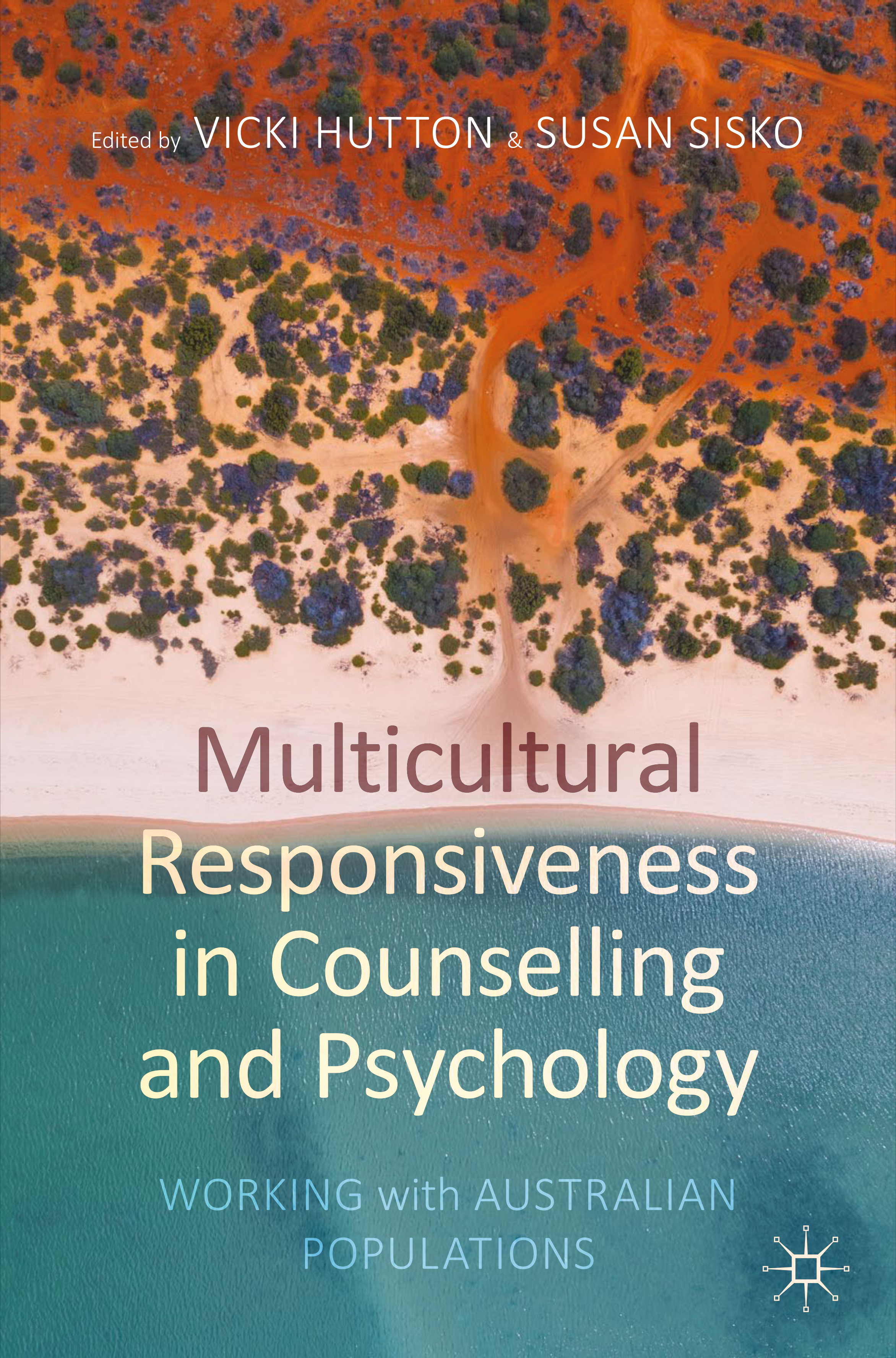

Edited by VICKI HUTTON & SUSAN SISKO

Multicultural Responsiveness in Counselling and Psychology

WORKING with AUSTRALIAN POPULATIONS

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Editors

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palgrave
macmillan

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ISBN 978-3-030-55426-2 ISBN 978-3-030-55427-9 (eBook)
https://doi.org/10.1007/978-3-030-55427-9

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This Palgrave Macmillan imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

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Cultural Responsiveness in Counselling and Psychology: An Introduction

Susan Sisko

Contents

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_1

Trailer

In this chapter, Susan Sisko talks about the importance of developing a multicultural understanding and responsiveness as counsellors and psychologists. The chapter outlines Australian history and the impacts of colonialism and postcolonialism and how the ongoing effects of how these oppressive practices have informed hierarchical systems and impacted non-dominant individuals and groups. The chapter looks at both significant issues related to oppressive practices and approaches to developing multicultural understanding and responsiveness including decolonising practices, intersectionality frameworks and counsellor reflexivity.

1.1 Introduction

- **A call for cultural responsiveness in counselling and psychology**

In this section, we will review issues in counselling and psychology and the importance of understanding multicultural perspectives in the field through a social justice framework.

Australia is considered one of the most multicultural nations in the world. Australia's rich cultural diversity highlights more than 300 languages spoken in homes, over 100 religions and more than 300 different ancestries. This wide variety of backgrounds, together with the many cultures of Aboriginal and Torres Strait Islander peoples, has helped to create a uniquely Australian identity (Australian Bureau of Statistics, 2016).

As a result, understanding multicultural perspectives in counselling and psychology has become a requirement in the training and professional development for accredited practitioners. Training standards for counselling in Australia include subject knowledge around "cultural and social diversity" as a core curriculum requirement (Psychotherapy and Counselling Federation of Australia, PACFA, 2018, p. 3), and specifically "knowledge and integration of the range of understanding diversity including culture, gender, sexual identity, sexual orientation, age, ability, class, religion and ethnicity, plus specific training in indigenous history" (PACFA, 2014, p. 3). The Australian Psychology Accreditation Council (APAC, 2019) requires knowledge and skills of psychology in a manner that is "reflexive, culturally appropriate and sensitive to the diversity of individuals" (p. 11), and that "cultural responsiveness, including with Aboriginal and Torres Strait Islander cultures, is appropriately integrated within the [training] programme and clearly articulated as a required learning outcome" (p. 9).

1.2 What Are the Issues?

Despite the aim and intention of regulatory bodies to include multicultural perspectives in training programmes, multicultural counselling and psychology practices are falling short in making a significant impact in meeting the needs of diverse individuals and groups seeking counselling and mental health services. As indicated in a report by Mental Health in Multicultural Australia (2013), mental health services often fail to capture information on cultural and linguistic diversity, which in turn limits the level of service access or mental health outcomes in some diverse communities. Mental health experiences and outcomes of some diverse groups are very different to other Australians—first- and second-generation immigrants, refugees, asylum seekers and their families are groups of concern. The Fifth National Mental Health and Suicide Plan (2017) has highlighted the diversity of experiences of mental illness across population groups, including Aboriginal and Torres Strait Islander peoples, older age groups, the LGBTIQA communities and people living with a disability. Unfortunately, outcomes continue to show that there is a large inequity gap in Australia across all statistical categories of non-dominant groups.

Clearly, the need to include multicultural training for counsellors and psychologists is not in question, but what does remain unclear is what are the most appropriate and effective frameworks and approaches in order to deliver impactful and meaningful multicultural counselling and psychology services. To address the disparity in mental health service access and positive outcomes, we must first ask what needs to be understood and investigated in order to be able to develop and provide beneficial multicultural counselling and psychological services.

As a starting place, we need to ask whose culture and whose knowledge is underpinning multicultural counselling and psychology? Mainstream counselling and psychological training is based on traditional theories that emphasise helping clients manage their own interpersonal or internal conflicts, and this reflects a colonial and Eurocentric approach to practice that does not reference collectivist cultures or social constructs. Ways of knowing in the field have been filtered through the dominant colonial and Eurocentric values and norms, and it is from this position that multicultural counselling has been described, understood and improved. Hernández-Wolfe (2011) describes this position as "systemic suppression of subordinated cultures and knowledges by dominant Eurocentric paradigms of modernity, and the emergence of knowledge and practices resulting from these experiences" (p. 294). If traditional Eurocentric inflected counselling and psychological theories underpin multicultural counselling and psychology, how does that impact outcomes for non-dominant and diverse individuals and groups whose cultures and knowledges have been silenced? If multicultural counselling and psychology fails to explore the systems that create and maintain oppression and marginalisation of non-dominant individuals and groups, are we actually creating damaging multicultural counselling and psychological practices?

In recent decades, important progress has been made in identifying the need to include frameworks for multicultural perspectives in counselling and psychology training programmes and in practice. However, whilst these frameworks have progressed the field—in opening up discourse and practice in multicultural counselling—they may have inadvertently continued to perpetuate a colonial mindset. The broad emphasis in these frameworks has been to define sets of attitudes and beliefs that the counsellor should develop in working with clients from different cultural backgrounds to themselves. The focus has been placed on the counsellor working with individuals different from themselves. The frameworks rely on the counsellor developing an understanding of the client's worldview or having a type of "global literacy" (Lee & Park, 2013) that "includes knowledge of ethnic variations in history, travel experience and knowledge about current world events" (p. 7). These frameworks often encourage a "how to" approach of working with different non-dominant groups, for example, how to work with Asians or how to work with LGBTIQA populations. As a result, these frameworks have been developed from traditional colonial theory where the counsellor is invited to adjust their attitudes or beliefs by understanding individual difference based on comparison to existing norms. These frameworks often maintain binary positions in order to fit simplistic ways of identifying "others" and in doing so, potentially stereotyping non-dominant individuals and groups further while ignoring intersecting identities (e.g. gay men or biracial women).

Hernández-Wolfe (2011) describes multiculturalism and a decolonising stance as not merely about cultural differences or group identities but also understanding relationships to power, access and opportunity. Further, racism historian George Frederickson states, "racism is not merely an attitude or set of beliefs; it also expresses itself in practices, institutions and structures that a sense of deep difference justifies or validates" (Frederickson, 2002, p. 6). Gorski and Goodman (2015) suggest that based on current frameworks, counsellors and psychologists may be meeting a minimal bar of cultural competence rather than a transformative multicultural responsiveness grounded in the ideals of equity and social justice. Through these ideals and a decolonising view of multicultural counselling, they propose "pushing us to gaze up the power hierarchy, where inequities are embedded in systems and structure that privilege few at the expense of many" (Gorski & Goodman, 2015, Location 341). Most multicultural counselling and psychology frameworks do not reflect the type of transformation that is necessary to ensure multicultural counselling and psychology supports cultural democracy and social justice.

The inequity gap in Australia is well established—evident across all statistical categories of non-dominant groups. Accordingly, we must be willing to delve into our history including our own socialisations, our complicities of systems and our power and privilege in order to fully understand issues of well-being for non-dominant groups and to develop impactful multicultural counselling and psychology practices. It is important to understand multicultural counselling and psychology through multiple levels—including the uniqueness of the individual, similarities and differences of groups as well as broader social and historic levels (Sue, 2001). We must consider how colonialism has impacted individuals, groups, culture and society in Australia? We must ask how Australian history has impacted leadership, policy making and social systems. We must consider what steps might need to be taken to develop truly transformative multicultural counselling and psychology.

1.3 Australian History

1.3.1 Indigenous Australians

Indigenous Australians are Aboriginal and Torres Strait Islanders, and they are considered to be the one of oldest cultures on earth. The earliest human remains found in Australia are of Mungo Man and Mungo Lady which have been dated around 50,000 years before present (BP) times. Recent archaeological evidence from charcoal and artefacts suggests a date as early as 65,000 BP. There are commonalities between Indigenous Australians; however, there is also significant diversity among different Indigenous communities, each with its own elements of culture, customs and languages (Davidson & Wahlquist, 2017; Wright, 2017).

1.3.2 Settler Colonialism

British colonisation of Australia began with the arrival of the first fleet in Sydney in the 1780s. When the British colonisers arrived—despite the presence of the Indigenous Australians—they deemed Australia to be "Terra Nullius"—which means empty and unoccupied land. This legal doctrine effectively rendered Indigenous Australians rights to land or resources invisible. It allowed the British colonisers to treat Indigenous Australians as sub-human. With colonisation came the complete disregard for Indigenous rights or life. Australia was not colonised with treaties drawn up between the British and Indigenous peoples but through misleading systems and deception. Immediate consequences of colonisation included epidemics of European diseases such as measles and small pox, seizure of land and water sources, frontier wars, abuse and prostitution of Indigenous women (Connor, 2016; Richards, 2014), and destroying native food sources such as kangaroo in favour of imported sheep and cattle. During Australia's early history, the practice of forcibly removing Indigenous children from their families began. Various government policies allowed indigenous children to be forcibly removed from their families between 1910 and as late as the 1970s—these children are now referred to as The Stolen Generation. The purpose of removal was to eradicate Indigenous Australian culture. The forced removal of children has had a significant impact on the psyche of Indigenous Australians, and it has greatly impacted not only the children who were removed and their parents but also their descendants. Many of the children were abused—sexually, psychologically or physically—after being removed and while living in group homes or adoptive families, but in removing the children from their families, they were also deprived of their culture (Australians Together, 2018).

Indigenous Australians—whose voices were silenced through systemic oppression, cultural imperialism, exploitation, marginalisation and violence—were taught to feel inferior and inadequate compared to the dominant group of British Settlers. They were denied identity and personhood; thus, their experiences, histories and knowledge were disqualified. Mignolo (2005), as referenced in McDowell and Hernández (2010), used the term "colonisation of being" to refer to the ideas and practices which communicate that “certain people do not belong to history” (p. 95). There is significant evidence that indicates that the material, physical and emotional well-being of Indigenous Australians has been harmed by the process of colonisation. The oppression of Indigenous Australians has continued and aptly described as an injustice towards Indigenous Australians that began with colonisation and is an ongoing wound in our nation today (Australians Together, 2018).

1.3.3 Postcolonialism

Australia is described as a “postcolonial” country which suggests an overcoming of colonialism, but postcolonialism should not be confused with being devoid of colonial influence, practices or systems. The adage “to never discuss politics or religion in polite society” has been attributed to Mark Twain in postcolonial North America. In the mid-1800s, polite society referred to those who were considered socially superior individuals and by virtue of their alleged social superiority were able to set standards of behaviour for everyone else. The construct of polite company evokes an image of seemingly respectable members of society seated around invitation-only tables where the rules of engagement, including behaviour, beliefs and values, were established and known to them, and then imposed on others. Those at the table determined who was included and excluded based on status and perceived worth. The adage also suggests that things might get much less polite, if one were to put forward different norms, values and beliefs to those accepted by the dominant group. Twain’s social commentary may be attributed to a much earlier time and place, but the truths about who has been at the postcolonial table and who has not and how this impacts society remains constant. In more contemporary terms, the unequal division of power and privilege in our society that was established during Australia’s colonial roots has resulted in the intergenerational inequities that are entrenched in our current systems. Those with power and privilege have created and enforced societal norms and ways of knowing that emerged from a social history of the dominant group, whereby the experiences and perspectives of non-dominant individuals, groups and cultures are accosted within a stereotypical notion and easily dismissed as “otherness” (Scheurich &Young, 1997). The outcomes of colonisation, as Bell (2007) describes, are features of oppression that are pervasive, restrictive, hierarchical, across relationships, internalised and with shared and distinct characteristics of “isms”. Marginalised individuals and groups have “distinct and specific histories but that there are also common patterns that connect and mutually reinforce different oppressions in systems” (p. 6).

Oppression exists across multiple levels within contemporary Australian society, including individual, institutional and historic socialisations where broad assumptions become so deeply imbedded within dominant group realities that “other” realities and ways of knowing are rejected entirely. How might these issues impact non-dominant individual and groups’ emotional, physical and psychological well-being today?

1.3.4 Cycle of Socialisation

To further understand the impact of colonialism, oppression and social justice in multicultural counselling and psychology, Harro (2008) describes a cycle of socialisation that occurs where at the core ignorance, fear, confusion and insecurity maintain the cycle for those individuals and systems in power. Former American President Abraham Lincoln who abolished the slavery of African Americans famously stated that “Nearly all men can stand adversity, but if you want to test a man’s character, give him power”. People with power and privilege may not be able or willing to risk losing this position. People without power may not be able to see a way to challenge oppression having been systematically subjugated. Harro’s cycle of socialisation includes the *beginning* of socialisation which suggests we are all born into a world where the mechanics of assumptions, rules, roles and structures of oppression are already in place and that our *first socialisation* within our family groups shapes our identity and self-concepts and how we relate to others. This is followed by *institutional and cultural socialisation* where government, schools, places of worship and medical services are easily accessible to the dominant group, so those who benefit from these systems do not tend to notice if they are unfair or inaccessible to others. Those who do not fit in or follow the rules live with a constant sense of discomfort or distress and ultimately experience oppression and disadvantages at individual and group levels. Harro further describes *enforcements* in the cycle of socialisation where individuals or groups may begin to think independently about rules, roles and oppressive structures and where there are rewards for privilege but members of a society who break the rules are punished. For example, Indigenous Australians are significantly overrepresented in custody and in prisons compared to other groups, women continue to earn considerably less than their male counterparts do and non-heterosexual individuals’ right to marry has only just been legalised by a controversial national vote in 2017. More subtle examples of enforcements are statements and messages about individual or group expectations based on societal rules and roles. For example, someone from a lower socio-economical background who advances economically may be referred to as a “cashed-up bogan” or statements such as “children are to be seen and not heard” or attitudes that attribute aggressive or sexualised behaviours to women who succeed in leadership roles. Sue (2010a, 2010b) refers to these messages as microaggressions. Sue states that microaggressions are “lifelong and insidious effects of silencing, invalidating and humiliating the identity and the voices of those who are oppressed” (p. 66). Enforcements serve to suppress the individuals and groups who challenge the societal norms of roles, power and privilege.

The results of the cycle of socialisation are devastating. The results are often evident in the disproportionate number of individuals from non-dominant groups facing societal problems—or rather social justice issues—such as mental health issues, homelessness, substance misuse and abuse issues and poverty issues. Poverty and inequality are the strongest determinants of health problems in our nation; and with the large inequity gap in Australia across all statistics with non-dominant groups, it is important to understand the connection between mental health, human rights and social justice. We may wish to move beyond our colonial past but it remains present.

1.3.5 Discrimination and Bias

The cycle of socialisation perpetuates discrimination against non-dominant individuals and groups, and it is ongoing and impacts the lives and well-being of people who experience subordination and oppression. Social justice issues, including discrimination, oppressions, poverty and inequality, can seem like overwhelming concepts to fully understand and further to be able make changes within systems that have been long standing and seem fixed. Australian Human Rights Commission (AHRC) describes human rights as "principles of dignity, equality and mutual respect, which are shared across cultures, religions and philosophies. They are about being treated fairly, treating others fairly and having the ability to make genuine choices in our daily lives" (AHRC, 2013a, 2013b, np.). AHRC is dedicated to eradicating discrimination for individuals and groups including Aboriginal and Torres Strait Islanders, asylum seekers and refugees, older adults and children, people with disabilities and people experiencing racism, sexism and heterosexism. AHRC describes discrimination occurring when "a person, or group of people are treated less favourably than another person or group because of their background or certain personal characteristics [and/or] when an unreasonable rule or policy applies to everyone but has the effect of disadvantaging some people because of a personal characteristic" (AHRC, 2019, np.).

Understanding discrimination and bias is an important starting place in developing responsive multicultural counselling and psychology practices. It is important to understand human attitudes and beliefs to be able to change discriminatory and bias behaviours. Research into understanding how the mind informs attitudes and determines behaviour, including decision-making, has been central to developmental, social and cognitive psychology scholars. Fundamental to this is the understanding of the concepts of unconscious influences and whether these play a significant role in one's behaviour. Theories of the unconscious in decision-making emerged in the 1920s, and these theories suggested that decisions could be influenced by unconscious mental processes outside the awareness of the individual. By the mid-1970s, the concept of unconscious influences on behaviour was generally accepted suggesting people typically lack insight into their own mental process (Newell & Shanks, 2014).

The concept of unconscious influences related to race and discrimination research gained traction, and in the mid-1990s, the Implicit Association Test (IAT) was developed as a systematic measurement of unconscious or implicit attitudes at the individual level (Greenwald & Banaji, 1995; Project Implicit, 1998a, 1998b). The IAT measures the strength of associations between concepts (e.g. White person, gay person, fat person) and beliefs (e.g. good or bad). The score is based on how long it takes a person to sort the words suggesting one has an implicit bias towards a certain association (e.g. White person/good, gay person/bad, thin person/bad) if they are faster to categorise these associations (Project Implicit, 1998). The IAT rapidly became the worldwide standard for assessing implicit attitudes, stereotypes and identity. Further, it has been widely accepted that implicit bias is harboured in the minds of individuals and that attitudes and beliefs based on race, gender and other social categories may lead to discrimination without intent, or possibly even awareness. As a result, “implicit bias morphed from a useful psychological theory of cognitive function into a master narrative of framing legal and policy responses to race and racism” (Kahn, 2018, p. viii). As a result, the focus has not been on the harm or impact towards the individual or group being discriminated against but towards an understanding of the intentions of the individual perpetrating racism, violence and oppressions. This discourse about implicit bias being unconscious and therefore absolving perpetrators of holding responsibility for acting on their prejudices threatens to undermine broader issues of discrimination and social justice, and as a result, alternate views and approaches are emerging to bring implicit bias back into balance (Kahn, 2018).

Current discourse related to implicit bias is changing whereby Payne, Vuletich and Lundberg (2017) state that “the idea of behaviour as morally problematic as discrimination, without the kind of conscious intent that would bestow moral culpability, strikes many as perplexing in itself” (p. 233). Newell and Shank’s (2014) research on unconscious influences indicates there is little convincing evidence on decision making, and as a consequence, such influences should not be assigned a prominent role in theories of decision making and related behaviours. In fact, they state that “conscious thoughts are by far the primary driver of behaviour and that unconscious influences – if they exist at all – have limited and narrow effects” (p. 2).

Recent research findings have raised questions about the nature of implicit bias, particularly about the instability of individual level implicit bias with a shift towards the social level of discrimination and bias. To that point, Payne et al. (2017) describe the Bias of Crowds (BoC) model by addressing three issues of emphasis on individual implicit bias. First, tests of implicit bias show robust average over time but there is little temporal stability in an individual’s levels of bias. What this means is that if the same individual was tested one month apart, they would likely show different levels of bias at each test. Second, young children display implicit bias levels similar to the levels of adults, which suggests to many that implicit biases are learned early. Yet, if implicit biases are unstable over weeks, how can they be stable for decades? Third, individual differences in implicit bias are only associated weakly with individual differences in behavioural outcomes. Yet “aggregate levels of implicit bias (i.e., countries, states, regions) are strongly associated with aggregate levels of disparities and discrimination” (p. 233). This means that just because an individual holds implicit biases, it is not indicative of whether they will act on these. But if a group of people hold the same biases, it is likely they will act on these. For example, if the dominant group holds high level of bias towards a non-dominant group, it is likely they would behave in a way that reflects their prejudice. But it is hard to predict whether an individual who holds implicit bias will act on this. The BoC model resolves these issues by treating implicit biases as outcomes of dominant situation-related rather than individual-related factors. According to this view, implicit biases reflect the momentary accessibility of mental concepts associated with different groups, which is shaped by the level of prejudice and discrimination in a person’s environment (Gawronski & Bodenhausen, 2017). Whilst the discourse and debate around implicit bias have shifted away from an emphasis entirely on individual-related factors, there is still argument about mental processes and representations that determine concept accessibility and the significance of individual-related factors in the activation of mental contents (Gawronski & Bodenhausen, 2017). However, implicit social cognitive researchers and scholars do agree that racial attitudes are not hard-wired and they are malleable, and subsequently, the impact of situations and environments is a significant factor in discriminatory behaviours (Kahn, 2018). Kahn (2018) states, "implicit bias cannot be understood apart from its social and historical context, which has been suffused with explicit bias for generations" (p. 225), thus reinforcing the importance of understanding multicultural counselling and psychology from a social justice perspective.

In sum, it is evident that non-dominant individuals and groups historically, and currently, suffer from the impact of colonisation, oppressive and discriminatory practices. The hierarchical structures of postcolonialism remain prevalent in Australia today where attitudes, beliefs and systems continue to negatively impact non-dominants individuals and groups. Postcolonialism contributes to socialisations that prefer dominant knowledges, ideals, values and structures including government, medical and education systems. As a result of colonialism and the cycle of socialisation, discrimination and bias against non-dominant individuals and groups impact the well-being of people and create significant social justice issues. These power hierarchies privilege a few at the expense of many causing oppression, discrimination and bias. The focus of understanding discrimination and implicit bias has been limited to individual-related factors with a core understanding on the intentions of the perpetrator of discrimination and not focused on the harm done through discriminatory behaviours to non-dominant individuals and groups. The focus of implicit bias has also been binary in nature, failing to consider where multiple oppressions exist simultaneously and cannot be separated from race, class, sex or social and historical contexts. We need to understand that social determinants impact the well-being of individuals and groups and that discrimination and bias must be understood from social and historic contexts. We do not need to accept that current hierarchical systems, discrimination and bias are fixed or inevitable. In developing a truly transformative multicultural responsiveness in counselling and psychology, it is important to understand the impact of history, societal structures, discrimination and bias against non-dominant groups and individuals. Moving forward using a framework of social justice—where decolonising counselling and psychology, understanding intersectionality and the development of reflexivity and self-awareness of the counsellor and psychologist—will allow for broader knowledges to underpin multicultural perspective which will create, inform and change systems, structures and practices in counselling and psychology.

1.4 Approaches to Responsiveness to Multicultural Counselling and Psychology

In this section, three important focus areas in developing multicultural understanding and responsiveness for counsellors and psychologists will be discussed: first, critically examining decolonising practices in training and development of counsellors and psychologists; second, developing an understanding of intersectionality and the use of this framework in multicultural counselling and psychology theory and practice; and finally, reviewing reflexivity and self-awareness of the counsellor and psychologist and the importance of the therapeutic relationship as a place of healing, and integrating transformational learning to support reflexivity and self-awareness in developing responsiveness and understanding for the multicultural counsellor and psychologist.

1.4.1 Decolonising Counselling and Psychology

Earlier in this chapter, we discussed how knowledges have been produced and legitimised through colonisation and that these assumed knowledges have shaped societal norms as this relates to multicultural counselling and psychology. Colonial and Eurocentric knowledges have been privileged and assumed as core foundations to the discipline, while all other perspectives are assessed as deviations.

To better understand and develop multicultural counselling and psychology, it is critical to de-colonise knowledges and their core foundations. It is generally understood that decolonising analysis is born of critical theory found within transformative paradigms of western traditions (see Mertons (2005) as referenced in Dudgeon, Bray, D'Costa and Walker (2017)). However, whilst the scholarly origins of the concepts are widely accepted, the meaning and application of the concept of decolonisation present as a contested term in current literature. "Decolonisation has multiple meanings, and the desires and investments that animate it are diverse, contested, and at times, at odds with one another" (Andreotti, Stein, Ahenakew & Hunt, 2015, p. 22). McDowell and Hernández (2012) define decolonisation as "a framework that stands on a perspective of coexistence rather than opposition to Euro-centric thinking because unlike Euro-centric universal endeavours, decolonial projects seek to be pluriversal" (p. 95). However, Tuck and Yang (2012) describe decolonisation as being used metaphorically and that use misses the mark because the settler is viewed in a place of innocence, avoiding the need to actually address the physical, ecological, spiritual or symbolic harms of colonisation. For these authors, "Decolonisation offers a different perspective to human and civil rights-based approaches to justice, an unsettling one, rather than a complementary one. Decolonisation is not an 'and'. It is an elsewhere" (Tuck & Yang, 2012, p. 36). McNamara and Naepi (2018) bring yet another position by describing "the term 'decolonisation' (removing colonial influences) versus 'indigenisation' (adding Indigenous elements to existing structures) (p. 340). Here indigenisation is brought forward implying that a complete rejection of the current colonial system is too extreme and the current systems might be redeemed through the integration of Indigenous worldviews. Dudgeon et al. (2017) describe decolonisation as centred in the settler discourse, whereas an Indigenous paradigm centres on Indigenous knowledges. They further state, that while a decolonising perspective remains necessary, it is not the epistemological centre of an Indigenous perspective. "Indigenous psychology is founded on sovereign Indigenous knowledges and is not merely a decolonised form of (white) psychology. A decolonising critique of psychology and Indigenous therapeutic epistemologies has different intellectual and cultural traditions" (Dudgeon et al., 2017, p. 316).

For the purposes of this book, we are defining decolonisation as being centred in a settler discourse recognising colonial impact and the power and privilege associated with that, challenging the hegemonic views that marginalise non-dominant individuals and advocating change through social justice that is based on values that promote equity, access and opportunity without limitation. As Hernández-Wolfe (2011) describes, a decolonised position is not just concerned with cultural difference or group identities but also with the difference of power and access to opportunity.

Goodman and Gorski, (2015) describe five critical areas important to decolonising the training and practice of counselling and psychology. *First,* training and educating towards critical consciousness where independent thinking is encouraged. The authors describe the process of attaining critical consciousness which involves genuine questioning, having healthy dialogues and discourse, creating opportunities for independent and divergent thinking and the freedom to arrive at one's own decision regardless of the status quo (Location 4224). This style of teaching and learning can decolonise traditional pedagogy and allow for opportunities to explore different knowledges and points of view. *Second,* infuse multiculturalism and social justice throughout the teaching and learning processes in counselling and psychology education (Goodman et al., 2015, Location 4243). In order to avoid minimising, stereotyping and "othering" individuals and non-dominant groups, all aspects of multicultural counselling and psychology training and practice should be understood as a "complex and life long journey" (Henderson et al., 2010). Multicultural training should not be viewed as a one-off course, rather an ongoing and reflexive process. *Third,* promote meaningful engagement and self-reflection of the counsellor and psychologist in developing multicultural understanding and responsiveness. Goodman et al. (2015) caution using activities or learning opportunities that may unintentionally reinforce and perpetuate a voyeuristic curiosity of the lives of the oppressed instead of promoting individual and social responsibility for acting with and on behalf of the oppressed (Location 4291–4301). The risk of reifying privilege by signalling that privileged people have the right of voyeurism, or the ability to observe and interpret without engagement must be avoided (Hyland & Noffke, 2005. p. 380). *Fourth,* the importance of counsellors and psychologists' immersion in marginalised communities where engagement is meaningful and allows for social justice theory to be put into practice. Limiting discussions of diversity to a single course or limiting the practice of community engagement to placement or internship experiences can be viewed as colonising if the training and experiences are not embedded in the overall practices (Goodman et al., 2015, Location 4396*). Finally*, political engagement and advocacy is the ethical responsibility of counsellors and psychologists to learn and think deeply about the social, political and public policy issues that impact the lives of non-dominant individuals and groups (Goodman et al., 2015, Location 4472). If counsellors and psychologists are engaged with the well-being of their clients, they must act against injustices. Aligning the decolonisation of training and practice should occur in conjunction with the relevant regulatory body code of ethics and training standards.

1.4.2 Understanding Intersectionality

Intersectionality is a framework that helps to address the complexity of identity and experience in systems of oppression (Shlasko, 2015). Systems of oppression, such as racism, heterosexism, ableism and so on, are systemic directional power relationships among social identity groups, in which one group benefits at the expense of other groups (Adams, Bell, & Griffin, 2007). These systems are complex with multiple and interlocking interactions. The term "intersectionality" was first attributed to American critical legal race scholar Kimberlé Williams Crenshaw. The concept was used to describe the multidimensionality of the lived experiences of women of colour in contexts of sexism and racism (Crenshaw, 1989, 1991). Some scholars trace the earliest articulations of intersectionality further back to the manifesto of the Combahee River Collective, a group of Black, lesbian-identified feminists, who in 1977 said: "We … find it difficult to separate race from class from sex oppression in our lives they are most often experienced simultaneously" (see Eisenstein (1978) as referenced in Timothy, 2019). The women were highlighting that they had multiple interrelating components of their identity, and that each component intersected with others to produce a nuanced and multidimensional lived experience. For example, the experiences of oppressions faced by being a Black lesbian may differ from those experienced by a Caucasian lesbian. Hankivsky (2014) states, "according to intersectionality perspective, inequities are never the result of single, distinct factors. Rather, they are the outcome of intersections of different social locations, power relations and experiences" (p. 2). This is echoed by Rodó-de-Zárata (2014), describing intersectionality as developing out of a growing recognition that it is not possible to separate identities of gender, race, class and sexuality and explain them through a single framework. Intersectionality has become an important framework in developing an understanding of multicultural perspectives in counselling and psychology. What is important to understand is that people typically do not fit neatly into a category, and having a broader understanding of individual experiences of who they are is important in counselling and psychology.

To that point, Hankivsky (2014) describes the Principles of Intersectionality which can provide a guide to "doing" intersectionality informed work. *Intersecting Categories* acknowledges that human lives cannot be reduced to single categories in understanding individual's needs and experiences. Intersectionality conceptualises social categories as interacting with one another to create unique social locations that vary according to time and place. *Multi-level Analysis Intersectionality* describes understanding the effects between and across various levels in society, including global- and national-level institutions and policies, regional-level institutions and policies, and community-level grassroots institutions and policies, as well as the individual level. Attending to this multilevel dimension of intersectionality also requires addressing processes of inequity and differentiation across levels of structure, identity and representation (Sue, 2001). *Power Intersectionality* operates at multiple levels, includes some knowledges, and shapes positions of privilege and penalty between and within groups (Harro, 2008). From an intersectional perspective, power is relational and individuals can experience varying levels of power and oppression at different times. *Reflexivity Intersectionality* recognises multiple truths and a diversity of perspectives which gives added space for voices that are often silenced. *Time and Space Intersectionality* emphasises the importance of time and space in any analysis. How we experience and understand time and space depends on when and where we live and interact. *Diversity of Knowledges Intersectionality* is concerned with theories of knowledge and power and the relationship between power and knowledge production, including the perspectives and worldviews of people who are typically marginalised or excluded in the production of knowledge. *Social Justice Intersectionality* challenges inequities at their source and requires questioning social and power relations. It is also about creating new ways of thinking to problem solve and change systems. *Equity Intersectionality* is tied to social justice and is concerned with fairness. Inequities exist where differences are unfair or unjust. This principle is not looking only at a single equity, but also at the impacts of the intersections of multiple positions of privilege and oppression. *Resistance and Resilience Intersectionality* can disrupt power and oppression. Intersectionality highlights multiple, intersecting identities along with associated power dynamics, and they have unique experiences with privilege and disadvantage because of those intersections. "Given its activist roots, focusing on systems of oppression and the need for structural change to promote social justice are central components of intersectionality" (Rosenthal, 2016, p. 475).

The framework of intersectionality assists in transcending conceptualisations of oppression organised around single axes of identity (McDowell & Hernández, 2010). Intersectionality offers an interpretive framework to identify individuals' or groups' intersections of privilege and oppression. This framework can potentially build knowledges required for social change (Hernández-Wolfe, 2011). Therefore, counsellors and psychologists using an intersectional framework can recognise the complex and cumulative ways in which the effects of multiple forms of discrimination (such as racism, sexism and classism) combine, overlap or intersect—especially in the experiences of marginalised individuals or groups. Collins (1998) as referenced in Hernández-Wolfe (2011) explains that looking at intersecting identities "highlights how social groups are positioned within unjust power relations, but it does so in a way that introduces added complexity to formerly race-, class-, and gender-only approaches to social phenomena" (p. 298). Intersectionality focuses on interlocking systems of oppression as experienced by the individual or group, and the need to work towards structural-level changes to promote social justice and equity (Rosenthal, 2016). It is important to understand that intersectionality is not just about focusing on multiple identities but it is also about addressing change.

Intersectionality is reflected in the manner in which it encourages counsellors and psychologists to engage beyond symptom reduction and interventions. For example, using a framework of intersectionality in counselling and psychology might shift a diagnosis and assessment of depression using the *Diagnostic and Statistics Manual of Mental Health* (American Psychiatric Association, 2013) for a biracial lesbian to understanding the multiple oppressions experienced and culturally bound nature of mental health symptoms. The client's gender, sexuality, age and ethnicity and how these components of their identity intersect produce a unique life experience that should be considered in the client's care. As a counsellor or psychologist, considering how expressions of sexuality might be impacted by other locations (e.g. age, race, life stage) and debunking assumptions about women's emotional health and how depression may intersect with other social determinants (e.g. socio-economic status). Intersectionality encourages clinicians to "attend to the connections of individuals' intersecting identities with societal structures that create experiences of both privilege and oppression, as well as to consider the potential role clinicians can play as activists" (Rosenthal, 2016, p. 478).

1.4.3 Reflexivity and Self-Awareness in Counselling and Psychology

Reflexivity is the process of becoming self-aware and acknowledging the effect of your position in the world. Self-awareness has been identified as being a critical component of effective counselling and psychotherapy. Pieterse, Lee, Ritmeester and Collins (2013) quote Edwards and Bess (1998) in stating that "the development of a therapist's self-awareness must carry at least as much weight in his or her professional education and training as the accumulation of knowledge about theories and methodologies" (p. 191). In fact, the person of the therapist has been widely acknowledged as critical in the process of effective counselling and psychotherapy and has been referred to as "self as instrument" (McWilliams, 2004). It is through the counselling relationship where change and growth are experienced. Pieterse et al. (2013) define self-awareness as a "state of being conscious of one' s thoughts, feelings, beliefs, behaviours and attitudes, and knowing how these factors are shaped by important aspects of one's developmental and social history" (p. 191). Counsellors' and psychologists' self-awareness matters because they may experience a range of emotional reactions to clients in the therapy process and therefore need to make sense of their own responses and reactions to be able to work effectively with their clients. Counsellors and psychologists may also discover that their values and worldviews will be challenged as a result of working with clients, and they are encouraged to develop reflexivity and openness to understand how their own values might influence the therapeutic process. Approaches to developing self-awareness of counsellors and psychologist in training programmes typically include personal development groups, individual counselling and supervision.

1.4.4 Reflexivity and Self-Awareness in Multicultural Counselling and Psychology

Self-awareness specific to developing multicultural perspectives and competence has focussed on the counsellors' awareness of their worldview, bias and reactions to clients who are different from themselves and how to manage those interpersonal relationships (Arredondo et al., 1996; Sue et al. 1992). The importance of self-awareness in developing multicultural perspectives in counselling is well established; however, the caution here is that training programmes may have inadvertently reinforced Eurocentric perspectives that perpetuate a colonial mindset where the focus has been placed on existing norms and the position of the counsellor. Current multicultural research supports reflexivity and self-awareness including an emphasis on developing attitudes, beliefs, knowledges and skills; however, adding that meaningful engagement with individuals and communities needs to go beyond the counsellor observing others (Goodman et al., 2015). Comstock et al. (2008) refer to multicultural counselling competencies as being “grounded in an awareness and knowledge of the ways in which cultural oppression, marginalisation and various forms of social injustice lead to feelings of isolation, shame and humiliation among persons from devalued groups” (p. 280). The authors suggest the result of these oppressions causes disconnections and power differentials resulting in health disparities and other social injustices. Comstock and colleagues state that we are “mutually challenged to collectively work through the results of historical mistrust that have been engendered between persons in different racial and cultural groups” (2018, p. 284). The authors discuss the importance of expanding beyond cultural competencies of self-awareness, cultural knowledge and skills by creating and participating in growth-fostering relationships which are essential dimensions of human development and psychological well-being. Further, by being aware of the psychological impact of oppressive cultural contexts, counsellors’ can more effectively work with clients by fostering relationships that promote resilience.

1.4.5 Transformational Learning Approaches to Reflexivity and Self-Awareness in Multicultural Counselling and Psychology

As previously stated, developing self-awareness and self-reflection in counselling and psychology can include personal development groups, individual counselling and supervision. These activities are often experienced as transformative for individuals because they make meaning of experiences and challenge thoughts, beliefs and behaviours. Transformational learning theory describes the process whereby a person learns to question their perspective, beliefs, attitudes and values (Mezirow, 1991). Transformational learning theory acknowledges that epistemic thinking and meaning making develop when cognitive dissonance occurs (Vesely et al., 2017). Mezirow (1991) describes that particular points of view can unwittingly become deeply ingrained and that it takes a powerful catalyst, such as a forceful argument or a disorienting dilemma, to shake them. What this means is that we develop ways of knowing and these ways of knowing inform beliefs, attitudes, values and behaviours—these ways of knowing are not typically questioned unless they are challenged. It is not uncommon that having one’s beliefs, attitudes, values and behaviours challenged can be experienced with alongside some defensiveness and resistance. Epistemic thinking, as it relates to multicultural counselling and psychology, serves as a foundation to invite open and reflexive thinking and to develop cultural humility through understanding and experiencing intellectual and cultural traditions different from Eurocentric knowledges that have been pervasive in the mental health fields. Transformational learning processes intentionally designed to develop cultural humility support the counsellor and psychologists’ reflexivity and self-awareness in multicultural perspectives.

The use of transformational learning activities supports this process through active personal involvement in learning where a willingness to participate in self-examination, engagement and sharing can occur. In addition to developing self-awareness through personal development groups, individual counselling and ongoing supervision, example of transformational learning towards multicultural perspectives can include viewing movies depicting real life stories of oppressed individuals and groups, or activities where the learner is directed to look through a different lens to see individuals and situations from a new perspective. Additionally, immersion programmes where meeting with individuals and disenfranchised groups and their environments (e.g. where people live, worship, work) can be valuable and transformative. However, in all cases transformational learning must include challenging the beliefs, attitudes and values of the learner. This creates opportunities for reflexivity, as well as discussion and debriefing to allow for a depth of understanding about oneself and about others as opposed to a position of observation. It is through these transformative learning processes that the counsellors' self-awareness will develop and genuine relationship connections will occur, in turn breaking down power differentials. Further, according to Adams et al. (2007), individuals are more likely to engage in social action when they feel emotionally connected to the people and issues at hand.

1.5 Conclusion

Multicultural perspectives in counselling and psychology training should invite philosophical and educational understandings that encourage critical consciousness of social justice issues through genuine dialogue, questioning, creativity and transformational ways of learning. In order to avoid minimising, stereotyping and "othering" individuals and non-dominant groups training should not be viewed as a one-off course, rather an ongoing and reflexive process.

The therapeutic relationship is critical in the change process, and therefore, the counsellors' and psychologists' self-awareness is important to establish genuine connections with clients and in social activism. Transformational learning activities can support this process through active personal involvement in learning where willingness to focus on self-examination, engagement and sharing can occur. For transformational learning to be effective, counsellors and psychologists need to assess their attitudes, beliefs, values and assumptions and the consequences of these assumptions.

In the following chapters, Postcolonialism—Indigenous Australians, Racism, Classism, Sexism, Cisgender and Heterosexism, Ageism, Ableism, Sizeism and Religious Hegemonism will be critically examined. Although these chapters have been grouped together under specific "isms", we recognise the impossibility of narrowly confining the content of these chapters. By grouping these "isms", we provide an entry point for understanding and discourse. It is abundantly clear that individual narratives represent multiple aspects of identity and experiences and cannot be reduced to labels or groups. The intersections of society, power, privilege, oppression, knowledges, race, gender, sex, age, ability, age and religious affiliation often simultaneously impact the identity and experiences of individuals. Each chapter consists of three parts: part one will commence by contextualising the topic by researchers and scholars. Part two includes current affairs articles and reflective essays where individuals share stories about their identities and experiences, and part three introduces transformational learning activities to cultivate further insight, engagement and understanding of oppressions and multicultural experiences.

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Post-Colonialism (Aboriginal and Torres Strait Islanders)

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V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_2

Trailer

In this chapter, Noritta Morseu-Diop talks about the ongoing effects of colonialism and the need to put aside pre-conceived ideas and build trust and rapport when working alongside Aboriginal and Torres Strait Islander people. Corrinne Sullivan reflects on her confusing and sometimes haphazard experiences in 'Western' education. And finally, Sharlene Cruickshank describes both personal and professional experiences as an Aboriginal woman working in mental health.

2.1 Introduction

Vicki Hutton

Australia's Indigenous peoples comprise two distinct cultural groups made up of Aboriginal and Torres Strait Islander peoples. The Australian Bureau of Statistics (ABS) reports over 649,000 people living in the major cities, regional and remote areas of all states and territories identify as Aboriginal and Torres Strait Islander peoples (ABS, 2018a). This is approximately 3.3% of Australia's resident population.

Definition

According to s51 (25) of the High Court of Australia (1983), defining 'Aboriginal and Torres Strait Islander peoples' is based on three key points: descent, self and community. This is clarified in the following definition: 'An Aboriginal or Torres Strait Islander person is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander (person) and is accepted as such by the community in which he or she lives' (Queensland Health, 2019). This three-part definition received some debate in the 1990s when it became evident that it was open to different interpretation around which criterion—descent, self or community—was the most important if all three could not be confirmed (Gardiner-Garden, 2003).

Irrespective of legal definitions, there is great diversity within these two groups of First Australians, as evidenced by over 250 different language groups across the nation, and laws and customs to determine membership of specific groups (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2018).

Statistics

One issue common to both Aboriginal and Torres Strait Islander peoples is their continuing reduced life expectancy at birth compared to non-Indigenous Australians. In 2015–2017, life expectancy of Aboriginal and Torres Strait Islander men was 8.6 years lower than non-Indigenous men, and life expectancy for women was 7.8 years lower than non-Indigenous women (ABS, 2018b). In remote and very remote areas, these differences became more evident, with differences at birth for the

Aboriginal and Torres Strait Islander groups being 13.8 years lower for men and 14 years for women compared to non-Indigenous Australians.

At the other end of the lifespan, child mortality amongst Aboriginal and Torres Strait Islander children aged 0–4 years remained higher than amongst non-Indigenous Australian children in 2017 (Australian Institute of Health and Welfare, 2018). Identified as a crucial target for change in the Federal Government's 'Closing the Gap' agenda, the 2017 data analysis indicated there was still almost 90 deaths per 100,000 more among Aboriginal and Torres Strait Islander children compared to non-Indigenous children.

Globally, the United Nations estimates there are more than 370 million Indigenous peoples living in 70 countries. Many retain their own unique knowledge systems, beliefs and traditions and importantly, a special relationship to their ancestral lands, waters and territories which is of fundamental importance for their physical, emotional and cultural survival (AIATSIS, 2018). This is evident in Australia where Aboriginal and Torres Strait Islander peoples may refer to themselves by names relevant to the greater region they are connected to (e.g., Koori, Murri or Nunga), a geographic location, or with names that relate to the environment in which they live (e.g., 'saltwater people', 'freshwater', 'rainforest' or 'desert'). All this highlights the strong connections Aboriginal and Torres Strait Islander peoples retain to their lands, and the implications of not understanding this connection, or removing a person from this connection.

Developing sensitivity when working with Aboriginal and Torres Strait Islander peoples must therefore occur at a range of overlapping and interconnected physical, emotional, social, historical and environmental levels that may seem overwhelming at first. Attempts to develop a 'one size fits all' response will fail to capture the diversity and uniqueness of each person and group identifying as Aboriginal and Torres Strait Islander persons. This is crucial when considering the mental health statistics of this group.

Australia's *Fifth National Mental Health and Suicide Prevention Plan* draws attention to the untenable and profound levels of distress among Aboriginal and Torres Strait Islander individuals, families and communities (Department of Health, 2017). The Plan reports that Aboriginal and Torres Strait Islander adults are almost three times more likely to experience high or very high levels of psychological distress, and have twice the rate of suicide, compared to non-Indigenous Australians. They are also hospitalised for mental and behavioural disorders at almost twice the rate of non-Indigenous people.

Statistics

The 2014–2015 National Aboriginal and Torres Strait Islander Social Survey (ABS, 2016) provides a range of information into the wellbeing of Aboriginal and Torres Strait Islander people aged 15 years and over who self-reported being told by a doctor or nurse that they had a mental health condition (i.e., depression; anxiety; behavioural or emotional problems; and/or harmful use of, or dependence on drugs or alcohol). Based on this criterion, 29% of Aboriginal and Torres Strait Islander people self-reported as having a mental health condition. Approximately 23% reported both a mental health condition and one or more long-term physical health conditions. Mental health conditions were less likely to have been reported by young people (22%) compared to older age groups (30–35%), and more likely to be reported by females (34%) compared to males (25%). Mental health conditions were also reported among twice as many Aboriginal and Torres Strait Islander people in remote areas (33%) compared to non-remote areas (16%).

A strong cultural identity and connections to country, family and community were identified as protective factors, countered by the commonly cited stressors of: serious long-term illness, alcohol and drug-related problems; overcrowding at home; being treated badly and/or discrimination; unemployment; poverty; isolation; trauma and trouble with the law (ABS, 2016). In addition, having been removed, or having had relatives removed, from their natural family was cited more often among those with a mental health condition (50%) compared to those with a long-term physical health condition (42%) or no long-term health condition (34%).

Despite there being a clear need for support, there is evidence that Aboriginal and Torres Strait Islander peoples have lower than expected access to mental health services and professionals (Department of Health, 2017). Some barriers to accessing these services include the cost of health services, the cultural competence of the service, remoteness and availability of transport, and the attitudes of staff. Experiences of discrimination, victimisation and exclusion played a significant role in whether Aboriginal and Torres Strait Islander individuals attended health services, and their acceptance and adherence to treatment.

Given the strong connection of Aboriginal and Torres Strait Islander peoples' wellbeing to spiritual and cultural factors, especially connection to the land, community and traditions, it is evident that culturally informed mental health services are essential. Services that respect this holistic concept of health and respect traditional and cultural healing are fundamental to maintaining an Aboriginal or Torres Strait Islander person's social and emotional wellbeing. Where non-Indigenous mental health practitioners interpret symptoms within the Western medical model rather than the complex Indigenous socio-cultural context, there can be misdiagnosis and/or non-adherence to treatment. Therefore, inclusion of Aboriginal and Torres Strait Islander people in planning and implementing mental health services, as well as training non-Indigenous staff to better understand how to respect and incorporate culture into therapy, is crucial to building culturally respectful and effective models of care.

2.2 Post-Colonialism: The Myth

Noritta Morseu-Diop

The term ‘post-colonialism’ is synonymous with the after effects of colonisation in a former colony (Morseu-Diop, 2010). History tells us that Lieutenant James Cook landed in North Queensland in 1770 and Governor Phillips arrived in Botany Bay in 1788 (Bennett, 2013; Morseu-Diop, 2017). These historical events have also placed the idea in the minds of many Australians that colonialism ended when this country was “discovered” and settled. In actual fact, this notion is far from the truth.

In reality, Aboriginal and Torres Strait Islander Peoples continue to live under a colonialist regime brought to their Land and Islands by the first boat people (Hagan, 2017). Colonialism is still ongoing and continues to be a debilitating factor in their lives today (Elder, 2003; Green & Baldry, 2013; Phillips, 2003).

Therefore, as a First Nations Australian, I declare that post-colonialism is a myth. For us First Nations Australians, colonialism is still here, we are still being colonised (Heiss, 2012). More precisely, hegemonism is alive and well and exists on all levels of Australian society (Morseu-Diop, 2017).

This chapter will shed light on the post-colonialism myth and it will bring to the forefront the myriad of challenges facing social workers, allied practitioners and all those who wish to work with First Nations Australians. I will begin this discussion with an excerpt from my book, *Healing in Justice: Giving a Voice to the Silent and Forgotten People* (Morseu-Diop, 2017).

2.2.1 The House on the Hill

Quote

> » There was once a big house that stood on a small hill, overlooking the beautiful green valley and the gentle flowing river down below. Blue mountains in the horizon, stood regal and strong as they stretched endlessly into the sunset as far as the eye could see. In this house lived a mother, a father and their six children. The father and mother were avid gardeners and planted many fruit and nut trees and root vegetables around the house. The family lived there happily, they ate the fruit, nuts and vegetables from their garden and they caught fish, yabbies, eels and mussels from the river, they were proud, healthy and strong.
>
> » Then one day, another family walked past their house and they saw that the land was good, and this house on the hill had everything they’ve always wanted. Even though they knew that the house on the hill, the river and the surrounding valley belonged to someone else, they decided that they wanted this house, they wanted this land and so they took their guns and shot and killed the father, the mother and four of the children. The other two children were down in the valley and saw what had happened, so they ran in fear for their lives and hid in the mountains.

> » The new family then moved into the house on the hill and lived there. They ate the fruits, vegetables, nuts, fish, mussels and yabbies to their hearts content and they were very happy. A couple of years later, the two children that ran away, decided to go and check on their house on the hill and see who is living there now. They had been living in abject poverty up in the mountains and now cold, destitute and hungry, they went up to the front door of the house that was once theirs and knocked on the door.
>
> » Upon hearing the knock on the door, Mr. Cook opened the door and asked, "What can I do for you?" The children then replied, "Please sir, we are cold and we are hungry, can you help us?" Mr. Cook replied, "of course! James go and gather some fish and mussels for these poor souls. Matilda, go and pick some fruit for them. Mrs. Cook, bring some spare clothes and blankets for these two, they look very sickly indeed!"
>
> » So, James gave them some fish, yabbies and mussels from their river and Matilda gave them the fruit, nuts and vegetables from their parent's garden and Mrs. Cook brought them some blankets and gave them their own clothes to wear (Morseu-Diop, 2017, pp. 25–26).

The House on the Hill story noted above depicts the impact of colonisation on the lives, land and livelihood of Aboriginal and Torres Strait Islander Australians. It depicts the theft of their land and islands and the disruption to their ways of being and highlights the gross injustice meted out upon them since the dawn of colonisation in Australia (Gapps, 2018; Moses, 2004; Trigger, 2010).

Furthermore, it indirectly highlights the current mentality and attitudes of the racists in Australia, the notion that they have already given enough to First Nations Australians and poses the question, "How much more do we owe them?" When in reality what they have given already belongs to First Nations People, and it is merely a teardrop in an ocean (Morseu-Diop, 2017). No amount of money can ever compensate what has been lost; the magnitude of the loss is incomprehensible.

I ponder and reflect on the thoughts of my Ancestors at the arrival of Lieutenant James Cook who took possession of the east coast of Australia for King George III from the shores of Bedanug or Bedhan Lag, a tiny island in the Torres Strait renamed by Cook as Possession Island. I also wondered about the perception of the Eora Nation when the Tall Ships arrived into their waters in 1770.

For mainstream Australians, the 26th of January marks a day of celebration, with festivities around the country marking the arrival of Governor Phillips into Botany Bay on the First Fleet (Gapps, 2018). However, First Nations Australians perceive this day as a day of mourning. This day heralds the beginning of the massacres, mass incarceration and wars that decimated whole communities of Australia's First Peoples, starting in Botany Bay and spreading throughout the continent (Elder, 2003; Harding, Broadhurst, Ferrante & Loh, 1995; Richards, 2008; Trudgen, 2004). For First Nations Australians, the 26th of January is perceived as Invasion Day or Survival Day. For us, genocide is alive and well in Australia even until this day (Morseu-Diop, 2017).

2.2.2 The 'Benefits' of Living Under a Colonialist Regime

There is a perception that the arrival of the colonisers was indeed a blessing to Aboriginal and Torres Strait Islander Peoples because the colonisers developed the land and brought in all of the modern conveniences and the technology that are enjoyed today. Furthermore, First Nations People are recipients of special benefits for everything from health and housing, to education and employment, and more. The two questions I ask here are, "How has the past and current colonialism been a blessing to First Nations Australians?" and "What types of benefits have First Nations Australians received since the arrival of the colonisers?"

In retrospect, Aboriginal and Torres Strait Islander Peoples lived long and healthy lives, they were strong in their cultural ways of being. They were a healthy and happy people, self-sufficient, living off the land and sea. They lived in what could be described as "paradise on earth". They had complex cultural systems and lores guiding their customary practices. Each Nation had their own laws governing their behaviour and conduct, wrongdoers were dealt with according to their own customs and traditions and there were no prisons (Morseu-Diop, 2010). Their spirituality and ways of being were and continue to be deeply connected to their Ancestors and embedded in respect for Mother Earth (Morseu-Diop, 2017).

Today, Aboriginal and Torres Strait Islander Peoples are continuously dealing with the past and present consequences of colonialism. They are Australia's most disadvantaged people. They are stricken by poverty and ill-health and die 15 to 20 years before their mainstream counterpart. First Nations Australians are struggling to maintain their cultural ways of knowing and cultural ways of doing within the confines of the current political, societal and economic agenda of the colonialist government (Phillips, 2003). They are a disenfranchised and disempowered people in their own country due to the implementation of racist policies serving to subjugate them on all levels. I reiterate that the present colonialist regime have disrupted their traditional customs and cultural ways. Colonialism continues to bring immense devastation to the lives, livelihood and subsistence of Aboriginal and Torres Strait Islander Peoples throughout the country. This is hardly beneficial, nor is it a blessing.

2.2.3 Exploitation of the Natural Resources

Since the arrival of the First Fleet to this present day, First Nations People have witnessed first hand the degradation and destruction of their natural environment and resources (Reynolds, 2003). The vast wealth and riches of this country have been acquired through the exploitation of the land and resources stolen from Australia's First People (Morseu-Diop, 2017).

Australia is currently a leading exporter of coal and gas and other minerals, all of which are being extracted from stolen land. Hence, the colonisers have become extremely wealthy from the mining industry, the fishing industry, the farming industry, the gas/fracking industry and the past whaling, pearling and sealing industries just to name a few (Altman & Kerins, 2012; Neumeier & Schaffer, 2014).

Alarmingly, the ongoing extraction of resources from the natural environment has caused insurmountable, if not irreversible, damage to the land, rivers, lakes, estuaries, creeks, reefs, ocean and sea. The Australian rivers, streams, creeks and estuaries are polluted. For example, in Queensland, there are approximately 40,000 fracking wells (J. Buckingham, Former Greens MP, personal communication, 2016). The fracking industry has caused ground tremors and earthquakes and poisoned the land and rivers.

The ongoing environmental carnage and degradation has brought irreparable destruction to traditional homelands. Aboriginal and Torres Strait Islander Peoples have been actively fighting to preserve their lands and homelands for their grandchildren's grandchildren.

All over Australia, First Nations people are taking a stand to preserve their homeland and environment. For example, the Wangan Jagalingou people of the Galilee Basin are currently battling to protect their homelands from the mining giant Adani. Adani has been granted permission by the federal and state governments to commence their coal mining industry at the Carmichael coal mines in the Galilee Basin of Central Queensland (Wangan Jagalingou Family Council, n.d). The federal government has also granted Adani unlimited access to water for the next 60 years. The Galilee Basin sits directly on top of the Great Artesian Basin, Australia's major underground water source. It is envisaged that the poisons from the Adani mines will contaminate the Great Artesian Basin, which will impact adversely on the natural environment, including the lives and livelihood of all Australians.

Furthermore, the people of the low lying islands of the Torres Strait archipelago are taking a stand and lodging a complaint against the Australian government at the United Nations Summit for their failure to address climate change and its impact on their island homeland. Rising sea levels have threatened the subsistence of Torres Strait Islanders, and the Australian government has turned a blind eye on the highly critical issue of climate change. This ongoing struggle to protect their homelands has caused immense trauma, grief, loss and ongoing physical, social and emotional ill-health amongst First Nations Australians. In addition, the colonialists' descendants have not only benefited immensely from the sins of their forefathers, many are also following in their footsteps.

2.2.4 A One-Sided Story

I reflect on the stories that have been told or should I say not been told about First Nations People. Since their arrival on this land, the colonisers have set the template for the history of Australia. The history has been told through their eyes (Anderson, 2003), but the Australian story has been a one-sided story, the story of the colonisers (Huggins, 1998). It has been about their achievements, their successes, their goals and their victories. Their history asserts that they came in "good faith" as if we did not exist; they settled, built and developed the land with their own blood, sweat and tears.

In reality, there were frontier wars when the colonisers arrived. Aboriginal people fought hard for their land and country, but their spears could not withstand the colonisers' guns (Gapps, 2018; Reynolds, 2003). Furthermore, this one-sided story was written without acknowledging the contribution of Aboriginal, Torres Strait Islander and South Sea Islander Peoples in the building of this country. First Nations Australians and South Sea Islanders were instrumental in the building of Australia.

In addition, the story in the history books has been about the colonisers' pain and suffering. It is about the battles that they fought and won to protect the land they named Australia. They commemorate their ANZAC Day annually, and they remember their dead who fought in Gallipoli. The Australian history books and classroom education from Primary School to High School have deliberately omitted the stories of the First Peoples of this country (Kidd, 2002). They deliberately omitted the contribution of Aboriginal and Torres Strait Peoples who fought for this country and died in the war.

Aboriginal and Torres Strait Islander Peoples are now writing their own stories and recording their own history and telling their side of the story. They contributed immensely to the development of this land, and the majority of this contribution has been through 'slave labour'. For example, Torres Strait Islander People were actively involved in the railway industry, breaking the world record in the Pilbara, Western Australia, for laying down 7 km of railway track in 11 hours and 40 minutes compared to the previous US world record of 4.6 km set in 1962 (Lui-Chivizhe, 2011). They also laid down 400 km of track between Mt. Newman and Port Hedland in Western Australia in just 9 months. The non-Indigenous men would have found this work unbearable in the extreme Western desert sun.

The Torres Strait Islander men worked under extreme heat, and the work was backbreaking. On the 22nd of September 2012, a statue was erected to honour the Torres Strait Islander men who worked on the railway tracks, a clear example of our contribution to the building of this country (Lui-Chivizhe, 2011).

Australians use the 50 dollar note every day, but very few of them know the identity of the Aboriginal gentleman depicted on this note. The Aboriginal person depicted on the Australian currency is David Unaipon (1872–1967). He was born on 28 September 1872 at the Point McLeay Mission, South Australia, fourth of nine children of James Ngunaitponi, evangelist, and his wife Nymbulda, both Yaraldi speakers from the lower Murray River region. He was a preacher, author and an inventor. He had approximately 19 inventions, and one of them is the shears for shearing the fleece of the sheep brought to this country by the colonisers. David Unaipon was an extremely skilful man with a brilliant mind and he was referred to as the black Leonardo Di Vinci (Jones, 2019).

First Nations Australians were actively involved in the labour force as domestic servants and in the pastoral industry and in the mining industry and in the Australian armed forces fighting for Australia on home soil and overseas just to name a few. The sickening reality is that Aboriginal and Torres Strait Islander Peoples were paid pittance for the amount of work they carried out to build this country and to represent this country in the war; hence, I describe this as slave labour.

Moreover, due to the extreme heat in Australia, the colonisers brought other slave labour from the South Pacific Islands to work in the sugar cane industry in a practice known as blackbirding.

Racist government policies have kept First Nations Australians at the very bottom rung of the political and economic ladder. These colonial processes have meant that colonialism is still here, it has not gone away and it is not over. Aboriginal and Torres Strait Islander Peoples are still experiencing the ongoing damaging effects of colonialism in all aspects of their lives (Hagan, 2017). These experiences have impacted significantly on their social, emotional, cultural, spiritual, psychological and mental health and wellbeing (Bird, 1998; Fejo-King, 2015a, 2015b; Morseu-Diop, 2017).

With racist government policies came the removal of children from their family, also known as the Stolen Generation (Garimara, 1996; Moses, 2004; Ranzijn, McConnochie & Nolan, 2010). From the 1900s to the 1970s, the removal of Aboriginal and Torres Strait Islander children was a common practice causing widespread trauma, loss and grief. Today, children facing out of home care are being removed from their family and community network and placed in non-Indigenous foster care, all of which are sanctioned by the government; hence, this practice has been branded as the new Stolen Generation (Bird, 1998).

In reality, many people in the Aboriginal and Torres Strait Islander Community are suffering from intergenerational grief, loss and trauma due to the unjust policies and practices of this colonialist regime (Boulton, 2016; Hegarty, 2015; Wingard & Lester, 2001). For many, these practices and policies have caused a wounding of the soul and a breaking of the spirit (Morseu-Diop, 2017; Garimara, 1996).

2.2.5 Personal Experiences of Ongoing Colonialism as a First Nations Australian

Looking back over the last 50 years, I reflect on my own life journey under the colonialist regime. I was born on Thursday Island, situated in a remote community in far North Queensland in the Torres Strait archipelago. I was raised on Tamwoy Town reserve during the time of the Assimilation Policy. Going to school, I did not understand the policies that separated children according to our cultural heritage. First Nations children were separated from the others and placed in a different class. We were not allowed to speak our own language at school. Those children who were caught speaking their language were sent to the office to be caned. As a child, I observed that all of the non-Indigenous people living on my island were all very affluent. They were described as ‘rich’ by my grandmother—some owned big fishing boats, and they lived in beautiful homes and were all gainfully employed.

My grandfather was the son of a Rotuman pearl diver and was not under the Act, and was able to buy land, which was allotted to him and his brothers on Tamwoy Reserve. As for my family, we lived in a two roomed house that my grandfather built and we had no running water, refrigerator or electricity and we had a wood stove for cooking and we collected rainwater for drinking in two 44 gallon drums. For washing our clothes, we walked down the dirt path to a well where we collected water not only for our washing but also for our baths.

On Tamwoy Reserve, there was a Native Police as they were called, to monitor everything and everyone (Richards, 2008). A big black police van called locally known a black mariah would come onto our reserve frequently to keep everyone in order and to usurp their authority. There was a curfew too, and those who did not keep the curfew were locked up in the watch house, and if they were unlucky, they would be sent down to Palm Island Mission and other faraway places, far from their loved ones.

My grandmother suffered from mental illness and was a ward of the state. She was sent down to Cherbourg where she spent a number of years in the single women's dormitory, and she gave birth to her son in Cherbourg.

I remember going to the general store with my grandfather to purchase some groceries, and I did not see any exchange of money between my grandfather and the storekeeper. My grandfather simply wrote his initials on a type of logbook, and we were then allowed to 'purchase' some potatoes, rice, sugar and flour.

