Tinia mai: Interventions and Treatment. Moderator - Moana Waitoki

Biculturalism in practice, 'Te Pounamu': Integration of a Māori model with traditional clinical assessment processes.

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Note: The author would like readers to be aware that they should not try to implement the strategy Te Pounamu in their own workplaces, if they have not had training in it's use.

Traditional clinical psychological assessment follows a western paradigm of interaction, which relies heavily on verbalisations of internal and external symptoms. This process relies upon the assumption of and acceptance that tangata whaiora (consumer/s) are able to do this. Training encourages a clinical psychologist to take into account differences which may or may not be obvious, e.g., differences in religious beliefs, gender, hearing, or sight. However, as clinicians we often neglect to assess tangata whaiora abilities to verbalise such information. Te Pounamu, as a Māori model demonstrates the underlying principles of Te Tiriti O Waitangi. Providing the best treatment outcomes is about acknowledging all aspects of one's wellbeing: physical, mental, spiritual, and whānau. Te Pounamu provides a process that acknowledges such aspects in a way of knowing that is healing. From clinical experience, the interactive mode that Te Pounamu utilises has been found efficacious in assisting tangata whaiora to understand how such factors contribute to poor mental health.

At the time of first penning this presentation, there were two areas of research into Māori participation in the profession of Psychology that were commissioned by the New Zealand Psychological Society. A focus of this research was about how to encourage more Māori to enter into the psychology profession. A further section of this research involved investigating the issues that challenge Māori to become involved in this area. As a Māori Psychologist, I put forward that the experience of psychology from either side, as a clinician, or as a tangata whaiora (consumer) can bring forth the same questions and challenges about Māori in Psychology. Tangata whaiora can be scared and fearful of the situation in which they are placed, having to seek help from a professional, and similarly as clinicians we can be experiencing doubts also, but these are focused on whether we are approaching our work in the best way possible for the tangata whaiora and whānau (family) we are working with, or whether we are even skilled enough to be attempting this type of work. When I discuss 'this type of work', I am referring to working with Māori.

One of the key principles, which continually rises to the surface throughout many academic and non-academic writings about how to work with Māori, is identity. Mason Durie's invaluable work over the past two decades keeps highlighting identity as the beginning of wellness for Māori. For mental health workers, the Mental Health Commission (2001) identifies that cultural assessment pertains to the significance that tangata whaiora place on their identity and how they perceive the role of their cultural heritage in assisting them to achieve wellness. Cultural assessment is seen to lead to more informed and appropriate treatment and support for tangata whaiora.

The starting point for working with Māori is in the assessment phase, and

providing an appropriate 'cultural assessment' is vital to the engagement of, and working relationship with, tangata whaiora and whānau. When undertaking an assessment, the principle of Culturally Just Practice demands that the cultural standpoint of both clinician and tangata whaiora and whānau be acknowledged as a necessary condition to ensure their safety (Nairn & The National Standing Committee on Bicultural Issues, 2000). For this to occur, individually we must be aware of the local moral order, which determines the way we (as clinicians) work. For tangata whaiora to be safe in interactions, they must likewise "…be familiar with the local moral order operating and also be able to express themselves effectively within it, without becoming more open or vulnerable than they would wish", (p.128, Nairn et al., 2000).

For Māori tangata whaiora, being able to express themselves as an individual when placed in front of a clinician who writes material down, which they cannot see, is a distressing experience when viewed within the context of identity and 'their' (the tangata whaiora's) local moral order. Being aware of the way in which Māori tangata whaiora identify themselves as part of a whole, has in this instance placed tangata whaiora at risk for being unable to effectively express themselves.

It follows that interactions between individuals operating with differing local moral orders create a high risk of misunderstandings that may have serious consequences for one or more of the participants involved in the interaction. As clinicians, we may unconsciously, or consciously impose or assume the correctness of our (Predominantly European/North American taught culture: which places individual achievements as more worthy than collective and collaboration means, which include spiritual causes as important for well being), local moral order in interactions, possibly leading to unsafe outcomes for those involved.

Nairn and colleagues (2000), highlight this creation of possible harm. Where tangata whaiora and whānau share a local moral order that differs from that of a clinician they are placed at risk being damaged by the processes.

