town they always get shame because other people saying to that man, “go to clinic”...“nah I don’t want to go”...they talk like that. “There are a lot of people at the clinic, they might stare at me”.’

Interestingly, the small number of men at Nyirrpi who did not drink alcohol did not share this mode of thought and their help-seeking behaviours were quite different from their contemporaries who did use alcohol. These men were almost considered above reproach as their status as non-drinkers was well known and this was reflected in their behaviour. These men made frequent visits to the clinic and appeared to have no difficulty being in the clinic. When asked about their apparent ease at being in the
clinic, responses were related to concerns for personal well-being as revealed by the following statement:

‘...nah, I don’t get shame...I just worry for my body you know.’

There was only one response concerning the communicable nature of sexually transmitted disease.

‘...ah somebody might lie for him, other people, “ah this bloke has got sickness. I don’t want to catch it”. You know how they think, they won’t sit next to him, they won’t share it to him, long as he can get his own billycan. Some other blokes...not me.’

The above statement, which is infused with elements of contagion, illustrates the erroneous knowledge concerning disease transmission. It is the pre-eminence of sexual health in men’s notions of health and well-being that is of greatest significance here. However this pre-eminence does not necessarily translate into behaviour modification. There is no doubt that rates of sexually transmitted disease are inordinately high in many Central Australian communities. This is an issue of extreme concern in view of the human immunodeficiency virus pandemic.

This presents a conundrum for practitioners. By shifting the emphasis away from sexual health to a holistic model as enshrined by well men’s screening we will eventually effect a change in men’s thinking about what men’s health constitutes. Perhaps then, men will be more likely to make greater use of health services. But given the problem of sexually transmitted disease in the Aboriginal community, should we be shifting the emphasis away from sexual health, given that it is uppermost in men’s thinking and remains perhaps the most pressing of men’s health issues?
The Preponderance of Female Staff

A number of men reported the predominance of female health staff as the main barrier to attending the clinic:

‘...ah some people don’t go to the clinic when the nurse is there. They don’t want to explain it to her, they just want to see someone else. Like those man doctors or sisters.’

This reluctance seems to be associated with physical examination. Revealing or exposing the body is something which is done ceremonially and some men expressed the belief that as men, they were not obliged to ‘show themselves’ to women and uninitiated men as revealed by the following statement:

‘...yeah that is the main part now, if a man has a big boil here (indicates genitals), well woman can’t take your clothes off...only man can do that. See, some man get big shame like that.’

However, exposing one’s body to other men in clinical examination is not a straightforward matter either. The revelation of the body is something that has certain cultural restrictions. Meggitt claims that for people of the same sex ‘there is no taboo on seeing each other’s genitals’ (Meggitt 1962, p. 89). However, Nyirrpi men reported that such a prohibition exists between yarlpurru, men who were initiated at the same time. Traditionally, Warlpiri were naked but Meggitt claims that with the adoption of clothing came considerable modesty. Thereafter the deliberate exposing of one’s genitals became not only a ‘breach of etiquette…but also a vile insult’ (Meggitt 1962, p. 90). The reluctant and circumspect manner in which many men expose their bodies for examination, even with non-Aboriginal male practitioners with whom they are familiar, suggests this cultural restriction has been maintained. This impacts on the
degree to which a Warlpiri male can be examined when presenting for a sexually transmitted disease.

Not all men however, viewed female health staff in a negative manner. Two men who had experienced lengthy hospital admissions for surgical procedures spoke positively about female nurses caring for Aboriginal men. One man described his experience as such:

'like woman nurses, they looked after me properly, worrying for me.'

Another man commented on the impartiality that many nurses displayed when dealing with Warlpiri men. While nurses were seen by some men as being non-judgmental others saw them as being ignorant of 'yapa way'. The term 'yapa way', literally meaning 'the Aboriginal way' refers to the secular aspects of Warlpiri affairs. There was no expectation that nurses be cognizant of these matters, in fact nurse's ignorance was seen as contributing to their non-judgmental approach. One informant however viewed the nurse's ignorance of Warlpiri Law as being potentially dangerous and contributing to culturally unsafe practice.

Problems with English Language Communication

A number of informants claimed that difficulties with spoken English could cause shame. Comprehension of spoken English is determined by a number of factors. In some instances the causes may be physiological. Hearing deficits from chronic middle ear disease compromises the comprehension of spoken language. Such problems in adults are often not diagnosed and rarely investigated or treated. Warlpiri people with hearing difficulties are referred to as being warungka, the word having two meanings, deaf and mad. Warlpiri people when describing others as warungka will often qualify their meaning with additional information. Unless this qualification is made it is
possible that problems with comprehension may be inadvertently attributed to psychological rather than physiological causes.

In other instances, the language spoken by health professionals, especially the use of technical terminology, may inadvertently distance the Warlpiri client from the practitioner. So great was the shame associated with misunderstanding language that people may feign comprehension regarding directions for treatment rather than expose themselves to ridicule by asking for clarification from another Warlpiri speaker.

For some men the problem of language was one easily remedied by having Warlpiri speakers employed in the clinic. Many informants commented on the long-term absence of a male health worker in the clinic at Nyirrpi:

‘...what I think they need is yapa (Aboriginal) on the side with kardiya (non-Aboriginal), working with the man, it would be okay because like a translator...see that's the sort of thing that can help.’

A number of informants reported that disclosure was far more appropriate with non-Aboriginal health staff. For some men the problems posed by English language were less than that of the subject matter. These men considered there was a degree of safety in the fact that non-Aboriginal health professionals were unaware of Warlpiri social conventions.

‘Well it is like um...kardiya does not know yapa way and I think they realize that sister does not talk to other people.’

A number of men felt that younger people had the greatest problem communicating in English. One man reported that his sons, both young adults, were unwilling to visit the clinic on their own and frequently asked one or both parents to translate and act as an
advocate. Young people were considered particularly at risk because of their reticence, their poor English language skills and their denial of illness.

The clinical encounter can be shaming, especially when the practitioner is unknown to the client. These situations are not uncommon given the high turnover of medical and nursing staff in remote areas. History taking involves incessant questioning, a situation where the client becomes the focus of attention. This becomes problematic when language complicates and hinders the communication process. Both parties in a cross-linguistic conversation are equally responsible for the success of communication. There are however, unexamined assumptions made by the English language speaker that in conversations employing English, both parties are equal. This linguistic ‘level playing field’ is rarely achieved and the burden of failed communication that ensues is borne by the Aboriginal party. The following statement illustrates these difficulties:

‘...like I was thinking he (doctor) might ask me a lot of hard questions you know, because he does not really know me see...like my background, what I been through. That is why he might start asking me a lot of questions and from there I might not answer that question now.’

Problems with comprehension lie not only with the Aboriginal speaker of English. The non-Aboriginal English speaker can assume quite incorrectly that as both parties converse in English the meanings are similar if not the same. Aboriginal speakers of English often structure their sentences differently, in particular word order and emphasis and tone of delivery. These can have significant implications for the implied meaning. The following anecdote illustrates this point:

I discussed with an informant his reluctance to see a doctor. His reluctance stemmed from the fact that the doctor did not ‘know his face’. I interpreted this response quite literally to mean that the reluctance stemmed from the fact that the respondent was unfamiliar with the doctor. Reflecting on this conversation,
I became aware of what had actually been stated. The reluctance stemmed from the fact that the doctor did not know the informant. Was this just a matter of ordering words and concepts differently or was the intended meaning different from my interpretation. I returned to the informant and related our conversation and explored his concerns further. From the informant’s perspective it was important that the doctor knew his medical history but this could only be ascertained in part by asking questions.

This constant questioning was shaming as it both drew attention to the individual and burdened the Aboriginal person with the task of comprehending ‘hard English’.

**Focused Attention on the Individual**

In the Arrente definition of shame, reference is made to ‘standing out’ and ‘putting oneself forward’ as causes for shame (Henderson & Dobson 1994). Hiatt (1978) cites Darwin’s early work on the classification of emotions. Darwin linked shyness and shame with modesty and self-attention. For Warlpiri people, any situation in which attention is focused on the individual is considered shaming. Whilst shame is most commonly reported in these situations, the behavioural responses I have observed suggest a transient and mild reaction. Men reported a number of clinical situations in which attention could cause unease.

Being less frequent visitors to the clinic than women and children, men are often unfamiliar with clinic procedures. When men, through their uncertainty, are forced to ask others, either women or children for assistance they bring shame upon themselves for being *muru* or ignorant. Such concerns were often linked to language skills:

‘I reckon people might laugh at them. “Yeah...you can’t speak properly English”. They don’t like it.’

197
Many men spoke about the 'hard English' they encountered in clinic visits and reported the constant questioning that accompanied medical consultations as being shameful. Given the high turnover of non-Aboriginal staff in remote communities, this constant questioning becomes a characteristic of the health encounter. Direct questioning is the primary way in which non-Aboriginal health professionals gather the information essential to history taking. In style, it differs from the subtle and indirect methods Warlpiri employ to elicit information. It is a style that puts Warlpiri people at a disadvantage. Ready agreement, silence or inappropriate responses signify failed communication. This calls into question the accuracy of the information gathered by the practitioner, not to mention the comprehension of medical information by the Aboriginal client. The following statement highlights such concerns:

'ah...well if you show the person who can’t speak proper English the medicine and you explain about the medicine and it is simple, well I think they still won’t understand.'

People who experience problems comprehending spoken English may be reluctant to seek clarification. Seeking clarification will draw attention to the individual especially if a third party is involved for the purpose of translation. The following statement illustrates this reluctance:

'...he must be really desperate, he must be sick inside and he wants to find out you know, what this nurse is saying, then he sings out for someone to explain it to him.'

The problems associated with language and communication is inordinately complex. I fear that many practitioners fail to appreciate the difficulties of cross-linguistic communication. I will examine some of these difficulties in detail in the following chapter.
The Importance and Impossibility of Confidentiality

The concept of confidentiality is one that is both understood and valued by Warlpiri people. Informants expressed concern about privacy, particularly the maintenance of privacy in a small community and the ease with which privacy can be breached. This can occur in a number of ways. Clinic design, work practices and workload can impact on the use of the clinical space by both practitioners and clients. Where there is an emphasis on communal space as opposed to private space in clinic design and use, the protection of private information can be problematic. The ease with which private information can be overheard is illustrated by the following comment:

‘Well sometimes they talk about it. Talk about what is wrong with him. Sometimes he hear them, the health worker, “ah...he got sickness”, called whatever, you know. They tell everybody then, everybody who is waiting around. And he thinks, “ah...I don’t want people to know what sort of sickness I got”.

A number of informants discussed experiences in which they believed confidentiality had been breached. Some seemingly innocent aspects of nursing practice could not only elicit extreme shame but could also be considered a breach of confidentiality. The most sensitive of these mechanisms involved the clinical practice of urinalysis. Most men considered any procedure involving urine as being suggestive of sexually transmitted disease. Men consistently requested that the collection and testing of urine be conducted in strict privacy. This unfortunately is not always the practice. While the collection of the urine specimen is done in private, the testing may be done in a public space. The following statement summed up the experience:

‘When they make mawu (urine) and they bring it out where woman is watching, they get shamed. Woman think, “ah something wrong with that man”’.
Urinalysis is a basic element of a physical examination and is routinely performed. Therefore the clinical encounter and its inherent potential for shame is an ever-present concern for men. There were no similar concerns about blood collection however, venepuncture was seen as a legitimate screening procedure and one not associated with sexually transmitted disease.

Meggitt (1962) commented on the virtual absence of a private life in Aboriginal communities. Given that life in Central Australian communities is essentially conducted outdoors, private lives are played out in a public arena and as such are highly visible. Men considered their recall to the clinic for treatment as a breach of confidentiality. Any contact between health staff and a male client outside the clinic was likely to be observed and the reason for the contact speculated upon. The practice of collecting a male client from his home and taking him to the clinic was also likely to raise suspicion. In the minds of those observing such proceedings was the ever-present doubt about a man’s state of sexual health. This is a unique problem of Aboriginal community life. Privacy and sexual health in small rural communities has previously been identified as problematic (Warr & Hillier 1997). In Aboriginal communities, the high index of suspicion that accompanies men’s contact with a health service coupled with the visibility of this contact diminishes privacy to the point of alienation.

One suggestion for overcoming the problem of recalling young men to the clinic was for the practitioner to go through an intermediary. This person would ideally be the ngumparna (brother-in-law) who has the ultimate responsibility for a young man’s welfare. The problem with this approach is that the brother-in-law may become the focus of speculation and any information given to him by the practitioner represents a clear breach of confidentiality. The application of confidentiality and privacy issues in Aboriginal communities is not a straightforward matter and is an area that requires further research.
The Concept of *Jampardi*ni

*Jampardiyi* is the Warlpiri term meaning avoidance. The Encyclopedia of Aboriginal Australia defines avoidance as the restrictions that exist between different categories of kin (Horton 1994). Avoidance relationships are characterized by limits on social contact or formal and constrained behaviour between certain people (Kessing 1981). In Central Australia, as well as kin restrictions, avoidance may also be associated with death and mourning, aspects of ceremonial life and geographical sites. Avoidance is in essence a behavioural style that permeates many facets of contemporary Aboriginal life.

