

# The Australian Community Psychologist

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## General Information

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## Editorial: Special Issue

### Ignored no longer: Emerging Indigenous researchers on Indigenous psychologies

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Indigenous peoples have been primarily constructed as exotic subjects of research. We have often been denied the status of informed research instigators and producers of valid knowledge. In many respects Indigenous psychologies remain marginalised in the broader discipline of psychology. Research in the global discipline has failed to recognise or embrace our own psychological systems, histories, socio-economic and political conditions and worldviews. Further, psychological research rarely employs cultural concepts germane to our distinct groups when interpreting our thoughts and behaviours. These omissions reflect missed opportunities and the continued dominance of Anglo-American worldviews in the global discipline of psychology.

Indigenous psychologies recognise that people have complex and highly developed understandings of themselves and there is more than one legitimate psychological approach to understanding the social world, the place of different people within it. The development of many Indigenous psychologies has been closely associated with processes of decolonisation and with assisting Indigenous and minority groups to find a voice and gain access to resources for self-determination. Dissatisfaction with the unquestioned, derivative, and explicative nature of psychological research that is deeply rooted in individualistic strands of North American focused psychology has led Indigenous researchers to look outside the

discipline in order to begin solving the devastating problems within our own communities.

The discipline of psychology is expanding world-wide and requires the establishment of psychologies relevant to each culture around the world. These various traditions can be constructively connected to an evolving global discipline that embraces diversity and difference (Lawson, Graham, & Baker, 2007). Globalisation offers an invaluable opportunity for psychology to enhance its content, methods and scope. This must be nurtured and it should be addressed by an open and inclusive discussion on how we may implement it. What is required is a strategic collaborative interaction that seeks a responsive global psychology (Lawson et al., 2007).

Many decisions shaping the circumstances of Indigenous peoples are made beyond their life worlds, and it is up to us, as critical Indigenous scholars working with community groups, to help bridge this divide through advocacy and joint action. As current and future psychologists, we need to situate our work within local socio-political contexts. This special issue highlights analytic approaches informed by Indigenous world views which are crucial for extending our psychological engagements with human diversity in more complex and relevant ways. Here we explore the breadth of Indigenous psychologies through the current work of emerging Indigenous researchers on issues of relevance to our communities.

In this special issue, edited by Mohi, Bridgette, Shiloh, Pat and Darren, we showcase work conducted within several such Indigenous psychologies. This collection of papers from emerging Indigenous scholars reflect a vibrant, healthy and supportive research environment in which conversations relevant to Indigenous peoples are taking place, and where culturally diverse perspectives and methods are valued and accepted. Here, culture is not simply seen as an abstract set of concepts. Culture constitutes a field of human action, meaning making, and self-production. It is through culture that all people construct themselves and make sense of the world (Groot, Hodgetts, Nikora, & Leggat-Cook, 2011; Nikora, Rua, & Te Awekōtuku, 2007).

In doing so, we consider the position of emerging Indigenous psychologies within Australia, Aotearoa and the broader Pacific region. This leads us into the first theme for this special issue of *people*, their cosmologies and orientations, where they come from and how they understand the world and their place in it. From there we move into how indigenous people's understandings of themselves and the world inform *theorising* within Indigenous communities by Indigenous scholars. This in turn informs the *methods* we use to work with our people rather than on our communities. Indigenous theoretical frameworks and research methods allow us to develop the ways in which community issues are understood and addressed in dialogue with those communities. Theories are often developed from within our communities inform the use of research methods to obtain insights that can be *applied* to addressing a range of social and economic issues.

It is important to start with a paper from Country where this journal is located. Anna Dwyer's contribution lays the foundations for this special issue. Anna talks of the enduring resilience, creativity and deep understanding of the relationships between human beings

and their environment that Indigenous peoples share across oceans. The title of this article 'Pukarrikarta-jangka muwarr – Stories about caring for Karajarri Country' recognises the centrality of Country to social relationships and the spiritual and emotional wellbeing of Aboriginal and Torres Strait Islander individuals, families and communities (Kelly, Dudgeon, Gee & Glaskin, 2010). The importance of fostering Indigenous social and emotional wellbeing through an understanding of the connection to land, language, culture, spirituality, ancestry and family and community is explored. These factors are inextricably intertwined and afford a bastion for Indigenous peoples to draw from in the face of adversity, buffering communities from the impact of stressful circumstances on their social and emotional wellbeing (Kelly et al., 2010). Anna leads readers through the supportive consultation process between Indigenous and academic institutions resulting in the Kimberley Aboriginal Caring for Country Plan. This contribution challenges a dominant colonial framework in Australia that continues to undermine the legitimate use of Indigenous people's extensive and comprehensive knowledge to manage homelands.

Byron Malaela Sotiata Seiuli's paper titled 'Uputaua: A therapeutic approach to researching Samoan communities' calls attention to the significant gap witnessed between an inclusive understanding of health and the realities of Samoan and other Pacific communities. The Uputaua Approach outlined in this paper provides a supportive guide for clinicians, health professionals and researchers alike to be reflective of their role throughout the engagement processes. Byron draws upon his own personal, cultural and professional experiences to unpack the conceptual framework encompassed by the Uputaua Approach. Where psychology has historically neglected the spiritual dimension of human existence the Uputaua Approach addresses this oversight. In his paper, Byron contends that the specific beliefs of Indigenous people must be

considered in order to bridge gaps between psychological concepts developed in one cultural context and the application of these ideas to addressing the needs of Indigenous people in other contexts (Sue & Sue, 2008). Beyond addressing the body, mind and social dimensions is the need to locate these within their familial, ancestral, environmental and divine connections.

Ingrid Waldron makes an invaluable contribution to the comprehensive yet historically muted body of research on African-centered psychology. This paper titled 'Out from the margins: Centring African-centred knowledge in psychological discourse' assertively critiques the applicability of Anglo-American psychology to the African peoples of the diaspora experience with its assumptions of inferiority. Ingrid contends that marginality can be more than a place of exclusion. It can also constitute a space for resistance. Her paper provides an overview of the vast healing approaches utilised by African peoples of the Diaspora that are informed by Indigenous and various Euro-Western approaches. Within an African conceptual framework it is recognised that spirituality is an intimate aspect of the human condition and a legitimate aspect of mental health work (Sue & Sue, 2008). Such recognition is extended through Ingrid's discussion of the limitations of Cartesian-orientated Anglo-American psychology which is challenged by Indigenous people's conceptualisation of the interconnected self.

Andre McLachlan, Ruth Hungerford, Ria Schroder and Simon Adamson's contribution titled 'Practitioners experiences of collaboration, working with and for rural Māori' showcases how qualitative research strategies can be indigenised and adapted to better reflect Māori cultural concepts and values. Andre and colleagues challenge assumptions that prescribe Kaupapa Māori Research (KMR) as a descriptor for research with Māori communities. They present KMR

as comprising the development of a rich philosophical framework and theory that outlines a set of methodological principles, processes and intervention strategies. From this perspective, KMR does not preclude the use of quantitative methodologies. KMR can be used to shape and inform different research methods with emancipator relevance for Indigenous peoples. Through an example showcasing the use of KMR across health and social services in a rural setting to address the needs of Māori with substance use issues, Andre and colleagues highlight the need to recognise the diverse lived realities of Māori today. These authors argue that it is crucial to understand that Māori practitioners and those Māori accessing services may have different understandings and experience of the use of tikanga (practice informed by Māori values).

Our fifth paper, by Arama Rata, Jessica Hutchings and James Liu titled 'The Waka Hourua Research Framework: A dynamic approach to research with urban Māori communities', employs a methodological framework at the interface between Indigenous knowledge and Western science. Utilising such a research approach allows for the generation of new and distinct insights that enriches both knowledge bases. Ancient Māori values utilised in the framework provide the bases and processes of scientific inquiry. The Waka Hourua (double-hulled sailing vessel) research framework was developed as part of a community-driven intervention at a low-decile State secondary school to reflect the diverse realities of Māori community members. Arama and colleagues draw comparisons across indigenous communities encompassed by a holistic approach to research where analyses comprise social relationships and connections between people, the physical environment and historical events. While it is difficult to turn research into action within the limits of a PhD, Arama successfully contributes to broader agendas of change. This is evidenced by key stakeholders expressing satisfaction with the outcomes of intervention activities central to

this project.

Arlene Laliberté's paper titled 'Participatory action research in Aboriginal contexts: 'Doing with' to promote mental health' details her experiences and reflections as a Canadian First Nation community psychology researcher working alongside Aboriginal Australian peoples. This paper highlights the positive contributions the Collaborative Research on Empowerment and Wellbeing team that Arlene has been involved with in supporting positive mental health outcomes within Indigenous communities. Employing a participatory action research approach, Arlene demonstrates the strength of supportive relationship building when working with Indigenous communities. Participating communities included two remote communities, a rural community easily accessed and close to a large town and a mixed Aboriginal and non-Aboriginal community close to a large urban centre. Arlene reflects on the tensions and strengths of integrating "insiders," "outsiders" and multiple perspectives to obtain a comprehensive and integrated understanding of the issues that face Indigenous communities and how we might respond in constructive ways.