When interacting with tangata whaiora, Te Tiriti O Waitangi (The Treaty of Waitangi) provides a framework for safe practice and understanding. In essence, the articles, as defined by the Crown (Government), are: to provide opportunity for all to be treated alike and protected in the same way, to have participation in all things, and to have a say as equals, in partnership.

However, in reality, our discipline (the practice of Psychology), and its local moral order, do not provide adequate coverage of the articles in practice. The majority of us (clinicians) have received our training in an institution that reflects a predominantly Westernised view of wellbeing. An example of the lack of autonomy granted to tangata whaiora and whānau, is seen in how a large proportion are referred from within Crown agencies, such as health, education, justice, or welfare.

In those situations where Māori initiate the contact with psychologists themselves, like all people, they are entitled to participate in practices that are culturally just. Therefore, as alluded to above, a clinician must be competent in their ability to identify, either directly, or more commonly, in consultation with the tangata whaiora and whānau, the appropriate local moral order operating, and also the safe practices consistent within it (Nairn, et al., 2000).

According to the fourth General Principle for Practice penned by Nairn and colleagues: "In a culturally just encounter, there is an active balancing of the (cultural) needs and rights of those involved that appropriately includes their peoples. Psychological practitioners must be committed to achieving such balance and know when they lack the competence to recognise/achieve such balance" (p 134, 2000).

Within New Zealand, there is seen to be a gap between what is provided to acknowledge Māori values, when working with tangata whaiora and whānau, and that which is currently being granted. Mental Health Professionals, as an ever growing number, can help to recognise cultural balance and move outside Westernised

boundaries by working alongside traditional Māori 'healers' such as Kaumātua and Tohunga. For this to occur, clinicians need to be prepared to accept that Western models of health are not the only valid frameworks for understanding physical and mental health disorders (Glover & Robertson, 2000).

When working with Māori, clinicians also need to be aware of the cultural differences with respect to boundaries. Māori and non-Māori have different views on such aspects of protocol, and Western influences, when working with those that are unwell, condone breaches of such protocols. However, beliefs are part of everyday life for Māori and as such, protocol or tikanga practices are a sign of respect and whānaungatanga (treating as whānau). These can include physical touching (non-erotic) such as hongi (touching of noses), a kiss or hug upon greeting, self-disclosure around related matters such as whakapapa (whānau links) and role respect for Māori tikanga. This may necessitate a ritual of formal powhiri (welcome) which could take several hours to move through before one can even talk to the person who has been identified as unwell (Gilgen, 2000).

The Ministry of Health (1995) proposed that when assessing Māori, there are six main objectives to achieve, and this has been supported by Durie (1995) and others. These objectives are:

- acknowledging mana whenua
- establishing and maintaining kawa whakaruruhau
- strengthening the wairua of the individual
- promoting taha whānau of the individual
- ensuring the taha wairua of the institution/service
- developing whakapapa through mythology, kawa, tikanga, and te reo of the individual

It is essential to assess the identity of the person seen as well as their understanding and acceptance of Māori tikanga and its association with health, as Māori as a people are at different levels of understanding about such things (Durie, 1996; Ministry of Health, 1995).

From the assessment comes an appreciation and consideration of socio-cultural factors as important for improving treatment outcomes and health. The more a clinician is able to appreciate the cultural perception of the individuals they work with, the better the therapeutic relationship will be (National Health Committee, 1996).

The Māori view of ill health is as a product of spirit, body, mind, and the social environment, and Durie (1994, 2001) has extensively written about this concept of health coming under the umbrella of Te Whare Tapa Wha. This concept was promoted at the Hui Whakaoranga – the Māori Health planning Workshop held at the Hoani Waititi marae in Auckland, 19-22 March 1984, as part of a major national Hui for Māori Health. The Hui Whakaoranga recognised a united conception of Māori Health as Te Whare Tapu Wha. The four dimensions or cornerstones of well-being that make up this concept are:

- Te Taha Wairua (spirituality)
- Te Taha Hinengaro (thoughts and mental well-being)
- Te Taha Tinana (physical wellness)
- Te Taha Whānau (family cohesion)

When Māori become unwell, it can be due to one or all of the concepts being misaligned. Health is essentially about ensuring the Mauri (life force) of Māori people is allowed to find its full expression. Mauri assumes that each individual can live a life that maximises wairua (spirit), tinana (body), hinengaro (mind) and mana (personal authority). A person's unfulfilled potential or the development of an illness can be an indication of the absence of an individual's Mauri (Durie, 1996).