As a child growing up I had no understanding of the assimilation and segregation policies of the government during that time. I could not comprehend why all of the different Nations of Aboriginal and Torres Strait Islander Peoples lived together on Tamwoy Reserve at the back of the Island. It was only through my Aboriginal Studies course at the University of Queensland that I was able to learn about the true history of Australia and the plight of Aboriginal and Torres Strait Islander Australians.

Learning about the true history of this country not only opened my eyes to what really happened during my growing up years; it also opened up a pandora's box to the current living reality of all First Nations Australians. They were and are disempowered, and they have no voice in decision-making about their lives, their livelihood, their land, their islands and their community. All of the decisions impacting on their lives and ways of being are made for them by the colonisers. It gave meaning and understanding to the terrible inferiority complex that plagued my life from childhood to adulthood and still raises its ugly head and impacts on my psyche today.

2.2.6 Building Bridges

Working as a social worker or allied practitioner within a colonialist construct and finding ways to build bridges, the late Dr. Ranginui Walker said, "In order for Māori people to have good mental health and well-being, Pakeha people need to view us as their social and intellectual equal" (R. Walker, Wellington School of Maori Studies, personal communication, 2006, n.p.). Although Dr. Walker was referring to the situation for Māori people, I believe his words of wisdom are also relevant for working with Aboriginal and Torres Strait Islander Peoples. I highly recommend that you take heed of his words when you come into our community.

Working as a social worker within a colonial construct has opened my eyes to the degree of hopelessness and helplessness faced by Aboriginal and Torres Strait Islander individuals and families on a day-to-day basis. There is a sense of melancholy that exists in the Indigenous community throughout this country. At times it is difficult to measure the wave of grief, loss and trauma constantly flowing in the community like the ocean. It comes in and washes over you and it goes out and comes back again and again and again, it is never-ending (Morseu-Diop, 2017). These are the things that I had to understand first and foremost; I had to learn ways in which to break into that shell surrounding my clients that had become so hard due to the general feelings of mistrust towards social workers and the colonialists in general.

Hence, I ask this question, “How do we find a solution to work effectively in the Aboriginal and Torres Strait Islander communities?”

One of the first things that social workers and allied practitioners must be mindful of, when entering into our communities, is that Aboriginal and Torres Strait Islanders are still living under colonialism. They are the most disadvantaged group in Australian society today, due to the degree of losses faced by them since colonisation.

Important

An important factor to remember is that First Nations Australians are not homogenous. There are similarities as well as vast differences in each community. Be patient and ask questions. It’s okay if you don’t know, by asking questions, you will learn and you will know.

You may have read all the articles about the cultural ways of Aboriginal and Torres Strait Islander people; however, keep in mind that reading about us and working one-on-one with us at the coalface are two different things. In reality, you will be faced with many challenges; some of these challenges are the cultural norms, customary practices, non-verbal communication, multi-layered languages, idioms, body languages and more. A lot of this cannot be found in academic theses or books. You will learn from being at the coalface, sitting with Elders and becoming involved in hands-on work with First Nations individuals, families, groups and communities (Morseu-Diop, 2010).

Putting aside your pre-conceived ideas and coming in with a humble heart, patience and an open-mind and with a desire and a willingness to learn is a good start. Looking, listening and learning will help you significantly (Morseu-Diop, 2010). Building trust and building a rapport is paramount when coming into our communities to work alongside us. It is important to understand that there is no 10-point plan, and everything will not happen overnight. It can take months and even years, before you are accepted into our community.

Important

I will end with the words of our much-loved Elder, Dr. Aunty Lilla Watson, “If you have come to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together”.

2.3 Personal Stories and Current Affairs

2.3.1 Ending the Confusion: A Reflection of My Experiences in Australian Education Spaces

Corrinne Sullivan

Education. Learning and Teaching. Research. These are not new concepts for Indigenous Australians. We have been educators, learners, teachers, researchers and knowers since the beginning of time. My grandmother was my main teacher. Though when I was young I would sit on the ground with my great-grandfather who would tell tales of the ancestors, I remember them to be great stories that I would want to hear again and again. I now understand how those stories hold Knowledge, and that great lessons were being passed to me. I learnt how to read animals, how their movement would signify the weather or the season. I learnt how to find foods, and in which season certain foods could be found. I never mastered the ability to play the gum leaf, my great-grandfather was a pro, as a child I was sent for great walks to find a good leaf. I did not recognise then that I was learning country, feeling country and knowing country. After my great-grandfather passed, my grandmother took the role of imparting Knowledge to me, my siblings and my cousins. She would tell stories of the old days, as well as the story of the Dyirri-dyirri (Willie Wagtail). She would often remind us of how animals would communicate with us. Ants tell the rain story, birds bring us messages and cautionary notes. We were enriched with Knowledge, an education that was not contained by classrooms, chalkboards and curt teachers. My grandmother was a firm believer in education. Education was our ticket out. Out of what I was not sure. Education, albeit a 'Western' education, meant that we could play the game, the colonial project. You go to school, you get a good job (a good job is determined by income—not by how much but having one), marry, have children, die—masquerading in a White society that my body betrays.

Primary school and secondary school were bewildering entities for me and for most Aboriginal and Torres Strait Islander children. I was confused by the wonderment of the discovery of Australia by Captain Cook, a land I knew as existing from the beginning. I recall learning about the 'Aborigines'. A disembodied education filled with brown and black crayons, lap-laps, spears and cartoons of noble, savage, often singular, and always male, for my feeble fingers to colour. A confusing task, these caricatures only exist in 'Western' classrooms, they were not representative of me, my family or, in fact, any Aboriginal person I knew—Torres Strait Islanders were not represented, it was as if they did not exist. I was confused. In secondary school I confused others, my pride in my identity and culture became a source of my teenage rebellion, a way to be unique amongst my mostly Anglo-Saxon peers. I became both the Aboriginal expert in class at the same time as having to prove I was Aboriginal to both my peers and my teachers—how much? How authentic? How real was I? It would have been 'easier' to deny my Aboriginality, to be silent, to be invisible, the desirable figure in the colonial project. I was confused, they were confused. It was confusing.

In spite of my haphazard experiences in 'Western' education, I would later enrol in university study. I was at a crossroads in my life. I had a 'good' job, but I wanted more. I yearned for more. I feel sometimes that I am construed as the 'Aborigine' above my station, that I lost my place and that I forgot to be invisible. I guess my teenage rebellious streak was still firmly engaged. However, in my imagination, university would be the space that would nurture my thirst for more. I was excited and terrified. I was ready to learn and grow—I did, but not without some powerful and painful 'lessons'. I entered the illustrious halls of higher education believing that I would find a space of higher understanding, that academics would somehow be better than everyone else. Academics, I surmised, would be ultra-intelligent, clever and sophisticated, they would behold a kind of worldly knowledge that was to be revered. I had high expectations. I suspected such demi-gods of higher learning would know about Aboriginal people, about human rights, about building and guiding humanity to a better world. Instead, I learnt that even academics and the institutions in which they serve are not above racism and discriminatory practices.

At university I encountered classrooms filled with racism, at times subtle and casualised, other times, it was firmly directed at me. Although there are multiple stories to recall, one that stands out to me occurred in my first semester of study. I delivered a presentation to my class, my self-selected topic was on Aboriginal affairs. At the end of my presentation, just one question was directed to me. My lecturer asked, 'why do you still lay claim to your negroid gene'?. I was devastated and felt humiliated. Just like in primary and secondary school, I was both subject and object—it did not matter what I had said, only who I was, or should not be. I had not yet developed the language nor the muscle to respond. Yet it was obvious to me that I would have to fight if I wanted to stay. I was out of place. I was confused, they were confused. It was confusing.

Ironically higher education is where I make my living. I turned my anger and out of place-ness into my driving ambition. A need to prove that not only do Indigenous people belong in universities, but that we also have much to contribute, we have as much right to this space/place as everyone else. I am developing the language and the muscle to speak back. I will take up space and find ways to make space for others. I am not alone. I owe an enormous amount of gratitude to my Indigenous colleagues, those who have come before me, those that stand beside me. Our collective voice and support of each other are paramount. Seeing Indigenous faces and hearing Indigenous voices should not be underestimated. Most Indigenous Australian academics and students will probably recall similar feelings of unease, displacement and outright racism delivered within the sacrosanct halls of the Australian education system. From early childhood to tertiary education, there is a continuance of silence, ignorance and avoidance of all things related to Indigenous peoples, places and philosophies. However, Indigenous education or the education of Indigenous people is just one part of this story.

I have worked for many years teaching Indigenous Studies, influencing how students, both Indigenous and non-Indigenous view, experience and make sense of the world. More often than not students come to Indigenous studies feeling disorientated and bewildered. Out of place. Why had they not heard this before? Why was this their first experience of learning about the histories and contemporalities of Indigenous Australia? Buoyed by student outrage, I looked to the wider higher education sector noting that students are not given knowledge of Indigenous people, places and philosophies unless they are in specific courses. The need to include Indigenous Australian perspectives and knowledges across university curriculum is two-fold. Firstly, to provide Indigenous Australians with an avenue in which to learn and grow, and to position the Knowledges that they bring to the university space with value and respect. Secondly, to provide non-Indigenous students with an instrument in which to discover, learn and realise Indigenous Knowledge sets that both challenge and compliment 'Western' knowledge systems.

There is a real lack of Indigenous people, places and philosophies within Australian education curriculum. Indigenous content has been cited mostly in anthropological and historical texts written from the perspective of non-Indigenous scholars, this content formed what would be considered Indigenous knowledges and cultures within the curricula since they were introduced some 40 years after the first university in Australia was established. This limited and one-dimensional content would be taught in Australian universities right up to the 1960s. The evolution of curriculum change arose in 1961 with the establishment of the Australian Institute of Aboriginal Studies (AIAS) which was assigned the task of embedding Indigenous knowledges. As the new millennium approached, varying degrees of inclusion were witnessed in university curricula. Offerings across institutional degree programmes were often left to the goodwill of individuals, and rarely a systematic approach implemented. However, there has been a rise in advocation for inclusion of Indigenous Knowledges. In 2017, Universities Australia introduced their Indigenous Strategy 2017–2020, which outlined a collective intention to address the cultural capability of every graduate, bringing with it a dilemma in how to achieve the embedding of Indigenous Knowledges.

Indigenous Graduate Attributes were born of this era. Institutions are in the infancy of implementing these attributes. For the most part, the development and incorporation of Indigenous Knowledges have been the work of Indigenous academics. However, should institutions be serious about their commitment to implementing Indigenous Graduate Attributes, then that burden needs to be carried more systematically. At this point, there appears reluctance to embrace teaching about Indigenous people, places and philosophies more broadly. It would be my position that such discomfort stems from those that will need to do the most work. Largely non-Indigenous academics who are not likely to have been exposed to Indigenous Knowledges within their own programmes of study, or within their research. They simply do not know where to start, what to include and most likely afraid of what to say. Non-Indigenous academics are crippled by their inexperience. But we are no longer in an era where ignorance is tolerable. We all live in a time where information is at a click at the end of your hand. The writings by Indigenous scholars is but a Google away. This is not the time for cognitive dissonance. There is no time for confusion.

In the academy, Indigenous scholars are developing, advocating and implementing Indigenous Knowledges within their curricula. It is paramount that non-Indigenous academics look to Indigenous colleagues to guide and inform approaches to introducing Indigenous content. The work of Indigenous scholars provides a roadmap of knowledge creation, as well as building and dismantling 'Western' knowledge systems. This scholarship which when read and heard with intent can assist our non-Indigenous counterparts to wrestle with their confusion and discomfort. It is okay to be uncomfortable, but allowing discomfort to stymie social justice and to halt change in the way in which academic institutions do business is inexcusable. Indigenous scholars have been doing this work for decades. However, Indigenous academics are under resourced and overburdened by this reliance on us to inform, craft and deliver content—we simply cannot do all the work, we need non-Indigenous scholars to step into the space of crafting and delivering content too. The active engagement of Indigenous and non-Indigenous people in this space can only serve to nourish the collective space of academic institutions for everyone.

Why am I here when my experiences have suggested that Australian educational spaces are not for me, or people like me? The boundaries placed around Indigenous Australians still exist, but they are being challenged, upturned and rebutted. I believe in the power of change. I believe in people. I believe that to make change you have to create change. Indigenous Australians do belong in all educational systems; it is as much our space as it is anyone else's. There is unique, valuable and insightful ways that Indigenous people see the world that hold deep Knowledge. I implore all of us to challenge this outdated concept of the 'Western' institution. A systemic change is required across all institutional spaces; I believe that starts with education. Knowledge is power, and while education systems and 'western' learning have been weaponised against Indigenous peoples, they can present an opportunity to develop the emancipatory weaponry that we all need to dismantle the colonial project. From early childhood right through to tertiary education, all students need to be afforded the knowledge, skills and experience to work *with* and *for* Indigenous Australians. Such challenge promotes new space in which knowledge can be introduced, created, built upon and dismantled in ways that are not only exciting but may well hold the key to solving some of the crisis we face globally. Let's no longer be confused.

I sit in two spaces, happily, though not always comfortably. As a consequence of the invasion of Australia, the way in which Indigenous Australians know, do and be has shifted. I walk in the colonial project, but I also walk on country. I am always on country, learning, growing, questioning. It is not my country that I walk on most days, but as I take up space on unceded lands, I know that country holds deep knowledge, so I listen—we should all listen. There is an assumption that Indigenous Knowledges no longer exist due to invasion and colonisation, but Indigenous Knowledges have been here since the beginning, and they live in the past, the present and the future. My Knowledges are both deep and shallow, learnt on country, with country, with family, with friends, with Indigenous colleagues. My Knowledges have also been learnt within Australian educational spaces, within the academy I have cemented these Knowledges in ways in which I could not have imagined, and in ways I am yet to imagine. My yearning for more is unquenched. I am less confused. However, I am yet to find that elusive gum leaf and learn to play it just like my great-grandfather.

2.3.2 The Past Is Always Present

Sharlene Cruickshank

My name is Sharlene Cruickshank and I am an Aboriginal person. I am a descendant of the Wandi Wandandian - Wodi Wodi and Jerrinja peoples of the Yuin nation on the New South Wales' South Coast. My story line or song line covers from one end of the state to the other, from Far West New South Wales to the South Coast of New South Wales with a few diversions along the way. I have over 30 years' experience working in health-related areas including the past 13 years in community mental health, social and emotional wellbeing.

There are a few events that have influenced the way I work with individuals' families and communities throughout my life. Like many Aboriginal people in Australia, I have questioned my own identity as an Aboriginal person at times—feelings of confusion, embarrassment and sadness as well as pride, love and honour.

My mother who was a non-Aboriginal woman instilled a great amount of pride in her children about our Aboriginal heritage and was the first person to teach us about the positives of being part of the oldest living culture in the world; she also instilled the importance of family, obligations and connections to community. Our dad, an Aboriginal man, was sadly a man who was a bit shy and a bit reluctant to talk about his heritage or his community until later in life when he would talk about how the family had been moved from their ancestral lands to the other side of the river by the colonial system and chuckle that "the white man tried to breed us out but were just breeding in"

One incident I recall when I was about 18 years old working as a trainee enrolled nurse at the Broken Hill Base hospital; as the least experienced and junior staff member, I was often assigned into the gastroenterology ward for children. One afternoon shift a tiny little baby boy was flown in by the Royal Flying Doctor Service (RFDS) from a small town a couple of hours from Broken Hill. He was very unwell and was described as a "failure to thrive" baby; he was covered in scabies, had severe gastro and the most heartbreaking cry I had ever heard. The story I was told at the time was that his mother was an "alcoholic" who had rejected this little boy and abandoned him under a bush. I can still feel the rage, confusion and embarrassment I experienced at the comments and judgement staff levelled at the mother and the Aboriginal community in general. I also questioned at that time how could a mother leave her sick baby? Obviously, all the stories my mum had told us about family being so important to Aboriginal people were lies.

My next big learning moment or series of moments was about a year later I had gone off to teacher's college in Bathurst, NSW, and I stayed in an Aboriginal hostel which housed Aboriginal students from all over NSW. This was an interesting experience in many ways as for the first time I was meeting Aboriginal people who all looked different—no typecasting here redheads, blondes, brown hair blue eyes, pale skin and freckles we were all as diverse as the towns and cities we came from. Here I met two of the most memorable women, Viv (19) and Sally (25). I have ever met even now many years later both of these girls one who I will call Viv who was about the same age as myself 19 or 20 and Sally who was a few years older than me in her mid-20s. Both were beautiful, intelligent, funny, caring people. Taught me so much about my own privilege and the impacts of child removal and trauma on Aboriginal people.

Viv, she was tall and beautiful with short black curly hair which she styled in a very modern 80s' style. She wore great clothes and fabulous earrings; in fact, I borrowed a pair and still wear them to this day. She was smart and a bit sassy, and we got to know each other very quickly in the way people do when they are thrown together and away from home. We would sit in her room, which she shared with Sally, talking about our studies, music, other people—whatever young people talk about. We also partied and that included a bit too much alcohol, I must admit.

As we got to know each other, I started to notice some strange or unusual behaviours: isolating herself, crying a lot and cutting and scratching herself on her arms and legs. One day I asked her about these cuts and some old scars and fresh wounds of varying depths, a few quite deep wounds and other more superficial. What she told me shocked and horrified me at the time (I was quite a naïve country kid back then). She told me about being removed from her Aboriginal mother along with her younger brother, that her mother didn't want her anymore and that her mother had abandoned her and her brother. Viv was put into care and then adopted by a "lovely" German family. Unfortunately, that lovely German family turned out to be full of people who abused and traumatised a beautiful little girl and made her feel worthless, hopeless, guilty and ungrateful.

Her adoptive grandfather began to molest her from the age of 4 years; her adoptive father raped her several times from the age of 10 and finally her adoptive brothers took turns to rape and abused her from the age of 14 until she ran away at the age of 16 with her younger brother then only 14. So, three generations of a family who were supposed to love, care and keep her safe actually almost destroyed her.

Sally also had her own story to share. Sally told us her experiences of being removed from her mother and never knowing her father. At age 26 she found out that she had several siblings who had also been taken away from their mother "due to neglect". She was told that her mum had asked for support, and this was used against her to remove all of her children. This led Sally's mum to use alcohol to deal with her grief over the loss of her babies. So when Sally finally met her mum, she was very unwell and died only months after meeting with Sally and one of her brothers. Sally struggled to make sense of losing her mother for the second time, and this led to a decline in her mood and behaviour. Sally was probably one of the most intelligent women I have met in my life. A true story teller and artist who struggled with mental illness for many years; often locked in her room, experiencing flashbacks and nightmares of past physical and emotional abuse, long periods of depression and several periods of what I now know would be called mania; not sleeping, singing, laughing, writing, drawing or spending money; sometimes creative, sometimes erratic or disorganised. I heard years later that Sally had died by suicide.

I struggled myself in that year in Bathurst to adjust to studying, people and my own sickness for home so I deferred and ran back home to Broken Hill. I kept in contact with these girls for a short time but lost contact as we do; but I never really forgot their stories and the impact they had on me, and when 18 years later I finally went back to study, this time about Aboriginal mental health and wellbeing, I found out the reason why.

Their stories I would later come to realise reflected some of the experiences of many Aboriginal people across Australia later to be known as the Stolen Generation. In 2005, I commenced my studies at Charles Sturt University (Bachelor of Health Science [Mental Health]) and worked as part of the community mental health and drug and alcohol service in Broken Hill Far West NSW. I moved back to my home town which brings with it some challenges as well benefits—some people knew me but many more knew my family, my parents and my five younger siblings.

Although I had grown up in Broken Hill, I needed to gain trust and build rapport in the local communities which include the nearby communities of Wilcannia and Menindee; both of these communities have a history of being Aboriginal Mission towns which to this day influence the social structure of the towns. I met people with great passion resilience and character in these little communities.

One memorable young man, George, I can still see his gorgeous smile which masked his painful and sad story. He was the same age as my youngest daughter and attended school with her so I think that may be why our brief contact mattered so much to me. He was brought into the emergency department by police intoxicated and threatening self-harm. The next morning we talked about what was happening; he denied suicidal thought. By the time I saw him, however, he told me briefly his story. On the day before he was brought into the emergency department, he had seen the person who had sexually abused him as a young child, and he felt unable to tell his family as he didn't want to worry them. He didn't think they would understand. We talked at length about his feelings and his strategies for dealing with his trauma and stressors. He assured me he would be safe so was discharged into the care of his parent, and he agreed to follow up in the community. We actively followed him up with minimal success, and then we were told he had been moved to live with family in a large regional town in NSW. Several months later, my daughter came to me crying telling me she had heard from friends that George had died by suicide.

One of the uncles I have worked with over the past 7 years is a member of the Stolen Generation. He is funny and passionate about his community but also quick to anger, mistrusting and easily distracted. Like many members of the Stolen Generation I have met, there is a powerful resilience and sense of protection.

Another fellow I worked with was referred for alcohol and "anger issues". When we talked about his history, he told me he had been incarcerated for about 20 of his 36 years. Through his narrative, I learnt that he had witnessed the murder of his mother at the age of 8 years, and the adults and carers around him at that time didn't know how to deal with a grieving, terrified and traumatised little boy, so they gave him some cannabis to help calm him down. It worked as well as it does, and this became the norm for him. According to him, this led him to using alcohol and other substances, risky behaviours including stealing cars, selling drugs, assaults and other behaviours that ended up with his incarceration at a rate that could make him the poster boy for Aboriginal and Torres Strait Islander incarceration. In June 2019, according to the Australian Bureau of Statistics "Aboriginal and Torres Strait Islander prisoners represented 28% of the total fulltime adult prisoner population" across Australia (► abs.gov.au). We talked at length about his mother, and he told me that I was the first person to ever ask about his mum or talk about how it felt to miss her, grieve for her and love her. We talked about his anger, which you may have guessed had turned out to be fear, sadness and hurt. We explored his childhood and some of the events that impacted on his life choices including the use of substances, often to deal with pain, lack of trust for adults or authority figures.

Aunty M who was a member of the Stolen Generation in her 90s when I met her—she had recently been diagnosed with dementia. As is common in people with dementia, she was often transformed to her younger years telling stories of her childhood and young adulthood. She told of being removed from her mum as a child and the sadness and longing for home she still felt as an elder; her train journey across New South Wales to live with family members she didn't know and who treated her like free labour and housekeeping staff. She spoke of her fight for justice for others, taking in young homeless, pregnant women who had nowhere to go in a small country town. She spoke of not meeting her mother again until she was in her 50s and her mother's grief.

If these stories sound familiar, it's because they were and still are true that Aboriginal women and men are still being deeply impacted by the policies and practices of colonisation and racism. Just because I am an Aboriginal person doesn't guarantee immediate engagement or rapport with other Aboriginal people. It requires time, respect and lots of vouching.

Let me end this essay with a couple of stories that happened to me and my family this year. In May 2019, the same week as I was working on a community project for reconciliation and commemorating Sorry Day (26th May), my daughter and her partner took their two babies to the local health district hospital emergency department; their two-year-old daughter had fallen out of a box while playing and sustained a fracture to her lower leg; the five-week-old had a temperature and was also unwell. Instead of treating the family with compassion and understanding due to what can only be put down to racial profiling, they were interrogated by a hospital social worker. They had to put up with racist remarks and received poor treatment which only added to the fear, mistrust, stigma and stereotypes many Aboriginal people experience when trying to access a service that is meant for all Australians equally and without discrimination.

My last story happened in the small seaside community I live; while waiting for a coffee, I was standing in the July sun when another customer, an older White male, struck up a conversation. We were chatting about the weather, the area, what people do for a living, how we each came to be living here. When I commented about my connections to the local area and what had brought me to the area, I stated that my Grandmother had been born on the Aboriginal Mission of Rosebay Park at Orient Point and that my Pop had been born at Greenwell Point across the river. I told him that I had been coming to the area all of my life. He expressed surprise and exclaimed that he was unaware of any Aboriginal community and had never heard of Jerrinja (the local Aboriginal community). He also crudely said that he was surprised to hear I was Aboriginal as he thought I looked like "something more exotic". I was a bit affronted; but instead of acting on the burning rage I felt slowly rising inside my gut, we had a pleasant conversation about colonisation and the effects this has had on the diversity in the look of Aboriginal peoples. Only later did I think about what he said—Tell me truthfully, what could be more exotic than being part of a culture that has survived for more than 60,000 years or over 600 generations?

The truth is that Aboriginal and Torres Strait islander people have been living across this country we call Australia for thousands for years, and we still have cultural connections to our lands, sea, animals and sky, as well as our families, communities and spirituality. There are strong Aboriginal people across the country working together to improve the wellbeing of all Australians. Talk to us, engage with us, engage in community activities whether it is Reconciliation or Sorry Day events. We are the tapestry of Australia.

2.4 Experiential Activities

Important

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant, and they should provide participants with ways to resolve feelings that may arise as a result of the activity including reflection and debriefing.

Activity 1

Title Movie time: 'Rabbit-Proof Fence' (2002)

Purpose Film can be a powerful experiential learning activity for cultural awareness. 'Rabbit-Proof Fence', directed by Phillip Noyce, is loosely based on the true story of three young Indigenous girls who ran away from a settlement north of Perth, WA, after being placed there in 1931. The nine-week journey home on foot to their Aboriginal families followed 2400 km of the Australian rabbit-proof fence (Noyce, Olsen & Winter, 2002).

Purpose Watch the 93-minute film and respond to the following questions.

- **Questions**

1. Were you aware of this part of Australia's history?
2. What specific images stayed with you after the movie was over?
3. What do you feel is the underlying message of the film?
4. How has watching this film contributed to your understanding of the impact of past events on Aboriginal and Torres Strait Island peoples' collective identity?

5. How has watching this film contributed to your self-awareness in working with Aboriginal and Torres Strait Island people?
6. What were some of the different ways prejudice and discrimination were exemplified in the film?
7. How does power influence prejudice and discrimination in the film?

Discuss your responses in pairs or groups.

Outcome To enhance students' cultural awareness and understanding of Aboriginal and Torres Islander peoples' culture and family ties.

Activity 2
Title Yarning Circle

Purpose A yarning circle (or dialogue circle) is used within Aboriginal and Torres Strait Islander People's culture to learn from the collective group, build respectful relationships, and preserve and pass on cultural knowledge (Morseu-Diop, 2013). (You can learn more about yarning circles at ► http://eprints.qut.edu.au/61361/7/61361.pdf ► https://www.qcaa.qld.edu.au/about/k-12-policies/aboriginal-torres-strait-islander-perspectives/resources/yarning-circles and ► https://www.qcaa.qld.edu.au/about/k-12-policies/aboriginal-torres-strait-islander-perspectives/resources/yarning-circles).

Students are invited to respectfully form a yarning circle to focus on aspects of Aboriginal and Torres Strait Islander culture and mental health.

- **Process**

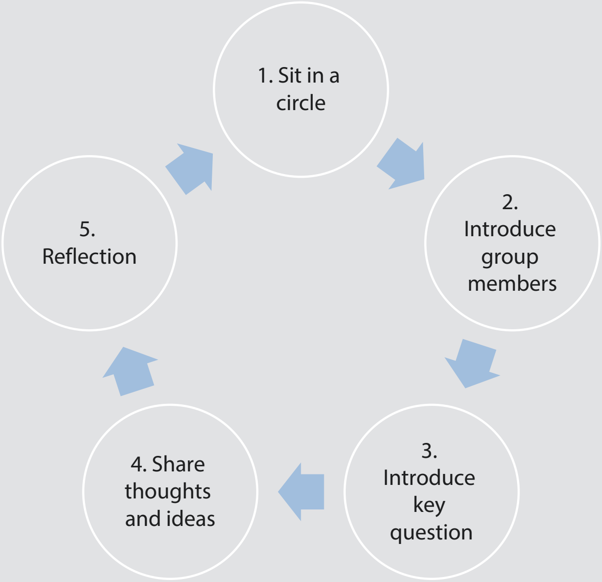
Aboriginal and Torres Strait Islander cultures are among some of the longest continuing cultures in the world. Strong culture has been identified as essential to health and wellbeing, and studies such as the Mayi Kuwayu Study are attempting to develop measures of cultural participation and expression to support this belief. (You can learn more about the Mayi Kuwayu study at ► https://mkstudy.com.au/about-mayi-kuwayu/). Identifying protective factors in this way would allow a shift in the sometimes negative portrayal of these groups from a deficit discourse to a strengths-based perspective. Rejecting the deficit discourse does not downplay challenges that Aboriginal and Torres Strait Islander peoples face, rather it reduces the tendency to overlook diversity, capability and strength. Exploring the relationship between culture and health and wellbeing described above will inform the discussion in your yarning circle in this activity.

Yarning circles are hosted by an individual—teacher, student or visitor. Participants sit in a circle, and all are considered equal within the circle. The host invites participants to introduce themselves and share a piece of information about themselves. The host introduces the focus question and encourages participants to take turns to talk. This promotes reciprocal sharing and learning. Thoughts can be written or drawn after each person speaks, using butcher's paper, or drawn in the dirt if sitting outside. Finally, any actions or issues identified are resolved, or agreed to follow up in the next yarning circle. (See image below).

▪ Questions

Some focus questions for ongoing yarning circles include:

1. How could cultural participation and expression promote wellbeing?
   (a) Think of some specific examples from your own culture.
   (b) Drawing on your knowledge of Aboriginal and Torres Strait Islander peoples, suggest and explore some examples from these cultures, and some of the things that could get in the way of full participation and expression in twenty-first century Australia.
2. What are some examples of the deficit discourse about Aboriginal and Torres Strait Islander peoples?
   (a) How could these be perpetuated?
   (b) How could these be avoided?
   (c) What can you do about this?
3. Based on the above discussions, the group then decides on actions or issues to be followed up in the next yarning circle, or actioned in students' wider learning.



YARNING CIRCLE SEQUENCE. (Image adapted from: ► https://www.qcaa.qld.edu.au/about/k-12-policies/aboriginal-torres-strait-islander-perspectives/resources/yarning-circles)

Outcome Students experience reciprocal sharing and learning in a unique and culturally sensitive way as they explore concepts linked to culture, health and wellbeing. Importantly, this collaborative means of learning from the collective group, building respectful relationships, and preserving and passing on cultural knowledge can be adapted to a range of situations throughout the students' education and work life.

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Racism

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V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_3

Racism

Trailer

In this chapter, Yin Paradies provides compelling evidence as to the extent of racism in Australia, and its impact on a person's mental health and wellbeing, while Alperhan Babacan critically analyses the fear and discrimination facing asylum seekers seeking to flee to Australian shores. Bringing this information to life, Caroline Wang pens a letter to Asian girls, detailing the things about racism she wished she known, and Alanna Kamp reflects on the implications of being a "White passing" cis woman. Karen Zwi and Lisa Woodland provide personal reflections on working with children and families from refugee backgrounds in the health system. Anton Piyarathne explores how members of both majority groups in the Sri Lankan ethno-national conflict have fared when relocating to Australia and navigating minority status, discrimination and tension in their new home, and Rachael Jacobs reflects on systemic oppression in Australia.

3.1 Introduction

Vicki Hutton

Apart from Aboriginal and Torres Strait Islander peoples, current residents of Australia either immigrated over the past two centuries or have descended from those immigrants. By the 2016 Census, two thirds (67%) of the Australian population reported being born in Australia. Almost half (49%) of the population had been born overseas (first-generation Australian) or reported one or both of their parents being born overseas (second-generation Australian) (Australian Bureau of Statistics [ABS], 2017). While England and New Zealand remained the most common country of birth after Australia, and English the most common language, the 2016 Census reported more than 300 different languages spoken in Australian homes. The most common languages (after English) included Mandarin, Arabic, Cantonese and Vietnamese, with 21% of Australians speaking a language other than English in their homes. People born in China and India comprised the fourth and fifth largest groups reported in the 2016 Census.

Over the years, the terms "migrant", "refugee" and "asylum seeker" have tended to be used interchangeably in common language when describing newcomers to Australia's shores (Refugee Council of Australia, 2019). Australia has gained a reputation as one of the world's major "immigration nations", with the settlement of over 7.5 million people since 1945 (Phillips & Simon-Davies, 2017). Some of the ways that permanent migrants enter Australia include as skilled and family migrants, the Humanitarian Program or refugees and those in refugee-like situations. Labelling a person as immigrant, refugee or asylum seeker can have long-term implication as to how they are perceived and treated in their new country. The Refugee Council of Australia (2019) helps clarify these distinctive terms.

Definition

While the United Nations defines a "long-term international migrant" as someone who lives in another country for at least a year; in Australia, the term "migrant" has traditionally been associated with someone who moves permanently to Australia, or a temporary migrant such as students or short-term work visas. An important defining feature of the migrant is that they choose to move, usually to improve their lives, and they can return safely to their home country if and when they wish.

In contrast, refugees flee their home due to conflict or persecution, and are unable or unwilling to return home based on well-founded fears of further persecution due to their race, religion, nationality, membership of a particular social group or political opinion (Australian Human Rights Commission [AHRC], 2014).

This distinction is reflected in international law and Australian policies such as the Migration Program and the Refugee and Humanitarian Programs. Conflating the terms migrant and refugee thus fails to acknowledge the reasons each group leaves their home, and the reasons refugees cannot return unless the situation that forced them to leave improves.

Similarly, conflating the terms "asylum seeker" and "refugee" can have implications for public perceptions and a person's wellbeing.

Definition

A person becomes an asylum seeker when they flee their own country and apply for protection in another country as a refugee (AHRC, 2014). They remain asylum seekers as they await their claim for refugee status to be assessed.

By arriving in Australia without a valid visa or documentation, the person must be held in immigration detention under the Migration Act 1958 (Cth) (AHRC, 2014). What remains in dispute is the length of time for which a person may be held, and the mental health implications of potentially long periods of detention and accompanying uncertainties.

"Refugee" and "asylum seeker" are often confused and bracketed together, with both groups sometimes perceived as "not belonging" by sections of, or individuals within, society (Refugee Council of Australia, 2019).

Even when living in Australia with the appropriate documentation, around one in three new migrants describe hurdles in finding their first job, including lack of Australian work experience and references, language difficulties and difficulties having their skills or qualifications recognised (AHRC, 2015).

Many migrants and refugees also report experiences of racism, especially when newly arrived, resulting in feelings of being second-class citizens (Refugee Council of Australia, 2019).

The Australian Human Rights Commission (2017) makes the point that racism can take many forms and happen in many places. Defined as prejudice, discrimination or hatred based on colour, ethnicity or national origin, it is evident in abuse, harassment, name-calling, jokes or social exclusion.

Irrespective of its form, racism creates barriers that prevent people from experiencing dignity, freedom and equality in their day-to-day lives. It can also have long-lasting and profound effects on their mental health and wellbeing. Working with migrants, refugees and asylum seekers requires sensitivity to past experiences that brought them to Australia, present experiences that can include racism, and future expectations and fears. The current DSM-5 includes a Cultural Formulation Interview designed to assist practitioners who work with people from diverse backgrounds (American Psychiatric Association [APA], 2013).

3.2 Racism

3.2.1 Racism and Mental Health

Yin Paradies

3.2.1.1 The Nature and Extent of Racism

Definition

Racism can be conceptualised as unfair and avoidable disparities in power, resources, capacities or opportunities across ethnic, racial, religious or cultural differences (Berman & Paradies, 2010). Racism can manifest through cognitive beliefs (e.g. stereotypes), feelings (e.g. prejudice) or discriminatory behaviours. Racism can occur at three interrelated levels: internalised, interpersonal or systemic racism.

Internalised racism is characterised by a sense of inferiority about one's own ethnic/racial group and/or perceiving other ethnic/racial groups as superior (Paradies et al., 2009). Interpersonal racism occurs in interactions between people from within the same racial group (i.e. intraracial racism) or between people of different racial groups (i.e. interracial racism). Systemic racism (also called institutional or organisational racism) encompasses a range of processes, practices and policies that occur beyond individuals within organisations and institutions (Berman & Paradies, 2010).

A 2015–2016 national survey with 6000 respondents, with probability-based sampling designed to be representative of the national population, found that the majority of Australians support cultural diversity. However, strong views that minority groups should assimilate and a considerable degree of Islamophobia were also revealed (Kamp et al., 2017). Ongoing repeated nationally representative surveys suggest that about 20% of Australians report experiences of racism at least once a year, with this proportion rising to 34% among Australians from non-English speaking backgrounds (Markus, 2017).

A 2014–2015 survey, which assessed exposure to racism across multiple domains (e.g. home, work, education, recreation, etc.), indicated that 34% of Indigenous adults reported experiences of racism in the past year (ABS, 2016). Representative national longitudinal data from 2008 to 2013 indicate that 14% of Indigenous Australian children aged 5–10 years have experienced racism (Shepherd, Li, Cooper, Hopkins, & Farrant, 2017), while a 2012 nationally representative survey found that 23% of Indigenous Australian children (aged 12–13) experienced racism in past 6 months (Priest, King, Bécares, & Kavanagh, 2016).

The most prevalent forms of racism for minority racial groups in Australia appear to be teasing, jokes, verbal abuse, being ignored or excluded, stereotypes as well as physical assault and property damage (Ferdinand, Paradies, & Kelaher, 2012; Ferdinand et al., 2015). Internalised racism has been examined in qualitative studies (Bennett, 2014; Clark, Augoustinos, & Malin, 2016; Doyle, Hungerford, & Cleary, 2017; Hickey, 2016). In an Indigenous context, internalised racism is also sometimes known as lateral violence and often centres on indigenous authenticity (e.g. skin colour or cultural knowledge), manifesting as innuendo, exclusion, insults, sabotage, undermining, scapegoating, backstabbing or failure to respect privacy (Bennett, 2014). For example, a 2018 survey of 149 Indigenous university staff in Australia found that two thirds (66%) experienced lateral violence in the workplace from other Indigenous colleagues (National Indigenous Unit of the National Tertiary Education Union, 2018).

The widespread presence of systemic racism for minority groups in Australia has been documented in areas such as employment (Booth, Leigh, & Varganova, 2012; Hughes & Davidson, 2010), housing (MacDonald et al., 2016), education (Bodkin-Andrews, Denson, & Bansel, 2013), healthcare (Bastos, Harnois, & Paradies, 2018; Cunningham, 2002), public transport (Mujcic & Frijters, 2013), media (Proudfoot & Habibis, 2015) and criminal sentencing (Jeffries & Bond, 2012). For example, in one study, 4000 fictional resumes were sent in response to job advertisements. Despite these resumes detailing equally qualified and experienced applications, resumes with "Indigenous", "Middle Eastern" and "Chinese" names attracted 35%, 64% and 68% fewer interviews than resumes with "White" names (Booth et al., 2012).

3.2.1.2 The Impacts of Racism on Mental Health

Overall, racism can result in negative health impacts through several key mechanisms (Paradies et al., 2013):

- Cognitive, emotional and physical strain, stress or damage impacting upon mental, physical spiritual or social wellbeing
- Reduced engagement in adaptive behaviours (e.g. physical activity)
- Maladaptive behaviours (e.g. alcohol and drug use).
- Compromised access to key health-promoting settings (e.g. education)
- Attenuated benefit from everyday routine activities (e.g. sleep)
- Heightened contact with health-damaging exposures (e.g. toxic substances)

In relation to mental health impacts, it is thought that racism causes increased susceptibility to stress proliferation (Gee, Walsemann, & Brondolo, 2012) whilst also sharing convergent processes with mental disorders such as anxiety, depression and psychosis (Berger & Sarnyai, 2015). Researchers have also started to examine the negative mental health impacts of being a perpetrator of racism (Kwate & Goodman, 2014). In Australia, Grigg and Manderson (2015) found that racist attitudes were associated with psychopathic personality traits in 402 Australian adolescents and adults.

A growing interest in racism as a determinant of mental health has resulted in a number of systematic reviews and meta-analyses on this topic (Brondolo, Brady, Libby, & Pencille, 2011; Conklin, 2011; Goto et al., 2013; Kirkinis, Pieterse, Martin, Agiliga, & Brownell, 2018; Schmitt, Branscombe, Postmes, & Garcia, 2014), including some that have focused on specific population groups such as Asian-Americans (Lee & Ahn, 2011) and African Americans (Britt-Spells et al., 2018; Lee & Ahn, 2013; Pieterse, Todd, Neville, & Carter, 2012).

The only meta-analysis on racial discrimination and health across all population groups and national contexts, to date, found 293 unique studies on this topic up till late 2013 (Paradies et al., 2015). This review found that racism is significantly related to poorer health, with this relationship strongest for poor mental health and weaker for physical ill-health. Poor mental health was about twice as strongly related to racism ($r = 0.18$) as physical ill-health ($r = 0.09$). In relation to mental health, the most consistent association was with depression and anxiety (Paradies et al., 2015).

► Example

Among 1139 Victorians of diverse non-Indigenous migrant backgrounds, racism was associated with increased psychological distress (Ferdinand et al., 2015). In a sample of 698 Australian high school students, racism was associated with worse health, with females more likely to have decreased health/wellbeing as a result of racism compared to males (Mansouri et al., 2012). For 51 refugee youth (aged 11–19 years), racism continued to have a significant impact on their subjective wellbeing 8 years after arrival (Correa-Velez et al., 2015). A study of 47 Middle Eastern and Asian children and young people aged 7–15 years found that experiences of racism were associated with greater emotional problems, withdrawn social behaviours and indirect aggression (Runions et al., 2011). For 142 students from diverse racial/ethnic backgrounds across 7 Victorian schools, experiences of racism were associated with loneliness and depression assessed 12 months after racism exposure (Priest et al., 2017). Among 78 Indigenous prisoners in Victoria, experiences of racism were associated with psychological distress (Shepherd, Delgado, & Paradies, 2018).

Among Indigenous Australians, racism has been associated with poor self-assessed health status (Paradies & Cunningham, 2012a), mental ill-health (Ziersch, Gallaher, Baum, & Bentley, 2011), psychological distress (Kelaher et al., 2014), depression (Paradies & Cunningham, 2012b) and reduced general physical and mental health (Larson, Gilles, Howard, & Coffin, 2007). Kelaher et al. (2014) found that those experiencing racism in healthcare settings were almost twice as likely to have high or very high levels of psychological distress compared to Indigenous people who experienced racism in other settings.

Among Indigenous Australian youth, racism has also been associated with emotional/behavioural difficulties and suicidal thoughts (Zubrick et al., 2005), anxiety, depression, suicide risk and mental ill-health (Priest, Paradies, Gunthorpe, Cairney, & Sayers, 2011; Priest, Paradies, Stewart, & Luke, 2011) as well as increased alcohol, tobacco and marijuana use (Zubrick et al., 2005). In an Australian national longitudinal study, racism was associated with child mental ill-health, asthma, obesity and poor sleep outcomes (Shepherd et al., 2017), while data from the same survey indicate that racism was associated with poor general health and increased anger, worry and depression for adult primary carers (Bodkin-Andrews et al., 2017). ◄

3.2.1.3 Combating Racism

Reducing interpersonal racism can be achieved by: (1) highlighting egalitarian values of fairness, minimising incompatible beliefs and developing anti-racist motivation; (2) providing accurate information and dispelling false beliefs; (3) decreasing anxiety and increasing comfort with other racial groups; (4) fostering empathy and perspective-taking as well as improving regulation of negative emotional responses and (5) strengthening anti-racist social norms and bolstering personal accountability (Chapman, Kaatz, & Carnes, 2013; Paradies et al., 2009).

When responding to racist incidents, it is important to take them at "face value" as a subjective experience that "hurts" regardless of their "objective" validity. Remember that neither you nor those experiencing it are responsible for fixing racism (at least, not in the first instance as an "initial responder"). Rather, it is important to find ways to acknowledge and cope with these experiences while also exploring options for reacting, responding and resisting future racist incidents. Expressions of shame, guilt anger and frustration are appropriate responses to racism (Elliott, 2008; Pieterse, 2018).

Important

There are four key areas for addressing systemic racism: (1) increasing staff cultural and racial diversity; (2) improving institutional accountability; (3) fostering community partnership and (4) implementing and evaluating anti-racism/cultural competence training. Accountability can be enhanced by implementing non-discriminatory standards across strategic plans, policies and performance indicators as well as developing fair and equitable planning, policies, processes and practices.

Anti-racism training can involve courses as well as mentoring and on-the-job learning. Attitudes, beliefs and behaviours need to be considered in relation to intercultural awareness and communication as well as examining one's own prejudices and discussing individual behaviours that can address racism in the workplace. Key aims include: (1) examining one's own biases/prejudices and being willing to "make mistakes" from a stance of cultural humility; (2) understanding stereotyping, prejudice and bias and how to respond to racism; (3) developing a familiarity with diversity, inequality and affirmative action and (4) fostering opportunities for positive contact between people from diverse cultural and racial backgrounds (Paradies et al., 2009; Trenerry, Franklin, & Paradies, 2010). Various recent reviews suggest that anti-racism can be effective when well-designed, applied appropriately and used in conjunction with other approaches to reducing interpersonal and systemic racism (Alhejji, Garavan, Carbery, O'Brien, & McGuire, 2016; Bezrukova, Jehn, & Spell, 2012; Dobbin & Kalev, 2016; Kalev, Dobbin, & Kelly, 2006; Kalinoski et al., 2013).

Effective training should be neutral, informal and use multiple instruction methods (e.g. role plays, small group discussion, readings, audio-visuals) (Pedersen, Fozdar, & Kenny, 2012). Training should be tailored to each organisation, linked to operational goals and specifically address behaviour, while trainers should engage participants respectfully and interactively, build and invoke social norms, while enhancing awareness, attitudes and skills (Ben, Kelly, & Paradies, 2020).

3.2.2 Racism Against Asylum Seekers in Australia

Alperhan Babacan

3.2.2.1 Introduction

Australia's post-war refugee and asylum policies were founded upon the Cold War. Australia, like other Western states, historically provided refuge to asylum seekers as part of its fight against communism (Martin, 2000). Following the downfall of communism, the asylum route was blocked by Australia and other western states through the implementation of harsh interdiction and interception policies. Measures enacted in Australia since the 1990s included the introduction of the Temporary Protection Visa, safe third country rules, mandatory detention, offshore processing and measures to stop/turn back boats. As a result of these changes, asylum seekers have been increasingly undertaking hazardous boat journeys to seek refuge in Australia. Although Australia appears as a tolerant multicultural society which is welcoming of diversity and refugees, a closer assessment reveals that there has been increased racism towards asylum seekers over the last two decades. Asylum seekers who once were afforded compassionate treatment are now portrayed as a threat to Australia's sovereignty and security and portrayal as a group who are incompatible mainstream Australian society (Gale, 2004, 2006; Watson, 2006). This chapter will provide an overview of the nature and extent of racism against asylum seekers and the role of politicians and the media in the creation and perpetuation of racism. It is advanced that Australia has historically been a racialised nation and racism has played a central role in public policy. Politicians and media create and perpetuate racism against asylum seekers through generalised and categorical talk about asylum seekers.

3.2.2.2 New Racism and Asylum Seekers

Australia has historically been a racial state with racially motivated policies and practices being central to nation building (Thornton & Luker, 2010). The Oxford Dictionary of Current English defines racism as (1) the belief that each race has certain qualities or abilities, giving rise to the belief that certain races are better than others; and (2) discrimination against or hostility towards other races (Oxford, 2006, p. 740). Historically, anglocentricity has defined nation building. The White Australia Policy was a cornerstone of Federation which was directed at keeping out Asian migration. Whilst the White Australia Policy was abolished in the 1970s, the adoption of multiculturalism coincided with the emergence of global formations and nationalism based on race which heightened anxieties about Australia as a white nation. To this end, racial prejudice in Australia is not directed at a static other or group but is directed at changing populations. Hence, racelessness as a policy (multiculturalism) masks the nationalism and the differing forms of nationalism that have emerged in recent years and enables policy makers to shift racist treatment to different populations in Australia (Thornton & Luker, 2010).

The "new racisms" in contemporary Australia focuses not on skin colour as "old racism" did, but on cultural differences and incompatibilities to the mainstream Australian population. Therefore, a key element of the "old racism" remains in that the emphasis is on the incompatibility of various groups to mainstream Australian society (Corlett, 2002). Since the 1990s, government and media discourses about asylum seekers have vilified and fed anti-asylum seeker sentiments (Augoustinos & Every, 2007; Augoustinos, Tuffin, & Every, 2005; Every & Augoustinos, 2007; Pedersen, Watt, & Hansen, 2006).

Politicians frequently resort to language which portrays asylum seekers as a "threat" to Australia's social cohesion and depicts asylum seekers as the "other" which in turn engenders fear in the Australian populace (Gale, 2004, 2006). The community's false views of asylum seekers often matched the racially loaded words, phrases and statements used by politicians which are "drummed up" in the media (Suhnan, Pedersen, & Hartley, 2012; Pedersen et al., 2006; Every & Augoustinos, 2007). Examples of racist language used by politicians when talking about asylum seekers include use of categorical generalisations, use of mythical constructs around the nation, and notions of "us" and "them" and resort to discussion of cultural differences and the "incompatibility" of asylum seekers to Australian society (Augoustinos & Every, 2007; Every & Augoustinos, 2007). These negative representations are particularly emphasised when harsh legislative responses are enacted and communicated to the public. Since the 1990s, the arrival of asylum seekers and the alleged necessity of harsh measures to protect Australia's borders have become a central aspect of federal election campaigns in Australia (Wanna, 2010).

Various studies have documented that for many people, the media is the key source of information about asylum seekers (see e.g. Turoy-Smith, Kane, & Pedersen, 2013). Whilst politicians set the policy agenda, the media portrays the entering of asylum seekers by boat as a crisis and attempts to justify the hard-line measures used to stop the boats, detain asylum seekers and process asylum seekers offshore. This in turn contributes to anti-asylum seeker sentiments in the community (Briskman, 2015). The next section provides key examples of how racism is perpetuated against asylum seekers by politicians and media.

3.2.2.3 Racism Against Asylum Seekers

Jumping the Queue

Politicians and the media have often used the term “queue jumpers” when referring to asylum seekers. The use of this term leaves an impression that there is an “orderly queue” and that those who jump this queue are doing so at the expense of others—namely “more deserving” asylum seekers who may apply to come to Australia via Australia’s offshore asylum programme (Fitzgerald). The constant use of the term “queue-jumpers” strongly results in negative views about asylum seekers (McHugh-Dillon, 2015; Pedersen et al., 2006).

Important

The debates around asylum seekers and constant use of the term “queue” enable politicians and the media to use the so-called “queue” as an impartial bureaucratic feature of the system which does not distinguish between race and class. Resorting to the use of the term “queue jumper” presents asylum seekers as violators of fairness which in turn discredits asylum seekers and gains support for negative practice or silence about the government’s harsh asylum policies and practices.

Illegals

Another term frequently used by politicians and the media is the term “illegals” or “illegal entrants”. This term has been used by parliamentarians to describe asylum seekers since the 1990s. For example, Tony Abbott used the term “illegal” to describe boat arrivals which resulted in the media picking up and reporting his statements with a resultant public outcry for assertive action (Fitzgerald, 2013). Various studies which looked at the use of the term “illegal” and queue jumpers have found a direct correlation between negative public sentiments and the use of these terms by politicians and the media (Hartley & Pedersen, 2007, 2015; Hartley, Pederson, & Dandy 2012; McHugh-Dillon, 2015).

Qualitative studies conducted with members of the public regarding the use of the term “illegal” reveal that the public often associated the use of the term “illegal” as those who committed an illegal act by seeking refuge in Australia, those who committed an illegal act or those who posed a security threat to Australia in the form of criminal acts or potential terrorist threat (McKay, Thomas, & Kneebone, 2012). Other members of the public who were asked what they understood of the term “illegal” have stated that they doubted the genuineness of those asylum seekers who entered Australia illegally and that Australia could not afford to open its doors to these people (Hartley & Pedersen, 2007; Hartley et al., 2012; McHugh-Dillon, 2015).

► Example

> » *People who use criminal acts to gain access to Australia, should not be welcome into the country. All illegal emigrants should immediately be sent back to their country of origin. If they have been able to pay $10,000 US dollars to get on an illegal boat then they are able to apply for genuine refugee status offshore* (Hartley & Pedersen, 2015, p.23 – cited in McHugh-Dillon, 2015).

> » *Asylum seekers are illegal immigrants and queue jumpers and do not deserve to be "rewarded" with preferential treatment ahead of those applying through the correct channel. (*Pedersen, Watt, & Griffiths, 2008 – *cited in* McHugh-Dillon, 2015). ◄

The overwhelming findings of studies demonstrate a denial of racism and the dehumanisation of asylum seekers. Differentiation of asylum seekers as "illegal/genuine" is a strategy to deflect criticism of the harsh treatment of asylum seekers which are couched in terminology and practices of fairness and equality (Augoustinos et al., 2005; Augoustinos & Every, 2007).

"Genuine" Refugees

The belief that asylum seekers who arrive by boat are not genuine refugees has formed a key part of the research on asylum seekers-related discourse over the years. Numerous studies have found that there is a common belief that "unauthorised" entry into Australia is "evidence" that asylum claims made by this group of asylum seekers lack merit and that this posed an injustice to Australia (in terms of an abuse of Australia's resources and good intentions and that it posed an injustice to genuine refugees who had to wait for their turn in the queue) (Hartley & Pedersen, 2015; McKay et al., 2012). Studies have found that those who believed that asylum seekers who arrived by boat were not genuine were unsympathetic towards asylum seekers and were supportive of the government's punitive measures to stop and/or deter the arrival of asylum seekers (Hartley & Pedersen, 2007; McHugh-Dillon, 2015).

Use of Loaded Terms

The use of loaded terms such as "stop the boats" or "turn back the boats" by politicians and the media serves to justify the harsh legislative responses directed at curbing the arrival of asylum seekers and their subsequent treatment by the Australian government. The use of such loaded terms is couched and justified by politicians as necessary to protecting the integrity of Australia's borders, a concern to uphold the integrity of Australia's Humanitarian Program and for the wellbeing of asylum seekers who face many risks through the hazardous sea journey they undertake to reach Australia. Any racist intent is denied. Racial overtones are cloaked with concerns over border security and safety and the emphasis on the alleged cultural incompatibility of asylum seekers with the Australian community.

► Example

For example, during the Children Overboard incident in 2001, Foreign Minister Downer stated that: "*These people had behaved abominably right from the start. The disgraceful way they treat their own children. Any civilised person would never dream of treating their own children in that way*". (Corlett, 2002, cited in Maddox, 2018). On the same matter, John Howard stated: "*I don't want people like that in Australia. I tell you - I don't want people like that in Australia! Genuine refugees don't do that"* (cited in Maddox, 2018). ◄

Bleiker, Campbell, Hutchison and Nicholson (2013), who conducted a detailed content analysis of newspapers, advance that media images and headlines on asylum seekers have framed public debates on asylum seekers. In particular, the authors note that the focus on boats over a period of a decade by the media has reinforced fear in the Australian public through "unauthorised boat entry" which allege to violate Australia's security and sovereignty (Bleiker et al., 2013). Lueck, Due and Augoustinos (2015) who undertook an analysis of media reports of two boat incidents in 2009 advance that the media portrayed the arrival of asylum seekers by boat as an economic threat to Australia which warranted tighter border protection policies to enable Australia to protect its sovereignty and maintain a homogenous population.

Politicians have legitimised their stance to "stop the boats" and their hard-line policy by asserting the Australian government had a responsibility to maintain a robust and orderly border security policy. In the lead up to 2013 election, Tony Abbott also argued that it was the duty of the Australian government to maintain an orderly programme and that a loss of control of who enters Australia amounts to a peaceful invasion (Bourke, 2012). Repeated use of such terms during elections evokes fear and anxiety towards refugees and gains support for harsh border protection policies (Burke, 2001). The use of such loaded terms with racist overtones creates a barrier between "us" and "them" (Every & Augoustinos, 2007).

Islam

There is conclusive evidence that the arrival of asylum seekers has been intertwined and conflated with Islam (Briskman, 2015; Turoy-Smith et al., 2013). McKay et al.'s study documents (2012) reveal that participants in their study feared asylum seekers from Muslim backgrounds and were concerned with the numbers of Muslims arriving on Australia's shores (McKay et al., 2012). Various studies document that the public are concerned that Muslims are unable to integrate to Australian society and will bring extremism and violence to Australia (Hartley & Pedersen, 2007; McHugh-Dillon, 2015; McKay et al., 2012; Turoy-Smith et al., 2013).

Threat

A number of studies have found that asylum seekers pose a threat to Australia with such views being a cause of negative sentiments against asylum seekers (McHugh-Dillon, 2015; McKay et al., 2012; Schweitzer, Perkoulidis, Krome, Ludlow, & Ryan, 2005; Suhnan et al., 2012). Threats alleged to be posed by asylum seekers can be "realistic" or "abstract". "Realistic" threat relates to the concern that asylum seekers threaten the existence of Australia and the physical wellbeing of Australia or Australians (Bizman & Yinon, 2001). "Abstract" threat relates to the belief that asylum seekers threaten Australia's national identity, culture and values (Schweitzer et al., 2005). Both forms of threat perception lead to negative attitudes towards asylum seekers (Schweitzer et al., 2005).

3.2.2.4 Contemporary Anxieties

The categorical denial of racism by politicians and media and the continuous exclusion and demonisation of asylum seekers have been key features of Australia's contemporary response to asylum seekers. Resort to discursive strategies and language is often justified as not being racist in nature but necessary for the best interests of Australia (Augoustinos & Every, 2007; Every & Augoustinos, 2007). Van Dijk (1992) explains that the shift from the "old racism" to the "new racisms" with its emphasis on incompatibility of various out groups lies in the fact that in contemporary times it is unpalatable to use overtly racist terminology. Rather the media and politicians present their messages and language as being sound, necessary and rational for security, fairness and sovereignty-related justifications and the so-called incompatibility of Muslim asylum seekers.

Pickering and Van Acker and Hollander discuss in detail the specific use and adverse impact of language in the criminalisation of asylum seekers (Pickering, 2005; Van Acker & Hollander, 2003). They advance that the repeated use of oppositional terms such as deserving/undeserving or legal/illegal by politicians and the media results in the establishment of difference between asylum seekers and the host society with asylum seekers being criminalised in the public domain. This distancing between the asylum seeker and the citizen in turn enables the government to easily implement a punitive asylum regime in Australia.

Australia's response to the politics of asylum represents a liberal paradox whereby western states demonstrate a transitional openness to economic trade and growth whilst simultaneously demonstrating political closure (McNevin, 2007). Martin (2015) advances that recent Australian government campaigns to stop the boats and to deter boat arrivals are linked to deep-seated anxieties about Australia's national identity and its fear of being invaded which has been tied to contemporary concerns such as the war on terror and Muslim asylum seekers being portrayed as a threat to Australia's cohesion. Martin advances that this moral panic is now a relatively permanent feature of Australia's response to the arrival of asylum seekers and the war on terror as opposed to being a one off response (Martin, 2015).

3.2.2.5 Punitive Measures

Asylum seekers are intercepted en route to Australia and processed in offshore detention centres. Detention is mandatory with no fixed timelines. When compared to the wider Australian population, asylum seekers collectively have a higher risk of suffering from a range of health problems. These problems stem from inadequate nutrition, the mental stress arising from their asylum-related experiences including their journey, harsh treatment and uncertainty about their future. Stresses and anxiety caused by lengthy immigration detention and uncertainty about their refugee application status, lack of social and family support and poor living circumstances add to poor mental health. The harsh treatment of asylum seekers and the uncertainty of their future often result in depression and post-traumatic stress disorder (PTSD)) (Hadgkiss, Lethborg, Al-Mousa, & Marck, 2012).

Important

An assessment of the situation of asylum seekers from a “Social Determinants of Health” perspective reveals that asylum seekers are disadvantaged in the following domains:

- Income and social status
- Social participation and social support networks
- Education
- Health literacy
- Healthy living conditions
- Racism, discrimination and culture
- Access to healthcare (Hadgkiss et al., 2012)

Depriving asylum seekers of these domains amounts to Australia’s breach of the Refugee Convention and various other human rights treaties and conventions including those relating to:

- Economic, Social and Cultural Rights,
- Civil and Political Rights,
- Elimination of All Forms of Racial Discrimination,
- Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Rights of the Child

In a detailed study of asylum seeker health issues, Hadgkiss et al. (2012) state that asylum seekers have many serious and complex mental health issues and are in need of culturally appropriate services including the need of interpreters. Health services currently available to asylum seekers are limited and stretched and are often provided by volunteers and professionals offering services on a voluntary basis (Hadgkiss et al., 2012; Spike, Smith, & Harris, 2011). As a consequence of challenges associated with researching the health needs of asylum seekers, there are very few such studies available with no studies on the long-term impact of health issues faced by this group. The studies that are available concern the significant psychological stress faced by asylum seekers who have been kept in immigration detention (Coffey, Kaplan, Sampson, & Tucci, 2010; Green & Eagar, 2010; Hadgkiss et al., 2012; Robjant, Hassan, & Katona, 2009). These reports document depression, PTSD and anxiety which have resulted in self-harm and suicide. Children who have been subjected to immigration detention suffer from distress and behavioural and emotional disorders and demonstrate developmental delays.

For asylum seekers who live in the community, psychological problems are the most common illness faced by this group including depression, PTSD and anxiety. These conditions are caused and exacerbated by two key factors: torture and trauma suffered and challenges they face when they arrive in Australia: fear of being sent back home and their uncertain visa status. Other factors which add to their stress include barriers relating to accessing housing, financial services and social isolation (Hadgkiss et al., 2012).

3.2.2.6 Conclusion

This chapter has documented the nature and extent of racism against asylum seekers in Australia. It has been argued that racism against asylum seekers has been perpetuated by politicians and the media and that there has been an ongoing denial of racism and racist sentiment. The discursive language used by politicians and the media is cloaked by references to Australia's safety, security and sovereignty. The shift from the "old racism" which is predominantly predicated on skin colour to the "new racism" which places emphasis on the cultural incompatibility of asylum serves to mask deep-seated anxieties about Australia as a "white nation".

3.3 Personal Stories and Current Affairs

3.3.1 A Letter to Asian Girls: Things I Wish I Knew

Caroline Wang

A few years ago, I was on a date.

We were walking back to his place when a group of loud, drunk white men approached us on Lonsdale Street. One of them turned to my partner and whisper-shouted, "Congratulations mate, you got an Asian girl!"

We looked at each other and kept walking. They followed.

"Mate, how did you get an Asian? You're black". There were wolf whistles. Slaps on the back.

We were silent on the way back to his place. Outside his apartment, he turned to me and asked, "Is there anything you want me to say?"

More silence. My date had charmed me with his intelligence, humour and his sharp insight over dinner. We had laughed about our parents, our degrees and the books we were reading. We spoke about our futures, favourite political commentators and the complex relationships we had with our own racial identities.

But in that moment, I didn't have an answer for him.

"Caroline, what can I do for you?"

I realised then that I'd never had an answer. I told him, "Nothing. Don't do anything. I'm used to it".

What I couldn't tell him was that time I was eight years old and a white middle-aged man approached me in the supermarket. I was picking carrots for my mother when he told me, "I really like Asian pussy. I can't wait to try out your tight cunt".

I didn't know what I had done. I was eight, and I didn't know there were so many ugly words in this world that people could use to describe me.

What I couldn't tell my partner was that other time I was ten years old, and another white middle-aged man approached me. This time, I was in a bookstore. The shelves were a sacred place for me. I loved reading and more than anything, I wanted to be Claudia Kishi from the Baby-Sitters Club because she was artsy and effortlessly cool.

But what I didn't tell my partner was this: the man in the bookstore started asking questions. His first question, like so many others before him who had asked the same question, was, "Where are you from?"

When I told him that I was from Melbourne "born and raised", he then asked, "But where are your parents from?" I told him, they were from China and that I was Chinese.

He looked at me and said, "Did you know that Chinese girls make good prostitutes? Do you want to go out for coffee, and I can show you?"

When I was 12 and 13, and old enough to take public transport by myself, I was sexually assaulted on the train. Both times, the men started with, "Where are you from? You are so beautiful. Are you Japanese? Are you Chinese?"

The first time, I froze as he began touching me and pressing me against the carriage wall. I didn't know what was happening. My mother had always told me that bad things would happen to girls who didn't listen, who stayed out too late and talked to strangers. But I hadn't been bad. And I didn't know what I had done.

The second time was worse because no one did anything, and no one said anything. Not the other passengers who watched from their train seats, and definitely not my mother. I came home crying, and she told me, "Don't be so naive. You're too young to understand what happened. Don't talk about this again".

We've never spoken about it to this day.

As I got older, I wanted nothing to do with my race. I went to bed every night wishing I could *just wake up white*. I hated my parents because my life would have been so much easier if they weren't Chinese—if I hadn't been born Chinese. I stopped speaking my language. I had heard too many *ching chong chang*'s when I walked down the street, courted too many catcalls, encountered countless white men who would leer as they passed me and shout *"ni hao"* at the same time.

I watched as English infantilised my parents, as teachers, waiters and real estate agents asked me to "translate" my parents' broken English while laughing at their accents and incorrect grammar. I resented my parents for their foreignness, for not learning English well enough, for embarrassing me in public when they spoke Chinese.

I realise now that I was breaking my parents' hearts.

I broke my father's heart when I begged him to dye my hair blonde when I was six. (Baba told me this story many years later, when I became an adult and moved out of home.) My mother's when I asked her if she loved me because she was always working and never picked me up from school. Back then I didn't know we were poor, or that my parents worked long hours in textile and car factories with hundreds of other migrants.

I was the only Asian child in my very white primary school, a school with a veggie patch and a trout farm sequestered in the beachy south-eastern suburbs of Melbourne. The children around me would pull their eyes into slanted slits and ask questions about my squishy nose. They asked if I ate dog and ran away from the dumplings my mother had made the night before, rolling out the dough, carefully filling each pocket, sealing the dumpling shut. By the time I was 12, I stopped eating the lunch my mother packed, and I started researching plastic surgeons that could turn my flat Chinese nose into a beautiful white nose, my small Asian eyes into round double-lidded eyes.