Pita King, Amanda Young-Hauser, Wendy Li, Mohi Rua and Linda Waimarie Nikora's contribution titled 'Exploring the nature of intimate relationships: A Māori perspective' looks at the imperfect beauty of intimate relationships from a Māori perspective. The complex interplay between identity change, violence perpetuated by men and women, communication and culture is explored. The processes of colonisation have undermined the role of women in Māori society and are seen to be a major contributing factor to the high rates of intimate partner violence within the Māori population. The sadness and loneliness played out in relationships as they sometimes dissipate, as well as the cultural values

enacted in each relationship, providing a framework to connect, negotiate and relate to one another is considered. Pita and colleagues seek to enhance current understandings of the nature of intimate relationships as a preventative approach to promote more loving, compassionate and violence free intimate relationships.

Our eighth paper by Glenis Mark and Kerry Chamberlain, titled 'Māori healers' perspectives on cooperation with biomedicine', outlines some of the tensions occurring between Māori health practitioners and General Practitioners, whilst providing practical solutions to emerging tensions. Glenis explores the contemporary role of Rongoā Māori as part of a traditional system of healing that has developed out of the cultural traditions of Māori. Where *tohunga* (traditional Māori priest) once held a prestigious position in Māori society, colonial policies aimed at suppressing the practices of such *tohunga* have seen the role of *rongoā* relegated to a secondary and alternative form of health treatment in Māori society today. The authors contend that Indigenous healing practices and belief systems entail experiential and lived realities. The paper demonstrates the importance of holistic care involving spirituality for Māori healers during *rongoā* healing could be shared with doctors. Conversely, healers may benefit from becoming informed of basic biomedical practices such as recognising the need for patients to be referred for biomedical treatment.

Stanley Kamutingondo, Darrin Hodgetts, Shiloh Groot and Linda Waimarie Nikora's paper, titled 'Zimbabwean medication use in New Zealand: The role of indigenous and allopathic substances', considers what becomes of indigenous forms of knowledge regarding medications and health care when groups move from their homelands to another country; in this case from Zimbabwe to New Zealand. With the colonisation of Zimbabwe and the creation of a Westernised professional class in urban centres, there has been a shift away from *vanaChiremba* (traditional healers) towards Western



medications and associated practices. Zimbabweans come from a background of interdependence where sharing, unity, respect and love are important components to their everyday lives. The authors explore how these families respond to illnesses within domestic spaces in a new country in the context of both their traditional and Western medical approaches to support each other and ensure the appropriate sourcing and use of medicinal substances. These authors reflect on how striking divisions between Indigenous and Western traditions is problematic in that, once taken into the home, allopathic substances are transformed socially into cultural objects through their use in household healthcare practices.

In our final paper titled ‘Māori children and death: Views from parents’, Juanita Jacob, Linda Nikora and Jane Ritchie consider (through the eyes of their parents) children's participation in tangi (Māori death rituals) as an important forum for the expression of grief and providing continuity and support with familial networks. While death may come to us all, how children understand and respond to death varies across cultures. Tangi as an institution has largely withstood the devastations of colonisation and remains deeply rooted within Māori communities. The process of conveying knowledge of death, dying, mourning and culturally defined responses from parent to child occurs within the whanau (family) rather than through media or counselling. The increasing challenges of urbanisation and associated kinship fragmentation threaten the continuation of this practice and the authors emphasise the need to ensure these practices continue to persist between parents and their children.

Each paper located within the pages of this special issue shares multiple commonalities and echoes Martín-Baró's definition of liberation psychology as “a paradigm in which theories don't define the problems of the situation; rather, the

problems demand or select their own theorization” (Martín-Baró, 1994, p. 314). Combined, these papers demonstrate that while structural intrusions have clearly posed challenges to Indigenous wellness, we are not passive in the face of socio-political upheavals. We are resilient and we are adaptive. This special issue problematises racist discourses regarding Indigenous peoples that associate dark skin with a lack of motivation, low achievement, poor self-discipline and violence (Gowan, 2002; Groot et al., 2011; Kingfisher, 2007). The analyses offered by the 10 papers comprising this collection, rupture negative stereotypes that focus on deficits, and demands that the broader discipline shifts over to incorporate Indigenous strengths, capacities and knowledges into our responses. If articulation is the catalyst for change, then to be heard, to be read, connects us. After all, “without language, there are no true meanings” (Dwyer, this issue).

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## Pukarrikarta-jangka muwarr – Stories about caring for Karajarri country

Anna Dwyer

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*I am a Karajarri woman from Bidyadanga community in Western Australia. As a researcher at the Nulungu Research Institute, located at the Yawuru buru (Broome) campus, of the University of Notre Dame Australia, I am often required to bring together traditional knowledge and Western rationalist approaches to knowledge generation in my research endeavours. This article reflects on my cultural background, knowledge, traditional language and beliefs. It locates these important elements of my life in contemporary modern Australia, and challenges the prevailing colonial frameworks that continue to undermine the legitimate use of our knowledge to manage our homelands. Using my Karajarri family to illustrate, this article explains the importance of caring for country and describes the belief systems that establish and maintain our cultural obligations to country. The importance and connectedness of language to country is highlighted, and the significance and value of country is demonstrated through our spiritual understandings and cultural practices.*

I am a Karajarri woman. Karajarri-kura ngurra, traditional Karajarri country, is located south of the township of Broome in the Kimberley region of Western Australia. It encompasses the contrasting environments of the south Kimberley coast and the adjacent Great Sandy Desert. Karajarri ngarrungu, the Karajarri people, are Aboriginal people who are locally identified by others, as Karajarri. Our collective name Karajarri literally means ‘west-facing/being’ or ‘west-oriented’ (Bagshaw, 2003, p. 29). Karajarri country is surrounded by Yawuru (north), Nyikina (north east), Mangala (west) and Nyangumarta (south). Karajarri people consider their neighbours as both relatives and ‘countrymen’.

In the kinship system of Karajarri people, we have four skin groups which are Panaka, Parrjarri, Karimpa and Purungu. My skin is Panaka and it comes to me from my mother’s mother. The Karajarri-kura muwarr (Karajarri language) includes three closely related regional dialects. The Naja dialect is traditionally associated with the coastal region. The Nangu dialect is associated with the central region of Karajarri-kura ngurra while Nawurtu dialect is associated with the eastern hinterland. Karajarri-kura muwarr was inscribed on my

country by the travelling Pukarrikarta (creation) beings.

I speak Nangu Karajarri and strongly follow my traditional culture. I learnt many things from my old people during my childhood and subsequently, throughout my life. These lessons and skills that were taught to me are still a strong part of my life today. My father and mother were the main inspiration in my life. They taught me about my skin groups and the cultural protocols that are associated with them. The language we speak is a living language and is used throughout the West Kimberley and Pilbara regions of Western Australia. The three dialects of Karajarri-kura muwarr are related to each other and the words and sounds are spoken in a similar manner. My language is intricately connected to my people and country.

### **The First Word from Kimberley Traditional Owners**

In the past, Aboriginal people of the Kimberley region fought for their land as European invasion and settlement occurred. Kimberley traditional owners felt the impact of this ‘take over’ and reacted to it by fighting for their rights. Government has not listened to Aboriginal people about the

values accorded to country and what it means to Aboriginal people. Country includes land, sea, rivers, waterholes and all living things. Kimberley people have fought for recognition as traditional owners of their country and campaigned to be included in decisions about how country should be managed based on their common law rights, existing kinship systems and their knowledge of how the land works. Traditional owners wanted to establish and build a new foundation to look after and protect country into the future. They thought about a project that aimed to show why caring for country activities must be based on the principle of ‘right people, right country and the right way’.

Many people in the Kimberley region have talked about caring for their country for many generations. Old people talked about it in their communities, in meetings, around campfires, with families, and with other traditional owners. These conversations were about making commitments to take care of country and to make sure that it is respected – ‘keeping it alive’ and healthy. Country is very important to Aboriginal people. It enables us to express strong values through our connections to country, language, and law and culture.

The Kimberley Aboriginal Caring for Country Plan (the ‘Plan’) began in 2004 when people from the region came together to talk about a big plan for sustainable land management and conservation. This meeting was held at Bungarun (the old Leprosarium) near Derby in the West Kimberley. Traditional owners and their families travelled long distances to present their views and their concerns about managing country. Kimberley Aboriginal people had a vision of owning and managing country, keeping language strong, and keeping knowledge of country alive. Aboriginal people said that healthy country is a priority for our people and our future generations.