Most of the literature on avoidance concerns the relationship between the son-in-law and mother-in-law (Duncan 1986; Hiatt 1984; Merlan 1997; Rose & Jolly 1942). Merlan claims that the mother-in-law son-in-law taboo stems from the social possibility inherent in a spouse-giving and spouse-receiving relationship. The social possibilities implicit in spouse-giving include issues of sexuality, reproduction and the realization of adult status. Spouse-giving is essentially an economic exchange, for it generally carries with it the obligation to provision in-laws with food, namely meat. Merlan reports that:

...the most profound emotion which Aborigines have reported to be associated with this affinal bond and its strong mutual obligation is shame (Merlan 1997, p. 98).

Hiatt claims that in this manner shame exists to prevent sexual attraction between a mother-in-law and her son-in-law. Merlan points out that this prohibition is fairly universal across cultures but only in Australian Aboriginal societies is such strict avoidance required. Merlan (1997) contends that the shame emanates from the power imbalance that spouse-giving implies. Essentially the debt owed by a man to his in-laws is so great that his obligations towards them can never be expunged.
Elkin (1968) describes two categories of avoidance, one determined by marriage and the other by consanguinity. These can be further divided by sex. This suggests the possibility of an extensive network of people with whom a person may be required to behave in a circumspect manner.

Little attention has been devoted to the avoidance relationships that exist between men and more importantly how this might impact on their lives. Extensive avoidance relationships exist in Warlpiri society. For men, the two most strictly observed avoidance relationships are with his mother-in-law and the female kin of the boys he circumsizes. Warlpiri describe avoidance literally as ‘no room’. This description implies the behavioural aspects of the term, specifically that persons who are in an avoidance relationship should not come into close social contact. Warlpiri differentiate between social and spatial distance, those in avoidance relationships can be in close physical proximity but are expected to avert their gaze and not interact directly. Merlan differentiates between the social and spatial distance of avoidance as:

\[\ldots\text{not the complete proscription of social co-presence and interaction but rather a mode of interaction which emphasizes deference and social distance (Merlan 1997, p.106).}\]

Duncan in her study of shame examines in detail the brother-sister taboo amongst the Yolngu of eastern Arnhem Land. Whilst this is not a feature of Warlpiri social life (Meggitt 1962), there exists a formal code of conduct between brothers, sisters and cousins. This code denotes primarily speech behaviours that are characterized by indirectness. It is a way of speaking correctly, particularly in relation to the sharing of possessions. The term \textit{juulku} is used to explain the etiquette of sharing among siblings and cousins. This is a way of making a request by hinting at the object desired. When the request is not openly stated the potential for shame is circumvented.
The burden and responsibility of avoidance relationships is overwhelmingly borne by men. The genesis of these relationships lies in the fact of manhood and its concomitant ceremonies. Adult male status is conferred by and through ritual, culminating in genital inscriptions that signal forever the attainment of adult status. The jamparidiyi relationship generated through initiation ritual applies only to circumcision. The same behavioural prohibitions do not exist for sub-incision. Although the term, jamparidiyi is employed by men following sub-incision rituals, there is no expectation of avoidance. The term is used more as a signifier of the special relationship that exists between the two men brought together via this ritual. A formal process, the shaking of hands or the exchange of gifts negates the necessity for avoidance. Some men likened this process to freedom, the freedom from lifelong avoidance and the consequent inconvenience that it undoubtedly carries.

In circumcision, strict avoidance lies between the circumciser, the boy and his female kin, specifically his mother, sisters and aunts. The relationship between the circumciser and the boy's brothers and father is one based on obligation. He calls these men pirlalyi and while full social intercourse is permitted, there is the expectation that the circumciser can call on his pirlalyi for assistance, most usually the provision of material aid.

As the following figure demonstrates, the avoidance relationships generated through circumcision are extensive, particularly for the circumciser. With each boy circumcised, the number of female kin a man must avoid increases exponentially. Some younger men at Nyirrpi reported their reluctance to get overly involved in circumcision rituals because of the burden and inconvenience that avoidance places on their lives.
Amongst Warlpiri men, strict avoidance exists between the circumciser and the initiate. Circumspect relationships exist between brothers, between father-in-law and son-in-law and on occasions between *yarlpurru*. Both the degree and circumstance of avoidance can vary depending on the relationship. The rules of avoidance between men seem to be less rigid than those between men and women. Meggitt (1962) claims that contact between men who regard one another as *jamparidi* as likely to cause distress in the form of shame and fear. Men reported that while close physical proximity between male *jamparidi* was possible, speech or visual contact was prohibited. A form of speech referred to as *jamayi-mayi*, may be employed when those in avoidance come into contact. This is a form of speech conducted via a third party.

The shift to community living seems to have impacted greatest on men’s lives. Their mobility is restricted as is their free access to important communal spaces. Elkins makes an interesting observation about non-Aboriginal awareness of Aboriginal social life:

> We often see things without understanding their significance, or indeed without realizing that they have any significance at all (Elkin 1968, p. 147).
This is an extremely perceptive observation, one that resonates with as much significance today as it did when made by Elkin some four decades ago. Much of the behaviour involving avoidance was almost invisible to me, despite many years living and working in Warlpiri communities. Awareness of these behaviours and the motivations behind them only occurred when they were explained. So well were these behaviours camouflaged by seemingly normal daily social intercourse, that I failed to see them as anything else.

There are formal rules for determining right of way when people in avoidance relationships come into contact in confined communal spaces, such as the clinic. These rules were different for women and men. Men reported that between men ‘the person coming behind’ gave way, that the person already in place had right of way. This did not seem to be affected by the age of those concerned. For instance, a younger man would not necessarily give way to his elder. Women however, were expected to give way to men, regardless of the order of presentation. In practice this is rarely enforced and it is usually the men who wait until women vacate a space and give them ‘room’. This was a point of contention for many men. They complained about having to wait for women before they could gain access to the clinic and the store. The following statement indicates this displeasure:

‘Yes...“ah my jampardivi is there”...they walk away. They might wait there a long time. “Ah too long I’m waiting now”. They get sick of it, standing around, maybe they go.’

So in essence this concept of avoidance has a significant impact on the way that Warlpiri men use communal spaces. As we can see by the above statement men do not appreciate having to wait for ‘room’ and will simply walk away, thus surrendering their right to service. They may choose to return at another time or may simply abandon the endeavour.
The possibility of coming into contact with one’s *jampardiyi* in a confined communal space such as the clinic may make people apprehensive about being in those places. Despite well-established protocols for conduct and resolution in these situations, the effect produced is one of social discomfort. In a sense men are placing themselves at risk for such discomfort every time they enter one of these confined spaces. The danger that these spaces represent is summed up by the following statement, which was made in response to avoidance within the community at large:

‘Nah…they see it and go somewhere else.’

The safety afforded by open spaces is that they allow for proper avoidance. A person has some warning of imminent contact and is able to adjust their itinerary so as to avoid embarrassment. An enclosed communal space such as a clinic offers little protection, as proper avoidance cannot be maintained.

Avoidance can greatly impinge upon the practice of Aboriginal male health staff. Men appear to have more avoidance relationships than women and these can make clinic-based work difficult. These constraints include who can perform a clinical examination and to what degree an examination can be conducted. For those people classified as *jampardiyi*, the Warlpiri male health worker can only have an indirect involvement. In these instances physical examination is prohibited, unless conducted through a third party. A Warlpiri male health worker cannot perform a genital examination on his *yarlpurru*. It is probable that non-Aboriginal colleagues poorly understand these restrictions.

The above may seem a well-defined set of circumstances but they indeed are not. Community life with its subtle and complex determinants of interpersonal behaviour is revealed in the variation in which people interpret and apply cultural and social norms to their individual lives. In his study of the social function of avoidance language, Rumsey (1982) claims that avoidance relationships are not fixed and non-negotiable
but are selectively invoked. Rumsey claims that flexible speech and social strategies facilitate this variation in avoidance behaviour. There also appears to be a degree of intergenerational incongruence in the application of avoidance behaviour. All these variables determine individual responses in any given situation. People will always act outside community expectations and such variations need to be considered not as aberrations but variations from the norm and as having their genesis in a multitude of possible causes. One such variation is related to age.

A Matter of Age

The experience of shame appears less applicable to the elderly. My observation has been that elders rarely avoid situations that might be considered shaming. In a sense they have 'no shame' which does not mean they are shameless but merely recognition of their elevated position in Warlpiri society:

‘...they (elders) can tell them off, if people are staring at them.’

The respect for elders requires that others should, within certain limits, ignore their social transgressions. In other instances people acknowledge the infirmities associated with old age:

‘...they be thinking all the jampardiyi, may be a bit warungka (mad)...too old you know.’

The practice of elderly males to go unclad within their 'camp' but in public view was considered normal and not at all shameful. And yet similar behaviour in a younger male would be considered shameful in the extreme.
Others argue that the liability to experience shame naturally diminishes with age. With age the sense of self, both the ideal and the actual become one entity. Thrane (1979) states that in old age a person's virtues become their nature.

Discussion

The study of shame and its associated emotions in an Aboriginal context highlights the complexities of cross-linguistic communication. This examination has focused largely on the social and cultural context of the Aboriginal experience of shame. It also illustrates how Aboriginal speakers of English apply different meanings to English language words. This linguistic variation suggests points at which misunderstanding can occur.

The cause of shame for a Warlpiri person will have either a social or cultural base, one that is well recognized by other Warlpiri people. Recognition implies expectation. Failure to display appropriate social reticence, to observe expected social protocols and kinship obligations are likely to elicit criticism. Whether these deficits are highlighted or not, the transgressor will be very aware of his or her shortcomings. Myers (1986) claims that in Pintubi society, shame and respect are inextricably linked. He suggests that shame can be experienced in an extreme form such as mortification or to a lesser degree as respect. Respect is demonstrated by shyness and inherent in this social reticence is a desire to avoid embarrassment.

This idea of degree is important in distinguishing between shyness and shame as experienced by Warlpiri people. These terms and their use by Warlpiri speakers appear to be different points on a spectrum of social unease. The defining point appears to be the shame stimulus as opposed to the degree of emotional response.
Nowhere else in the health literature has shame been so consistently reported as a barrier to help-seeking behaviour. There appears to be little previous work done on shame as either a barrier to or a consequence of the clinical encounter. Lazare (1992) examines in detail the shame and humiliation that can result from illness. He lists the indignities of examination and treatment regimes and the physical and psychological deficits associated with illness as the source of shame in clients.

For Nyirrpi men, the experience of shame differs in that it does not need to arise from a clinical condition but rather the fear of being perceived as having a particular illness, specifically a sexually transmitted disease. What appears significant in this phenomenon is not the illness itself but the behaviours that caused the illness. What is unclear however is whether the shame is linked to the sexual act itself or the possibility of promiscuous sexual behaviour. There was only one comment regarding the contagious nature of sexually transmitted infections and little evidence of the stigma associated with disease itself.

Anthropological accounts of other western desert societies suggest a degree of sensitivity surrounding the act of sexual intercourse. Tonkinson (1978) discusses the reluctance of the Mardudjara to discuss the physiology of paternity, conception being explained in terms of a ‘spirit child’ whose entry into the mother’s body is independent of the husband and future father. Specifically, semen and sexual intercourse held no relevance to procreation in Mardudjara beliefs. Myers (1986) makes a similar observation of Pintubi men, who while acknowledging the male role in procreation were reluctant to discuss these matters, which they considered shameful. Myers contends that for the Pintubi, a necessary part of being a human and sexual being was having an awareness of shame.

For Nyirrpi men, shame is generated by the perception that others are speculating about possible illicit relationships, particularly those proscribed by kinship. This speculation is prompted by two factors, alcohol consumption and clinic attendance. Whether such
relationships are real is irrelevant. It is the possibility of an illicit relationship as suggested by alcohol abuse, which constitutes the stimulus to shame. So fundamental is the shame associated with such liaisons that it becomes a universal reaction amongst Warlpiri men predisposed to conspicuous alcohol consumption. This is possibly what Lazare (1992) refers to as the vulnerability of the subject to shame. The Warlpiri term *warrura* (wrong, improper, counter to laws, particularly marriage) seems to be rarely invoked to describe the sexually promiscuous behaviour of men. However, the implications of such behaviour are not lost on men. It would seem that a lack of propriety rather than infidelity is the shame stimuli for many Warlpiri men. Myers (1986) states that among the Pintubi, promiscuity and sexual relations outside kinship laws were viewed as shameful behaviour. Meggitt (1962) seems less definite on this issue when discussing promiscuity amongst Warlpiri men. He states that:

While it is recognized that some men are likely to initiate sexual liaisons with certain extra-familial relatives, the overt norm in sexual relationships is that men should only copulate with their wives and reproduction should only occur within the family. Illegitimate births are strongly deplored (Meggitt 1962, p. 81).

Meggitt (1962) suggests that merely being aware of another person's sexuality gives rise to contemplation of that person's sexual behaviour. This is the very shame-inducing mechanism reported by Nyirrpi men in this research. Meggitt (1962) claimed this contemplation, while tacit, was acknowledged by both parties, each sharing in the experience of shame.

Shame is a complex of behavioural, cognitive and affective states. It is a pervasive feature of Aboriginal social life. The maintenance of harmonious social relationships hinges on the invocation of the shame response across a range of social settings. The concept of *jampardiyi* or avoidance suggests the central theme of correct social distance in the maintenance of relationships in Warlpiri society. Shame or the threat of
shame is the mechanism by which this social distance is maintained. The maintenance of correct social distance has become a burden, especially for men, with the shift to community life. Avoidance was not difficult to maintain in traditional Warlpiri society. People lived a semi nomadic existence, the residential group limited to the nuclear family that only came into contact with other groups occasionally (Meggitt 1962). With community living has come a reduction of social distance, with those people in avoidance relationships brought into close and constant physical proximity. This has meant many adaptations and to a large extent limitations for men who bear a greater burden of jampardiyi or avoidance relationships.