There were the school teachers who asked parents to proofread their children's homework, and I forged my dad's signature after every English task because how could my parents help me with spelling and grammar? My parents had asked me to bargain with plumbers and electricians, ask shop assistants for discounts and refunds, and book appointments for colonoscopies and pap smears before I could even learn how to punctuate my sentences.

My English helped my parents survive, but it also took away my childhood. My parents needed me to navigate the healthcare system, my education and their work rights. I helped my father write a resignation letter, detailing his depression, his deteriorating mental health and how the stress had made him suicidal. In so many ways, I became a parent to my mother and father, when I was just a child and needed someone to look after me.

My parents' illiteracy forced me to be precocious, the good daughter, the dutiful daughter. But the guilt I felt for resenting my parents, after they had sacrificed so much to give me a better life, kept me silent.

Instead, it manifested in other ways.

I developed body dysmorphia. An eating disorder. Intense anxiety. I couldn't eat because if my face could never be beautiful, then at least my body could be. I couldn't go to school because I was too scared to leave the house. Every time I stepped outside, I had this crippling fear of being racially and sexually assaulted.

During high school, I heard things like, "Have you noticed that there aren't any pretty Asians?" and "Was the guy hot? Nah, he was Asian". No one around me ever had a crush on an Asian person, and whenever someone told me I was pretty, they always told me I was a "pretty Asian". As if the default appearance of all Asians was set to average-unattractive, and the Pretty Asian was an anomaly.

I could never just be a "pretty person". People like me were always judged against beauty standards made for the white woman.

When my Asian friends tell me now that they don't find Asians attractive, I am angry, but I also understand. I have hated my appearance for nearly all my life, and this hatred has defined attractiveness as always white and never Asian. I understand because it was my appearance that marked me as different, a body that never belonged in this country, a target for middle-aged white men.

It was my appearance that made people shout ugly racist things to me, that reduced me to a preference that boys "don't do". And it was my appearance that entitled strangers to ask "Where are you from?" and shout bastardised Chinese words across the street.

I empathise with my friends who say they only date white boys. Did they grow up like me, thinking I could never be beautiful because of my Asianess, my small eyes, flat face and flat nose? Did they spend their childhood and early teenage years comparing themselves to white women? Maybe.

I started healing in university. Slowly. I discovered Homi Bhabha and Ghassan Hage, Ien Ang and Alice Pung, and they gifted me the vocabulary to express the confusion and hatred I had felt for the past 20 years. I read and read and read, and through my reading, I found comfort in these scholars who had experienced what

I had: that perpetual feeling of "inbetweenness", of being a hyphenated identity that would never belong anywhere, forever displaced. For the first time, I could articulate my isolation and loneliness; and, most importantly, the anger.

From Carole Tan, I put into words how my appearance had always—and still—excludes me from the white Australian imaginary. And from Michelle Law, I recognised in her writing the alienation I felt on the rare occasions I visited China, in the only place I should have passed.

I grew up in the west, surrounded by white people with white values, eating white food, not speaking Chinese. In a space where I look Chinese in a sea of other Chinese people, I am silent, mute, infantile, and they can always tell that I'm not from *here*. It's in the way I dress, my mannerisms, how I hold myself, my assertiveness. In the way I always look to my parents to speak for me, and the confusion that follows when shopkeepers, waiters and taxi drivers see an adult who can't speak.

I fell into Gender Studies, critical race studies and took classes called, *Genders and Desires in Asia*, *Race and Asian American Literature*, and a history subject that traced the patterns of migration in Australia. Slowly, I began to fit my own story into an unimaginably long history, a narrative made up of others like me.

In an essay about media representation, I realised that Claudia Kishi was revolutionary. Out of all the books I read as a child, and all the books I begged my mother to buy, Claudia was the only character whose family looked like mine, who stood out in the whiteness of her fictional town Stoneybrook.

I found the theory that explained the fraught relationship with my mother and the gap that had widened over the years from things left unsaid, from the language I had lost and my refusal to visit China and return to my ancestral homeland.

In this theory about affect and spectres, I realised why my mother never comforted me when I cried about those men and what they did to me many, many years ago. She never did anything because she didn't know how to. Because she realised that she couldn't protect her own daughter from the same men and the same words that had hurt her.

Now, at the age of 22, I have more or less come to terms with being both Chinese and a woman. I no longer harbour an intense hatred for an appearance and a culture I never asked for, but I regret all the nasty words I screamed at my parents, the years I missed speaking Chinese, the mooncakes, pork *bao* and century egg soup I never ate.

It has taken me nearly two decades to identify as an Asian Australian woman. I still recoil at the question, "Where are you from? No, where are you *really* from?" and I continue to grapple with new ways this country gets to represent and define me.

I get angry when I see Broadsheet and Urbanlist articles titled, "Top 5 Dumplings in Melbourne" and "Where to Find the Best Yum Cha". I get angry when I see people I knew from primary and high school post photos of dumplings, at the night noodle markets posing with their *bao* and duck pancakes to their Instagram. You used to call my food weird and gross and smelly but now that dumplings are popular, now that white people have decided that my mother's food is worth eating, I should just ignore my anger, forget how I was teased, isolated and made to feel like nothing.

There are so many things I wish my younger self knew. To be kind to yourself. You are not alone. Don't be ashamed of speaking Chinese. Learn to cook your mother's food. If I knew, maybe I would still be able to speak two languages. Maybe my relationship with my mother wouldn't be what it is now. Maybe I could have seen myself as beautiful. I don't know.

What I do know is that I am still living with that girl who has never been able to grow up, move on, "Caroline, why are you still thinking about it? It happened years ago". I know that I will never be able to leave behind that small shy Asian girl who has been scarred from this white country, but who, in so many ways, has been made strong by what she has endured.

3.3.2 White Mongrel

Alanna Kamp

In 1992, Stan Grant, one of Australia's most well-known and influential TV journalists, interviewed Shawn Slater, a US leader of the Ku Klux Klan on Channel 7's *Real Life* current affairs news programme. During the interview, Mr. Slater voiced his opinions on the natural division of the human races, opinions that are rooted in "old racist" ideas of blood purity and a belief in a hierarchy of humans. According to such ideas, at the top of the human hierarchy is the more civilised, moral, intelligent, pure [read: "White[1]"] race. At the bottom are all the other inferior races—those that are considered morally and intellectually inept, savage and maintaining physical remnants of human's ape-ish evolutionary past [read: "coloured" races]. The disparate races of humans should be kept separate as interbreeding contaminates the "pure" White race and sets human evolution on a backwards path. The White race should be left to thrive and conquer, while the inferior coloured races should be held at the mercy of Whites—to be exploited in mind, body and spirit. It is the understanding of people who hold such beliefs, such as Mr. Slater, that this is the natural order of things as the "survival of the fittest"[2] ensures only the best of humanity survives.

In the Australian context, Aboriginal and Torres Strait Islander Australians have borne the brunt of such racist ideology. Institutionalised and structural racism has seen governments, since British colonisation, attempt to eradicate the Indigenous population via obscene acts of violence and warfare, by stealing children from their parents, their land and their communities in attempts to "breed out the colour", and continued marginalisation of Australia's first peoples in all aspects of social, political and economic life. Beyond the institutional, experiences of

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[1] There are inconsistencies within the Whiteness studies literature in regards to the capitalisation/non-capitalisation of the term "White". I have chosen to capitalise the term as it is used in this instance as a proper noun denoting a socially constructed racial group not as a common noun denoting colour or shade (as also argued by Wachal, 2000).

[2] A phrase coined by Charles Darwin in regards to the animal kingdom but later adopted by Social Darwinists and their racist followers.

"everyday" racism in contemporary Australia are far more common for Aboriginal and Torres Strait Islander Australians than for non-Indigenous Australians. In a recent survey conducted by Reconciliation Australia (2016), almost one in two (46%) Aboriginal and Torres Strait Islander respondents reported having experienced racism such as verbal abuse or physical violence in the past six months (compared to 18% of non-Indigenous Australians). Stan Grant, a Wiradjuri man, had up until that interview on *Real Life* rarely (if ever) spoken publicly about his Indigenous heritage and identity.

I remember watching the interview like it was yesterday. I was eight years old. With eyes glued to the screen, I remember Stan Grant asking Mr. Slater what then would the KKK consider him to be as an individual of mixed Aboriginal and European ancestry?

"A mongrel".

Eight-year-old me was shocked and horrified by the blatant disrespect and racism towards an Aboriginal Australian, a fellow human. Shocked and horrified that such racist ideas existed, and shocked and horrified that it was aired on national television. Upon reflection, this moment also had such an impact on me because it tapped into something deep inside my being—something that I had never been aware of and made me question who *I* am and where *I* am positioned in this world. In that moment, I was made aware that I too was a mongrel. I was an eight-year-old mongrel—a child who had just been told that she was equivalent to a cross-bred dog.

I cannot claim Aboriginal or Torres Strait Islander ancestry and therefore am complicit in the colonial project that continues to marginalise Australia's first peoples. I am the result of the union of migrants to this land—a White European father and an Asian mother. As such, I hold a position of privilege in this nation as a non-Indigenous Australian. At the same time my ancestral "mixing" makes me, according to the KKK, a racial anomaly, a scourge on the White race. I therefore occupy a complicated position of both settler of the land and unsettler of racial dichotomies. What adds to my anomalous position is that my "mixed-race" heritage is not clearly marked on my body (perhaps a perfect example of an unidentifiable mongrel). My skin is fair. My eyes are brown as is my hair—a wavy mass I inherited from my European father. Very rarely does anyone identify me from my physical form (alongside my European name) as an Asian Australian. This has not, however, made me immune or untouched by racism, and I am constantly reflecting on my own complex positionality.

I grew up in Sydney's Eastern suburbs in the late 1980s and 1990s, by the beach but only five kilometres from the city. Where I grew up was the epitome of cosmopolitan Sydney. My childhood friendship groups were like the *United Colours of Benetton*—several of us having migrant parents from all corners of the globe (Asia, Europe, the Middle East, South America, the West Indies), some of us hailing from convict roots. We were a mish-mash of kids from all walks of life who just happened to go to the local Catholic school or walk our dogs at the same neighbourhood park. Everyday life was great and pretty uneventful. However, I also remember being a kid and hearing a rather grubby middle-aged man tell my mum to "go back from where she came from" at a lunchtime visit to a local

RSL. Entrenched in my memory are recollections of new acquaintances asking my mum if she was from the Philippines or Thailand (with the assumption that she was a “mail order” bride). It is a commonly told story at our family table how mum used to always get asked if she was our babysitter—apparently, the only logical explanation as to why such a youthful Asian woman would have children that looked like my sister and I. Why was it that I clearly belonged in my family, my neighbourhood, my country, when my mum did not? It was our racial markers—skin colour, eye shape, hair type—that set us apart.

Not having my ethnic ancestry marked on my skin has been increasingly confusing and often very hurtful in my adult life. I have had people, strangers and those very close to me, rant about the invasion of Asian students who are taking up all the university spots and the hordes of greedy Chinese who are coming to Australia to buy up all the property. Little do they realise that my mum was one of the “Asian” international students, and I am living in an apartment bought by my “Asian” grandparents in the 1970s to house their international-student children (I can’t help but laugh at the irony). I have been called “slope-head” and “rice-muncher” by people who I have had very close relationships with. All these racist rants and “terms of endearment” were excused by the perpetrators either because they don’t recognise my cultural identities or because “Alanna, you’re not *really* Asian”. To be honest, I don’t know what’s worse—being denied my Asian heritage or being taunted *because* of my Asian heritage.

It is perhaps because of my background that I have wandered down my professional path. Almost three decades on from that life-changing “mongrel” moment, I am now a post-colonial feminist geographer, interested in Australia’s migrant history, national identity and our experiences of belonging and exclusion. Through my research and own self-reflection, I am constantly interrogating our diverse positions of power and privilege, and what it means to be “Australian”, but more particularly, what it means to be an Australian woman and how those in privileged positions can provide a space for the previously invisible and voiceless to be seen and heard.

I contemplate these ideas with acknowledgement of my own privileged position. I am a “White passing” cis woman in my mid-30s, Australian-born, heterosexual, highly educated and middle class. I work at a university, conducting social research and in the relatively early stages of my career have already taught thousands of university students who are in training to be teachers, social workers, criminologists, urban planners among many other pivotal jobs in society. I therefore hold a great deal of power within and beyond the walls of the university and do my best to provide my students with the skills to be active and engaged citizens who can apply their learning to advocate for themselves and their communities.

Alongside such power and privilege, it is undeniable that my gender, age and ambiguous racial position have provided challenges in various aspects of my adult life. I have seen less qualified and experienced males move up the career ladder much faster (and easier) than myself. I have been subject to sexualised taunts and unwanted touching by men I don’t (and do) know. I am constantly aware of my personal safety and restricted mobility when walking alone at night in my own suburb, on my own street, at a bar, in a unisex bathroom, empty park or train carriage. I am aware that my "biological clock" is ticking and that if I don't have children soon I may never have them and if I do have them I question how it will impact my career. I have been told at academic forums on racism that I need to acknowledge my Whiteness before presenting my research on experiences of racial discrimination—as if I have no right to speak about it. I have been asked when presenting my research on Chinese Australian women—why are you doing this research? As audience members question why a White woman would be interested in issues impacting Asian Australians. My gender and age are constantly at the fore while my cultural heritage is continually being erased. I am not Asian enough. I am not permitted to use that identity category to define myself or my position. I am somewhere in-between. Will I ever be given permission to be considered "non White"? Do I want to be considered non-White? I cannot be "non White" just as I cannot be "White"—this is the problem of these racial and identity categories. They are based on exclusive ideas of belonging or not belonging. I belong nowhere. I am a different kind of Other.

Despite such intersectional messiness, it is undeniable that my "Whiteness" will always mark my position of power and privilege on this stolen land, regardless of my gender, age or other social variable. As Marilyn Lake (adapting bell hook's (1987) iconic arguments about race and privilege in the US) so pertinently describes:

> » Despite the predominance of patriarchal rule in Australian society, Australia was colonized on a racially imperialistic base and not on a sexually imperialistic base. No degree of patriarchial bonding between white male colonizers and Aboriginal men over-shadowed white racial imperialism. In fact, white racial imperialism granted to all white women, however victimized by sexist oppression, the right to assume the role of oppressor in relationship to Black women and Black men (Huggins, 1987, 77).

I therefore cannot escape or ignore my privilege and complicity in the colonial project. I do not want to be silent about my Whiteness as I do not want to be silent about my Asian heritage and identity.

As my reflections hopefully reveal, identity, privilege and oppression are highly personal experiences, yet we cannot disentangle identity, privilege and oppression from the collective, be that collective (majority) views and politics that impact groups of people based on some shared identity or experience, or collective voices of resistance. Each individual is unique and views the world through their own human lens (or lenses) that are not only shaped by "race", but also gender, generation, position within family, class and so on. These are a complex and complicated web of positions, experiences and perspectives. For me, this web cannot be untangled, and distinct patterns cannot be easily discerned. I am in a continual process of trying to understand my multiple identities, the way they intersect but also where they diverge. Where do they challenge each other? Where do they stand in complete contradiction? A counterpoint? I no longer allow "mongrel" to define my identity, instead my process of knowing and unknowing, untangling and re-tangling will be my forever process of becoming.

3.3.3 Creating a Safe Space for Children and Families from Refugee Backgrounds in the Healthcare System in Australia: A Health Professional Perspective

Karen Zwi and Lisa Woodland

An unprecedented 68.5 million people around the world have been forced from home. Among them are nearly 25.4 million refugees, over half of whom are under the age of 18 years old (UNHCR, 2018). Australia currently accepts around 20,000 refugees flown in each year through the United Nations programme and has policies that detain and send to offshore processing centres those who arrive by boat. Refugee children come to the healthcare service with great strengths and significant vulnerabilities. Their strengths are evidenced by their survival through enormous adversity and their capacity to achieve and contribute to their reception countries at extraordinary levels, including higher educational and employment status within a generation (Hutchinson & Dorsett, 2012). Their resilience has been well documented and includes survival and thriving in the face of extraordinary life experiences.

However, we often encounter them when they are unwell, as well as adjusting to a new country, language, school and healthcare system. Professionals working with refugee people tend to focus on their trauma to the neglect of their strengths, imposing a deficits model that defines refugee people as traumatised victims. Optimising the strengths and resilience that are often present and supporting families through the barriers they face (such as transport, English proficiency and discrimination) are likely to enhance their resilience and provide improved engagement and health outcomes (Chazin, Kaplan, & Terio, 2000; Hutchinson & Dorsett, 2012; McCashen, 2005).

Unfortunately, our healthcare system is somewhat inflexible and largely designed for people who are literate and numerate in English, are reasonably educated, have transport and perceive health in a similar way to Australians. We believe we should expect our healthcare systems and professionals who practice within to adapt to deliver the highest quality of care to all people. In our experience, ensuring patients feel safe and welcome brings their strengths and resilience to the fore. Putting the patient at the very centre of the healing process, respect and the development of a trusting relationship are essential to good clinical care. We feel honoured to work with refugee and asylum seeking children, who have so much to teach us about resilience, tenacity and survival. We consider working with refugee children and their families one of the most rewarding aspects of our respective careers.

Overview

This section is about our personal reflections on working with children and families from refugee backgrounds in the healthcare system. The term “refugee backgrounds” includes children and families granted refugee status and those from refugee like backgrounds who may not have formal refugee status or who are awaiting such status, such as people seeking asylum. This is a rewarding field of work and one that challenges us to think very deeply about the care we deliver. Like all of life's challenges, there is no "right answer" and there is no defined end point. Delivery of culturally safe and effective care involves a process of reflection, constant growth and learning. On the other hand, oversensitivity to the issues can be disabling and may cause clinicians to shy away from confronting the complexity some patients present. Most importantly, we suggest you be your own authentic self in your interactions with your patients, and integrate the ideas in this chapter into the best version of your clinical self. Even people considered "experts" make mistakes all the time but we share our reflections in the spirit of moving together towards a more healing and safe space for our patients and their families. Here we present possible strategies we can employ to create a therapeutic space for families.

It covers:

1. *How can we help children and their families feel safe in our healthcare system?*
2. *How can we influence change in our workplace and impact on systems change?*

3.3.3.1 How Can We Help Children and Their Families Feel Safe in Our Healthcare System?

Children from refugee backgrounds and their families have almost invariably experienced discrimination, human rights violations and reduced access to healthcare and other services in their countries of origin and during their journeys. We have a responsibility to provide a therapeutic space in which our patients can develop trust in the healthcare system. This requires a range of strategies, discussed in more detail below, including making the spaces welcoming, deep listening, using professional interpreters, considering the words we use, making every encounter an opportunity to develop a relationship, addressing what is most important to the patient, practicing self-reflection and challenging our own sense of what is "normal", providing trauma informed care, addressing social-emotional wellbeing and aiming to build resilience.

Make the Spaces Welcoming

There are many ways we can provide a safe and welcoming environment. Simple measures including messages of welcome in languages other than English, translated health materials and providing toys and books that reflect cultural diversity may reduce the sense of alienation or "othering". The presence of bilingual and bicultural staff working in the healthcare setting may also enhance a sense of inclusion. Wayfinding strategies, such as maps and coloured paths, reduce the family's anxiety in finding their way around often complex healthcare environments.

The process of respectful interaction should begin long before the first appointment is made. The phone calls, letters or emails, the contact with the receptionist, the layout, artwork, toys and patient mix in the waiting area all require thoughtful consideration to ensure that children and their families feel empowered, safe and comfortable to interact with our services.

Embrace the Power of Listening

The key tool we have as health professionals is the power to validate the patient's experiences and perceptions of the health issues they face. (We use the term patient due to our experience working with patients and their families within various healthcare settings; "client" may be the term preferred by other healthcare professionals.) Validation can occur through respectful listening to what and how the patients present their problems. The defining lived experiences of children and families from refugee backgrounds include that their stories have not been heard, they have been discriminated against and they are likely to have felt unsafe. Deep and respectful listening and allowing children and families to control the information they share is a powerful way to ameliorate the effects of these past experiences and to develop a trusting relationship essential for any therapeutic intervention. Even where we have no answers for certain problems, the experience of someone listening in a deeply respectful manner can in itself be highly therapeutic and can motivate the patient to find their own solutions.

Use Professional Interpreters and Address Health Literacy

To listen respectfully, health professionals must engage the use of professional interpreters where any one person in the family is not fluent in English. The use of professional interpreters reduces the risk of adverse events, improves patient experience and compliance and is associated with improved health outcomes (Flores, Abreu, Barone, et al., 2012; Garrett, 2009; Johnstone & Kanitsaki, 2006; Karliner, Jacobs, Chen, & Mutha, 2007; Lindholm, Hargraves, Ferguson, & Reed, 2012).

When booking interpreters, especially for children and families of refugee backgrounds, it is important to check with the family or referring service about the dialect and gender of the interpreter required. Where the interpreter is from the same small community as the family, telephone interpreters may be preferred to protect the family's sense of privacy.

Before the consultation, we should brief the interpreter about the nature of the consultation and what we hope to achieve. We can also consult privately with the interpreter to ask general questions such as "how is this concept understood within your culture?" and "how do families within your culture generally deal with these issues?" Be aware that some words and concepts do not exist in certain languages. At the beginning of the consultation, explain to the family that professional interpreters are covered by a code of conduct and are expected to maintain confidentiality.

An important aspect of working with interpreters is for us as health professionals to maintain control of the clinical consultation and the therapeutic relationship. We don't look at the interpreter when they are speaking but continue to relate to your patient and their family. We may need to interrupt side conversations to ensure that we are fully aware of each family member's understanding of what is happening and their response to it. Take time to explain concepts and give the interpreter time to interpret at frequent intervals. We may need to debrief with the interpreter if the consultation has covered traumatic material. Expect the consultation to take double the length of time of a session without an interpreter.

Misunderstandings can easily occur in cross-cultural communication. If we notice the patient or family member seems disengaged or offended, take the time to be curious about how they understood what was asked/mentioned, apologise and explain our intention. Teach-back is a method that health professionals can use with children and families (Culture, Ethnicity and Health, 2020). We can ask direct questions such as "can you tell me what you understand about what I have told you?" or "can you tell me in your own words when to take the medication?" to check that everyone has understood the information provided.

Important

Steps in the teach-back technique

1. Explain one concept to the client at a time
2. Assess the client's recall and understanding by asking the client to explain what you said
3. Repeat the process until the client can demonstrate they have a satisfactory understanding of the information
4. Introduce the next concept

Key elements for using teach-back

- Be respectful of the client's existing expertise
- Be mindful of the amount of information conveyed at one time
- Information should be broken up into small chunks so it can be relayed easily and avoid confusion
- Phrasing your question in a supportive way so that the client doesn't feel like they are being tested

Consider the Words We Use

As health professionals, we need to be conscious of what patients experience in our healthcare system, particularly the words that we use. The very least we should expect of ourselves is not to humiliate or offend our patients in any way. This can occur easily and unexpectedly. Use of language such as "vulnerable", "disadvantaged", "asylum seeker" or even "refugee" may be perceived as disrespectful and shaming by patients and their families. Show awareness and respect by using language that is not interpreted as undermining. If such terms are required to access additional resources or for prioritisation, then explain this to the patient.

The language we use can be perceived as judgemental and lacking in respect for the patient and their families' choices. "Failed to attend" and "Discharged Against Medical Advice" presume that our medical advice is "correct" and fail to take into consideration the patient's perspective or more pressing needs. We need to consider the role that *we* play in not facilitating the patient's access. Did we address transport issues? Did we provide appointment letters and signage in the patients' language? Did the patient feel safe in our spaces?

Consider Every Encounter an Opportunity to Develop a Relationship

Building a relationship with children and families takes time and respect. Asking respectful questions to elicit the patient's/family's understanding of the health condition, before offering our own interpretation, can engage the family and provide valuable insights and opportunities to develop a therapeutic relationship. The

Cultural Awareness Tool suggests nine questions to explore the patient's explanatory models, priorities and expectations of care in order to build a therapeutic alliance (Benson, 2006; Bensonn, Thistlethwaite, & Moore, 2016; Mezzich, Caracci, Fabrega, & Kirmayer, 2009; Seah, National Mental Health,, & Multicultural Mental Health, 2002).

Important

The Cultural Awareness Tool suggests nine questions:

- What is the main problem you would like me to help you with today?
- How is this problem affecting you?
- Why do you think it started when it did?
- What do you fear most about this problem?
- What solutions have you tried or have you thought of?
- What were you hoping that I would do for you today?
- How can your family and community help you with your problem?
- How will we know when you are well again?
- When would you like to come back?

At the centre of high quality patient-centred care is the patient's expertise in their healthcare problem, what matters most about it and how to solve it. The health professional's role is to bring their expertise to the patient's formulation of the problem and to offer evidence-based solutions that add value. A management plan should be negotiated such that the patient retains a sense of dignity and control over their health. Only where there are distinct dangers to health of the patient's cultural approach should this be respectfully discouraged and an explanation provided.

Address What Is Most Important to the Patient

There is clear evidence that the social determinants of health, such as housing, education, employment, social isolation or experiences of racism and discrimination, are more important in determining long-term health outcomes than the health service offered (Henry, Houston, & Mooney, 2004; Marmot, 2005; Woodland, Burgner, Paxton, & Zwi, 2010). Patients will bring their social needs as well as their health needs to the clinical encounter. Listening to the challenges they are experiencing in all domains of life is important in developing a therapeutic relationship. As health professionals, we may not be able to effect change, but it will be much appreciated by the patient if we actively assist (rather than simply refer) the patient to find the right person and stay in the picture until the issue is resolved. We can use our influence as health professionals to advocate at an individual level for our patients. For example, if we believe housing or the school environment is contributing to the patient's health condition, we can write advocacy letters to the housing or education department advocating on their behalf. This advocacy is key to engaging with families and building a therapeutic relationship.

Practice Self-Reflection and Challenge Your Own Sense of What Is "Normal"

Another way in which we may inadvertently be disrespectful is that we internalise our own culture and consider it "normal".

► Example

For example, we may use tone of voice, body language and eye contact that is "normal" for us but could be uncomfortable, disrespectful or even rude to our patients. It requires sensitivity and self-awareness to communicate in ways that match the cultural context of the patient, mirroring their cultural norms for showing respect (be it shaking hands, averting gaze or being silent at times) whilst maintaining our own integrity. This extends to understanding the relative importance of the extended family or community in shared decision making and giving patients time to do this within the context of our timed, appointment-driven system. ◄

Furthermore, people from refugee backgrounds may have unique understandings of health, illness and death and may have experienced a very different healthcare system in their country of origin compared with the Australian system. They may be mistrustful of a system that they don't understand and feel too intimidated to ask questions. Respect for our patients extends to trying to understand the health belief system that makes sense to them.

Our role as health professionals is to understand the differing heath belief systems and cultural practices and take this into consideration while offering the best available evidence-based treatment (see ◘ Fig. 3.1). Heath belief systems are not mutually exclusive, and we should anticipate that we all have complex, overlapping and inconsistent belief systems. These may vary within and between families from similar cultures, across the life course and across generations, and may change at times of illness, fear, childbirth or death of loved ones (Raman, Nicholls, Ritchie, Razee, & Shafiee, 2016). Health professionals may need to adopt different approaches with different family members and explore the intergenerational issues between parents and their children to find common ground.

Where beliefs do not harm the patient or are not contraindicated for medical care (which can be the case for some traditional medicines during cancer treatment), we recommend that clinicians take an additive approach in this context by not refuting the family's cultural understandings but adding information into their existing knowledge base to assist them to make informed decisions.

The LEARN model provides a way for health professionals to explore health beliefs, provide health education and negotiate mutually acceptable healthcare plans in a way that builds on a patient's knowledge and beliefs (Berlin & Fowkes Jr., 1983).

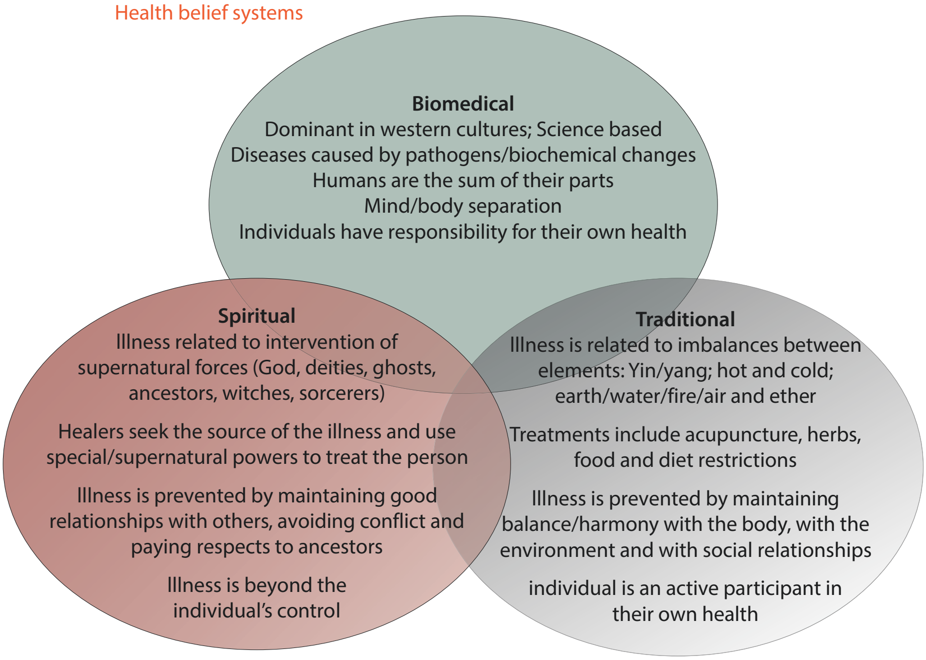

Fig. 3.1 Health belief systems are not mutually exclusive (Holland & Hogg, 2001; Zwi, Woodland, Kalowski, & Parmeter, 2017)

LEARN model (Berlin & Fowkes Jr., 1983; Zwi et al., 2017)

Listen with empathy and understanding to the patient's perception of the problem. Encourage the patient to discuss his/her understanding of the causes and effects of the illness and the treatment that will contribute to recovery. "What do you feel may be causing your problem?" And "What do you feel might help or hinder your recovery?" are examples of questions that elicit patient feedback.

Explain to the patient your understanding of the illness taking into account the patient's level of health literacy. Explain your patient's illness, the recommended plan of care and subsequent management of self-care. Even without a diagnosis, it is essential that you explain what you have in mind in terms the patient can understand. Take into account literacy level, cultural beliefs and past experiences which may affect understanding and acceptance of any suggestions you give. Try to link your explanation to something the patient already knows. Do not ask for feedback by asking "Do you understand or have any questions?" but rather discuss a particular point or pose a problem to which the new information can be applied.

Acknowledge and discuss similarities and differences between your perceptions and the patient's perceptions. If the patient proposes a treatment which may be harmful or is incompatible with the treatment you recommend, explain the consequences. Acknowledge your patient's feedback and understanding of his/her illness and plan of care. Discussing the differences and similarities with your observations will help promote patient involvement. Areas you agree upon should be recognised and differences resolved. Whenever possible, integrate your patient's suggestions into any care approach. This will give him/her a sense of control and commitment. If his/her suggestions would have a negative effect, explain the consequences and try to make the appropriate plan of care more desirable.

Recommend a healthcare plan that integrates the patient's suggestions to enhance their sense of control and commitment. Recommend a plan of care that fits within the patient's parameters. This can be accomplished after completing the three previous steps. The more involved your patient is in the development of his/her plan of care, the more interested s/he will be in its outcome. It is important to listen to concerns your patient may have and agree on solutions that will enhance commitment.

Negotiate agreement that is mutually acceptable. Negotiate agreement with your patient on a course of action. This requires a keen understanding of your patient's perspective and the ability to integrate the information you gained in the previous four steps. Successful completion of this final and key step can lead to a variety of patient-specific approaches that will increase the change of a successful recovery and healthier life.

The tendency in some patients to deference in interactions with authority figures may also hinder the development of a therapeutic alliance. They may hint at rather than assert their views, have a strong sense of shame or honour in relation to certain conditions, or have an alternate sense of timing in certain situations. For example, we may consider it "normal" to seek healthcare immediately if your child is injured but some may see it as important to see what happens over time. This may have significant impact on how we "judge" our patients, including in the context of child protection. Similarly, we consider it "normal" for patients to ask questions in a healthcare interaction and may judge patients as disengaged rather than embarrassed, shamed, unconfident or simply assuming that the health staff will say whatever needs to be said. Health seeking and health communication behaviours are driven by multiple factors operating at the family and community level and should not be oversimplified.

Provide Trauma Informed Care

In working with refugee patients, there is a high likelihood that patients accessing our services have experienced trauma. Trauma-informed care is a framework for service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs, such as their processing of information, memory and confidence to challenge authority or even ask questions (Harris & Fallot, 2001). The underlying philosophy is to do no harm and provide healthcare which is physically and psychologically safe, strengths-based and empowering (Kezelman & Stavropoulos, 2012). It requires us to have an awareness and sensitivity to the patient and their family in the context of their trauma history. Trauma-informed care involves the patient telling their story at their own pace and for us to undertake careful questioning only if necessary around previous trauma experiences. It includes sensitivity to triggers that may be re-traumatising, such as exposure to loud noises, ambulance sirens and use of medical equipment such as dentist drills. It is important to consider the organisational interfaces likely to come into contact with individuals who have experienced trauma from a “client journey” perspective. This may include the presence of professional interpreters or health professionals from cultural backgrounds associated with the opposing side of the conflict they have fled; as well as a range of other staff (e.g. phone/intake staff, reception area staff, as well as catering, cleaning and security staff).

One of the strategies used to work with children who have experienced trauma is called PACE, which stands for Playfulness, Acceptance, Curiosity and Empathy (Allen & Vostanis, 2005). This approach can help children to feel more secure and to build the skills they need to master challenges. Using PACE also enables the health professionals and the parent to see the strengths and positive features that lie underneath more negative and challenging behaviours. Understanding that the child is behaving a certain way due to the family trauma or sense of dislocation can be helpful in reframing that the child is not simply “naughty” or “disobedient”.

Overview

Playfulness, Acceptance, Curiosity and Empathy (PACE) is a framework to enhance the sense of safety felt by the child.

Playfulness is about creating an atmosphere of lightness and interest when you communicate, like when story telling rather than lecturing, creating a sense of fun, joy and safety which builds trust and gives hope.

Acceptance is at the core of the child’s sense of safety and is about actively communicating acceptance without judgement.

Curiosity is wondering about the thoughts or meaning behind behaviour for the child, for example by saying “I am curious how you explain this”. “What do you think was going on?” or “I wonder what…?”

Empathy allows the adult to demonstrate that he or she knows how difficult an experience was for the child and communicating that the child will not have to deal with the distress alone.

Address Social-Emotional Wellbeing and Build Resilience

Some parents view their children’s health holistically and include issues such as feeding, sleeping, play and behaviour in their overall account of health, whilst others may consider these personal matters. Discussing and assessing social-emotional wellbeing, either through general discussion or using specific tools such as the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), can provide a framework within which to address this. It is important to consider all the child’s needs and not to focus on physical health alone. Not only does this open up a more comprehensive conversation about the child’s health and wellbeing, but it also opens doors for health professionals to engage with school and other settings where there may be very useful practical resources to assist the child with anxiety or distress, missed education or financial difficulties.

Evidence suggests that experiences such as exposure to trauma and parental mental illness can impact on child wellbeing and development (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007; Hanes, Sung, Mutch, & Cherian, 2017; Mares, 2016). Some parents may have an appreciation of this; however, making a direct link may also be humiliating for parents who have had no control over these aspects of their lives and have tried to protect their children as best they can. Building resilience requires the clinician to identify the strengths of the patient, family or community and to try to mobilise and build on these strengths. It is important for us to adopt a strengths-based, solution-focused approach rather than a focus on deficits and problems.

Tip

Some practice tips for opening up conversations (Zwi et al., 2017).

- Reflect on your own cultural beliefs and practices
- Do some preparatory work on who your patient is, where they have come from and identify possible cultural issues likely to be relevant
- Brief the interpreter before the consultation and ask about any general cultural information which may be relevant to the consultation. For example, “How is this understood within this culture?”; “How do families generally deal with these issues?”
- Allow longer consultation times when using interpreters; maintain clear communication within the consultation and always look at the patient rather than the interpreter
- Create a respectful environment that optimises communication, builds trust and allows time for shared understanding to be reached
- Take time to learn about the family’s health beliefs and add information into their existing knowledge base to assist them to make informed decisions
- Check that everyone has understood the information you have delivered by asking “Can you tell me what you understand about what I have told you?”
- Maintain the patient and family’s dignity above all else and never imply that “we know best” or are “more advanced” at risk of humiliating the patient
- Identify when and how cultural issues may be impacting on the consultation; adapt the process to enhance communication and relationship-building
- Be alert to signs that the patient or family has become disengaged, confused, upset or withdrawn and address this directly. For example, “Is there something that I have said that has made you concerned or upset?” “Is there something that you feel you cannot tell me about?”
- Allow the patient and family the time they need to tell you what they would like from you and what they see as the next steps in the healing process

3.3.3.2 How Can We Influence Change in Our Workplace and Impact on Systems Change?

In addition to providing clinical care, healthcare organisations frequently engage in various forms of advocacy on behalf of vulnerable patient groups. Below are strategies for influencing change and working towards high quality and equitable health services.

Advocating Within Our Organisations

Individual advocacy for each child at each institution becomes highly inefficient when there are organisational barriers preventing equity of care to whole groups of children. Health professionals can advocate within their organisations to adopt best practice models and policies that ensure patient needs are better met and that health professionals are supported in the delivery of appropriate care.

Studies on healthcare delivery models for refugees and migrants in resettlement countries show that access to healthcare is improved by multidisciplinary staff, use of interpreters and bilingual staff, no cost or low cost services, outreach services to facilitate clinic attendance, free transport to and from appointments, longer clinic opening times, understanding and addressing determinants of health such as housing, welfare, employment, gender-sensitive providers especially for women, case management, home visiting and cultural training of staff (Zwi et al., 2017).

► Example

Examples of organisational policies and strategies to enhance equitable healthcare provision

- Use education and training as opportunities to promote cultural change within organisations
- Inspire people to be interested and give them specific ways of becoming involved
- Mentor, support and supervise colleagues and trainees to follow a career dedicated to making the system safer and more equitable
- Develop an Equity Policy that ensures that all children, independent of their circumstances, are treated equitably, which means some may require more resourcing to achieve the same health outcomes
- Develop a Prioritisation Policy for refugee children such that they bypass long waiting lists for services and appointments
- Develop a Fee waiver policy for Medicare ineligible asylum seeking families
- Develop a Strategic Plan, endorsed by the Executive and the Board, which addresses critical aspects of health service provision for refugees and asylum seekers
- Ensure Financial Support Policies for low income families to support payments for medications, radiology and/or pathology
- Develop a Policy on the Treatment of Detainees in Health settings ◄

Institutional racism is well described in Australia, and there is good evidence that discrimination negatively impacts on child and youth health (Henry et al., 2004). This is not only in terms of increased anxiety and depression, but also in terms of behavioural issues such as Attention Deficit Hyperactivity Disorder (ADHD), aggression and conduct problems, low self-esteem and even physical health problems such as prematurity and low birth weight (Naomi Priest, Social Science and Medicine 2013). Specific examples of racism and discrimination should be routinely reported through incident reporting and management systems.

Policies to address inequities and racism require widespread communication within the organisation and may need repeated reinforcement to ensure adverse and humiliating events do not occur, such as sending billing invoices to patients, or inadvertently embarrassing patients without Medicare cards. Comments about patients' refugee, detention or visa status within earshot of others can be deeply humiliating for patients. In some circumstances, staff need to go to great lengths to compensate for the systems humiliation imposed on the patient, for example in the case of children in detention admitted to hospital who were unable to play with other children without being accompanied by their detention guards.

It can be argued that organisational barriers to providing evidence-based and quality care also impact on the health and wellbeing of health professionals attempting to provide care for children. This may require meetings with senior management. Advocacy at this level can create tensions between health professional advocates and managers and is best approached in a strategic way with due consideration of the organisational context.

Systemic Advocacy

Some issues are beyond the scope of individual advocacy and require a broader systemic approach. Systemic change may be required to ensure each and every child has equitable access to high quality and safe healthcare. However, advocacy for broader systems change can be controversial. Examples of issues requiring systemic advocacy include indefinite detention of asylum seeking children and families arriving by boat and their ineligibility for the National Disability Insurance Scheme.

► Example

Options for systemic advocacy available to health professionals to address the ethical dilemmas they face in their workplace include:

- Link with colleagues and their organisations to develop responses to broader systems issues. For example, develop standardised approaches to ensure that children in immigration detention receive safe, effective and person-centred care within hospitals and that immigration detention guards respect the patient's privacy and should not adversely affect the patient's healthcare ► http://webapps.schn.health.nsw.gov.au/epolicy/policy/4571
- Link with professionals colleges/organisations to develop position statements. For example, Royal Australian College of Physicians (RACP) Policy Statement Towards better health for refugee children and young people in Australia and New Zealand: The RACP perspective. Available at: ► http://www.racp.edu.au/hpu/policy/index.htm. (Zwi, Raman, & Burgner, 2007)

- Volunteer to work with organisations outside the health system that are working on similar issues. For example, Amnesty International Emergency Health Forum to End offshore detention (2018); Australia's Compliance with the Convention on the Rights of the Child (2018); Australian Human Rights Commission National Inquiry into Children in Immigration Detention (2013–2014)
- Use options available to you as a private citizen. For example, write to your local member of Parliament, attend public rallies or sign petitions
- Generate and/or promote evidence to support policy and practice change. For example, presenting the latest research findings to key decision-makers to try to influence that policies are evidence and practice informed and best meet the needs of patients
- Present your evidence in a strengths-based way. For example, write about protective factors and resilience rather than risk factors and deficits
- Publish about the systems issues and ethical dilemmas in peer reviewed scientific as well as more accessible literature. For example, The Conversation ▶ https://theconversation.com/profiles/karen-zwi-140052/articles
- Join research organisations with people interested in creating a better future for all children in Australia. For example, Refugee Health Network of Australia (RHeaNA), a network of health and community professionals who share expertise in refugee health
- Join professional organisations interested in social justice issues. For example, International Society for Social Pediatrics & Child Health (ISSOP) ◀

Advocacy for broader systems changes may create ethical dilemmas for health professionals trying to address policies impacting on their patients' wellbeing and raises the possibility of conflict with health service management. Feeling constrained within one's organisation can be frustrating for clinicians passionate about addressing systems change to address their patients' needs. Addressing issues that impact on health but are not supported by ethical government policy requires courageous leadership and a supportive workplace culture. Organisational support is important and lends credibility to any advocacy efforts so it may be more appropriate to seek professional body support through our professional agency/union, medical college or University, where there may be more flexibility and willingness to engage with controversial issues. Talking and publishing about the ethical dilemmas are also important in raising awareness amongst our colleagues. It is rewarding to inspire people to be interested and to give them specific ways of becoming involved. Participating in the public debate not as a healthcare professional working for a specific organisation, but as an individual or concerned citizen still brings credibility due to our status as health workers.

In summary, developing expertise and skills in working with refugee and asylum seeking populations will deliver many rewards to both our patients and ourselves as practitioners. Although this is lifelong learning and no specific end point is ever reached, continuous practice, self-reflection, discussion with our team members and analysing what went wrong when errors are made add value to the way in which we relate to all our patients.

3.3.4 Who Are the Sri Lankans in Australia?: An Outline for Mental Health Workers

Anton Piyarathne

In Australia, many of the Sri Lankans who congregate around Sydney and Melbourne are at risk of an identity crisis due to the many ways they are labelled—for example, *Sri Lankans, Australians, Lankan-Aussies, South Asians, Curries* (Athukorala, 2010). As a result, some may experience problems in obtaining full socio-psychological (and cultural) acceptance as Australian citizens. Over the years, there have been two groups of migrants to Australia from Sri Lanka. The first group migrated in the 1960s, 1970s and 1980s, and the second group after 1990, mainly due to political reasons (Gamage, 2014). The post-1990s immigrants have been described as living between two cultures (Gamage, 2014), with the associated complex and subtle psycho-social dimensions around everyday social lifeworld construction and maintenance.

A person's social lifeworld is shaped by the way they have been socialised. Socialisation is the process through which somebody learns to understand and construct their life, including meanings around good and bad, happiness and sadness, anger and hate. This phenomenon is evident among Sri Lankans where they have been living in politically divided worlds since the 1950s in general, and the 1983 July ethnic riots in particular. During my fieldwork there, I often heard people refer to the ethnic "other" with comments like "those people are incompatible with us, so we cannot live with them". I see this notion of an ethnic "other", so evident in today's mass ethno-political consciousness, as a colonial mechanism that maintains the power of political elites. It allows power holders to deny existing similarities between groups of people (Harrison, 2003), and to generate differences in order to maintain power and their way of life for future generations. Disenfranchising citizenship rights in 1948 and the political ethnic riots since the 1950s have maintained the population's evolving identities as "incompatible" partners (see Kapferer, 2012). Harrison (2003) suggests that ethnicity is generated through either denying or muting resemblances. Overall, the race conceptions of ethnic differences have become deeply ingrained in the reality of life for Sri Lankans, a legacy of colonialism and subsequent electoral politics post-colonialism. Sri Lanka gained its independence in 1948 in the midst of unresolved issues associated with colonisation, and the inherited Westminster system with its majoritarian ethno-political model seemed to offer more advantages to the majority ethnic group than to the minorities. I argue that the history of conflict in Sri Lanka is political, in that particular cultural resources have been deployed to suit the interests of the key political actors, resulting in nearly three decades of protracted heavy-weaponry warfare post 1980s. During and after the battles and warfare, many people attempted to reach Australia by fishing boats. This means many of the Sri Lankans living in Australia have some connection to this war and associated fear and distress.

From my experience as a Sri Lankan person living in Australia, many Australians would often ask me whether I am a Tamil or a Sinhalas. I found the response was that if I am a Sinhalas, I am a "bad guy". If not, I am an "innocent Tamil man" who is a victim. This thinking added to the distress of the Sinhalas in Australia, but was also not beneficial for the Tamils who did not seek sympathy, instead wanting to live as respectable citizens. This differentiated thinking has impacted the social lives of Sri Lankans living in Australia in different ways according to their ethnicities.

On the one hand, some Sri Lankans who live in Australia may avoid meeting ethnic "others" at places like shopping centres for fear of possible threats or attacks. On the other hand, some scholars like Athukorala (2010) suggest that the second generation of Sri Lankan rival ethnic groups may in fact cooperate and collaborate in the Australian context. She suggests that the ethnic identity is not "singular" and "immutable", rather "plural", "temporal", "flexible" and increasingly open to change. This may require a continuous construction and re-constructions of identities depending on their loyalty to be "Aussie" or "Sri Lankan" or little bit of both. Young second-generation Sri Lankans may find this a more painful or difficult process than their parents, resulting in some psychological distress.

In addition, the socio-psychological and physical life of Sri Lankans may differ according to the ethnic, religious, class, age, gender, purpose of stay, education and political background of each person, family and community. This is something I experienced during my 4 years in Sydney between 2010 and 2014 and through the social media discussion I had with my friends. There are some common characteristics which can be called the "Sri Lankan way of living" or "culture" for anyone from Sri Lanka. For example, Sri Lankans as a group tend to have a public social life, talking to neighbours, sharing food. This community-based social life differs to the living style of many Australians. In general, Sri Lankans build their social lifeworlds around nuclear and extended families, applying much effort to ensuring the welfare and wellbeing of others. This may reflect the patriarchal value system in which they live which promotes respect for parents, and the caring for older parents and relatives by the younger ones. Parents work and sacrifice to create a better future for children. There are also some common issues experienced by Sri Lankans in Australia, such as maintaining connections with close relatives in Sri Lanka, negotiating minority status within Australia and managing student life for those entering higher education.

Sri Lankan students come to Australia carrying the hopes and expectations of their nuclear and extended family, or even the whole village. They must complete and do well in their studies within the stipulated timeframe to meet all these expectations, adding another dimension of pressure to their life. One of my colleagues studying his PhD was reduced to tears in front of his supervisors when they could not understand the financial, family and social demands he faced, in addition to routine study demands.

Another of my friends, now a university lecturer, came to Australia for higher studies and eventually settled in Sydney permanently. She would only punish her daughter in the privacy of their home, saying "mama hondata denawa dorawahala katawath sadde ahen nethiwenna, nethnam megollanwa hadanna behe" (*I punished my daughter severely in closed doors so that no neighbours can hear it. Otherwise these guys cannot be properly socialised*). I have observed similar practices among other friends who now live in Australia permanently. When different values and cultural systems are taught in Australian schools, some parents are unable to tolerate their children questioning Sri Lankan culture, norms and value systems. This intergenerational conflict connected to two different value systems and lifestyles is a common crisis that Sri Lankans must learn to confront and cope with (see Gamage, 2014). Most of the Sri Lankan parents I have met in Australia or other countries in Europe prefer to socialise their children in the Sri Lankan way because they feel the Western way would "spoil" their children. This varies of course, with some families and parents having a better understanding of Western culture and trends, while others resort to the traditional Sri Lankan authoritarian way to sort out issues. This can be psychologically and physically painful.

I also noticed that Sri Lankans must also try to cope with their minority status compared to Australians and Europeans. The Sri Lankan ethno-national conflict was between two groups—Tamils and Sinhalas—who both identified as the majority. In Australia, both groups are now minorities, and may experience day-to-day discrimination and tension around their culture including food, clothes, stores and other cultural activities. Gamage (2014) also highlights that some Sri Lankans raise philosophical questions around the "meaning of life" in Australia. Both older and younger Sri Lankans may struggle to find a clear and achievable meaning of life in their new country. For them, there is a "foreignness" in the local history and heritage of their host country compared to the history and heritage in Sri Lanka as highlighted by Valentine Daniel (1989). This context may create a difficult situation for both the younger and older generations.

3.3.5 Systemic Oppression

Rachael Jacobs

In contributing to this publication, I decided to start with some questions for myself: When did I become aware that Australia is a county in which systemic oppression is in active play, and when did I become aware that I was both a subject and perpetrator of that oppression?

The answer lies somewhere in the story of where I'm from. I grew up in the north-west of Sydney in a racially diverse middle-class suburb with "good schools", but boring shops and barely existent public transport options. Born in Papua New Guinea to Indian parents, I have been in Australia since I was 3 months old and have only known an Australian life. My parents migrated from India to Australia in 1969. They were among the first wave of non-white migrants to settle in Australia after the abandonment of the notorious "White Australia Policy" by which non-European migrants were forbidden from settling in Australia prior to 1967. As a result, my parents accepted and adopted the popularised assimilation model whereby migrants abandoned their language, culture and customs in favour of becoming fully Australian. I grew up with dark skin, hair and eyes, but eating vegemite sandwiches from my lunchbox and speaking only English.

It might sound like the start of a sob story, but assimilation as a method of survival is built into my family's DNA. We are Anglo-Indian, part of a minority group of 500,000 people with mixed British and Indian heritage. The diaspora evolved from a combination of slavery, concubines and love marriages, and led them to be both ostracised and self-segregated from the rest of the Indian population. Sensing the power associated with their British heritage, they adopted an Anglo-centric culture, spoke English as their first language and practiced Christianity. This lineage made my family's assimilation almost seamless. We had none of the challenges of language acquisition, and all have Anglo names. I'm still often asked by Australians what my real name is, or people assume I took my husband's name. Despite these petty annoyances, I recognise the inherent privilege that my family has had. Racism has been part of my experience, but it is not served even handedly in Australia. Those with non-Western accents or names, speakers of other languages and observers of non-Christian or atheist beliefs receive a raw deal where othering is concerned.

Growing up, I was constantly perplexed by the paradox that Australia presented to me. I felt Australian inside, yet Australians constantly reminded me that I looked different and could never truly belong. Australia proudly heralded itself as a multicultural success story, having the most ethnicities in the world living together harmoniously. I was incredibly proud to be part of that story. I helped to form an anti-racism taskforce at my high school and became a spokesperson for the virtues of the multiculturalism and harmony. My privilege in being almost-Australian born, having an Australian accent and English as my first language enabled me to walk what I saw as a much-needed line between migrant and "full-Aussie". I felt I was able to play both sides of the fence. I could explain to Australians that migrants should be accepted, honoured and celebrated, but I could also demonstrate to new migrants the importance of embracing an Australian identity. I thought I embodied the best of the migrant story—educated, hard-working, vocal but not disruptive, a positive contributor and a voice for social cohesion.

But I shifted with unease when many Australians told me I was "one of the good ones". Despite having extolled the virtues of Australia's multicultural project, evidence of erasure, pervasive whiteness and oppression were all around me. Casual racism was (and still is) rife. Systemic racism kept me out of countless rooms and steered me away from various professions, such as media. Despite having lived my entire life in Australia, I experienced constant micro-aggressions that betrayed people's true attitude towards migrants. My cultural art and knowledge was minimised or exoticised. Australia of the 1990s loved to loudly chest beat that is was "colourblind", implying that we'd reached out post-race utopia, while refusing to talk about race. My vision of the most accepting nation on earth was held together by a thread, before it actively fell apart.

As an adult, I recognise the culture of erasure of which I was both a victim and an active contributor. It was not until I was older that I understood that it was in White Australia's interest to keep me exoticised, keep migrant communities confined to cultural pockets of Sydney and Melbourne and most importantly, keep us quiet. I observed that the best thing a migrant could be was quiet; along with that, hard-working, English-speaking and compliant, but mostly quiet. This was something my family had excelled at. Never disruptive or complaining, my parents and their wider families earned their title as "good migrants", in the same league as the Europeans who had gained acceptance for their positive contributions to the nation and hard-work ethic.

My story does not take place in isolation of context. In fact, the most important contextual acknowledgement that must be made is that this story takes place on Gadigal land in the Eora nation. This land was stolen, never ceded and I continue to live and work on what always was and always will be Aboriginal land. My Indian heritage means that my family carries the scars of invasion, partition, dispossession and tyranny at the hands of a white, foreign coloniser. However, there is further complexity when new arrival becomes the coloniser as I have, reaping the benefits of living on stolen Aboriginal land. My family and I also led an expatriate coloniser life in my country of birth, Papua New Guinea. While I have seen my own and other communities of colour marginalised and excluded by white Australia, my family and I continue to be complicit in the ongoing process of colonialism. As a misguided teen, I somehow thought that a shared colonised past at the hands of the British meant that I had some solidarity with Australia's First Nations people. We had a common experience of racism and exclusion. I felt that we'd somehow knocked on the door rather than barging our way through with weapons.

The reality is that my people never knocked. Nor did any of us acknowledge that First Nations people were and are the rightful custodians of this land, never mind engaging in serious discussions over reparations, treaties or dedicated seats in parliament. Furthermore, I've witnessed members of the Indian diaspora propagating racist attitudes towards First Nations people, as if somehow sharing in those disgraceful attitudes can make one more white. It is a well-known phenomenon that marginalised groups often spend lifetimes struggling for acceptance. When it has been even partially achieved, they pull the ladder up after they have ascended. Or to use a different metaphor, close the door behind them, refusing to pave the way for others and disallowing other minority groups to experience the poisoned chalice of acceptance that we all crave.

I am now determined not to accept that chalice, and not to accept anything less than racial justice for our First Nations people first and foremost, and for the migrants who continue to be treated as others in our own homes. Australia is a country built on white supremacy and racism. It is in the fabric of our being and can be seen in past and present policies created by politicians of both persuasions of our two-party system.

Australia was a multilingual, multicultural nation for over 65,000 years with over 300 languages being spoken over more than 250 nations. White supremacy began with invasion, genocide and ongoing genocidal acts, such as the forced removal of Aboriginal children as part of the stolen generation. Our First Nations people are the most incarcerated people on the planet and continue to have a life expectancy of on average 10 years less than the rest of the population. White supremacy was then perpetuated through the blatantly racist White Australia policy and restrictions on immigration. Today Australia enforces a brutal treatment of refugees who arrive by boat. They are detained or deported, even though it is legal to seek asylum. Like many countries, Australia has been infected by the rise of the far right and regularly elects politicians with openly racist views. Racism has now become so acceptable that it is almost expected from our parliament, all protected under a guise of free speech. Those who stand against them are considered fringe.

All of this leaves the colonised turn coloniser with a conundrum in terms of response. After a lifetime of being on the outside, being continually asked where you're from, being told by white men "sorry, I don't date Indians", being interrupted by white women, being overlooked for professional roles, being shouted at from cars, being stared at in bars, being mimicked and parodied, being singled out by security at airports, being erased, whitesplained and minimised ….yes, it's very tempting to lean into whiteness and become a quiet, compliant and complicit Australian. But it is no longer a good enough response because the truth is, I love being Australian. I want to see it become a better nation—the true embodiment of positivity and fair go that so many profess it to be. Therefore, I must push my fellow Australians, my family and myself to do better. We won't get anywhere by perpetuating the myths and smokescreens of the past.

The complexity of my story is perhaps best encapsulated in the following account of what I do on the 26th of January, somewhat of a perplexing day for the Indian diaspora in Australia. It's Indian Republic day, celebrating Indian sovereignty and will of the nation to throw of the shackles of British rule. It's also Australia Day, a public holiday marking the arrival of the first fleet of British ships landing in New South Wales. Having a national day aligned to the invasion is deeply troubling for our First Nations people. It perpetuates intergenerational trauma and erases their custodianship prior to 1788. It has come to be also known as "Invasion Day" and "Survival Day" by many.

I begin January 26th at the Republic Day ceremony held at the Indian Consulate in Sydney. I wear traditional dress, watch traditional dancing and eat samosas and Indian sweets. I then walk a few streets to Hyde Park to listen and support our First Nations people who gather to protest and celebrate their resistance. Still in my sari, I march with the crowd to the Yabun festival, an Aboriginal festival celebrating their continuing culture and resisting passive and active invasion. After a day of music, dance and bush tucker, I change out of my sari and take myself to my Mum's house in that quiet suburb where I grew up. She will offer me a BBQ and a pavlova, and I'll quietly explain why I don't feel like celebrating. But I'll eat the pavlova. Because I really like pavlova.

3.4 Experiential Activities

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant, and they should provide participants with ways to resolve feelings that may arise as a result of the activity including reflection and debriefing.

Activity 1

Title Privilege statements: Racism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to a person's racial group. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

Here are the statements:

1. The political leader of Australia is also a person of my racial group.
2. When someone is trying to describe me, they do not mention my racial background.
3. When expressing my opinion, I am not automatically assumed to be reflecting my racial background.
4. I can be certain that when I attend an event there will be people of my racial group there.
5. When I am with others of my racial group, people do not think we are segregating ourselves.
6. If pulled over by a police officer, I can be sure that I have not been singled out because of my racial group.
7. I have never been mocked because of my accent.
8. I have never lied about my racial group as self-defence.
9. I have never been a victim of violence because of my racial group.
10. No one has told me "you would never know I was [my racial group]" and meant it as a compliment.

Are the scales balanced, or tipping one way or the other?

Questions

Reflect on the following questions:

- How did you feel doing this activity?
- What does it feel like to have, or not have certain privileges?
- Can you identify other privileges that you may or may not experience?

Learning outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privilege, students become more sensitive to the multifaceted nature of racial privilege within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title A community genogram

Purpose A community genogram emphasises the importance of understanding that the settings in which a person exists are also important in constructing meanings and beliefs about themselves and their culture. Students are asked to develop a schematic representation of physical locations within their community of origin. The purpose of this activity is to encourage students to think about the places and locations associated with their growth and development.

Process A community genogram does not follow the traditional structures and symbols of family genograms. Instead, houses, buildings, gathering places, schools, churches, mosques and temples, transportation areas such as train stations and bus depots, open spaces such as football ovals and playgrounds, shopping complexes and neighbouring communities are identified and included.

Students are asked to draw a community genogram that represents their community of origin during their early childhood years.

Once this is complete, students work in pairs or groups to share their genogram and provide a narrative of their family and cultural development depicted in the genogram. Group members are encouraged to respectfully ask questions to elicit meanings and memories from the diagram.

After discussion, group members identify similarities and differences in the socialisation process evident in these community genograms and reflect on cultural values based on the communities in which individuals were raised.

Learning outcome Students develop a sense of awareness of how their communities of origin and community-based experiences help form their cultural identity. This is a powerful tool for working with clients of diverse backgrounds.

Adapted from 'Community Genogram and Parallel Process Links', Diversity Activities Resource Guide. Retrieved from ▶ https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 3

Title Where do I stand?

Purpose We often hold beliefs and values that we take for granted as correct and never think to question the potential lack of evidence. This activity asks students to think about and explain some of their beliefs and values when they are forced to select a position.

Process Students physically relocate to one of four corners based on whether they AGREE, STRONGLY AGREE, DISAGREE or STRONGLY DISAGREE with a series of value statements.

Here is a selection of value statements, but facilitators can also develop their own to match the student cohort.

1. Role models and mentors are more effective if they are of the same race as the mentee.
2. Helping professionals are more effective if they are of the same race as the client.
3. A racist joke can be funny if it is made by a person of that race.
4. It's okay for racial minorities to be racist.
5. Asylum seekers should always be admitted to Australia.

Once each student has selected a corner, the group is given 5 minutes to develop a succinct and persuasive argument to support their response. Each group has 3 minutes to present this argument. After all groups have presented, students are invited to reflect on their original group's preliminary discussions as well as the persuasive arguments they have just heard, and change groups if their current group no longer adequately reflects their position.

Once new groups have formed, students examine why they changed, or did not change groups during this activity.

Learning outcome Students have the opportunity to explore and defend their own beliefs and values while simultaneously hearing the rationale behind other people's beliefs and values in a safe and respectful setting. Students also have the opportunity to change their beliefs and values without judgement.

Adapted from 'Four corners' exercise, Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 4

Title **Movie time: "Wedding Sari Showdown" (2006/2008)**

Purpose To use film as an experiential learning activity for cultural awareness. "Wedding Sari Showdown" (2006/2008), directed by Kylie Boltin, documents the difficulties an Australian Sikh woman and an Indian student face when they marry at a local registry office without their parents' knowledge. The young couple struggle to maintain their relationship under the increasing pressure of family obligations and cultural expectations.

Process Watch the two 25-minute documentaries, and respond to these questions.

- **Questions**

1. What specific images stayed with you after watching these documentaries?
2. What do you feel is the underlying message of the film?
3. What are some of the obstacles you identified to this couple's relationship and parenting?
4. How has watching this film contributed to your understanding of the impact of cultural expectations for marriage and parenthood?

5. How has watching this film contributed to your self-awareness when working with people experiencing cultural clashes within their interpersonal relationship?
6. What were some of the different ways prejudice and discrimination were exemplified in the film?

Discuss your responses in pairs or groups.

Learning outcome To enhance students' cultural awareness and understanding of the many ways that cultural expectations and family ties remain fundamental to interpersonal relationships.

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Classism

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Contents

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_4

Trailer

In this chapter, Matthew Fisher takes a social justice view of mental health in Australia, suggesting that questions of health and illness cannot be separated from social and economic conditions, structural inequalities and political choices. Christopher Scanlon describes Australia's class system highlighting the colloquial terminology such as 'bogans' and 'hipsters' as means of denying class. And finally, Bernard Deojee, who works in social services, describes his experiences and shares stories of individuals whose lives are deeply impacted by current social systems and housing issues.

4.1 Introduction

Vicki Hutton

Definition

Mental health and wellbeing do not reside solely within the individual. Rather, they can be dependent on, and be shaped by social, economic and political aspects of a person's environment (Dulaney, 2018). Poor physical and mental health can be a consequence of poverty whereby lack of access to material resources such as income and wealth can reduce access to adequate healthcare, affordable housing in a safe and clean environment, stable and ongoing employment and healthy food (Australian Council of Social Service [ACOSS], 2016). Impeded access to all or any of these factors can result in a self-perpetuating downwards spiral that places a person at ongoing risk of unpredictable income, poverty, homelessness, isolation and mental health struggles (Mind Australia Limited, 2019).

Statistics

According to the 2018 Poverty in Australia Report released by the Australian Council of Social Service [ACOSS], there are over three million people (13.2%) living below the poverty line in Australia, including over 700,000 children (ACOSS, 2018). That equates to one in eight adults and more than one in six children living in poverty in Australia. Low-income households (i.e. the 20% of households in the lowest net worth quintile) are more likely to rely on government pensions or allowances as a main source of income, with lone person households over-represented in the low-income group and couple only households in the high-income group (Australian Bureau of Statistics [ABS], 2018). Despite Australia maintaining consistent economic growth in the last three decades, it remains one of a group of English-speaking wealth nations with above-average poverty levels (ACOSS, 2018).

The *Inequality in Australia 2018* report prepared by the Australian Council of Social Services and the University of New South Wales provides some statistics that clearly demonstrate income inequality in Australia (ACOSS & University of New South Wales, 2018). The report indicated that someone in the highest 1% of the income scale earns more in a fortnight than someone in the lowest 5% earns in a year. In addition, someone in the highest 20% of the income scale lives in a household with five times as much income as someone in the lowest 20% of the income scale.

In terms of wealth inequality, those in the highest 20% of the wealth scale hold around 67% of all wealth, while people in the lowest 50% hold only 18% of all wealth. The average wealth of a household in the top 20% of the wealth scale is almost 100 times that of the lowest 20%. Excessive inequalities such as these can be harmful and cause divisions within society.

These divisions may be compounded by evidence that certain identifiable groups are more likely to be in the lowest 20% income groups. These groups include people who are unemployed; Aboriginal and Torres Strait Islander peoples; people with a disability; single parents; people aged over 65 years and people born overseas in non-English speaking countries. Women in particular are more likely to live in households below the poverty line, reflecting the lower incomes of female-headed households such as sole parents or older women living alone (Good Shepherd, 2019). A report into poverty in Australia by the charitable organisation St Vincent de Paul concluded that the number of Australians experiencing income poverty, low wealth and living with multiple deprivations is significant and growing (St Vincent de Paul, 2019).