People sat and talked about the Plan during this meeting at Bungarun. At night, people prepared themselves for the big event –

traditional singing and dancing known as *pirntirri* (corroboree). The painted designs on people’s bodies are very spectacular and have different meanings attributed to them. When performing *pirntirri*, Aboriginal people engage artefacts to represent the cultural story for each dance from the communities gathered together. For example, the Karajarri *pirntirri* comes from dreaming places in Karajarri country and from Yatangal, which means birthplace country.

When people sing in language, it awakens the ancestors and brings the country to life. In the surroundings at Bungarun, we could hear our ancestors, our natural spiritual choir, joining in with us. We believe this is the presence of our elders who passed away a long time ago. This occasion is important. It is about family reunion, storytelling, sharing knowledge, planning and interacting with other countrymen from the Kimberley region. Traditional owners and community members wanted to voice their opinion for a big plan to care for country. Singing the songs from the country brought the Plan to life.

### **How the Kimberley Aboriginal Caring for Country Plan Started**

At the Bungarun meeting, the Kimberley Aboriginal Reference Group (KARG) was formed to provide a forum for Kimberley Aboriginal people to voice their opinions about looking after country and to take a positive step towards influencing planning for country. KARG is comprised of representatives from the four key regional Aboriginal representative organisations: the Kimberley Land Council, the Kimberley Language Resource Centre, the Kimberley Aboriginal Law and Culture Centre, and the Kimberley Aboriginal Pastoralists Incorporated. KARG’s priorities were to have governments recognise Aboriginal cultural values and to get them to listen to traditional owners, so that they could understand the impacts of *kartiya* (non-Aboriginal) use and development of country and to recognise how important country is to traditional owners and all Aboriginal people.

Traditional owners explained how country is considered a valuable cultural resource. Aboriginal people relate to country differently from non-Aboriginal people because they come from many language and cultural groups and from many different parts of the Kimberley region. As a result of the discussions at the meeting, four landscape types were identified in the Kimberley region – Saltwater country, Desert country, River (Freshwater) country and Rangeland (or Cattle) country. These landscapes were identified by traditional owners to inform the management of Kimberley ecological systems by governments. This landscape distinction also sought to make Natural Resource Management (NRM) programmes and projects more aligned with the priorities of Aboriginal people and to deliver to them mutually beneficial outcomes. Traditional owners viewed NRM as an opportunity to manage natural resources and the environment by promoting new ways of involving Aboriginal people and knowledge in government planning processes that aim to look after country.

People wanted the Plan to be a top priority. They wanted their voices to be heard because their aspiration was to see their own people working on country. From 2004 to 2008, KARG kept thinking about the Plan and how it was going to work; they dwelt on this idea for a long time. Then in 2007, an Aboriginal chapter was introduced into the overall Kimberley Natural Resource Management (KNRM) plan. Many Aboriginal people felt that just adding a chapter was not the best way to incorporate culture and knowledge. Later KARG became aware that funding was available through the Australian government and this provided the opportunity to set things down properly by developing the Plan.

### **Community Consultation**

In December 2008, the KARG Steering Committee had meetings with the Nulungu Centre for Indigenous Studies (Nulungu), located on the Yawuru buru (Broome)

campus of the University of Notre Dame Australia, to develop the Plan. Nulungu encourages the pursuit of research excellence through the valuing of community-based Aboriginal knowledge and within culturally appropriate community protocols. The Plan commenced with the development of a Discussion Paper that identified key caring for country issues, what the Plan intended to do, and why it was important to traditional owners. Nulungu researchers also asked traditional owners and community people many important questions about country and its management. A comprehensive literature review was undertaken to identify previous research and documents relating to caring for country.

Nulungu developed a community consultation model based on cultural blocs which is the concept of ‘right people for right country’. This model reflected the existing cultural and social organisation of traditional owners within their respective homelands from across the Kimberley region. Cultural blocs also reflect the way traditional owners organise themselves to make decisions and when planning is required over large areas of the region outside of the respective homelands of traditional owner groups.

This way of operating was reinforced by the outcomes of successive Native Title determinations in the region by the Federal Court of Australia and the subsequent establishment of Registered Native Title Bodies Corporate (RNTBC) to hold and manage the legal rights and interests of traditional owners following their determination of Native Title.

Having completed this ground work, Nulungu researchers moved to talking with, and gathering information from, 414 Aboriginal people across the Kimberley. Consultation with key regional stakeholders and government departments and agencies also occurred. Nulungu researchers asked people to identify their values for country; their future goals and aspirations; the threats and pressures on country; and their key

priorities for cultural and natural resource management. The activities people are currently involved in and what they wanted to see happen in the future were also explored (Griffiths & Kinnane, 2011).

### **What People Said**

#### *What is Caring for Country?*

Kimberley Aboriginal people consider that country should be protected. For example, this means keeping the land healthy, caring for it in a proper way, and recognising the cultural connection between traditional owners and their country. Kimberley traditional owners will always meet their obligations and responsibilities to care for their country in accordance with Pukarrikarta-jangka (law and culture). Kimberley traditional owners wish to see that respect for cultural governance and social organisation is recognised as something important to them. They would like to see caring for country activities organised and undertaken properly on country. For example, senior traditional owners and community members should make decisions for country and they would like to see 'real jobs' (rather than subsidised jobs through Community Development Employment Projects) happening on country so our people can earn 'real wages' that properly reflect their efforts and expertise.

#### *Respecting the Country and People*

According to traditional Kimberley protocols, it is customary to welcome people to country. This is a traditional practice of special significance. For example, Karajarri traditional owners have many ways to welcome strangers to country. Alternatively, when a Karajarri person visits different places on Karajarri country, they will talk to their spiritual ancestors to identify who they are, explain who is accompanying them, and why they have brought them. This is to show respect for Karajarri country and the features that comprise that country such as the environment around you; the fishing spots, hills, waterholes and the sacred sites and areas of special cultural significance.

While traditional owners often welcome visitors, there are certain places in country to which access is restricted. It is dangerous to enter sacred traditional ceremonial grounds. Some places can only be visited by men or by women respectively. In some waterways, creeks, waterholes or beaches, it is inappropriate to swim or fish for cultural reasons. Acknowledgement and respect for these protocols is very important. To ensure visitors do not get hurt and places are not damaged, advice from senior traditional elders or someone who knows the particular details of these special places is required. Language also plays a significant role in respecting country. If you are talking to an Aboriginal person, it must be recognised that they may speak differently to Kartiya people; English may be a second, third or fourth language. Respect for these people is demonstrated through acknowledgment of kinship relationships, families, language, and land.

#### *Respecting Language*

The Kimberley is one of the most linguistically diverse areas in Australia (Figure 1). There are 30 recognised languages in the region and a number of dialects (Kimberley Language Resource Centre [KLRC], 2011a; 2011b). Language is central to the cultural activities of traditional owners and many Aboriginal people with connections to their traditional homelands. Language protocols are very important in many ways and provide guidance in relation to how people work within communities, how people work with other organisations, how people work with schools, and how people work with linguists and other consultants.

Cultural knowledge on country is based on language, the meanings derived from language, and communication of these meanings. This enables traditional owners to identify and share the names of plants and animals and to tell stories for certain place. Language explains relationships between living things, Pukarrikarta spiritual (creation)



your 'Rai', the child spirit from the place where parents first dream of a baby. The Rai becomes the central identity of a person. As a person grows and matures, the Rai grows to become a protector and custodian of the place it originated from. The Rai connection can come in the form of an animal such as fish, lizard or in a plant form belonging to that country. When a person passes away, the Rai returns to its dreaming place and becomes a child spirit once again and awaits an opportunity for another spiritual rebirth. This demonstrates how people, their Dreaming place, language, kinship systems, law and culture are all connected with country.

Being on country also means that young people learn about their culture in the right way, from the right people, in the right places. Our future generations must keep on talking about and practising law, culture and language, using the stories of our ancestors in a culturally appropriate or 'proper way'. For example, elders teach young people about using the stars to navigate and sing the important Pukarrikarta songs regarding spiritual beings and their associated creation stories. This suggests that Aboriginal people have had knowledge of astronomy for a long time and are recognised as astronomers and scientists within their own culture and country. Elders always understood the extent of seasonal variations and know the relationship between different flowering plants and the proliferation of native animals. For example, in parrkana (cold season) the salmon are running and fat to eat. In laja (the hot season and build-up before the rain), goanna and other lizards and snakes begin to wake up from hibernation. This is the best time for stingray (Yu, 1999). Young people learn cultural knowledge including the right names of country, to help understand the places they are required to look after, and how they should care for the land and the things in the country from what our old people told us.

#### *Access to Country*

Having the ability to access country is very important to all Kimberley traditional

owners. Some of our people experience difficulties trying to access certain areas in their Traditional homelands. For example, sometimes station managers keep gates locked on pastoral leases. Some people don't have the necessary resources such as a vehicle to take young people out to experience life on country and talk about or demonstrate caring for country practices. Traditional owners feel barriers to accessing country must change for future generations because people suffer physical, mental and emotional stress when they do not have access to their country and their 'ngarlu' is 'no good'. Being on country strengthens an individual's ngarlu. Ngarlu is a Karajarri term for defining the place of the inner spirit. This place in our stomach is the centre of our emotions and wellbeing (Roe, 2010).