Issues surrounding confidentiality are likely to remain problematic for practitioners. A discussion paper for the protection of privacy of health information in the Northern Territory offers little guidance for practitioners in Aboriginal communities (Department of Heath and Community Services 2002). Vague recognition is given to the fact that privacy issues for Aboriginal people might be different from those of non-Aboriginal people. The reality of remote area work often jeopardizes privacy and can leave practitioners open to criticism. I suggest that many practitioners are unaware of these issues. These issues are experienced daily by Aboriginal people and are a source of considerable concern.

There is no doubting that the transition from a semi-nomadic to a sedentary existence has wrought enormous change for Aboriginal people. This transition has only occurred in the past sixty years for the Warlpiri and the changes to Warlpiri society continue to manifest in a variety of ways to the present day. Unfortunately, Warlpiri men have borne the burden of these changes; their existence has changed irrevocably within a few generations. A number of men suggested their cultural inheritance had been poorly maintained, that the richness and detail of ceremonial life had been greatly diminished. Many older men commented on the difference between their passage into adulthood and that practiced today. Some men expressed a degree of resignation
regarding this difference, stating that cultural change was inevitable, that contemporary Warlpiri life was itself different and that Warlpiri culture had to evolve with change.

Women’s role in Warlpiri society has been less affected than that of men. While women’s nurturant role remains intact, men’s primary economic responsibility, the procurement of protein food, has become redundant. In a contemporary economic sense, all Aboriginal adults are equal in that they receive social security payments. But this economic dependence has been catastrophic for men. The social impact of so-called ‘sit down’ money has been enormous, providing both the cause and means for men to drift into substance abuse. This is perhaps a simplistic view of what are undoubtedly very complex social, economic and political consequences of change in a traditional society. There is however, no denying the havoc wrought by rapid cultural change, the overwhelming burden of which continues to be borne by Aboriginal men.

Conclusion

The Warlpiri concept of shame, as in other Central Australian societies, embodies the view of what it means to be a person and how one should conduct oneself in social relations with others. The public presentation of self is as much about personal dignity as it is about respect for others. Shame remains a fundamental component of personhood in Central Australian Aboriginal communities. However, the experience of shame has evolved with the changes in contemporary Aboriginal life. Community living has amplified the effects of avoidance relationships by significantly reducing social distance. This amplification is particularly evident in communal spaces such as the clinic. It is incumbent on practitioners to be cognizant of the central role that shame continues to play in Aboriginal social life and to deliver care in a manner that protects both dignity and health.
Chapter 11

Language and Communication
Chapter 11

Language and Communication

All speech is a hazard; oftener than not it is the most hazardous kind of deed.

Miguel de Unamuno
-The Life of Don Quixote-

Introduction

The dominant but by no means sole vehicle of human communication is to be found in language. Language is a sign system that gives meaning to reality by providing a mechanism through which information, knowledge and experience can be shared.

Perhaps the most significant challenge within the methodological domain concerns semantics, the intended meaning of both the written and spoken word. While language is primarily concerned with meaning, many other aspects of the human speech act influence how accurately this meaning is conveyed.

In this chapter I will examine issues of language and communication and how these impact on cross-cultural understanding.

Styles of Conversation

Walsh (1997) proposes that distinct and radically different conversational styles exist between Aboriginal and non-Aboriginal societies. He describes non-Aboriginal styles of speaking as dyadic, where speech alternates between a speaker and listener and communication is contained either by time or topic. Aboriginal conversational styles are communal with speech broadcast publicly in a continuous flow of dialogue. Liberman (1985) refers to the congenial and consensual nature of Aboriginal discourse.
He claims these elements are essential to a communal style of speech. He argues that non-Aboriginal people are unable to ‘engage in structures of discourse that are traditional to Aboriginal people’ (Liberman 1985, p. 178). These difficulties become apparent where Aboriginal and non-Aboriginal speakers reveal conversational styles so diametrically opposed as to exclude one from the other.

This then raises the question of the difficulties that interviewing poses for Aboriginal informants and researchers. The conversation style of interviewing is very much dyadic. The speech is characterized by face-to-face contact and directed at the individual. This in itself is likely to cause discomfort for Aboriginal participants as attention is focused on the individual. Non-Aboriginal participants consider periods of silence awkward, however these are valued as both polite and strategic elements of conversation by Aboriginal participants. I would suggest that it is difficult in the extreme to modify speech behaviours and that a mere awareness of speech differences is not enough to counter the disadvantage that imposed conversation styles can present.

The Aboriginal Use of English

Aboriginal English is defined as the variation in spoken English by Aboriginal Australians. Aboriginal English is dissimilar to Standard Australian English or a creole (modified language of dominant group for use by dominated group). Aboriginal English contains distinctive features of accent, grammar, semantics and use that suggest a valid rule governed language type rather than ‘bad or broken English’ (Kaldor & Malcolm 1991, p. 67).

Dixon (1980) makes the claim that in most Aboriginal communities there is a dialect continuum ranging between Standard English and Aboriginal English. It is suggested that characteristics of Aboriginal spoken English are determined by the order of language acquisition (Kaldor & Malcolm 1991). For the Warlpiri people of Nyirrpi, English is at best a second language. Warlpiri remains the primary language of
communication within the community. Many adults have a functional knowledge of other Central Australian languages.

Communication problems often arise between speakers of Standard Australian English and Aboriginal English. These are not always the result of linguistic differences but may be related to factors such as differing cultural values, philosophical perspectives, alternative interpretations and difference in speech behaviours (Kaldor & Malcolm 1991).

An ability to comprehend speech involves knowledge of the salient characteristics of Aboriginal English and how these differ from Standard Australian English. Comprehension might assume a more parochial nature and involve an appreciation of the nature of bilingual communities and the communication problems that are most likely to be encountered in a specific location (Kaldor & Malcolm 1991). This suggests that these problems do not exclusively arise from linguistic differences. Cultural values, different speech related behaviours and physical disability impinge upon communication. Endemic middle ear disease and hearing loss in many Aboriginal communities is perhaps the greatest non-linguistic impediment to successful communication.

Transcribing Aboriginal spoken English presents considerable challenges. Applying standard grammatical conventions to Aboriginal spoken English is not always possible as this detracts from the style and context of the spoken word.

**Interpretation and Understanding in Cross-Cultural Inquiry**

Interpretation is the principle theoretical perspective of this research project. Honderich defines interpretation as:

...the theoretical or narrative account of facts, texts, persons or events that
renders the subject matter intelligible (Honderich 1995, p. 414).

This would seem a fairly straightforward definition, but in the philosophy of hermeneutics, interpretation comes to mean much more. Honderich goes on to say that:

...in the hermeneutical tradition, interpretation becomes the most essential moment of human life. The human being has understanding of itself, the world and others. This understanding consists of subjective-relative and historically situated interpretations of the social life-world (Honderich 1995, p. 414).

This definition raises several points that need to be elaborated. The hermeneutic experience is ontological as it reveals the 'being of things'. Heidegger (1973) first revealed the ontological nature of understanding. According to Heidegger (1973), understanding became the fundamental mode of existing in the world. What it means 'to be' is seen in terms of how the facts of the world are revealed to us. Understanding of our life-world and ourselves is not seen as subjective but rather something that is encountered and disclosed from the outside. This gives us a sense of how we are placed in the world and it is this that forms the horizon of our existence (Palmer 1969). Therefore, understanding is not a product of a reflexive consciousness but a way in which phenomena are disclosed.

Understanding in a grammatical sense means more than the realization of knowledge. It is applied to the ability to know. One criterion of understanding is an awareness of the relationship between an expression or action and the language of which it is a part. If the language is different from one's own, then these expressions and actions can only be comprehended in terms of realizing their role in the lives of people as a whole (Thompson 1985). Wittgenstein (1922) claimed that this realization could only be achieved by reference to the universal centrality of human experience, the common behaviour of humankind. This theme was developed by Winch (1989) who believed
that all expressions and actions followed general rules. Only an awareness of these rules would allow identification and understanding, because the centrality of these rules within the organization of any society is always the same (Thompson 1985).

Understanding can only occur because it is shared. It is shared because it is linguistically and historically based. Understanding is always positional; it stands at a given point in history. History is always at work in understanding and creates a tension between the horizon of the interpreter and the narrative. The pre-structure of a person’s understanding is in essence historically formed vision of both ‘the self’ and ‘the world’. It is historical because this vision has been bequeathed from the past. In this manner, we exist in a historically formed world of understanding. Thinking, experience and understanding can only be realized through language. As Gadamer (1975) asserts, it is only through the medium of language that one has a world, as it creates the possibility for the disclosure of being. Whilst language is manipulated to allow communication, human beings participate in language by allowing the phenomena of the world to be represented in language.

Hermeneutic theory is predicated on the interpretive possibilities that are spread out before speakers of any language. Writers such as Husserl, Ricoeur and Merleau-Ponty were concerned with the indeterminate nature of understanding. This interim indeterminacy suggests the potential for multiple interpretive efforts. There are numerous interpretive possibilities because understanding begins in either ignorance or partial comprehension. According to Husserl (1973), a deep understanding of an alien culture is not immediately possible. However, an inkling of potential meaning can open up the possibility of further meaning. For Ricoeur (1974), indeterminacy arose as much from the context of meaning and the creativity of the interpretation process. Context assumes considerable relevance in cross-cultural inquiry, the multiple and divergent possibilities in meaning contributing to this creativity. For Merleau-Ponty (1962), understanding was enabled by ambiguity, the potential for alternate meanings inherent in language creating the interpretive horizon.
The following excerpt from an interview reveals the role of indeterminacy in cross-cultural communication:

Informant: 'Sometimes I don't really talk to my close...brother.'

Researcher: 'Yes.'

Informant: 'Little bit of shame.'

Researcher: 'To talk to other Jagamarras'? (actual and classificatory brothers)

Informant: Yeah.'

Researcher: 'Why would that make you shamed'?

Informant: 'No...its sort of in culture way.' (ambiguity arises because of multiple applications for the word 'culture')

Researcher: 'Well that is the sort of thing I would like to know.'

Informant: 'See when we...everyone share what we want.' (referring to demand sharing and reciprocity along kinship lines)

Researcher: 'Yes.'

Informant: 'What we ask for...

Researcher: Yes

Informant: ...that why we doesn't know...make a joke. We just sort of ah...quiet...you can't talk to each other...like you know, we don't really talk too much you know...sort of culture way.' (ambiguity continues with the use of the word culture and the multiple applications of this word)

Researcher: 'Yes...is that all the Jagamarras or just your brothers'?

Informant: 'No some...like L.' (actual brother)

Researcher: 'So just the Jagamarras in your family'?

Informant: 'Yeah.'

Researcher: 'Like being respectful'?
Informant: ‘Yeah.’
Researcher: ‘And is that like shame’?
Informant: ‘Like sometimes I don’t talk to L too, I just talk...ah...ah...some of them don’t talk much.’
Researcher: ‘And is that yapu way...culture way’?
Informant: ‘Yeah.’
Researcher: ‘And is that from when you went to business’? (initiation)
Informant: ‘Yeah.’ (gratuitous concurrence as the informant agreed with the researcher’s proposition only to change his thinking in the next sentence)
Researcher: ‘Or is it different’?
Informant: ‘Nah, I think it is the family...probably it is like children is grown up.’

In this exchange ambiguity arises from the use of the English language word culture. To fully comprehend what is being said in this instance requires an understanding of the Warlpiri use of this word. The ambiguity surrounding the semantic use of this word opens multiple interpretive fields. A number of possibilities were explored including kinship obligations and ceremonial requirements. The nature of the topic initially appeared to resemble avoidance, but grasping the mechanism behind these sibling relationships eluded me. I returned to the informant to clarify his intended meaning. The process of clarification resembled a negotiation with pieces of information being traded back and forth until a consensus was reached. What was being imparted in fact had little to do with avoidance, merely the correct speech behaviour appropriate to certain kin. The term yungka-jurlu is used to make direct requests of close kin. This is a respectful speech style in which shame can be circumvented by making the request without face-to-face contact and without naming the person to whom the remark is directed.
That most Warlpiri speak or at least understand other Central Australian languages as well as being proficient in English is a testament to their linguistic abilities. My interest in the Warlpiri use of English emerged from the experience of this research project with the realization of subtle differences in English language use by Warlpiri people. This assumes considerable significance given that most health interactions are conducted in English.

When there is a difference in the use of English by either party to a conversation, there is a potential for misunderstanding. Liberman (1985) claims that this is an essential feature of cross-cultural communication. Conversations have the appearance of being intelligible but are characterized by half formulations, indeterminate senses and ambiguities. Liberman (1985) contends that indeterminacy is an essential part of the hermeneutics of cross-cultural communication because it places the potential for understanding ahead of the participants. This arises from the fact that language only provides part of the meaning essential to understanding and that both parties to a cross-cultural conversation negotiate or construct shared meaning through the act of talking. This talking is described as not always being precise but rich in meaning. This semantic abundance opens the potential for both understanding and misunderstanding.