Pertinent to Māori wellness is the formation and recognition of one's identity. A large part of becoming ill has been placed on lack of identity as causative (Durie, 2001), and cultural identity is a fundamental part of the Māori view of health. Access to a cultural identity is a fundamental right and an option that might or might not be acknowledged. The development of a positive cultural identity is necessary for optimal mental health growth (Durie, 1995).

Te Pounamu

The Te Pounamu model has not been researched and therefore there are no statistical analyses to determine its effectiveness. At this stage, a clinician's and a tangata whaiora's perspectives have been used to assess its usefulness within a Māori Mental Health Service. With this beginning, for the Te Pounamu model to stand alongside traditional clinical assessment procedures in the future, appropriate research must occur.

Te Pounamu takes into account the identity that one has: the process by which this assists in providing a more informed and appropriate assessment of tangata whaiora is seen through its use of the participation of tangata whaiora to help the clinician do a more thorough and meaningful assessment. The meaning that Te Pounamu gives to tangata whaiora and whānau represents a way of 'knowing' that assists the clinician in having a meaningful understanding of all presenting issues, how they impact on one another, and how to bring about change.

The Te Pounamu model has been an assessment and treatment model at Te Whare Marie since 1996. Ruha (1999) has trained clinicians at Te Whare Marie in the use of Te Pounamu Model to assist in the assessment of Māori that present with mental health problems.

The whakapapa of Te Pounamu model is that Peta Ruha, a Ngāti Awa descendant, developed it. Ruha developed the model after seeing an idea presented by Tangi Hepi (Ngāti Maniapoto) which utilised a visual approach and an analogy of a human form. Ruha first began adapting the model during time spent at Oranga Hinengaro (Māori Mental Health Service), in Palmerston North in 1996. The model was then introduced to the Specialist Māori Mental Health Service, Te Whare Marie in Porirua by Ruha and was termed the 'Bottle Approach'. A Kaumātua of Te Whare Marie, Kuia Ani Sweet, named the model, Te Pounamu.

Due to the effectiveness of the visual approach Te Pounamu utilises, and its impact in assisting tangata whaiora and whānau in having a meaningful understanding of their presenting issues, it has been further developed with specific regard to Māori Mental Health from 1996 onwards. As an approach, it is a way of knowing that assists the clinican in having a meaningful understanding of all presenting issues, how they impact on one another, and how to bring about change. The model utilises a visual representation of a person's difficulties based on the past and present, including presenting issues, coping strategies, whānau relationships, deep seated hurts, and the strengths and weaknesses of the individuals who present.

The Te Pounamu model is based on the notions of Te Tiriti O Waitangi (Durie, 2001). It encapsulates the protection, partnerships and participation of Māori tangata whaiora (clients) within the framework of Te Whare Tapa Wha (Durie, 1994, 1995, 2001). By giving tangata whaiora the opportunity to participate, we give them equal partnership in the relationship, and the chance to protect themselves, for example, by being able query visually documented information that may have been mistakenly recorded.

A brief way of working with the Te Pounamu model at Te Whare Marie will now be discussed. The session is opened using karakia (prayer) or whakatauki (proverb) or what is appropriate as determined by the tangata whaiora and whānau. If mihimihi (introductions) have not been done, then this process is engaged in to promote whakawhānaungatanga. If tangata whaiora and whānau have never been engaged in the service before then they are told about confidentiality and limits to confidentiality. Tangata whaiora and whānau have the purpose of the session explained to them until they understand the process that is going to occur. That is, the meeting is about gathering information that represents them and their whānau and what are the current issues occurring in their lives. Additionally, the information gathered will also represent those areas of life that are contributing to the ongoing difficulties being experienced, and highlight where change can occur.