Many traditional owners worry about people who have no cultural or legal rights to be on country accessing places or locations without permission. Occasionally, these people gain access to important and significant sites on country without the permission and supervision of traditional owners from that place. In response, traditional owners want to manage country properly which includes managing access to country through the issuing and enforcement of permits, by developing places where visitors can go, and establishing Aboriginal Men and Women's Ranger programs. Ranger programs are an example of the right people looking after the right country, and vesting cultural authority in traditional owners.

#### *Moving Back to Country*

Some Aboriginal people have moved away from their Traditional homelands to towns or cities to access better economic, social and educational opportunities. However, many Aboriginal people often have a strong desire to return and live in their own homelands because this connects them closely with their families, their country, law and culture, and provides opportunities to learn, listen and speak language. Moving back to



country is a very important way of maintaining the strong identity of Aboriginal people and to appreciate that country is a beautiful and sustaining place. That is why people often return to their homelands in an effort to understand who they are and where they belong. Old people have pioneered the development of family-based outstation communities so they can be closer to their country, meet their obligations and responsibilities to country, and make sure that young people grow up knowing their country and their relationship to it, their family, and their countrymen.

*Right People, Right Country, Right Way*

‘Right people for right country’ is a term used to describe the principle by which any activities on country need to be decided upon and approved by traditional owners who have the right to speak for that country (Griffiths & Kinnane, 2011). It then follows from this principle that the oversight of the management of country must be undertaken by traditional owners within their traditional boundaries or horizons. This can also occur in association with neighbouring traditional owner groups. Native Title determinations have reinforced this approach and embedded it in the common law of Australia. To undertake this responsibility, support needs to be afforded to the traditional owners. This will enable the right people to establish and maintain caring for country activities in the right way.

*Cultural Blocs*

In the context of caring for country, Kimberley traditional owners organise themselves into ‘cultural blocs’ when certain decisions are required (Figure 2). This bloc is “a cultural sphere of influence related through language, laws and belief systems to country that usually encompasses several language or traditional owner groups sharing common cultural features” Griffiths & Kinnane, 2011, p. iii). Traditional owners organise in this way to discuss and consider issues of regional or sub-regional importance. For example,

these issues include the progression of Native Title applications, negotiation of agreements that have local and regional significance and impacts, and to discuss the protection of cultural and natural heritage values. Sitting together, traditional owners can speak for extensive tracts of country that are related through law and culture.

Cultural blocs do not equate with the four landscape types of Saltwater, Freshwater, Desert and Rangelands that were developed as part of the KNRM approach to managing the Kimberley region. The distinct nature of these landscapes affect how people relate to different types of country but not how law and culture informs the specific rules and practices for country. When traditional owners choose to meet within their cultural blocs, all the right people, for the right country, and with the right knowledge about country are together as one and the best solutions or decisions are reached. A significant outcome of this approach is that traditional owners are refining superimposed colonial boundaries within the Kimberley to align more closely with their cultural governance structures. This ensures that people are in control of their destinies and do not compromise their country or themselves when important decisions are required.

**What Kimberley Traditional Owners Want**  
*Priorities – What people said was most important to them*

Kimberley traditional owners are very clear about the position they occupy as the custodians and managers of country for future generations. In the work undertaken by Nulungu, they outlined a distinct relationship between law and culture, language and country. The concept of ‘Healthy Country, Healthy People’ emerged as their top priority. In accordance with culture, Traditional owners say if you look after country, the Country looks after you. Conversely, if you do not look after country then people become sick.

In terms of the general priorities and actions that traditional owners want as an outcome from the Kimberley Aboriginal Caring

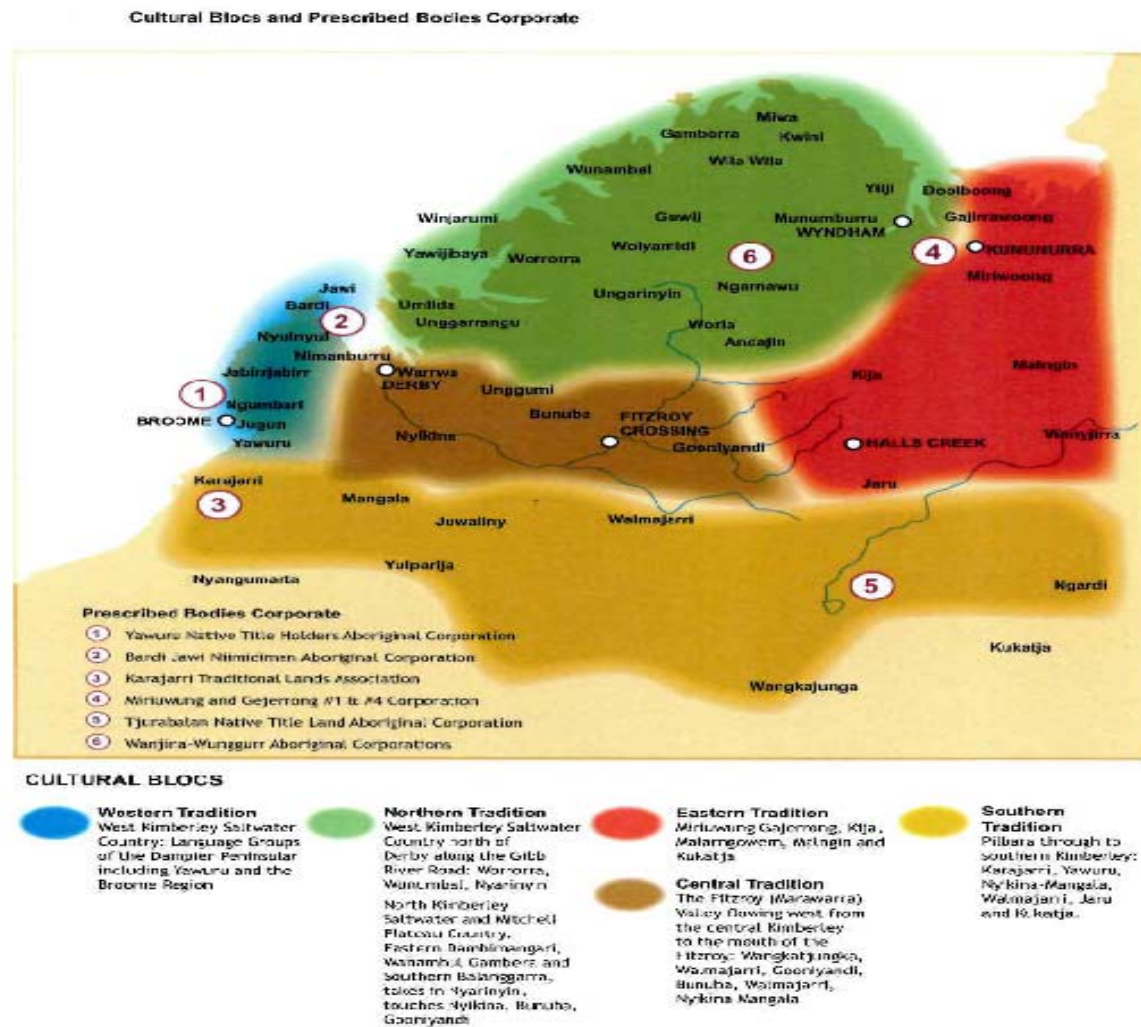


Figure 2. Cultural Blocs and Native Title Prescribed Body Corporates (Source: Griffiths & Kinnane, 2011. Reproduced with permission).

for Country Plan, the following were identified as important:

- Enable Aboriginal people to get access to country;
- Protect important cultural sites and monitor significant areas including islands and sea Country (e.g., reef locations);
- Respect for cultural protocols by doing business the right way, with the right people for the right country;
- Ensure cultural knowledge is passed on from old people to younger people;
- Plan for Caring for Country projects at a regional level;
- Plan projects through RNTBCs;
- Provide opportunities for paid jobs, skills development and training for Aboriginal people;
- Secure adequate resources for Caring for Country projects;
- Resource and support for a regional Caring for Country governance structures;

- Protection of Aboriginal knowledge and intellectual property;
- Maintenance and development of strong partnerships;
- Provide opportunities for language transmission through Caring for Country projects;
- Manage and use of fire the proper way;
- Ensure the health of water sources on country;
- Monitor water quality in rivers, and other jila (i.e., waterholes);
- Monitor plants, animals and habitats, particularly for threatened species and species of cultural significance (e.g., turtle and dugong, vine thickets and seagrass beds);
- Eradicate or reduce weeds to protect threatened species or ecological communities;
- Reduce and control feral animals such as camels, pigs, cats, foxes, horses and cattle;
- Reduce the threats from introduced weeds and pests (e.g., noxious weed called Noogoora burr);
- Direct visitors to the right people for the right country, ensure they are accompanied by the right people;
- Control visitor access to culturally and environmentally sensitive areas and monitor visitor numbers and the impacts on country;
- Ensure that rubbish is removed so it does not threaten the health of country including (e.g., marine areas and on beaches).