It seems obvious that communicating across cultures and languages is problematic and fraught with danger. Problems arise from technical constraints inherent in the acts of listening and speaking and the differing world-views and various structural aspects of cross-cultural discourse (Liberman 1985). Timmins (2002) systematically reviewed the available literature on the impact of language barriers on the health of Latinos in the American medical system. She found support for the notion that language barriers not only affected access to services but also contributed adversely to both the quality of care and the health outcomes. This problem, which essentially involves communication between two distinct languages, has become the basis for interventions such as interpreting services and language training. Whilst these are legitimate concerns and appropriate interventions, there seems to be little recognition of the
barriers posed by a monolingual approach to a bilingual interaction. Services provided in English language can disadvantage people for whom English is a second language. I suggest that there are significant barriers in such interactions with considerable potential for misunderstanding.

This proved to be an important finding with implications not only for the research project but extending to all communication endeavours with Aboriginal people. Most health interactions between Aboriginal and non-Aboriginal people are conducted in English. A common assumption is that when both parties speak English they are essentially on an equal footing as the words, concepts and the meanings are the same for both parties. I would suggest that this is rarely the case. It became evident in the conduct of this research that Warlpiri speakers of English often ascribe different meanings to words and concepts.

Naturally occurring conversations can have the appearance of being intelligible while leaving all parties uncertain about what it is that is being communicated (Liberman 1985). In part Liberman is correct, these naturally occurring conversations do appear outwardly intelligible but only through the language in which they are conducted. I disagree with Liberman's assertion that all parties are aware of communication problems. Cass et al. (2002) found in a study of cross-cultural communication in a health care setting that miscommunication often went unrecognized. The advantage in these conversations is always with the first language English speaker. While the responsibility for comprehension lies with both parties, it is the Aboriginal participant who bears the greater burden when communication fails. In Central Australia, most cross-cultural communication occurs at the point of service delivery and therefore the impact of failure can be considerable.

Comprehension is the business of much social research and considerable effort is made to ensure the success of communication. But in everyday interactions, we are perhaps
less committed to communicative effort, trusting that the use of a common language is sufficient for mutual comprehension.

Habermas (1988) proposes that understanding is much more than the mutual comprehension of language by two subjects. He points to a much deeper accord involving the recognition of an utterance in relation to a mutually acknowledged background. This suggests that immersion in a society to the point that some degree of acculturation occurs is essential if understanding of the other’s point of view is to be achieved. If we acknowledge that we approach the Aboriginal world from a non-Aboriginal perspective then it is only possible to record what it sounds and looks like from where we stand. This makes problematic the mutually acknowledged background that Habermas suggests is prerequisite to understanding.

Bain (1992) describes the mechanics of intercultural communication using an optical metaphor. She asserts that the best we can achieve is to view another culture from our own cultural standpoint. Whilst this might be problematic, the methodological implications can in part be countered as long as this standpoint is acknowledged. In Bain’s optical metaphor, the viewing of another culture through the lens of our own culture causes refraction or a bending of the truth. In an optical sense, this bending causes visual distortion. However, unlike optics there is no corrective lens for inter-cultural communication. The distortions arise specifically from the issue of standpoint. The understanding we achieve is an interpretation based on our cultural standpoint and our very inability to experience the lived reality of the ‘other’.

Understanding involves a great many competencies, both practical and worldly and includes a system of reciprocity on many levels. Liberman (1985) criticized this view as it amounts to a perspective taken outside the interaction. He contends that it misses essentially the phenomenon of understanding as lived by participants who are engaging in the communicative action. Liberman (1985) believes that the hermeneutic endeavour in cross-cultural dialogue is developed from within the conversation. He
describes this as a practical orientation towards an evolving content that is progressively developed via shared meanings.

To understand cross-cultural interaction in Central Australia requires an appreciation of the structural aspects of intercultural discourse. The first of these concerns semantics, the meaning inherent in language and the differences that exist between cultures.

Semantic Differences

In this research both translation and interpretation were employed as tools of inquiry. In translation, we seek to recover what is meant in the narrative or discourse. Unfortunately, a range of possible meanings is available. The meaning potential of the narrative or text is regarded as the range of semantic choice present in a linguistic system (Hatim & Mason 1990). Meaning is central to the act of translation. In translation we attempt to uncover the same meaning as the original. Inevitably we employ our own beliefs, knowledge and attitudes into our processing of texts and narratives, so a translation will reflect the translator’s own mental and cultural outlook despite the best attempts at impartiality. This is partly the case in hermeneutic theory where the perspectives of the researcher and those he seeks to understand are progressively overlapped through reflexive interpretation to a point where comprehension occurs.

In interpretive inquiry we are concerned with the pragmatic as opposed to the semantic meaning. The analysis of narrative or discourse requires exploration of the social and cultural conditions in which it is produced. The very words that make up a text or narrative hide an underlying structural arrangement that reflects the relationship between concepts and objects. Salmond (1982) claims that these underlying structures are the fundamental patterns of logic universal to all human condition. The great challenge, according to Salmond is to think deeply and penetrate the patterns which lie behind the surface of human life and by explication bring them to light.
An explanatory approach to the study of cross-cultural discourse should both uncover and critique what participants hold to be natural. This highlights how the use of language and the making of meaning are shaped by the social situation in which they are produced. The task of translation is to preserve the range of possible responses to a text or narrative, and in so doing ensure the dynamic role of the reader or participant. This corresponds closely to the core tenets of interpretation in which every reading of a text is but one of many possible readings.

Language presents the single greatest barrier to the successful communication of information between the Aboriginal informant and non-Aboriginal researcher. As researchers we should never assume that we are speaking the same language, even when we are communicating in English. We can never be sure that the words we use have corresponding meanings. One example is the use of the word murder. The word murder has different meanings to Aboriginal and non-Aboriginal people. To the non-Aboriginal person, the word murder means the unlawful act of killing of another human. Many Warlpiri use the word murder to imply assault. There are numerous examples of the Aboriginal use of English words for quite different purposes. These different meanings are a trap for non-Aboriginal researchers and they can profoundly impact on the quality of information.

Some differences in the meanings of English language words may be obvious in the context of their use. But to rely on the apparent idiosyncratic use of words to detect semantic difference can be unreliable. An example of this can be seen in the ritual cleaning of place following death. The cleansing ritual uses eucalyptus leaves to sweep away the tracks of the deceased. The ritual is commonly referred to as sweeping. The use of this word adequately describes the action but reveals nothing of the underlying cultural meaning of the practice. Given the sensitive nature of this practice, questioning to uncover the cultural intent and meaning would be inappropriate and so comprehension of the concept may well be limited.
Conceptual Differences

Deutscher (1968) states that obtaining conceptual equivalence is paramount and that lexical comparability is of a lesser concern. Liberman (1985) seems to concur with this approach by stating that it is possible to arrive at some comprehension of another’s speech without that understanding being lexical. It is the paralinguistic elements that help to convey meaning such as the context, the emotional content, the motivation of speech participants and non-verbal behaviours.

An example of this was the discovery of the Warlpiri word *jampardivyi*. The word as we now know describes the relationship of avoidance. This word, while not recorded in any of the existing Warlpiri lexicons could only be understood in the context of its usage. Understanding the meaning of the word only came with comprehension of the concept of avoidance in all its complexity. The nearest lexical equivalent in English is probably avoidance, but this word is meaningless in the context of its Warlpiri usage. The word avoidance does not indicate the kin to whom relationships apply or convey anything of the behavioural manifestations associated with avoidance.

An example of conceptual difference became evident in preliminary discussions with community members regarding the intent of this research. Men’s health was the focus of research interest. The concept of men’s health is very broad and includes any number of facets of men’s experience. As a topic it has physical, social and psychological aspects. For men at Nyirrpi however, men’s health is equated specifically with sexual health. This conceptual difference has many important implications, not only for research but also for health service delivery.

The problem of conceptual difference is linked inextricably to both language and culture. Language is a cultural artifact determined by social configurations in which it is located (Deutscher 1968). Substituting words with similar meaning does not necessarily convey the same meaning. Words and their semantic content must to be
considered within the cultural context in which they are used. A vocabulary is not merely 'a string of words; immanent within it are societal textures' (Wright Mills 1963, p. 436-7). It is these very social textures that determine the semantic content of words and the concepts they describe. Therefore, not only should we consider comparisons between words, but the inherent meanings of those words as used in their culture of origin.

This suggests that considerable knowledge of local culture and language is required in order to gain conceptual equivalence. However, such concerns would be considered a luxury for most remote area nurses whose professional responsibilities keep them preoccupied with clinical issues. Good communication is the basis of sound clinical skills. While some encouragement is given to remote area nurses to undertake Aboriginal language courses, there seems little recognition of the significance of communicating in English.

The notion of conceptual difference applies equally to the use of both English and Warlpiri languages. When the meanings of Aboriginal concepts do not exactly fit those of English language, misunderstanding can occur. The following anecdote illustrates this problem:

I investigated the role of grandmothers in the lives of their grandchildren. I was attempting to establish which relatives were responsible for the welfare of children. I was consistently told that both maternal and paternal grandmothers were the same or equal in their responsibilities to their grandchildren. My observations however, suggested that grandmothers were primarily concerned with the children of their daughters and less so with those of their sons. Ethnographic literature confirmed my observations and suggested that the maternal grandmother shared the same matrimoiety as her daughter's children.
I became intrigued as to how this apparent discrepancy in understanding arose. The consistency of the information I was given by the men suggested that the problem was one of language. I began my search by looking at Warlpiri language. The word *jinta-juku* literally means one and the same. There appeared to be a good ‘semantic fit’ between the Warlpiri and English concept of equal. However it seemed men interpreted my inquiries in a social rather than a behavioural sense. The social concept of grandmother naturally implied sameness despite overt behavioural differences between maternal and paternal grandmothers. These differences are reflected in the terms *yaparla* (paternal grandmother) and *jaja* (maternal grandmother). The English language concept of grandmother does not permit such discrimination.

**Avoidance Speech**

As we have seen, avoidance is the socially prescribed setting of distance between people in specific kin relationships that is characterized by distinct behaviours and speech styles. Avoidance speech is a style of speech employing special vocabularies to replace all or part of the normal lexicon (Haviland 1979). The term *jamayi-mayi* refers to styles of speech used by Warlpiri people in avoidance relationships.

The words *marralyani, miti-pinyi, ngarri-jarrimi* are avoidance terms used to indicate actions such as go, come, act on it, stand, sit or lie. The meaning is dependent upon context within which the term is used (Swartz 1998). *Marralyani* is used specifically in the presence of the wife’s brother, *miti-pinyi* is used in the presence of the wife’s mother’s brother and *ngarri-jarrimi* is used with the wife’s mother and father’s father (Dixon 1980). This is an inordinately complex system of communication, one with no equivalent in English language.

I could find no evidence to suggest that specific avoidance terms were still in use at Nyirripi. Dixon (1980) claims that the Warlpiri avoidance vocabulary is restricted to a
few score words and indeed Swartz (1998) has only recorded 17 words for use in avoidance. Of these, none were recognized or in use at Nyirrpi at the time of this research. Whilst avoidance protocols are still observed, they appear to take the form of behavioural rather than linguistic conventions. The current practice for avoidance speech is referred to as ‘sideways talk’. This style of speech is characterized by indirect conversation, either through a third party or without eye contact.

Secret Speech

Avoidance language was secular, learnt by all members of the community as part of yikirrinji, the avoidance behaviours required by kinship. There were however special languages known only to certain people. These secret languages were often associated with ceremonial life. In Warlpiri society, there appears to be two types of secret language. The first concerns specific jukurrpa (associated with the Dreaming) used by custodians in relation to specific sites and ceremonies. The second concerned the speech of opposites, the use of antonyms to make speech appear unintelligible. Men used this speech style exclusively for ceremonial purposes (Hale 1971).

Underlying Cultural Associations

The use of English language words by Warlpiri speakers sometimes conveys more than subtle semantic difference. For instance, there are important semantic differences in the Warlpiri use of certain kinship terms. These differences are also common to other Aboriginal languages. The term mother is extended to include the biological mother’s sisters. The same rule operates for fathers. The term granny is used to denote both grandmother and grandfather in Warlpiri usage. This term is also extended to include male and female relatives of the grandparents. A man’s male cousin may be referred to as either a brother or cousin brother. Whilst Warlpiri terms exist which specifically denote these relationships, confusion can arise when English language terms are applied to Warlpiri relationships.
The term ‘business’ is usually associated with ceremonial practices. Men’s business is commonly taken to mean initiation or men’s religious activities. The term can also mean secular affairs belonging to either men or women or an institution. The use of ‘business’ with Warlpiri speakers should always be clarified. Whilst this project concerned men and therefore ‘men’s business’, there was a constant requirement to distinguish between men’s ceremonial business and men’s health business. This clarification shifted the emphasis from the sacred to the secular therefore making semi-public discourse possible.

Word Order and Sentence Structure

In Aboriginal spoken English, the way that sentences are constructed can be very important to meaning. Wurm (1969) notes that in many Aboriginal languages word order in sentences is extremely free, to the extent that word order can change with each repetition of a sentence without effecting the semantic content.

Warlpiri speakers of English may order words within sentences very differently from English speakers. This outwardly strange sounding word order may not appear to significantly alter meaning and these sentences may be interpreted at face value. Word order and the apparent illogical progression of concepts can contribute to what Liberman (1985) calls ‘strange talk’. According to Liberman (1985) this ‘strange talk’ has more to do with the content, which having arisen from different perspectives assumes an element of unfamiliarity. If we accept the face value of this strange speech for the sake of continuity, there is a risk of missing potential meaning because the true nature of the dialogue does not mature.

The notion of ‘strange talk’ should not be limited to content alone. The construction of sentences, the order in which words are placed and the sequencing of concepts may appear awkward to non-Aboriginal speakers of English as evidenced in the following dialogue:
Researcher: ‘Is that Warlpiri way’?