The Te Pounamu model is drawn on a whiteboard and each of the terms or headings is explained to tangata whaiora and whānau. Next, tangata whaiora and whānau are invited to talk about what brought them here and what is currently

happening for them in their lives. As they talk, key words/phrases are placed under the appropriate heading, or headings, as required, and the clinician's interpretation is checked. The Te Pounamu model, see Figure 1., has a circular motion attached to it, with arrows representing the impact each area has on another in the tangata whaiora and whānau's lives.
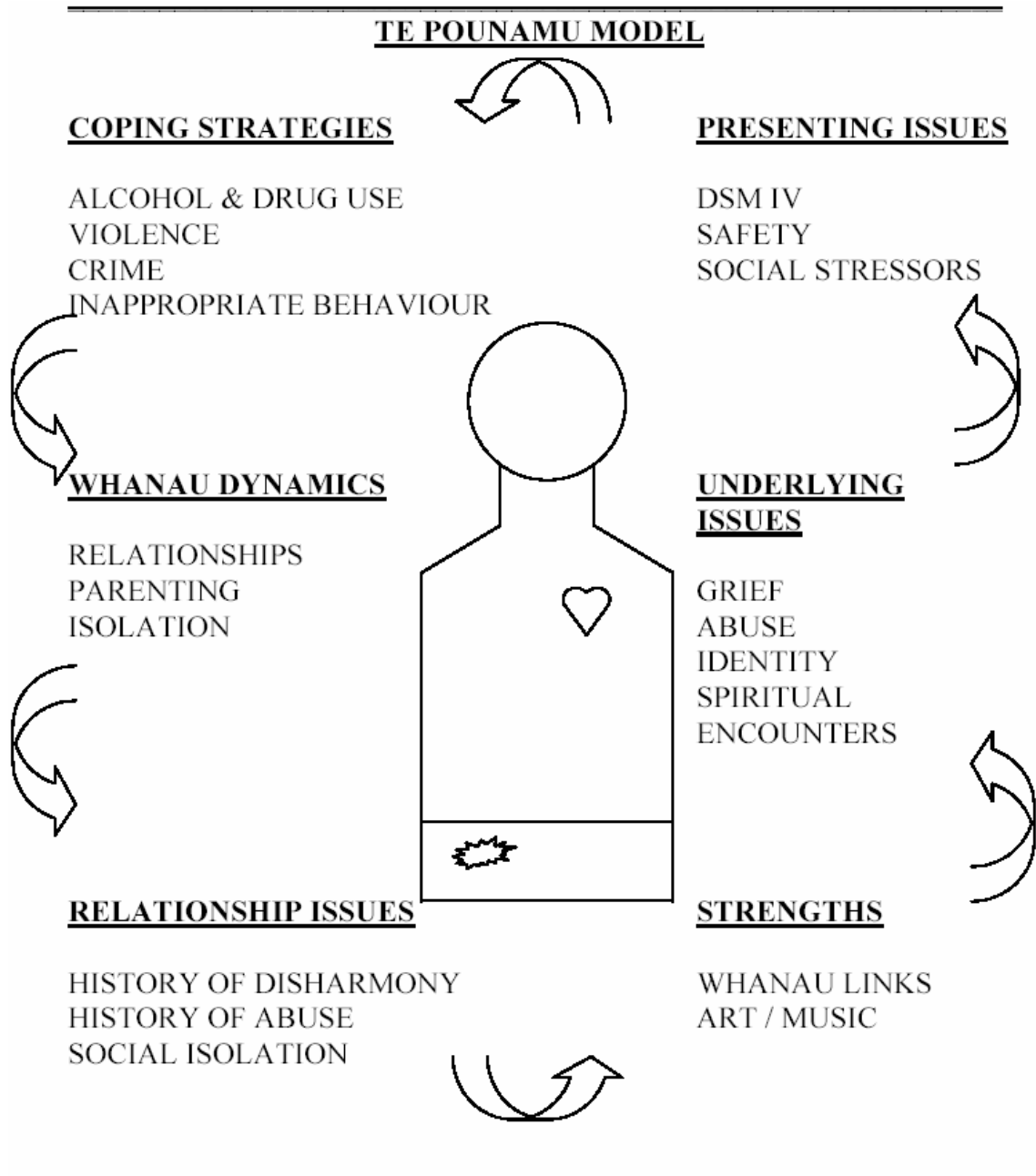
TE POUNAMU MODEL

COPING STRATEGIES

ALCOHOL & DRUG USE
VIOLENCE
CRIME
INAPPROPRIATE BEHAVIOUR

PRESENTING ISSUES

DSM IV
SAFETY
SOCIAL STRESSORS

WHANAU DYNAMICS

RELATIONSHIPS
PARENTING
ISOLATION

UNDERLYING ISSUES

GRIEF
ABUSE
IDENTITY
SPIRITUAL
ENCOUNTERS

RELATIONSHIP ISSUES

HISTORY OF DISHARMONY
HISTORY OF ABUSE
SOCIAL ISOLATION

STRENGTHS

WHANAU LINKS
ART / MUSIC

Figure 1. Te Pounamu model.