Traditional owners want to see these things happen in the future. Nulungu found that most of the priorities were being addressed in positive ways through existing or proposed projects. The challenge is to take these great ideas and turn them into reality.

#### **Last Word**

I am a Karajarri traditional owner. Currently, I do not live in my country but I visit when I can. I work as a researcher in the Nulungu Centre for Indigenous Studies at the Yawuru buru (Broome) campus of The

University of Notre Dame Australia. As a traditional owner and researcher, I have extensive experience living and working with elders and community members from the different cultural groups across the Kimberley. Most of these people are my family and people I know very well. During the consultation phase of the Kimberley Aboriginal Caring for Country Plan, I talked with many people and they told me their views and aspirations for the future. During this research, I had to work wearing ‘two hats’ – one as a traditional owner and the other as an academic researcher. I found that this project inspired me to continue working with my people, to listen to and respect all traditional owners in the Kimberley region. Above all, I learnt to understand the authority contained within my community, my country and my culture.

This is the ‘Last Word’ of my countrymen. They have aspirations and future plans for looking after country. The majority of people said that management planning in the Kimberley requires proper agreements amongst stakeholders and the resources to implement the plans of the traditional owners. This will enable traditional owners to balance the varying demands placed on them and to establish a regional body that guides and manages caring for country initiatives and can make proper decisions for people across the Kimberley region. People in the Kimberley recognise that the strength of the Plan is drawn from local knowledge. Given the threats and pressures on the country, and recognition that the future of the Kimberley region is being impacted on by global pressures for natural resources, Kimberley traditional owners are aware that the pressures of human growth and consumption are increasing and feel this cannot continue unmanaged without harm to cultural and natural resources. A recommendation of the Kimberley Aboriginal Caring for Country Plan is the maintenance and growth of Aboriginal Ranger Programmes across the

Kimberley to manage the country and to ensure special places are protected and valued so that our culture remains strong and vibrant. This is our responsibility to the generations that will follow us into the future.

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## Glossary

Aboriginal Elders	The moral and spiritual leaders of various communities; they are care givers they are also teachers who pass on cultural knowledge. They are role models to the younger generations.
Caring for Country	A term used in the Kimberley to describe the protection and management of cultural and natural resources. Caring for Country is associated with cultural responsibilities and rights (Griffiths & Kinnane, 2011).
CDEP	Community Development Employment Program (CDEP), an employment programme for Aboriginal people subsidised by the Australian Government.
Country	Country includes land, waters (both fresh and salt), and the air which lies above and below the ground or out of sight. The term ‘country’ encompasses the physical, spiritual and cultural meaning of landscape. People are a natural resource and are considered to be part of country. The use of a capital ‘C’ gives the place its respect and significance, a proper name, a proper noun (Griffiths & Kinnane, 2011).
Countrymen	A colloquial, gender-neutral term describing an Aboriginal person from their Traditional Owner community or a neighbouring Traditional Owner community. Countrymen is a word taken from the Kriol language used in the Kimberley region.
Cultural Blocs	A Cultural sphere of influence related through language, laws and belief systems; a sub-regional grouping usually encompassing several language groups sharing similar cultures (Griffiths & Kinnane, 2011).
Indigenous / Aboriginal	When referring to Indigenous people in the Kimberley, people prefer the term Aboriginal rather than being referred to as Indigenous.
Jila	Water holes, natural springs on country.
Karajarri Language	Karajarri is an Aboriginal Language spoken in Karajarri country and primarily in Bidyadanga Aboriginal Community located near Broome, Western Australia. There are three dialects. The dialect I speak is “Nangu” ( na + ngu ) and is presented in this article. The other dialects are called Naja and Nawurtu. Each of the three words – Nangu, Naja and Nawurtu mean ‘this’ (McKelson & Dodd, 2007).
Kartiya	A term of reference to describe anyone who is non-Aboriginal.

Kriol	Is the Aboriginal Creole language which is spoken widely across the north of Australia; in parts of the Kimberley, the Northern Territory and Queensland (Berry & Hudson, 1997).
Language	Refers to Traditional Aboriginal languages spoken in Kimberley region of Western Australia.
Law	Aboriginal Law is handed down from ancestral beings since time immemorial. Many different creation beings existed in the Kimberley creating specific laws and rules that have been handed down through oral tradition, ceremony, ritual, practice and observance (Griffiths & Kinanne, 2011).
Laja	Hot season.
Muwarr	Talking by engaging in conversation. Muwarr is a language word. Ngana Nyuntuku Muwarr? Translates as ‘What is your language? My language is Nangu Karajarri.
Ngarlu	Ngarlu is a Karajarri term for defining the place of the inner spirit. This place in our stomach area of the human body is the centre of our emotions and wellbeing (Roe 2010).
Ngurra	Land/country, where you are from.
Parrkana	Cold season.
Pirntirri	Corroboree. A traditional Aboriginal dance.
Pukarikarta	Is the way Karajarri People explain life and creation from their world view and covers the connections with spiritual beings. Sometimes in Karajarri language we describe these stories to explain a “vision”.
Rai	The spirit that comes from where the parents first dream before a baby is born. The Rai becomes central to an Aboriginal person’s identity. The spirit Rai becomes the protector and custodian of the place that it originated from, especially from that dreaming place.
RNTBC	Registered Native Title Body Corporate.
Right People, Right Country, Right Way	A term used to describe the principle by which any activities on country need to be decided upon and approved by Traditional Owners who have the rights and cultural authority to speak for country. Sometimes termed ‘proper way’ (Griffiths & Kinnane, 2011).

Skin Group	Purungu, Panaka, Parrjarri, Karimpa are skin groups in the areas covered by Bidadanga, Port Hedland and Broome. Traditionally orientated groups of Karajarri people divide their communities as their ancestors did into four groups. All the members of the group are related to one another by blood ties or by the very fact that they belong to the group (McKelson & Dodd, 2007).
The First Word	Meaning 'First' or 'Earliest Known'. The beginning of an Aboriginal person's journey in life.
Yatungal	Spirit child, from Karajarri country and is connected to the Rai.

## Uputaua: A therapeutic approach to researching Samoan communities

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*O le ala i le pule o le tautua*

The pathway to leadership is through service

*The predicted future growth of the Pasefika<sup>1</sup> population in New Zealand renders attention to the ongoing development of culturally sensitive approaches to health research, particularly those that are therapeutically anchored. This article discusses the Uputaua Approach; a contextualised contribution into the reservoir of theorising on Samoan and Pasefika research perspectives. The Uputaua Approach seeks to make important connection with Samoa cultural concepts, as a process of tautua (service) to Samoan people everywhere.*

In 1947, the World Health Organization (WHO) provided a definition of health which continues as a benchmark for generalised 'holistic' understanding which states that: "... health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (Morice, 2006, p. 1). However, despite the advancement of medicine and health knowledge, there is still a significant gap which exists between an inclusive understanding of health proposed by the WHO definition and the realities of minority communities such as Samoans and other Pacific groups. This article examines a holistic view from a Samoan perspective. It also significantly features auto-ethnographic perspectives where the author draws from both personal observations and experiences to highlight these connections more explicitly.

When situated within a health and research paradigm, holistic means the attempt to address the totality of the person, especially taking care to address their spirituality and sacredness of their customs and traditions. In other words, beyond addressing the body, mind and social dimensions of a person, is the need to locate these within their familial, ancestral, environmental and divine connections. In the Samoan context, these connections are embedded in associated cultural imperatives traceable to the practices and functions of fa'asamoa or the Samoan way of life.

### *Pasefika Health Perspectives*

Samoan and Pasefika communities have significantly contributed to greater understandings and meanings of holistic health beyond the western based ideas traditionally associated with its bio-medical orientations (Ministry of Health, 2006; Morice, 2006; Neimeyer, 2001). Resultant is the emergence of indigenous models of health and research perspectives that integrate a more inclusive approach akin to their experiences and worldviews. Of particular relevance are their contributions to encompass and champion traditional roots and paradigms, whilst at the same time, encouraging a bold transition into the current environment. For example, the *Fonofale Model* (Pulotu-Endemann, 1982) encourages health professionals to think holistically about their engagement with Samoan and Pacific communities, and to bear in mind the environment, the context and time constraints of such engagements. The *Fonofale* model has been instrumental in theorising the Uputaua Approach, particularly as the conceptual framework that aided its initial development. Like other Pasefika forerunners, Pulotu-Endemann's pioneering work in Samoan and Pasefika health paved the way for health and wellness perspectives like the Uputaua Approach to continue in the legacy. By using these important foundations as a launching pad, the Uputaua Approach



has further developed and added to its ideas, particular being mindful of therapeutic outcomes when engaging in clinical settings, client assessments or health research. This is a unique and significant component of the Uputaua Approach.