Informant: ‘Yeah, that’s Warlpiri way.’

Researcher: ‘And is it finished now’?

Informant: ‘Yeah that’s finished now.’

Researcher: ‘What sort of things do you think has made them forget about it’?

Informant: ‘Ah, like uncle’s side, you know, uncle side nothing. Playing card. They never look after him that young fellow. All gone. That thing they do with him that hair, from that dead body…you know! And they ask him that thing, maybe his own brother call, they ask him, “ah what happened to you”. And something snap off, what country they call him and they snap off. You know break off…well that is how they know.’

Researcher: ‘Where that business comes from’?

Informant: ‘Yeah.’

Researcher: ‘That sickness business’?

Informant: ‘Hmmm.’

This example illustrates a number of features of cross-cultural dialogue in jeopardy. The response to the inquiry about abandonment of traditional practices appeared inappropriate and was almost incomprehensible. It was accepted at face value in order to preserve the integrity of the conversation and only on later analysis did the response begin to reveal some meaning. The respondent complained that men were no longer bothered by kinship obligations for the care of young men who were themselves increasingly the victims and perpetrators of violence. The respondent then discusses post-mortem practices in which the hair of the deceased was used to identify the perpetrator. My attempts to confine this response to ‘sickness business’ was met with gratuitous concurrence, possibly signaling that this interpretation was incorrect or perhaps an indication from the respondent that the topic was closed to further discussion given it’s sensitive nature.
Liberman contends that:

...in strange discourse, the net of potential signification is cast very widely, as the parties range freely in search of adequate interpretations (Liberman 1985, p. 177).

Meaning can only emerge if the ‘strange talk’ is allowed to run its course, for its full potential to develop in the subsequent dialogue. However, Liberman goes on to say that where attempts to grasp conceptual meaning fails, this limitation of logical analysis must be admitted in order to avoid imposing an ‘alien logic upon...the strange discourse’ (Liberman 1985, p. 178). In the above example, there appeared to be no conceptual connection between the abandonment of traditional practices and post-mortem investigations. Perhaps this was what the speaker intended. The strange utterances encountered in cross-cultural conversations emerge from the world-view of a community and despite how outwardly incomprehensible they might seem should not be discarded but analyzed with interest and respect.

**Emphasis and Tone**

Liberman (1985) claims that facial expression is capable of performing endless communicative tasks. It is possible to arrive at some understanding of another’s talk without that understanding being based on spoken words. In this research such non-linguistic markers included silence, gaze aversion, decreasing tone, and word emphasis. These markers served to signal communicative difficulties, a poor understanding of the question, a culturally sensitive topic or idiosyncratic difficulties.

A falling or rising tone is usually indicative of some emotional content. Anger, embarrassment and anxiety are accompanied by explicit speech behaviours. These are possibly universal human speech characteristics. In the Warlpiri repertoire, shame and embarrassment are accompanied by both verbal and non-verbal cues. A downcast gaze
and a lowering of the voice signal some degree of emotional distress in Warlpiri speakers.

Emphasis and tone are crucial speech conventions in Aboriginal spoken English. The tone of delivery and the emphasis on certain words functions as punctuation. I only became aware of this feature when transcribing interviews. In transcribed sentences the disjunctive function of punctuation is lost because the minor vocal inflections used to punctuate speech are not recorded. Aboriginal spoken English sentences rely heavily on tone and emphasis to separate related word clusters. The effect of this is evident in transcriptions where topics of speech are not visibly separated resulting in a continuous string of written words.

Another function of tone and emphasis in Aboriginal spoken English is to indicate the source of relayed speech. In English, speech is generally attributed to a specific speaker. A Warlpiri informant relating a conversation rarely indicates the ownership of speech. This is achieved solely through tone and emphasis. This is almost an invisible feature of Aboriginal spoken English and again does not become obvious until the spoken word is transcribed. The lack of tone and emphasis in written transcripts can make these relayed conversations difficult to follow.

**Gratuitous Concurrence**

The strongest indication of misunderstanding is revealed by gratuitous concurrence. Liberman defines gratuitous concurrence as ‘an agreement or confirmation that has no basis in anything semantic being understood’ (Liberman 1985, p.197).

Gratuitous concurrence is a common feature of conversations between Aboriginal and non-Aboriginal people, particularly in Central Australia. As a speech device, it is used to indicate a readiness to engage in co-operative dialogue. However most commonly it signals failed communication.
Gratuitous concurrence often goes unchallenged giving the impression that all is well in the communicative endeavour. Liberman (1985) proposes that this device has arisen to facilitate the flow of conversation and to avoid confrontation in a seemingly futile situation. In this instance it becomes a marker of the power differential between speakers. However, I believe that in many instances this unmitigated willingness to agree stems directly from a failure to comprehend.

Gratuitous concurrence may take many forms. In the following dialogue my questioning concerned adapting behaviour to a sudden change in status following initiation.

    Researcher: ‘When you became a young man was it really hard’?
    Informant: ‘Hmmm.’
    Researcher: ‘How did you learn to behave properly when you became a young man’?
    Informant: ‘I don’t know.’

The reluctant agreement to my question may in fact have been a genuine response. However when asked about behaviour the response suggested that the informant was uncomfortable with this line of questioning. In this instance, the accompanying non-verbal cues of tone and gaze aversion were as important as the spoken word in conveying meaning. The non-verbal response may be the sole indicator of gratuitous concurrence. Considerable care needs to be taken interpreting such non-verbal responses. These responses may only indicate a willingness to co-operate and may be unrelated to comprehension.
Other Speech Conventions

As well as the lexical and semantic variations between languages, there are informal rules of communication that are equally important to cross-linguistic inquiry. Communication rules vary between languages and cultures and pose significant risks to those attempting communication across both linguistic and cultural divides. Every culture has its own system of logic, a manifestation of that culture’s world-view and language. This logic becomes evident, not only in the spoken word but also in the associated speech behaviours of each culture.

When speakers of the English language ask a question of another English speaker, a response of some type is expected. The question may be answered immediately or if the respondent is thinking of a reply they usually give some indication that a response is being formulated and will be forthcoming at some point in the immediate future. Expressions like ‘um’ and ‘ah’ are used to suggest to the person asking the question that thinking is in progress. In most cases, any delay in receiving a response is signified by these expressions and they essentially reassure the inquirer that all is well in the communication process. The inquirer may be happy to wait for a reply or may rephrase the original question.

When asking a question of a Warlpiri speaker a common response is silence. This is very disconcerting to the English speaker. There seems to be a natural reticence on the part of many Warlpiri speakers especially if they are meeting someone for the first time. This is often attributed to shyness. However there are other causes for this silence. Interpreting the cause and significance of these silence responses is essential to successful cross-cultural communication. Walsh (1997) called these silence responses ‘delayed’ reactions and attributes them to diametrically opposed styles of speech.
Many Warlpiri are fluent speakers of other Central Australian languages, such as Luritja, Pintubi, Kukatja, Pitjantjatjara and Anmatyere. When a question is asked of a Warlpiri speaker they must translate the question from English into Warlpiri. The success of this translation is dependent upon their competence with English. A response then has to be formulated; this cognitive process is undertaken in Warlpiri. This might entail concepts that have no similar counterparts in English. The response must then be constructed in English. This process obviously takes time. The inquirer may become uncomfortable with the delay in response. The usual cues that indicate that the question has been understood and is being processed, the thinking expressions such as ‘um’ and ‘ah’, are often lacking. The inquirer is uncertain as to what is happening, whether the question has been understood or if they have somehow caused offense. It can be very difficult to ‘ride the silence’, to wait for the eventual response. English speakers are not good at dealing with silence as evidenced by the frequent rephrasing of questions.

The silence response may also indicate that the Warlpiri speaker has fully understood the question but that the speaker has asked for information that they are not entitled to hear. This silence response is significant as it indicates that both the inquirer and respondent are on culturally unsafe ground. Cues from the respondent that may indicate this situation include averting the gaze, a general unease or silence.

So acutely may the Warlpiri speaker feel that the conversation is ‘off limits’, that they will respond in an attempt to ‘change the subject’. This response may be misinterpreted by the English speaker as a cue for further questioning. These ‘change the subject’ responses might include expressions such as ‘I don’t know’ or ‘I can’t tell’. Asking a cross-gender question will elicit such a response. Asking a man something that would ordinarily be considered within the realm of women’s experience may be dismissed as ‘women’s business’. De Laine (1997) discusses the issue of ‘question threat’ in the ethnographic interview. This occurs when a level of unease is generated in an informant from a particular question or line of inquiry.
Repetition is a feature of Aboriginal discourse and this has a legitimate hermeneutic function (Liberman 1985). Repetition represents a form of concurrence although it may not necessarily imply comprehension. It is nevertheless an important feature of the cross-cultural conversation because it maintains the uninterrupted development of potential meaning and understanding. The following conversation reveals how repetition allows this development:

Researcher: ‘In some situations, like at the clinic or the shop, men and women have to be separate. When men have to go where the women and kids are, they get upset.’

Informant: ‘Yeah.’ (quietly)

Researcher: ‘Why does that happen’?

Informant: ‘I don’t know...women makes you nervous. You know like your jampardiyi.’

Researcher: ‘Your what’?

Informant: ‘Jampardiyi...(possibly thinking about how to explain this concept). Sort of mother-in-law.’

Researcher: ‘Oh! Like no room’?

Informant: ‘Yeah, no room.’

The conversation proceeded in this manner, gradually developing a working definition of the jampardiyi concept. The repetition of both the word and the key semantic components served to center the conversation and confirm the accuracy of my understanding.

Researcher: ‘So who do you have no room for’?
Informant: ‘Ummm (hesitates)...Nangalas.’

Researcher: ‘Mother’?

Informant: ‘Yes.’
Researchers: 'And is this because you initiated their sons'?

Informant: 'Yes.'

Researchers: 'So what do they call you'?

Informant: 'Ah...they call me jampardiyi.'

Researchers: 'Oh they call you jampardiyi'?

Informant: 'Yes.'

Researchers: 'But what about your mother-in-law, what do you call her'?

Informant: 'Same.'

Researchers: 'Oh...so you call her jampardiyi'?

Informant: 'Yes.'

This conversation well illustrates the repetitive and often circuitous nature of inquiry in the cross-cultural context. Liberman makes the point that, 'what one is able to do with the words in the systems in which they operate is more significant than the words formal definition' (Liberman 1985, p. 203). This is well illustrated by the above example in which a repetitive and circuitous form of inquiry was employed to develop not only a definition but also the associated cultural and behavioural manifestations of the word.

Discussion

Most non-Aboriginal people are unaware of the linguistic diversity and complexity within Aboriginal societies. Most varieties of Aboriginal English are comprehensible to speakers of Standard Australian English and yet misunderstandings are frequent, often going unnoticed, particularly by non-Aboriginal speakers. The power differential favours the first language English speakers and second language English speakers always bear the burden of failed communication.
The success of translating concepts from one culture to another and negotiating language-related issues can be enhanced by experience and understanding of the particular system and culture under study (Hunt et al. 1964). This applies equally to all cross-cultural research regardless of the language in which the research is undertaken. Information proffered may be specific to any number of factors such as age, gender, culture, individual, community or institution.

Often our perceptions are superficial and literal. We interpret what we see and hear very much at face value. This problem arises in part from our specific cultural perspective, the immutable lens through which we interpret the world. A glimpse through the lens of others can reveal the hidden meaning in seemingly ordinary events and behaviour. Such glimpses can be gained through language, observation and reflection.

The above analysis suggests flawed communication between Aboriginal and non-Aboriginal people in Central Australia. The implications are considerable, particularly in the health care setting where the diagnosis and treatment of illness rest solely on comprehension. The communicative difficulties revealed in the process of this research are probably characteristic of many cross-cultural interactions in Central Australia. They are often unchallenged enabling miscommunication to replicate itself. A mere awareness of these communicative difficulties is perhaps insufficient to remedy this situation. Speech habits are ingrained and attempting to set them aside in the presence of an alien system is difficult.

The solution perhaps involves acquiring skills in language, speech styles, world-view and other socio-cultural variables, all elements that are constituent of communication. Essentially what I propose here is part acculturation with the societies in which people are to work and live. Such acculturation takes both commitment and considerable time. However, given the present employment reality that favors contracts of limited duration this acculturation will rarely be achieved.
Miscommunication impacts on two important areas of remote area practice. Eliciting information is central to history taking, and hence an important part of forming a clinical impression. The description of symptoms is likely to vary due to subjective interpretation of symptoms. For example, the adjectives sharp and dull are often used in eliciting the nature of pain. These words are confusing to a Warlpiri speaker and possibly not related to pain. The Warlpiri word *parntirni*, meaning to pierce or prick does not convey the same meaning as the English word sharp. Warlpiri people often describe sharp pain in terms of a biting or poking sensation.

The provision of information regarding treatment is equally at risk of failure. Instructions concerning the quantity and times of medication are inordinately difficult to communicate. The combined effect of miscommunication in these areas can seriously compromise the health-care of Aboriginal clients.

**Conclusion**

Communication difficulties between Aboriginal and non-Aboriginal people in Central Australia are pervasive and present a considerable challenge to understanding. These communication difficulties have enormous ramifications for the success of cross-cultural endeavours. The magnitude of these difficulties largely goes unrecognised by non-Aboriginal people because English language and its associated speech styles are imposed as the prime mode of communication with Aboriginal people. The consequences are further disadvantage for Aboriginal Australians. This disadvantage can be addressed by training service providers in the technical aspects of speaking and listening in specific cross-cultural contexts.
Chapter 12

Homophobia and Homosociality: Explaining Male Health Behaviour
Chapter 12

Homophobia and Homosociality: Explaining Male Health Behaviour

Tell me what company thou keepest and I'll tell thee what thou art.