In Western cultures, societies are often stratified into social classes, also known as socioeconomic status (SES) . These are usually determined by income, as well as other key variables such as level of education and occupational prestige, and evident in observable attributes and behaviours such as accents, tastes, manners and style of dress (Simandan, 2018). According to Chen and Miller (2013), the subjective experience of social class can influence the outcomes of physical and mental health for upper versus lower class individuals. There is evidence that the lower a person's social class, the greater a person's level of chronic psychological distress, largely mediated by fewer resources to control the environment resulting in experiences of uncertainty, helplessness and lack of freedom (Simandan, 2018). In contrast, being positioned in a higher class brings more financial, social and intellectual resources, bolstering feelings of control and social value.

Despite Australian society often being characterised as egalitarian compared to the stricter class hierarchies of nations such as the United Kingdom (Sheppard & Biddle, 2017), economic stratification through wealth and income can and does impose divisions within society resulting in social exclusion and disadvantage. For example, there is evidence that people who live in poverty tend to cluster in certain localities. Within these clusters, indicators such as lack of material resources, unemployment and under-employment, and reduced access to social and community support segment them within society and negatively impact physical and mental health (St Vincent de Paul, 2019).

4.2 Social and Economic Determinants (Classism) and Mental Health

Matthew Fisher

- **Introduction**

In order for practitioners in fields such as psychology, counselling, psychotherapy or social work to do their work effectively, it is highly desirable that they are able to adopt both an individual and a *social* or population view of mental health and mental illness. In the nineteenth century, the English physician, John Snow, famously investigated an outbreak of cholera in an area of London and recognised that incidence of disease was clustered around a particular street water pump, supplying local households. He suspected something in the water from that pump was behind these cases of disease and worked to get the pump closed. The point of the story here is that, as a physician, Dr Snow had to shift his perspective from the individual patient to the *population*, and from symptoms of disease to the *environment* in which disease occurs. In doing so, he came to understand a health problem, and potential solutions to that problem, in a different way.

Health and social service practitioners dealing with issues of mental health and illness will often rightly give their attention to the needs of individuals. There are many ways in which the norms of their profession will endorse this approach. However, if they do not also adopt an informed social and population view, their capacity to understand and make a difference to the problem of mental illness and the possibilities of mental health will be severely limited. This chapter presents a social view of mental health and illness in Australia. As we will see, when this perspective is taken, questions of health and illness cannot be separated from other questions about the social and economic conditions in which we live, structural inequalities in these conditions and the political choices that shape these inequalities. We will see that public health policy in Australia overwhelmingly adopts an individualised, illness-focused, biomedical view of 'health' and thus fails to confront the socioeconomic inequalities that contribute to inequalities in mental health. It is through the perpetuation of social and economic inequalities that *classism*—the differential treatment of people according to their social class—affects mental health.

4.2.1 Social Determinants of Health

John Snow is credited with originating the science of epidemiology; the study of relationships between the environments in which we live and work and incidence or prevalence of disease. Although health and illness are certainly influenced by individuals' genetic makeup, there is much evidence from epidemiological research showing that environmental factors play a crucial role in determining the health trajectory of individuals over the life course, and some of these factors are decidedly social in nature—they have to do with the structures and practices of contemporary human societies (Baum, 2016; World Health Organisation [WHO] , 2008).

These social factors are now commonly referred to as the *social determinants of health* (Marmot & Wilkinson, 1999). They include material factors such as level of income, employment status, access to primary healthcare, food environments and conditions of housing. They also include cultural or relational factors such as social isolation and exposure to discrimination or violence. Conditions of abuse or neglect in early childhood are known to increase risk of ill-health over the whole life course (Irwin, Siddiq, & Hertzman, 2007). The health impacts of social determinants of health may occur over different timeframes and may affect states of physical or mental health, or both. Here of course we are mainly interested in how social determinants affect mental health (Fisher & Baum, 2010; Friedli, 2009).

There are a variety of ways in which social determinants can affect health. These include, but are not limited to, the influence of social, economic or cultural factors on health behaviours such as diet, exercise, smoking or alcohol use (Krueger & Chang, 2008). For example, people living on a low income may be at higher risk of obesity because they are unable to afford a healthy diet and instead rely on cheap but palatable processed foods or ‘fast’ foods.

One of the most important features of population health revealed through epidemiological research is the existences of health inequalities between social groups. Not all such inequalities are produced through the impacts of social determinants of health. For example, women are at higher risk of breast cancer than men, but this is thought to be largely due to genetic differences. However, many health inequalities *do* result from the impacts of social or economic conditions. One way in which research demonstrates these impacts is by measuring the prevalence of disease, risk factors, premature mortality or life expectancy between groups defined according to a marker of socioeconomic status (SES) such as income, education level or employment. It has now been shown in Australia (Glover, Hetzel, & Tennant, 2004; Harris, Fetherston, & Calder, 2017) and in other countries (Banks, Marmot, Oldfield, & Smith, 2006; Marmot, 2013) that many forms of disease are most common among those groups in society that are most socially or economically disadvantaged, less common among those somewhat better off and least common among the most advantaged groups. This pattern of outcomes is referred to as a *social gradient* in health. Apart from this gradient form of health inequality, there are also gaps in health outcomes between different groups. For example, around 27% of Aboriginal and Torres Strait Islander adults report high or very high levels of psychological distress, compared to around 13% for non-Indigenous adults (Australian Institute of Health and Welfare [AIHW], 2009). Health inequalities also exist between countries, according to their overall level of national wealth.

Some may argue that health inequalities linked to SES happen because illness occurs first and then leads to socioeconomic disadvantage, or because those less well-off just choose (more often) to smoke tobacco, or eat a bad diet, or not to visit the doctor when they should (Canning & Bowser, 2010). On the illness-first hypothesis, firstly, it is true that illness can contribute to disadvantage, but this effect explains only a small part of the phenomenon of health inequalities linked to SES. On the second point, it is true that people subject to social or economic disadvantage may tend to adopt unhealthy behaviours at a higher rate than others, but it is simplistic and wrong to think that this is simply a result of poor individual choices.

Health inequalities linked to SES is primarily the result of systemic social differences in *exposure* to social and economic conditions that (in a variety of ways) are favourable or unfavourable to health, over the life course (Commission on the Social Determinants of Health, 2008; Marmot & Friel, 2008). For this reason, the term 'social determinants of health' is used to refer to people's everyday living and working conditions *and* to the higher level political and economic factors that *distribute* social resources unequally (Commission on the Social Determinants of Health, 2008). Furthermore, some argue that structural inequalities in health linked to SES—that is, to social class—are not only problematic for prudential reasons such as the costs of healthcare, but are also *unfair* or unjust because, if we made different political choices as a society to reduce socioeconomic inequality, then the associated health inequalities could be reduced (Whitehead, 1992). In Australia, the term health *inequities* is used to signal this ethical position, and I will use this term from here on.

4.2.2 Social Determinants of Mental Health

A range of social and economic factors have been identified as adversely affecting mental health including low income, low employment status or unemployment, limited education, insecure housing, poor social relationships and social isolation, exposure to racism or other forms of discrimination, and being subject to abuse or neglect in early life (Fisher & Baum, 2010; Friedli, 2009; Irwin et al., 2007; Li, Mcmurray, & Stanley, 2008; Thoits, 2010). Of course, even though the specific influence of each of these factors has been analysed through research, in the real world multiple factors may be present in a person's life and will interact in complex ways to shape their health trajectory over time (Singh-Manoux & Marmot, 2005). The range of factors acting as social determinants of mental health is not necessarily static, and new issues may arise with social or environmental change. For example, recent research has found that increased screen time for adolescents is associated with worse mental health outcomes, relative to those who spend more time on other activities (Twenge, Martin, & Campbell, 2018).

Epidemiological research on mental health outcomes in populations has mostly focused on the high-prevalence conditions of mood, anxiety and substance abuse disorders. Given the factors just noted, it is no surprise to learn that such research in many countries consistently shows the existence of inequities in prevalence of these conditions between social classes, often taking the form of a social gradient (Fryers, Melzer, & Jenkins, 2003). This gradient pattern is important because it suggests that the adverse influence of social factors on mental health is not just a problem for those worse off, but also affects people across the socioeconomic spectrum. Interestingly, research comparing mental health outcomes in different OECD countries has found that countries with higher levels of socioeconomic inequality also have higher rates of mental health problems across the whole population, compared to more equal countries (Wilkinson & Pickett, 2009).

In Australia, our current performance on mental health is poor and compares poorly to other similar countries (Wilkinson & Pickett, 2009). The lifetime prevalence of any mental health disorder is over 40% and the 12-month prevalence is around 20% (Australian Bureau of Statistics [ABS] , 2007). Thus, in any 12-month period, around 5 million Australian adults will be subject to some form of mood, anxiety or substance abuse disorder! Again, these outcomes are not evenly distributed but are more common among those subject to social or economic disadvantage (ABS, 2010; Glover et al., 2004) including Aboriginal and Torres Strait Islander Australians (AIHW, 2009). The evidence on social determinants of mental health strongly suggests that social class differences in Australia are fundamental underlying causes of our poor overall performance on mental health, and of significant inequities in mental health outcomes. Australia is one of the more unequal countries within the OECD groups of wealthier nations, and our relatively poor performance on mental health reflects that fact (ABS, 2007).

4.2.3 Stress and Mental Ill-Health

In order to properly understand social determinants of mental health, it is useful to go beyond the epidemiological evidence, to examine *how* exposure to certain social conditions can ‘get under the skin’ to affect mental health. It is particularly important to understand the role of *stress arousal* (Fisher & Baum, 2010; Kristenson, Eriksen, Sluiter, Starke, & Ursin, 2004). Human stress systems originate in brain structures such as the amygdala and hypothalamus, and from there, via both endocrine and neural pathways trigger arousal of the sympathetic nervous system and the adrenal gland, stimulating release of stress hormones including cortisol and adrenaline (Brunner, 1997; de Kloet, Joëls, & Holsboer, 2005; Kristenson et al., 2004). Acute stress arousal also involves stimulation of brain structures involved in sensory acuity, attention and goal-directed behaviour (Panksepp, 1998), and is widely understood as an adaptive response, supporting rapid behavioural adaptation to perceived social–environmental threats or challenges (Panksepp, 1998). Stress responses are anticipatory, being triggered when the brain anticipates a possible challenge, based on prior learning. If a big dog barked aggressively at you as you passed a certain house yesterday, then it is very likely that your stress system with ‘switch on’ as you approach the same house today, *before* the dog appears. Stress responses are particularly sensitive to negative social evaluation of oneself from other people, and to a perceived lack of control (Dickerson & Kemeny, 2004).

Acute (short-term) bursts of stress arousal play a significant role in everyday social cognition as we navigate social environments. The problem for mental health arises when acute stress turns into chronic stress arousal (Fisher & Baum, 2010). In basic terms, this is likely to occur when a person perceives the continued presence of a stressor stimulus, but does not have (or cannot see) any way to resolve or avoid the problem (Fisher & Baum, 2010). For example, consider two people who cannot pay their rent—an everyday stressful situation. Person A knows that she can borrow the money from a friend, and will be able to repay the loan later. Person B knows that, with his low income, he will be unable to pay and will likely have to deal with an unhappy landlord and possible risk of eviction.

Both people undergo some stress arousal, but it is person B who is more likely to experience chronic stress.

Chronic stress can affect mental health directly by disregulating the functions of key parts of the brain involved in social cognition (Chrousos, 2009). It can also affect mental and physical health when people turn to the use of drugs or alcohol to gain relief from the psychological pain of chronic stress (Krueger & Chang, 2008). Chronic stress has been invoked as a likely underlying cause of increased risk of mental ill-health associated with exposure to: low income/economic hardship (WHO, 2011); unemployment (Bartley, Ferrie, & Montgomery, 1999) and insecure employment (ACTU, 2011); low control in the workplace (Stansfeld, Head, & Marmot, 1998); adverse life events (Lantz, House, Mero, & Williams, 2005) and insecure or low-standard housing (Gill, Taylor, Winefield, Chittleborough, & Koster, 2009). A broad range of research has shown that the cumulative 'load' of exposure to various stressors over the life course correlates positively with worse health outcomes, and appears to explain a significant part of health inequalities between groups according to gender, race/ethnicity, social connectedness and socioeconomic status (Thoits, 2010).

Thus, it is reasonable to conclude that inequalities in exposure to social or economic stressors are a major underlying cause of inequities in mental health between social classes. However, in addition to factors implicated in causing inequities in mental health, it is important to also pay attention to matters that may influence stress arousal and mental health across social classes. In modern, urbanised societies, the daily norm of 8–10 hours of sustained goal-directed behaviour in complex social settings is itself likely to carry a significant load of stress arousal (Baum, Garofalo, & Yali, 1999), even if nothing 'bad' happens. Perceptions of the world—whether accurate or not—can also affect stress arousal; for example, perceiving one's surroundings as unsafe, or awareness of the threat of climate change.

Just as we have discussed social factors that adversely affect mental health, it is just as important to consider the other part of the picture; those social conditions that are protective of positive mental health and wellbeing. Often these are simply the converse of the conditions we have considered as risk factors and include: secure and caring conditions in early life; adequate income; secure employment in which one can exercise a measure of control; secure and stable housing; a sense of safety and supportive social relationships. Recognition of these determinants of mental *health* is consistent with the position of the World Health Organisation, which defines mental health as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO, 2018).

4.2.4 Policy Action on Mental Health in Australia

Burden of disease studies use two measures, years of life lost due to premature mortality and years of life affected by non-fatal disease, to assess burden of disease within a particular population. On the second measure, mental health and substance abuse disorders constitute around 25% of the total disease burden in Australia, more than any other chronic condition (AIHW, 2019), and are a major part of the burden of disease globally (Vigo, Thornicroft, & Atun, 2016). These effects on population health have major implications for the costs of healthcare, economic performance and social functioning. Thus, Australian governments have strong interests in reducing the burden of disease caused by mental ill-health. However, despite the abundant evidence on social determinants of mental health, and on the role of stress as a mediating factor, the great majority of Australian health policy on mental health adopts a *biomedical* and *individualised* view of the problem and fails to tackle social causes (Fisher, Baum, MacDougall, Newman, & McDermott, 2016). In other words, overwhelmingly, the policy strategies adopted approach mental ill-health as nothing more than an aberrant condition of individual neuropsychology, to be treated with drugs or other therapies. This is not wrong as such, but is far too limited because it does not understand mental ill-health in its social context, does not adopt a population level view of the problem and does not recognise social determinants of mental health as targets for policy action. One unfortunate outcome of this approach has been the medicalisation of what are really social problems, and nowhere is this more clear than in the rapidly escalating rate of antidepressant use in Australia, with consumption doubling between 2000 and 2013 (OECD, 2015).

The question of why Australian health policy adopts this approach is too complex to tackle in any depth here. However, some argue that the willingness of Western liberal governments to individualise health problems is driven by an intersection between two powerful social forces: the strength of a biomedical view, which 'sees' health and illness as matters of individual biology and psychology; and the dominance of individualist ideology in countries like Australia, dominated by neoliberal ideology (Baum & Fisher, 2014). Governments may also find it more politically palatable to limit their view of health and illness to biology and individual behaviour because to truly face up to the social and economic dimensions of health would require substantive change (and imagination and courage) and threaten the perceived interests of powerful corporate actors (Baum & Fisher, 2014).

4.2.5 Conclusion

Individual practitioners working in the area of mental health of course cannot directly address the broad scope of social determinants of mental health. However, they can take account of determinants in the way they work. In the first place, rather than seeing instances of distress and illness as purely internal to an affected individual, practitioners can consider that person's circumstances and relationships, the role these may be playing as contributory causes of the problem and what might be done to improve them. Also, it may be useful to shift focus from adverse factors to think about determinants of mental *health*, and ask how people might be supported to act in ways likely to improve wellbeing. Having a sense of control over one's life is a fundamental determinant of wellbeing, and the thoughtful practitioner could aim to support his or her clients to do things—even small things—to enhance their sense of control and capability. Fourthly, it is important to think beyond the individual and consider the scope for local collective action, in whatever form that might take. There are many things that can be done at the community level to enhance health and wellbeing, addressing determinants such as social relatedness. Finally, the practitioner should consider adding their voice to forms of collective political action calling for changes likely to be beneficial for public health, including measures to reduce socioeconomic inequalities.

4.3 Personal Stories and Current Affairs

4.3.1 Bogans and Hipsters: We're Talking the Living Language of Class

Christopher Scanlon

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► https://theconversation.com/bogans-and-hipsters-were-talking-the-living-language-of-class-23007

'This is bullshit', the student muttered under her breath. The tutorial topic assigned for that week was class. I'd kicked things off by asking whether class existed in modern Australia, or whether it was a relic of nineteenth century Europe.

Struck by the student's response, I asked her to elaborate. She did:

Quote

> » Look, I went to a private school and my Dad's a CEO and most of his friends are business people.
>
> So I guess that's supposed to make me upper class? But class has nothing to do with it. Going to a private school was my parents' decision. And my Dad's friends are just his friends.

I suggested that the choice of school—not to mention the capacity to afford the fees (Scott, 2013)—and her father's friendship network might have been shaped heavily by their class position. That wasn't to say there was anything wrong with it, but it did show how our lives are shaped by larger social and economic forces we don't control.

The student was having none of it. It was clear that she'd encountered the notion of class before and found it singularly unconvincing. In her world, everything was simply a matter of individual choice—choices that were unconstrained.

She didn't say it, but class seemed to be an excuse for people who made the wrong choices in life. Alternatively, it was a way to unfairly label people like her and her family who'd worked hard for their success, presenting their achievements as little more than the luck of being born into the right family.

Her response isn't surprising. Many Australians share her view. Part of the reason for this is that class is less visible than it once was.

Ready access to cheap credit has blurred class distinctions. When most people can afford the latest smart phones, wear Prada, get about in four-wheel drives and take overseas holidays, class seems like an irrelevance.

About the only time we hear the word 'class' in public debate any more is when someone questions the wisdom of rewarding CEOs with multimillion dollar salary packages. In a culture that has internalised the mantra of 'You Can Do Anything', this apparently constitutes the first salvo in a class war (Menadue, 2014).

The only time we're happy to discuss class openly is when it can be viewed from the safe distance of the past or another country, as in shows like Downton Abbey. Class in this world is a simple matter of upstairs/downstairs.

It's About Much More Than Money

But class has always been more complex than this view would suggest. As the late French sociologist Pierre Bourdieu argued in his book *Distinction*, class—and the reproduction of class—has as much to do with your tastes, the way you speak and comport yourself as it has to do with income levels (1979).

Taking this broader view, class is as prevalent as it ever was. It's just that when we talk about class, we don't use the 'C word'. Instead, we use other less threatening terms—'*bogan*', for instance.

One definition of a bogan is someone who fails to conform to middle-class standards of taste, dietary habits, leisure activities, styles of dress and ways of speaking. You don't have to have read sociology or understand the political economy to notice such distinctions.

When, for example, Channel Ten launched the 2014 season of *The Biggest Loser*, which centres on the town of Ararat in Victoria's south-west, a theme running through the audience reaction on Twitter centred on class. Some of the uglier tweets included:

Quote

> » That's the entertaining thing about #biggestloserau We're laughing at them cos they're bogans.
>
> FunFact My cousin used to own a $2 shop in Ararat he did a roaring trade, couldn't keep up with track suit & thong orders.
>
> Hahahaha no money for your poor town unless you lose weight. No pressure. #biggestloserau

The crime of the contestants—and by extension Ararat—is that the show features people who don't conform to middle-class standards of health and wellbeing. Like the worst stereotypes of the working class that have been around since Karl Marx was a boy, they are assumed to be slovenly, poor and poorly educated, and lacking in taste and refinement.

Looking through the biographies of the contestants, you begin to notice that most are working class or lower-middle class. Along with a couple of students, the contestants are supermarket managers, a baker, nurses and what former US Secretary of Labor Robert Reich refers to as ‘in-person service providers’. The few professionals who are on the show tend to be ones that, relative to other professions, are on the lower end of the income scale, such as nursing or teaching.

Of course, the class hatred expressed on Twitter at The Biggest Loser contestants is nothing new. But it’s now wrapped up in messages about health and exercise. Income, occupation, residence and eating and activity habits are all part of what defines people’s class.

At the other end of the spectrum to bogan is the hipster. Whereas bogans fail to conform to the lifestyle norms, values and tastes of the middle classes, a hipster cleaves to them closely to the point that they end up a parody of them. Hipsters trade on authenticity, individuality and a rejection of the mainstream. Sometimes this parody is ironic, while in other cases it is unconscious.

I have no doubt that these arguments wouldn’t find much traction with my former student. Imbued with a heightened sense of choice, she would probably regard all this as people just being funny on Twitter about a TV show or, in the case of the hipster, simply a personal matter of style and taste rather than pointing to any deeper social reality.

■ Popular Culture Makes No Sense Without Class

The problem with this kind of response is that if class truly does not exist in modern Australia, or has no bearing on shaping—not determining, mind, but shaping—one’s behaviour and life chances, then large swathes of contemporary Australian culture appear completely random and utterly baffling.

Everything from plays (and movies based on the plays) like David Williamson’s *Don’s Party* and *Emerald City*, to novels like Helen Garner’s *Monkey Grip* and Christos Tsiolkas’ *Loaded and The Slap*, to comedies such as Upper Middle Bogan, The Castle, Kath & Kim and Ja’mie: Private School Girl are premised on the social realities of class.

All of these presume their audiences have some experience of social class. Ja’mie’s behaviour is appalling, in large part, because she’s oblivious to the privileged bubble in which she lives. The slap in Tsiolkas’ book of the same name is based on differences in working- and middle-class attitudes to parenting and what constitutes appropriate discipline.

If class were not a lived part of people’s everyday experience, these productions simply would not resonate with audiences in the way they do. They would just appear surreal, completely disconnected from Australian culture.

For those whose choices are more constrained, this is self-evident—a point that was underscored for me by another student in a different tutorial. Unlike the first group, the students in this tutorial had lower ATARs and lived in suburbs with lower incomes.

Once again, I kicked off the tutorial by asking if they thought class existed in modern Australia. They looked at me as if the answer were obvious: of course, it did.

I asked one student why he was so certain. He replied simply:

> » I live in Frankston and work at Woolworths.

4.3.2 Working in the Community

Bernard Deojee

As a manager for a community outreach centre in Redfern, an inner-city suburb of Sydney, I have been confronted with a number of challenges this year, the main one being the challenge of establishing a new understanding of how our social support system works and coming to terms with the reality that it is not as perfect as I once thought. As an immigrant coming to Australia from a young age and being taught by my parents that we live in a country that has a social welfare system that takes care of all people from all walks of life. I, in my middle-class blindness, believed that if there were people living on the streets or begging for food or money on the foot paths, it was because of the choices they made to end up in those circumstances, and if they truly wanted to get out of those circumstances, they could simply leverage the support networks provided to turn their lives around. Unfortunately, this is definitely not the reality, and I will provide you with a few examples of how the system has failed these people in need in the following reflection.

First, a little about the community centre we run and some of the services we provide. From the beginning, our leadership team wanted to part of the already established community of support in Redfern and wanted to be seen as a hub providing services and then referring community members to other local organisations such as St. Vincent's, Salvation Army, Hillsong or Mission Australia if we could not meet their specific needs. Our main focus consisted of free meals throughout the week, food parcels, counselling services, technology assistance, pastoral care and cooking classes throughout the year. We did not want to reinvent the wheel or compete with our support neighbours by doing something that was already done at a more professional level elsewhere, so what we did, we did intentionally.

Here are a few stories from members of our community who I have had the privilege of meeting and working with.

Ella came into the centre and shared her story with me. She came from Iran and due to unknown circumstances ended up on the streets. She was placed in a women's refuge shelter where they searched for private accommodation for her but she could afford this accommodation on a social security benefits/Centrelink payment. She was unemployed, however actively seeking work. The women's refuge shelter eventually found her a place where she had to share a room with another woman in a shared house. Unfortunately, the other woman stole a number of personal items from her. When the other woman moved out, the landlord offered her a male roommate instead, which she reluctantly accepted. Unfortunately, she did not have much of a choice as the women's refuge shelter was no longer available to her because it was at capacity and her only other alternative was to go back on the streets. I met her when she came into our community kitchen one afternoon seeking support and also requesting that we help her install a lock on the door or her room to protect her belongings. She shared with me that the male roommate had moved out to return to his home country but not before sexually abusing her. I asked her why she did not report the sexual abuse and the response she provided me reflected fear towards the authorities so I didn't press it further. She had a new male roommate, and when I questioned why she would want me to install a lock on their room, it broke my heart to realise that she cared more about her stuff then her personal safety and wellbeing. In that moment what other option did she have?

An elderly gentleman by the name of Marcus came into the cafe one day and I could tell that he was quite anxious so I sat down and had a chat with him. He had come to the centre seeking counselling because he was suicidal. He shared with me how he no longer wanted to stay in the apartment he was currently living that was provided to him by housing authority because the majority of his neighbours were either addicted to or dealing drugs. The main struggle he had was being constantly kept up at night because of the fear and anxiety of ongoing threats and violent tendencies he would experience from his neighbours affected by methamphetamine, ice, heroin or other drug they would be on at the time. He reported that the housing authority were unable or unwilling to assist him in finding other temporary accommodation because they believed that the place they provided for him was satisfactory while he waited for more permanently housing. However, Marcus was aware that finding permanent housing can take months where he concluded that he would be safer to risk it and go back and live on the streets until housing found him something better. One of our initiatives at the centre is to provide people with swags/tents because they have been forced to take a similar path due to housing situations.

There are many more stories that I can share of people who come into the centre but I will close with the story of Paul who came into the centre one afternoon when we were just about to close up. He came in and simply asked if we were a place where he could get some support. He stated that he was tired of being addicted to drugs and he wanted to turn his life around. After congratulating him on the decision he was making, I asked him what he needed support with and replied to me with ‘anything, I'll take it’. We provided him with some food as he hadn't eaten all day, and we began searching for detoxification clinics because Paul stated to me that he wanted to get clean and wanted to go into rehab. We went through the list of all the alcohol and drug addiction services, and I was surprised to discover what the process for most organisations was. Generally, the organisations did not take walk-in clients into their facility. They had arduous processes for assessment and admissions into detoxification programmes or recommended other solutions. I could see Paul was getting more and more deflated when we were told by each organisation that someone would contact him within 3–5 days. At one stage, he turned to me and stated that he would have a needle in his arm by the end of the afternoon if no one was willing to help him. After another half an hour of researching clinics and programmes, we finally found St Vincent's Hospital who would take him in for an immediate assessment; however, it would take him approximately 45 minutes for him to get there. I called him an Uber to get him there and tracked the Uber to make sure that he got the clinic safely.

From our centre we have heard countless stories of our community members who feel that the system designed to support them is deeply flawed. Sharing of instances where people are forced into a loop where they need financial support and the only way they can receive their Centrelink or social benefit payments is if they make certain appointments or go to job interviews. However, if the person does not have transport to get to the appointment, they either risk missing the appointment and not getting their payment, or risk getting a fine using public transport with no money on their travel cards and having to use the payment to pay off the fine instead.

There is hope when I know that there are solutions and resources available provided by different organisations; however, these supports may not be utilised due to lack of information or awareness by our community members who need such services. An area of concern is realising there is no point in having a website that shows community members places where they can go to get accommodation, food and financial aid if they have no way of accessing this information. If a community member does not possess a phone with data or if they don't have skills in using the internet or computers, it makes this information worthless to them. It is a Catch-22 for members of our community to get genuine and sustainable support when they need it.

4.4 Experiential Activities

Important

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant and they should provide participants with ways to resolve feelings that may arise as a result of the activity including reflection and debriefing.

Activity 1

Title Privilege statements—Classism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to a person's socioeconomic status. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. In my family, it is seen as normal to obtain a university degree.
2. If I see something advertised that I really want, I will buy it.
3. In my family, at least one of my parents has been unemployed, not by choice.

4. In my family, we had to rely on welfare payments at some point in my childhood.
5. If I can't work, I have savings to pay the rent or mortgage and other expenses for a while.
6. Insurance companies do not charge extra for house and car insurance in my neighbourhood.
7. People assume that I am actively trying to improve my social class.
8. If I lobby politicians for my social group, I am not perceived as looking for a handout.
9. My dental health is n ot inhibited by my income.
10. If I choose to wear second-hand clothes, this is not attributed to my social class.

Are the scales balanced, or tipping one way or the other?

■ Questions

Reflect on the following questions:

- How did you feel doing this activity?
- What does it feel like to have, or not have certain privileges?
- Can you identify other privileges related to socioeconomic status that you may or may not experience?

Outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privileges related to socioeconomic status, students become more sensitive to the multifaceted nature of privilege within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title *Photovoice: Hidden privilege*

Purpose The concept of 'photovoice' allows students to use photography to identify and communicate perspectives of social issues in their environment (Photovoice, 2019). Students then use these images to examine and understand the social system and their role within that system, thus facilitating a greater awareness of social justice, social privilege and cultural sensitivity.

Process Students critically evaluate their environment with regards to social privilege. They then take a photograph of something that represents social privilege in their environment. Remind students not to include recognisable faces in their images, as these photos will be shared with other members of the class.

In pairs or groups, each student tells the story behind their chosen photograph, and how and why they feel it represents social privilege within their social environment. As a larger group, identity common themes in the images presented, and reflect on the following questions.

■ Questions

1. Did you identify any evidence of privilege hidden within the normal sights and activities of social environments presented by your fellow students?
2. Did you identify any evidence of social injustice within the normal sights

and activities of social environment presented by your fellow students?
3. How could you apply this growing awareness to the social environment you will be working within?

Outcome By studying images and listening to the stories behind them, students will develop a greater awareness of their own status, as well as privilege and social injustice in their social environment.

Adapted from: Ergüner-Tekinalp, B. & Harper, A. (2011). Photovoice: Understanding Social Privilege. In M. Pope, J.S. Pangelinan, & A.D. Coker (eds). Experiential Activities for Teaching Multicultural Competence in Counselling (pp. 222–224). Alexandria, VA: American Counseling Association.

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Activity 3
Title Reverse classism line-up

Purpose Students respond to a series of questions by stepping forward or backwards. While discussions of classism often focus on those from disadvantaged backgrounds and lower socioeconomic status, it is possible to also feel bias against people from more affluent backgrounds. This activity raises students' awareness of the assumptions around wealth and affluence.

Process Students line up in the centre of a large space. Ask them to take one step forwards or backwards in response to the statements and directions you give. If they wish to pass on a particular statement, they may do so by remaining in the same spot.

Here are the statements and directions:

1. If you get annoyed by people you feel are flaunting their material resources, step forward.
2. If you have ever felt ashamed of your material possessions in a social setting, step backwards.
3. If you have ever pre-judged someone you have never met based on their real or perceived upper class membership or wealth, step forward.
4. If you have ever been called a 'snob' because of the school you went to, step backwards.
5. If you disagree with the statement 'poor little rich kid' (i.e. children from affluent backgrounds may be poor in other ways), step forward.
6. If you feel mental health and substance abuse issues among people with wealth are more self-inflicted (and therefore blameworthy) compared to those among people with 'real' problems associated with low income, step forward.

Pair up with someone who is in a different position to you in the line-up.

Questions

Together, work through the following processing questions:

- Do you believe reverse classism exists? Why or why not?
- How could reverse classism affect you as a practitioner?

- **Outcome**

Recognising and responding to classism sensitively means understanding that it can occur at both ends of the spectrum. Students explore the possibility that assuming wealth and privilege is protective may be discriminatory.

Adapted from 'Journeys Privilege Exercise', Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

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5

Sexism

Fiona Kate Barlow, Raine Vickers-Jones,
Beatrice Alba, Emma Williamson,
and Vicki Hutton

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V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_5

Sexism

Trailer

In this chapter, Fiona Kate Barlow and Raine Vickers-Jones explore the complexity of sexism and its relationship to mental health issues. Beatrice Alba describes women's experiences of sexism that can happen on a daily basis and how that can impact well-being. And finally, Emma Williamson describes the gender inequality gap by looking at how this can manifest through motherhood. Williamson gives several examples of how we can easily fall into traps at home and how that can reinforce the gender pay gap

5.1 Introduction

Vicki Hutton

Definition

Sexism and discriminatory stereotypes occur when a person is treated unfairly based on their sex. In Australia, the *Sex Discrimination Act 1984* operationalises Australia's international human rights obligations by making sex discrimination and sexual harassment illegal across many areas of public life (Australian Human Rights Commission [AHRC], 2018a). This means people cannot be treated unfairly because of their: sex, gender identity, intersex status, sexual orientation, marital or relationship status, family responsibilities, present or future pregnancy, and breastfeeding (AHRC, 2012).

Despite formal protection under the *Sex Discrimination Act*, there are still some areas in their lives where females experience inequality, discrimination and restricted choices. For example, despite females comprising around 47% of all employees in Australia, Australia has maintained a national gender "pay gap" of between 15% and 19% less take-home pay for females for the last two decades (AHRC, 2018a). This is partly attributable to the gender segregation in the Australian workforce, with female-dominated industries such as aged care, child care and health and community services traditionally undervalued and associated with part-time, low-paid and insecure positions (Australian Bureau of Statistics [ABS], 2017a).

Compounding this are statistics indicating that females comprise almost 60% of unpaid primary carers for older people and people with a disability, and spend up to twice as many hours caring for children each day, compared to males (AHRC, 2018a). These inequities have resulted in Australian women reaching retirement age with less superannuation than the average male, and therefore at greater risk of poverty in their retirement years (Tanton, Vidyattama, McNamara, Ngu, & Harding, 2009). In 2006, Australia was ranked fifteenth on a global index measuring gender equality, but by 2017, this had slipped to a 35th ranking (AHRC, 2018a).

In addition, there are reports that more than half of the women aged 18 years and over have experienced some form of sexual harassment in their lifetime (ABS, 2017b). Specifically, approximately one in two women had experienced sexual harassment by a male or female perpetrator, and an estimated one in four males had experienced sexual harassment in their lifetime. One in three women have experienced physical or sexual violence in their lifetime (AHRC, 2018a), with violence against women and their children estimated to have cost the Australian economy over 22 billion dollars in 2015–2016 (KPMG, 2016). Having a disability or long-term health condition increased the likelihood of a woman experiencing sexual harassment (ABS, 2017b).

Under the *Sex Discrimination Act 1984*, sexual harassment is defined as:

Any unwelcome sexual advance, request for sexual favours or conduct of a sexual nature in relation to the person harassed in circumstances where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated (AHRC, 2018b). It can include, but is not limited to:

- Unwelcome physical touching
- Staring or leering
- Suggestive comments or jokes
- Unwanted requests to go out on dates
- Requests for sex
- Emailing pornography or rude jokes
- Sending sexually explicit texts
- Intrusive questions about your private life or body
- Displaying posters, magazines or screen savers of a sexual nature.

Sexism, gender discrimination and gender equality can be strongly linked to gender stereotyping. Gender stereotypes comprise predetermined and rigid ideas whereby males and females are assigned characteristics and roles based on their sex. For females, stereotypes can create and reinforce attitudes, values, norms and prejudices, thus justifying and maintaining traditional power relations, and affecting women's education and participation in the economy and public life (Council of Europe, 2019).

Studies suggest that while both females and males can experience sexism and sexual harassment, perceptions of workplace gender discrimination are more likely to be associated with poor mental health amongst women (Harnois & Bastos, 2018). It is therefore important that mental health professionals remain alert to the effects of socialisation, stereotyping, bias and discrimination on the mental health and well-being and identity of both women and men. This requires knowledge about gender roles, stereotypes, oppression, privilege and identity unique to each individual.

5.2 Sexism and Mental Health

Fiona Kate Barlow and Raine Vickers-Jones

5.2.1 What Is Sexism?

Sexism can take many forms; it can be direct and confronting, or subtle and covert (Swim, Aikin, Hall, & Hunter, 1995). One of the most popular psychological conceptualisations of sexism breaks it down into two core domains: hostile and benevolent (Glick & Fiske, 1996). Hostile sexism comprises negative attitudes towards women who challenge the status quo (e.g., career women and feminists). Benevolent sexism, on the other hand, represents an ostensibly kind, protective and positive attitude towards women. This protection is only afforded to women on the provision that they adhere to restrictive gender roles (e.g., as mothers and carers), however, and display purity, kindness and chastity. Together, these types of sexism are thought to reinforce male dominance over women—they are the carrot and the stick. Women who try to challenge gender inequality get the stick (the animosity of hostile sexism), while women who conform get the carrot (the paternalistic protection of benevolent sexism) (Glick & Fiske, 1996).

Another form of gender attitudes is modern sexism. In the current climate, overt negativity towards women based on their gender (traditional sexism) is discouraged, and people who display sexism often face social disapproval (Swim et al., 1995). However, this does not stop everyone from having sexist attitudes. Consequently, these people need to find "socially appropriate" ways to display sexism. Modern sexism is typified by the denial of any ongoing gender inequality, coupled with the assertion that women are getting too demanding and pushy (Swim et al., 1995).

Overview

Throughout this section, we will talk about negativity towards women in general, taking a broad approach to sexism. In the following sections, we make it clear that gender disparity exists across the globe (including in Australia), and detail how sexism can derail our mental health, body image and relationships. We discuss how intersectional experiences of discrimination can magnify sexism, and how sexism can affect gender-queer people. We then acknowledge that men can face rigid expectations, negativity and harassment based on their gender. Finally, we conclude with suggestions for how sexism can be challenged.

5.2.2 Gender Inequality Across the Globe

Even though overt, hostile sexism is no longer accepted the way it used to be in many countries, the negative attitudes towards women held within benevolent and modern sexism (as well as the last holdouts of hostile sexism) do have a real, serious impact on women—and societies—around the world. Hostile and benevolent sexism predict gender inequality across 19 nations (Glick et al., 2000), and sexism defined generally directly predicts increases in gender inequality across 57 societies (Brandt, 2011). Sexism is linked with gender inequality in several domains, including pay disparity, educational achievement disparity, sexual harassment and intimate partner violence (IPV).

The Global Gender Gap Index measures gender disparity in several dimensions, including Educational Attainment, Health and Survival, and Economic Participation and Opportunity (World Economic Forum, 2018). When it comes to political and economic leadership, women are far behind men. Women hold a third of the managerial positions available globally, and fewer than 25% are ministers or parliamentarians. Women also have reduced access to financial services and land ownership, achieving 60% and 42% of men's access, respectively.

It appears that averaged across the globe, women earn around 80–85% of what men do (International Labour Organization, 2018). This gap is more apparent when examining monthly pay over hourly, indicating that the amount of time people can work has an impact on that gap. Twice the number of women are engaged in part-time work than men (International Labour Organization, 2018). This may be from choice, but it could also be because there are fewer full-time opportunities available for women, or that they must choose to work part-time to take care of the domestic responsibilities that fall mostly to them. Women consistently spend twice as much time on average on housework and other unpaid activities (such as caring for relatives) than men do (World Economic Forum, 2018).

Women are also in physical danger from gender inequality. The global lifetime prevalence of intimate partner violence (IPV) for women who have ever had a partner is 30% (World Health Organization [WHO], Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, & South African Medical Research Council, 2013). Seven per cent of women worldwide have been sexually assaulted by someone who wasn't a partner (Devries et al., 2013). Overall, 35% of women have experienced IPV or non-partner sexual violence.

5.2.3 Gender Inequality in Australia

Although Australia fares better in many ways than a multitude of countries around the world, there is still a considerable way to go to continue improvement. Sexism has been identified as a problem in Australia in a number of areas, including within emergency medicine (Jamieson, Tran, & Mackenzie, 2016), mining (Rubin, Subasic, Giacomini, & Paolini, 2017) and education (Ellerman, Dowling, Hinschen, Kemp, & White, 1981). One in three women experienced sexual harassment in their workplace between 2013 and 2018 (AHRC, 2018b).

Australian women earn approximately 86% of what men do when both are working full-time (Workplace Gender Equality Agency [WGEA], 2019a). Men are nearly twice as likely to be managers as women are, and even in female-dominated industries are more likely than women to be managers (WGEA, 2019b). In the home, men spend an average of 13.30 hours a week on housework and 5.40 hours on caring for relatives. Women spend an average of 20.40 hours a week on housework and 11.30 hours on care—70% more than men on unpaid work in total (Wilkins & Lass, 2018). This is better than the global average but still far from equal.

When it comes to interactions with others, Australian survey data shows us that nearly 18% of women aged 18 or above (ABS, 2017b) reported experiencing sexual harassment between 2015 and 2016. Approximately 9% of men reported the same. It is not merely that the victims are more likely to be women; men reported experiencing roughly the same amount of lifetime sexual harassment from women as from men, while women reported experiencing sexual harassment from men at a rate of five times that which came from other women (ABS, 2017b).

Seventeen per cent of women and 6% of men in Australia have experienced physical violence from a partner (ABS, 2017b), while 23% of women and 16% of men have experienced emotional abuse from a partner. One in five women and one in 20 men have experienced sexual violence since turning 15 years old (ABS, 2017b).

5.2.4 Mental Health

Gender inequality can affect health in a number of ways outlined above: in the form of gendered violence, lack of access to healthcare and services, wage and hiring discrimination, and sexual harassment. Exposure to everyday sexism, however, can have also have a pernicious effect on women's mental health and well-being. Throughout this section, we will take a broad and encompassing look at mental health, comprising both the absence of distress (e.g., depression, anxiety) *and* the presence of well-being (e.g., happiness, agency, life satisfaction). This approach fits with the World Health Organization's definition of health, contained in its constitution. This is that: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946).

5.2.4.1 Psychological Distress

As highlighted at the introduction of this chapter, sexism has no single fingerprint and takes no single form. It may include obvious examples of sexual harassment or abuse (e.g., boasting about grabbing women by their vaginas), and preferential hiring or promoting. It may alternatively involve a colleague calmly explaining that women ("in general, not you Sue!") are unsuited to taking on specific jobs or roles, jokes about gendered violence, stereotypes about women's lack of mental ability or using terms such as "girly" or "like a woman" to mean bad or lesser. To some, the latter examples may seem harmless, but the reality is that cumulative sexist experiences can have a marked effect on how women see themselves and feel about their lives.

There is a simple logic to sexism, much like any other type of prejudice. That is, if you are a woman, and there is something fundamentally *lesser* about being a woman, then there is something fundamentally lesser about you. As a result, repeated exposure to sexism can make women feel uncertain, powerless and depressed.

In one study, Landry and Mercurio (2009) asked female college students from the United States (US) about their recent experiences of sexism. Participants were asked how many times they had been called a sexist name, or treated unfairly by employers, and their family, because they were a woman. They were also asked how in control of their life they felt, agreeing or disagreeing with statements such as: “In general, I feel I am in charge of the situation in which I live”. The more that women experienced sexism, the less personal control they felt, and women who felt less control went on to report more psychological distress and lower self-esteem (for more work on sexism and control, and sexism and self-esteem, see Bourguignon, Seron, Yzerbyt, & Herman, 2006; Fischer & Holz, 2010; McCoy & Major, 2003; Schmitt, Branscombe, & Postmes, 2003). Similarly, the more that adolescent girls internalise traditional conceptualisations of femininity (e.g., being quiet and subservient, focusing on how they look rather than how they feel), the more likely they are to experience low self-esteem (e.g., feel that they are worthless) and depression (Tolman, Impett, Tracy, & Michael, 2006).

The theme of not being able to “speak up” and be heard is a strong one within sexism research. Traditional conceptualisations of femininity prohibit assertive and decisive speech, and having opinions that disagree with those of others (particularly men). Perhaps in part because of this, women often feel that they need to act placidly and pleasantly in the face of sexism.

In line with this idea, an early study found that while most women thought that they would actively reject sexism, the majority stayed silent when actually exposed to sexism (Swim & Hyers, 1999). In one study, Rebecca Hurst and Denise Beesley (2013) asked over 100 US college students about their experiences with sexism. They measured their exposure to sexism through the *schedule of sexist events* (Klonoff & Landrine, 1995). This scale asks women questions such as “How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are a woman?” and “How many times have people made inappropriate or unwanted sexual advances to you because you are a woman?” They also measured how often the women in their sample reported *self-silencing* (i.e., holding back their true thoughts and opinions).

Hurst and Beesley (2013) found that the more sexism women reported experiencing, the more they self-silenced, agreeing with statements such as, “I don’t speak my feelings in an intimate relationship when I know they will cause disagreement” and “Caring means putting the other person’s needs above my own”. Women who self-silenced also reported experiencing more psychological distress. The authors proposed that sexism itself might lead women to feel that they do not have the right or ability to be authentic, which in turn might lead to depression. Work with both students and faculty at another US university provides support for these results: The more that women report passively accepting gender inequality, the more psychological distress they also report (Moradi & Subich, 2002).

From the above research, it is clear that sexism can be experienced as a trauma. Post-traumatic stress disorder can arise following any traumatic event, involving re-experiencing the traumatic event, emotional numbing, somatic difficulties and general psychological distress, among other symptoms. Some scholars have argued that chronic exposure to sexism, especially if that sexism takes the form of degradation or assault, can result in post-traumatic stress-like symptoms (Berg, 2006). Consistent with this idea, Berg (2006) found that women who had experienced recent sexist degradation also reported more trauma symptoms. In this study, experiences of sexism accounted for variance in post-traumatic stress symptoms over and above other general stressors and life burdens (e.g., relationship breakdown or financial pressure).

It is important to know that many of the studies we discuss in this chapter consider general life stressors, and statistically control for them. This body of work indicates that it is not just people who find everything stressful (including sexism) that are distressed; rather there seems to be something specific about experiencing sexism that is related to anxiety, depression, self-esteem and post-traumatic stress disorder.

There is also convergent evidence that exposure to sexism can lead to physiological, as well as psychological stress. In one study, Salomon, Burgess and Bosson (2015) had US students come into the lab. Male research assistants then gave instructions to participants in a hostilely sexist manner, a benevolently sexist manner or a neutral manner. The authors found that when exposed to either a hostile or benevolently sexist experimenter, women showed cardiovascular responses consistent with stress, suggesting that repeated exposure to sexism may have marked health outcomes (see also Eliezer, Major, & Mendes, 2010). In line with this proposition, one study found that experiencing sexist discrimination was associated with negative physical and psychiatric symptoms (including premenstrual symptoms, somatic symptoms, and total psychiatric and physical symptoms) than generic stressors alone (Landrine, Klonoff, Gibbs, Manning, & Lund, 1995). A later study found that sexist discrimination accounted for *more* negative physical, gynaecological and psychological symptoms than generic stress did (Campbell, 2000). The way that people deal with the stress associated with sexism can also be maladaptive. For example, exposure to sexism has been found to be positively associated with higher levels of smoking (Borrell et al., 2010).

5.2.4.2 Body Image and Eating Disorders

One aspect of mental health that is strongly and consistently associated with sexism is body dissatisfaction. This is perhaps mainly the case for a particular type of sexism: sexual objectification.

Definition

Sexual objectification involves reducing someone to a sexual object, or thing, rather than a person (Holland, Koval, Stratemeyer, Thomson, & Haslam, 2017). It is important to clarify that as a mating species, we are, of course, going to view one another in a sexual way, and see one another as potential sexual partners (at times, and when appropriate). Sexual objectification falls outside of this normal mating dance; the word "object" is meaningful here—whereas one might engage with, talk with and respect people, objects are non-sentient and are used.

In one Australian study, Elise Holland and her colleagues (Holland et al., 2017) had 81 young women download a smartphone app to their phone. This app allowed Holland and her team to contact participants at random intervals throughout the day, and ask them what had been happening—and how they were feeling—in the moment. This technique is referred to as *ecological momentary assessment* (Shiffman, Stone, & Hufford, 2008) and allows researchers to limit the extent to which errors in memory affect results. Over the course of a week, participants were contacted approximately every hour and a half, every day. When their phone buzzed, they were asked to complete a quick measure of the sexual objectification that they had experienced since the previous survey. Participants could tick off experiences (if they had happened) including: hearing catcalling, car honking or sexual remarks, and being touched or fondled against one's will, or being the subject of a degrading sexual gesture. Seventy-five per cent of women experienced objectification at least once during the week. The average woman in the study felt sexually objectified 3.69 times during the week. Objectifying gaze was most common (making up 55% of experiences), with touching/fondling being least common (making up 4% of experiences). Objectification was not benign here; the more that women experienced sexual objectification, the more that they reported self-objectification.

Indeed, there is a body of work showing that women who are exposed to more sexist events are more likely to engage in disordered eating (Sabik & Tylka, 2006). Further, women who experience more sexual objectification are more likely to report more body surveillance, body shame and disordered eating (Moradi, Dirks, & Matteson, 2005). In an experimental study, women exposed to benevolent sexism reported increased self-objectification and body shame (Calogero & Jost, 2011).

Objectification is also interesting because there is evidence that it causes people to focus on appearance, and away from activism. In her paper, titled: “Objects don't object”, American psychology professor Rachel Calogero reported two studies in which she found both correlational and experimental evidence that self-objectification is associated with lower feminist or gender-based social action (Calogero, 2013).

5.2.5 Relationships

Sexism isn't just evident in sexual objectification; it also spills into our intimate couple relationships. One area that sexism is beginning to be recognised is in heterosexual intimate relationships (for an overview, see Hammond & Overall, 2016). Nickola Overall, a psychology professor at the University of Auckland, is leading the way in this research, and has conducted multiple studies revealing how sexismcan damage intimate relationships, as well as mental health (for an informative book on the subject, see Fletcher, Simpson, Campbell, & Overall, 2013).

In Overall's Auckland lab, heterosexual couples are often brought into the lab to discuss conflicts. These discussions are then coded, and response styles are statistically associated with sexism. Work by Overall and her team has shown that hostilely sexist men are more aggressive when talking to their partner, and less open to hearing her point of view (Overall, Sibley, & Tan, 2011), and that they also tend to see both affection and criticism more negatively than do men who are less hostilely sexist (Hammond & Overall, 2013). Hostilely sexist men, perhaps unsurprisingly, are also less satisfied in their romantic relationships (Hammond & Overall, 2013). Benevolent sexism, on the other hand, can undermine relationships in less obvious ways. People high in benevolent sexism are more likely to call it quits on an imperfect relationship (Hammond & Overall, 2014).

Sexism, then, can influence our mental health, how we feel about our bodies and how we experience love. It can also, as will be illustrated below, affect women negatively at work.

5.2.6 Sexism in the Workplace

The behaviour of sexist colleagues can negatively affect the well-being of female employees. With one in three Australian women experiencing sexual harassment in their workplace (AHRC, 2018b), this can have a profound impact on Australian women. Two Australian studies found that female miners who experienced organisational and interpersonal sexism felt a lower sense of belonging in the organisation, leading to poorer mental health and lower job satisfaction (Rubin et al., 2017; Rubin, Paolini, Subašić, & Giacomini, 2019). In the second study, 305 female members of a large Australian industrial workers' union completed a survey about their experiences of interpersonal and organisational sexism within the last 12 months, with questions such as "I have been treated unfairly by my co-workers because I am a woman". They also reported their sense of belonging in their workplace within the last 12 months, as well as their job satisfaction. A short form depression, anxiety and stress scale measured their mental health over the prior week. Both organisational sexism and interpersonal sexism were positive predictors of mental health problems, while only organisational sexism negatively predicted job satisfaction (Rubin et al., 2019).

A number of studies in other countries have shown that gender discrimination and experiences of sexism are associated with negative workplace well-being for women, independent of other stressors (Harnois & Bastos, 2018; Pavalko, Mossakowski, & Hamilton, 2003; Sojo, Wood, & Genat, 2016). This pattern has been found across a number of different industries and workplace roles, including female faculty members at universities experiencing higher rates of harassment and abuse than male (Richman et al., 1999), and female construction workers experiencing sexual harassment and gender discrimination from supervisors and coworkers (Goldenhar, Swanson, Hurrell, Ruder, & Deddens, 1998).

Organisations themselves can also contribute to negative mental health consequences for their employees. Women who earn less than men in similar roles experience higher rates of depression and anxiety than those earning more than men (Platt, Prins, Bates, & Keyes, 2016). Female employees who believe that their organisation is tolerant of gender discrimination report more sexual harassment than those who believe their organisation is less tolerant, which is in turn related to absenteeism, distress and intentions to quit their job (Fitzgerald, Drasgow, Hulin, Gelfand, & Magley, 1997). Another study found that when an organisation was lower in responsiveness to gender discrimination, women experienced greater psychological distress, especially when working in female-dominated careers (Bond, Punnett, Pyle, Cazeca, & Cooperman, 2004).

5.2.7 Intersectionality

Up until this point, we have largely talked about prejudice towards women. This is, of course, the focus of this chapter, but ignores the fact that people can experience discrimination on a range of fronts. Intersectionality is the way in which multiple facets of a person's identity, such as race, gender, sexual orientation and class, interact with one another to affect well-being, health, politics and one's lived experience of the world (Cole, 2009; Crenshaw, 1991). Some correlational work has examined the consequences of sexism from an intersectional perspective. Moradi and Subich (2003) found that experiences of racism and sexism were highly correlated for African American womensuggesting that it is rare to experience one without the other. Another study found that African American women who attributed others' negative evaluations of themselves to ethgender prejudice (racism and sexism intertwined) reported increased stress and lower self-esteem (King, 2003).

A study examining the intersectionality of age and gender found that elderly women did experience sexist discrimination, and it predicted negative psychological health more strongly than generic stress. However, the women reported decreased sexual harassment as they aged, indicating that the sexist discrimination they experienced as younger women stayed with them for a lifetime (McSwan, 2000). Turning to sexual orientation, lesbian women who have experienced recent sexist events have higher levels of psychological distress, especially if they have also experienced recent sexual-orientation-based hate crime (Szymanski, 2005).

Thus far we have been discussing "men" and "women", but there are people who do not identify as cisgender (i.e., have a gender identity that matches their sex assigned at birth). Transgender women (i.e., women who were assigned a non-female sex at birth) are particularly vulnerable to gendered violence (Greenberg, 2012), and both transwomen and transmen report experiencing sexism (Daley, Solomon, Newman, & Mishna, 2007). There are also people who do not identify with the gender binary. These people may identify as gender non-conforming, agender or a plethora of other gender identities. Genderqueer people who do not identify with the gender binary people report experiencing substantial gender-based discrimination, and the more they experience this discrimination, the more likely they are to report depression and social anxiety (Testa, Habarth, Peta, Balsam, & Bockting, 2015).

5.2.8 Men Experience Gendered Inequalities Too

Above we note how women (and gender diverse people) are damaged by sexism and have also outlined statistics that reveal gender inequality where women across the world are disadvantaged relative to men. However, men also suffer negative effects from gender inequality in similar and different ways to women. Many of these are a result of rigid gender roles and gendered expectations for men. For example, male rates of suicide are dramatically higher than female rates (ABS, 2017c). They can feel pressured to withhold emotions, to "man up" and act dominant at all times. Parents want their sons to be more fearless and better at suppressing their anger than their daughters (Diener & Lucas, 2004). Depressed men are evaluated more negatively than depressed women and are described as "unmanly" (Brody, 1999). Men who violate gender role expectations for their emotional expression (such as expressing vulnerability) may experience shame and anxiety about doing so (Osherson & Krugman, 1990). Men are often stereotyped as sexual predators, and sexually violent—and at the same time devalued if they do not show enough sexual agency; men who are more sexually aggressive are seen as more masculine (Murnen, Wright, & Kaluzny, 2002). Men who are concerned about being seen as weak or feminine feel less confidence to intervene as a bystander during sexually aggressive events, showing they cannot even object to others' sexual violence without being seen as less "manly" (Leone, Parrott, Swartout, & Tharp, 2016). Male experiences of being the victim of domestic violence are often downplayed, or seen as a joke (Benatar, 2012). Like women, men also struggle with body dissatisfaction and pressure, and can feel objectified (Grogan, 2016). Men are also often seen as less capable of caring for children than women are.

Nineteen per cent of Australian children live with a single mother, as opposed to only 2% with a single father (Australian Institute of Family Studies [AIFS], 2016).

Although women experience gender-based derogation at higher rates than men do (Kessler, Mickelson, & Williams, 1999; Swim, Hyers, Cohen, & Ferguson, 2001), men are not immune from its negative effects. There is also some evidence that men who experience sexism can have lower comfort and self-esteem in the moment, and higher levels of anger and depression (Kessler et al., 1999; Swim et al., 2001), although results are inconsistent (Dambrun, 2007; Schmitt, Branscombe, Kobrynowicz, & Owen, 2002). Much like attitudes towards women can be both positive and negative (Glick & Fiske, 1996), attitudes towards men can be broken down into stereotypically complimentary (e.g., "bold") and derogatory (e.g., "bad") components (Glick & Fiske, 1999). Interestingly, negative attitudes towards men (as well as women) seem to reflect gender inequality. One 16-nation study (including Australia) found that both women and men in countries with more gender inequality reported more hostility towards men (Glick et al., 2004).

Men die younger than women (Australian Institute of Health and Welfare [AIHW], 2019) and work more rough/unpleasant/dangerous jobs (ABS, 2019; Safe Work Australia, 2018). In school, while girls who win academic competitions are rated less favourably than boys who win, the opposite is true when they lose. Boys who lose competitions are rated more unfavourably than girls who lose. In short, we expect boys to win, and when they don't, they are downgraded and devalued (Ellerman et al., 1981). The pressure that men feel to always win and generally "behave like men" can also have a marked and negative effect on their mental health.

Wong, Ho, Wang and Miller (2017) conducted a meta-analysis of studies looking at conformity to masculine norms and mental health outcomes. They accessed data from 78 samples and over 19,000 participants (primarily men). Results indicated that feeling pressured to conform to masculine norms (e.g., of winning, being self-reliant, having power over women and having to be a playboy) was consistently related to increased negative and decreased positive mental health outcomes.

So why do we find it hard to think about male and female suffering side by side? One answer is found in the human drive to find easy solutions to difficult problems—it is much simpler to reduce problems to victim and perpetrator, aggressor and aggressed against. In short, we often fall into the trap of seeing group-based inequality as a zero-sum game; that is, that any improvements in the conditions of one group come at the cost of detriments to the other (Norton & Sommers, 2011). From this perspective, gender relations are a battle—when women win, men lose, and when men win, women lose. It turns out, however, that when you buy into zero-sum gender beliefs, everyone loses. Men's zero-sum gender beliefs are related to their mental health, for example (Wong, Klann, Bijelić, & Aguayo, 2017). In two studies across Chile and Croatia, Wong, Klann, Bijelić and Aguayo (2017) found that men who accepted the idea that gains to women come at a cost to men also reported increased psychological distress. This relationship was explained in part by the fact that men who had zero-sum gender beliefs were less satisfied in their romantic relationships, which in turn was associated with distress.

5.2.9 Conclusions and Solutions

Sexism is clearly a pernicious problem, damaging the health, relationships and well-being of women. Likewise, rigid gender roles and attitudes also seem to damage men. Consequently, it is sensible to ask, "What can be done about sexism?"

Tip

There is some evidence that simply educating people about how harmful sexism can be can reduce it (Becker & Swim, 2012; Becker, Zawadzki, & Shields, 2014). Encouraging women to attend to everyday sexism can increase their engagement in collective action on behalf of women, and getting men to see sexism and feel sympathy for the target of sexism can reduce their sexist beliefs (Becker & Swim, 2011). More generally, however, more needs to be done to understand how sexism can be reduced, not just what it does and what encourages it (Becker et al., 2014). Reducing sexism in turn may have positive consequences for our school and organisational productivity, as well mental and physical health, and the health of our relationships.

5.3 Personal Stories and Current Affairs

5.3.1 Still Serving Guests While Your Male Relatives Relax? Everyday Sexism Like This Hurts Women's Mental Health

Beatrice Alba

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► https://theconversation.com/still-serving-guests-while-your-male-relatives-relax-everyday-sexism-like-this-hurts-womens-mental-health-116728

Sexism and misogyny harm women in many obvious ways. Women experience economic, workforce and healthcare disadvantages, and intimate partner violence and gendered violence in public places, and street harassment.

Women are also faced with denials, and gender inequality still exists in 2019. Some people presume antidiscrimination legislation, equal pay and ensuring motherhood is not a barrier to workforce participation are all that's needed to achieve gender equality (O'Brien, 2019).

But sexism pervades society in many more subtle ways—and its impacts are not always so tangible. This discrimination is committed not just in the workplace and on the streets, but in social settings and in our own homes, sometimes by the people who love us.

It can also start young, like when parents enlist daughters to serve guests at a family gathering, and sons are free to relax with their male relatives.

Everyday sexism might not be noticed by perpetrators or bystanders, but it can wear women down and is linked to poorer physical and mental health (Landrine et al., 1995).

■ What is "everyday sexism"?

Researchers have examined experiences of everyday sexism using a daily diary method. In a series of studies from the United States, researchers asked 107 women and 43 men to record in a diary any sexist incidents they encountered over a period of 2 weeks (Swim et al., 2001).

One type of sexism the participants encountered was the endorsement of traditional gender role prejudices and stereotypes. One participant, for example, reported being told not to "worry her pretty little head about these complex insurance issues".

Another type of everyday sexism the participants encountered was demeaning or derogatory treatment, such as sexist jokes and language.

A third type of sexism was sexual objectification, such as street harassment and unwanted touching. For example, one participant reported having a stranger at a party squeeze her waist while he was walking past. In some contexts, women may not experience any formal barriers to participation, but may still be faced with cultural norms that disadvantage them.

Women in traditionally male-dominated fields such as STEM (science, technology, engineering and maths), for instance, can be targets of prejudice and negative stereotyping (Barthelemy, McCormick, & Henderson, 2016) which undermines their success (O'Brien, McAbee, Hebl, & Rodgers, 2016).

This negative stereotyping may include being underestimated and assigned easier tasks. Women might also experience social exclusion and isolation, such as not being invited to out-of-hours catch-ups.

Rules and laws against gender discrimination don't prevent people with sexist attitudes from treating others unfairly in everyday interactions. This is particularly true when it is perpetrated unconsciously, in ways that aren't detectable to everybody.

- **Discrimination gets under your skin**

While individual instances of this unfair treatment might seem as minor as to be harmless, they can be frequent and ubiquitous. Everyday sexism is often present at a constant low level in the background of our lives, adding an extra layer of stress.

Unsurprisingly, these subtle forms of everyday sexism have been linked to poorer mental health.

The daily diary study described above found more frequent reports of everyday sexism predicted poorer psychological well-being.

Earlier research showed that experiences of sexism were linked to poorer mental and physical health (Landrine et al., 1995), including post-traumatic stress disorder (Berg, 2006), binge drinking and smoking (Zucker & Landry, 2007).

More recently, a study found experiences of gender discrimination in the workplace accounted, in part, for poorer health outcomes in women compared to men (Harnois & Bastos, 2017).

There are, however, factors that moderate the relationship between discrimination and health outcomes. Women with higher self-esteem (Moradi & Subich, 2004), for example, don't seem to suffer the ill-effects of discrimination as much.

Given the pervasiveness of gender discrimination, research on its impact on mental health is still disproportionately low. But the existing research findings are corroborated by studies of the mental health impacts of discrimination based on race (Paradies et al., 2015) and sexual orientation (Perales, 2018).

- **It might be invisible to some**

Studies consistently show that the perception that you're being discriminated against on any grounds is linked to poorer mental and physical health (Pascoe & Smart Richman, 2009). And subtle forms may be as harmful as more overt forms of discrimination (Jones, Peddie, Gilrane, King, & Gray, 2016).

Everyday sexism might be difficult to recognise by those who don't experience it. Research shows that men are less likely to accept evidence of gender discrimination than women (Handley, Brown, Moss-Racusin, & Smith, 2015). This is likely due to perceptions and everyday observations being limited by our own experiences and our biases.

Anecdotal evidence alone is insufficient to demonstrate the full reality of everyday sexism and its impacts. Scientific research reveals far more than our intuitions do about the nature of these phenomena, with greater accuracy.

- **Sexism is a health issue**

Given this link to well-being, it's reasonable to consider sexism a public health issue.

Doing so widens the circle of those considered responsible for protecting the well-being of those affected. Governments are obliged to reduce this health disparity, just as they invest in reducing other public health concerns, such as smoking and obesity.

While gender stereotypes remain entrenched now as they were 30 years ago, there is promising evidence we can learn to reduce everyday sexism (Haines, Deaux, & Lofaro, 2016).

One such intervention simulates an experience of discrimination by randomly assigning one group of participants to experience "small and seemingly innocuous advantages" in a game.

Direct experience of discrimination, and critical reflection on it, increases recognition of the harm it causes and increases the intention to overcome it (Cundiff, Zawadzki, Danube, & Shields, 2014).

Creating a fairer society requires some antidote for the health impacts caused by sexism. But as we know, prevention is better than cure.

5.3.2 Four Home Traps That Contribute to the Gender Pay Gap

Emma Williamson

This article is republished from The Conversation under a Creative Commons license. 23 August 2019.

► https://theconversation.com/four-home-traps-that-contribute-to-the-gender-pay-gap-122261

Australia's gender pay gap is diminishing, says a new report, but some contributors to it seem harder to overcome than others. For me, the finding hit close to home.

The Workplace Gender Equality Agency report by KPMG for the Diversity Council of Australia and Workplace Gender Equality Council, 2019 (WGEA, 2019c), says the pay gap declined from $3.05 an hour in 2014 to $2.43 in 2017. Women on average now earn A$31.14 an hour compared with A$33.57 for men.

The report breaks down the economics to some very specific factors. Overall, two thirds of the decline is credited to diminishing industrial and occupational segregation.

Proving harder to erode is "gender discrimination" (which the report defines as that portion of the pay gap unexplained by other factors) and the impact of career interruptions. For women, time out of the workforce is generally to care for young children or other family members, the report states, with such interruptions being "gendered and highly persistent".