In acknowledging the work of Pulotu-Endemann as foundational in Pacific health and research circles, however, this article will solely focus on the Uputaua Approach and its applications. The approach, as being culturally grounded and contemporarily situated is where the Uputaua Approach seeks to offer a point of difference beyond the means of health and research support for Samoan and Pasefika cohorts. While the Uputaua Approach is primarily contextualised using Samoan examples, some of its cultural and therapeutic concepts may find similarity or connections with other Pasefika or indigenous settings who share similar worldviews, whereby then, the Uputaua Approach could be a useful comparative resource.

#### *Uputaua Approach*

The Uputaua Approach utilises the metaphor of the *faletalimalo* (Figure 1), a modern Samoan meeting house specifically built for receiving and welcoming guests, as its conceptual framework. ‘Uputaua’ comprises two Samoan words (*upu* and *taua*) combined to form Uputaua. In English, *upu* means ‘word’ or ‘a saying’ (e.g., *o le upu moni*, meaning, the word of truth, or, *o upu fa’amaoni* meaning, a faithful saying) and *taua* is used when making reference to something that is deemed ‘sacred’ or ‘important’. Therefore, when *upu* and *taua* are combined to form *Uputaua*, it can then be understood to mean ‘words of wisdom’ or ‘sacred conversations’. ‘Approach’ denotes the concept of advancement towards a proposed space. In Samoan context, the proposed space is commonly referred to as the *va fealoalo’ai* or the relational space which various parties respectfully negotiate. Approach also signifies the ‘manner’ of

advancement or positioning one adopts when engaged within this sacred space.



Figure 1. A Modern Faletalimalo located in Malie, Samoa.

In counselling therapy, client needs assessment and health research, Uputaua Approach recognises the important skills involved in facilitating *talanoa* within the conversational space, the needed role of wisdom in crafting speech and the use of respectful language as negotiated and exchanged in the process of *fa’atalatalanoa* or “purposeful and deliberate talk” (Te Pou, 2010, p. 3). Furthermore, the Uputaua Approach provides a supportive guide for the clinician, health professional and researchers to be reflective of their role throughout the engagement processes. It is acknowledged that other negotiations are plausible outside of the contexts explored in this article. Although the Uputaua Approach is primarily built on the notion of ‘sacred conversations’ or ‘talking therapy’ (Te Pou, 2010), it also recognises and acknowledges that the healing journey for Samoan, like their Pasefika cohorts, is far more encompassing to include the embrace of their environment, ancestral wisdom, associated rituals, and spiritual beliefs both of religious and traditional orientations.

#### *A Gift from the Ancestors*

Anae (1999) suggests that “we are carrying out the genealogies of our ancestors ...over time and space” (p. 1). With this premise, the ideas presented in the Uputaua

Approach are firmly traceable to ancestral forerunners. It is a *meaalofa* (gift) handed down by the *tua'ā* (ancestors), such as my grandmother 'Uputaua' Leiatuaalesā Tuilaepa Seiuli; to whom this approach accredits its title. Uputaua, or *tinā* (mother) as her grandchildren referred to her, left a profound impact on those she cared for. Safety and security were the hallmarks of her caring nature that provided a secure refuge in times of trouble. Her kind and gentle words and warm affirmation nurtured a strong sense of confidence that minimised any harm, real or perceived. The values she endorsed and displayed provided the emotional strength to be brave and strong when chaos or despair loomed. Uputaua left behind a sacred *meaalofa* reflective of her love and life which is being passed onto others. This living legacy solidifies, supports, and knits us together through time and space. Her gift finds significance when as a counsellor and researcher, I engage with people in 'sacred conversations' or actively participate in 'wise collaborative counselling' within the relational and sacred therapeutic space. Like grandmother Uputaua, there are significant moments in my counselling and pastoral work

that I am called into this sacred space, to be a co-holder and a co-collaborator of people's lives. What a privilege!

The next section outlines the key features of the Uputaua Approach. However, as important as it is to offer another perspective in our endeavours to support the work with our communities, there is a realisation that such efforts can also be a two edged sword. That is to say, it can be misused, misrepresented or misunderstood and therefore be potentially harmful rather than be helpful. It is my purpose to not repeat these same mistakes. With this in mind, I proceed with sensitivity and cautioned provided by the Health Research Council (2004) which urges:

The path that leads to a new vision of research has been paved with good intention and some bad practice. There are many barriers to doing Pacific research. ...while there is a legacy of mistrust, there is also a new vision that has the energy to propel us into the future. (p. 7)



Figure 2 . Uputaua Therapeutic Approach.

*Uputaua Therapeutic Approach.*

1. Roof – Ola Fa’aleagaga (Spirituality)
2. Land – Tu ma Aganu’u Fa’asamoa (Culture and Customs)
3. Foundation – Aiga Potopoto (Family, Kin and Relationship Network)
4. Internal Boundaries – Le Va Fealoaloa’i (Relational Space)
5. Left Frontal Post – Ola Fa’aletino (Physical Wellbeing)
6. Right Frontal Post – Ola Fa’aleloto (Social Wellbeing)
7. Left Rear Post – Ola Fa’alemafaufau (Psychological Wellbeing)
8. Right Rear Post – Ola Fa’alelagona (Emotional Wellbeing)
9. Neighbourly Boundaries – Tausi Tua’oi (External boundaries)
10. First Step – Meaalofa (Gifting Process)
11. Second Step – Loto Fa’atasia (Collaborative ‘we’ approach)
12. Third Step – Mana ma le Mamalu (Maintaining honour and dignity)

*Ola Fa’aleagaga* or life according to the spirit represents the roof or the covering that maintains safety and governance for Samoan people in the context of their *aiga* (kin and relationship network), their *nu’u* (village), the *atunu’u* (nation) and *ekalesia/lotu* (church/religion). Although spiritually are often equated with Christian or religious worldviews, it is important to note that Samoan people have also maintained deep rooted understandings and practices of spiritually from their genealogical beginnings (Fraser, 1891; Kramer, 1901; Suaalii-Sauni, Tuagalua, Kirifi-Alai, & Fuamatu, 2008). The perspective that the person is never just a manifestation of the physical, social and emotional characteristics, but together with these attributes, is the belief in an inherited spiritual connection to *Tagaloa-a-lagi* or Tagaloa-who-lives-in-heaven (Kramer, 1901; Tui Atua, 2004). These divine connections strongly emphasises that as spiritual beings, we are inseparable and are therefore divinely connected to the physical and the natural, as much as to the spirit worlds and the cosmos, which in turn forms an important part of Samoan people’s pre-Christian existence.

This is clearly articulated through the use of various terminologies that connects the physical and the natural with the divine. For example, the Samoan words *ele’ele* and *palapala* means blood. These are also the same words that are used to mean earth or

dirt. The Samoan word for land/ground is *fanua*, which is also the word used for the placenta. In Samoan customs, the *fanua* (placenta) belonging to a child once born is generally buried in the *fanua* (ground), particularly a sacred ground such as in-front of the church or some other sacred land (*cf.* Tui Atua, 2011). This practice may find variation in the different villages or districts throughout Samoa, or be replaced altogether.

Since early missionary contact, Samoan people have prescribed predominantly to the core beliefs of Christian teachings and practices (Taule’ale’ausumai, 1997; Va’a, 2001). In recent times, the church has become “...as an important institutional referent for Samoan ethnic identity” (Kallen, 1982, p. 104). In other words, Samoan churches serve as the hub of cultural growth and religious life for its communities (Ablon, 1971; Anae, 1998). Nevertheless, Samoans have maintained spiritual connections beyond the church doors, reflected by their special bonds with their fellowman, their physical environment, their ancestral heritage, their understandings of life and death cycles, and finally, the *tapu* (sacredness) and *mamalu* (dignity) associated with the non-physical world. In this context, the imperatives connected to the role of spirituality are much more expansive and inclusive for Samoan cohorts, beyond the realms of Christianity or religious affiliation.

*Tu ma aganu'u fa'asamoa* or the cultural context represented by the land is important in contextualising the Samoan way of life to health research and therapeutic perspectives. Within this context, one is expected to understand and assume appropriate etiquettes when considering cultural practices inherent within such concepts as the *va fealoalo'ai* (relational space), *feagaiga* (covenant relationships) and *tautua* (service). It is therefore prudent to ensure that 'the understanding and practice of things Samoa' is not assumed to have transpired, but must be taught and caught, thereby providing it in written and verbal formats to all sectors of Samoan society.