Don Miguel de Cervantes
-Don Quixote-

Introduction

Social processes impact on human thought and action. Attitudes and behaviours fashioned in this manner evolve differently across social and cultural settings. In this chapter, I will explore the concepts of homosociality and homophobia. Specifically, I will use these terms to explain some fundamental differences between Warlpiri and Australian male society and how these in turn might influence illness behaviour.

A Cautionary Note on Language

A number of issues need to be addressed before proceeding further with this line of inquiry. The terms homophobia, homosociality and homosexuality help us to consider aspects of human behaviour. These terms are neologisms or new words. The term homosexual entered the German language in 1869 and the English language in 1892 (Plummer 1999). Homophobia is a far more recent addition to the lexicon, first appearing in 1967. Similarly homosociality has a very recent history. These terms came into existence as a result of social inquiry. As social terms they are as useful as they are problematic.

Prior to the introduction of the term homosexual the concept did not exist, although the behaviour it describes has long been part of human sexual history. Concern about this
behaviour was limited almost exclusively to the male domain (Fone 2000). Behaviour, specifically practices such as sodomy, appear to have defined the phenomenon. While sodomy in particular was viewed adversely to the point of being prohibited in law, it was not until the notion of an abnormal or alternate sexuality appeared that other negative connotations emerged (Plummer 1999).

As social constructs then, we cannot assume that the concepts we use in our society are in use in other societies. It is important to stress that while concepts may not be shared across cultures some behaviour may be common. It does not necessarily follow that these behaviours are invested with the same meaning and significance.

Homosociality has never been assessed in an empirical study although certain features such as male-to-male intimacy are well represented in the literature. While I rely on this literature to illustrate some fundamental differences between Warlpiri and Australian society, I am acutely aware of rapidly evolving social practice that might give rise to questions of validity. I therefore use this term in a broad sense and in full recognition that it carries a potential for generalization.

**Homosociality Defined**

The term homosociality emerged from the field of sociology and was first proposed by Jean Lipman-Bluman in 1976. She defined homosociality as; ‘the seeking, enjoyment and or preference for the company of ones own sex’ (Lipman-Bluman 1976, p. 16). She distinguished homosociality from homosexuality by the proscription of sexual interaction between members of the same sex. Lipman-Bluman’s theory linked resource allocation to same-sex interests by proposing that males and all male institutions control most occupational, economic and political spheres in society (Lipman-Bluman 1976).
Eve Kosofsky Sedgwick (1985) examined homosociality in her study of male homosocial desire as depicted in nineteenth century English literature. Kosofsky Sedgwick (1985) defined the term homosocial as the social bonds between people of the same sex. She believed the term to be analogous with, but clearly distinguished from, homosexuality. When homosociality is associated with activities such as male bonding, homophobia operates to both define and separate social and sexual behaviour.

In all-male environments, homosociality is specifically non-sexual in nature. Homosociality promotes clear distinctions between hegemonic masculinities and non-hegemonic masculinities by the segregation of social groups. Bird (1996) argues that homosocial interaction between heterosexual men promotes hegemonic masculinity by a process of perpetual definition, a process which both rewards adherence and punishes deviation. Bird (1996) suggests that male homosociality is characterized by emotional detachment, competitiveness and the sexual objectification of women, and that these contribute in part to maintaining a hegemonic form of masculinity.

**Homophobia Defined**

The term homophobia was first described by Weinberg as ‘the dread of being in close quarters with homosexuals’ (Weinberg 1975, p. vii). While this was attributed to heterosexuals, Weinberg believed that homophobia featured in the lives of homosexuals in the form of self-loathing. Weinberg claimed that the consequences of this ‘irrational revulsion and condemnation of homosexuals’ were often enacted in ‘violence, deprivation and separation’ (Weinberg 1975, p. vii).

While Weinberg’s (1975) definition in part matches the criteria for phobia, homophobia is not a true phobia. Plummer (1999) lists five characteristics that differentiate homophobia from a true phobia. Among these, two key points emerge. Firstly, homophobia is often associated with confrontation and aggression as opposed
to the fear and avoidance characteristic of a true phobia. Secondly, homophobia has a political agenda, something not associated with other phobias.

As a social phenomenon, homophobia is complex, pervasive and destructive. There is considerable research evidence on the role of homophobia in the construction of compulsory heterosexual masculine identity in both boys and young men (Kimmel 1994; Martino 2000). I will broaden my use of homophobia to include the extensive and at times hidden ramifications it plays in the lives of men.

Homophobia is far more than an aversion to homosexuals. Homophobia can be viewed more broadly as a fear of other men. Kimmel claims that this fear of other men is inextricably linked to issues of masculinity:

What we call masculinity is often a hedge against being revealed as a fraud, an exaggerated set of activities that keep others from seeing through us, and a frenzied effort to keep at bay those fears within ourselves (Kimmel 1994, p. 130-31).

Kimmel goes on to describe homophobia as a reaction against:

...the fear that other men will unmask us, emasculate us, reveal to us and the world that we do not measure up, that we are not real men (Kimmel 1994, p. 131).

The need to prove oneself, to measure up and fit in with others of the same gender is inculcated at an early age and continues well into adulthood. This is one of the primary mechanisms by which masculine ideals are replicated and remain dominant. Powerful forces of peer expectation shape behaviour and attitudes; the central tenet of which is the subjective rejection of anything deemed feminine. This sets in train a mode of existence that has the potential to be both limiting and harmful.
The Link Between Homosociality and Homophobia

Uniquely homosocial male environments are considered by participants to be bastions of heterosexuality. As such homophobia serves to maintain heterosexual identity, the fear of being labeled as deviant unites men within the boundaries of traditional male roles. Homosexuality is viewed as a betrayal of masculine gender role (Britton 1990).

Thompson et al. (1985) found that the motivating dynamic in masculine behaviour was not the pursuit of a masculine ideal but rather the avoidance of anything feminine. In this manner homophobia in exclusively male environments serves to reinforce masculine gender-definition as well as define the boundary between social and sexual interaction.

For heterosexual men homosociality can only exist where issues of sexuality between men do not arise. Male bonding and homosexuality exist on the same continuum but the continuity between these two elements is denied by society. This denial in part takes the form of homophobia (Britton 1990).

Homophobia is one component of a strong traditional view of male gender role. Another link between homophobia and male gender role is the inexpressiveness that characterizes many relationships between men (Devlin & Cowan 1985). In these relationships men are not expected to be emotionally sensitive, expressive or self-revealing especially of feelings of vulnerability or weakness (Bank & Hansford 2000). These are viewed as essentially feminine qualities, and for a man to display them is to risk being labeled homosexual. Bank and Hansford (2000) reported homophobia and emotional restraint as significant mediators of friendships between men.

Britton (1990) examined the variables that correlate with homophobia. Among these, Britton lists male gender, age and education and religious and sexual conservatism as featuring strongly (Britton 1990). Her empirical study found that support for
traditional male roles increases homophobia and that there was a distinct correlation between homophobia and anti-femininity. Perhaps most importantly Britton (1990) found that homosociality at an individual and institutional level was positively correlated with homophobia.

What does this link between homosociality and homophobia in males mean? Kosofsky Sedgwick (1985) argues that patriarchal structures are characterized by 'obligatory heterosexuality' and as a consequence homophobia becomes an important component in all-male or male-dominated social structures. Britton (1990) proposes that homophobia serves as a boundary between the social and sexual interaction in homosocially-stratified societies. In this manner, male homosociality and homophobia come to represent more than mere opposite ends of a behavioural and attitudinal spectrum. I would suggest that there is no clear-cut boundary between these two components as Britton (1990) suggests, but rather a behavioural and attitudinal spectrum, which is disrupted by shades of both homosociality and homophobia. These are essentially contradictory forces, one encouraging men to group together, the other keeping men apart. The distance imposed by homophobic concerns helps reinforce dominant forms of masculinity.

The social ideals of masculine identity are not set in stone. They evolve over time and they are mutually understood and shared meanings. Despite this, there remains much variation in the masculine ideals assumed by individuals. Individual men incorporate different variables to form their gender identity. Some of these become central to their core identity while others are merely acknowledged as being appropriate to the norm without being personally adopted. Individual variations may be experienced as personal dissatisfactions but these dissatisfactions never rise to challenge the mainstream gender identity (Bird 1996). To do so would be to place the individual's masculine identity in jeopardy. Instead they are incorporated as personal idiosyncrasies.
Homosexuality and Homophobia in Aboriginal Society

Reference to homosexual practice amongst Australian Aborigines in the anthropological literature is rare but by no means non-existent. An examination of these references reveals something of the practices and social meanings of homosexuality in Aboriginal society. This examination is hampered by the semantics of the English-language word and the various affective associations, which once applied to cultural practice, which can impart an alien meaning. For this reason, it is perhaps best if these same-sex practices are examined in light of their original descriptions and not under the label of homosexuality.

There are numerous accounts of ritualized homosexuality in various Melanesian societies. The practice of ‘boy insemination’ was an integral part of male initiation rites throughout the region (Creed 1984; Herdt 1989; Knauf 1990). While this practice has not been recorded in Australian Aboriginal societies, a number of same-sex practices are reported, nearly all seemingly associated with male initiation.

Numerous references dating from the late nineteenth and early twentieth century report the existence of a boy-wife system in various Aboriginal societies (Hardman 1889; Murray 1992; Roheim 1929). Some of these references question the exact homosexual nature and function of these relationships, limiting any same sexual activity to mutual masturbation. Mathews commenting on these practices noted the ‘the natives repudiate with horror and disgust the idea of sodomy’ (Mathews 1907, p. 146-63).

Meggitt makes only one reference to male homosexuality amongst the Warlpiri:

When a boy is in seclusion both before and after his circumcision and in the care of an unmarried brother-in-law, sometimes he becomes the object of homosexual practice... (Meggitt 1966, p. 65).
While Meggitt (1966) does not specify the nature of this practice, he says they were deplored by other men and could provoke violent retaliation. Meggitt (1966) does however state that included in the repertoire of Warlpiri masculine humor is the subject of sodomy, although he does not suggest that this manifests in homosexual behaviour.

There is a paucity of information on homosexuality in the Pintubi and Kukatja, southern and western neighbors of the Warlpiri (Myers 1986; Peile 1997). This does not necessarily mean that same-sex practices did not feature in Aboriginal social life. This may simply reflect either a lack of enquiry by ethnographers or an unwillingness to disclose such information by informants.

The debate as to the presence or absence of homosexuality in Aboriginal society is perhaps irrelevant. What is at issue is the manner in which societies are organized. In non-Aboriginal societies, sexual identity has become one method of social organization. The categories of heterosexual and homosexual manifest as both a sexual and social dichotomy upon which much human endeavour is based. Sexual identity or sexuality plays no such part in the structuring of Warlpiri society. The categories of homosexual and heterosexual do not exist, either linguistically or cognitively. Rather, it is gender identity and gender roles upon which Warlpiri society is conceived and enacted.

I am not suggesting that sexuality plays no part in Warlpiri society; in fact female sexual maturity was explicitly linked to male sexuality (Meggitt 1962). The central feature of social organization in Warlpiri society is as Merlan attests, based on ‘the structural separation of men’s and women’s domains’ (Merlan 1992, p. 169).

In my twenty-year association with the Warlpiri, both at Yuendumu and Nyirrpi, I am unaware of any sexual relationships existing between men. I have on many occasions witnessed men’s initiation ceremonies and have been involved in the aftercare of initiates. I have been left in no doubt as to the homoerotic atmosphere of these
ceremonies. Willis (2003) examined in considerable detail the deflection of homosexual desire and practice amongst the Pitjantjatjara people of Central Australia. Willis (2003) states in graphic detail the eroticisation of the male body in ritual, with particular focus on male genitalia. He suggests that homoerotic desire is diverted away from homosexual practice and into a narrow repertoire of heterosexual practice. Heterosexual relationships were the basis of both reproductive and productive life, perhaps the single most important feature of Pitjantjatjara social organization. Homosexual relationships posed a significant threat to modes of reproduction and production thus diminishing the viability of life in an arid environment.

The apparent absence of homosexuality and the consequent absence of homophobia in Warlpiri society are significant. This highlights the dangers inherent in assuming the universality of certain complex social concepts such as homosexuality. Inherent in ideology, language and society are the meanings we adopt to describe human existence. These are relative and as such give rise to diversity. Failure to recognize this relativity is to deny alternate modes of being.

**Male Homosociality in Warlpiri Society**

To begin my examination of homosociality in Warlpiri society I need to first consider the broad structure of Warlpiri society and the importance that gender plays in Warlpiri social structures.

Numerous ethnographic accounts of Australian Aboriginal societies describe the feature of male-female separation as a central component of social structure (Elkin 1968; Meggitt 1962; Merlan 1992; Myers 1986; Tonkinson 1978).

The anthropological literature lists the gender divisions in Warlpiri society, particularly in the areas of labor and religion (Meggitt 1962). Meggitt (1962) does not suggest that Warlpiri society was overtly patriarchal, however he describes activities that are
demarcated by gender and also communal in nature. Warlpiri use the terms *wati-kurlangu* (belonging to men) and *karnta-kurlangu* (belonging to women) to indicate this division.