As an academic, working architect and chair of a national committee for gender equality (Williamson, 2016), I've been engaged with discussions and research about what holds women back in their careers. The report data reports many women leave the profession in their late twenties or 30s and never return (Matthewson, 2018). This is hardly unique.

There is a lot of talk about what can be done through government and corporate policy to welcome women back to the workforce. That's all good, but I've also been thinking about how we can address the issue more holistically.

I have been reflecting on the sudden gender divide that happened when I gave birth to my first child. My husband and I had gone to university together and worked together. We both considered ourselves fierce feminists. Yet when we started our family, it was an almost instant shift to gendered roles: I gave up full-time work, and he stayed in full-time work.[1]

At the time it seemed the efficient thing to do. We both thought it was just a phase. But it has been harder to shift than we first imagined.

I see four traps we can easily fall into at home and work that reinforce the gender pay gap.

1. *Being the home-maker*

Breastfeeding binds women and children and ensures we stay close. But when not performing this miracle of sustenance, we are often looking for other ways to be the perfect mother and home-maker. We turn our attention, energy and intelligence to conquering the domestic situation in full. Cooking, cleaning, washing and ironing slowly but surely become our responsibility as the person who is at home the most.

The pattern once set is hard to change. Studies in countries with paid parental leave, such as Sweden, show that when housework and child care are divided more evenly at the beginning of a child's life, that division is likely to be maintained at a more equitable rate in the longer term, and be associated with women having a higher participation rate in paid work (Almqvist & Duvander, 2014).

2. *Counting childcare costs*

Returning to work is usually preceded by weighing the relative costs and benefits of time away from the baby with a desire for meaningful paid work. Most of us will also factor in the costs of childcare.

But comparing the cost of childcare and associated domestic assistance against the amount of money the woman will earn is one of the biggest mistakes we, and our partners, can make. This isn't something that should be considered just as an immediate cost. It's a long-term investment in ensuring both parents have the chance to progress their careers (WGEA, 2017).

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[1] For more, read DeRose, L. (2019, August 8). Gender equality at home takes a hit when children arrive. *The Conversation.* Retrieved from ► https://theconversation.com/gender-equality-at-home-takes-a-hit-when-children-arrive-118420

3. *Devaluing part-time work*

Many women I know have returned to work part-time or started their own small business because they want the flexibility to fit their work around looking after children. Their partner meanwhile maintains the consistent full-time role as main financial provider.

The danger for those of us in this position is that we are the ones who drop everything. Our work is thus disproportionately affected and devalued.[2]

4. *Reverse sexism*

The last trap is thinking only mothers need support to balance the demands of working and parenting. Fathers need it to—just in different ways.

Organisations like the Workplace Gender Equality Council help ensure there is now a lot of fantastic support to women to take maternity leave, return to work when they are ready and have flexible work arrangements.

We need more support for men to unshackle themselves from the demands of full-time jobs—often working overtime and sacrificing time with their family for the sake of the family.

Our kids don't just need mothering. They need parenting. Until paternity leave and flexible workplace arrangements are not only available but taken by both women and men, the gender pay gap will persist.

By avoiding these traps, we might help dismantle some persistent contributors to the gender pay gap. It's not wholly in the hands of individuals, or families, or companies, or governments to change these dynamics. For the social good, it's a project we should all be working on.

5.4 Experiential Activities

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant, and they should provide participants with ways to resolve feelings that may arise as a result of the activity including reflection and debriefing.

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[2] For more, read Ruppanner, L. (2019, August 15). Women aren't better multitaskers, they're just doing more work. *The Conversation.* https://theconversation.com/women-arent-better-multitaskers-than-men-theyre-just-doing-more-work-121620

Activity 1

Title Privilege statements—Sexism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to sexism. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. When I am angry or emotional, people do not dismiss my opinions as symptoms of "that time of the month".
2. When I strongly state my opinion, people see it as assertive rather than aggressive.
3. I can choose the style of dress that I feel comfortable in and that most reflects my identity, and I know that I will not be stared at in public.
4. I do not worry about walking alone at night.
5. People assume I was hired based upon my credentials, rather than my gender.
6. People assume that I got a promotion at work or a good grade or anything else I worked hard for because whoever gave it to me found me attractive.
7. I think it is normal to assume the mother should stay home with the children if they are sick.
8. I have never been whistled at or made to feel uncomfortable when walking in public.
9. I do not believe it is more unnatural for a mother to walk out on her children compared to a father walking out on his children.
10. I can always find an appropriate change room in a sports facility.

Are the scales balanced, or tipping one way or the other?

■ Questions

Reflect on the following questions:

- How did you feel doing this activity?
- What does it feel like to have, or not have certain privileges?
- Can you identify other privileges related to sexism that you may or may not experience?

Outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privileges related to sexism, students become more sensitive to the multifaceted nature of privilege within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title Photovoice: Gendered nature of the environment

Purpose The concept of "photovoice" allows students to use photography to identify and communicate perspectives of social issues in their environment (Photovoice, 2019). Students then use these images to examine and understand the social system and their role within that system, thus facilitating a greater awareness of social justice, social privilege and cultural sensitivity.

In this activity, students are asked to explore the "gendered nature" of urban space through the images they capture. These can be positive or negative experiences of gender equality—for example, sexist advertising, pram accessibility, change facilities at sports grounds and potentially "unsafe" areas to walk.

Process Ask students to take a photograph of something that represents gender equality or inequality in their physical environment. Remind students not to include recognisable faces in the images they may present, as these photos will be shared with other members of the class group.

In pairs or groups, each student tells the story behind their chosen photograph, and how and why they feel it represents gender equality or inequality. As a larger group, identity common themes in the images presented, and reflect on the following questions.

- **Questions**

1. Were there many examples of hidden gender inequality in these images?
2. How could you apply this growing awareness of gender equality or inequality in the physical environment to your own work and life?

Outcome By studying images and listening to the stories behind them, students will develop a greater awareness of gender equality or inequality within their environment and how this can impact a person's day-to-day life.

Adapted from: Ergüner-Tekinalp, B. & Harper, A. (2011). Photovoice: Understanding Social Privilege. In M. Pope, J.S. Pangelinan, & A.D. Coker (eds). Experiential Activities for Teaching Multicultural Competence in Counselling (pp. 222–224). Alexandria, VA: American Counseling Association.

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Heterosexism and Cisgenderism

Michael Barnett, Filipe Fotheringham, Vicki Hutton, and Kieran O'Loughlin

Contents

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_6

Trailer

In this chapter, Vicki Hutton and Kieran O'Loughlin consider the potential outcomes of not identifying as, or being perceived as, heteronormative or cisgendered. Filipe Fotheringham's account of growing up non-binary culminates in their relief at finding unconditional acceptance in an unexpected place. Mike Barnett describes his somewhat reluctant journey to turn around LGBTIQ intolerance in the Jewish community, and an interview with therapist Kieran O'Loughlin sheds some light on the meaning and importance of gay affirmative practice.

6.1 Introduction

Vicki Hutton

Estimating the number of Australians who identify as lesbian, gay, bisexual, trans, intersex, gender diverse or non-cisgender has been difficult due to the lack of comprehensive, publicly available data (Australian Human Rights Commission, 2014). These minority groups were subject to increasing scrutiny during the public debate over same-sex marriage and leading up to the Australian Marriage Law Postal Survey in 2017, but there remains a need for further demographic research and sexual and gender minority estimates for health and social justice reasons (Wilson & Shalley, 2018).

The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy (Department of Health, 2015) estimates that Australians of diverse sexual orientation, sex or gender identity may account for up to 11 percent of the Australian population, while the Australian Bureau of Statistics (ABS) 2014 General Social Survey reported 3 percent of adults identified as gay, lesbian or as having an 'other' sexual orientation (ABS , 2015). The 2016 National Drug Strategy Household Survey estimated 3.2 percent of adults identified as homosexual or bisexual, with 2.4 percent not sure/other orientation (Australian Institute of Health and Welfare [AIHW], 2018). These disparities may be partly explained by different data collection methods and questions, and importantly, because many individuals, especially young people aged 16–24 years, may hide their sexual orientation or gender identity at school, at work, when accessing services, and at social or community events. The need for current sexual minority population estimates, including age, sex and gender, and geographic detail, continues to present a challenge when reporting on the health of these potentially stigmatised minority groups (AIHW, 2018).

Definition

Defining who should be included in sexual and gender minority estimates is also a challenge. Sexual orientation has been defined as "an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes" (American Psychological Association, 2019), and comprises sexual attraction, sexual behaviour, and sexual identity. Gender identity (a person's psychological identification as male, female or something else) and intersex (differences in sex chromosomes, gonads, reproductive ducts and/or genitalia) are separate to sexual orientation, but individuals identifying as either group may be of any sexual orientation.

While the Australian Bureau of Statistics has compiled statistics of same-sex couples living together since 1996, they acknowledge that reporting of same-sex relationships may be influenced by a person's willingness to report as same-sex couple (ABS, 2018). The 2016 Census noted a 39 percent increase of same-sex couples living together since the 2011 Census (i.e. 46,800 couples compared to 33,700 couples), and four-fold increase since 1996. That means, in 2016, around one in 100 Australian couples were same-sex, with 49 percent of these being female, and one quarter of the female same-sex couples having children (AIHW 2018). Less than 5 percent of male same-sex couples had children. There is some evidence that children aged 5–17 years with same-sex parents scored higher on measures of general health and family cohesion compared to Australian children from other family contexts and backgrounds (Australian Human Rights Commission, 2014).

People in same-sex relationships reported a mean age of 40 years, compared to 48 years for opposite-sex couples, and were more likely to live in capital cities, rather than outside capital cities (Australian Human Rights Commission, 2014). They were also more highly educated and more likely to have higher incomes. Fifty seven percent of people in same-sex relationships reported they had no religion (ABS, 2018), perhaps indicative of the church's ambivalent responses to homosexuality over the years.

Evidence from a range of small-scale LGBTI targeted studies as well as some larger population-based studies, suggest that LGBTI people face increased negative outcomes in terms of their mental health, sexual health and rates of substance abuse (AIHW, 2018). Some key issues strongly interconnected with these disparities include verbal homophobic abuse, physical homophobic abuse, cyber-bullying, social exclusion and humiliation (Australian Human Rights Commission, 2014). Transgender people in particular are likely to experience significantly greater rates of non-physical and physical abuse compared to lesbians and gay men. It is not surprising then that almost half of lesbian, gay, bisexual and transgender people hide their sexual orientation or gender identity in public for fear of violence or discrimination.

The minority stress model is often adopted as a theoretical framework within which to explore lesbian, gay, bisexual, transgender and intersex wellbeing (Carmel & Erickson-Schroth, 2016). This model claims that living in a hetero-centric, gender-normative society stigmatises and discriminates against lesbian, gay, bisexual, transgender and intersex people, thus subjecting them to chronic high levels of stress. This ongoing and potentially cumulative stress is responsible for the greater risk of negative mental health outcomes compared to the general population.

6.2 Heterosexism, Cisgenderism and Mental Health

Vicki Hutton and Kieran O'Loughlin

In many societies, heteronormativity is perceived as the natural, unquestioned and privileged option (Hertz & Johansson, 2015). Defined as "a societal hierarchical system that privileges and sanctions individuals based on presumed binaries of gender and sexuality" (Russell, McGuire, & Russell, 2012, p. 188), heteronormativity encompasses the overt and hidden ways that heterosexuality is normalised, naturalised and unquestioned in everyday life (Myers & Raymond, 2010).

Interlinked with heteronormativity is 'cisgender', a descriptive term for people whose gender identity and the gender role they perform in society matches the sex they were allotted at birth (Tate, Ledbetter, & Youssef, 2013). As with heteronormativity, cisgender characterises the majority group in many societies (Tate et al., 2013), thus creating a strong interconnection between sexuality, gender and the standards of 'normality'.

Definition

An outcome of not identifying as, or being perceived as, heteronormative or cisgendered can be experiences of heterosexism or cisgenderism. These two processes grant privileges to heterosexuals whose behaviours and appearance match the gender roles assigned to them, and can oppress lesbian, gay and bisexual individuals, as well as anyone displaying non-cisgender behaviour, identity or experiences such as transgender individuals.

The terms also intersect with other discourses of dominance, including racism, sexism and classism (Croteau, Lark, Lidderdale, & Chung, 2012). While the focus in this chapter is on heterosexism and cisgenderism, it needs to be acknowledged that these are only two aspects of social identity. Indeed the experiences of disempowerment and marginalisation afforded by them cannot be fully understood without also considering factors, such as age, race, ethnicity, economic class and disability.

Compounding the negative experiences associated with heterosexism and cisgenderism is the popular media tendency to group all those perceived as not conforming to the standards of heteronormativity under an indistinguishable collective of acronyms, ranging from LGBT (Lesbian, Gay, Bisexual, Transgender) to LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer) to LGBTIQA+ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual + Other Diverse Sexual Orientations and Gender Identities). This homogenous labelling fails to clarify the heterogeneous conceptions of identity and the unique lived experience of the individuals within each of these disparate groups.

The contra-indications of linking all these experiences together is reinforced when considering the interrelated concepts of anatomical sex, gender identity and sexuality underpinning each group to varying degrees. This means that while Lesbian, Gay and Bisexual tend to be categorised as 'sexuality', Transgender as 'gender identity', and Intersex as 'anatomical sex', an individual's lived experience cannot be confined within the one category when two or more of these concepts may reside within the one person. For example, a person who identifies as lesbian (sexuality) may also identify as transgender (gender identity). Therefore, when considering heterosexism and cisgenderism, it is necessary to recognise and understand the diversity and fluidity of individuals who face these experiences, and that some laws, privileges and experiences may apply specifically to one group and not the other.

Ironically, being grouped under this homogenous umbrella of acronyms is contra to the very meaning of 'Queer' denoted as the 'Q' at the end of the LGBTIQ acronym. In the 1990s, the term was initially reclaimed as an affirmative identity category for same-sex attracted people and then re-appropriated by queer theory to actually deconstruct or problematise all identities based on sex, gender and sexuality.

Definition

According to Jagose (1996, p. 3) Queer theory:

> …focuses on mismatches between sex, gender and desire, … locates and exploits the incoherencies in those three terms which stabilise heterosexuality. Demonstrating the impossibility of any 'natural' sexuality, it calls into question even such unproblematic terms as 'man' and 'woman' Jagose (1996, p. 3).

This post-structuralist school of thought has had a paradoxical impact on the politics of identity in that the term 'queer' is now widely used by people who do not see themselves falling easily under the banner of the other, more essentialised identities which precede it in the LGBTIQ acronym. For example, persons who describe themselves as genderqueer do not align themselves with traditional notions of transgender, where an individual aspires to or has completed full transitioning from female to male or vice-versa. Equally, a person who is sexually attracted to people of various genders (male, female, transgender, gender queer) might describe themselves as queer rather than in terms of the discrete and stable identity categories of lesbian, gay, heterosexual or bisexual. In other words, a queer identity is a conscious choice made by an individual to distance themselves from what they see as the essentialised, stable and therefore confining identities based on sex, gender and sexuality. Perhaps because of its unstable and contested meaning, and therefore its challenge to more orthodox traditional identity politics, the Q in LGBTIQ is often discarded as a category of people in the research literature and government policy.

Background Information

It is also important to consider the controversial medical history associated with any groups that do not meet the cisgendered social norms of heteronormativity. 'Homosexuality' per se has a long history of being associated with mental illness. Prior to 1973, homosexuality appeared under a broad umbrella of sexual disorders in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), despite debate around the diagnostic validity and clinical utility of conceptualising sexual preference as a mental disorder rather than a normal sexual variant (Spitzer, 1981). Although the medicalised construct of homosexuality was removed from the second edition of the Diagnostic and Statistical Manual (DSM II) in 1973, it was replaced with the category 'Sexual Orientation Disturbance' to describe those who were disturbed by, in conflict with, or wished to change their sexual orientation (Spitzer, 1981). Over four decades later, the American Psychoanalytic Association (APsaA) formally apologised for treating homosexuality as a mental illness, acknowledging that this contributed to decades of discrimination and trauma for LGBTI people (Trotta, 2019).

The historical pathologising, persecution and even criminalisation of individuals based on their sexuality has been linked to conversion therapy and the range of interventions designed to change a person from lesbian, gay or bisexual to heterosexual (Flentje, Heck, & Cochran, 2014; Mogul, Ritchie, & Whitlock, 2011). In 2015, the United Nations Human Rights Council compiled a list of recommendations to target violence and discrimination against individuals based on their sexuality and gender identity, specifically mentioning the need to ban conversion therapy (Human Rights Council, 2015, p. 20). However, there are reports that some mental health professionals and religious organisations in countries, including Australia, continue to offer conversion therapy, with interventions ranging from attempts to "pray away the gay" (Tomazin, 2016); to threats of ex-communication from the religious community (Flentje et al., 2014); to aversive conditioning of the brain and body (Craig, Austin, Rashidi, & Adams, 2017). These practices endure despite it being described as ineffective, potentially harmful and lacking scientific credibility (Flentje et al., 2014).

Gender identity has similarly been pathologised and stigmatised. The current construct of Gender Dysphoria in the DSM5 (2013) is premised on the distress that may accompany any incongruence between a person's experienced or expressed gender and their assigned gender (APA, 2013). This conflict may manifest as being uncomfortable in their body and/or expected roles of their assigned gender, through to significant distress and/or problems functioning (APA, 2019). Transgender and gender diverse individuals can experience prejudice and discrimination related to cisgender attitudes (Babir, Vandevender, & Cohn, 2017), leaving them at an increased risk of violence (Grant, Mottet, & Tanis, 2011). They can also face varying degrees of discrimination from health professionals, which may contribute to an avoidance of healthcare, delaying of medical care and use of substances to cope (Reisner et al., 2015). Drawing on the Minority Stress Model as a theoretical framework within which to explore the discrimination and chronic stress experienced by LGBT people living in a hetero-centric, gender-normative society (Meyer, 2003), there is evidence that transgender and gender diverse individuals report greater rates of adverse mental health outcomes relative to their gender-normative lesbian, gay and bisexual peers (Carmel & Erickson-Schroth, 2016).

6.2.1 LGBTI Mental Health

While many LGBTI people live healthy and fulfilled lives, a disproportionate number experience a higher risk of suicidality and worse mental health outcomes than their non-LGBTI peers. Using a range of studies done in Australia and other countries, the Australian National LGBTI Health Alliance (2016) provides a snapshot of LGBTI suicidality and mental health outcomes for LGBTI populations compared with the general population. The report notes that the lack of inclusion of sexual orientation, gender identity and intersex status in population research and data collection in mental health services has resulted in significant deficits in knowledge, which in turn has contributed to some invisibility in mental health and suicide prevention policies, strategies and programmes.

Australia's Fifth National Mental Health and Suicide Prevention Plan (2017) acknowledges this shortfall when developing strategies to operationalise *Priority Area 6: Reducing stigma and discrimination*. Acknowledging that the LGBTI community have experiences of mental health problems and suicide rates far higher than in any other group in the Australian population, the Plan focuses on the need to develop comprehensive data sources to better understand the extent and impact of stigma and discrimination as barriers to seeking and receiving care and support for people who identify as LGBTI (Department of Health, 2017).

The following statistics from the Australian National LGBTI Health Alliance (2016) underline how critical it has become to accurately record and improve the appropriateness of mental health services for LGBTI communities.

► Example

- Compared to the general population, LGBTI people are more likely to attempt suicide in their lifetime. Lesbian, gay and bisexual young people aged 16–27 years are *five times* more likely; transgender people aged 18 years and over are *nearly 11 times* more likely; and people with an intersex variation aged 16 years and over are *nearly six times* more likely. Moreover, LGBTI young people who experience abuse and harassment are even more likely to attempt suicide.
- Compared to the general population, LGBTI people are more likely to have thoughts of suicide. Lesbian, gay and bisexual people aged 16 years and over are more than *six times* more likely; transgender people aged 18 years and over are *nearly 18 times* more likely; and people with an intersex variation aged 16 years and over are *nearly five times* more likely. Again, LGBTI young people who experience abuse and harassment are even more likely to have thoughts of suicide.
- Compared to the general population, LGBTI people are more likely to have engaged in self-injury in their lifetime. Lesbian, gay and bisexual people are nearly *twice as likely* to engage in self-injury; transgender people are *six and a half times* more likely and people with an intersex variation are *three times* more likely. In addition, LGBT young people who experience abuse and harassment are even more likely to have self-harmed.
- Compared to the general population, LGBTI people are more likely to experience and be diagnosed with a mental health disorder (including anxiety, depression and other disorders). Lesbian, gay and bisexual people are *twice as likely* to have symptoms that meet the criteria for a mental health disorder in the past 12 months; and LGBT people are *twice as likely* to be diagnosed and treated for mental health disorders.
- Compared to the general population, LGBTI people are more likely to experience and be diagnosed with depression. Lesbian, gay and bisexual people aged 16 years and over are *nearly six times* more likely to meet the criteria for a depressive episode; LGB people aged 16 years and over are *nearly three times* more likely to be diagnosed with depression in their lifetime; transgender and gender diverse people aged 18 years and over are *nearly five times* more likely to be diagnosed with depression; and people with an intersex variation are nearly twice as likely to be diagnosed with depression.
- Compared to the general population, LGBTI people are more likely to experience and be diagnosed with anxiety. Lesbian, gay and bisexual people aged 16 years and over are currently *more than twice* as likely to meet the criteria for an anxiety disorder; LGB people aged 16 years and over are *three and a half times* more likely to be diagnosed with anxiety in their lifetime; transgender people aged 18 years and over

are *nearly three times* more likely to be diagnosed with an anxiety disorder in their lifetime; and people with an intersex variation aged 16 years and over are *twice as likely* to be diagnosed with anxiety in their lifetime.

- Compared to the general population, LGBTI people experience higher levels of psychological distress. LGBT people score higher on the Kessler Psychological Distress (K10) Scale indicating moderate levels of psychological distress, and LGBT people who have experienced verbal abuse, physical abuse and harassment score higher on the K10 scale indicating high levels of psychological distress. ◄

As mentioned earlier, the tendency to use homogenous labelling can mask the unique lived experience and challenges of individuals within each acronym. The following disaggregated statistics provided by the Australian National LGBTI Health Alliance (2016) highlights this anomaly.

There are differences between the mental health and wellbeing of gay men and lesbian women. Lesbian women are more likely to be diagnosed and treated for a mental disorder or anxiety, and are more likely to engage in self-injury and attempt suicide than gay men. Gay men are more likely to have thoughts about suicide, but are less likely to attempt suicide than lesbian women. However, gay men and lesbian women have a similar level of psychological distress.

There are also differences between the mental health and wellbeing of gay men and lesbian women compared to bisexual people. Bisexual people are more likely to be diagnosed and treated for a mental disorder or anxiety and have higher levels of psychological distress. However, gay men and lesbian women are more likely to self-harm, have thoughts about suicide and attempt suicide. There are also differences between the mental health and wellbeing of bisexual men and bisexual women. Bisexual women are more likely to be diagnosed or treated for a mental disorder or anxiety, to have higher levels of psychological distress, and to self-harm. While bisexual men are more likely to think about suicide, both bisexual women and bisexual men have similar rates of suicide attempts.

A range of differences have been identified between the mental health and wellbeing of lesbian, gay and bisexual people, and transgender and gender diverse people. Transgender people have a higher rate of suicide attempts than LGB people, and are nearly three times more likely to have had thoughts of suicide. They experience high levels of psychological distress, compared to moderate levels experienced by LGB people. Transgender and gender diverse people are also nearly twice as likely to be diagnosed with or treated for a mental disorder and anxiety as lesbian and gay people.

There are also differences between the mental health and wellbeing of transgender men, transgender women and people with non-binary gender. Transgender women are more likely to have thoughts of suicide than transgender men and people with non-binary gender. Transgender men are more likely to be diagnosed with depression and anxiety in their lifetime than transgender women, while transgender men and transgender women have similar levels of psychological distress. Transgender people are more likely to experience depression than people with a non-binary gender, but people with a non-binary gender are more likely to experience anxiety than transgender people.

People with an intersex variation report significant differences in mental health and wellbeing compared to lesbian, gay, bisexual and transgender people. Social and medical constructions can play an important role in how people feel about their own bodies and Intersex variation. For many, there is a negative impact on wellbeing as a result of having undergone medical interventions, including a traumatising or unwanted surgery, beginning hormone therapies and/or feeling emotionally impacted or unlike themselves.

Similar to the general population, there are life stage differences in the mental health and wellbeing of younger LGBT people and older LGBT people. Specifically: LGBT young people aged 16–24 years have a higher rate of being diagnosed with a mental disorder than older LGBT people, and this group also has the highest level of psychological distress across all age groups. Rates of psychological distress for gay men, lesbian women, bisexual men, bisexual women and transgender women declined with age. Rates for psychological distress among transgender men were consistently high across all age groups, and the number of transgender people who met the criteria for a depressive or anxiety disorder decreased with age.

The Australian National LGBTI Health Alliance (2016, p.1) reports that these negative mental health outcomes "…are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTI". Widespread cisgenderism and heterosexism thus have far-reaching social and personal implications for anyone not identifying as, or being perceived as, heteronormative.

6.2.2 Heterosexism and Cisgenderism in Counselling

Heterosexism in the counselling profession has been recognised to some extent in the literature, certainly more so than cisgenderism around which there is still a deafening silence. Using a narrative method, Croteau et al. (2012) documented the experiences of LGB counsellors in their personal lives, professional training and subsequent practice. Their primary purpose was

> … to provide perspectives to their readers concerning navigating and working for positive change on sexual orientation in the counselling professions, [and] to move LGB-affirmative practice, training and research from the 'edge to the centre' of the counselling and other helping professions (Croteau et al., 2012, p. 3).

Conversely, one of the specific signs of enduring non-affirmative perspectives these authors noted was the persistence of professional writing which advocates conversion or reparative therapies to change LGB orientations and the relative lack of clear condemnation of such practices by mainstream professional scholars. This is also still true of many professional counselling associations around the world. Croteau et al. (2012) called for a 'multidimensional' (now often referred to as an 'intersectional') approach to working with identity in counselling, where consideration of privilege and oppression around sexuality is linked to age, race, ethnicity, class, disability and gender.

While noting that there was no developed model of affirmative therapy for transgender clients McGeorge and Carlson (2011) presented three areas for heterosexual therapists to explore before working with LGB clients: (1) their own heteronormative assumptions about what is a normal and healthy sexuality; (2) the nature and power of heterosexual privilege; and (3) the development of heterosexual identity which plays a powerful role in "…the maintenance of heteronormativity and the continuation of heterosexual privilege" (p. 18). They also identified three possible strategies for developing LGB affirmative practice, which include claiming an identity as an LGB affirmative therapist, communicating an LGB affirmative stance and deconstructing the influence of heterosexism on LGB clients and the therapy process. Using this third strategy "… LGB clients are encouraged to shift their understanding of the [presenting] problem as being exclusively related to an individual pathology to a pathology that exists within a larger social structure." This is important because they are often directed to internalise their mistreatment or discrimination as a problem residing only within themselves (e.g. internalised homophobia), thus rendering the larger systemic processes of oppression invisible.

6.2.3 Conclusion

Given the relationship between heterosexism, cisgenderism and mental health, it is imperative that those in the helping professions adopt sensitivity and responsiveness. Statistics presented in this chapter provide a broad indication of areas of concern, but there is no 'typical' LGBTI person. Each person is a mix of their own unique lived experiences that extend beyond their LGBTI identity to encompass other domains such as race, ethnicity, age, class, ability and religion. Seeking to understand a person's social situation and individual needs, as well as their resilience and survival strategies, is fundamental to developing a relational and empathic response.

6.3 Personal Stories and Current Affairs

6.3.1 "The Space We Created"

Filipe Fotheringham

My name is Fi, soon to be Filipe. I have known about my attraction to all genders since I was ten and I should have known about my Non-Binaryness (enby), when I was ten, but didn't until I was 20.

When I was a child, there were no words to express what I was. The identity words I use now weren't common knowledge. I knew I was a girl because I was born that way, and back then, that was the only common knowledge on gender there was. I hated being a girl, though. I hated the idea that I would get periods, that I was treated differently and the expectations put on me from the world. I used to create up scenarios where I was a boy. This is where Philip came from. He featured in my fantasies until I learnt to think outside the binary. Until then, I ended up hating myself for something I had no control over.

Not knowing about Transgender people was a main cause for my depression, and others not knowing about them, was a main cause for my anxiety. I knew I was different, the way people treated me told me so. I learnt to own it, but when you're young and you don't understand why you are being treated that way, it's diminishing. As an adult, I've realised why. I didn't wear girls' clothes, I hated make-up and I wanted to play the way boys played. I enjoyed doing things that were typically considered feminine, but I hated that I loved them.

When I lived in South Africa, my normal was playing with children as boys typically play, and having men who were openly gay and straight around me.

When I moved to Australia, things changed. We moved to a more conservative place. Gender stereotypes were the normal. Anything out of that was ostracised. And that's what happened, to me. It probably didn't help that my brother started to treat gender stereotypes as law. For the first time in my life, he treated me like a girl. He no longer wanted to play with me. I felt alone and I hated myself for being different. Philip helped with that, a lot.

My differences didn't stop there. I was one of the two openly Bisexual people in my grade. I was proud and I didn't care who knew. Because I grew up with gay and straight men, in South Africa, I think my brain automatically thought that being attracted to all genders was normal. I learnt that wasn't the normal when I started high school. While I was open at school, I was not at home. At home, I was closeted in every sense.

As an adult, I had a conversation with my mother about expectations and my sexuality. She told me she would have accepted me no matter my sexual preference. I had to explain to her that it wasn't about that, it was about how she unknowingly put expectations on me to be straight. I had to get her to admit that she expected me to be straight, because that is the normal of the world we live in, so being the abnormal is what made me worry about coming out. And the way I came out to my mom was scary. I had just had a depression episode and I had to explain to my mom what was going on. I had to tell her that sometimes I cry because my brain tells me to. She asked if I was depressed because I was a lesbian. I told her no, and then I took a leap of faith, I told her I wasn't straight either. That is probably the happiest coming out story I have, regarding my relatives.

I came out to my brother when I was 16. He was the first in my family I came out to. He denied it. He immediately asked if I'd had sex with a girl. When I said no, he told me I was bicurious, not bisexual. I challenged him by asking if I hadn't had sex at all, does that mean I was asexual. He responded with: no, it doesn't work like that. When I told my dad about his reaction, which is how I came out to my dad, he said I can't control how other people react to my choices.

As an adult, it's easier to see how the world denies the existence of non-heterosexual people. Here's an example; I was in a relationship with another vagina wielding enby and when we used to hold hands in public and be all couple-like, we were referred to as friends by random people we encountered. We used to play with it, "Yes, friend" "Gal pals". I've noticed it's a regular thing but only when it's someone who looks to be the same gender as you.

Though sexuality isn't the only place society assumes wrongly. When I started my first full-time job, everyone called me by my dead name, or she/her. Right from the beginning, I told everyone to call me Fi. The misgendering I was used to, but not on that magnitude. I ended up not coping, within the first few days, I started to dissociate at work, I'd come home and physically sag in relief when I was called Fi and referred to as They/them. It took me 4 months to get my gender and name changed in the system and to get an email sent out about my gender. The day that went out, I was excited but incredibly anxious. I got lucky. I was accepted, and it was a huge weight off my shoulders. I'm still called she/her at work, but it is often followed by a correction to my name or my correct pronouns.

One of the things that has come from coming out is dissociating. Now that I have a new name and pronouns that fit, I dissociate when others call me by my dead-name or I am called by feminine pronouns a lot. Dissociating is like your brain just going "nope, I'm out" and then leaving, and all that is left is a body. It's hard to come back from.

I have many bad stories that have come from me being out, but I have a few amazing stories that make all the bullshit worth it.

The most significant one is the first time I went to a barber. I was freaking out; from the moment I booked the appointment, until I sat down in the chair. When I booked the appointment, I added a note, "Please don't freak out that I have boobs." They don't actually check the notes before you arrive. I arrived early, wearing a dress, and walked in. There were two men cutting hair. The one closest to the door, freaked out. I could see it in his eyes. When I told him I was there for my appointment, his panic increased, he told me to sit in the waiting area and continued to cut his current client's hair. I just kept my head down. I was panicking, I wanted to leave but my social anxiety stopped me. When the second man finished cutting his client's hair, he checked to see if I was his next client. I was. He, very happily, introduced himself as Nas and told me to have a seat. Once I was sitting down and told him what kind of haircut I wanted, he told me he was excited to cut my hair, because I stayed. I opened up to him about my gender, sexuality and about how I hated going to hairdressers. He asked me many questions, that day. He had never met anyone like me. That situation could have easily gone badly, but because Nas didn't judge me based on how I looked, he ended up learning about a group of people he had never encountered before, and I gained a friend and ally.

When spaces are created for genders, binary genders are what is in mind. This results in the spaces inherently omitting other genders from feeling welcome in them. Meaning people like me have to create space for ourselves in those predefined spaces. It's exhausting.

Nas has his own barbershop now and has declared, on social media, that all genders and sexualities are welcome, but that they only do traditional barbershop haircuts. I'm not sure he is aware of the magnitude of what he has done. I am often at the shop. It is a space I can just exist, without having to make space for myself. I have tried to tell him about the good he has done in creating this space, but he just corrects me with "The space we created".

Through my journey, I have come across some of the most amazing people who are like me. We don't fit into what society deems the norm and we have relatives who refuse to change. From our shared experiences, we have created a family and a space where we can be ourselves.

6.3.2 A Gay Man's Reluctant Journey to Turning Around LGBTIQ Intolerance in the Jewish Community

Michael Barnett

My early years

My name is Michael Barnett. I was born in Melbourne in 1969.

My mother and father were immigrants to Australia, coming from New Zealand and Rhodesia (now Zimbabwe), respectively. My mother's family were Ashkenazi Jews from Grodno, now located in Belarus, and were native Yiddish speakers. My mother's first language was Yiddish as a child. Her parents moved to Palestine in the 1920s before deciding the Jewish community in Wellington was a far more appealing place for them to live.

My father's family were also Askhenazi Jews who had lived in northern England for some generations, with one side of the family having originated in Alytus, now located in Lithuania. We believe the family name Barnett was anglicised from Berzynski. At the end of WW2, they looked for sanctuary and found it in Rhodesia, where they started a new life.

When I was 6 months old, my parents moved from suburban Glen Waverley back to Salisbury Rhodesia to reconnect with my father's family. Four years later, my parents felt the growing political unrest was not a good environment in which to raise a family and decided Australia would be a safer place for me and my baby brother to grow up in. Taking advantage of my Australian citizenship and my mother's NZ citizenship we returned to Melbourne in August 1973 after a two-week ocean journey on the passenger ship Galileo Galilei.

The Jewish neighbourhood of Balaclava became our new home. There were kosher butchers, bakeries and Judaica shops in every direction and it was a wonderful place to live if you wanted to be immersed in Jewish culture.

My paternal grandmother (bobbe Addy) resettled in Melbourne from Africa a few years later and dad's sister's family came over not long after that. On my mother's side, her brother's NZ family also came to live in Melbourne and so we had a growing family around us. Lots of afternoon teas, simchas and broigus in all directions. I was immersed in yiddishkeit.

My sexual awakening

In 1978, my parents decided to buy a house in a more affordable neighbourhood that was also close to a Jewish community. With those prerequisites in mind we moved to East Doncaster and I started attending the local state school. It was at that time I started going through puberty and also started noticing the boys in my class in a different way to before, and in a way that I didn't notice the girls. Thus began my sexual awakening. I had a crush on one of my grade 4 classmates and particularly enjoyed the times he'd clown around the change room before swimming lessons completely starkers. It was also when some of the boys in my class started teasing me, particularly those who were the more sporting types and who took advantage of my complete lack of talent or interest in sport by degrading and abusing me because of it.

Thus began the start of the bullying that persisted throughout the remaining 9 years of my schooling, spanning three different schools. I was always the outsider, and always reminded that I was a "pansy" and a "poof". It was only in my teenage sexual fantasies that many of my homophobic classmates became my best and most obliging friends.

And so throughout my schooling years, a couple of deeply loyal friends aside, I was for much of the time a lonely kid who didn't know how to relate to others around me, had no support for my developing sexual identity and felt like a complete loser much of the time.

My parents were always there to support me, but sexuality was not a topic they knew how to raise with me, and was the one area I needed the most support with.

My sexuality and coming out

At the age of 26 years, a lot of things came together for me. I see it as a time when my emotional maturity caught up with the rest of me. I felt more comfortable with my relationship with my parents, I accepted myself as a gay man and I started feeling normal for the first time. It was in 1995, through a newly formed Jewish support group for gay men called Aleph Melbourne, that I first told anyone I was gay. I was now able to get on with my life, and I did in a big way. It was the most euphoric time of my life. I had been repressing myself for a decade and a half and everything was happening at once, in the most wonderful way. It lasted like this for months. I saw the world around me in such a different way. I could look at people and read them. I noticed details, body language and things I had never seen before. It was an exciting, wondrous adventure. I never knew how good it was to be alive.

I also realised that I wanted to ensure others like me didn't have to go through the same suffering I did. Having grown up in a fairly conservative Orthodox Jewish community I was surrounded by people who had more traditional values, who expected men to meet women, get married to them and then raise a family.

The rabbis at our synagogue never spoke in a complimentary way about people whose sexuality deviated from this path. Homosexuals, as we were called, were frowned upon and we were reminded that homosexual behaviour, whatever that was, was sinful.

I was also reminded by my bobbe Addy, that what 'puftas' (her way of saying "poofters") did was filthy and disgusting, and the last thing I ever wanted to do was disappoint her. That locked my closet door shut for many an additional year.

The irrational fear of being kicked out of home was also a factor that played strong on my mind as I entered my twenties. If only they'd just once told me that they'd still love me if I was gay. The time my father asked me to take him to a PFLAG meeting, days after eventually telling him I was gay, was a sign of just how accepting he was and how much he wanted to be there for me. I just wish it had happened a decade or so sooner.

My activism

Through the friends and acquaintances I made in Aleph, and the networks I was forming in a post-AIDS gay Melbourne, I started to find my footing as an activist. I realised I was capable of having opinions, and being outspoken on them. I realised that gays did not need to be outsiders in the Jewish community, and began agitating for our inclusion, and for greater visibility and acceptance.

Being an outsider and a loner through my years at school, and not having a huge network of friends suddenly became an asset. I could be controversial and outspoken and not fear losing friends or distancing myself from people. I started advocating for the underdog, writing letters to the editor, making the news and then breaking it to the media. I was a news reader at the gay and lesbian radio station JOY 90.7 (later to become 94.9) from 1996 to 2003 and, during that time, I learned much about writing a timely media release, and how to engage the media.

I used my news reading and news-making skills to form relationships with journalists and editors. I was meticulous at keeping news clippings and recordings of radio interviews (long before podcasts were a thing), and with these I was able to hold people to account for what they had said long after they had forgotten about it.

It was in 1999 when the biggest battle of my activist life took place. As the then President of Aleph Melbourne, I took on the Orthodox Jewish community in an effort to secure a place at the table for our small organisation on the Jewish Community Council of Victoria. The issue raged for months in the Jewish community, with edition after edition of the Jewish News carrying letters to the editor, feature articles and front-pages. Two votes at the council's plenum meeting later, the first passing on simple majority but failing on a technicality, while the second failing to get the constitutionally mandated two-thirds majority, and we lost our opportunity to gain membership. That was especially disappointing, but for me it was far from a loss. In fact, I saw it as a massive success. Why? Well I had put homosexuality on the agenda in the Jewish community, front and centre. It was no longer a topic you had to talk about in hushed tones and behind your hand. It was out in the open and unavoidable.

My activism was simmering along and it wasn't until two young queer people were killed in a shooting in Tel Aviv in August 2009 that I realised there was a lot more work to do, and urgently. Silence on this issue from the state and national leadership of the Jewish community reignited the fire within me and I took on a complacent Jewish community. I single-handedly shook the branches of these roof bodies and told them they had to speak out against those injustices that affected LGBTIQ people, alongside the injustices they readily spoke out on affecting other sections of society, Jewish and otherwise.

The momentum started building faster, conversations were being had. People wanted to shut Michael Barnett, the angry gay, up, but he wasn't going to be shut up.

When Rabbi Shimon Cowen called for Safe Schools Coalition Victoria to be disbanded, I campaigned the Executive Council of Australian Jewry and they felt sufficiently uncomfortable that they issued a statement in 2012 saying his views were not reflective of those of the mainstream Jewish community, as respected as he was. Shock horror! The Jewish leadership called out a recalcitrant rabbi. That was without precedent.

By 2019, we had come a long way. The Jewish News includes my name as a leader in the Jewish community when reporting on relevant topics. The Jewish Community Council of Victoria and the Executive Council of Australian Jewry have statements of respect for LGBTIQ people. Both organisations declared support for civil same-sex marriage in 2017. It took some effort but the JCCV eventually issued an unreserved apology in April 2019 for the shameful homophobia that occurred at their plenum meeting in May 1999 when Aleph Melbourne failed to gain membership. The JCCV have also done some groundbreaking work with young queer kids in the Jewish community.

I've come to realise it takes 20 years to make something happen overnight. It's been a hard slog changing attitudes in the Jewish community, at times reducing me to tears and making me wonder why I should bother, but I always come back to the single goal of wanting to make sure another person doesn't have to suffer like I did as a kid.

The Jewish community is far from perfect, and has a very long way to go, but it has come on a massive journey, and is so much better for it. Jewish Care Victoria is a shining light of LGBTIQ inclusiveness, a number of Jewish schools are proudly LGBTIQ inclusive, most Jewish schools have publicly stated their support for LGBTIQ staff and students, and the Jewish contingent in Pride March reached 100 members in 2019 and is set to be much larger in 2020.

This has been a whirlwind of a journey and one that has a long way to go yet, but it has borne so much sweet fruit in recent years that I know my relentless efforts have been worthwhile.

I thank my husband Gregory for his support and strength along the way, along with my parents Merv and Naomi, my brother Garry, and so many other wonderful family members, friends and other people in the community who have been there to support me and stand alongside me through this necessary struggle. We can only win this together and, as a community, we will all be better for it.

6.3.3 Interview with a Gay Affirmative Practice Therapist

Vicki Hutton

Gay affirmative practice has received both support and criticism over the years. In this interview, therapist Dr. Kieran O'Loughlin explains his reasons for using this approach, and some of his experiences along the way.

Q - *How do you understand the meaning of affirmative practice in counselling among the LGBT community?*

KOL - My understanding is that it's an approach that embraces a positive view of LGBT identities and relationships and in a very direct way addresses the negative influences that homophobia, biphobia, transphobia, cisgenderism and heterosexism have on the lives of LGBT people. It seeks to counter those societal influences. I think it's important to say from the outset that I don't think it's what I would call a counselling modality or approach, rather it's a framework within which therapists work with LGBT people. I think you could use a range of modalities and still be an LGBT affirmative practice therapist.

Joe Kort's 2008 seminal publication of the book, *Gay affirmative practice for the straight clinician* talks about some fundamental principles. He was writing very deliberately for heterosexual clinicians, and he starts with the need to understand the nature of heterosexism and heterosexual privilege. This means understanding the importance of an affirmative approach that seeks to counter the alienation that many LGBT people feel in a heteronormative and cisgendered society. And it addresses not only the external sources of homophobia and transphobia, but also the internalised homophobia and transphobia.

When I first came across these concepts of internalised homophobia and transphobia, it was almost as if they were pathologising the LGBT person. As if it was somehow a deficit and almost the fault of LGBT people, but to me that's the classic introjection. It's what is inevitably absorbed from living in a heterosexist, cisgenderist society. It's not about people needing to be cured of their internalised homophobia or transphobia. It's a matter of helping them to learn to reduce, manage it as best they can, given the world they live in.

One of the really important things about doing affirmative practice, whether the counsellor is LGBT or not, is confronting their own homophobia or their own internalised homophobia, and developing a strong sense of self-awareness around that. Being a gay person doesn't necessarily mean that you're going to be a great affirmative practice therapist, and in my experience, I've seen some extraordinary things happen with people who have said they're LGBT actually practising things like conversion therapy for people who come in saying they don't want to be gay, and not even thinking there's an ethical issue. What it comes down to is that the counsellor hasn't worked through their own internalised homophobia or transphobia.

Q - *You seem to be saying that sometimes an LGBT person is better with a heterosexual counsellor who has embraced affirmative practice rather than an LGBT person who is ambivalent about their own gender or sexual orientation.*

KOL - Definitely. This is where the peer-based models can sometimes run adrift because, in community health, especially in the minority specialist agency like the one I work in, there can be the idea that peer counselling, and peer services in general, are the most effective. However, I've seen some incredible things happen when people are too close to the issue they are working with. I'm thinking of the AOD [alcohol and other drugs] services within the agency I work in. It was very difficult at times to distinguish between counsellors and clients. They would be doing therapy in groups and all out having cigarettes in the break on the street. It's that kind of model that needs examining critically as it's not always superior.

Q - *Who then do you think is best suited to use affirmative practice?*

KOL - First, I need to emphasise that just because someone is working theoretically in an LGBT affirmative practice context doesn't mean they will enact its principles, even when they've had affirmative practice training. I'll give you an example from the minority agency where I work.

Somebody presented on a client and they shared a genogram. The client seemed to have had a relatively good childhood and acceptance of their sexuality by their family, but they were struggling in their current relationship. It turned out the therapist had omitted from putting on the genogram, and glossed over in the presentation, the fact that this person had been in 12 year abusive same-sex relationship before the current one. It was almost like that relationship was invisible. It was therefore not validated as having any significant influence on the client's capacity to form a new intimate relationship. I was the only person in the room who raised the issue, probably because I've been trying to enact affirmative practice for almost a decade, but it was interesting no one else picked this up.

Q - *How could this have been better handled by a therapist?*

KOL - I would want to have found out about the 12-year relationship and included it in any genogram. That shows you how heteronormative those genograms can be even though there are now symbols for individuals who might be gay. I've noticed that some people don't seem to actually embed lesbian and gay ex-relationships. Once they're gone, they're invisible. There's coding for if you divorce somebody in a heterosexual relationship and they're always included on genograms. So the first thing I'd be mapping is the client's history of intimate relationships on the genogram and I'd bring that forward into the discussion about the impact of that relationship on the client and their capacity to establish and maintain a new intimate relationship. There had been significant emotional and physical abuses but the therapist just wanted to keep going back to their childhood and couldn't work out what the problem was.

For me it's firstly about affirming that people have a relationship history when lesbian or gay, and that was a very substantial relationship so it's bound to have had a very complex and negative impact on future relationships. There was abuse, but there was also some good things about the relationship. There's complexity everywhere, but because of the invisibility of that relationship the therapist was trying to tell the client to finish the new relationship because it wasn't going to work. I asked why and the therapist said because the client feels really anxious in the relationship. To me it was so glaringly obvious that the anxiety was the legacy of the previous relationship.

At a larger level, it's not seeing lesbian and gay relationships as significant enough—once they're over they're not even worth considering as part of the person's psychological history. It's a trivialisation of the relationship. It's not what we call homophobic, but it's very heterosexist. My sense these days is what we are seeing are not practices that are explicitly homophobic—that would fall more into actual conversion therapy. But the heterosexist and cisgenderist principles are very much alive and flourishing. It's still this idea of lesbian and gay relationships as second order, they're inferior. They exist, but they're not serious, they're not as substantial.

Q - *Even if a couple are married now?*

KOL - That might start to change but I've yet to see it. When they voted for marriage equality—well they didn't vote for marriage equality, they voted for lesbian and gay people to be able to marry, but it doesn't necessarily mean that they see the relationships as equal. Not yet.

Q - *Are there any controversial aspects to using affirmative practice?*

KOL - There are therapists who say the client has the right to self-determination. It's a really big ethical dilemma. I'm going to talk about a case study to show you. I worked with a client who came to see us because he was Muslim but he was also same sex attracted. Now there was a whole lot of complexity in his life because there was the issue of whether he would go back to his family in the Middle East. There was lots of pressure from his family to marry. He was living with a man in Australia, but unbeknownst to his partner, was also a sex worker. Lots of complexity, and lots of commitment to Islam as well. We had so much unpacking to do around who he wanted to be.

My position in relation to affirmative practice with this client was to stress that his decision to be gay was a viable option for him within the frame of the decision-making he needed to make. I put that out there as one really important thing he had to grapple with. Now if he decided that that wasn't going to work for him, in the total scheme of his life, then that was fine. But I think the best work he did was actually the validation of that option for him because that had never been validated as an option before.

Unlike the person-centred people who move more towards self-actualisation that was non-contextual, they are more likely to say if you're gay you're gay. Your socially culturally constructed self is a false self, you've got to be your authentic self as if that's some simple thing, as if the true self was gay and nothing but gay. I guess, because of my long-term interest in working with culturally diverse people too, I'm very interested in intersectionality and what people do with conflicting value options. I think a more nuanced sophisticated version of that is not to go at it with a hammer but with a feather. To bring the affirmation in but stress that that is a valid option, but in the end, self-determination is about people making choices with all of the complexity of their lives.

To me using an affirmative practice framework is being truly client-centred. But it's not the only framework that we can use if we're going to be ethical.

Q - *Are there any reasons for not using affirmative practice?*

KOL - I could have opted to not use an affirmative practice lens, but I wanted to try to stretch the model as far as it would go in the context of this client's complexity. I think it's a framework that people need extensive training in so my answer is, I can't see any case where some kind of an affirmative lens couldn't help. I have another case study.

Sometimes we have clients who go to that agency specifically to convince themselves that they are not gay. If they can convince someone in an LGBT agency that they are not same sex attracted or they are not trans then that's the ultimate victory, they can then feel completely justified in not living that sexuality. This client came to intake saying he had a problem with his sexual identity and wanted to speak to a male. Nothing about the sexuality of the male counsellor. He had a complex view of himself in terms of his sexual identity in that when he was feeling less masculine, that was when he was more attracted to men, and when he was feeling stronger and more masculine, that was when he was more attracted to women. What struck me was the associations there were between weakness, vulnerability and same sex attraction. That's a powerful nexus that's embedded within our culture. Back in the day when gender and sexuality were conflated there was always this idea that only effeminate men were homosexual and you'd always be able to spot a homosexual man because they'd be effeminate. To me, he was carrying this sort of notion in his head. He also blamed his mother and sister who had apparently been emotionally manipulative in many ways for scaring him off women and making him gay. When I asked him if he thought being gay was a disorder he became really angry and said he was sure it was a disorder for him. His mission there was for me to tell him his true sexuality was heterosexual and that his false self was really the homosexual aspect of him. In a strange way he was trying to bully me into colluding with that and I really had to stick to my affirmative lens which was that being gay is a valid, equally dignified equally valid for a person, in his case a man, to live out. His own internalised homophobia was so strong that he dropped out of counselling. But I feel like, in another context, he was more likely to get the counter-argument that he was heterosexual because he had quite a convincing argument. The misogyny towards his mother was a stereotype, there was so much that was sexist, heterosexist and homophobic, so much to unpack but he couldn't do it, he wasn't ready.

One of my things with affirmative practice is that I'm never looking for a clear outcome because I think it depends on people's stage in coming to terms with and dealing with their sexuality.

With the Muslim same sex attracted man, he found this wonderfully creative solution and everything came together well for him. He decided that rather than having to think of himself as gay and Muslim, so putting gay first, he actually inverted that and was able to deal with that. He said I am a Muslim who is gay and he was more able to make his peace with that because for him being Muslim was the most important piece of this identity. But that didn't mean he had to be anti-affirmative and that's why I say someone who uses an affirmative lens with a hammer might have said oh, no, your most important identity is being same sex attracted and that's not necessarily the case. And in his case, the other thing that was awful for him was that he was doing the sex work to send money home to his family to appease his family for not coming home to get married so that was performing a protective function, but he finally got his partner visa which enabled him then to say to his parents that he wasn't coming back and also then enabled him to give up sex work which was not helping him. That gives an idea of the complexity. I felt very proud of that case because that means he found his own solution that was right for him.

Q - *You mentioned sex and gender diverse people. Do you see many gender diverse clients?*

KOL - I'm very conscious of the yawning silence there is around transgender affirmative practice. I did a quick check and I noticed there is an article from the American psychological association with guidelines for transgender affirmative practice. There is work being done. What it really feels like is exactly like what it was like for me when I came out almost 40 years ago. That's where the trans trajectory is. Still got a lot of fights to fight. Even in the specialist agency I mentioned, there is a greater tendency to pathologise trans people than same sex-attracted people. There's even more violence, even lateral violence within the LGBT umbrella towards trans people and still a long way to go, but it does feel very much like 40 years ago for me when I was young. I enjoy talking to the young trans and giving them my history and trying to give them hope that in 40 years' time perhaps they will have found their own feet and legitimacy.

Because of the possibility of wanting medical interventions, it makes it more of a struggle. But medical interventions can be a positive, whereas in the past the only interventions for same sex attracted were negative, like conversion therapy. I was part of a queer therapist group and because trans end up having to see a psychiatrist as part of their trajectory, psychiatrists' big thing is medicalisation and deciding whether a person is really trans or not. Or, is there really some underlying personality disorder? To me that's starting from the wrong end, they're looking first for the pathology. The person has to work to convince them they don't have a personality disorder. Their road is going to be a trickier one.

Q - *Thanks for talking to us, Dr O'Loughlin. Is there anything else you'd like to add?*

KOL - Opponents of affirmative practice say it's too much about promoting the lesbian and gay agenda, whereas to me, it's about successful integration of the person's sexuality or gender into the rest of their being, their self.

6.4 Experiential Activities

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant and they should provide participants with ways to resolve feelings that may arise as a result of the activity including reflection and debriefing.

Activity 1

Title Privilege statements–Heterosexism and cisgenderism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to heterosexism and cisgenderism. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. In most social situations, I can express affection to my partner and not expect hostile or violent reactions from others.
2. I can easily buy greeting cards that represent my relationship with my significant other.
3. I do not have to wonder if I am the only one of my sexuality in a class, on a job or in a social situation.
4. I do not have to wonder how other people will react to my sexuality.
5. I can live with my partner openly and expect most people will accept this.
6. I could adopt and raise children without people believing I will molest them or force them onto my sexuality.
7. I can dress, talk and act as I choose, without people perceiving it as a reflection on my sexuality.
8. I can go wherever I wish (including overseas) and feel confident I will not be harassed, beaten or killed because of my sexuality.
9. I can easily find positive and accurate media images of people with whom I can identify.
10. I expect that if I have children, they will be given texts in school that support my type of family unit.

Are the scales balanced, or tipping one way or the other?

■ Questions

Reflect on the following questions:

1. How did you feel doing this activity?
2. What does it feel like to have, or not have certain privileges?
3. Can you identify other privileges related to heterosexism and cisgenderism that you may or may not experience?

Learning outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privileges related to heterosexism and cisgenderism, students become more sensitive to the multifaceted nature of privilege within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ▶ https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title What's in a pronoun?

Purpose Gender neutral or gender inclusive pronouns do not associate a gender with the individual who is being discussed. The natural and automatic use of appropriate language should be a fundamental part of working with gender diverse populations, but misgendering can occur when a person uses language that is not aligned with how the other person identifies their own gender and body. It is always preferable not to base pronoun and gender on looks alone, rather check in with the person before making assumptions. Where a mistake is made, it is important to apologise immediately and avoid making the same mistake again.

The English language has no gender neutral or third gender pronouns that do not associate a gender with the individual being discussed. This dichotomy of 'he' and 'she' can be frustrating for the transgender and gender queer communities. Over the years, existing alternatives such as 'one' and singular 'they' have been adopted, as well as specially created gender neutral pronouns such as those in the table below.

This activity raises students' awareness of the importance of developing a consistent and sensitive approach to using correct language.

Gender Neutral Pronouns

So instead of...	*you may use...*	*which is pronounced...*
he/she	sie **zie**	"see" **"zie"**
him/her	hir **zir**	"here" **like "sie" with a "z"**
his/hers	hirs **zirs**	"here's" **like "sirs" with a "z"**
himself/herself	hirself **zirself**	"here-self" **Like "sir-slef" with a "z"**

▶ https://lgbtrc.usc.edu/trans/transgender/pronouns/

Process Students work in pairs to develop a range of respectful ways to enquire about pronouns. These questions should reflect that using correct pronouns is not just a person's preference that you are acknowledging, rather it is a requirement that you are respecting.

For example, rather than ask "What pronouns do you prefer?", it is preferable to ask directly: "What are your pronouns?"

After developing some appropriate questions, each pair of students joins with another pair of students to practice the questions they have developed. Partners can alternate, with one person asking the question while their partner takes notes on the response, including body language. Students provide respectful, constructive feedback to each other as to how they felt when asked these questions. Each pair of students has the opportunity to provide a rationale for their questions, or modify them based on other students' feedback.

Each pair of students then writes case notes for the brief practice sessions, using the pronouns requested in response to their questions.

Learning outcome Language is a powerful and often overlooked tool when working with diversity. This collaborative exercise provides students with the opportunity to contemplate the power of language and provide and receive feedback in a safe environment.

Activity 3

Title Movie time: 'Holding the Man' (2015)

Purpose Film can be a powerful experiential learning activity for cultural awareness. 'Holding the Man', directed by Neil Armfield, tells the story of two young boys who fall in love while at their all-boys' secondary college. Their relationship lasted for 15 years into the 1980s and the height of the AIDS epidemic in Australia and the world. Together they faced discrimination, family conflict, losses, HIV and AIDS, and death.

Process Watch the 127 minute film, and respond to the following questions.

■ Questions

1. Were you aware of this part of Australia's medical history and the impact on the gay community?
2. What specific images stayed with you after the movie was over?
3. What do you feel is the underlying message of the film?
4. How has watching this film contributed to your understanding of discrimination, past and present, within the gay community?
5. How has watching this film contributed to your self-awareness in working with members of the LGBTI communities?
6. What were some of the different ways prejudice and discrimination were exemplified in the film?

Discuss your responses in pairs or groups.

Learning outcome To enhance students' cultural awareness and understanding of discrimination within the LGLBTI communities, and how discrimination can shift into the medical world with fatal consequences.

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Ageism

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V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_7

Trailers

In this chapter, Catherine Barrett explores fear of ageing in Western society through the lens of theoretical concepts such as Terror Management Theory. She warns of the impact on wellbeing when older people are devalued and disrespected. Ilsa Hampton provides insight into the meaning of spirituality as a person faces the challenges of ageing, while Julie describes the double discrimination associated with living with an incurable sexually transmitted disease at 70-plus years of age.

At the other end of the age spectrum, Magenta Simmons, Ellie Brown, Nicholas Fava and Vivienne Browne discuss the mental health and wellbeing of young Australians and some of the challenges and risks associated with this age group. Sarah Bostock and Alessandra Chinsen describe their own mental health and life challenges, and Professor Lucas Walsh disputes the apathy of young people, when volunteering and activism are included as meaningful activities undertaken by this age group.

7.1 Introduction

Vicki Hutton

The percentage of the Australian population aged 65 years and over increased from approximately 5% in 1927 to 9% in 1977 to 15% in 2017 (Australian Institute of Health and Welfare [AIHW], 2018b). This is projected to reach 22% of the population by 2057 and 25% by 2097. Historical data and future estimates consolidate the position of older people as the fastest-growing group in Australia and is due in part to the increased longevity of many sectors of the Australian population. The profile of older Australians is also changing, with the number of Australians aged 85 years and over increasing by 125% in the preceding two decades (Australian Bureau of Statistics [ABS], 2018a). In 2017, more than half of older people were aged 65–74 years and 13% aged over 85 years. This is projected to increase to one in five older people being 85 years and over by 2047 (AIHW, 2018b).

An ageing population is characteristic of most developed nations, resulting from a combination of sustained reduced family sizes and increased life expectancy (ABS, 2018a). Over the two decades 1998–2018, the proportion of children aged 0–14 years in Australia decreased from 21 to 18.8%. This mirrors a decline in fertility rates from a peak of 3.5 children per woman in the early 1960s to 1.8 per woman, which is below the replacement rate (Parliamentary Budget Office, 2019). These rates position Australia to soon catch up with nations such as the United Kingdom, Canada, Italy, France, Sweden, Greece and Japan where the number of people aged 65 years and over already exceeds the number of children aged 0–14 years (ABS, 2018a). An imbalance in age groups like this has fiscal implications in regards to reduced labour force and tax revenue, and greater demands for government programmes, health systems and care facilities that support older Australians (Parliamentary Budget Office, 2019).

Changes associated with ageing can be both physical (primary ageing) and sociocultural (secondary ageing). Sociocultural ageing varies according to the cultural and social interpretations of ageing within the person's environment (Vazquez, 2010). This means there is no 'typical' older adult, as each brings their unique identity, gender, spirituality or religious affiliation, social class, race or ethnicity, sexuality and health status. Despite this, they may be subject to ageist attitudes based on incorrect age stereotypes that can adversely affect both the community and the older person. Similarly, young people may also face ageist attitudes based on stereotypes and misconceptions resulting in discrimination on an individual level, and on a wider structural level. Stereotyping different age groups can also impact relations between generations and result in conflict between people of different ages (Ageing Equal, 2018a).

Definition

Defined as discrimination based on age without any evidence base, ageism ignores a person's unique lived experience and can negatively impact the way that person views themselves. Ageism can be particularly detrimental to the very old age groups through the refusal to recognise their rights, needs, dignity and continuing contributions to society (COTA Australia, 2019). For young people, ageism can create barriers and challenges in areas such as employment and affordable housing. Ironically, inadequate income and precarious living arrangements are two challenges that may also confront older people (Ageing Equal, 2018b).

Another challenge shared by these two groups at opposite ends of the age spectrum, is an over-representation of mental health issues and risk of suicide. Suicide accounts for one in three deaths among people aged 15–24 years, while in 2017, the highest age-specific suicide rate was reported among males aged 85 years and over (Department of Health, 2017). Chronic health conditions were more likely to have been present amongst people aged over 65 years (for example, cancer was present in a quarter of suicides amongst those aged 85 years and over), while younger groups recorded a greater association with drug and alcohol use disorders and intoxication (Beyond Blue, 2019). Mood disorders were evident in all age groups, but less prominent in those 85 years and over (26%) compared to those 5–24 years (34.3%).

7.2 Ageism – Older and Younger Australians

7.2.1 Projecting Beauty in an Ageist World

Catherine Barrett

7.2.1.1 Introduction

The number of older Australians (65+ years) is growing. There are currently around 3.7 million, and the number is expected to reach 8.7 million by 2056 (Australian Institute of Health and Welfare [AIHW], 2018b). Rather than focusing on the potential opportunities this increase offers, responses have been heavily influenced by economic analysts warning of a ‘tsunami’ of older people draining resources and creating economic burden. The ageing body is presented as a crisis of decreased labour power and increased social expenditure, and cited as the cause of declining GDP, global insecurity (Grande, 2018), climate change and the lack of affordable housing for young people.

These responses illustrate how ageism is deeply entrenched in Western culture. The prevalence of ageism was documented by the Australian Human Rights Commission (2013) in a survey of 2020 Australians, with 71% reporting that ageism is common. The survey elaborated that experiences of ageism include: being turned down for a job; being ignored; being treated with disrespect; and being subjected to jokes about ageing. It also found that younger people are more likely to associate ageing with loss (e.g. health, hearing, mental capacity, income) and find it extremely difficult to identify any benefits associated with ageing. Similarly, 79% of the 1400 Australians who completed a survey for the Benevolent Society (Fase, Sidione, Martin, & Barkl, 2017) reported that ageism is a problem in the workplace, health and aged care services, families and local communities.

Ageism drives destructive attitudes towards older people, mistreatment, and policies and practices that reinforce negative stereotypes (Butler, 1980). The experience of ageism is also a predictor of poorer mental health and wellbeing (Lyons et al., 2018).

Concerns about ageism have led the World Health Organisation (2007) to establish a Global Network for Age Friendly Cities. The Network is underpinned by a framework recognising the role that ageism plays in health and wellbeing and calling for respect and social inclusion, positive media images and stories, recognition of older people’s expertise and intergenerational exchanges. While the Global Network is being embraced by many countries around the world, cultural change is slow. This can be attributed, in part, to the insidious nature of ageism; there is little momentum to be free from something we cannot yet see. Our inaction can also be understood as influenced by the marketing pitches of capitalism (Barrett & Hinchliff, 2017) which convince us that ageing is a battle ground—we are at war with ourselves.

Overview

This section outlines new insights and strategies to challenge ageism at an individual and cultural level in order to promote wellbeing. It begins by exploring the causes of ageism, drawing on Becker’s (1971, 1973, 1975) Terror Management Theory, or the fear of ageing and death, to explain our attitudes towards ageing and older people. It then proposes that ageism has been exploited by cosmetic and pharmaceutical companies for their own profit; and outlines how this marketplace has fuelled further ageism. The ruthlessness of capitalism combined with less intergenerational contact make ageism more of a problem now than it ever was.

Next, the section explores the problems of Elder Abuse and workplace discrimination—two social issues that have thrown ageism into the spotlight. It then focuses on an innovation called Projecting Beauty (Barrett, 2017), hosting fashion parades for older people to challenge internalised ageism, promote the good characteristics of ageing, and a protective factor against ageism. The principles underpinning the Projecting Beauty project are presented as an approach for health practitioners to promote wellbeing when working with older people or those experiencing the damaging impacts of ageism.

7.2.1.2 The Roots of Ageism

Understanding the roots of ageism, and factors that feed it, are critical steps in determining how ageism can be addressed and how wellbeing can be promoted. In particular, Terror Management Theory is presented as being at the heart of ageist attitudes, fed by capitalism and a decline in intergenerational contact.