The verities of fa'asamoa cultural rituals and practices generally discussed to mean 'the Samoan way', refers to the traditional customs of the Samoan people (Lima, 2004). These perspectives, generally linked to historical practices of ancestors or family history, present the realities that form an integral part of Samoan social identity (Mallon, 2002; Meleisea, 1995; Mulitalo-Lāuta, 2000; Sahlins, 1985; Va'a, 2001). The initial work of Pratt (1911) defines fa'asamoa as "acting according to Samoan customs" (p.131). Tui Atua (as cited in Field, 1991) took this a step further by pointing out that fa'asamoa is more accurately defined as:

...a body of custom and usage inclusive of a mental attitude to God, to fellow men and to his surroundings. It is a collection of spiritual and cultural values that motivates people.... It is the heritage of people... Fa'asamoa provides individuals, the aiga and the nu'u with an identity...with carefully defined, but unwritten roles and rule. (p. 20)

The fa'asamoa instils values and principles that govern life for most Samoans, spanning from a child, to the *matai* (chief) who resides over the family affairs or village council. Likewise, Anae (1995) contends that fa'asamoa refers to a social, economic,

historical and moral structure that defines Samoan people. Fa'asamoa therefore plays a crucial role in the formation of one's identity and of self-governance. When considering all these perspectives, fa'asamoa provides the solid base for the building work of the Samoa family, cultural values, spirituality, religion, customs, beliefs, and identity to be practiced, negotiated, maintained, reciprocated and passed on to future generations. Additionally, fa'asamoa as a way of life, provides an important context to view one's cultural heritage; a set of structural principles for ordering one's social life; provides guiding principles for one's behaviour; a solid foundation to underpin one's ethno cultural identification, and a moral praxis in achieving relational harmony with God, the gods, the environment and one's fellowman. As Mulitalo-Lāuta (2000) points out, fa'asamoa is the "total make-up of the Samoan person" (p. 15).

The cultural context moreover represents one's *tulagavae* (similar to the concept of *turangawaewae* in Maoridom) such as one's significant place of belonging, one's ancestral connections and cultural birthplace. For the many that are now located in Euro-urban settings, the cultural context represents a re-negotiated identity that includes the ethnic diversity resultant from their diasporic experiences. Significant in this cultural context is the provision of required space for the children of the diaspora to feel that they too, have as much right to returning home to their ancestral homeland, and to reconnect with their *tua'ā* (ancestors), as their parents. Because of this diversified identity, the cultural context is a fluid and evolving concept dependent on where one's aiga or community is situated (Pulotu-Endemann, 1982). Culture is not one of rigidity and of concrete absolutes, but a living and breathing organism significant in shaping of the Samoan identity. Reciprocity is the key feature of understanding the basis of this significant relationship with the cultural identity. In fact, the flexibility found

within this cultural context provides space to utilise traditional ideas, as well as embracing contemporary knowledge and understandings to support Samoans in their advancement, identity and healing journeys.

*Aiga Potopoto or family, kin and relationship networks*, serve as the foundation of the faletalimalo. In the Samoan context, the aiga provides a crucial role as the foundational component that connects, support and elevate Samoan people with their spiritual responsibilities, physical characteristics, social relationships, emotional wellbeing, psychological functioning and economic viability. It is within the context of the aiga that the Samoan identity of 'self' is germinated, nurtured, matures and replicated. Gender issues, sexuality, roles and responsibilities, learning, observing and activity, all find their purposes and meanings within the context of the Samoan family. Furthermore, other roles associated with *matai* (chief, family leader) and other statuses (minister, elderly), *feagaiga* (covenant relationships), *taule'ale'a* (untitled men), *aualuma* (unmarried women) and *tama'iti* (children) are important functions of the aiga, and therefore find their place, identity and belonging under the nexus of the family unit. A Samoan proverb reflects this sense of belonging which says; *o le tagata ma lona tofi*, which means, each person has his or her designated role and responsibility. This idea further reflects the importance of the Samoan aiga in defining and designating roles to its members.

In the current context, the makeup of the family could contain traces of both the traditional makeup, as well as a diversity of other ethnic mixes. In adopted countries like New Zealand and America, the extended family in earlier migration periods extended to include any Samoans in the locality or city. Therefore, important consideration of the contemporary *aiga potopoto* (extended family network) in diasporic locations would not only be focused on the family and kin,

but the ethic structure of the family network that are re-modified and readjusted to suit current community. Such important considerations need to validate the complexities of cultural variants that exist within each and every family or community group. The functions of existing and emerging family networks are closely linked to the boundaries that exist in the *va fealoalo'ai* (relational space).

*Le Va Fealoalo'ai or relational space* as signified by the internal boundaries of the faletalimalo are important because they serve to protect the aiga, while at the same time, maintain safety parameters with people outside of the family construct. These internal boundaries encompass, but are not exclusive to, the practises of *aga'alofa* (love/charity), *fa'aaloalo* (respect/deference), *agaga feasoasoani* (support/helpfulness) and *fealofani* (relational harmony) (Mulitalo-Lāuta, 2000; Seiuli, 2010). A well-known Samoan expression that reflects the importance of safeguarding the internal boundaries advocates; *'Ia teu le va.'* This means, one must always remember to 'cherish, to nurse, to nurture, and to take care of the relational space, firstly within one's family, and then with the wider Samoan community to whom one belongs (Pereira, 2011). Tui Atua (2003) captured the essence of connectedness and belonging within the relational space for Samoan people where he says:

I am not an individual; I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas and the skies. I am not an individual, because I share my tofi (an inheritance) with my family, my village and my nation. I belong to my family and my family belongs to me. I belong to my village and my village belongs to me. I belong to my nation and my nation belongs to me. This is the essence of my

belonging (Tui Atua, 2009, p. 80).

The va is an important space that needs to be '*tausi*' (nurtured) and '*teu*' (put in order or into its right place) so that the likelihood of the space being '*soli*' (trampled) is avoided, particularly when one is considering engaging a family or community. According to Wendt (2006, p. 3), the va is "...the space between, the in-betweenness, not empty space, not space that separates but space that relates." When considering the importance of relationships that are negotiated and fostered within the relational space, in its proper context, the va fealoalo'ai helps Samoan people understand their proper connections with one another, their world, their ancestry and their spirituality. However, it is also acknowledged that meanings may change or be renegotiated, as relationships and the contexts of these relationships also shift and change over time.

Pereira (2011) emphasises that the lack of people's awareness and understandings of the paramount responsibility and duty that exists to nurture and take care of the va, has led many (both Samoan and others) to *soli* (trample) the sacredness of the relational space. Consequently, the trampling of the space has led to the breakdown of communication between parties, or the refusal and withdrawal of some to further participate in any conversation, until the sacredness of the space has been restored and healed. The efforts to heal the va is represented by the notion of '*teu*', that is, to restore it back to its respectful place and purpose. If the va is deemed unsafe, the prospect of achieving any helpful or beneficial therapeutic outcomes is almost nil. Therefore, the Uputaua Approach premises on the important role to take care of the va.

*Ola Fa'aletino or the physical aspect of life* is represented by the left post of the faletalimalo. The reason for their frontal positioning is due to the straightforwardness in which it takes one to notice these apparent

characteristics when engaged with Samoan or Pasefika communities. For example, the Samoans physical presence, like their Pasefika cohorts, is often easily recognisable, such as their towering stature, their strong sense of loyalty, their happy attitude, and their unique language. Samoan worldviews have always been regarded as holistic, inclusive and relational. Figel (1996), a Samoan author, concludes that identity and the interpretation of the self is fundamental in the way Samoan people perceive themselves and make meaning of their world around them. She writes:

'I' does not exist. 'Myself' does not belong to me because 'I' does not exist. 'I' is always 'we'. 'We' is part of the aiga, the village, the church, the youth group, the school... (p. 135)

Within the physical sphere is the notion of reciprocity, meaning, we are all connected and are a part of the larger tapestry of life, not the centre of life. All things are living, sacred and related (Morice, 2006). As a result, we are inseparable and inescapably a manifestation of the greater whole (Tui Atua, 2009). Therefore, it is our duty and responsibility to both use and nurture our relational ties with the physical, social and spiritual world we live and exist in. This is an important part of our legacy.

*Ola Fa'aleloto or the social dimension* makes up the second frontal post of the faletalimalo. The Samoan social self is better understood along the 'socio-centric' dimension which Geertz (as cited in Mageo, 1998) defines as, "...the dramatis personae, not actors, that endures; in the proper sense, they really exist..." (p. 5). Samoan people are often referred to as some of the 'friendliest', 'accommodating', 'warm' and 'happy' people in the world. Samoans are relational people and have abundant social connections. It's often heard said that you can hear a Samoan person's laughter before you see them. Similar with their Pasefika cohorts,

Samoans people's social values are ones that emphasises collectively sanctioned and endorsed actions and responsibilities. By this, one's calling is for one to stand resolute at one's appointed post in the role of *tautua* (to serve), not of one's self independent of others, but in close community.