The following factitious formulation is an example of how Te Pounamu can be used (see Figure 2.). Jane is a 33-year-old woman of Tuhoe descent. She has been having increasing difficulty with the onset of sleep, often taking up to 2 hours to go to sleep. Jane has been preoccupied with whom she will 'see' tonight, and what will be the next thing that is going to go wrong in her life. Jane has lost around 8 kg's in the last month, and she believes this is her punishment for failing the last lot of workplace assessments she was undertaking, which would have given her a

promotion. Her core beliefs are very negative, and she is struggling to 'stay afloat', but at the same time believes she needs to be strong for the family who are relying on her to get them through recent tough times. Jane is not currently suicidal, but has over the past two weeks felt like wanting to take her life, she has no plan, but there are lots of means available, e.g., car, sharp knives, Panadol, sleeping pills prescribed by her GP, etc… Ten days ago, Jane's grandmother had a stroke and apparently if it weren't for Jane chancing upon her grandmother on the floor, she most likely would have died, as she was not breathing. Some four months ago, Jane's grandfather had a heart attack and there was some concern that at the time, he was not going to live. At that time, it was assessed that he had early onset Alzheimer's and doctors and medical staff are still undecided whether he has some dementia as well. At work, Jane has been feeling pressured into moving upwards in the hierarchy. This necessitated her sitting the assessment process to be considered for promotion. However, after doing the assessment, Jane believes she was not prepared for the process she went through to ascertain her suitability for career advancement. Jane is the middle child of three children, and her grandparents mainly raised her. When she was seven years old, she happened to find an elderly neighbour who had fallen into a diabetic coma. Jane reported believing he was dead, and that about two weeks after the event (unsure of the exact time frame), this neighbour visited her at night. Jane believed he was a ghost for a short time, not believing he was still alive, as he would only visit her room at night. As her grandparents raised her, Jane has always taken on the role of caregiver when someone in the family has been unwell as taught to her by her tipuna. Jane has always felt neglected by her family and believed she had to achieve for her own family to be proud of her, and was therefore always one of the highest achieving children from the area. This followed into her tertiary studies, where she initially trained as a teacher and then became interested in management. Jane's family have always believed she was strong enough to handle things, and because Jane has never indicated otherwise, they have never stepped back and lifted the pressure on her to fulfil certain roles in the wider family. Jane sees the family's lack of support as challenging her to be even better and more worthwhile, not realising that she doesn't have to always do everything. Jane was chosen to be raised by her grandparents because she was a good listener as a toddler and child. She also was able to know, intuitively, when someone was not feeling well, and was seen by her grandparents as a tohunga in this respect. Since she was a teenager, Jane has drawn pictures to help her express hurts and feelings. The family are always around whenever Jane is busy, but she often does not see them as supportive because of her involvement in being the primary carer for those that are unwell.

Where to From Here?