- **Terror and gerontophobia**

Becker's (1971, 1973, 1975) Terror Management Theory is often cited as a useful framework for understanding the roots of ageism. Becker proposes that our instinct for self-preservation and the self-consciousness around our vulnerability and mortality terrifies us. He notes that in Western cultures the fear of death haunts humans to such an extent that it is the prime motivator for human activity—we are preoccupied with denying our ageing and trying to overcome death. Consequently, Martens, Schimel, and Landau (2004) note that we psychologically distance ourselves from older people to avoid being confronted by our mortality. In older people we see ourselves, with limited life expectancy remaining (Chonody & Teater, 2016).

Recognition of the role that Terror Management Theory plays in ageism could greatly assist in addressing this problem. In response, this chapter calls into question the adequacy of the term 'ageism'—which refers to prejudice or discrimination against a person because of their age. The term ageism is not specific to older people and it fails to highlight the important underlying issues of death denial.

Definition

A more useful term is gerontophobia, which will be used in this chapter in the following way:

> Gerontophobia can be described as the fear of ageing, morbidity and death which leads to the denial of ageing, internalised ageism and a desire to distance ourselves from older people, particularly those who are older and frailer than we are. Gerontophobia underpins the dislike, fear or hatred of older people and the devaluing, disrespect, abuse, violence and mistreatment of older people.

Using the term Gerontophobia reminds us of the root of the problem and the responsibility that we all have to make cultural change happen. We have all contributed to a gerontophobic cycle in which the fear of ageing and mortality has added burden to ageing—and is itself something that we fear. We are aged by our culture (Gullette, 2015) and if we are to liberate ourselves, we need to understand how capitalism feeds off the fear of ageing and death to create a so-called 'fight against ageing'.

Capitalism and the 'fight against ageing'

The fear of ageing and death has been exploited as part of a multibillion-dollar capitalist agenda calling us to join the 'fight against ageing'. It plays on biomedical constructs of ageing as deficit, illness, failing bodies and it points us to anti-ageing 'cures' (Gullette, 2015). Companies driven to maximise their profits, produce seductive marketing promises of agelessness, eternal beauty and youthful function. While these advertisements appear harmless, they reinforce the fear of ageing, death and the devaluing of older people.

The success of the call to join the 'fight against ageing' is evident in the take up of cosmetic products and surgery related to fighting the visible signs of ageing. The global cosmetic products market was valued at USD 532.43 billion in 2017; and is expected to reach $805.61 billion by 2023 (Costello, 2018). This surge has been driven by an ageing population and the desire to retain youthful appearances by using products to prevent wrinkles, age spots, dry skin and uneven skin tone (Costello, 2018). Looking old is seen as a reminder that we are getting old—and the more we fear ageing, the more we fear looking old (Chonody & Teater, 2016).

Similar demand is triggering a boom in cosmetic plastic surgery. Figures from the American Society of Plastic Surgeons show that Americans spent more than $16.5 billion on cosmetic plastic surgery and 'minimally invasive procedures' in 2018. This figure includes 7.5 million wrinkle treatment injections—making this the most common procedure.

The push to fight ageing has also extended to sexual wellbeing, with sexual function now being framed as an indicator of 'successful' ageing (Marshall, 2012). This is apparent in relation to older men's age-related erectile decline (Barrett & Hinchliff, 2017) which has been reframed as erectile dysfunction (Tiefer, 1994). This pathologising change has been driven by the profit motives of pharmaceutical companies (Conrad & Leiter, 2004), like Pfizer, who produce Viagra with a revenue of $2 billion worldwide in 2012 alone (Trenton, 2013).

The fight against ageing and the fear of death are particular to Western culture. Becker (1971) notes that in some cultures, death is celebrated as the definitive promotion, elevating humans to a higher form of life and the enjoyment of eternity. In Aboriginal families in Australia, Elders play an extremely important role as role models, care providers, educators and key decision makers (Walker, 1993). Respect for Elders is instilled in children from a young age and keeps Aboriginal culture alive—this is underpinned by the belief that if respect for Elders is lost there is no hope of gaining the necessary knowledge or encouragement to keep striving (Walker, 1993). The role Aboriginal Elders play in the lives of young people highlights the importance of intergenerational contact in addressing gerontophobia and promoting respect for older people.

Declining intergenerational contact

Intergenerational contact has a beneficial impact on positive perceptions of older people—more contact is associated with an increase in positive attitudes (Löckenhoff et al., 2015). Younger people who have limited exposure to older people tend to believe gerontophobic stereotypes; and intergenerational contact also provides opportunities for social and emotional growth for all generations involved (Chonody & Teater, 2016).

Despite the importance of intergenerational contact, a survey of 1400 Australians, conducted by the Benevolent Society (Fase et al., 2017), found that only 35% had contact with older family members once a month (or less)—and this rose to 50% for social contact with older people more broadly. These low levels of contact with older family members are not surprising given that only 5% of Australian children are living in a three-generational home with their parents and grandparents (Baxter & Warren, 2016).

In many cultures, significant value is placed on intergenerational reciprocity—older and younger family members care for each other and adult children are morally obliged to care for their parents (Lamb, 2015). This is still the case in some families, with three generational homes being more common in Indigenous and Asian households in Australia (Baxter & Warren, 2016); but there is a trend towards decreased family bonds and social isolation (Lamb, 2015).

There is a need to build intergenerational contact within families and communities. To achieve this, we need to take up opportunities for cross cultural learning about respect for older people in a range of cultures. Awareness of this need has been emphasised with recent data on the extent of gerontophobia throwing the issue into the spotlight.

7.2.1.3 Gerontophobia in the Spotlight

The problem of gerontophobia is now being given attention by those concerned with the problems of Elder Abuse and the workplace discrimination experienced by older people. Both these issues have their roots in gerontophobia and can have devastating impacts on physical, financial and emotional wellbeing.

Definition

Elder Abuse is defined by the World Health Organisation (2018) as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. Elder abuse can be financial, physical, psychological and/or sexual; and is often perpetrated by family members.

Elder abuse is experienced by around 15.7% of people aged 60 years and older; although the number is likely to be much higher, given that only one in 24 cases are reported (World Health Organisation, 2015). Elder Abuse can have devastating impacts on wellbeing, leading to physical injuries and serious long-lasting, psychological consequences, such as depression and anxiety (World Health Organisation, 2015). Additionally, people who experience Elder Abuse are twice as likely to die prematurely as their counterparts (Lachs, Williams, O’Brien, Pillemer, & Charlson, 1998).

Concerns about Elder Abuse have led to calls for primary prevention, or addressing the cultural attitudes, values and beliefs that enable Elder Abuse to occur. This includes addressing gerontophobia and is particularly important in contexts where older people feel compelled by family loyalty, or the lack of resources, to continue living with an abusive family. These efforts will promote the wellbeing of those who feel unable to change their circumstances in the longer term, but are unlikely to assist older people who are currently experiencing abuse.

The second phenomenon to throw the spotlight on gerontophobia is workplace discrimination. In their research on age discrimination at work, the Australian Human Rights Commission (2012) noted that people aged 55 years and over make up around 25% of the population, but only 16% of the total workforce. Older people face longer periods of unemployment and 33% of those who experienced age discrimination gave up looking for work. Additionally, 27% of people over the age of 50 reported experiencing age discrimination at work. The research found older people have difficulty obtaining work and achieving promotions; experience overt age-related discrimination and are targeted for redundancy because of their age. These factors have financial, personal, working life and emotional impacts. They can leave older people feeling diminished, undervalued, unmotivated, disconnected, depressed, anxious, powerless and disengaged.

Strategies to address these issues, and the underlying problem of gerontophobia, are needed at every level of society and will require significant resourcing if they are to be successful. However, there are some simple, local initiatives that could be implemented in the context of therapeutic relationships between health practitioners and older clients or those experiencing reduced wellbeing as a consequence of gerontophobia.

► Example

Projecting Beauty is one example of engaging older people in a project to support their wellbeing. Innovative approaches to promoting wellbeing are required if we are to engage the interest of older people and the broader community in cultural change. One such initiative is a project called *Projecting Beauty*, or Catwalks Against Ageism, developed by the Celebrate Ageing Program (Barrett, 2017). The project invites older people to participate in fashion parades challenging narrow definitions of beauty as the prerogative of youth. Beautiful is pitched as an attitude and models are asked to challenge their internalised ageism and articulate the attitudes they want to take onto the catwalk as first time models. Catwalk attitudes often include feeling: confident, playful, embodied, strong, beautiful and safe from the negative views of others. The models are then encouraged to take these attitudes into their everyday life as a protective factor against gerontophobia. Rather than waiting for the world to be less gerontophobic, the project encourages older people to empower themselves and promote their own wellbeing—now. Once embodied, these positive characteristics are then projected out into the world from the runway—and younger people watching older people in the fashion parades are inspired to see the positive characteristics of ageing that they want to replicate or age into.

The principles underpinning the Projecting Beauty approach include addressing internalised gerontophobia and making visible the good characteristics of ageing and older people. These principles could inform an approach to working with older people and those experiencing gerontophobia. ◄

Addressing internalised gerontophobia

Every day we are bombarded with messages on social media, in advertising, in news stories, and in conversations with others—telling us that our ageing is something to be feared and fought. Perhaps then, it is not surprising that these messages are internalised or become an unconscious part of the way we think and feel about our ageing.

Definition

In this chapter, internalised gerontophobia is defined in the following way:

> Internalised gerontophobia is when a person unconsciously accepts the gerontophobic values and beliefs of the world around them. This can include the fear of ageing, morbidity and death, which leads to the denial of ageing, devaluing our own age and a desire to distance ourselves from older people, particularly those who are older and frailer that we are. Internalised gerontophobia may lead to a reduction in our expectations of valuing and respect by family and community. It may also result in reduced expectations of ourselves as we age.

Internalised gerontophobia can diminish perceptions of self-worth and create a sense of shame, anger or sadness (Australian Human Rights Commission, 2015). It can result in poorer subjective health, higher feelings of loneliness, more frequent dependency behaviours, and reduced will-to-live (Sargent-Cox & Anstey, 2015). It can also lead to older people denying their age and distancing themselves from other older people (Butler, 1980; Calasanti, 2005). What is particularly striking about the research on internalised gerontophobia is the link between subjective age (the age an older person feels) and mortality.

In the USA, Yannick, Sutin, and Terracciano (2018) tracked 17,000 people in middle and older age over a 20-year period to explore the link between subjective age and mortality. The study measured subjective age, demographic factors, disease burden, functional limitations, depressive symptoms, and physical inactivity at baseline and over a 20-year period. The results showed that on average participants felt 15–16% younger than their chronological age. It also demonstrated that feeling 8, 11 and 13 years older was related to an 18%, 29% and 25% higher risk of mortality, respectively. Their analysis showed that disease burden, physical inactivity, functional limitations and cognitive problems accounted for the associations.

The link between subjective age and mortality is often described as a younger identity protecting against or disassociating a person from the negative stereotypes of older people (Weiss & Lang, 2012). People with more positive self-views are more likely to engage in behaviours that might be indicative of youthful agency (e.g. health behaviours, social and recreational activities) and this is reported as a younger subjective age (Kornadt, Hess, & Voss, 2017).

To investigate this issue further, Kornadt et al. (2017) explored a number of 'domains' of subjective ageing and age-related changes in 593 people aged 30–80 years. The researchers proposed that subjective ageing is multidimensional and so measured subjective ageing related to domains of family, friends, leisure, personality, finances, work and health. They found that subjective age, and how discrepant this is from actual age, depends on the life domain being measured and actual age. Over time, participants reported feeling younger for the domains of life that were associated with negative stereotypes (e.g. work, finances and health) than those that were positive (e.g. family, friends and leisure). Growing older increased the probability that people evaluate their own ageing experience against society's reference standards. The gap between subjective and actual age broadened with age—which is not surprising given that younger people are less likely to feel threat to their age. In other words, the research identified that gaps between subjective age and actual age appeared in response to gerontophobic stereotypes.

The research on subjective age highlights the impacts of internalised gerontophobia and provides compelling rationale for addressing this issue. The call is not to 'think young' but to raise awareness of the positive characteristics of old age. Ageing is a privilege and death is inevitable. If we can learn to celebrate our ageing, we can learn to recognise the preciousness of life and build our own wellbeing. To achieve this, it is useful to explore the ways that ageing and older people are characterised and to outline good character—or the positive aspects of ageing.

7.2.1.4 Making Good Character Visible

The invisibility of older people and the negative portrayal of ageing and older people are manifestations of gerontophobia identified by The Australian Human Rights Commission (2012). The Commission's research has found that older people feel invisible or overlooked and undervalued in services, in relationships with family and friends and in popular culture. But it is not just the lack of visibility that is problematic, the negative ways in which older people are represented is also a significant issue.

Negative stereotyping of older people is particularly problematic in the media. Older people are often characterised as frail, weak, victims, unwell, forgetful, slow, vulnerable, burdensome, grumpy or sick (The Australian Human Rights Commission, 2015). The promotion of these characteristics disempowers older people, particularly those who internalise these messages, and it perpetuates a cycle of gerontophobia.

Important

To cut the cycle of fear and disrespect, there is a need to promote the positive characteristics of ageing. These characteristics may include wisdom, authenticity, compassion, patience, integrity, humour, depth, expertise and life experience. Innovative approaches could also be utilised to ask individual older people to identify their own good characteristics—to promote their own wellbeing and to challenge negative stereotypes in the broader community. This approach will assist in building a new narrative of ageing as a privilege to be valued and respected. These strategies can be adopted by health practitioners working with older people and those experiencing age-related discrimination. It will require that health practitioners understand the impacts of gerontophobia on their own ageing narratives—so that what is subconscious becomes known and does not reinforce gerontophobic barriers to older people's wellbeing.

7.2.1.5 Conclusion

This section explored gerontophobia, its root causes, the impacts on wellbeing and strategies to minimise the harm. The task ahead is an enormous one, given that the fear of our own death motivates us to act in ways that deny ageing and enable older people to be devalued and disrespected. Change will require the support of governments, significant resources and will take a considerable length of time. However, rather than waiting for the world to change, each and every one of us needs to identify our own internalised gerontophobia and the ways in which it restricts our wellbeing. Negative self-talk about our own ageing does not serve us. Ageing and death are inevitable, and acceptance of these truths can enable us to live our lives to the full. These steps are essential for those of us who work with older people. They are also essential for those of us who are not yet old, who want to enjoy wellbeing in our old age.

7.2.2 Millennials. Walking Around Like They Rent the Place

Magenta B. Simmons, Ellie Brown, Nicholas J. Fava and Vivienne Browne

7.2.2.1 Introduction: The Mental Health and Wellbeing of Young Australians

In this section, we provide an overview of issues faced by young people aged 12–25 years in relation to their mental health and wellbeing. In June 2018, there were an estimated 4.48 million young people aged 12–25 in Australia, or 17.94% of the Australian population (ABS, 2018). The current generation of young Australians is known as 'Gen Z' or 'Post-Millennials' (birth years from the mid-1990s to the mid-2000s) (Wiki Contributors, 2019), and follow on from the previous generation 'Gen Y' or 'Millennials'. Surveys of young Australians aged 15–19 (Carlisle et al., 2018) and 18–29 conducted in 2018 show that mental health is the primary issue of concern for approximately 40% of young people. Adolescents and young adults are right to be concerned about their mental health, as the vast majority of mental health problems first begin when people are young.

- **Prevalence and burden**

Approximately 50% of mental disorders occur by the time a person is 14 years old and 75% before the age of 24 (Kessler et al., 2005). The most common mental disorders experienced by young Australians are anxiety, mood and behavioural disorders (e.g. attention deficit hyperactivity disorder, conduct disorder) (Lawrence et al., 2015). Other disorders are less common (e.g. schizophrenia) but usually result in more significant burden to the person. For example, although only 0.3% of adolescents will be diagnosed with anorexia nervosa, eating disorders carry a significant burden and lifetime mortality rates are almost 6-fold for this disorder (Orygen, 2016).

Experiencing any type of mental disorder as a young person can lead to poorer outcomes in terms of physical health, social relationships and social inclusion, success at school and work, ability to contribute to and feel a part of their community, and the recurrence of existing mental disorders and development of additional, co-morbid disorders (Australian Institute of Health and Welfare [AIHW], 2007; McCloughen, Foster, Huws-Thomas, & Delgado, 2012; O'Dea et al., 2014; Patel, Flisher, Hetrick, & McGorry, 2007). The risk of developing a second, co-morbid disorder is highest in the first year after the onset of the initial disorder (Plana-Ripoll et al., 2019), meaning that this period of life remains risky for the development of further mental health problems. Additionally, young people are the most likely age cohort to die by suicide, as suicide is the leading cause of death for young Australians aged 15–24 (AIHW, 2018a).

Risk factors for poor mental health and wellbeing outcomes are identifiable early in a child's life. Using population-based studies, researchers have identified factors seen before the age of five (e.g. child maltreatment, parent diagnosed with mental disorder, parent committing forensic offence, smoking during pregnancy) that increase the likelihood of early onset (between the ages of 6 and 13) mental disorders (Green et al., 2018; Green et al., 2019).

As you will hear in other sections of this book, different groups of young people also experience a disproportionate degree of psychological distress and impact to their mental health and wellbeing, including, but not limited to, young people with chronic physical illnesses and disabilities (Delamater, Guzman, & Aparicio, 2017; King et al., 2018); young people who identify as LGBTIQ (AIHW, 2007), including transgender and gender diverse young people (Strauss et al., 2019); both young people who are bullied and those who bully others (Ford, King, Priest, & Kavanagh, 2017); young people who experience childhood trauma (Bendall et al., 2018); young Aboriginal and Torres Strait Islander people (Carlisle et al., 2018); refugees and immigrants (Wyn, Khan, & Dadvand, 2018); and young people who experience racism (Carlisle et al., 2018; Wyn et al., 2018).

▪ Help-seeking in young Australians

Despite the high prevalence and substantial burden of mental disorders in young people, they are the age group least likely to seek help (AIHW, 2011). An Australian national survey showed that only one out of every four young people (aged 16–24) with a diagnosable mental disorder had sought help in the previous 12 months (AIHW, 2011). A number of reasons for this reluctance to seek help have been identified or posited, including stigma; self-reliance and a preference to handle problems independently; lack of belief in the benefit of particular sources of help; poor past experiences of help seeking; and low mental health literacy (Rickwood & Braithwaite, 1994; Rickwood, Deane, & Wilson, 2007; Rickwood, Mazzer, & Telford, 2015a). Alongside reluctance to seek help, other physical, financial and cultural barriers to accessing support, for example, distance to a service, public transport availability, 9 am–5 pm hours of operation and service information not translated into languages other than English can result in help-seeking intentions remaining un-actioned.

There are a number of people and places where a young person can seek help in Australia, largely dependent on where they live. Adolescents are most likely to confide in a family member first (Jorm, Wright, & Morgan, 2007); but may have also spoken with other trusted adults (e.g. teacher), friends, school welfare officers, TAFE or university counselling services, general practitioners or other health professionals, or telephone and online help services. The landscape of mental health services has changed significantly over the past 15 years. Along with the increased recognition that young people bear the brunt of mental ill-health onset and burden, there has been a shift towards early intervention services for 12–25-year-olds.

► Example

Headspace, the National Youth Mental Health Foundation, is the primary example of this move towards youth-friendly primary mental health care services (b; McGorry et al., 2007; Rickwood, Mazzer, & Telford, 2015a, 2015b), and there are now 110 Headspace centres across Australia, with 30 more funded in the 2019–20 Australian Government budget. Each Headspace centre offers care structured around four core service streams (McGorry et al., 2007; Rickwood, Mazzer, & Telford, 2015a, b):

- Mental health
- Drug and alcohol services
- Primary care (general and sexual health) and
- Vocational support.

Central to the delivery of these services is a multidisciplinary workforce, which may include GPs; allied health (psychologists, Aboriginal health workers, mental health nurses, sexual health workers, alcohol and other drug workers, etc.) and vocational specialists. Headspace in part utilises the Medicare funded 'Better Access' initiative, whereby, after obtaining a mental healthcare plan, individuals can access Medicare rebated sessions with psychologists, psychiatrists, general practitioners, social workers and occupational therapists (Department of Health, 2019). Headspace was designed to meet the needs of young people experiencing mild to moderate mental health issues. ◄

There are approximately 3% of young Australians who are experiencing a severe mental health condition in any given year (Department of Health, 2017). State- and territory-funded mental health services generally provide tertiary care to those in the population with the greatest severity of illness. For young people, these are often delivered through Child and Adolescent Mental Health Services (CAMHS) (0–18 years) or, in some areas, Child and Youth Mental Health Services (CYMHS), which can go up to 25 years (Victorian Auditor-General's Office, 2019). The transitional age point into the adult mental health system remains a substantial challenge in delivering youth-appropriate and evidence-based care for young people with more severe conditions. The private sector also offers fee-for-service counselling, psychological therapies, psychiatry and other services.

- **Different settings for mental health support (incl. apps)**

The World Health Organization defines adolescent-friendly services using five key domains: equitable, accessible, acceptable, appropriate and effective (World Health Organisation, 2012).

The ways these translate specifically in service development, design and delivery for young people include services that (Hetrick et al., 2017):

- Provide holistic and integrated care to support multiple issues.
- Offer flexible duration of care and support re-entry if needed.
- Are accessible (e.g. by public transport, central location, and multiple entry points).
- Behave in a safe and youth-friendly environment (e.g. not overly clinical in appearance).
- Include art and recreational activities and 'chill-out' spaces.
- Employ staff skilled in working with young people.
- Promote youth (and family) participation in all aspects of designing, delivering and evaluating the service.

Mental health and wellbeing for young people should be considered within the broader context of physical, developmental and social changes. This includes navigating puberty; juggling home, education and work lives; forming friendships and romantic relationships; increasingly making decisions; and developing a sense of autonomy and identity. These developmental milestones have long been part of adolescence; however, there are unique issues facing the current generations of young people. These issues include changes to technology, employment and affordability.

7.2.2.2 Issues Faced by Young Australians

- **Digital technology**

Compared with previous generations, a defining feature of 'millennials' and 'post-millennials' is the degree to which technology has been a part of their life since birth. Dubbed 'digital natives' (Prensky, 2001), these generations have grown up with the use of technology embedded in their everyday lives. Older generations have had to learn to adapt to new technologies, whereas younger generations can no longer remember a time without them. And this trend continues, with surveys of young people conducted in 2008 and 2012 demonstrating an ongoing rise in the ubiquitous and prolific use of technology (Burns et al., 2013), with an average screen time of nearly 5 hours a day (Granich, Rosenberg, Knuiman, & Timperio, 2011).

Digital technology represents a change in the way young people interact with other people (e.g. social media), how they seek information (e.g. readily and unfiltered), and how they may take care of their mental health and wellbeing (e.g. by using applications, whether or not they are evidence-based (Wang, Varma, & Prosperi, 2018). The internet and other technologies offer young people potential benefits, such as ready access to evidence-based supports and enhanced global opportunities; possible risks, such as privacy breaches; and potential harm, such as being exposed to disturbing content relating to, for example, self-harm or suicide

(VicHealth and CSIRO, 2015). Whilst scientific debate about whether the use of digital technologies truly have a significant impact on a young person's psychological and emotional wellbeing is ongoing (Bell, Bishop, & Przybylski, 2015; Orben & Przybylski, 2019), awareness of the information they may be exposed to through technological mediums is required.

Another potentially damaging consequence of technology on the lives of young people is the advent of a new platform upon which bullying and harassment can occur. Whilst bullying is by no means a new phenomenon, 'trolling' and cyberbullying are facilitated by easier and quicker methods to share information with broader groups than was previously possible, and can be done so anonymously. Bullying has serious consequences for those who are bullied as well as those who bully their peers. Adolescents who were both bullies *and* bullied others can have the highest risk of self-harm, suicidal ideation and behaviours, as well as poorer general mental wellbeing (Ford et al., 2017). Unfortunately, technology provides other avenues for this conduct. A meta-analysis in 2014 (Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014) of cyber and traditional bullying found that whilst cyberbullying is less prevalent, they were highly correlated. This suggests that they tend to be different methods of enacting a similar behaviour (being mean to others) and that the form of communication may be less important than the behaviour itself.

▪ Impact of technology on physical health

The increasing use of technology is also impacting the physical health of young Australians (Martin, 2011). Those who spend excessive time watching television, playing electronic games, using the computer or using screens overall are more likely to be overweight or obese, engage in lower levels of physical activity, have worse cardiovascular fitness, and poorer sleeping and eating habits (Babey, Hastert, & Wolstein, 2013; Rosen et al., 2014). For teenagers, greater technology use predicts poorer health (including psychological issues, behavioural problems, attention problems and physical problems), even after controlling for demographics, unhealthy eating and lack of physical activity. One way out of this potential spiral into mental and physical ill-health may be to ensure young people (and their family members if relevant) are aware of their screen time use, and encouraging the development of self-management 'screen time plans' (Maniccia, Davison, Marshall, Manganello, & Dennison, 2011). The importance of engaging in other activities, particularly physical activities, should be emphasised.

▪ Impact of technology on sexual health

Technology is also changing the sexual health of young Australians. Mobile dating apps have been firmly integrated into dating culture, with apps such as Tinder reporting having millions of users worldwide, half being aged 18–24 years old (Dredge, 2015). Whilst such apps can have a positive outcome for some (a Australian Broadcasting Corporation, survey found that 1/4 of 18–29 year olds met their partners on a dating app; Australian Broadcasting Corporation, 2018), there is evidence to suggest that young people who seek sexual partners through online domains engage in more high-risk sexual behaviours (Buhi et al., 2013). This shift in mode of forming relationships comes at a time when an individual is developing their sexual identity, as well as establishing potentially long-term health and social behaviours.

Technology can be used for other, potentially more damaging, sexually-related purposes. This includes seeking out pornographic material, engaging in online-only sexual relationships, and sharing sexual images of themselves (sexting). Engaging in these behaviours has the potential to occur to such an extreme to be labelled as an addiction (Griffiths, 2000). Easy access to sexual material online could also be skewing young peoples' perceptions of what constitutes a 'normal' sexual relationship.

- **Opportunities from increased technology use**

Given the growth in the use, availability and capabilities of technology, as well as the growing importance that it has in society, it is important to amplify and support its positive engagement while identifying and minimising potential risks. Technology allows for online community building and connection, 24-hour access to counselling and support for young people in almost all areas of the country, a source of information to increase mental health literacy and cost-effective mental health promotion, prevention and intervention programs (Blanchard, Hosie, & Burns, 2013).

7.2.2.3 The Future Is Insecure

Whereas some groups in previous generations of Australians have benefited from relative prosperity (bar the recession of the early 1990s), the current generation of young Australians are experiencing far greater uncertainty around their future. Two issues they can begin to face in adolescence are job security and housing affordability.

- **Job pathways and security**

Young people are disproportionately unemployed and underemployed, with the unemployment rate for young people being more than double that of the general Australian population (Dhillon & Cassidy, 2018). Over the past 30 years, there has been a significant shift away from full-time work to part-time work and workforce casualisation, which has hit young people aged 15–24 harder than their counterparts aged 25 years and older (Brotherhood of St Laurence, 2018). A report from the Brotherhood of St Laurence (2018) highlights that this has occurred despite continuous economic growth for most of this time, and points towards the recession in the 1990s and the global financial crisis of 2008 as contributing factors. The report suggests that the transition from adolescence to young adulthood in vocational pathways is becoming increasingly insecure, with part-time work being common for young people who are not studying, or who have completed their studies or qualifications in other areas.

This trend towards part-time and casual work, often involving multiple jobs, is echoed in 'The New Work Order' report by the Foundation for Young Australians (Foundation for Youth Australia, FYA, 2015). It highlights that young people will need to work collaboratively (e.g. with multiple employers) and globally (e.g. with international workforces) in the near future, and will also be heavily impacted by automation. They estimate that a significant proportion of young people are currently studying for jobs (60%) or entering the workforce in jobs (70%) that will be "radically affected by automation" (Foundation for Youth Australia, FYA, 2015). Low-paying and low-skilled jobs are likely to be impacted most by automation (Angus, 2015) and more advanced training is now required for entry-level positions (Foundation for Youth Australia, FYA, 2015; VicHealth and CSIRO, 2015). The requirement for young Australians to have substantial qualifications is now increasingly important, further contributing to financial pressure and insecurity.

- **Housing affordability**

Alongside this growing problem of job insecurity and instability, young people also face the worst housing affordability in living memory (Daley, Coates, & Wiltshire, 2018). This is seen not only in the dramatic rise in the cost of buying a house compared to the rise in the average wage, but also in the lack of affordability and availability of properties in the rental market. A series of government initiatives (e.g. negative gearing) designed to increase the number of affordable rental properties in Australia have instead resulted in tax benefits for older, wealthier Australians (Blunden, 2016). This has contributed to a shrinking rental market, further impacted by recent trends such as short-term rentals (e.g. Airbnb), which are marketed towards tourism rather than ongoing accommodation (Anglicare Australia, 2019).

For almost a decade, Anglicare Australia has taken a 'Rental Affordability Snapshot', which is a census of all rental properties available in Australia in one weekend (Anglicare Australia, 2019), painting an alarming picture for Australians experiencing vulnerability and attempting to rent a home. For those on government support payments or earning the minimum wage, there are virtually no appropriate and affordable advertised rental vacancies. The most disadvantaged people in Australia simply cannot afford the cost of a rented home, which has led to increased vulnerability of tenants, increased rates of homelessness, and a reduction of spending on other essentials, such as food (Anglicare Australia, 2019; Daley et al., 2018).

7.2.2.4 Conclusion

The mental wellbeing of young Australians remains a concern for politicians, service providers, carers and young people themselves. Statistics about youth suicide rates frequently feature in the Australian media. Factors unique to their situation such as current and predicted job and housing markets, and digital technology have the potential to further impact on mental wellbeing. Researchers, clinicians and policymakers need to be thinking creatively about how technology can be harnessed to support young people to be aware of their mental health needs and successfully access care in a timely manner.

7.3 Personal Stories and Current Affairs

7.3.1 Spirituality and Ageing in Contemporary Care

Ilsa Hampton

Talking, thinking and engaging with spirituality in Australia is very tricky. In the context of ageing, it becomes even more complex. As with other major societal changes such as technology, there is a massive generational gap between frames of reference, discourse and experience. In Australia, we have at least three parallel tracks that influence the way that spirituality is understood in the context of health and human services with an ageing population. We have the experience of the older generations, the experience of the cohort who are offering care and support, and the local and international evidence.

Members of the older generations are from a time when it was assumed that spirituality and religion were one and the same (Indigenous communities have always been an exception to this). As a community in Australia, we are now in transition from that time when it was taken for granted, rightly or wrongly, that the majority of people shared a Christian faith or at least, were part of the Christian church one way or another. According to the Australian Bureau of Statistics (ABS), 82.2% of the population identified as Christian and 0.7% as 'other religion' in 1966. Five decades later, in 2016, just half the population identified as Christian (52.1%) and 8.2% 'other religion' in 2016 (ABS, 2018c). It's not hard to find a picture of the full churches of the 1950s with everyone in their "Sunday best" (it was considered a sign of respect for God and the church to dress up for the occasion). For the majority of the population, belief in something more than yourself, something beyond yourself, was taken for granted and was named 'God'—or at least, participation in rituals, traditions and communities that reflected these beliefs was taken for granted. This is what is meant by 'organised religion' and reflects the experience of older generations, 70% of whom still indicated Christianity in the 2016 Census. The 30.1% of Australians who indicated 'no religion' in the Census were more likely to be young people (ABS, 2018c).

Participation in these faith communities had many limitations and flaws, but they also offered a lot. Right now, some people in our society are in reaction to those many limitations and flaws that became the hallmark of the church, including the poor view of women, oppression of people who were not heterosexual, and the rejection of 'otherness' in whatever way it showed up. Ironically, Jesus Christ is known for his radical commitment to 'others', privileging women and the poor, and challenging views of institutional religion. Given these flaws, if you are not part of a religious community today, it can be puzzling to see people still participating in faith communities or holding to personal faith, even without belonging to a group. New professionals who are not part of a faith community may *only* have heard about the sad and bad things associated with such places.

Experiences of younger generations—that is, many of you who are training to become our health and community services professionals of the future—are very different from the older generations. You will know that not everyone is part of a religious community. In fact, if you are part of a faith group yourself, you will be painfully aware of this as you may be viewed with some suspicion, or at best curiosity, by your teachers and peers. The flaws of organised religion will have been cited throughout your studies with a collective 'tsk tsking' at the terrible things that religious institutions have brought about in our communities. It's true, 'organised religion' has much to answer for; for example, the Royal Commission into Institutional Responses to Child Sex Abuse (Commonwealth of Australia, 2017). If you are not part of a faith community, you may be wondering, why does anyone bother?

Meanwhile, research about spirituality and the place of spiritual care, especially in healthcare, has seen a massive increase in the last two decades (Cobb, Puchalski, & Rumbold, 2012). Whilst there is no agreed definition, key terms overlap.

Definition

"Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices." (Puchalski, Vitillo, Hull, & Reller, 2014, p. 643). You can see that spirituality does not depend on religion but religion is all about spiritualty. This underpins a lot of my work at Meaningful Ageing Australia.

Spirituality is innate to our humanity, which is why the history of Homo sapiens includes a history of ritual and relationship with 'Something Bigger'. (Something Bigger is the term used by Julie Fletcher in her original development of the ConnecTo spiritual screening tool, adapted by Meaningful Ageing Australia for use with older people and others. 'Something Bigger' can be understood as something beyond ourselves, called by some the sacred, transcendence, God or the universe.)

Religions can offer a way to engage with deeper parts of life. Human dysfunction aside, they provide a frame of reference, patterns of relationship and ritual, and a continuous opportunity for both nurture and challenge for an embodied and engaged life. Whilst not everyone has a religion, it can be argued, we all have a spirituality. Put in everyday terms, our spirituality is that which sustains us at a profoundly deep level. We need physical food to survive, we need spiritual food also. We can't assume what form that spiritual food comes in. Even *within* faith communities, for example, each person will have their own story of what it all means to them, as much as they may participate in a shared perspective within that group. It may be through traditions and it may be through other practices. Whether someone is part of a faith community, or they are not, it is important to explore what sustains them.

By broadening our view of spirituality, we are better able to work with the spirituality of others. It is not uncommon for a person's spirituality to become more important in the face of crises, or health challenges, or what may be described as the pointy end of life (Mackinlay, 2006). This means it is vital that people working in health and community services are able to engage with this aspect of a person's experience. Some people tell me, "It's too private." This is an excuse on the part of the professional. Have a think about the very many private things you are exposed to when you are assisting someone in their recovery or to navigate the system they are in. It doesn't mean we force awareness of spirituality on anyone, but it does mean that we need to be sure we are noticing what matters to people. We need to invite those things that sustain them in to the way we support them.

Spirituality is like a muscle—it needs to be worked on to become stronger. If neglected, it will become weak and unavailable when you need to do some heavy lifting. As with all exercise, it can seem pointless to build up muscles if you have no feeling of urgency at needing them. However, as with moving house, if you have not exercised for months or years it is ten times harder to set up your new home if you are not in good shape. So it is with our spirituality. Spiritual questions such as, 'Who am I?', 'Where do I belong?', 'What is my source of hope?', 'Am I living in keeping with my values?' and 'What is of ultimate concern to me?' can become much more acute when our bodies force us to slow down. One way 'in' to thinking about spirituality is through the lens of connection (Lepherd et al., 2019).

This brings us to spirituality and ageing. Ageing comes with many challenges, including concern about what it means to be an ageing person in Australia. Meaningful Ageing Australia conducted an on-line Community Survey in 2019 with 1000 participants over 65 years. Our interim report (unpublished document) showed that 63% of people experience some degree of fear of ageing. As much as ageing poses many challenges physically and socially, it may offer new opportunities for authenticity and growth. There is evidence that tells us an older person's spirituality can be a real buffer in times of stress, and especially when dealing with the particular challenges of ageing (Mackinlay, 2006; Manning, 2013). As our bodies become less able, our spirits, or inner selves, can become stronger.

We are in an exciting time of transition in Australia as we learn to understand and talk about spirituality as either religious, or without a particular religious framework. We are also learning to explore the nuances of each person's spirituality at their particular life stage, formed in the context of multiple relationships, although notably the context of care must be taken into account (Rumbold, 2006). As health and human services professionals, the onus is on all of us to become aware of our own spirituality and learn how to notice and work with the spirituality of others. If this is challenging for us, we need to take the time to explore why.

Meaningful Ageing Australia has a wide range of practical tools and resources to help organisations understand and respond to the spirituality of older people, ► www.meaningfulageing.org.au; and a initiative to help older people feel more valued and learn to use the language of spirituality when looking for care services, ► www.seemeknowme.org.au.

Questions

Some reflective questions to ponder…

1. Do you agree that "In Australia, we have at least three parallel tracks that influence the way that spirituality is understood in the context of health and human services with an ageing population"?
2. How comfortable are you thinking and talking about spirituality? Why?
3. What gives you your sense of purpose in life? Can you imagine this changing as you grow older?
4. There are five key domains of *connectedness* that are common themes when unpacking a person's spirituality. Take a moment to reflect on these domains in your own life.

   What is important to you in relation to each of these domains, and how connected do you feel to what is important?
   - Connection with others
   - Connection with creativity
   - Connection with nature
   - Connection with self
   - Connection with 'Something Bigger' (could be the sacred, God, the universe)
5. How well is spirituality acknowledged and supported in the care contexts with which you are familiar?
6. Think about some older people you know, or have seen on video. How do you think they would answer questions about their important connections? Now watch the ConnecTo video of older people: ► https://youtu.be/pq2NUSSkaxo. Did they talk about what you expected them to talk about?

7.3.2 Age Shouldn't Matter, but It Does…

Julie, as told to Vicki Hutton

Age shouldn't matter, but every passing year I'm finding that it matters more and more. I'm heading for 70 now, and the way my health is, I'll soon be looking to go into some sort of care. I won't be able to keep my secret then, and that terrifies me because I'm an older woman living with HIV.

I've heard that only about 10% of the 27,000 people with HIV in Australia are women. I guess that's why I've never spoken to another woman of my age with HIV. I've seen women at the Infectious Diseases Clinic but they're younger than me and when I hear them talking, it's all about wanting children or having children. I'm probably exaggerating but not one of them is talking about getting older, and feeling discriminated against because you're getting older, and facing having to go into care. I keep my distance from them all.

I was born in 1947 in a tiny town in outback New South Wales. I grew up knowing I'd get married and have kids, grandkids, join the Country Women's Association, bake cakes, then die in that town. Nothing went to plan. After years and years of drought the town was dying and some of my friends were heading to the city to find boyfriends and husbands. I went too because back then a country woman had no function without a husband.

I was married with two children by the time I was 20, then spent the next 20 years avoiding his foul temper and his fists. I never knew a warm loving physical relationship, just sex, bruises and broken bones. I left him in the nineties, thinking I'd still have time to find out what a proper relationship meant. He died 2 years later, and that's when I found out he had AIDS. I'd been his beard for 20 years—is that what they still call it? I was the woman who legitimised his masculinity so he could go off and sleep with men. I think he always resented needing me to give him legitimacy, and that's why he'd beat me up for nothing.

Just when I should have been free to finally enjoy life as an independent albeit mature women, I discovered I was HIV-positive too. I needed a routine blood test before getting my varicose veins fixed and I remember the young male doctor being so embarrassed because I looked like a respectable elderly middle-class woman and he had to ask about my sex life. It was written all over his face that a woman of my age wouldn't be having sex, so it must have happened decades ago. Once he found out I wasn't in a relationship, he didn't even give me the safe sex talk I would have got if I was younger. He just assumed I wouldn't be interested at my age and I was too embarrassed to ask. I've heard all the stereotypes about ageing—romance is only for the young, old people are too old for that, old people should only do what's appropriate for their age. I've heard them and so after that day I let them define my life.

I never got my veins done, and I never found that warm loving physical relationship because I stopped looking the day the doctor told me I was positive. These days nobody except my GP and the specialist doctors at the Infectious Diseases Clinic know I've got HIV, and I work hard to keep it that way. I get a taxi to the Clinic because I never learned to drive—my husband would never let me. I never get the taxi from my home. I walk to the nearest shops and pick one up, and I never let it drop me outside the Clinic. If I need medications in-between Clinic visits, I get them to send them to a pharmacy two suburbs away and pick them up from there. I wouldn't risk anyone recognising those medications at my local pharmacy and finding out my secret. They couldn't tell anyone, but I'd know they know.

I told my older sister when I was first diagnosed and the first thing she said was don't tell the others, especially her husband and our mother who was still alive. The second thing she asked was how did I catch it at my age, as if my age made it so much more embarrassing. We never spoke of it again, and my sister is dead now so nobody in my family knows.

I hide my medications when my son or daughter and their children come over. Right now, my daughter, her husband and two children are staying with me while they're having renovations done, and it's hard to keep things hidden, but I do. I can't bear to think of their faces if they knew Nanna has AIDS. They'd be disappointed—and yes, embarrassed—that a woman of my age has a sexually transmitted disease.

The doctors at the Clinic look younger and younger every time I go there. Every once in a while they'll ask if I'm sexually active, but I can see they've already ticked no before I answer. One said to me a while ago it was easier at my age when you don't have to worry about sex anymore and I couldn't even take offence. Isn't that what everyone in society thinks when you reach a certain age? But I'm still sick of getting caught in the assumption that I'm too old for sex, too old for anyone to want to come near me, and too old to have this disease. I sometimes wonder if the men experience the same level of ageism?

I've got arthritis, my eyesight and hearing are bad because my mother had Rubella when she was pregnant, and I'm barely managing to survive on a pension. My HIV viral load is undetectable as long as I take my medications, but I know I can't hold out much longer living alone. My family will move out in a month, and while that will be a relief because I won't have to hide so many things, I have a feeling they're going to push for me to go into care.

These days, living with HIV is a lot easier with the new medications. Now my biggest concern is getting older and the double stigma when people eventually find out I'm an old woman with HIV. Age shouldn't matter, but it does.

7.3.3 Fighting for Control

Sarah Bostock

» I'm not a very good therapy patient

I crossed my legs and look over at my new psychologist, Chris. He laughs and raises his eyebrows but he doesn't try to fight me on this. I don't remember many of the names of my psychologists before him and I think one day I may forget his too, though I hope that I don't. Dressed in the same spotted shirt he was wearing in our first session, he crosses his legs too. Leaning forward in the kitsch armchair set we're sharing, he lets out a breath it feels like he's been holding. His eyes are blue and seemingly unblinking. I think that the only blue-eyed people I know are doctors and that maybe that has meaning. He runs a hand through his beard, thinking. I am suddenly reminded I don't like beards and reluctantly add a strike against him, hoping that the negatives don't outweigh the positives and that I haven't made a huge mistake in trying this process again. He stops looking and writes something down, mouth ajar.

» Okay, so why is that?

I could start at the beginning. I'm 14 the first time I see a psychologist and mum waits in the nearby *Grill'd* for the full hour once a fortnight. All I can remember clearly of my first psychologist is that she was the first. She wears a frizzy grey halo and substitute teacher's clothes. Offering me self-help pamphlets on overcoming fear, she wafts the smell of rosemary my way and I can't tell if its perfume or lunch.

» How long have you known you're not straight

My teeth feel too big for my mouth and it feels as if on reopening my mouth, they might fall out with the words. I explain that I'm not sure, but that it isn't why I'm sad, or if it is, it's not like how she thinks. There is a poster on the wall with a rainbow flag. She talks about how big this decision is for *someone my age.*

> Do you think that keeping this a secret might be contributing to your worries?

I close my eyes and sink into the chair and out of the room; I tune into the traffic that circles the building. I am standing at the lights watching them cycle through red to green. Sometimes I am aware she is still talking, explaining things or reciting learnt platitudes. Nine minutes into a mindfulness session she asks why I'm watching the clock and we end the session early.

The seven psychologists that come after her and before Chris commit similar offenses: interrogating my sexuality, worksheets that would make an 8-year-old feel bored, CBT until I want to scream.

At 16 I'm so tired of fighting it that, for a while, I just nod and agree with what they say and fill in the worksheet on the bus to my appointments. I become an expert at mind-maps, lists and values charts, but the tightness in my chest doesn't go away.

By 18, new counsellors get caught in the residual crossfire of their colleagues and I find innovative reasons to fire them: the room is too small (or too big), their waiting room makes me queasy, I don't like the photos of their kids that stare at me as I talk about childhood.

The route of the Melbourne bus clatters past Chris' office on time after every appointment. Inside the room, I wonder if the bus driver ever worries when they don't see me parked on the wire chair outside or if someone should tell the psychs that their clients have an audience.

Chris, initially, is on his way to committing many of the same sins as his predecessors. Paisley with stripes on his shirt? Too distracting. Fake Chinese proverbs hung on ornamental curtains in his waiting room? At best patronising and at worst racist. Using an iPad to take notes? I nearly walk out of the first session.

> Tell me a little about why you're here today.

I could also start with the youth psychologist just before him. Her office was filled with miniature plastic figures. Every surface was covered with them like she had a habit she couldn't ever quite satiate. There were tiny green statues up to half scale figurines of characters I didn't recognise; a slim lamp in the corner basked us in yellow. She sat opposite me and talked me through my confidentiality as I catalogue. Spirituality, it is revealed, is key for her. Homework is essential, noting down feelings and keeping track of my dreams. We write letters to the people who've hurt me and I cry at an empty chair, the chorus of plastic figures watching on. The full spectrum of emotion starts to open up to me, tearing at the seams until its own momentum is doing the work and making space for me to climb inside. But then it is happening too fast and I am nose diving into the rip. Like an old time cartoon on loop, crumpling against the hidden concrete and lining up to dive again and again with a smile on my face. I sit in her office and beg for answers.

> It sounds like you're asking me for something, something I can't give you. I can't give. It has to come from you, you need to know what the answers are.

I choke out something about how I have tried looking. That what I need right now is someone to say they understand, it's not my fault, and that sometimes we can't predict how unlocking the past can affect us in the present. That of course I thought I knew it all, because I'm 19 and felt indestructible, but right now I am being destroyed and don't know how to stop it. It will be another 3 months until a kind doctor offers me some reading on OCD and walks me through a checklist of symptoms, ticking almost every box as I explain the last few months. But right now, she just looks at me and a week later sends me an email with helpline numbers.

I look at Chris and think about telling the truth. That I have thought many times I'm done seeing psychologists and counsellors because I don't think I can handle another disappointment. I look at him and remember looking at all of the rest and knowing they were trying their best but that something was missing. Maybe part of that was that they weren't the right fit. Looking at him now, though, I also know that there is a part of me so sure that if they had listened to me, seen me as more than a scared kid who didn't know enough to advocate for herself or make decisions about what was best, deviated from clinical language and diagnostic criteria, laughed with me and let me be messy and vague and (sometimes) a bad patient, maybe I would have stuck around.

» I don't trust medical professionals

The skin around my thumb is nibbled and I'm making short work of the pointer finger next to it. Chris laughs, as he often does.

» "Well that's good then…because technically I'm an allied health professional." I laugh too; baiting him doesn't seem to be working.

The first few sessions with him are a test. I lay out my well-worn traps and wait for him to walk straight into them. I tell him I might quit, he nods and asks why and doesn't make promises. I ask him about his life, he doesn't give much away but offers me enough so that he doesn't feel like a stranger anymore. When I feel like I might walk away he holds the door open and asks if I know the way home. He lets me think I'm sprinting in front even when he's ahead laying down the safe path for me to travel.

At 21, I manage my own appointments, pay my Medicare gap out of my own earnings, and share the waiting room with 30- and 40-somethings looking for the same answers I am. I think the further you go with therapy the more you realise the basic rules don't change no matter your age; it is best done on an empty bladder and full stomach; your psychologist's method of note-taking is not an indicator of their morality; sometimes when a psychologist or counsellor says they understand, they mean it more than you can comprehend.

What changes is that when you're young, and unwell, you have to fight to have control and no one is going to give it to you easily. You will instinctively distrust anyone who claims to know what you have been through. It will seem like there are insurmountable reasons to quit. What I know now is that the trick is knowing if the reason is me, or them or bigger than both of us.

When I make Chris laugh I feel like I'm winning at therapy. I think that might be an unhelpful thought and one I should share but he has told me I should try to stop pathologising my behaviour. I have decided that maybe I just like to feel as if I am giving something back to him.

7.3.4 Finding the Right Community and Psychologist

Alessandra Chinsen

I was 16 the first time I was spoken to by a social worker. In a corner of Alf's, the food court attached to the hospital my mother was in, I picked tepidly at a soggy blueberry muffin while she asked me how I was. It had been a few months since my mother had been diagnosed with acute myeloid leukemia, and my life had quickly blurred into an interminable cycle of school and sickness. Days previously concerned with grades, friends and crushes had been replaced with bone marrow, platelets and chemotherapy. I went to my classes, picked up my younger sister, and spent the afternoon at the hospital.

I told the social worker that it had been hard, and that I was not doing well. Although she seemed genuinely concerned, she eventually returned me to the ward with nothing more than an aphorism and a business card to show for it.

In the months that came after that, social workers, teachers and school counselors followed a similar script. They invited me to cafes, classrooms and offices. They asked me how I was, encouraging me to uncover and examine my feelings and memories. They eventually returned me to my family with a platitude and a sympathetic look.

While they sincerely tried to help, the advice that they gave me always seemed to require time, money or energy that I did not have. I said that I was tired, and they told me to exercise (but I was at the hospital until seven or eight o'clock each night). I said that I couldn't manage the housework and caring, and they told me to ask my parents to hire a cleaner (but we could not afford it). I said that I was anxious about my mother dying, and they told me to do mindfulness (but my mother was dying). I would often leave their sessions feeling more helpless than I had before, placating their suggestions with nods and affirmations, but knowing that I would never be able to fulfil what they wanted from me.

My mother was discharged from the hospital as the school year ended. I picked up some bad habits in the lethargic, aimless summer that followed. I started going to sleep in the early hours of the morning and waking up at lunchtime. I stopped responding to my friends' texts. I downloaded a fitness app on my phone, and started tracking each kilojoule and calorie that entered and left my body, acutely aware of the imprint of each banana and muesli bar. The routine of school and hospital had been terrible, but it had at the least given me a purpose and velocity that occupied my time and distracted me from myself.

The social workers, counselors and teachers were no longer around to check on me. After the first few weeks of the new school year, they stopped altogether.

Sixteen is a lonely, vulnerable age, even more so when your mother has cancer. I needed the professionals in my life to understand that I was struggling to look after myself, and that my parents and family didn't have the capacity to help me either. I was unable to access most of the resources that they recommended to me. I would have been able to care for myself more successfully if they understood and empathised with the money, energy and time I had available. I also needed them to persist in their care, and to understand that the trauma of my mother's leukemia did not end when her hospitalisation did.

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I was 19 the first time I spoke to a psychologist. In a room furnished with tasteful leather couches and a plastic cactus, on the second floor of a terrace house, I fidgeted with a cushion while she asked me how I was. It had been a few years since my mother had gone into remission and been discharged from hospital, and a number of months since my brain had been filled with what felt like permanent static.

I had looked at the clinic's website at home and scrolled through the photos of the psychologists to decide whose faces I trusted. I had made a shortlist, but on my first, timid phone call to the clinic's intake team, I was told that none of them were seeing new clients and that their next available appointment was with her.

During our first session, I told the psychologist that I was doing pretty well, but that I had been experiencing some anxiety and nervousness. She proceeded by cycling through a checklist of different parts of my life, stopping to ask me if they were good or bad. My relationship with my parents. My friends. University. Job. Diet. Exercise. Sleep. The inquiry slowed when a potential trauma was identified (moving country, leukemia), and quickened when everything seemed to be under control (balanced diet, gym membership). By the end of our first session, we had talked about almost everything I had ever been through, except the anxiousness that had brought me there in the first place.

The psychologist quickly decided that I had generalised anxiety disorder, and we started working through the basic tenets of cognitive behavioral therapy. Mental wellbeing and recovery, I believed, were achieved through workbooks and activities. I was ecstatic that I had clear tasks to complete each week, convinced that if I did them well enough my brain would eventually slow down and become quieter.

The workbooks relieved my nervousness for a short period, but I quickly became fixated on each of the tasks they described. Identify the thought. Then do it again and again. Restructure the thought. Then do it again and again. Each attempt to neutralise my disordered thinking was quickly subsumed by a new one, and then a new one, and then a new one.

Although the psychologist thought that the therapy was helpful, the activities that she gave me often had no impact or seemed to make me feel worse. I knew that something wasn't working, but I didn't have the literacy or language to explain what, and she never asked. The psychologist seemed certain that I had an anxiety disorder that could be treated with this approach, and it felt like a failure to admit that my brain was actually growing louder.

I trailed off from the sessions slowly, at first telling her that I would be booking them further and further apart, and then stopping them entirely.

Nineteen is a chaotic, turbulent age, even more so when you have undiagnosed and untreated obsessive-compulsive disorder. I needed my psychologist to understand that I needed to build a trusting and honest relationship with her, and that it would take time. I was not comfortable discussing my traumatic experiences 15 minutes after meeting her, or being diagnosed with a mental illness half an hour later.

I would have been able to explore my feelings and treatment more effectively if I had trusted her, and felt that we had an open and mutually respectful relationship.

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I am 23 now. The food court and terrace house, locations that were once central to my life's geography, have receded to the back of my memory.

Despite this, each of the social workers, school counselors, teachers and psychologists that I saw throughout my adolescence played some part in my mental health and wellbeing today. The university counselor I saw for three sessions (the clinic's limit) solidified for me that I did not have generalised anxiety disorder, and unwittingly convinced me to see an obsessive-compulsive disorder specialist. The white psychologist I saw for one session (she denied that I had experienced racism) concretised for me that I wanted to see an Asian clinician who could understand my experiences. While some of them were not the right fit, the fact that they gave me a chance and wanted to help allowed me to find a community and psychologist that would eventually work just right.

7.3.5 Stop Calling Young People Apathetic

Lucas Walsh

'Stop calling young people apathetic. For many, volunteering and activism go hand-in-hand' was published in *The Conversation* on September 19, 2019.

► https://theconversation.com/stop-calling-young-people-apathetic-for-many-volunteering-and-activism-go-hand-in-hand-123754

Senator Jacqui Lambie has proposed establishing a Senate inquiry to increase the number of volunteers to address challenges such as climate emergencies (Crowe, 2019).

One way she suggests doing this is by conscripting young Australians to national emergency service. The Senator argues that:

> » today's generation don't really want to volunteer themselves and commit to certain things. They want to show up to a rally once a year and apparently that's giving back … It bothers me that kids today wouldn't know a bloody sandbag, let alone a spade.

Her proposal comes on the back of criticism of youth climate protesters by several prominent politicians, such as Resources Minister Matt Canavan, who has said 'the best thing you'll learn about going to a protest is how to join the dole queue.'

■ Young people are already volunteering

Collectively, these statements reflect a view of young people that is wildly inaccurate.

Firstly, Lambie echoes a familiar but negative view of young people as disengaged, indifferent and immature.

Volunteering rates are indeed declining. In 2014, volunteering declined for the first time since 1995, when the ABS started conducting national voluntary work surveys (Australian Bureau of Statistics, 2015). The proportion of people aged 18 years and over who were volunteering fell from a peak of 36% in 2010 to 31% in 2014. (This is the most recent data available).

Historically, younger people are less likely to engage in civic activities than older Australians (Office of Youth, 2009). But wider research during the last decade suggests something more nuanced.

A national youth survey in 2018 found volunteering to be one of the top three activities for young people—ahead of arts, culture and music activities (Mission Australia, 2018). ABS figures from 2014 also showed that while overall rates of volunteering were on the decline, young people aged 15–17 had the highest rate in the nation at 42%.

The measures used to track volunteering also fail to capture the breadth and depth of volunteering that takes place among young people.

The ABS has defined volunteering as: 'the provision of unpaid help willingly undertaken in the form of time, service or skills, to an organisation or group, excluding work done overseas' (ABS, 2018b).

For young people, many types of volunteering take place invisibly through online activities like constructing news groups on Facebook that contribute to a wider cause. Such online activities may not be for a particular organisation or group and may be conducted internationally.

In addition, the boundaries between personal and civic contributions are sometimes blurred. For example, volunteering in some culturally and linguistically diverse communities is just part of life, and not considered to be volunteering.

Similarly, research has shown that some young people don't necessarily think of activities, such as umpiring a local sporting event, as volunteering, because for them it is just an interesting pursuit (Walsh & Black, 2015).

As a result, these contributions by young people sometimes go unrecognised.

Acknowledging that its definition does not account for informal volunteering like this and other activities such as activism, the ABS is now seeking to capture a broader range of volunteering activity and characteristics (ABS, 2018b).

■ Protesting is an equally valid way of giving back

Young people are also increasingly motivated to take part in another form of civic participation: peaceful protest. For many, protesting for important causes is considered an equally valid way to give back to society.

The most prominent example of this are the student climate strikes around the world that have been galvanised by youth activist Greta Thunberg. Thousands of Australian students are expected to walk out of their classes again on Friday.

Jonas Kampus, a 17-year-old protester from Switzerland, described the importance of these efforts to the Guardian: 'For people under 18 in most countries, the only democratic right we have is to demonstrate. We don't have representation.'

Canavan has a different view, saying that young people "don't learn anything" from leaving school to protest.

But experiential learning through activism can be powerful and connect people to finding common solutions. Education isn't just about securing future jobs, as

Canavan has suggested. It's also about developing inquisitive, creative and critical thinkers who fully participate in society.

Young people throughout the world are demonstrating these attributes and participating in ways that do not register in conventional measures. Many are actively engaging the challenges facing our society and are acutely aware of the value of education.

There is another important connection between protesting and volunteerism. One international study has found that 'people involved in voluntary associations are up to five times more likely to make political demands than those without such membership.'

University of the South Pacific researcher Jacob Mwathi Mati and his colleagues argue that activist movements can serve as "schools of democracy that teach civic skills and foster civic attitudes" (Mati et al., 2016). Taking part in climate change protests, for example, can build capacity for citizen engagement in the same way as more traditional forms of volunteering.

The great majority of politicians are hardworking and dedicated to making a difference in society, and painting them with broad-brush criticisms that reinforce negative stereotypes does not do them justice.

It's equally unfair to reduce young people to passive and clueless individuals in need of compulsory volunteer conscription.

7.4 Experiential Activities

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant and they should provide participants with ways to resolve feelings that may arise as a result of the activity including reflection and debriefing.

Activity 1
Title Privilege statements – Ageism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to ageism. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. My professionalism is never questioned because of my age.
2. When I go shopping, I can be fairly sure that the sales or security people will not follow me because of my age.
3. I can be sure that my age will not affect my employment prospects.
4. I often feel that people don't take me seriously because of my age.
5. I often feel discriminated against because of my age.
6. I can be pretty sure that if I ask to talk to the 'person in charge' I will be talking to someone of my own age group.
7. I can be confident that if I had a car accident, people wouldn't blame my age.
8. I have never been the punch-line of jokes because of my age.
9. People never assume I am set in my ways.
10. I have never been spoken down to or ignored because of my age.

Are the scales balanced, or tipping one way or the other?

■ Questions

Reflect on the following questions:

1. How did you feel doing this activity?
2. What does it feel like to have, or not have certain privileges?
3. Can you identify other privileges that you may or may not experience?

Learning outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privilege, students become more sensitive to the multifaceted nature of ageism (both young and old) within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ▶ https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title Changing priorities

Purpose As a person grows older, they may experience both explicit and implicit constraints. The explicit constraints can be physical and financial, but there is also a range of implicit constraints associated with personal and cultural age norms that may become internalised by the individual. In this activity, participants identify their own top priorities in life from a list, then narrow this list down based on what they believe will be important as they age.

Process Develop a list of 10 personal life priorities that you feel are essential for your quality of life *now*. Include at least one life priority from each of the following domains:

- Health
- Physical ability
- Intellectual ability, including memory

- Friendship, including companion animals
- Family
- Intimate relationships
- Spirituality
- Community
- Work
- Independence, including choice

Imagine yourself in 20 years, and you have to give up five of your personal life priorities due to ageing. Imagine yourself 30 years from now and cross off four more. You only have one of the original life priorities left.

Questions

These questions are for group discussion and/or personal reflection:

1. What motivated you to remove certain priorities each 15 years?
2. How did you feel as you gave up some of your original life priorities?
3. Were you surprised at the top priority chosen by others? (if discussing this)
4. Did you remove any priorities based on your beliefs about norms of ageing?
5. How could the removal of these priorities affect quality of life?

Learning outcomes Students develop an understanding that the process of narrowing options as a person grows older may be influenced by social norms, stereotypes, and personal beliefs.

Adapted from Pedersen, P.B. (2004). *110 Experiences of Multicultural Learning.* Washington, DC: American Psychological Association.

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Ableism

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Vicki Hutton, and Susan Sisko

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V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_8

Trailer

In this chapter, Sarah Wayland and Jennifer Smith-Merry explore the complexity of ableism and its relationship to mental health and identity. Sarina Rakidzic and Amie O'Shea remind us that disability is only one part of identity through Sarina's poignant story of growing up with a pervasive developmental disorder, while navigating the meaning of identifying as lesbian. Richard Schweizer explains the complexity of living with schizophrenia for 16 years and the subsequent transformation of identity. And finally, Kate Gill describes the trauma and identity implications when living with an invisible disability and subsequently a visible disability, and her journey to find a place in society.

8.1 Introduction

Vicki Hutton

Defining disability is a complex task, often dependent on the perspective or theory being adopted. The World Health Organisation (WHO) emphasises that disability is not just a health problem. Rather disability is an umbrella term to cover impairments, activity limitations and participation restrictions (WHO, 2019). At a more pragmatic level, Australia's National Disability Insurance Scheme (NDIS) specifies in their assessment of disability requirements that the impairment must affect an individual's capacity for social and economic participation (National Disability Insurance Agency, 2019), drawing attention to inability to work as a key marker of fitting into society.

Definition

In Australia, the *Disability Discrimination Act 1992* (Cth) sets some clear parameters around what constitutes disability, thus providing a broad definition for concept (Australian Network on Disability, 2019). These include:

- Total or partial loss of the person's bodily or mental functions
- Total or partial loss of a part of the body
- The presence in the body of organisms causing disease or illness
- The malfunction, malformation or disfigurement of a part of the person's body
- A disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction
- A disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment, or that results in disturbed behaviour.

A person may be born with a disability, or acquire it later (for example, through accident, illness or ageing). A disability may be visible, or invisible; permanent or temporary; and vary in the impact it has on a person's abilities. This means disability is best understood on a continuum, ranging from having no impairment or limitation to profound or complete loss of functioning or ability to complete a task (Australian Institute of Health and Welfare [AIHW], 2019).

Important

Approximately 4.3 million people, or one in five people, in Australia have some form of disability, including hearing loss, vision impairment, mental health conditions and mobility limitations (Australian Network on Disability, 2019). About half of this group is of working age (i.e. 15–64 years), but overall, disability is more likely to affect older people. For example, 3.4% of children aged 4 years and under are affected by a disability, compared to 10% of adults aged 25–34 years, 40% of adults 65–69 years and 88% of adults aged 90 years and over.

While there is consistent evidence that people living with disability face significant barriers in work, study, sport and joining in everyday activities (Australian Human Rights Commission, 2012), there are many challenges in developing a complete picture and understanding of the experiences of people living with disability in Australia. Contributing to this lack of understanding is the different data collection sources, each defining disability in different ways depending on the purposes for which the data is collected (AIHW, 2019). One consistent finding suggests that people living with disability generally have lower rates of participation in the labour force, lower levels of educational attainment, and higher unemployment when seeking to enter the labour force (AIHW, 2019). For example, graduates with disabilities can take 56.2% longer to gain full-time employment compared to other graduates (AIHW, 2019). Inevitably this can result in lower levels of income.

Community attitudes and experiences of discrimination can further impact on a person's wellbeing. The medicalisation of disability, combined with everyday social impediments, such as higher rates of poverty and unemployment and continued difficulties with the physical environment (for example, access to buildings and public transport), positions people with disabilities as "less than" those without disabilities. The resultant ableism can lead to perceptions of the disabled as weak and needy, and experiences of rejection and oppression (Palombi, 2010).

This can also lead to violence or threats of violence, with one in seven people with a psychological disability or intellectual disability reporting experiences of violence in the Australian Bureau of Statistics 2016 Personal Safety Survey (ABS, 2018). One in 20 people with physical disability reported having experienced violence in the survey. People living with disability were also more likely to report stalking experiences (3.1%) compared to those with no disability (2.1%). There is evidence that over one third of women and over one quarter of men with disability avoid situations because of their disability.

As with ageism, the diversity of persons living with disability means that many also fit within other minority communities based on gender, spirituality or religious affiliation, social class, race or ethnicity and sexuality. There is some evidence that they are at risk of becoming oppressed or ignored within these groups, thus compounding experiences of ableism at multiple levels.

8.2 Understanding the Judgement of Others: Ableism and Mental Health

Sarah Wayland and Jennifer Smith-Merry

8.2.1 What Is Ableism?

Questions

Before this section starts, answer these questions:

- Look at the space in which you are reading this book. What bodies and minds is that environment created for?
- Now think about some of the common terms of ridicule used against other children when you were a school child. Can you identify particular terms of ridicule that specifically spoke about people with disability or mental illness?
- Now think about movies and TV. How are people with disability and mental illness portrayed in those? Are they heroes, villains, or just normal people?

Answering these questions truthfully may make you a little uncomfortable because it may show to you that the world around us, including the environments that we create ourselves, are often created in a way that either directly or indirectly discriminates in relation to disability.

Ableism refers to discrimination on the basis of ability. It arises from a belief that people with disability are inferior. This belief may be consciously held or exist as a subconscious belief that people do not even recognise in themselves. Beliefs about the inferiority of people with disability may give rise to discrimination which can be deeply damaging both physically and mentally.