There appears to be no behavioural or psychological correlates associated with these terms, they do not appear to imply masculine or feminine qualities but simply denote a gendered division of life. Bell eloquently describes this gender division in Ngarinyin society (Aboriginal people of the north west Kimberley) as such:

Ngarinyin philosophy and its reflection in the behaviours known as men’s business, women’s business is like the relationship between the right and left hands. They are both hands, yet they are physically and functionally different. Together in relationship they create a harmonious interaction while performing a single function (Bell 1998, p. 22).

It is possible that traditional Warlpiri society may have been based on a similar system of mutual respect and communal co-operation. The pragmatics of desert survival would have necessitated such an approach. The sexual division of labor remains pronounced in Warlpiri society. This is evidenced in hunting and food gathering activities that are still undertaken by Warlpiri at Nyirrpi today. Men are the hunters of large game, women the gatherers of plants foods and smaller animals, roles in which men are able to navigate with some freedom but which are fixed for women. The responsibilities of gathering food extend to both men and women. There is no gender-based exclusivity in the gathering of plant foods. The procurement, preparation and distribution of game remain solely a male responsibility, the practices of which are set in Warlpiri Law. These differences are less to do with devaluing of women’s role as food gatherers and perhaps more to do with the practicalities of procuring sustenance and the co-operative effort required to achieve these ends.

249
There are a number of aspects of Warlpiri culture that support my claim that Warlpiri male society is overtly homosocial.

Firstly, I will examine terms that describe the relationship between men who have come into adulthood at the same time. While the meaning in these terms appears to have changed since first being described by Meggitt (1962), their affective and behavioural characteristics remain very much the same. Meggitt (1962) describes in detail two terms, *yarlpurru* and *parnganga*, both of which apply to the relationship that exist between men who share initiation.

Meggitt (1966) defined *yarlpurru* as simply all men who have come into adulthood in the same ceremonial season. Meggitt’s (1966) interpretation of this term is essentially one of an age-mate, in which the relationship between men is based on mutual regard and an acknowledgement of time spent together in seclusion.

The term *parnganja* was defined by Meggitt (1966) as a co-initiate, a reference made to those men who were initiated into manhood at the same time, specifically at the same ceremony and on the same ceremonial ground. Meggitt is clear on the expectations concerning the relationship between men considered *parnganja*:

The men were expected to remain close friends, camping and hunting together and exchanging wives, they must never quarrel (Meggitt 1962, p. 239).

Today the term *yarlpurru* is used to refer to co-initiate. Warlpiri men at Nyirrpi no longer use the term *parnganja*. Warlpiri men at Nyirrpi continue to uphold and enact these relationships. They are expected to remain on good terms with one another, provide assistance when required and are prohibited from fighting. Warlpiri men are expected to maintain these relationships throughout their life. They are prohibited from attending the funeral of their *yarlpurru*, this being a mark of the grief they feel at the loss of such close relationship. Initiation into manhood is the defining point in a
Warlpiri male’s life and is invariably remembered fondly by Warlpiri men. Meggitt (1962) refers to it as both a ‘shared and remarkable experience’.

The passage from childhood to adulthood is characterized by a dramatic shift in the social world of young men. Their social world becomes one that is exclusively male in orientation, one that is governed by very strict rules of association. These rules of association dictate whom a young man can associate with socially. These rules must be adhered to without deviation. A number of men suggested these rules were strict in order to protect the secret and sacred knowledge that young men had been given.

Young men were forbidden to associate with women, girls and uninitiated boys. The people with whom they could associate include their male seniors, their elder male brothers, elder male cousins, fathers, uncles and grandfathers. By enforcing exclusive male company, not only was secret knowledge protected, but young men were also socialized into male adulthood. This sets the basis for exclusive male company that so characterizes contemporary Warlpiri society.

When there is such a rapid change in social status as results from initiation, there is an expectation that behaviours and attitudes will suddenly be transformed. Young men are certainly made aware of how they are expected to behave, but greater emphasis was placed on association. Informants were universal in their claim that correct association was by far the most important responsibility of a young man. The prohibition of women’s company is well demonstrated by the following comment:

‘You can’t go to woman’s road, you have to go your own road. You can’t cut across woman’s road. Where woman’s walking or where woman’s hunting. You have to go your own way.’

It is the duty of elder brothers to closely monitor a young man’s behaviour and to offer both encouragement and guidance. It fell to elder brothers to punish any
transgressions. Many men reported violent assaults from elder brothers but thought this an appropriate way to learn what was expected of them. One man related the punishment inflicted by his elder brother for the crime of playing with children:

‘He gave me a good hiding. With hose you know...really hard. Good lesson, that is the way lesson taught us.’

Young men are expected to behave in an appropriate manner. They were required to gradually abandon the pursuits of childhood, heed their elders and above all show respect. There was also a strict prohibition on swearing, especially when directed at siblings and close kin. These experiences were typically described in terms such as:

‘...um when I got out and my father told me, be like the grandfather, not to speak to anybody, he was only telling me stories. I was living by myself and hearing stories about what happened to my grandfather. He was stopping with his brothers, after that he went away, that’s what he told me happened to him now. Just to behave yourself...not acting a little kid.’

The requirement that young men behave in a respectful manner appears often in the data. Respect seems to be a defining feature of good interpersonal relationships for Warlpiri men. A perceived lack of respect may be cited as the reason for foregoing kinship responsibilities. Respect in a Warlpiri sense seems to be more about having concern for someone as opposed to feelings of regard. As the following statement indicates it is also about the debt owed by young men to those people who played a part in the making of their adult identity.

‘...and don’t swear, respect your mother and father and also respect your brother-in-law. That is the main one, and respect all your cousins and your brothers who were working for you at bush camp. Taking you mangarri (food) and everything.’

252
Some informants claimed that the punishment for inappropriate behaviour might be more severe and come in the form of banishment:

‘...if we don’t take notice we have to say goodbye for family and country.’

Given the strong attachment to both family and community these threats of banishment no doubt helped to conform young men’s behaviour to expected norms.

In Warlpiri male society, homosociality must be balanced with the numerous *jampardivi* or avoidance relationships. These two aspects of Warlpiri male society, while mutually exclusive, are co-existent. These seemingly contradictory social relationships have also been reported in Mardudjara society, western neighbours of the Warlpiri (Tonkinson 1978).

I am unaware of any overt link between homosociality in Warlpiri society and any form of homophobia. This can perhaps be explained in part by the conception of manhood in Warlpiri society. Adult male status is both conferred and earned. The ceremonial passage into manhood is very much a public one, after which adult male status is assured. The behavioural and psychological qualities of young Warlpiri men do not assume the same significance as in Australian society. The defining point of adult male status in Warlpiri society is that of passage. The journey once made is all the proof required in Warlpiri society of adult male status.

Discussion

Much of male behaviour is fashioned through a fear of being judged deficient in masculine attributes. In this manner homophobia becomes much more than an aversion to feminine qualities in other men, it is internalized as a fear of transgressing gender conventions leaving one exposed to the ridicule of other men.
The proposition that Warlpiri male society is highly homosocial in nature with little or no homophobia supports the idea that other forces are at play in determining how men use health services and approach issues of personal well-being. That Warlpiri male society is homosocial, and that this homosociality is primarily a cultural construct, diminishes the proposition that masculine ideals as molded by homophobia have any part to play in Warlpiri male thinking and behaviour. This research has revealed that the greatest phenomena impacting on Warlpiri men’s access to and utilization of health services is the experience of shame.

Male gender identity in Warlpiri society is created through ritual practice. The requirement for constant validation of this identity becomes redundant and is not seen in Warlpiri culture. The ritual passage into adulthood is mandatory and the quintessential defining moment in a Warlpiri man’s life. Homosociality may be seen as playing a role, albeit indirectly, by influencing men’s illness behaviours in mainstream Australian society, through links to homophobic fears. There is no such mechanism in Warlpiri society.

Conclusion

Warlpiri and other Australian men share common traits in illness behaviour. The motivations behind these behaviours are very different. The concepts of homosociality and homophobia explain how these seemingly similar behaviours have their genesis in different social forces. Practitioners must account for these differences if gender disparity in health service use is to be counteracted.
Chapter 13

Statement of the Thesis
Chapter 13

Statement of the Thesis

Introduction

This research was undertaken to explore the issues impacting on Warlpiri men’s use of health services in a remote area setting. The literature suggests that in other male populations, trends in illness, uptake of health care and associated behaviours reveal a degree of disadvantage relative to that of females. This literature also identified the concept of masculinity as a central factor in this disadvantage. The challenge of this research was to establish if similar patterns existed in a Warlpiri community and by description and analysis come to an understanding of any cultural differences that might exist. The challenge was also to suggest how health services could respond to specific cultural practices so that the care of Warlpiri men could be enhanced. In this chapter the main elements of the study are brought together.

Illness

In this inquiry two facets of men’s health experience were considered; health status and health service use. Compared to women, Australian men have greater rates of mortality from heart disease, shorter average life expectancy, greater rates of injury, higher levels of suicide and are more likely to abuse substances particularly alcohol. Men are also disadvantaged by their limited use of health services. The poor utilization of medical services as indicated by delays in seeking help and the under-reporting of symptoms feature prominently in the literature.

Warlpiri men living at Nyirrpi share some of these trends. These men carry a significant burden of chronic disease. Nyirrpi men have high levels of elevated body
mass index, diabetes and hypertension. Despite this morbidity, Nyirrpi men are under represented in clinic utilization data.

**Manhood**

Gender and gender relations are organized around local contexts and communities, personal and social networks and other points of social differentiation. As such, we can expect considerable diversity in gender identities both within and across particular societies. Male gender identity in Warlpiri and Australian society emerge from socio-cultural processes that are fundamentally very different. These differences are evident in the processes by which gender is constructed and maintained.

Validation is a prime component of male gender identity in both Warlpiri and non-Aboriginal society. However, this validation is manifest in differing ways. Manhood in Warlpiri society is achieved through ritual, with adult status literally inscribed on the body. These bodily inscriptions are now largely limited to genital modification in the form of circumcision and subincision. This is the prime requirement for the status of an adult male in Warlpiri society. Traditionally, the development of ritual knowledge and ongoing ceremonial involvement consolidated male gender identity. Other bodily inscriptions such as tooth avulsion and cicatrices signaled the attainment of advanced ritual knowledge. These are now rarely practiced among Warlpiri men and in contemporary Warlpiri society gender identity is less dependent upon ongoing ritual involvement.

In Australian society the validation of male gender is enacted and assessed in terms of performance. This requires constant self-evaluation in relation to certain standards of conduct. These standards are unstated but are almost universally recognized by men as benchmarks of behaviour and attitude, elements that are inherently important to male self-identity. These standards are constantly under review, with each generation modifying the standard or criteria by which adult male status is conceived and upheld.
The main difference between male gender identity in Warlpiri and Australian society is in conferral and evaluation. In Australian society validation of male gender identity is ongoing. The importance of enactment and validation continue into adulthood, only diminishing in importance with advancing age, by which time many behaviours and attitudes have become an ingrained feature of male character. In Warlpiri society male gender identity is achieved in a single event and no subsequent proof or enactment is required.

Boundaries

Exclusion from the male collective is a powerful force, one that can shape men’s behaviour. The threat of aspersions being cast against a man’s masculine identity forces conformity to gender norms. In many societies, homophobia defines and maintains the boundary between social and sexual interaction in homosocially-stratified groups. Through homophobia, male groups are bonded in a unanimous rejection of ‘the feminine’. This sets up barriers against homoerotic undercurrents in these male groups. In this manner, both gender and sexual behaviour are shaped by and between men. Homophobia is used not only against homosexuals, but also against men in general to maintain appropriate gender behaviour. In Australian society homophobia is a significant factor in shaping relationships between men and ultimately influencing men’s behaviour. Homophobia is one of the prime organizing principles of our cultural definition of manhood.

In contrast, Warlpiri male society is intensely homosocial and is characterized by an apparent lack of homophobia. Homosociality in this instance operates specifically to protect sacred knowledge imparted to young men during circumcision ceremonies. The enforcement of male companionship is a significant part of the gender socialization of young men.
Homosociality and homophobia are concepts of social organization that help to explain the different manifestations of shame and how this determines men’s illness behaviours in Warlpiri and Australian society. One similarity that these concepts share is the transmission of a collective ideal to individuals thus enforcing a degree of behavioural conformity.

Both homosociality and homophobia are inextricably linked to the ‘authorizing gaze’. In Australian society the fear of being viewed as feminine can lead to the rejection of behaviours and attitudes that might be considered suspect by other men. In Warlpiri society the ‘authorizing gaze’ is directed initially at ritual accomplishment and later at companionship.

Shame

The different ways in which male gender identity is constructed in Warlpiri and Australian societies is reflected in the various experiences of shame emanating from health service encounters. Shame profoundly shapes men’s responses to illness. Shame is a socio-cultural construct and as such the experience of shame in Warlpiri and Australian society reflect these cultural origins.

For Nyirripi men there is no direct link between gender identity and illness behaviours. The source of shame is the perceived link between clinic attendance and sexual health. Men, particularly those who abuse alcohol, believed the gaze of others to be both knowing and judgmental. Speculation about men and clinic attendance is never neutral; it is nearly always associated with sexual health. Shame is also linked to the cultural concept of avoidance, a style of relationship that impinges upon men’s use of public spaces making certain aspects of life problematic for Warlpiri men. Issues of communication and comprehension were also reported in men’s experience of shame in health encounters.
These bear no similarity to issues raised for Australian men. Despite the diversity in male gender identity from variables such as age, ethnicity and occupation, some general trends emerge. Behaviour is moulded on gendered norms. Shame can result when there is perceived deficiency in an individual in relation to collective gender norms.