The Te Pounamu model will continue to be used within Te Whare Marie to promote the wellness of tangata whaiora and whānau. The different parts of Te Pounamu will continue to be developed to have more meaning for those we use the model with. It is a goal to have the Te Pounamu model accepted as a clinical tool alongside of traditional western assessment processes in the appropriate assessment of Māori. Research can be undertaken to determine the usefulness of Te Pounamu from the perspectives of all who are involved in the use of this model. Research can also ascertain the appropriate place of Te Pounamu within the clinical assessment process and determine what key determinants are required in its presentation for Te Pounamu to be utilised effectively.
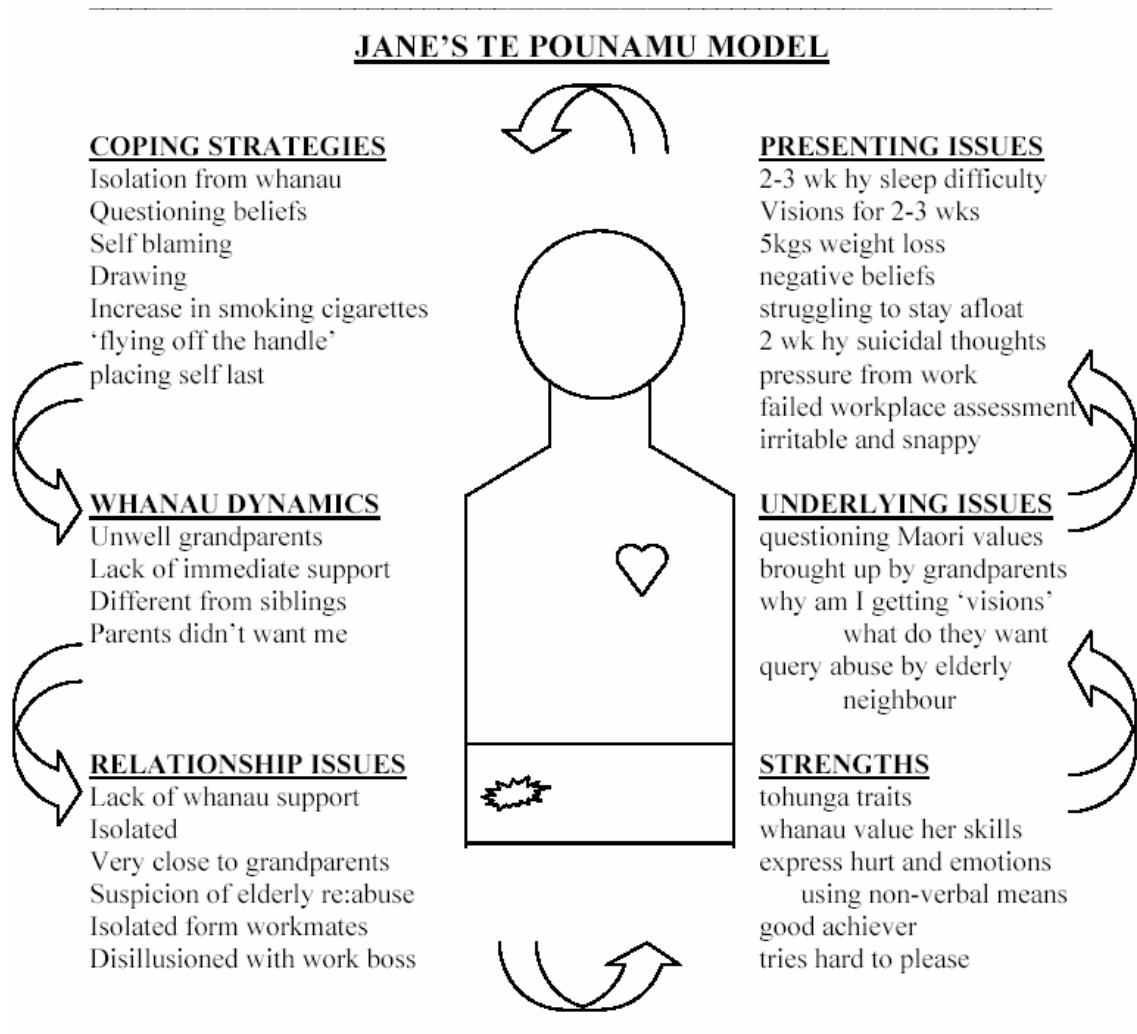
JANE'S TE POUNAMU MODEL

COPING STRATEGIES
Isolation from whanau
Questioning beliefs
Self blaming
Drawing
Increase in smoking cigarettes
'flying off the handle'
placing self last

WHANAU DYNAMICS
Unwell grandparents
Lack of immediate support
Different from siblings
Parents didn't want me

RELATIONSHIP ISSUES
Lack of whanau support
Isolated
Very close to grandparents
Suspicion of elderly re:abuse
Isolated form workmates
Disillusioned with work boss

PRESENTING ISSUES
2-3 wk hy sleep difficulty
Visions for 2-3 wks
5kgs weight loss
negative beliefs
struggling to stay afloat
2 wk hy suicidal thoughts
pressure from work
failed workplace assessment
irritable and snappy

UNDERLYING ISSUES
questioning Maori values
brought up by grandparents
why am I getting 'visions'
        what do they want
query abuse by elderly
        neighbour

STRENGTHS
tohunga traits
whanau value her skills
express hurt and emotions
    using non-verbal means
good achiever
tries hard to please

Figure 2. Fictitious example of the Te Pounamu model.

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