► Example

Historic examples of discrimination brought about by ableism include Nazi programs of genocide which involved the murder of people who were classed as disabled, mentally or physically feeble, or genetically inferior. Estimations of total numbers of deaths differ, but upwards of 70,000 people (and perhaps as many as 300,000) were killed through their 'Aktion T4' program over the years 1939–1945. This type of extreme discrimination was most associated with Nazi Germany, but other forms of state-sponsored discrimination, such as sterilisation, have been practised much more widely throughout the world. In the USA, programmes of forced sterilisation of people with disability first occurred in 1907, with other countries soon following. Germany's program did not start until 1933. Women and girls with disability still undergo sterilisation throughout many countries, including in Australia (Elliott, 2017). ◄

Forms of Ableism

Ableism can be overt and direct, normalised or indirect. Each form of ableism has a different meaning and impact on the individual.

Definition

Overt ableism refers to stigmatisation of people with disability and associated discrimination and poor treatment such as those examples above. Other examples include hiring practices, where an employer will pick a candidate without a disability over one who does even if the person with disability is more experienced. Children may also be actively excluded from mainstream schools because of disability.

Normalised ableism refers to a world that assumes an 'able' body and 'normal' mind. This type of ableism is a 'normalising' form because it assumes certain normalised attributes and creates environments (such as schools, streets, houses, playgrounds) which meet only those attributes. Schools are a good example of this because the physical structure, classroom routines and interactions are developed in a way that actively excludes people with some forms of disability.

Internalised ableism occurs because ableism is not just held by people without disability, rather it may be internalised by people with disability themselves. People with disability are just as subject to generalised stigmatised social messaging about the inferiority of people with disability as anyone else.

Saneism, sometimes referred to as 'mentalism', is a related term to ableism and refers to discrimination against people who experience mental illness. Mental illness is highly stigmatised in most societies with many people holding stereotyped views of the capacities and attributes of people who experience mental illness, including that they are dangerous or lack insight. These stereotypical views lead to overt and covert discrimination against people with mental illness.

People with disability are also subject to direct discrimination, such as that arising from living in an ableist world. There are few messages in society that counter these messages by portraying positive images of people with disability which individuals can self-identify with (Campbell, 2009).

While ableism is the term most frequently used in Australia, disablism is used in similar ways in other contexts, such as in the UK and Europe. They are often used interchangeably. However, some disability rights activists prefer to use the term 'disablism' instead of ableism, as a form of political action. This is because they think to use the term 'ableism' puts the focus on ability, where 'able' bodied is the norm and those who are disabled are abnormal because their bodies are different. It is linked to the 'medical model' of disability which focuses on the physical rather than the social context of disability, which is the focus of the alternative 'social model' of disability. People are defined as dis-abled or not abled where 'able' is the norm. Ableism puts the 'problem' of disability onto the body of the individual being faulty, rather than on society's practices towards people with disability. There are some links at the end of this chapter to blog posts from disability activists which comment on this more.

8.2.2 What Is the Current Experience of People with Disability and the Impact of Ableism?

In the early sections of this section, we explored the ways in which ableism can occur and the definitions that will allow health professionals to respond individually and collectively. This part provides you with an opportunity to understand what is at the core of ableism and information to illustrate how ableism impacts people and the broader community allowing people to take action.

For a moment, have a think about your own community and the plethora of daily interactions you will have. The transport system, the built environments, such as access to buildings, walkways and even the institutions we engage with—universities, hospitals, health care services. What you will find is that these spaces often promote access and inclusion of able-bodied people, rather than understanding the complexity of physical and psychosocial abilities of the people who exist within any community. Wolboring (2008) identifies that ableism values certain abilities, and that alternate abilities or those that are sometimes referred to as disabilities, are viewed as 'less than'. This can impact a person's identity, their sense of self and how they move about the community that they live within.

8.2.3 How Does this Relate to Mental Illness/Mental Health?

Current Australian data from the National Mental Health Commission (2014) states that almost four million Australians live with or are impacted by mental illness, with 690,000 Australians living with severe mental ill-health. People living with complex and severe mental health conditions are impacted in terms of how they engage with the community—through their capacity to sustain ongoing employment, to receive care that is person-centred as well as being receptive to the changing nature of their medical condition.

The lived experience of mental health and barriers that are experienced when people seek to live a life of their choice, as well as access health care (in terms of delivery of health related services, consumer involvement in medical research and broadly in the way that mental health is understood and supported by the community) can be impacted by the stigma of the community's understanding of mental health. Stigma, is the term used more often than ableism. Stigma may relate to the ways in which a person's illness is accepted, the community's capacity to tolerate the uncertainty or fear of mental illness and the lifelong nature of some conditions. This stigma can be exacerbated by the invisible nature of the disability, or by misunderstandings about the impact of the disability on the person's capacity to have choice and control as to how they live their lives. In Hancock, Smith-Merry's, participants located in the western suburbs of Sydney, Australia, reflected on their recovery journeys in learning to live with complex mental health conditions.

In terms of stigma, some reflected that the judgment that was directed at them results in a personal battle to reassert their own self in relation to others' stigmatising attitudes:

► Example

> » … she had become, "antisocial, to protect everyone else from me". Some participants talked about finding the strength to overcome self- and others' judgement and about starting to be gentler and kinder to themselves….one participant described her strength in overcoming previously hurtful comments from others: "you've got a choice either to let it get to you or... use it to… gain your inner strength". (Hancock, Smith-Merry, Jessop, Wayland, & Kokany, 2018, p.5) ◄

SANE Australia, an Australian mental health charity and service provider, identified that the negativity attitudes or beliefs from other people's misunderstanding or prejudice around mental illness can be 'as distressing as the symptoms of their illness' (2018). In addition to these reflections on the lived experience of mental illness, Holley, Stromwall, and Bashor (2012) noted that the labelling process (such as an emphasis on their diagnosis) that occurs with people with persistent mental health conditions, can be *othering*, leading to feelings of isolation and loneliness as the person attempts to engage in the recovery process of living with a mental illness.

Remember that the responsibility to challenge or 'live with' stigma does not rest on the person who experiences ableism. The responsibility, as explored further within this section, also asks that health professionals challenge the existence of ableism in the community.

8.2.4 What Happens When Comorbid Conditions Are Present – How Can These Be Acknowledged?

Co-morbid conditions refer to medical conditions that occur alongside each other. The Australian Bureau of Statistics (2014) reports that 15.8% of all Australians reported co-existing long-term mental and behavioural and physical health conditions. Bahm and Forchuk (2009) refer to interlocking oppressions when a physical condition occurs with a mental health condition, and the associated impact of that stigma that comes from the community. This stigma can create a double disadvantage given that people with a physical disability are more likely to experience stigma when accessing housing, public spaces or leisure activities, as well as some of the barriers relating to employment and fair work conditions. In addition, the barriers are created when a mental health condition is disclosed as people may be feared by others, due to their ignorance around the presentation or impact of the condition, or the way their needs are understood when they are spoken about in the community, including the media. The World Health Organization (2005) defines mental health as: "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Recognising that a state of well-being incorporates both the mind and the body, not two separate entities, is important in understanding the barriers that are sometimes created for people when accessing the health system and the need for a holistic approach to care.

The next part of this section explores policy and practice directives that provide a safety net for people with psychosocial disability when engaging with the community and the systems that are provided to address their health needs. The role of the health professional is twofold: to ensure awareness of legislation and policy to guide their practice, as well as the role of advocacy in ensuring that people who may be silenced by the way the community responds to their disability, are advocated on behalf of.

8.2.5 Policy and Practice Relevant to Addressing Ableism

Prior to understanding the need for awareness of policy and practices (relevant to the Australian health context), you should also reflect on your own values and assumptions about addressing ableism. These assumptions, that impact professional practice, must be reflexively explored relating to both perceptions about a person as well as awareness of the structural health inequalities that might also exist within the systems people work within.

Once you have reflected on your own assumptions, the following frameworks or policies can then underpin the delivery of health-related services:

- The *UN Convention on the Rights of Persons with Disabilities* (2006) (of which Australia has signed). The UNCRPD (Article 1) seeks to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities’, and to promote respect for their inherent dignity. Meaning that, in order for health professionals to uphold the convention in their work with a person, the following core values should be paramount: the equal right for people to have choice and control over the way they live life—where they live, work, who they choose to partner with—as well as a focus on full inclusion and participation in community. Article 25 of the Convention goes on to state that the role of the health professional working with people with disability should be awareness of the person’s human rights, right to dignity, autonomy and needs. This can only be achieved by providing space for the person to share their lived experience and to be actively engaged in decisions about their health and wellbeing.
- The Federal *Disability Discrimination Act 1992* seeks to provide protection to everyone in Australia against discrimination based on disability. It encourages everyone to be involved in implementing the Act and to share in the overall benefits to the community and the economy that flow from participation by the widest range of people. It is important for health professionals to understand that disability discrimination happens when people with a disability are treated less fairly than people without a disability are. Disability discrimination also occurs when people are treated less fairly because they are relatives, friends, carers, co-workers or associates of a person with a disability. In a mental health

context, this might include people being excluded from employment on the basis that their diagnosis might exacerbate use of sick leave, or by not understanding or including people in discussion about workplace modifications or awareness of the person's individual needs.

- The National Disability Insurance Scheme (NDIS) is implemented by the National Disability Insurance Agency (NDIA) and is guided by legislation outlined in the NDIS Act (2013). The scheme, and governing agency, was developed as a way to provide insurance cover for Australians under the age of 65, who live with a permanent and significant disability that impacts their daily life. From a mental health perspective, the scheme has revealed a significant gap in terms of its capacity to provide for those with severe mental illness. The *Mind the Gap* report (2018) by Smith-Merry, Hancock, Gilroy, Llewellyn and Yen identifies, from an ableism perspective that one of the reasons for the low uptake of the scheme for people living with complex mental health is that 'the language of disability and permanence does not fit well with the language of recovery and is alienating for people who do not wish to consider themselves as having a life-long disability but nevertheless would be eligible (2018, p. 5)

8.2.6 Listening Out for Lived Experience Expertise

Awareness is only one step in acknowledging the impact of the structural, cultural, physical and political environments that surround people, when living (and in many cases living well) with a mental health condition. Without challenging the environment, the perceptions of others and the way help-seeking is structured (such as the provision of services via the NDIS), the promotion of a culture where we fail to see people as being inherently different from each other is perpetuated. This form of ableism impacts the way people experience life and the political, institutional and social barriers they may experience.

8.2.7 Conclusion

In summary, this chapter presents that the role of the allied health professional is to recognise the diverse impact that experiences of ableism may or will have on a person's life. By listening to the stories of those who seek help from a health professional, alongside challenging your own thoughts about the perception of people living with a psychosocial disability, or our own lived experience, we provide an opportunity to challenge the ways in which ableism impacts the lives of people with mental health conditions.

Overview

- Ableism refers to discrimination on the basis of ability. It can be a conscious or subconscious belief that people with disability are inferior. In some places, ableism is referred to as disablism.

- Saneism, sometimes referred to as ‘mentalism’, is a related term to ableism and refers to discrimination against people who experience mental illness.
- Stigma is the experience of being ‘othered’ or misunderstood in terms of a persons lived experience of mental ill-health.
- In some circumstances, the impact of this ableism or stigma can be worse than living with the health condition.
- There are opportunities for health professionals to develop a framework of practice that emphasises the human rights approach to provision of mental health care—using the UNCRPD, the Australian Disability Discrimination Act (1992) and understanding the goal of the NDIS, alongside seeking to address factors that have created a low uptake of the scheme for people with complex and severe mental health.

► Example

Resources for readers:

Blogs:

https://stillmyrevolution.org/2013/01/01/disablism-or-ableism/

http://lisybabe.blogspot.com/2008/05/disablism-vs-ableism.html

http://meloukhia.net/2015/06/ableism_disablism_and_language/

► https://mydissociativelifeblog.wordpress.com/2016/05/09/living-disabled-in-an-able-bodied-world/

Laws:

United Nations Convention on the Rights of People with Disability: ► https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

Disability Discrimination Act (1992): https://www.humanrights.gov.au/our-work/disability-rights/guides/brief-guide-disability-discrimination-act

Websites:

National Disability Insurance Scheme: ► https://www.ndis.gov.au/

Australian Human Rights Commission: ► https://www.humanrights.gov.au/

People with Disability Australia: ► https://pwd.org.au/ ◄

8.3 Personal Stories and Current Affairs

8.3.1 The Rubik’s Cube

Sarina Rakidzic and Amie O’Shea

> I’d like to compare my life to a Rubik’s Cube. It has four sides, and you are thinking about lots of different things trying to work it out. My life has lots of sides to think about. It is challenging, but even getting one side down is a beautiful feeling.

My name is Sarina Rakidzic. I live with my mum and stepdad, and my three dogs and a cat. I'm 32, and 100% lesbian. I grew up in Melbourne. I lived with my grandparents and with my mum. When I was 3 years old, I was diagnosed with pervasive developmental disorder (mild intellectual disabillity).

I had a lot of help from the special day care I went to and I also had a teacher's aide throughout my primary school years. After that, I went to a special school for high school. Being a lesbian in high school was tough! I didn't want anyone to know because I knew they would treat me badly.

I had my first lesbian relationship with someone who treated me terribly so it left me with scars, but I moved on and I had a few short term relationships which have taught me a lot.

Having a disability, people target us because they think so little of us. But we are unique and special in our own way—why should people belittle us when we are just trying our best? Maybe they haven't met people with intellectual disability, but guess what? We are awesome!

I really like being around other lesbians, but sometimes it's hard. You try to talk to them and they just dismiss you. I like being around lesbians because they understand what you have been through, it is also hard being around lesbians because they don't understand your disability and that can be frustrating because, at the end of the day, you just want to be loved and to be treated as an equal, not an outcast.

Being Serbian, some people don't accept lesbians and that's not a good feeling. But otherwise, I'm proud of being Serbian and my family too.

Amie and I go and talk to people about our lives, being a lesbian and what it's like for me having an intellectual disability. I tell people that they should respect that people with intellectual disability are sexual just like anyone else, and that we have the same rights to respectful relationships. I tell them about the time that the doctor said I didn't need a pap smear, even though I knew I did. And the time my teacher said that girls can't go kissing girls.

Here's the number one thing I want you to know. I'm gay and proud. But you don't have to be fully out and proud to be proud of who you are. Being proud can look different, it is not always marching down the street with a flag on. I have to think about things before I tell people—like, will I be safe? What will happen?

There are staff and other people who, if you have an intellectual disability, are in your life and you don't get to choose if they are there. You have to be smart and know that you can make decisions about who to trust. I only tell people if I feel like nothing bad will happen. But that doesn't mean I'm not proud, it just means I get to make the decision who knows about me. I'm in control of that.

8.3.2 Never Give Up: Living with Schizophrenia

Richard Schweizer

I was having dinner with an old friend of mine and his family. We hadn't seen each other for many years, but we were close when I first developed schizophrenia. His mum was a psychologist, so he already knew a bit about mental illness. We were talking about the symptoms I had experienced, the blessing of medication, and the changes in my personality since I became unwell.

My friend relayed to me a comment that I had shared with him in the early stages of my illness. I had said, "These drugs have saved my life". I was talking about Clopine, which I still take today. He also told me something else. He told me that I had said to him, "I was hearing voices telling me to top myself".

This floored me.

I knew I had heard voices that said to me, "Ha-ha, you're going mad". That particular fear—fear of losing my mind—had always been especially intense for me, as I had so often relied on my mind in study and work. I also knew that I had been feeling suicidal at the time. But I could not remember these two symptoms of voices and suicidality arriving together.

Perhaps, I shouldn't be surprised. My memory around this time is hazy; particularly in the clinic, where I was on sedatives and the days blurred into the other.

I'd like to tell you a little about the symptoms I was experiencing.

I had cognitive challenges– I found it difficult to concentrate in group activities.

I had a handful of other symptoms too. I had delusions of reference, where things relevant to my condition seemed to "jump out" at me from the television or, in one bizarre incident, I saw a dancing fish toy in a toy store. It is a little difficult explaining what a delusion of reference feels like. It's kind of like parts of the world, such as television or radio, "jump out" at you with a particular significance for you. It's almost as if the television or radio or whatever is "sending you a message".

I had visual flashes of violence happening to my girlfriend whenever I saw her. I couldn't explain it, but it frightened me that I might one day act on these visual flashes.

I had very strange, distressing and intrusive thoughts. In the clinic, for example, I remember one day in the shower very clearly hearing the thought "Kill Bob Dylan". Again, I did not know if I would act on one of these thoughts, but the intensity of the thought was frightening.

And, of course, I heard the voice, mocking me for losing my mind and, evidently, telling me to take my own life.

I have to say, with these symptoms, I often felt like my mind was an island of sanity in an encroaching sea of irrationality. I was suicidal and I didn't know if I would cause harm to myself or harm to someone else. For me, that was the sticking point. The point of reaching out and when I first went to the clinic I couldn't be sure I wouldn't do any harm to myself or to others.

The mental health clinic that I stayed in is a strange place. It is simultaneously very calm and very unnerving; everybody there is going through some heavy challenges. I didn't really make any friends there, but I do value the social connections I made. I remember one young man with bipolar who told me he had decided to "fight for the light". I remember another girl telling me "managing schizo-affective disorder is a bitch". I know she was trying to empathise with me, but her remark upset me deeply because it made me feel helpless, hopeless.

Tip

At this point, I would like to make an observation parallel to this account. I believe that one's social network, and particularly a supportive family, can be vital for helping to recover from mental illness. This is especially so for schizophrenia, where people close to you can give you practical and emotional support, and even distract you from symptoms of the illness. Because of this, I feel that being put in a clinic, essentially alone and cut off from social and familial networks, may not be the best place to be for treatment of mental illness.

Certainly, receiving visitors when in the clinic is very important. When you are in a regular hospital with a serious non-mental illness, people come to bring love, bring cards, bring flowers. In a mental clinic, I guess they are not sure what to do. However, as with many illnesses, the lay public cannot help directly. Don't get me wrong—I think love and support is incredibly important for people struggling with mental illness—but I guess it must have been frustrating for friends and family seeing a loved one who is seriously unwell.

I was in the clinic for almost three months, over two stays. I needed to be in there while they tried different medications and waited to see the effect. This meant I tried a number of different anti-psychotic medications before I settled on what I take now – Clozapine. Clozapine is generally taken as a final resort as it requires a monthly blood test. The process is for two psychiatrists to agree that the drug is necessary before it is prescribed.

Luckily, the Clozapine has worked very well for me, and I have no ongoing psychotic symptoms. Unfortunately though, the drug has side effects. I sleep 12 hours a night and have put on a lot of weight, but I am in a good place.

In saying this, I had a few other factors on my side. I guess, despite the seriousness of the illness, I was lucky. First, I had insight into my symptoms, and I knew I was not actually "receiving messages" from the TV—it just felt like I was. I knew the voice, as unpleasant as it was, was not a thought broadcast into my mind. I was pretty sure that the visual flashes were just that—flashes, not commands or alternate reality. I also had a very rational brain, which I think helped me achieve insight, even if that rationality was an island in an encroaching sea.

Secondly, and one thing which has become clearer to me over time is that having a caring, understanding, and loving family is important. I am told by my mum, she picked me up every evening from the clinic to have dinner with the family at home and dropped me back at the clinic again. They never blamed me, never abandoned me, and never gave up hope that I would recover. I remember when I first came out of the clinic, my dad had bought me a print of a John Lennon drawing as a gift of love, to show he cared. The message written on it by John was "He tried to face reality", a message I felt was somewhat poignant. In more recent times, if I ever have an emotional challenge that gets me down, my brother is always there to support me.

Thirdly, I have a great professional support team behind me. I have a wonderful GP who is supportive and has seen me through some bad times. I have a great psychiatrist, who is positive and insightful. I see an alternative health practitioner too, from whom I receive wise counsel. And when things are tough I have a great psychologist, who is both analytical and compassionate.

So, here I am now, 16 years after first developing schizophrenia and I have come a long way.

I still sleep a great deal, and can only work part-time. But I have completed multiple degrees including a PhD research project. My PhD was about the sociology of schizophrenia. The thesis focused on the transformation of identity in people experiencing schizophrenia and having been diagnosed with schizophrenia. I could write about the thesis at length, but I don't wish to bore you! Suffice to say, about two-thirds way through the project I realised that I, too, had gone through a change of identity with the illness. I had gone from someone fairly extroverted, active and confident to someone more introverted, shy; also someone who was a bit more driven about improving the treatment of people with mental illness.

In my recovery, I also took on part-time work in the mental health sector. I currently work at One Door Mental Health as Policy Officer and as an advisor for the NSW Mental Health Commission. I share my story with students, support groups, academics and anyone who will listen.

With the perspective that the past 16 years has given me, I want to emphasise the importance of focusing on recovery. Recovery means something different for every person. It is deeply personal, and deeply connected to the individual's hopes and dreams. It is a journey—sometimes steps forward, sometimes steps back, but always on the path to that light on the horizon.

As bad as it can be, going through psychosis, getting diagnosed with a serious life-long mental illness, seeing your hopes and dreams go up in psychiatric flames; as bad as it can be—there is still hope. It may not come fast or easily, but with the right support and a positive team working with you, you can progress down your own recovery journey too.

I leave you with a saying from one Winston Churchill, "When you're going through hell, keep going".

Never give up. Recovery is possible.

8.3.3 Trying to Fit in: The Person Is Wrong, Defective and Needs to Be Changed

Kate Gill

We live in a society where we must be normalised in order to fit in and to be accepted. We are conditioned to live life meeting standard trajectories and standard socialised behaviours. People who don't follow a standard trajectory, who look different, who are different, who have different abilities and different needs, fail to fit in. They are excluded and made to feel like misfits that don't deserve to be present.

I was born with one disability, but over time, developed additional disabilities. From birth, I had a hearing disability, but it wasn't diagnosed till I was three years of age. My mum was convinced there was something wrong with me, but she couldn't pinpoint what it was. I seemed to follow directions, if she pointed to something and asked me to get it, I was able to follow cues and respond. In some ways, I appeared quite advanced, but in others, I was blank and not quite right. I didn't learn to talk like other kids my age. My parents couldn't believe that they would have a backward child. My parents repeatedly took me to the local family doctor saying something was wrong with me. The doctor tried to convince my mother that I was not backward but in fact was so intelligent I had my own language and had no need to communicate with the outside world. He advised I would eventually talk in my own time.

Sometime later, the local doctor's surgery would change hands, and a new young doctor, straight out of university, would become the family doctor. My mum looked at him with dismay, what would this young person straight out of university know? Yet in her first appointment with me, the young doctor announced that I couldn't hear and that was why I was not talking. We then went on a merry-go-round with doctors, ear specialists, surgeons, speech therapists and audiologists. I had repeated operations to try and fix the problems.

There always seemed to be something wrong with me that needed to be fixed. My parents took me out of school for appointments. The most important thing was, I needed to have "normal" speech. Mum was concerned the first thing potential employers would notice would be my speech, so I had to work hard at speech therapy to "normalise" my speech. She believed future employers would not want someone who sounded "deaf".

In the 1980s, FM transmitters were rolled out for hearing impaired children in the school setting. In principle, these devices were fantastic, in practice they were embarrassing, challenging and made me stand out as different and a problem. The original FM transmitters were bulky, heavy and looked like walkie-talkies. A teacher would wear a FM transmitter and I would wear the receiver which sent sounds directly to my hearing aids. Hearing wise it would make a huge difference. I could hear the teacher's voice clearly through my hearing aids and could concentrate and learn better. Yet, for the first few years of high school, I did not use the device much. I was not well supported at school. I found it embarrassing to walk up to the teacher in front of the class, to explain I needed her/him to wear the transmitter so I could hear. I was very self-conscious walking up in front of the class each lesson. Teachers didn't help me, I would be trying to give them the transmitter and they would ignore me and keep teaching. I had some teachers refuse to wear the device. Eventually it became too much and I stopped using the transmitter system in many classes. This impacted my marks as I would zosne out in class when I couldn't hear properly.

When I was 13 years, old a benign tumour was found in my right ear. It was operated on during the school holidays. I went back to school after the operation with my hair shaved off on one side, stiches around my ear and wound dressing. The kids took great joy in bullying me over my new and temporary look. I was physically bashed at the site of the surgery. I had to wear a bone conductor head band hearing aid as I was unable to wear the traditional hearing aid with the inner ear mould. This made it easier for the kids to pull off the hearing aid and throw it around the class room. The stressful challenges of being bullied for the way I looked post-surgery, and adapting and healing from the operation, led to me spiralling into anorexia, which took over my life for the next few decades.

To keep myself safe from the school bullies, I isolated myself in the school library at recess, lunch and after school. I began to compensate for all my deficits by studying hard. My marks improved, which helped my self-esteem. I started to use my FM transmitter in class so I could hear the teacher. My marks improved more. My world closed in. I spent all my time studying, I would get a high when my marks went up and my weight dropped. My perfectionism set in. I had to top every exam and every assignment. By the time I got to university, I was winning awards, prizes and scholarships for my high marks. I compensated for all my deficits by getting perfect marks. The obsession became huge. I had nothing but my marks. I was totally inferior and defective; all I could do was study hard and get good marks.

I was eventually admitted to hospital with severe anorexia and suicidal ideation. The treatment program for anorexia kept me physically alive but did a lot of harm. I was repeatedly punished for being underweight and not eating. I was isolated, not allowed to be with the other patients on the ward, made to wear a hospital gown and pyjamas while the other patients wore regular clothes. I was not allowed off my bed. The nurses followed me to the bathroom, and every morning I was threatened with tube feeding for failing to gain weight. The nurses pretended to role play a Nazi Concentration Camp whereby they were the Gestapo and Hitler and could keep punishing me. While the psychologist had ordered a behaviour modification program, the nurses took it too far and seemed to enjoy bullying me, punishing me, isolating me and denying me everything. I didn't see my family for half a year. I was denied visitors and phone calls. With weight gain, I might be rewarded with a timed five minute phone call. I failed to respond to the negative and punitive behaviour modification program. I gained no weight. I took my punishment and became more and more depressed and angry with the hospital. They failed to listen to me. When I spoke about what I needed and how the behaviour modification approach could be improved and adapted to meet my needs, I was shut down. I had no voice.

Six months later, with no improvement in my condition, they gave away the behaviour modification program. It clearly wasn't working. They decided to send me home to die. My parents refused to accept me. I was in limbo, my parents didn't want me home, the hospital didn't want me and health insurance wanted me out of hospital as I had been there too long. They then decided to tube feed me to their target weight. I was forced to comply, each week if I had not gained a kilo I would be tube fed. The fear of the tube forced me to comply, but secretly I was dying inside. I couldn't cope with the rapid weight gain, but the only way out of hospital was weight gain. The nurses kept reminding me I could lose the weight after I discharged.

I left hospital 25 kilos heavier, traumatised, full of self-hatred and with an inability to trust the outside world. There was no one I could trust, certainly not my family and not the health professions. I had no friends. I had directed all my efforts to losing weight and studying over the previous 10 years. I had nothing but my weight and my marks. I was traumatised from my admission and could not seek medical care for many years afterwards. I was terrified of anyone who I feared might be able to put me back in hospital.

Home was like a war zone. I couldn't trust my family and my mum couldn't trust me; my sisters were angry I was the cause of so much family problems. They barely spoke to me. I quickly set about losing the weight the hospital had made me put on. I was not going to be the weight the hospital had decided for me. The low weight had become my identity, I wore my illness; my body expressed the pain I felt, but could not express. The self-harm continued to rage, but I hid the unacceptable cuts that expressed my self-hatred of myself and the world. My parents insisted I kept all my self-inflicted wounds covered with clothing. The self-inflicted wounds were not acceptable to my family or society, and what would people think "*if others knew they had a daughter with mental illness*". There was an outer me, that people saw but the hidden world that engulfed me, had to be hidden away as it didn't meet society's acceptable norms. It was a silent and difficult time, with no one knowing what was really happening behind closed doors.

Over time, the long term anorexia, internal turmoil would lead to yet another disability. I developed functional neurological disorder [FND]. While no one really knows what causes FND, I believe the impact of long term anorexia, self-abuse, hospital trauma and pushing my body hard at the gym reduced the resilience of my body and my nervous system stopped functioning normally, causing the FND.

The FND would lead to significantly more challenges. I was unable to walk. I lost the use of my left side. Typical of FND, no major abnormalities are found on scans and the health professions could find no reason for me to be so disabled and symptomatic. I suffered exclusion and discrimination in care and I suffered exclusion and discrimination in the workplace. Over time, my condition worsened and I ended up in a wheelchair. I then experienced structural barriers to inclusion, and began to notice environmental factors that impede community accessibility to people in wheelchairs. For example, a car blocking a kerb ramp meant I couldn't access my street; lack of footpaths placed myself and dogs in danger as we had to walk in the middle of the road; I was unable to access certain train stations and buildings due to stairs, there was a lack of accessible parking and an inability to fit my wheelchair and service dog on crowded public transport.

I had spent so much of my life working to hide my disability, but all of a sudden, my invisible disability was obviously visible. The first thing people see before they see me is the wheelchair and the assistance dog. I am seen as different, requiring accommodations and a problem that no one wanted to take on. Why would they take on someone in a wheelchair when they could employ a person who was fit, healthy and would slot in with no accommodations.

I had to adapt to a new identity with the disability blatantly obvious. I found it difficult to get work with a visible disability compared to an invisible disability. I had always got every single job I applied for, all of a sudden as soon as employers became aware of the disability, I was not considered. In each application, I would progress until they realised I had a disability. Over time, I realised that the visible disability was too much of a problem and I had to take a new approach with employment. I began noting my disability in my application letters. I was sick of going for interviews and being knocked back as soon as they saw the wheelchair and the service dog. Once I was upfront with the disability, how I manage it, any potential accommodations that might be required and that it didn't affect my work productivity, I started getting work again. I began only associating with people who accepted me and gave up on others who tried to exclude or bully me. With time, I would find my niche, helping others with FND, a place where I was accepted and valued for what I could give to others on a similar journey. Recently, I received an award from the Minister for Lived Experience Leadership for my work in FND. I now accept my disabilities. I make no effort to hide them. I know some people won't accept me, but enough do.

My journey with disability has been one of determination to fit in, but I always felt quite alone in my battle to fit in and be like "normal people". Throughout my challenges, I never had a voice. Literally, from the time I was young and experienced pre-verbal trauma, to not being able to speak, to being able to speak but not being heard in the hospital setting and being silenced by health professionals. When people don't have a voice, they lose their voice. In hospital and at school, post-surgery I needed validation, but I never got validation. Being silenced, I found other ways to express my distress, through self-harm and starving my body. I was terrified of the medical profession that should have been there to help and support people in distress. The medical profession did far more harm than good when I was in care. I suffered ongoing trauma during this hospital admission that I never recovered from. They could have used the long time I spent in care to help me connect with others, to develop friendships with the other patients on the ward, to build my relationship with family, to engage in activities that support recovery, to feel included and find my voice, but the opposite happened. The damage and trauma I suffered in hospital still affects me to this day. While on the outside I might look like I am accomplishing things, experiencing success, have lots of friends and supportive networks through the organisation I set up to support others with FND—but the little exclusions, the accessibility barriers, the devaluation and having to compete with people without challenges still impacts me to the core. But with each challenge, I get up, find a way around the challenge and keep going. I might have hearing, physical and mental health challenges, but they don't stop me being a productive member of society.

8.4 Experiential Activities

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant and they should provide participants with ways to resolve feelings that may arise as a result of the activity, including reflection and debriefing.

Activity 1

Title Privilege statements – Ableism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to ableism. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. If I am going out to dinner with friends, I do not worry if the building will be accessible to me.
2. When attending class or other events, I do not have to worry about having an interpreter present to understand or to participate.
3. I can book an airline flight, go to a movie or ride in a car and not worry about whether there will be a seat that can accommodate me.
4. I do not have any physical disabilities.
5. I do not have any social disabilities.
6. People don't assume I have a learning disability because of the way I look.
7. I have never had difficulties getting health or life insurance.
8. Strangers talk directly to me, rather than the person I happen to be with.
9. I don't have to constantly prove I can do the things others take for granted.
10. I am not perceived as a burden to my family or society.

Are the scales balanced, or tipping one way or the other?

■ Questions

Reflect on the following questions:

1. How did you feel doing this activity?
2. What does it feel like to have, or not have certain privileges?
3. Can you identify other privileges that you may or may not experience?

Learning outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privilege, students become more sensitive to the multifaceted nature of ableism within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title Photovoice – Hidden ableism privilege

Purpose The concept of ‘photovoice’ allows students to use photography to identify and communicate perspectives of social issues in their environment (see About Photovoice 2019 at ▶ https://photovoice.org/about-us/). Students then use these images to examine and understand the social system and their role within that system, thus facilitating a greater awareness of social justice, social privilege and cultural sensitivity.

Process Students critically evaluate their environment with regards to ease of access and utility. They then take a photograph of something that represents abled privilege (for example, an attractive cobbled pathway leading to a tourist spot, but inaccessible to a wheelchair). Remind students not to include recognisable faces in their images, as these photos will be shared with other members of the class.

In pairs or groups, each student tells the story behind their chosen photograph, and how and why they feel it represents abled privilege. As a larger group, students identify common themes in the images presented, and reflect on the following questions.

▪ Questions

1. Did you identify any evidence of abled privilege hidden within the normal sights and activities of social environments presented by your fellow students?
2. Did you identify any evidence of ableism within the normal sights and activities of social environment presented by your fellow students?
3. How could you apply this growing awareness of abled privilege to the social environment you will be working within?

Learning outcome By studying images and listening to the stories behind them, students will develop a greater awareness of their own status, as well as privilege and social injustice in relation to abled privilege and ableism in their social environment.

Adapted from: Ergüner-Tekinalp, B. & Harper, A. (2011). Photovoice: Understanding Social Privilege. In M. Pope, J.S. Pangelinan, & A.D. Coker (eds). *Experiential activities for teaching multicultural competence in counselling* (pp. 222–224). Alexandria, VA: American Counselling Association.

Activity 3

Title Communicating without sound

Purpose Communication is an important part of day-to-day life. This activity encourages students to understand the potential difficulties of communicating without words and sound.

Process Choose a partner that you do not know well. Think about an important fact about yourself that your partner is unlikely to know. Convey that fact to your partner using gestures, eye contact, and pointing to objects or yourself – in fact any way, except spoken or written words. Your partner will write down the message they think you are sharing, but not show you. After you have conveyed the message, write down how it felt to not be able to use words. Once your partner shares the interpreted message, you then share the real message and your feelings with your partner.

■ Questions

Discuss the following points:

1. What emotions did this activity evoke for both the communicator and the recipient of the message?
2. What long-term implications arise if communication and understanding is difficult?

Reverse roles and repeat the activity.

Learning outcome It can be difficult to convey a message correctly without words and sound which may then lead to frustration and withdrawal. This activity allows students to experience the potential anger and miscommunication that can arise when two people must work harder to communicate.

Adapted from 'Multiple Disabilities', Diversity Activities Resource Guide. Retrieved from ▸ https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 4

Title When words make no sense

Purpose Reading is an important skill in day-to-day life. This activity encourages students to understand how difficult it can be to succeed at school and work if you have a learning disability. Reading disabilities are one of the most common learning disabilities.

Process Send a long text message to your partner. You partner holds their phone up to a mirror and has 15 seconds to read the message. After 15 seconds, your partner tells you what they think the message said, and you read out the actual message.

You can then reverse roles.

■ Questions

Discuss the following questions:

1. What difficulties did the message reader experience?
2. How did it feel to have your message misinterpreted?
3. What implications does this have for you as a practitioner when seeking informed consent?

Learning outcome Some people may choose to hide a reading disability to avoid embarrassment in a society that perceives literacy as fundamental. This activity allows students to experience the difficulties that can arise when reading takes longer than is normally accepted.

Adapted from 'Multiple Disabilities', Diversity Activities Resource Guide. Retrieved from ▶ https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

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Sizeism

Cat Pausé, Deborah Lupton,
Tayla Cadigan, Vicki Hutton,
and Susan Sisko

Contents

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_9

Trailer

In this chapter, Dr Cat Pausé explores the complexity of fat stigma and fat advocacy and its relationship to mental health and well-being. Deborah Lupton describes what fat discrimination looks like and the impact on individuals. And finally, Tayla Cadigan describes her experiences of fat stigma with medical and mental health providers.

9.1 Introduction

Vicki Hutton

Definition

Sizeism describes discrimination against individuals on the basis of their body size/weight (Chrisler & Barney, 2017). It can be used to judge a person's health, aesthetics or suitability for roles, ranging from jobs to parenthood. For many decades, the 'thin-ideal' has dominated Western perceptions of beauty (Swami et al., 2010). Fat activism arose to challenge the anti-fat prejudice—defined as negative attitudes toward, beliefs about, or behaviours against people who are perceived as fat (Fikkan & Rothblum, 2011)—that inevitably flowed on from the thin-ideal. In a world where fat bodies are hated, mocked and pathologised, fat activism work seeks to refute medical myths around obesity and health, focus on fat acceptance and counter experiences of sizeism (Chalklin, 2016). Strategies can range from pointing out problematic language and behaviours to political and social movements (Cooper, 2016). The term 'fat' is also embraced as an objective measure of size and a way to destigmatise the word that is used derogatively in many societies (Abakoui & Simmons, 2010).

Statistics

Anti-fat prejudice can be exacerbated by labels such as the 'obesity epidemic', as exemplified in the Australian Department of Health's description of obesity as a 'burden' on the individual and a long-term public health problem (Department of Health, 2019). This claim arose from figures reported in the 2017–18 Australian Bureau of Statistics' *National Health Survey* indicating that two thirds of Australian adults (12.5 million people) were overweight or obese (that is, 36% overweight and 31% obese), and that one quarter of children aged 5–17 years were overweight or obese (that is, 17% overweight and 8.1% obese). Thirty-eight per cent of people in the lowest socio-economic areas were identified as obese, compared to 24% in the highest socio-economic areas, demonstrating the social dimensions embedded within a person's physical characteristics (Australian Institute of Health and Welfare, 2019).

The establishment of a Select Committee into the Obesity Epidemic in Australia in 2018 and a National Obesity Summit in 2019 are testament to the concern engendered by this perceived threat to public health (Department of

Health, 2019). However, they are also indicative of the systems of power that coerce individuals and the general public to believe in one acceptable (thin) body size (Matacin & Simone, 2019), thus perpetuating sizeism at a structural level.

While fat-activists embrace the word ‘fat’ (for example, fat oppression, fat shaming), obesity remains the medicalised terminology that is assessed using the internationally recognised standard of Body Mass Index. This is based on a person’s weight and height, or by their waist measurement (AIHW, 2019). The resultant categories of ‘overweight’ (BMI 25–29.9) and ‘obese’ (BMI 30+) are then problematised, with the term overweight providing a warning of impending obesity, and reinforcing the perception that there is a correct weight which has been exceeded (Abakoui & Simmons, 2010).

Once a person is labelled as overweight or obese according to the stringent measuring system mentioned above, there can be an expectation that the person will rectify this outcome through limited food intake and increased energy expenditure (O’Hara & Taylor, 2018). Indications that women who are classified as ‘obese’ are at greater risk of experiencing depression than women who are not further pathologises this terminology (Berman, Morton, & Hegel, 2016), and confirms the ‘burden’ of obesity and the individual’s responsibility to fix it. Addressing this distress with behavioural weight management positions size and weight under the control of the person, rather than embedded in larger socio-cultural systems that privilege the thin-ideal and perpetuate sizeism within society.

9.2 Inside Out: Fattening Therapy

Cat Pausé

9.2.1 The Impact of Fat Stigma in Therapeutic Settings

This chapter explores the impact of fat stigma in therapeutic settings. Common assumptions and experiences from research are shared alongside alternative approaches to fatness. The chapter concludes with suggestions for counsellors who wish to be wise affirming in their practice. In this chapter, the term fat is used, as this is the preferred term of fat activism, Fat Studies scholars, and others who are engaged in fat liberation. This chapter on fattening therapy is written by a super fat woman, who is both a fat activist and a Fat Studies scholar. And following this chapter are additional stories from fat people about their experience in mental health spaces. This material should help counsellors reflect on their own personal attitudes around fatness, learn how fat stigma interferes with well-being, appreciate the role of fat stigma as a barrier to evidenced-based ethical practice and develop tools to ensure they provide appropriate care for their fat clients.

Anti-fat attitudes are prevalent around the world; fat people live their lives surrounded by structures, environments, communities and individuals who dislike them (Chrisler & Barney, 2017). Fat stigma leads to discrimination and oppression (Puhl & Heuer, 2009). It also contributes to poorer physical and mental health in fat people (Chrisler & Barney, 2017; Hunger, Major, Blodorn, & Miller, 2015; Schafer & Ferraro, 2011).

Unfortunately, anti-fat attitudes are pervasive among healthcare providers, including those in the mental health field (Pascal & Robinson Kurpius, 2012; Puhl, Latner, King, & Luedicke, 2013; Young & Powell, 1985). Doctors believe fat patients to be lazy, non-compliant and lacking interest in their well-being (Dixon, Hayden, O'Briend, & Piterman, 2008; Schwartz, O'Neal Chambliss, Brownell, Blair, & Billington, 2003).

Fat stigma is reproduced within the educational settings for healthcare providers, including those training in the mental health field. Body size is pathologised in these spaces, and fatness is presented as deviant, unhealthy and a moral failing. In addition, fat stigma and oppression is not covered in the education of healthcare providers, so providers have little, if any, understanding of the role of these in the lives and wellbeing of fat people (McHugh & Kasardo, 2012). "The lack of coverage of fat oppression in psychology courses and the medicalisation of size demonstrated in the field overall has critical implications for how clinicians react to, diagnose, conceptualise, and treat fat clients" (Kasardo, 2019, p. 183). Davis-Coelho, Waltz, and Davis-Coelho (2000) and Brochu (2019) argue that material on fat stigma and oppression represent an unmet need in clinical psychology training. "Issues related to sizeism should be included as a compelling and vital component of multicultural education and training, particularly for psychologists and other mental health practitioners who are concerned with their clients' well-being and who value the development of a practice grounded in social justice" (Bergen & Mollen, 2019, p. 169).

Kasardo (2019) reviewed 29 texts designed for use in postgraduate counselling courses and found very few addressed size as a social identity or site of oppression. They concluded their review by suggesting that students and practitioners both should seek the voices of fat people's experiences within therapeutic settings; they also suggest that course materials should include material written by fat people. Brochu (2019) suggests that psychology students and those training for work in the mental health field are receptive to information about fat stigma and oppression. She notes they are interested in understanding the impact of bias (even if they've never considered anti-fat bias before) and differing cultural viewpoints.[1]

9.2.2 Assumptions

When the American Psychological Association released their guidelines on multicultural education and training, they failed to recognise body size as a relevant

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[1] For more about how to teach this material, see Bergen & Mollen, 2019.

social identity (Bergen & Mollen, 2019). And in 2018, the APA adopted guidelines for obesity that focused on behavioural weight management (McHugh & Chrisler, 2019). The negative assumptions and stereotypes held by those in the mental health field place their clients of all sizes, but especially their fat clients, at risk (Brochu, 2019). These assumptions about fatness and fat people might include the following:

- A fat person's physical health must take precedence over their mental health.
- If a fat person is distressed, weight loss is the solution.
- Fat people must be binge eaters.
- A fat person cannot be happy with their body.
- Emotional issues cause excess weight, and once the issues are resolved, the person will lose weight.
- And fat bodies indicate sexual abuse, or a defence against sexuality.

Each of these assumptions interferes with the treatment a fat client may receive in a mental health setting. In addition, mental health providers may also hold negative attitudes about fatness and fat people. Mental health providers believe fat people to be gluttonous and in ill health (Barron & Lear, 1989). Mental health providers assign higher symptomatology to fat clients (Young & Powell, 1985), view them less favourably as non-fat clients (Agell & Rothblum, 1991), and expect them to experience fewer benefits from therapeutic settings (Davis-Coelho et al., 2000). These anti-fat attitudes almost guarantee that fat people will not receive bias-free, evidenced-based care from their counsellor.

9.2.3 Consider the Following Scenarios

► Examples

Mica is a fat eight-year-old who has become more withdrawn and quieter, according to their parents. Their parents have shared that Mica has recently changed schools and has begun to discuss their body size at home; Mica is also increasingly worried about what they eat and how active they are. At their last birthday, Mica refused to eat any of their birthday cake, and spent most of the party in tears. Mica finally shared with their parents that they are being bullied at school for their size. Mica's peers make fun of their size, hide their gym clothes and sometimes throw their lunch away in the cafeteria. Mica's parents are very upset that Mica is being bullied and has brought Mica to see you to help build Mica's self-esteem. They also suggested that you might be able to help Mica understand why they are fat and how they can lose weight.

Tony is a fat fifteen-year-old whose behaviour around food and exercise is beginning to worry their parents. Tony is insistent about eating at certain times of the day and becomes upset when food is served outside of those windows. Tony has been spending increasing amounts of time online, often on proana blogs. Tony's parents have done their best to monitor Tony's Internet activities, but they still worry they are missing key influences on their child's life. They have brought Tony into therapy, largely against Tony's wishes. Tony does not believe they need therapy; they insist their own problem is their weight. They would much rather their parents spend the money on fat camp or weight loss surgery. While Tony does not have a low BMI, the rest of their presentation seems consistent with a diagnosis for an eating disorder.

Sean and Taylor have been married for over 15 years. They began couples counselling before their marriage, believing that having a safe space to share tensions, fears and hopes, would help them build and maintain a healthy relationship. Across the years, Sean and Taylor have worked through issues related to finances, division of labour within the home, infertility (and subsequently parenting), and difficult relationships with in-laws. More recently, though, most of the issues raised in this space have related to the growing distance in their physical relationship. Taylor has shared in the therapeutic space that they believe Sean no longer finds them attractive; they have not had sexual relations in almost a year. Taylor believes that Sean has lost interest because they have gained some weight in middle age, and they worry that Sean might leave them for someone younger and more attractive.

Sloan is fat retiree. Sloan has a long list of things they would like to do, including places they would like to travel to and new hobbies they would like to begin. Sloan also has many aspirations around their relationships with their children and grandchildren and would very much like to develop deeper relationships with their family, especially the ones that live far away. Before retirement, Sloan had been very active in the community. In addition to their paid employment, Sloan sat on several community boards and volunteered as an usher at her local performance theatre. Sloan also enjoyed singing in the choir at church. Since retirement, Sloan has been spending more time at home and has been withdrawing from her community commitments. Sloan believes this is so they can travel more to be with family and tick things off their list. Sloan has shared, though, that they are waiting until they drop five more kilos before they begin working on anything on their list or suggest a visit to their family overseas. Sloan believes that losing that last bit of weight will make the activities more enjoyable, or more feasible; they just need to drop five more kilos and then they can start on their list. ◄

In all these scenarios, a counsellor might seek to support their client(s) through the process of trying to lose weight. Especially if the clients themselves, like Tony and Sloan, have identified this as a goal. But weight loss should never be a therapeutic goal (Brown, 1989; Chrisler, 1989; Pausé, 2019). It reinforces the thin-ideal, reproduces fat stigma and has no demonstrated efficacy.[2] Bergen and Mollen (2019) suggest that conversion therapy remains standard when working with fat clients because of erroneous assumptions about weight, health and responsibility. Drawing on principles of feminist therapy, providers can, instead, encourage clients to consider fat oppression and the systems of power (including white supremacy, patriarchy and capitalism) that pressure individuals to believe in a singular acceptable body size (Harrop, 2019; Matacin & Simone, 2019). Targeting the bullies at Mica's school, rather than focusing on changes Mica should made to reduce the bullying. Counsellors can assist their clients to reflect on fat stigma, fat oppression and their own lived experiences. Counsellors can workshop with clients the cognitive beliefs and stereotypes they hold about bodies and where these might come from (again,

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[2] For more info on the latter, see Bacon & Aphramor, 2009; Mann et al., 2007)

see white supremacy, patriarchy and capitalism). Counsellors can help their clients construct a new language for talking about fatness, bodies, food and health. And counsellors can brainstorm strategies for dealing with bullies, food policing from colleagues, concern trolling from friends and family, and hate from strangers.

For clients that have health concerns, counsellors can help them shift their focus away from weight and onto health, understanding that being fat is not inherently unhealthy (Bacon & Aphramor, 2011). Teaching clients that weight is not a proxy for health is a powerful therapeutic tool. Many might find the Health at Every Size approach useful; HAES promotes health through self-acceptance, learning to trust the internal cues of the body, intuitive eating, and joyful movement (for more, see Bacon, 2008; Bacon & Aphramor, 2014).

9.2.4 Counsellor Awareness and Knowledge

Counsellors should be aware of the dangers of letting their clients, of any size, to believe that the size of their bodies is the obvious source or cause for whatever issues or problems they may be experiencing (and the provider must avoid making this assumption as well) (Akoury, Schafer, & Warren, 2019). For many, body size is linked to how body dysphoria is understood (Harrop, 2019). Body shame and distortion must be recognised as problematic in people of all sizes.

And counsellors must ensure that their own anti-fat attitudes do not lead to incorrect or missed diagnosis based on body size. Mental health professionals often fail to "recognize when fat patients present with eating disorders" (Lee & Pausé, 2016, p. 8). In addition, "fat people are often encouraged, prescribed even, to engage in behaviors associated with disordered eating" and eating disorders by healthcare professionals (Harrop, 2019, Pausé, 2019, p. 82). This is especially troubling as eating disorders "have the highest mortality rates of any psychiatric illness" (Harrop, 2019, p. 45). A missed eating disorder diagnosis may stem from a variety of reasons, including diagnostic criteria requiring a low weight.

Harrop has written about her experience as both a typical anorexia nervosa patient and as an atypical[3] anorexia nervosa patient. She notes that while her presentations were the same, she was treated significantly different by the providers of the inpatient hospital in which she sought treatment. Sadly, Harrop's therapist "became an instrument in the system of weight oppression" (p. 47); she refused to recognize Harrop's eating disorder because of her fat body. In fact, she insinuated to Harrop that she did not really need a place in the treatment facility; that she was taking the space of a really thin and really anorexic individual who needed it more.

Counsellors need to acknowledge and address their own attitudes about fatness and the role they play in the therapeutic relationship. Counsellors should familiarise themselves with the National Association for the Advancement of Fat

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[3] Patients who have the symptoms of anorexia nervosa but have a BMI over 18.5, are diagnosed with atypical anorexia nervosa (Harrop, 2019).

Americans' (NAAFA, 2010) guidelines for mental health care providers and work to create physical spaces that are inviting for fat people.

At the very minimum, counsellors should seek to enact a weight-inclusive approach in their practice. Calogero, Tylka, Mensinger, Meadows, and Daníelsdóttir (2019) argue that a weight-inclusive approach is key; "A weight inclusive approach stresses that being fat is not wrong; it is a normal part of human diversity" (p. 22). As opposed to the current weight normative approach, a weight inclusive approach does not believe that body weight is a central determinant of health and well-being.[4] The weight inclusive approach disrupts the common love/hate relationship that people have with their bodies, and encourages people to approach their body with respect, care and compassion. Others, though, may be keen to develop fat positive, or size affirming spaces in their practice.

9.2.5 Counsellor Resources

Counsellors can engage with the Fatosphere, the online community of those engaged in various forms of fat activism (Pausé, 2014); simply reading through the writings of fat activists or scrolling through the images of a fat positive Instagram, can be informative and beneficial. Consuming material about fatness that is produced by fat people will help providers appreciate the nuance of fat lived experiences and build empathy. Engaging with these spaces and fat people on their own terms should benefit the therapeutic relationship a counsellor has with their fat clients.

Counsellors can also encourage their clients to build size affirming worlds. Getting rid of bathroom scales is a small, but transformative, step that clients can take.[5] They can also stop subscribing and clicking on materials designed to make people (especially women) feel bad about their bodies. They can click, instead, on fat positive materials from fat activists and scholars. Listening to fat positive podcasts is another way to bring size affirming material and conversations into their lives (Pausé, 2019).

Matacin and Simone (2019) argue that fat activism "can be an important avenue for clinicians to consider in a therapeutic context" (p. 201). They point to the belief within feminist counselling and psychotherapy that 'the personal is political' and suggest that activism has been found to be beneficial in other groups (Klar & Kasser, 2009; MacDonnell, Dastjerdi, Khanlou, Bokore, & Tharao, 2017). Activism is any act that contributes to social justice; it can be small, large, individual, or collective (Cooper, 2016). A fat person who lives their life without apology is engaging in activism.

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[4] See Calogero et al. (2019) for a review of other weight normative approach assumptions.

[5] For creative and adventurous clients, suggest they turn their existing scales in Yay! Scales instead (► http://www.fatso.com/). This may also be helpful for those who cannot imagine not having a scale.

9.2.6 Conclusion

Following this chapter, there is an article on fat discrimination and a story written by a fat individual; in producing this chapter. Taken together with this chapter, the reader should have a deeper appreciation for fat stigma and the oppression that can occur in therapeutic spaces. Following from this, the reader has an opportunity to reflect on their current practice and implement steps to make changes if necessary. Every counsellor can fatten their therapy; these chapters provide the tools.

9.3 Personal Stories and Current Affairs

9.3.1 What Does Fat Discrimination Look Like?

Deborah Lupton

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► https://theconversation.com/what-does-fat-discrimination-look-like-10247

People who are deemed overweight or obese (as the medical terms have it) or fat (as many fat activists prefer to call their body size) suffer discrimination, prejudice and humiliation from several fronts.

Television programs such as *The Biggest Loser* hold them up to contempt and public shaming. News media reports on obesity constantly display photographs of fat bodies with their heads cropped off—the “headless fatty” representation—and commonly use derogatory expressions ranging from “lazy” and “flabby” to “fat arses” and “unsightly slobs”.

Weight stigma has significant effects on fat people’s lives. Compared with others, fat people are statistically more likely to live in poverty, earn less income or be unemployed, have lower education levels, be employed in lower status jobs and experience lower living standards. Women in professional occupations are particularly discriminated against in the work place (Quast, 2012). If they are overweight, they fail to reach the higher echelons compared with thinner colleagues.

In social terms, fat people receive less respect from others and are often subjected to derogatory humour and pejorative comments from co-workers, friends and family members and, in public settings, from strangers. Healthcare workers openly admit to being “repulsed” by fat people.

Fat children are subjected to greater harassment and prejudice than other children, and experience ostracism, teasing and bullying to a greater extent (DeAngeles, 2004). Remarkably, even their own parents may favour their thinner children over their bigger ones (Rochman, 2010).

In a society in which most people understand that discriminating overtly against social groups such as women, people of minority ethnic or racial groups, gays and lesbians and people with disabilities is wrong and where such discrimination is legally prohibited, fat people are apparently fair game.

Why this hostility and lack of compassion towards fat people? Why this apparent urge on the part of many to shame and blame people who are deemed to carry too much flesh?

Perception of Fat Bodies

Fat bodies are culturally represented as inferior, deficient, ugly and disgusting. These meanings have developed over centuries, derived from the Judeo-Christian idea that the disciplined body is closer to God. An ascetic self-control over such bodily urges as hunger and sexual desires is evidence of moral superiority and relative lack of sin.

While we live in a more secular society today, these moral assumptions still dominate in our understandings of the value of self-discipline and how it is reflected in our body size and shape.

Added to these meanings are the newer ideas derived from medicine and public health, intensifying in the late 1990s, that an obesity epidemic has emerged in many countries that it is predicted will lead to higher rates of disease and premature mortality. Intensive mass media coverage of this issue has led to the idea that fat people are not only ill-disciplined but also inevitably sick and physically unfit, regardless of where they fall on the body weight spectrum.

Unlike other attributes that commonly attract discrimination and marginalisation such as skin colour, gender or disability, fat people are viewed as deserving of their fate because of their apparent lack of self-control. They are also often represented as threatening others by attracting higher healthcare costs. This reasoning is used to justify fat stigmatisation, even though others who may need higher levels of healthcare are not treated to such revilement.

Ironically, fat people often avoid attending medical appointments (Wilson, 2012) because of their concerns about being judged negatively by the doctor. This means they may not receive early preventative treatment for medical conditions they may have (National Task Force on the Prevention and Treatment of Obesity, 2002).

Fat Equals Failure

People who identify as fat or overweight are highly aware of the moral failure that their bodies represent. Research with fat people has identified the shame they may feel about their bodies, and the social humiliation to which they are often exposed by others. In an English study (Brandon & Pritchard, 2011) for example, one man spoke about his emotional distress at being laughed at by some young men while sitting in the sun in his shorts while on holiday:

> …they could see me and they were laughing and joking and carrying on and it was only as they got past that I realised that they were laughing at me, about how fat I was. And er, I mean, it hurts.

Fat people often express highly negative thoughts about their bodies. As a weight-loss blogger who wrote about her weight gain explained: “I felt ashamed. I felt ugly. I felt like some sort of animal.”

Fat people often feel very self-conscious about going out in public, particularly eating out or grocery shopping. They are highly aware that others are examining and making judgements about what and how they're eating (Owen, 2012). They feel out of place, open to mockery and very exposed. As one fat woman commented, for her, "even grocery shopping is an exercise in courage."

Given the discrimination to which fat people are subjected, it's not surprising they're more likely than others to suffer from depression, anxiety and low self-esteem, which in turn may lead to a greater likelihood that they will eat for comfort (Strong link between obesity and depression, 2009). Medication taken for these mental health conditions may also lead to gaining weight (Metherell, 2011).

Whether or not socioeconomic disadvantage leads to fatness, or whether fatness itself causes poverty and other forms of social and economic disadvantage is a point of debate.

The lower socioeconomic status of fat people in itself is more likely to cause health problems (► https://frac.org/). The combination of living in poverty, experiencing stigma based on body weight and accompanying diminished social status causes continuing stress.

In conjunction with poor living conditions and the lack of opportunity to exercise and consume a high-quality diet, disadvantaged people's exposure to stress may result in illness and disease. These medical conditions in turn may not be treated effectively because of lack of access to high quality medical care.

▪ Lack of Compassion

People who discriminate against fat people or consider it appropriate to use fat-shaming terms when talking about or to them don't seem to view fat people as real human beings who are hurt and humiliated by their actions and that they may be struggling with significant socioeconomic disadvantage or mental health conditions.

Or perhaps they simply don't care about this in their belief that fat people deserve punishment for their supposed inability to control their urges and their lack of conformity to idealised notions of physical attractiveness.

In a supposedly modern and compassionate society such as Australia, shouldn't fat discrimination be viewed for what it is? It is a kind of bigotry and represents a lack of understanding, compassion and tolerance for bodily difference.

It shouldn't just be fat people who call attention to fat bigotry and fat phobia. All of us are implicated if we accept the negative concepts of fatness that currently circulate in our culture and tolerate fat discrimination from others (Lee, 2012).

9.3.2 I Am More Than the Number on My Shirt

Tayla Cadigan

A brief summary of my experiences with mental illnesses, and how my body size impacted those experiences.

During my first visit with the psychiatrist, she asked all the *usual* questions: What's your diet like? Do you exercise? How would you describe your mood? How do you sleep? Are you having thoughts of harming yourself, do you have plans...?

We talked about what I like about myself, what I don't like. What my relationship was like with my family. What I did in my spare time, how was my job, my study. What happened before I was admitted to the psych unit last year. What happened during, after. What my medication history was. She didn't actually mention my weight at the time.

My mental illness history is complicated, a bit. Nothing bad ever happened to me as a kid, no trauma, no abuse, nothing like that. Just a bit of trauma, and maybe a bit of neglect? Haven't quite figured that one out yet. So why am I the way I am? The question has been spinning around in my mind for several years now, yet I can never seem to answer it. I've had depression since I was roughly 14, but thinking back, I've always had negative thought patterns. I can remember right back to primary school thinking I was never good enough. Not smart enough, not fast enough, not talented enough, and definitely not thin enough.

I was always a bit chubby, not so much when I was a kid. I do recall the moment when I actually realised I was fat though—I must have been 12 or 13. Having a job in a supermarket, and having my own money for the first time didn't help my waistline. I finally had the freedom to make my own choices about what to eat. Unfortunately, however, I believe that's when my sweet tooth developed and also when my sugar addiction started.

I experienced episodes of PTSD following my unfortunate one-day visit to Christchurch on the day that the February 22, 2011 earthquake occurred—still, to this day, I experience flashbacks and mild panic attacks triggered by shaking. Then I was present at an unexpected death, which was rather traumatic for 15-year-old me.

Then started the cycle of self-harm as a form of self-punishment. This continued for several years, and still happens sporadically today… I usually do this as a response to 'being disappointing' or if I've messed something up and feel guilty. When I cut, I also get angry about the size of my body and how much I dislike it which makes me more depressed, creating a rather vicious cycle that's often hard to escape. It's entirely possible I'm fat because I'm depressed, and I'm depressed because I'm fat. But I know I also have many more factors that contribute to my mental illnesses, and it isn't just that I'm fat. Perhaps it's pointed out because it's the most obvious thing that's *wrong*?

University was the first time I was seriously suicidal, and also when I developed anxiety. Throughout my degree, I saw psychotherapists, psychologists, psychiatrists, counsellors, crisis team, emergency psychiatric services, all for various treatments, with varying effects. They asked what my goals of treatment were.

"Would you like to lose weight?" I mean, I suppose, but I didn't realise I was seeing the dietitian today…

When I got my hands on a copy of that letter, from the first time I saw the psychiatrist upon my return home, post-degree—the sentence that sticks out the most is "Tayla is a significantly overweight young woman". Thanks for pointing it out, I hadn't noticed myself?! I do appreciate that perhaps I was not the intended audience for the psychiatrist's letter, but I do wonder what clinical relevance that statement brings to the table. What do we gain or lose (pardon the pun) by knowing or not knowing whether someone is overweight or not? Does this fact determine our course of treatment?

I wonder if my treatment and care would be the same if I were a size 10, rather than a size 20–22.

Of course, in mental illness, non-pharmacological therapies are the mainstay of treatment, in combination with medications (or not). And of course, the top of that list is exercise. Exercise this, exercise that – you'll feel so much better, they all promise. I do get it. But I don't understand why it's pushed as the answer to all the problems. What if the problems are deeper than that?

Realistically, I'm far more likely to die right now of suicide than of obesity. It would be nice if some healthcare providers saw past what they see on the outside, and saw that instead, in my mind, I'm a mess. Inside, I don't sleep, I don't stop thinking, I don't stop worrying.

As soon as a mental health professional comments on my weight, or my size, all it does is make me feel worse about myself. Not the kind of 'feeling worse' that goes away after a few hours. The kind that makes me think and think and think. I'm a chronic overthinker. I scrutinise every comment someone has made to me, or about me, and try and find the 'hidden meaning'.

Often there is no hidden meaning. It makes me feel invalid, like I don't deserve the services I'm receiving. As if the obvious answer is just to lose weight, because that's so simple and easy. Being fat, for me, is a summary of every single previous attempts to rectify my disordered eating, and failing. It's lack of willpower, loss of control. Patterns, and habits, that have formed over several years following trauma and neglect. Each subsequent attempt to get on top of my eating issues have all been futile—not one of the mental health professionals I've seen has offered support, or a referral to an appropriate agency. It's like a huge stab in the chest. I feel like they're implying it's my fault I'm fat (it is though, isn't it?) and therefore it is my problem to solve, and mine alone.

Regardless of the fact that my fatness does actually contribute to my mental health, but is ignored to my face, and then written about in clinic letters I'm not supposed to see.

9.4 Experiential Activities

Important

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant and they should provide participants with ways to resolve feelings that may arise as a result of the activity, including reflection and debriefing.

Activity 1

Title *Privilege statements – Sizeism*

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Process Read the following privilege statements related to sizeism. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. I can book an airline flight, go to a movie, sit in a crowded train seat and not worry about whether there will be a seat that can accommodate me.
2. People do not make assumptions about my work ethic or intelligence based upon the size of my body.
3. People do not make assumptions about my personality or habits based upon the size of my body.
4. When going shopping, I can easily find clothes that fit my size and shape.
5. I have never felt that people are looking at me because of my size.
6. I have never felt that people are wondering about my relationship if my partner has a markedly different body type to me.
7. I have never been shamed because of my body type.
8. I have sometimes pretended that jokes and metaphors about body type don't hurt me.
9. Sometimes I make jokes about myself to pretend I don't care.
10. I can easily find healthy and popular role models of my body type in pop culture.

Are the scales balanced, or tipping one way or the other?

■ Questions

Reflect on the following questions:

- How did you feel doing this activity?
- What does it feel like to have, or not have certain privileges?
- Can you identify other privileges related to sizeism that you may or may not experience?

Outcome Students consider some of the many forms of privilege in their environment, and if and how this impacts them personally. By raising awareness of potentially invisible privileges related to sizeism, students become more sensitive to the multifaceted nature of privilege within society.

Adapted from 'Understanding Privilege', Diversity Activities Resource Guide. Retrieved from ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Activity 2

Title Myths and stereotypes

Purpose Obesity has become stigmatised in society, with metaphors such as 'the war on obesity' adding to the perception that obesity must be battled and conquered. The aim of this activity is to challenge myths and stereotypes about obesity by first encouraging students to identify and examine some that they may hold.

Process Read the following vignette. Students are then asked to respond True or False to the series of questions that follow.

▪ Vignette

Carla has been referred to your mental health service by a medical practitioner. Carla needs minor surgery, but has been refused treatment based on her weight. She currently weighs 100 kilograms and is of average height. Carla arrives early for her 1 pm appointment, and you notice that she is eating in the waiting room.

▪ Questions

Answer the following questions without over-thinking them (i.e. answer True or False based on your initial reaction):

1. Carla is unhealthy.
2. Carla is unhappy.
3. Carla cannot control her food addiction.
4. Carla needs to learn self-control.
5. Carla is eating to meet unmet emotional needs.
6. Carla's obesity is a disease and can be cured by losing weight.
7. Carla can stop any stigma by changing herself.
8. I would work with Carla on learning self-control.
9. If a person of average weight was eating in the waiting room, I would not make any judgments.

In pairs, compare your responses and identify similarities and differences. Work through the similarities first, discussing the rationale behind these responses and exploring alternative responses. Next, consider any differences in responses and listen to, and challenge each other's viewpoints.