These fundamental differences are illustrated in figure 13.1. For both Warlpiri and Australian men, help-seeking can pose challenges. These have their genesis in shame.

Figure 13.1 Male Gender Construction, Shame and Illness Behaviour: a bi-cultural model
This research has demonstrated the importance of cultural configurations in shaping Warlpiri men’s responses to illness. This challenges the primacy of gender in the men’s health literature and suggests that other variables can influence men’s behaviour in times of illness.

Behaviour

Behaviour during episodes of illness is dynamic. While shame is prominent in Warlpiri men’s illness experience, other variables are likely to influence responses to illness. The Warlpiri have extensive beliefs and practices regarding illness. These remain a powerful means of explaining illness and appear almost universally upheld. These can determine how signs and symptoms are interpreted and the choice of treatment. In all societies interpersonal relationships are crucial to social and physical well-being. For the Warlpiri, these relationships are expressed in a specific and predetermined manner. However the particular roles and obligations that characterize these relationships have been eroded by social change. As a consequence, the welfare of young Warlpiri men has been placed at risk.

Conclusion

Warlpiri and Australian men share some similarities in their responses to illness. These behavioural responses are characterized by under-reporting of symptoms and delays in seeking treatment. The literature suggests that in many societies, the gender concept of masculinity is central to many of these behavioural responses. The alternate mode of gender construction for Warlpiri men suggests that forces other than gender influence Warlpiri men’s illness behaviour. The social forces of homophobia and homosociality define and delimit behaviour between men and further differentiate the experience of gender in Warlpiri and Australian society. For the Warlpiri, other cultural configurations assume primacy in men’s responses to illness. Only when these specific factors are considered can health services become fully inclusive.
Chapter 14

Recommendations
Chapter 14

Recommendations

Introduction

This research was undertaken to generate knowledge concerning specific aspects of health service delivery to men in a remote Aboriginal community. This knowledge includes aspects of traditional Warlpiri culture and the application of those traditions to contemporary circumstances. Practitioners bring to the health encounter their own traditions. These may contrast markedly with those of the people in their care. Beliefs and values can both contaminate and confound health practice. The preparation of staff for work in cultural environments different from their own assumes considerable importance. This will be reflected in the recommendations emerging from this research, which aim to enhance the preparation of practitioners for work in Aboriginal communities in Central Australia.

A number of areas of concern were uncovered in the process of this research. These have been developed into seven recommendations. They are as follows:

Recommendation 1

- To incorporate cultural safety issues pertinent to Aboriginal men into cultural awareness programs.

Cultural safety is the notion that health services are provided in an environment that is safe for both clients and practitioners alike. It is based on the recognition of cultural identity and service provision that does not conflict with the social and cultural conventions of clients.
Areas to be included:

- Avoidance relationships. Included in this topic are the spatial restrictions that avoidance imposes on men and the implications of avoidance for male Aboriginal Health Workers.
- Aspects of clinical practice, in particular the sensitivity surrounding urinalysis and the implications this has for screening programs.
- The help-seeking strategies of young adults.

The success of a health service is dependent upon the relationship that exists between the service provider and the community. Without a relationship based on mutual respect and trust very little can be achieved.

**Recommendation 2**

- The recruitment of male staff (Aboriginal and non-Aboriginal) to remote Aboriginal clinics as a matter of priority.

Male health personnel are central to the provision of health services to Aboriginal men. Informants were unanimous in their desire for Aboriginal men to be involved in the care of other Aboriginal men.

The quality of care was of greater importance to Warlpiri men. For these men, quality of care was inextricably linked to culturally safe care. Current cross-cultural awareness programs do not presently address specific cultural safety issues relating to clinical practice with Aboriginal men.
Recommendation 3

- To conduct further research into matters of privacy in a remote Aboriginal health context with particular attention to Aboriginal kinship structures.

- To develop best practice guidelines for confidentiality in relation to remote area Aboriginal health practice.

Privacy issues in cross-cultural care can be problematic and confidentiality remains a significant and complex issue for both practitioner and client alike. For many men, the option of a private consultation is fraught with difficulty, the need for privacy being balanced against the risk of public exposure. Nyirrpi men identified unintentional breaches of confidentiality arising from routine clinical practice.

In small Aboriginal communities such as Nyirrpi, life is lived very publicly. The recall of clients is not possible by mail or phone as practiced elsewhere in Australian society. The nurse’s interactions with community members are very public. These observed interactions are open to speculation and comment.

The Department of Health and Community Services Discussion Paper, ‘Protecting the Privacy of Health Information in the Northern Territory’ released in 2002 acknowledges the specific challenges for both community and individual privacy in remote Aboriginal communities. Unfortunately, the Discussion Paper does not consider in any detail the intricacy of privacy issues in remote Aboriginal communities.

The problem of maintaining privacy and providing confidential care in remote Aboriginal communities is complex and outside the scope of this research project. It is an important issue worthy of further inquiry.
Recommendation 4

- Promote screening for young Aboriginal adults.

The vulnerability of young men in times of illness was an unexpected finding of this research. This vulnerability results from a complex range of factors, chief amongst them the paucity of senior men able to fulfill obligatory guardianship roles.

Health screening is an effective strategy for detecting and monitoring disease focus. The screening encounter provides the opportunity for information sharing, counselling and education. Meaningful education is best achieved at the individual level. This contrasts with the current approach, which favors education and health promotion activities at the community level. The current protocol for adult screening to commence at 15 years of age remains appropriate but greater emphasis should be placed on opportunistic screening.

Recommendation 5

- Greater emphasis on language and communication in cultural awareness programs.

Cross-cultural communication carries enormous potential for miscommunication. In particular, the subtle differences between the Aboriginal use of English and Australian Standard English might contribute to miscommunication. This research has demonstrated the significant syntactical and semantic differences between Aboriginal English and Australian Standard English. These issues are well represented in the literature but receive little attention in cultural awareness programs.
Recommendation 6

- Incorporate an understanding of ‘shame’ as it relates to Aboriginal men and women as a major topic in cultural awareness programs.

Shame emerged as the main determinant of health seeking behaviour for Warlpiri men at Nyirrpi. As a social emotion, shame is predominant in many Aboriginal societies. The causes of shame as experienced by Warlpiri men are complex.

The most frequently reported source of shame was the fear of being perceived as suffering from a sexually transmitted disease. Alcohol abuse and sexual promiscuity are considered mutually inclusive. In Nyirrpi the majority of men episodically abuse alcohol. Clinic attendance by these men is seen as indicative of contagion.

Anonymous clinic attendance is the only way men can avoid the shame associated with health care. As a result of this finding structural modifications were made to Nyirrpi clinic to afford men a degree of anonymity when seeking treatment.

Recommendation 7

- Shift the emphasis in Aboriginal men’s health from sexual to holistic well-being.

Nyirrpi men strongly equate men’s health with sexual health. Sexual health issues have long dominated Aboriginal men’s health. The shame associated with sexual health problems impacts on men’s use clinic services. The active promotion of well men’s screening as an annual clinical event and one that is focused on general health is central to eliminating the stigma long associated with Aboriginal men’s health practice.
Conclusion

The interplay between socio-cultural traditions and the contemporary lives of Warlpiri men can adversely influence their access to primary health care services. Practitioners often fail to recognize these traditions and how they can influence the behaviour of men in their care. Only when practitioners are equipped with both clinical and socio-cultural skills will equity in access to health care become possible.
Glossary of Warlpiri Terms

J
Jamirdi........................................mother’s father
Jampardiyi....................................avoidance relationship
Jamavi-mavi...............................a style of speech used in avoidance relationships
Jangkayi......................................unmarried men’s camp
Jakuru...........................................young man
Janyungu......................................tobacco
Jarnpa...........................................executioner
Jinta-jurrku..................................one and the same
Jirrarni.........................................food
Jukurrpa......................................dream, Dreamtime, totem, Law, custom
Juurlku..........................................indirect form of request

K
Karna.............................................woman
Kardiya..........................................a non-Aboriginal person
Kirdana...........................................father
Kurnta..........................................shame, shy, embarrassed
Kurdu.............................................child
Kurdungurlu..................................opposite patrimoiey or ceremonial workers
Kuuku............................................monster

L
Lawa...............................................negative, absent

M
Mangarri.......................................food, vegetables, fruit, grains
Maparmpa......................................diagnostic entity used by ngangkayi
Marlu.............................................kangaroo
Marliyarra ........................................................ advanced initiate
Marral-yani ................................................ avoidance term to denote commands come and go
Milpa ............................................................... eye
Milpajarnta ....................................................... blind
Milpajararla ..................................................... deceitful
Milpa-narrara ..................................................... eyelikey, as in shape
Murra-murra .................................................... sick, in pain
Mawuva ............................................................. poison
Mawu ................................................................. urine, urinate, bladder
Miti-pinyi ........................................................ avoidance term to denote walk, sit or stand
Miyalu ............................................................. stomach, abdomen
Muru ................................................................. ignorant
Murrku ............................................................. pre-pubescent boy
Murrlpapa ........................................................ care or caution in the company of another
Ng

Ngamirni ........................................................ maternal uncle
Ngarrka .......................................................... initiated or married man
Ngarri-jarrimi ................................................ avoidance term to denote go, walk, act on it
Ngumparna ...................................................... wife’s brother, older than speaker, brother-in-law
Ngurrpa .......................................................... ignorant, innocent of wrong doing
Ngurrju ........................................................... good, well, happy

Ny

Nyanvi ............................................................... to see or watch
Nyarnu ............................................................. sickness
Nyurnu-warli-warli-wangu .................................. healthy, without sickness
P

Palka.............................................1. body, life form 2. physical characteristics 3. present
Papardi...............................................................elder brother
Para-parnta............................................................sub-incised boy
Parnganga............................................................co-initiate (same ceremony)
Parntirma..............................................................pierce
Pavi-warlpa.............................................................wind
Pirli................................................................stone, rock, hill
Pirlirrpapa...............................................................spirit or life force
Pinarrri.................................................................wise, knowledgeable, smart
Pirlalyi.................................................................guardian for initiates, ritual friend
Pina-wangu............................................................ignorant, stupid
Pina-pinjarrimi............................................................learn
Pirriyarlu-karlpimi.....................................................to suffer from the cold
Purlka.................................................................old man
Pupa.................................................................foreskin, uninitiated boy
Pupa-wangu...........................................................without foreskin, recently circumcised boy
Purdurru..............................................................hair string
Purunyungu..........................................................recently initiated boy

W

Walva...............................................................ground, earth, soil, sand
Wankaru..............................................................alive, in good health, healthy
Wankili..............................................................mother’s brother’s child especially male
Wamulu.............................................................plant and animal down used for decoration
Warlalja.................................................................one’s own things or kin
Warlpa.................................................................wind
Warringyiyi..........................................................father’s father
Warungka............................................................deaf, insane, forgetful
Warna..............................................................poisonous snake
Wijini..........................................................sore
Wita..........................................................small, small child
Wirriya..........................................................boy

Y

Yalparru..........................................................co-initiate
Yalyu.............................................................blood
Yapa............................................................person, human being, Aboriginal person
Yapunta-yapunta...............................................orphan, without family
Yampirri-warnu..................................................unmarried man, bachelor
Yarda.............................................................projected object intended to inflict harm
Yarla.............................................................bush potato
Yawalyu..........................................................woman's ceremonies
Yuparli..........................................................bush banana
Yupukarra........................................................married person
Reference List
Reference List


Bird, S. 1996, 'Welcome to the men's club: Homosociality and the maintenance of hegemonic masculinity' in *Gender and Society*, vol. 10, no. 2, p. 120-132.


Christie, M. 1993, 'Exploring Aboriginal alternatives to western thinking' in *Education Australia*, vol. 22, p. 6-8.


Couper Black, E. & Cleland, J. 1938, 'Pathological lesions in Australian Aborigines, Central Australia (Granites) and Flinders Ranges' in *The Journal of Tropical Medicine and Hygiene*, vol. 41, no. 5, p. 69-80.


Duncan, P. 1986, Shame in Australia, Bachelor of Letters thesis, Australian National University, Canberra.


276


Grant, B. 1997, 'Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population sample' in *Journal of Alcohol Studies*, vol. 58, no. 4, p. 365-371.


Hardman, E. 1889, 'Notes on some habits and customs of the natives of the Kimberley district' in Proceedings of Royal Institute of Anthropology, p. 73-74.


Horton, D. 1994, The Encyclopedia of Aboriginal Australia: Aboriginal and Torres Strait Islander History, Society, Culture, Canberra, Australian Institute of Aboriginal and Torres Strait Islander Studies.


Meggitt, M. 1966, *Gadjari Among The Walbiri Aborigines of Central Australia*, University of Sydney, Sydney, p. 129.


Ridley, M. 2003, 'Genes are so liberating: it no longer makes any sense to talk of "nature versus nurture" or "genes versus the environment". When it comes to human development, the two are inextricably intertwined' in *New Scientist*, vol. 178, no. 2395, p. 38-40.


Tatz, C. 1964, Aboriginal administration of the Northern Territory of Australia, Doctoral thesis, Australian National University, Canberra.


Vick, M. 2003, 'Danger on the roads: Masculinity, the car and safety' in *Youth Studies Australia* vol. 22, no. 1, p. 32-37.