▪ Outcome

There are many myths and stereotypes around body image and weight. First reactions are sometimes difficult to change and may be perpetuated when confirmatory evidence is sought in the actions of the individual who is perceived as overweight. Health professionals may also perpetuate myths and stereotypes through their assumptions and treatment plans. It is important to recognise that the conflict between assumptions and reality can negatively impact your ongoing response to, and treatment of a person perceived as having lost their 'battle' with obesity.

Adapted from: Myths, misinformation, and stereotypes regarding weight and fat.

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Religious Hegemonism

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Contents

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_10

10

Religious Hegemonism

Trailer

In this chapter, Kathleen McPhillips will explore the complexity of religious hegemonism and its relationship to identity, racism and social cohesion. Maxine Rosenfield and Ridwan Haq further describe personal experiences of growing up in non-dominant faith groups and the impact on identity and well-being.

10.1 Introduction

Vicki Hutton

Definition

Spirituality has often been linked to belief in a God or higher power, but it also transcends this limiting definition to encompass a sense of connection and 'oneness' with nature or the universe itself (p.380). Religion is often viewed as more structured, encompassing an organised system of worship, traditions and rituals. The High Court of Australia has proposed various definitions of religion (Australian Law Reform Commission [ALRC], 2016), whilst acknowledging that it would be difficult, or even impossible, to develop a definition to encompass and satisfy all the various religions which exist, or have existed, worldwide. Some suggested criteria or religion include belief in a supernatural Being, Thing, or Principle; and the acceptance of rules of conduct to give effect to that belief (provided these rules are within the law).

Statistics

Religious affiliation in Australia has changed significantly between the 1966 Census and the 2016 Census. Those identifying as Christian dropped from 88.2% of the population in 1966 to 52.1% of the population in 2016. Simultaneously, those identifying as Other Religions increasing from 0.7% in 1966 to 8.2% in 2016, and importantly, those reporting No Religion moving from 0.8% in 1966 to 30.1% in 2016. In fact, No Religion was the most common individual response on the 2016 Census, with young adults aged 18 to 34 years more likely to identify with this category than older adults (ABS, 2017a; Australian Bureau of Statistics [ABS], 2017b).

Australia has a long history of migration, with most Australians other than Indigenous peoples either immigrated to, or are descendants of migrants, over the last two centuries (Harrison & Parkinson, 2014). Different waves of migration resulted in a diverse range of cultures and religious beliefs, especially Catholics, Anglicans and smaller Christian traditions up to the middle of the twentieth century. Italian immigrants added to Catholicism, while Greek immigrants ensured a strong Orthodox community.

With the abolition of Australia's White Australia Policy in 1966, migration increased from non-European countries contributing to the increase in religions other than Christianity (ABS, 2017a). Increases were especially reported in Islam, Buddhism, Hinduism and Sikhism, with young adults aged 18–34 years more likely to be affiliated with religions other than Christianity compared with other adults. The Muslim community increased through immigration from other conflict-ridden countries such as Afghanistan and Pakistan.

Other Spiritual beliefs practised in Australia include the Middle Eastern religions of Bahai'I, Mandaean, Druse, Zoroastrianism and Yezid, Nature religions of Paganism, Wiccan, Animism and Druidism; East Asian beliefs of Taoism, Confucianism, Ancestor Veneration and Shinto; and Australian Aboriginal traditional beliefs (ABS, 2017b).

Australia is a secular nation, meaning the government cannot interfere with the exercise of religion. Religious freedom receives some protection under Section 116 of the Australian Constitution stating:

> The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance, or for prohibiting the free exercise of any religion, and no religious test shall be required as a qualification for any office or public trust under the Commonwealth (ALRC, 2016, p. 134).

The right to freedom of thought, conscience and religion is also recognised under the International Covenant on Civil and Political Rights (Australian Human Rights Commission [AHRC], 2014). Article 18 protects the religious beliefs of the major religions, as well as non-theistic and atheistic beliefs and the right not to profess any religion or belief at an individual and collective level.

However, there is no standalone law that represents the human right to religious freedom throughout Australia (Religious Freedom Review, 2018). While Australia does not have a national Religious Discrimination Act, most states and territories have their own legislation to prohibit discrimination on the basis of a person's religion. The Fair Work Act 2009 (Cth) also prevents discrimination in the workplace based on religion. Despite the relatively high level of religious freedom experienced in Australia and the direct and indirect protections against discrimination, some people may still be discriminated against on the basis of their religion or spirituality, thus potentially impacting their mental health and well-being.

The Australian Psychological Society (APS) ethical standards cautions psychologists against discriminating based on religion, and draws attention to the need to understand the consequences for people experiencing discrimination or stereotyping related to their religion (Australian Psychological Society, 2007). Counsellors and psychotherapists are similarly reminded to remain aware of their personal attitudes, beliefs and assumptions in relation to religion, and the impact of these on therapy (Psychotherapy and Counselling Federation of Australia [PACFA], 2017). The need for this self-awareness is particularly important in relation to religion and spirituality to avoid the risk of pursuing religious or spiritual goals contrary to the client's worldview, or alternatively, failing to recognise the importance of these domains in a person's identity and well-being.

10.2 Religion and Faith in Australia: Diversity, Plurality and Change

Kathleen McPhillips

10.2.1 Introduction

Australia is typically understood as a secular nation where religion plays a minor role in public life and values and is gradually decreasing in importance as secularism grows and organised religion fades (Stanley, 2015). This chapter will contest this notion and demonstrate the importance of religion in shaping the national character, providing significant social services, contributing to public policy and creating social cohesion. Importantly, studies show that religion can make a positive contribution to individual and community well-being (Bouma, 2011; Singleton, Rasmussen, Hapafoff, & Bouma, 2019).

Australia can be described as a religiously pluralist, multi-faith society, and where society in general values the inclusion and celebration of religious diversity and its contribution to social cohesion (Bouma, 2006, 2011, 2017). In particular, the contribution to religious diversity via immigration programs throughout the twentieth and twenty-first centuries have seen the religious base of Australia grow and diversify. At the same time, the numbers of Australians identifying as religious is consistently falling with the Millennial generations now having the lowest commitment to religion (48%) ever recorded (Bouma, 2017; Singleton et al., 2019).

This chapter will explore the major tenets of the history of organised religion in Australia over the last 230 years, and the impact of Christian hegemonism on national values and religious identity. As religious diversity increased in the twentieth century, so too did particular forms of racism and anti-religious sentiments. The dominance of Christianity, particularly Anglicanism and Roman Catholicism, ensured that public life was imbued with Christian values and rituals, which resulted in the construction of other religious traditions as exotic and 'other' to the norm of white, middle class Christianity. World religions, particularly Islam, Buddhism and Hinduism, are characterised by particular histories and politics which have had a significant impact on both public perceptions of these religious traditions and been a site of interest and curiosity. Religious identity, then, is complex, providing a sense of deep meaning, belonging and community for believers alongside contested ideas of what it means to be Australian.

As Australia moves into the twenty-first century and global immigration continues, religious practice and identity is increasingly pluralist and unstable. Three examples will be provided that explore the dimensions of this situation. First, the politics of Islam and in particular the debate around religious symbolism, such as veiling, will provide insight into how small ethno-religious groups become targets for national anxiety. Second, the current fraught debate around the protection of religious freedom following the passing of marriage equality laws in 2017. And finally, the impacts on religious organisations of the disclosure of thousands of victims of child sexual abuse across the twentieth century in religious institutions and their investigation via the national inquiry *Royal Commission into Institutional Responses to Child Sexual Abuse (2012–2017).*

10.2.2 Contexts and Histories of Religion in Australia

The impacts of Colonisation

Prior to the British colonisation of Australia in the late eighteenth century, Indigenous peoples lived across the land in sustainable, culturally rich societies for over 60,000 years (Pascoe, 2014). Evidence of trading with peoples from the now Indonesian archipelago in the northern parts of Australia as well as between Indigenous groups suggest that there was a peaceful co-existence and cultural and economic flourishing (Marks, 2018) amongst cultures and peoples. Historical evidence suggests that prior to colonisation, Indigenous cultures had complex, well-structured economies and belief systems with formal ritual practices and mythologies constructing powerful meaning makings systems, community identity and belonging to place (Pascoe, 2014).

Indigenous peoples were subject to systemic forms of colonial violence from 1788 onwards, which resulted in the organised destruction of cultural ways of life, including the loss of language and rituals. Practices of genocide, especially through organised massacres (Allam & Evershed, 2019; Ryan et al., 2020) and disease, devastated the Indigenous cultures which came into contact with British colonial forces and settler outposts. The nineteenth and twentieth centuries saw children forcibly taken from their families and institutionalised, policies of assimilation enacted through the herding of Indigenous peoples into Christian missions, sexual violence perpetrated against women and children, and the imprisonment of Indigenous men (Broome, 2019). The devastating impacts of colonialist policies on Indigenous societies has ensured that the later twentieth and twenty-first centuries have a legacy of racism that is yet to be reconciled and which Indigenous and non-Indigenous Australians are constantly engaged in redressing (Broome, 2019). The role of religion in colonialist agendas is complex (Carey, 1996). On the one hand, Christian missions across the country were deeply involved in the violent mistreatment of Indigenous people, often stripping them of access to country, family, language and ritual and forcing them into menial, degrading work or imprisonment. On the other hand, evidence suggests that some Christian missions provided education, health care and family support as people tried to recover from the impacts of colonial violence (Carey, 1996).

Politically, Australia was established as a secular democratic and constitutional monarchy by the British government from 1788. Religion was to be an important but not central part of public life, and the Anglican Church was formally recognised as the main religion (Carey, 1996; Kay, 2014). However, in its beginnings as a penal colony consisting largely of Irish Catholics, and with developing trading and shipping routes across the global south, there was a diverse religious representation from the earliest days of colonial life (Carey, 1996).

10.2.3 The Outcomes of Sectarianism

The politics of sectarianism[1] characterised the formation of the Catholic schooling and welfare system in nineteenth century Australia, where Anglicanism remained the established religion in all states in Australia and Catholics were locked out of state aid (Carey, 1996). The stigma attached to being Roman Catholic was significant and originated from the historical marginalisation of Catholicism in Britain and the association of convicts and the penal system with Irish Catholicism. To be Catholic in colonial Australia was to be denigrated and stigmatised. To counter this, from the 1850s, the Australian Catholic Church embarked on an ambitious program of school building, welfare assistance and business development with the express intent of improving the class position of Catholic Australians (Campion, 1982; Carey, 1996). Dioceses and parishes were formed, bishops appointed, and religious orders established to teach and care for the sick, as the Church built its empire across the land. Slowly over the next century, the impacts of sectarianism were alleviated—but not before it was common for Catholics to grow up in insular tribal communities, almost completely shielded from the influence of other religious and cultural groups (Carey, 1996). This insulation was later to be one of the main causes of the wide-spread sexual abuse of children in Catholic schools and parishes by Catholic clerics in the twentieth century (McPhillips, 2017).

10.2.4 The Impact of Migration on Religious Diversity

Although there were small numbers of devotees of numerous Christian denominations and world religions active in Australian communities in the nineteenth and early twentieth centuries, it was not until the post-war period from the 1950s onwards that the religious diversity of Australian social life developed with an ambitious immigration program aimed at building economic and cultural resources (Bouma, 2011; Carey, 1996). Orthodox and eastern Christians, Jews, Muslims and Buddhists came from a diverse array of nations across Europe, Asia and the Middle East (Carey, 1996)—with mosques, synagogues, temples and other places of worship springing up in cities and towns. The building of a multi-cultural and reli-

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[1] Sectarianism refers to the historical system where social and political sectors were divided between the largely dominant Catholic population and the smaller but more influential, state-supported Anglican population of nineteenth and early twentieth century Australia. The Anglican church in Australia was largely anti-Catholic and reflected the historical divide between these two religious groups in England and Ireland.

giously pluralist Australia was characterised by ethnic and religious tensions as well as attempts to build alliances across cultural divides. The old dominant values of Protestant Christian Australia were being challenged to make way for new expressions of religiosity and national identity and when the White Australia Policy was finally abandoned in the 1970s, it changed dramatically the ethnic population of the country. Jewish immigrants fleeing the post-war chaos in Europe were followed by increasing numbers of Buddhists from south-east Asia and Muslims from troubled areas in the Middle East. The 2016 Census records the small but significant numbers of non-Christian groups at 8.2%; and of that group, Islam is 2.6% and Buddhism 2.4%. This is compared with Christians of all denominations at 52.1% and those identifying with no religion at 30.1% (ABS, 2018; Bouma, 2017).

At the same time, secularist tendencies were steadily growing with the Australian Census recording a falling number of people both identifying as religious and attending religious services. In 1966, Australians professing a religious belief were recorded at 89% and, by 2016, this had dropped to 52% with only 8% regularly attending services. Those professing no religious identity were recorded at 0.8% in 1966 and, by 2016, this had jumped exponentially to 30.1%, most of whom were under the age of 35 years (ABS, 2018).

10.2.5 Religion in Contemporary Australia

Despite the dire predictions of social commentators and theorists that religion would fade into insignificance by the end of the twentieth century, religion has continued to thrive around the globe. In the twenty-first century the world religions of Christianity and Islam continue to grow in particular, with Christianity expanding into Asia and Africa, and Islam in the Middle East, Europe and Asia (Pew Research Centre, 2015). Western countries are largely multi-cultural, multi-faith societies with the continuing movement of peoples from developing nations to developed nations. An often uneasy truce between religious organisations and their claims for public recognition and state assistance and the state protecting religious freedom while maintaining secular government currently characterises the political landscape of numerous western nations.

In Australia, this truce is underpinned by a multiplicity of factors. The 2016 Census[2] figures show that traditional forms of religion are declining amongst the population while smaller world religions such as Islam, Sikhism and Hinduism have grown, mainly due to immigration over the last Census period. Importantly, the “No Religion” category has now become the largest single group identified in the Religion category. However, 69.9% of the population are still designating religion as important, and just under a quarter of all Australians nominate as Catholic (ABS, 2018).

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[2] The Australian Census is held every 4 years and represents a systematic collection of information from the Australian population across multiple categories of which religion is one. The Census question on religion remains the only question where respondents are able to nominate a category of religious practice/belief.

Statistics (◘ Table 10.1)
Despite the decline in traditional religions, religiosity remains a significant factor in signalling identity and belonging. Within this, of course, there are noteworthy differences.

◘ **Table 10.1** Top 20 Religions in Australia – 2016 Census (ABS, 2017a)

2016	**2011**
No religion – 30.1%	Catholic – 25.3%
Catholic – 22.6%	No religion – 22.3%
Anglican – 13.3%	Anglican – 17.1%
Uniting church – 3.7%	Uniting church – 5.0%
Christian, (not further defined) – 2.6%	Presbyterian and reformed – 2.8%
Islam – 2.6%	Eastern orthodox – 2.6%
Buddhism – 2.4%	Buddhism – 2.5%
Presbyterian and reformed – 2.3%	Islam 2.2%
Eastern orthodox – 2.1%	Christian (not further defined) 2.2%
Hinduism – 1.9%	Baptist – 1.6%
Baptist – 1.5%	Hinduism 1.3%
Pentecostal – 1.1%	Lutheran – 1.2%
Lutheran – 0.7%	Pentecostal 1.1%
Sikhism – 0.5%	Judaism – 0.5%
Other Protestant – 0.5%	Jehovah's witnesses – 0.4%
Judaism – 0.4%	Sikhism – 0.3%
Jehovah's witnesses – 0.4%	Seventh–day Adventist – 0.3%
Seventh-day Adventist – 0.3%	Other Protestant – 0.3%
Latter-day saints – 0.3%	Salvation Army – 0.3%
Oriental orthodox – 0.2%	Latter-day saints – 0.3%

Source: (ABS, 2017c)

10.2.6 Religion and Education

In recent years, a main area of contention between religious organisations and the state is the role of religion in the Australian schooling system. This covers three areas: first, state funding of private schools the majority of which are Christian;

two, the national school Chaplaincy program; and third, teaching religious education in public schools. Currently, approximately 30% of Australian schools are religious with most of those being Anglican or Catholic (Rowe, 2017). Internationally, this represents a significant section of the education market and points to the growth of the private education sector over recent years. Private school funding began in the 1960s, when the Menzies liberal government began funding Catholic secondary schools. Funding increased via federal education policy and expanded significantly in the 1990s under the Howard liberal government (Maddox, 2011). By 2008, nearly 40% of all school students were being educated in the private sector of which over 90% were religious (Maddox, 2011). A small percentage of private schools are Jewish and Muslim, and many private religious schools charge high fees thus restricting entry to those who can afford it.

The place of religious education in public schooling continues to be controversial (Halafoff & Byrne, 2014; Halafoff, Singleton, Bouma, & Rasmussen, 2019). Historically, public schooling was established in the states as 'free, secular and compulsory' (Maddox, 2011, p.301); yet, under pressure from Christian groups, religious faith-based education has been taught in state primary and secondary schooling for decades. In some states, such as NSW, education policy has involved students having to opt-out of religious education classes and not given educational alternatives until recently. In 2016, Victoria moved to shift religious education by faith groups out of state schools and include in the curriculum secular religious education which was premised on a diversity of cultures and viewpoints and aimed to increase understanding of world religions and ethical values (Halafoff et al., 2019).

While we have determined that Australia is religiously diverse and pluralist and that this can make a positive contribution to social and cultural capital and well-being, there are clearly areas of concern where some religions have been relegated to a marginalised status in Australian cultural life, where the position of women in patriarchal religious organisations is compromised and also where the hegemony of major Christian organisations seek to ascertain rights to discriminate against particular often vulnerable cohorts. The following three examples examine this problematic in detail.

► Example 1 Islam, Accommodation and Diversity

According to the 2016 Census, just over 600,000 or 2.6% Australians identify as belonging to the Muslim faith (ABS, 2018). This is a growth of 27% from 2011 and signifies a small growth indicator. In the broad Islamic population, the medium age is 27 indicating that the cohort is young, and just over 62% of believers are born overseas and now live largely in major cities. As Milani (2015, np.) states: 'As a young and diverse community , the future of Islam in Australia is still in the making'.

Beyond population figures, the Islamic community is very diverse in terms of country of origin, cultural and faith practices and opinions (Milani, 2015). The fact of this diversity often gets lost in public perceptions of Islam and can be fuelled by Islamophobia and ignorance of the basic tenets of the religion. A conflation between Islam, fundamentalism, violence and terrorism has been particularly problematic in shaping public opinion and has been fuelled by certain media, right wing groups and individuals, some of whom are state and federal politicians (Almond, 2019; Grattan, 2017; Pio, 2019). The idea of Western Christianity as benign and Islam as violent and aggressive, is, according to Almond (2019) and Said (1978), premised on historical mythical and ideological notions that construct Islam as the exotic violent cultural other to civilised European Christian states. This creates an ongoing underlying fear expressed through Islamophobic discourse that the state may be in danger of compromise when providing accommodative responses to the needs of Muslims, such as opportunities for prayer and dietary requirements. In some countries such as Canada, Germany and the UK, the state has controversially provided legal avenues that accommodate Muslim legal systems, including aspects of Sharia law (Goldenberg, 2013) although that seems unlikely to develop in Australia. Given the instability of politics in the Middle East and the instances of terrorism linked to Islamic fundamentalist groups such as ISIS, the Taliban, Boko Haram and their reach across the globe, it is not surprising that waves of moral panic have resulted in exclusionist foreign policy, racism and public panic. Such responses fail to recognise the contests between and within Islamic traditions and cultures and the great diversity of Islamic expressions (Almond, 2019). And it also fails to recognise the violent histories of Christianity in colonial and post-colonial Australia, particularly in regard to sectarianism and the treatment of Indigenous Australians.

Without doubt, Islamic communities in Australia have been largely accommodative of Australian cultural ways and legal systems, but one area that has been particularly problematic is that of gender, and specifically the position of Muslim women who veil. The human rights of Muslim women tend to act as a key litmus test applied to the accommodative capacity of Muslim communities to Australian values (Abraham, 2007). In popular conservative discourse, Muslim women are often stereotypically portrayed as being oppressed by Muslim men and lacking agency and autonomy and in need of rescue from patriarchal Islam (Carland, 2017). Western attitudes championing the freedom of sexual expression and the rights of women to equality are often articulated as central values of Australian society, despite evidence to the contrary that women in general face higher levels of personal violence and inequality in the workplace (Sandy & Powell, 2016). Since 9/11, a new intensification of anxiety around women who veil has played out in a number of ways in Australia (Abraham, 2007). Conservative politicians have attempted on numerous occasions to pass legislation banning the wearing of veils in public places. This has been attempted unsuccessfully in NSW parliament in 2010 and again in 2014. In 2014, a number of federal parliamentarians fuelled by supportive comments from the then Prime Minister Tony Abbott, moved—unsuccessfully—to ban women wearing the burqa or niqab from entering Parliament House (Maley, 2014; Zein, 2014) on the basis that they may be terrorists.

It is also the case that instances of terrorism linked to Islamic fundamentalism tend to create moral panics where Muslim women are often the target of violence. In 2014, when anxiety about the recruitment of young men to ISIS in Australia was heightened, Muslim women in south-west Sydney reported being spat at in the street, their veils yanked off, physically harassed and not feeling safe enough to leave their homes (Maley, 2014; Zein, 2014). Despite a clear counter-discourse from women, Islamic groups, politicians, journalists and academics contesting the representation of Islamic women as oppressed, the idea that Muslim women are passive and voiceless and Muslim men are patriarchal and dominating persists (Aly & Walker, 2007). This kind of specialist treatment of a small cohort of women who wear head, face and body coverings and who are already culturally marginalised demonstrates that it is often women who bear the brunt of national insecurities around security and safety in a post- 9/11 world.

Of course, there have been important developments in inter-faith dialogue between Christian, Muslim and Jewish groups and the diversification of Islam in Australia is slowly being publicly recognised. However, the implications for well-being amongst Australians who identify as Muslim remain a concern. ◄

► Example 2 Marriage Equality and the Question of Religious Freedom

In recent times, religious freedom has become a point of contention and debate focused around calls for further protections for religions to be enacted as part of federal anti-discrimination laws (Elphick, Maguire, & Hilkemeijer, 2018).

Protection of religion is already enshrined in Section 116 of the Australian Constitution which sets out the relationship between the rights of Australians to practice their religious beliefs accordingly, and the requirement that religious belief not interfere with the practice of public office. In effect, this was intended to settle the place of religion in Australian public life, ensuring that it was principally a private undertaking while protecting the secular character of Australian government. Religious belief and practice is also protected in state and federal anti-discrimination and equal opportunity law and religious groups enjoy a number of exemptions, including the payment of certain taxes and abiding by human rights laws that might restrict observance of religious rules. For example, in training programs for ministry, Catholic priests are only men, as ordaining women is against canon law provisions. And in the education sector, religious schools can refuse to employ staff and educate students who identify as LGBTQI+ on the basis that it is contrary to the values of tradition (Elphick et al., 2018).

Since the successful passing of the marriage equality laws in 2017, the call for further protections for religious groups has grown in some quarters. The reason for this is a perception that equal marriage might lead to discrimination of those who do not support marriage equality but who, through law, are forced to act against their religious beliefs. The famous example demonstrating this case is that of the 'gay wedding cake' where a baker refuses to bake a wedding cake for a gay couple based on their religious opposition to gay marriage. If the baker refuses, they are then breaking the law (Elphick, 2018). Other arguments from conservative Christian leaders championed the need to protect religious groups so that they could continue teaching religious doctrine that mitigates against LGBTQI+ rights.

In 2018, the federal government instigated a report into religious freedom in Australia to determine if current Australian law had effective protections for religious belief and practice (Religious Freedom Review, 2018). The report recommended that there be new federal laws to prohibit discrimination on the basis of religion, and in line with the states, effect further coverage of rights (Elphick et al., 2018). However, this also raised the issue of whether such laws would allow religious groups and individuals to effectively discriminate against others with whom they had moral disagreements, particularly LGBTQI+ people. Although, as mentioned above, religious groups already enjoy exemptions in human rights laws, the proposed laws would provide further protection and allow the circulation of public speech that could be harmful to already vulnerable cohorts.

The current situation in early 2020 is that following thousands of public submissions reviewing this legislation over two rounds of consultation, the government has delayed the introduction of new laws while it further examines details of the bill. It has come under opposition from various groups including the Australian Human Rights Commission and mainstream religious groups who do not think that further protection of religious rights is required (Martin, 2019) and if implemented could lead to a deterioration of religious pluralism and social cohesion by validating religious 'hate speech'. It does seem that the main supporters of the bill are conservative Christian groups who represent a very small proportion of the population. And there are serious concerns that the bill is structured to protect religious rights at the expense of other human rights (Karp, 2020). For example, the bill currently provides for religious organisations, such as hospitals, aged care centres, and disability services, the right to discriminate against employing staff on the basis that their religious ethos would be compromised and this will mean that blanket forms of discriminatory employment practices would be allowed (Karp, 2020).

While there has been government support for religious organisations to enjoy specific exemptions in human rights laws, it is also the case that this is contentious and perceived by many groups and individuals as an unnecessary accommodation to religious organisations. Without doubt, this contributes to an unsettled landscape around the rights of LGBTQI+ persons and groups. ◄

► Example 3 The Child Sexual Abuse Crisis in Religious Organisations

As noted above, for much of the nineteenth and twentieth centuries, religious organisations were actively engaged in community building and welfare work. Alongside the development of secular social policy aimed at redistributing wealth and providing welfare provisions and services for low socio-economic groups, religious organisations were providing parallel services as part of their mission to care for the more vulnerable people in their midst. One of the most vulnerable cohorts were children in poverty and from the early 1800s the Catholic church, in particular, undertook significant building programs including orphanages, boarding schools and missions to care for children. As well, parish schools and those run by religious orders multiplied and taught and cared for thousands of children over many decades. Many of these provided education, housing and care for poor children, but amongst the upper classes, elite Catholic boarding schools and university colleges were popularised.

In the early 1980s, reports of the sexual abuse of children in Australian religious institutions began emerging into public discourse, and importantly, the media began reporting on a growing number of cases. This was not a new phenomenon. As the historian Shurlee Swain points out, institutional abuse in child organisations has a long history in Australia with numerous inquiries and reports addressing the question of child safety and abuse from the early 1800s (Swain, 2018). From the late 1990s, a number of important public inquiries[3] specifically addressed the treatment of children

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[3] Historical Inquiries include – National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families 1997; Report of the Commission of Inquiry into Abuse of Children in Queensland institutions 1999; The Forgotten Australian Report, 2004; the Victorian Parliamentary Inquiry into the Sexual Abuse of Children in Victorian Institutions, 2013; and the NSW Special Commission of Inquiry into Child Sexual Abuse in Newcastle-Maitland, 2014.

(Swain, 2018, p.154), and, as evidence grew, supported by advocacy groups and media reportage, it led eventually to the establishment of the *Australian Royal Commission into Institutional Responses to Child Sexual Abuse* (2012–2017). The Royal Commission (2017) investigated the status of children across the breadth of Australian institutions, including sporting, artistic and cultural organisations, detention centres, schools and orphanages with a focus on how institutions had responded to reports of child sexual abuse and the outcomes of this. The largest group of institutions investigated by the Royal Commission were religious organisations where it became clear early in the life of the Royal Commission that such organisations had allowed the wide spread sexual abuse of children by religious workers to continue with little interference resulting in a systemic failure to protect children from harm (McPhillips, 2018).

The Catholic Church had the highest level of cases of child sexual abuse with 13 of the 57 public hearings addressing Catholic schools, parishes, orphanages and institutional redress mechanisms (McPhillips, 2018). The Royal Commission found that not only was there a systemic failure to protect children but that in many instances, religious authorities deliberately protected the perpetrator above the needs of the children by moving them around, denying that abuse had occurred, blaming and punishing victims who spoke out and using religious laws to slow and stymie responses to victims (Doyle, 2017; McPhillips, 2018; Tapsell, 2018). Perpetrators were mainly priests and religious brothers and a smaller number of lay teachers, youth group leaders and religious women. The public hearings from hundreds of survivors about their experience of sexual abuse and the documentation from the Royal Commission constitutes an important body of knowledge about this appalling travesty of justice in Australian social life.

The impacts of sexual abuse on children are well documented (Blakemore, Herbert, Arney, & Parkinson, 2017) and the effects are often debilitating and life-long, including adverse psychological health and well-being, impacts on social relationships and educative capacities, spiritual health, financial security and in many instances, suicide (Blakemore et al., 2017; Middleton et al., 2014). Over 8000 survivors gave evidence before a Royal Commissioner in private hearings and attested to the damage that abuse as a child had caused but also to the damage inflicted by poor responses from the particular institutions. Because religious institutions were generally respected as places specialising in pastoral care, they were trusted by the public and by Church members. The final report of the Royal Commission (2017) noted that in relation to religious organisations:

> …these institutions have played, and continue to play, an integral and unique role in many children's lives. They have been key providers of education, health and social welfare services to children for many years. They have been among the most respected institutions in our society. The perpetrators of child sexual abuse in religious institutions, were, in many cases, people that children and parents trusted the most and suspected the least. (p.44)

The outcomes of the Royal Commission findings and report, along with other public inquiries, indicate that public confidence in religious organisations to care for children and other vulnerable groups has been severely affected. Indeed, the results of the NCLS 2016 Church Life Survey report that Catholics had experienced 'a serious erosion of trust in the hierarchical leadership of the Church' (Millar, Vedelago, &

Schneiders, 2018, np.) Whether the Anglican and Catholic Churches can recover their status as trusted institutions is debatable. Their responses to the recommendations of the Royal Commission will be a key test of their intention and capacity to address governance problems and cultural change. Change so far has been slow and uneven (McPhillips, 2020). ◄

10.2.7 Conclusion

Religiously diverse, multifaith societies are characteristic of many countries in the twenty-first century, including Australia. Without doubt, as commentators have argued, the brief age of Christian dominance in Australian social life is quickly passing (Bouma, 2011) and new forms of belief are shaping social discourse and policy. The idea that the state would be underpinned by one religion and this would be the basis of social cohesion has long passed and 'diversity is the new normal' (Bouma, 2011, p. 14). While this is true, it is also the case that Australian institutions and public life are still shaped by Christian rituals, calendars and values.

Hence, religious diversity remains currently an unsettled space where the inclusion of different languages, cultural traditions and religions into public discourse and social organisation is still in a state of accommodation (Bouma, 2011). For example, the Australian Human Rights Commission (n.d.) has provided guidelines for work-places on incorporating the requirements of faiths for daily prayer into daily work life and a complaints mechanism for where this is not met. Many Australian foods have been certified by government bodies as being Halal compliant and the display of religious symbols in public places, such as schools and community centres, is generally accepted (Parliamentary Library, 2016).

Such diversity is only likely to increase as we witness ongoing migration across the globe for multiple reasons. We have seen that religious pluralism is generally valued and continues to make a significant contribution to social cohesion and Australian identity. We have also seen that religions other than mainstream Christianity can be represented in ways that are marginalising and stigmatising and that Christian hegemonism continues to make demands on the state for further rights and, in some instances, these are at the expense of religious, sexual and ethnic diversity. An important contribution to social cohesion is the work of interfaith and multifaith groups. An audit of multi-faith/interfaith groups in Australia by Ennis and Cahill (2018) found a small but engaged group of individuals and groups working to increase and support local and national initiatives around the social benefits of religious diversity. State policies that encourage equality and strong anti-discrimination and human rights laws also provide a necessary framework for social cohesion as do religious education programs that focus on world religions and are taught from a secular standpoint. Valuing religious diversity across all levels of social engagement is important and will have an impact on the well-being of individuals and groups.

The GenZ report[4] (Singleton et al., 2019) is perhaps one of the strongest indicators of how religious diversity will be valued in the future. Contemporary teenagers (13–18) comprise the Generation Z cohort and are most exposed to diversity in community and schools across the nation. The report showed that while the majority of teenagers do not identify with a formal religion (52%), over 91% of respondents believe that having a community of people from different faiths made Australia a better place to live (Singleton et al., 2019). This GenZ cohort overwhelmingly supported marriage equality (82%) and had a positive attitude to other world religions, particularly Islam, Hinduism and Buddhism (Singleton et al., 2019). Given that most of this cohort is likely not to be religious, it is very encouraging that their attitudes to those who are religious is generous and accepting.

10.3 Personal Stories and Current Affairs

10.3.1 A Pound of Flesh

Maxine Rosenfield

Growing up in northern UK in the 1970s, I was indoctrinated to ‘keep quiet’, ‘keep your head down’, never ever talk about money and never about being Jewish.

We lived in the North Manchester ‘ghetto’ area which was safe and secure, amongst ‘our own kind’. I attended a Jewish primary school where I learned about my heritage and the customs and practices of the faith, even though my family were not ultraorthodox, synagogue- attending on a weekly basis Jews. We were called ‘three times a year’ Jews—only attending on the Highest of the High Holy Days (Rosh Hashanah and Yom Kippur and sometimes Succot and SImchat Torah too—all around September/October). My dad worked on Saturdays, though we kids always had to dress nicely and we stayed home until I was old enough to have a Saturday job too. My family, however, was quite strict about their diet, never mixing milk and meat, only eating Kosher meat and observing Passover with the caging over of pots and pans and eating a complete change of food, guaranteed to be ‘leaven free’ for eight days (March/April, close to or during Easter).

At age 14, my parents moved us to the opposite side of the city. There I entered an anglicised world, foreign to me because even my previous high school had such a high proportion of ‘us’ in it that we were safe from the outside world prejudices.

The move to ‘south side’ plunged me into being the only Jew in the school (I was reliably informed). I was identified because of my darker skin and my surname. There was one Muslim Egyptian-born girl in my year and we actually had similar colouring and features, which served to make me more of a target. She had a big

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[4] A national report from findings into a study undertaken between 2016 and 2019 with school-aged teenagers aged 13–18 and which asked a variety of questions concerning views on sexuality, ethnicity and religion. Generation Z is those who are born post 2000.

sister at the school and seemed to be accepted. Most Muslims did not dress any differently to the rest of the white population and were 'exotic' in those days.

Sitting in a class in alphabetical order, next to a girl who had a cleft lip and was very popular, being sporty (I wasn't- we Jews were encouraged to be academic, not sporty), I was told that she was a Quaker and Quakers hate Jews. I am not sure this is accurate philosophy but coming out of nowhere, it was a shock to the core. I kept my head further down and my mouth further shut. She also told me Jews were evil because we killed Jesus. And this was at a selective grammar school, populated by intelligent and academically bright girls.

English lessons became hell. The teacher, a 'born again Christian' who ran the school's Christian Society lunchtime club, was Jewish born and was now virulently anti- all things Jewish. Added to that, our Shakespeare text for our national year 10 exam was 'The Merchant of Venice', an openly anti-semitic play. It was a year of hell in English class where I was constantly held up as spokesperson for all things and actions Jewish 'all Jews are careful with their money aren't they Maxine..?'; 'Shylock is like many Jewish men, scheming and grasping, isn't he Maxine?' and many more painful jibes, to which I was powerless to respond.

The teacher's club lackeys were in my class, of course, and occasionally picked on me at other times than English class, but I put my head down, kept quiet and never replied to anything.

In the Merchant of Venice Shylock's big speech goes:

> » I am a Jew. Hath not a Jew eyes? Hath not a Jew hands, organs, dimensions, senses, affections, passions; fed with the same food, hurt with the same weapons, subject to the same diseases, healed by the same means, warmed and cooled by the same winter and summer as a Christian is? If you prick us do we not bleed? If you tickle us do we not laugh? If you poison us do we not die? And if you wrong us shall we not revenge? If we are like you in the rest, we will resemble you in that. If a Jew wrong a Christian, what is his humility? Revenge. If a Christian wrong a Jew, what should his sufferance be by Christian example? Why, revenge. The villainy you teach me I will execute, and it shall go hard but I will better the instruction. (III.i.49–61).

Shylock seeks a pound of flesh as payment from Bassanio if he forfeits paying back money that Shylock has lent him to woo Portia.

Portia, the judge finishes her pronouncement with 'But wait a moment. There's something else. This contract doesn't give you any blood at all. The words expressly specify "a pound of flesh." So take your penalty of a pound of flesh, but if you shed one drop of Christian blood when you cut it, the state of Venice will confiscate your land and property under Venetian law'.

The Jew is mocked, humiliated, and, given there were no Jews in Elizabethan England after their exile in 1290, any myths of Jews being ritual murderers (such as kidnapping Christian children at Passover to use their blood in ceremonies) perpetuated unchallenged. In 1970s Manchester, I was mocked, humiliated and felt I should defend my entire race against ignorance and myths. But I put my head down and kept silent for fear of antagonising the perpetrators.

The holocaust impacted millions. My own family lost members, those who had not escaped their homes in time; the rest fleeing to Paris, Manchester, Texas and Tel Aviv. I grew up in the North Manchester ‘ghetto’ knowing some people who had blue numbers tattooed on the underside of their forearms, but those people never talked about what the numbers were.

Some people were anti-German—I remember a metallic pencil sharpener with ‘Made in W Germany’ on the back and being told I couldn’t get THAT one because it was ‘German made and we don’t want to help the Germans’. I studied German at high school because it was like the Yiddish I heard spoken in the family and community . It felt disloyal yet I was curious to know this language because it was similar to words I heard growing up. Besides this was the 1970s, surely some Germans were OK people?

As I moved into the professional world as a student and then in radiation therapy, counselling and teaching I kept my head down and mouth shut except when I saw injustices and then sometimes I would join a protest or write a letter. It took me years, well into my 20s, to feel comfortable with my family name as I became comfortable and confident within myself, and then it became a source of pride, and defiance, to use it.

I live in Australia now and whilst Australia has had a broader perspective than other countries in terms of Jews being able to hold high office (two Governors General have been Jewish) and participate as equals in political and military life, anti-Semitism does rear its head. It turns out that my school experience was and still is, experienced.

The Age published an opinion piece on 4/10/19 ‘Antisemitism in Victorian Schools is a monumental and hidden crisis’ citing examples of Jewish primary and high schoolers being targeted in their schools.

I feel shame when I read of atrocities committed between Israelis and Palestinians, but I was proud, oh so proud, of little Israel beating the mighty Arab nations in the Six Day War (1967) and Yom Kippur War (1973). I feel proud of the achievements of the early settlers in the newly defined state of Israel post 1948, thanks to the British Balfour Declaration of 1917. Imagine making the desert bloom, growing crops in inhospitable places. But I feel great shame at the actions of my race in the ‘Intifadas’ in the late 1980s and the early 2000s. No one is blameless, nothing is one sided, and I can be reduced to the teenager in the classroom when I hear anti-Semitic remarks being made in general society, as a ‘joke’.

In my naïve teens, it seemed right that all should be equal in society, everyone should have their fair share of pay for their labours and equal opportunity for education and health care. I flirted with the idea of kibbutz life in my idealistic dreams, but I had to get my studies completed first (‘don’t waste a good brain’) and by the time those days were over, I could see with clearer vision that nowhere was truly equal.

I am certain that my experience has led to me being more accepting and more curious about difference in race, ethnicity, religion, lifestyle, but don’t try to push your views onto me, whatever they are. I may listen and argue points of politics, or current affairs, but don’t tell me you are superior because of your race, social class or religion. At this, I will silently retreat, and we will have no further contact.

My experience has led to me being a watcher, often silent in a group, only pitching in my views if I sense there will be acceptance, or mature debate. Passion is diverted into other spheres where I have ‘influence’, in my teaching, in my counselling and supervision practices, amongst my family; the outside world remains a potentially hostile place for ‘people like me’—I can become the teen in the English class in a few seconds. I have focused many areas of life on trying to help others to reach their potential, irrespective of who they are, their family of origin, their views. This is easier to do in Australia than in England, even today. I am not judged by my accent as soon as I open my mouth. I learned how to play a safe game and advance my life within my social class constraints in England, I breathe much easier in Australia—but my conditioned response is to be always wary. I know and trust myself well; that is the lasting impact of my early years.

10.3.2 The Allure of Belonging; a Muslim’s Reflection on the Pressure of Secular-Christian Conformance

Ridwan Haq

The weight of religious hegemonism and its imposition on those off the margins is a phenomenon I have come to perceive as a long-standing fixture in my self-identity framework. The conscious appreciation of this, however, has only come well into my late 20s, leaving a large gap where this confluence was processed at a subconscious level. For the sake of clarity, I should disclose my perception of the religious hegemony, as a Brown Muslim male, as that of a White secular-Christian construct. I use the term ‘secular-Christian’ as I have often perceived the framing of our ‘secular’ society, and its companion ‘the Australian way’, as constructs imbibed with Christian values and attitudes. As such, I will use these terms interchangeably throughout this essay.

I will begin this reflective journey in my mid-teen years, the period where I first became consciously aware of my hybrid identity as an ethnic and religious minority. While lacking the intellectual capacity to comprehend what was transpiring, I was facing the common struggle experienced by young Muslims in Western settings; that between upholding the values of my nation of residence and my inherited ethnicity/religion. The balancing of this dichotomy felt akin to being the servant of two masters, with neither satisfied by my efforts to appease the other. This ideological conflict involved negotiating discrepancies between traditional Islamic values and the secular-Christian paradigm that underpins Australian societal norms. At a base level, examples of such clashes revolved around social relations with the opposite gender, sexuality in general, appropriate clothing standards, consumption of alcohol and values towards gender and sexual equality.

My experience with fellow young Muslims has found this clash to result in varying degrees of assimilation towards the secular-Christian values that underpin the ‘Australian way’. This assimilation often results from the pressure to align to a standard way of being, with the underlying reward being that of ‘belonging’ in

Australia. This pressure is perhaps felt more strongly from those of non-White ethnicities, where the colour of our skins acts as a subtle but inherent barrier to the goal of being viewed as an unconditional Australian. This invisible barrier is one that I subconsciously perceived during my mid/late teen years and perhaps why I chose such an overt identification and subscription to the secular-Christian way of being. I had several romantic relationships (not at the same time of course), went out clubbing and partying and very much bought into the drinking culture that is so engrained within the 'Australian Way'. I viewed partaking in such activities as my rights of passage that would signal my subscription to the status quo.

Beyond these overt measures, assimilation to the hegemony involved various gestures that (while minute), allude to a larger desire to appear as assimilatory as possible. A simple example of this is always saying '*bless you*' when someone sneezes, as opposed to the traditional '*alhamdulillah'* greeting that is typical within Islamic culture. I would often (and still do if I am being perfectly honest) wish people a 'Merry Christmas', even though my religion does not partake in the event. Christmas festivities represents perhaps the most challenging and overt example, for young Muslims, of our divergence from the religious hegemony. The months leading up to Christmas represented a yearly reminder of my exclusion from the norm of Australian society. Being unable to answer simple questions like 'What are you hoping to get for Christmas' often engendered a sense of forlornness and isolation, a reminder that I (as much as I tried) did not truly belong in Australian society.

Within my desire to assimilate to the centre, I positioned myself as an Australian first and thus ascribed to the popular assimilatory mantra of migrants needing to embrace Australian culture. I was on-board with rhetoric of migrants needing to confirm to our secular-Christian beliefs and was in favour of migrants needing to take values tests before being permitted entry. Australia is a Christian nation, I would always say as a teen, and thus it is imperative that everyone conform to the ways of the nation. In my desire to signal conformance to the central ethos, teenage me believed Islamic women should not wear the hijab/burka, as it is not the norm within Christian societies. It was non-negotiable (in my mind) that Muslim men should freely mingle with women (and vice versa), as this was the standard within a secular-Christian paradigm. I felt individuals should always make the effort to speak English in public, as this was the language of the land and thus should be respected. My sociological schema was, at the time, not sophisticated enough to appreciate the problematic undertones of such a position, with its supporting of a monoculture aligned with a White secular-Christian framework. It is only in adulthood that I have come to appreciate the pressures this conformance places on those seeking to retain a religious identity whose values deviate from the status quo. One should not feel obliged to freely mingle with the opposite gender if doing so engenders a great sense of discomfort. One is not obligated to speak English in a land whose Indigenous ancestry encompasses hundreds of dialects dating back thousands of years. Upon reflection, this is perhaps the greatest trick of multiculturalism and the 'Australian way'; its pretention of an acceptance of ethnic and religious diversity, provided said diversity conforms to a central unifying ethos.

I would like to briefly traverse to the problematic ‘Othering’ of Islam as this performance has troubling implications for Muslims interacting with the White secular-Christian hegemony. It is difficult to discuss religious hegemonism, as a Muslim, without acknowledging the post 9/11 paradigm that saw the discursive association between Islam and extremism. Within this sentiment includes the ‘Othering’ of Islam as a faith whose values are irreconcilable with the Australia’s secular-Christian ethos. Upon reflection, this ostracization is one I perceived in my teens and contributed to my desire to adopt a strong nationalist identity—an identity free from the troubling discursive associations being placed on an increasingly homogenised male Muslim identity. Indeed, this troublesome view of Islam perhaps explains my overcompensation towards secular-Christian values; an overall desire to be ‘one of the good ones’.

Within this established schema of national identity, I became critical of my religion’s attitudes towards women’s rights and gender equality. Beyond the perceived inequalities facing Muslim women surrounding family customs, sexual and gender inequalities were issues that particularly troubled me. Within my cognitive framework, the Hijab/Burka represented injustices to gender equality, garments that forced women to veil femininity to ensure appropriate engagement with the opposite gender. The fact that men were not required to employ similar practices represented an inequality irreconcilable with my notion of basic gender equality. My frustration with traditional Islamic relations led me to fall victim to the discursive trap of anointing secular-Christian society as a liberating force for Muslim women. On the surface, it is not difficult to see why such a framework is appealing. As a prescriber to the ‘Australian way’, being a part of a culture that ‘liberates’ Muslim women from the shackles of oppression is a romantic notion. The troubling ease with which such a notion can be accepted is evident with my personal example; I, as a brown Muslim male, was perfectly willing to buy into the narrative of White culture saving brown women from brown men.

What I failed to recognise of course is that my gender values were formed and based on secular-Christian notions. My submission to these values left no room for cultural nuances, the desires of Muslim women and their views of femininity. Many take pride in wearing their headscarves as a symbol of their religiosity and modesty. However, my rush to vanguard the secular-Christian spirit left me perfectly willing to remove the autonomy of Muslim women to make this decision about their own attire. While I do still have reservations regarding the power gap between the genders in Muslim communities, I now appreciate that such issues are best solved internally, and not through forced imposition from an external force.

This last example is a nice snapshot of the overall theme of my relations with a religious hegemony I am an outcast from—an understanding that my faith made me inherently alien from the status quo. A recognition (even subconsciously) that results in a pressure from the status quo, a tug towards centre with the purported rewards of acceptance and belonging to a greater collective. As an adolescent, I fully succumbed to these pressures and shaped an identity that I look back on with a tinge of regret. As an adult, I have come to embrace uniqueness and non-conformance to a status quo. I have come to appreciate that things need not be the same. The comfort of the hegemony is not a fair price for the loss of one's ability to express cultural and religious diversity. Such is the message I wish I had received during my teenage years, and one I hope is being given to the current youth in similar situations.

10.4 Experiential Activities

Important

The experiential learning activities are designed to enhance cultural responsiveness. When engaging in experiential activities, it is important to create a safe environment for participants to explore potentially uncomfortable feelings or situations. Facilitators should consider the type of activity and role of the participant and they should provide participants with ways to resolve feelings that may arise as a result of the activity, including reflection and debriefing.

Activity 1

Title Privilege statements – Religious hegemonism

Purpose Privilege refers to the special rights or advantages available only to a particular person or group. Sometimes a person or members of a group do not recognise the privileges they hold, and so they are perpetuated within individuals, families, communities and society in general. This activity is intended to raise students' awareness of some privileges they may take for granted.

Adapted from: University of Houston (n.d.). *Understanding Privilege* [Diversity Activities Resource Guide]. ► https://www.uh.edu/cdi/diversity_education/resources/activities/pdf/diversity%20activities-resource-guide.pdf

Process Read the following privilege statements related to religion. Count how many of the statements you identify with or you feel are true for your experience. Count how many of the statements that you do not identify with or feel are not part of your experience.

1. Most of the religious and cultural holidays celebrated by my religion are recognised with days off from work or school.
2. I have missed work or education events (for example, lectures, exams) because of my religious requirements.
3. I can feel comfortable speaking about my religion (or lack of religion) without feeling that I'll be judged.
4. I can feel comfortable meeting the requirements of my religion without feeling that I'll be judged.
5. I can find an appropriate place of worship within a five kilometre radius of where I live.
6. It is expected that I maintain the same religion as my parents and grandparents.
7. I have never lied about my religion as self-defence.

8. I have never been threatened because of my religious beliefs.
9. I have never been attacked because of my religious beliefs.
10. Nobody has ever tried to save me from my religious beliefs.

Are the scales balanced, or tipping one way or the other?

Questions

Reflect on the following questions:

- How did you feel doing this activity?
- What does it feel like to have, or not have certain privileges?
- Can you identify other privileges that you may or may not experience?

Outcome Students consider some of the many forms of privilege in their environment, and if and how these impact them personally. By raising awareness of potentially invisible privilege, students become more sensitive to the multifaceted nature of religious hegemonism within society.

Activity 2

Title Photovoice: Religion and spirituality in my environment

Purpose The concept of 'photovoice' allows students to use photography to identify and communicate perspectives of social issues in their environment (Photovoice, 2019). Students then use these images to examine and understand the social system and their role within that system, thus facilitating a greater awareness of social justice, social privilege and cultural sensitivity.

Process In this activity, students are asked to visually represent how religion or spirituality appears to them in their social environment. Ask students to take a photograph of something that represents religion or spirituality for them in their social environment. This does not need to be a formal religious institution. Rather, students are asked to explore beyond the structures of religion to the fundamental meaning of spirituality as they perceive it. Remind students not to include recognisable faces in the images they take, as these photos will be shared with other members of the class.

In pairs or groups, each student tells the story behind their chosen photograph, and how and why they feel it represents religion or spirituality. As a larger group, identify common themes in the images presented, and reflect on the following questions.

Questions

1. Were you surprised by some of the images of religion or spirituality presented by your fellow students?
2. Did you gain a greater understanding of the personal meanings of religion or spirituality from the images presented by your fellow students?
3. How could you apply this growing awareness to the people you may be working within?

Adapted from: Ergüner-Tekinalp, B., & Harper, A. (2011). Photovoice: Understanding social privilege. In

M. Pope, J. S. Pangelinan, & A. D. Coker (Eds.), *Experiential activities for teaching multicultural competence in counseling* (pp. 222–224). American Counseling Association.

Outcome By studying images and listening to the stories behind them, students will develop a greater awareness of the diversity of meanings behind a person's religion or spirituality.

Activity 3

Title Where did that knowledge come from?

Purpose Knowledge comes from many sources, some of which we are unaware. This activity requires students to write one descriptive comment about some of the identified top religions in Australia and identify where their knowledge or impression originated.

Process Students read through the list of religions in the table below and add one descriptive comment about that religion or spiritual belief (without referring to an online search engine or other sources). They can also choose to write 'unknown'. They must then identify how they developed that information—for example, media, family, or 'don't know'.

Students are reminded to be respectful in their descriptions.

Once the table is complete, students find a partner who they do not know well and compare lists.

Questions

Questions to consider are:

1. How similar, and different, are our descriptive responses?
2. How similar, and different, are our sources of information?
3. After discussion, could we identify any descriptions that may have been based on stereotypes?
4. How does this activity help develop self-awareness of stereotypes and assumptions about religious diversity?

The following table lists the top 20 religions and beliefs in Australia, as identified in the 2016 Australian Census (ABS, 2017a).

Religion or belief	What I know	How I know
Catholic		
Anglican		
Uniting church		
Presbyterian		
Islam		
Buddhism		
Hinduism		
Eastern orthodox		
Baptist		
Pentecostal		
Lutheran		
Sikhism		
Judaism		
Jehovah's witness		
Seventh-day Adventist		
Latter-day saints		
Oriental orthodox		

Outcome Religion can be a sensitive topic and often based on knowledge that has been passed down through families and cultures. Students gain a greater understanding of the diversity of religion and beliefs in Australia and learn to respectfully explore the source of this knowledge and how this can differ from others.

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Key Principles for Multicultural Perspectives and Responsiveness in Counselling and Psychology

Susan Sisko

Contents

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9_11

11

Trailer

In this chapter, Susan Sisko details multiculturalism and social justice as the fourth (Sue & Sue, 2016) and fifth (Ratts, 2009, 2011) forces in counselling and psychology. Further, the author describes significant recurring themes that have emerged in multicultural counselling and psychology. These themes have been structured into six interconnected principles that are based on leading research in multicultural perspectives and responsiveness in counselling and psychology and include; (1) decolonisation, (2) intersectionality, (3) cultural humility, (4) self-awareness, (5) engagement and connection, and (6) activism.

11.1 Multiculturalism and Social Justice in Counselling and Psychology

The interest in multicultural perspectives in counselling and psychology can be attributed to the increasing diversity of Australia. Australia's cultural diversity is evidenced by the broad variety of ethnic backgrounds, religions, cultures and languages that make up our population. In 2016, the Australian Bureau of Statistics indicated that 28% of the Australian population was recorded as overseas-born, with 49% of the Australia-born population having one or both parents born overseas—so almost half the population identified as either first or second generation. Diversity in the Australian population brings many positive dynamics to society, including knowledge from many cultures, arts, languages, religions, traditions, music and food—to mention just a few (Scanlon Foundation, 2019).

However, as the preceding chapters have highlighted, non-dominants groups—including but not limited to people who identify as Aboriginal and Torres Strait Islanders, people of colour, immigrants, asylum seekers and refugees, women, older adults, LGBTIQA communities and those living with a disability—experience discrimination, oppression and a lack of equity in Australia. Subsequently, non-dominant individuals and groups are disproportionately disadvantaged in a number of areas in comparison to the dominant group. This disadvantage manifests in terms of income, education, employment opportunities, access to resources and support (Australian Human Rights Commission [AHRC], 2020). Oppression and discrimination is perpetuated and experienced at individual, community and systems levels. What this means is that experiences of well-being for non-dominant individuals and groups living in Australia are lower than for those of dominant groups (Mental Health in Multicultural Australia, 2013; The Fifth National Mental Health and Suicide Plan, 2017). Both multicultural and social justice perspectives acknowledge the importance of diversity and recognise that oppression has a debilitating effect on mental health (Ratts, 2011). The Australian Psychological Society (APS, 2018) and Psychotherapy and Counselling Federation of Australia (PACFA, 2018) code of ethics both refer to guidelines related to the diversity and uniqueness of individuals and their rights to receive linguistically and culturally appropriate services. Additionally, multicultural responsiveness in counselling and psychology requires awareness, knowledge and skills and understanding the ways in which socio-political factors contribute to client experiences and understand how cultural variables shape the counselling relationship (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003).

Counselling has been described as having ‘multiple forces’—or historical traditions. The first force is psychoanalytic traditions, the second force is cognitive and behavioural traditions, and, the third force is existential and humanistic traditions. Multiculturalism and social justice are, respectively considered, the fourth (Sue & Sue, 2016) and fifth (Ratts, 2009, 2011) forces or historical traditions. Multicultural competencies frameworks emerged in counselling during the early 1990s—focusing on education, training, research and practices that were related to the counsellors’ attitudes, beliefs, knowledge and skills (Arredondo et al., 1996; Arredondo, Sue, & McDavis, 1992). Adherence to ethical guidelines of the counselling and psychology professions (APS, 2018; PACFA, 2018) requires cultural competence in counselling and psychology; however, Soto, Smith, Griner, Rodriguez, and Bernal’s (2018) metanalysis on multicultural competencies of therapists indicated that only 15 studies met inclusion criteria suggesting a need for additional scholarship on the topic. The metanalysis also indicated that few studies have been conducted to evaluate clients’ experiences in therapy decades after the multicultural competencies were promoted. This indicates that research of multicultural counselling and psychology will benefit from renewed interest and scholarship on this topic.

Further, the focus on cultural competency has begun to shift from mastery in understanding ‘others’ to a framework that requires personal accountability in challenging institutional barriers that impact marginalised communities (Fisher-Borne, Montana Cain, & Martin, 2015). The shift towards multicultural and social justice counselling perspectives encourages approaches that challenge the oppressive environmental conditions that hinder human development (Ratts, 2011). Goodman et al. (2004) define “social justice work of counselling psychology as scholarship and professional action designed to change societal values, structures, policies and practices, such that disadvantaged or marginalised groups gain increased access to these tools of self-determination” (p. 795). The authors also describe social justice work within counselling and psychology as happening on three different levels including individuals and families; communities and organisations; and finally, social structures and policies. Multicultural and social justice counselling perspectives help us to understand cultural differences and group identities but also to consider the importance of understanding relationships to power, access and opportunity.

Significant recurring themes have emerged that encompass the aims and objectives of multicultural perspectives in counselling and psychology. These themes have been structured into six interconnected principles that are based on leading resources and research in multicultural counselling (e.g. Arredondo et al., 1996; Australian Psychology Accreditation Council [APAC], 2019; PACFA, 2014, 2018; Ratts, 2009, 2011; Sue et al., 1992; Sue & Sue, 2016), social justice (e.g. Adams, Bell, & Griffin, 2007; Bell, 2007; Goodman et al., 2004), decolonising counselling and psychology (e.g. Goodman & Gorski, 2015; Hernández-Wolfe, 2011), cultural humility (e.g. Davis, Worthington Jr., & Hook, 2010; Tervalon & Murray-Garcia, 1998), intersectionality (e.g. Crenshaw, 1989, 1991; Hankivsky, 2014) and discrimination and bias (e.g. Australian Human Rights Commission [AHRC], 2013; Kahn, 2018; Payne, Vuletich, & Lundberg, 2017). The six interconnected principles include (a) decolonisation, (b) intersectionality, (c) cultural humility, (d) self-awareness, (e) engagement and connection and, (f) activism. Taken together, these principles can provide a framework to develop multicultural perspectives and responsiveness in counselling and psychology work in training, practice, research, policy and activism.

11.2 Six Key Principles for Multicultural Perspectives and Responsiveness in Counselling and Psychology

11.2.1 Decolonising Counselling and Psychology

Colonial knowledges have been privileged and assumed as core foundations in counselling and psychology, while different perspectives have been seen as deviations. A decolonising view recognises colonial impact and the power and privilege that remains associated with that. Most importantly, a decolonising view pushes us to gaze up at the power hierarchy where inequalities are embedded in systems and structures that privilege the few at the expense of the many (Goodman & Gorski, 2015, Location 331). Hernández-Wolfe (2011) describes a decolonised position as not just concerned with cultural difference or group identities but also with differences in power and access to opportunity. Researchers, educators, practitioners and policy-makers must challenge the hegemonic views that continue to marginalise non-dominant individuals and advocate for change that is based on values that promote equity, access and opportunity for all peoples. Decolonising counselling and psychology must be practised in the areas of research, teaching, practice and policy.

11.2.2 Intersectionality

Intersectionality offers an interpretive framework to identify individual and group intersections of privilege and oppression. Rodó-de-Zárate (2014) describes intersectionality as developing out of a growing recognition that it is not possible to separate out gender, race, class and sexuality identities and then to explain them through a singular framework. Therefore, researchers, educators, practitioners and policy-makers in counselling and psychology need to adopt an intersectional framework that recognises the complex and cumulative ways in which multiple experiences of identity combine, overlap, or intersect for individuals but especially in the experiences of marginalised individuals or groups. In order to address the inequities experienced by individuals who intersect with multiple forms of marginalisation, counsellors and psychologists must be able to make linkages between client identity, marginalisation and privilege (Ratts, 2017). Intersectionality is not only about focussing on multiple identities but it is also about addressing power, oppression and societal changes in response.

11.2.3 Cultural Humility

Cultural humility was first described by Tervalon and Murray-Garcia (1998) as a concept where practitioners engage in self-reflection and self-critique and as lifelong learners in multicultural perspectives. Davis et al. (2010) noted that definitions of humility typically included both intrapersonal and interpersonal components. The intrapersonal dimension describes individuals who are humble and demonstrate an accurate view of self. The interpersonal dimension describes individuals who maintain a position of being focussed on others rather than being self-focussed, for example, showing respect for others and a lack of superiority. In counselling and psychology, the culturally humble counsellor and psychologist is interested in and open to exploring the client's cultural background and experiences. PACFA (2018) Code of Ethics refers to cultural humility as awareness of our own beliefs, values, strengths and limitations without needing to claim superiority or correctness over others. A culturally humble counsellor and psychologist does not assume that their knowledges or theories are more valuable than the position of their client's worldview and experiences. Fisher-Borne et al. (2015) describe cultural humility as a position which considers the fluidity of culture and challenges both individuals and institutions to actively address inequity.

11.2.4 Counsellor and Psychologist Self-Awareness

Self-awareness has long been cited as a quality of the therapist, particularly as this relates to multicultural counselling (Arredondo, Sue, and McDavis, 1992; Arthur & Januszkowski, 2001). Pieterse, Lee, Ritmeester, and Collins (2013) define self-awareness as a "state of being conscious of one's thoughts, feelings, beliefs, behaviours and attitudes, and knowing how these factors are shaped by important aspects of one's developmental and social history" (p. 191). PACFA (2018) code of ethics includes self-awareness as a value where the counsellor recognises their perspectives and understands their biases and the impact of these on our clients and others. Counsellor self-awareness is directly linked to cultural humility and suggests that the counsellor and psychologist ought to maintain a willingness to constantly be aware of their own values, bias and attitudes—especially when working with marginalised individuals and groups. Further, counsellors and psychologists need to engage in ongoing self-examination and self-assessment of their own responses and reactions to be able to work effectively with their clients. Approaches to developing self-awareness of counsellors and psychologists include engaging in transformational learning activities that may include personal development through group and individual counselling, supervision, ongoing reading and research.

11.2.5 Engagement and Connection

Multicultural training and development are ongoing and reflexive processes. Meaningful personal and professional engagement in diverse communities is important to develop relationships and understanding. Comstock et al. (2008) describe the importance of relationships in order to understand the ways in which cultural oppression, marginalisation and various forms of social injustice lead to feelings of isolation, shame and humiliation among persons from marginalised groups. Engaging in mutual and meaningful relationships can work towards breaking down power and hierarchy differentials, in turn, this helps counsellors and psychologists to challenge rather than reify privilege. Counsellors and psychologists need to understand that they are not observers of marginalised individuals and groups. The field needs to make a shift to deep structure adaptations, for example, incorporating the ideas, beliefs and values of the culture into the treatment, which are much more difficult to understand, conceptualise and implement (Hwang, 2016). Working together helps to create understanding and fosters the ongoing development of support systems that can evolve in the client's own culture and ensures that clients can be supported in culturally meaningful ways.

11.2.6 Activism with and on Behalf

Counselling and psychology practices will only be partially helpful to clients if we ignore the impact of multicultural perspectives and social justice. It is equally important to balance individual counselling with advocacy (Ratts, 2017). Counsellors and psychologists must understand the impact of socialisations, hierarchical systems and the complexities of power and privilege in order to fully understand issues of well-being for non-dominant groups and to subsequently develop impactful multicultural counselling and psychology research, education, practice and policies. We must be "more adept at diagnosing environmental influences on individual well-being than at redressing those very systems and structures from which individual and community difficulties originate (Goodman et al., 2004. p. 797). More simply stated, counsellors and psychologists need to develop skills in activism and working at structural and systems levels to create change. Activism changes social systems, thus allowing marginalised individuals and groups autonomy and self-determination, which is strength-based and supports resilience and well-being.

11.3 Conclusion

Historically, the counselling and psychology professions developed primarily from a Eurocentric perspective. Additionally, the impact of colonialism has perpetuated knowledges in research, education, practice and policy that have continued to support Eurocentric perspectives despite the breadth of diversity within Australia. The impact of colonisation on structures and systems continues to manifest in contemporary society—in immeasurable ways—as evidenced in the preceding chapters of this text. A significant percentage of Australians experience oppression, discrimination and marginalisation by institutions and hierarchical systems that have been in place for a very long time (AHRC, 2020). It is important to understand these impacts in counselling and psychology and move beyond the forces of Eurocentric traditions in counselling and psychology research, education, practice and policy to a position where multicultural perspectives in counselling and psychology and social justice become central forces in the profession.

In recent years, the interest and intention in developing multicultural perspectives in counselling and psychology has increased, yet there is evidence that multicultural perspectives in counselling and psychology lacks in truly transformative outcomes (Goodman & Gorski, 2015; Hwang, 2016; Ratts, 2009, 2011; Soto et al., 2018). Creating a deep understanding of multicultural perspectives—including adaptation of content and cultural practices (Hwang, 2016)—is critical. Using the six key principles of multicultural perspectives and responsiveness in counselling and psychology including (1) decolonisation (Goodman & Gorski, 2015; Hernández-Wolfe, 2011), (2) intersectionality (Crenshaw, 1989, 1991; Hankivsky, 2014), (3) cultural humility (Davis, Worthington, & Hook, 2010; Tervalon & Murray-Garcia, 1998), (4) self-awareness (Arredondo, Sue, & McDavis, 1992; Arthur & Januszkowski, 2001; PACFA, 2018; Pieterse et al., 2013), (5) engagement and connection (Comstock et al., 2008; Hwang, 2016), and (6) activism (Goodman et al., 2004; Ratts, 2017) counsellors and psychologists will be able to better achieve meaningful work with and on behalf of their clients.

The work of truly developing multicultural perspectives and responsiveness in counselling and psychology will present challenges and barriers, and this will require changes at individual, community and institutional levels. However, the path towards change is critical for improving access to opportunity, equity and well-being for all Australians. Whilst this can seem an impossible challenge—it is not—'never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has' (attributed to Margaret Mead).

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Supplementary Information

V. Hutton, S. Sisko (eds.), *Multicultural Responsiveness in Counselling and Psychology*,
https://doi.org/10.1007/978-3-030-55427-9

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