There is a Samoan saying: '*A e iloa a'u i Togamau, ou te iloa foi oe i Siulepa*' which means; "if you do me a good deed in Togamau, I will reciprocate in Siulepa" (Tui Atua, 2009, p. 5). When *fa'asamoa* is positioned within the important role of *tautua* (service), the reciprocal performance of the customary responsibilities is motivated by the knowledge that if performed with the best possible motives, then it will be reciprocated in time and in kind. In essences, these prescribed expectations and actions are purposed to offer extensive support to within the family or community network when the *fa'alavelave* (emergencies or disruptions) occurs. Ablon (1970) observed that social support structures amongst the Samoan communities in West Coast America contribute to the alleviation of emotional distress overall compared to the general population. For Samoans communities, the extended family structure with its adhering patterns of behaviour and responsibility provides the stabilising force for personal and social life cycles.

*Ola Fa'alemafaufau* or *psychological wellbeing* is represented by one of the rear posts. *Ola fa'alemafaufau* is essentially concerned with the impact of thought processes and decision making on the ability of individuals and families to cope on a day to day basis. From a counselling perspective, personal observations reveal that although *ola fa'alemafaufau* (life according to the mind) is a vital component in the makeup of the Samoan self, it can be overlooked, pushed to the back or neglected altogether. It is imperative that these are not ignored or discounted because of its vital role in the holistic pathway to wellness. Furthermore, unrecognised psychological stressors can lead to mental

health challenges and difficulties in the long-term.

For instance, the *Te Rau Hinengaro: The New Zealand Mental Health Survey* highlighted that although the stigma attached to mental health related illnesses has subsided for general population, it is still a challenge for many Samoans and Pasefika groups to accept it when one of its member is diagnosed with a mental-health illness (Ministry of Health, 2006). For some, mental illness can still be interpreted as a 'curse' to be cured 'spiritually' or the consequence of a negative or shameful action that needs to be hidden or ignored (Te Pou, 2010). It is my experience that the attribution of such stigma has led to the fearfulness of some Pasefika people to talk openly about their psychological capacity. This then leads to further isolation and possible avoidance of health services that are imperative to supporting these communities in this important area.

The key role of psychological capacity means that it is vital to consider and discuss how Samoan and Pasefika people think, and feel about such topics as mental health, thereby supporting them through the processes of demystifying and normalising such life incidents when and if they occur within their aiga. It is through the paramount role of considering peoples' opinions and thoughts about a matter that shows respect for nurturing of the *va fealoalo'ai*, when located within this psychological context.

*Lagona* or *emotional wellbeing* is represented by the second rear post. Similar the psychological capacity (*fa'alemafaufau*) of the Samoan self, *lagona* is also recognised as a neglected but important component in the makeup of the Samoan person, hence, represented by the backward position of the post. However, in order to work holistically, this area plays a vital role in people's health and wellness in the current environment. It is within the context of the aiga that thoughts and feelings (emotions) are nurtured,

expressed and validated. However, if there is a breakdown in the pathways for conversations and emotional attachments to be fostered and matured, the likelihood of healthy emotional development and security is disrupted or undermined. To illustrate this, I want to consider the impact of *fa'alavelave* (disruptions or emergencies that demand contribution) to the emotional capacity of the Samoan person or their community.

From my observations of Samoan communities, *fa'alavelave* is a prominent factor contributing to on-going stresses within families. *Te Rau Hinengaro: The New Zealand Mental Health Survey* further revealed that Pacific people experience poorer health outcomes than the general population (Ministry of Health, 2006). These poorer health outcomes can contribute significantly to mental and psychological ill health. If untreated, these can lead to self-harming practices, suicidal ideations and suicide attempts. Furthermore, a report by Suicide Prevention Intervention New Zealand (SPINZ, 2007) also identified that “if family expectations are not met, if moral norms are violated, or if a person’s conduct reflects badly on the family name, a person can feel guilty and shame” (p. 9). The emotional, psychological and social stressors associated with guilt and shame has led some to contemplate self-harming practices or suicide ideations as a legitimate option for address (SPINZ, 2007).

It is well documented (see Maiava, 2001; Tamasese, et al., 1997; Tui Atua, 2006 & 2009) that the most prominent factor that contributes to the greatest acute level of stress in families is the struggle for economic survival, whilst balancing cultural responsibilities associated with *fa'alavelave*. The level of stress amongst family members is particularly notable when financial demands are made on the extended members to contribute. As a result, *fa'alavelave* was often felt to be a “burden” (Maiava, 2001, p. 132). Such demands and burdens have led to questions over the continuing bonds between

traditions of *fa'asamoa* and prescribed commitment by *aiga* members. This is an important consideration because of the close ties the practices of *fa'asamoa* has in the shaping and maintenance of the Samoan identity. As much as this tension represents the crux of life challenges within Samoan family structures, this article is simply highlighting this area rather than a full discussion. Therefore, if the emotional capacity continues to be ignored or discarded, there are serious long term repercussions for Samoan people everywhere. The author acknowledges the possibility of other important posts that are not mentioned in this article, however, as discussed, these four posts of the *faletalimalo* need to be supported and strengthened because of their vital role in safeguarding the *aiga*, thereby enabling its members to survive and thrive in their journey.

*Tausi Tua'oi* or *neighbourly boundaries* (external boundaries) serves as the safety coverage for the *aiga* with their local community, support groups, health professionals, helping agencies, researchers and so on. It also serves to guide the context of the work (research, assessment or therapy) proposed to be negotiated with the *aiga*. The boundaries provides safe space to negotiate desired outcomes, specific timeframes, *meaalofa* (gifts – money, reimbursements, resources, food, etc.), accountabilities of the parties involved and specific responsibilities that are required by all parties involved in the engagement. A crucial and very important component of the *tua'oi* is the role of the ‘health professional or researcher’ to maintain safety with and for the *aiga* throughout the engagement period, as well as on-going consideration afterwards. The *tua'oi* is an imperative extension of the *va fealoalo'ai*, one that needs on-going nurturing, both during the engagement period and importantly, after the face to face work has been completed.

As a health professional and



researchers, an instrumental component is concerned with maintaining alertness and mindfulness of the inherent risks associated with the responsibility to *'tausi ma teu le va'*, that is, to nurture and to maintain proper boundaries. This mindfulness is informed by Samoan peoples' sensitivity and past experiences with research and researchers. As discovered with an earlier project, one participant remarked "...we are sick to death of being researched...we are not brown Papalagi's" (Seiuli, 1997). This poignant statement echoes ongoing frustrations that are felt and experienced by Samoan and Pasefika communities whose *tua'oi* is often trampled and disregarded in the name of health assessments and wellness research. It is the responsibility of all health professionals and researchers to safeguard this sacred connection as represented by the *tua'oi*.

*Meaalofa- or gift/gifting*<sup>3</sup> represents the first of the three steps of the *faletalimalo* (Seiuli, 2004, 2010). These three steps are vital in the healing and restorative processes which support therapeutic and beneficial outcomes to be achieved by all parties involved. *Meaalofa* is a Samoan word for a gift or the rituals involved in the processes of gifting. *Meaalofa* literally means "an element of love" or "an object of affection" (Seiuli, 2004, p. 6). Additionally, *meaalofa* also encompasses the ideas presented by "...a love offering, a valued treasure, an object of adornment, one's legacy, one's heritage, one's spiritual calling, and one's service in life (*tautua*)" (Seiuli, 2010, p. 49). These attributes and values are evidently visible in and through the lives of Samoan and Pasefika communities. *Meaalofa* is not only seen and experienced by Samoan people as an integral part of Samoan life, customs, and core beliefs, but it also serves as a foundational component in the makeup of the Samoan person (Seiuli, 2004; Turner-Tupou, 2007). *Meaalofa* essentially, affirms and strengthens special relational bonds that are often accompanied by sentiments of gratitude, salutation, and more.

When functioned within a therapeutic environment, *meaalofa* is the interpersonal and relational practice of handing the gift of helping between the parties involved. That is, the engagement process and the exchange that happens within the relational space becomes a sacred gift, one that embraces the *mauli* (soul) of the participants, their environment and their occasion. The handing-over process provides the vital linking point between the giver and receiver. This distinctive connection, as provided by the *meaalofa*, is perceived by Samoan people to be the "[holistic] embodiment of the giver's feelings towards the receiver" (Sio, 2006, p. 1). Through rituals and processes of gifting, the attributes of human emotions, psychological capacity, reasoning, social and relational community, and their spirituality are connected through the exchange. Essentially, one can argue that the concepts inherent within the practices and customs of *meaalofa* (gifting) is a manifestation of the preeminent of what *fa'asamoa* has to offer.

*Loto fa'atasia or the collaborative (we) approach* is represented by the second step of the *faletalimalo*. *Loto fa'atasia* literally means 'to be of one heart or one soul'. *Loto* is the Samoan word that is often used to describe one's 'heart, soul or desire'. *Tasi* is the Samoan word for the number 1, and the prefix *fa'a* denotes the connection to something other than the number itself, which then takes on the meaning of 'to make or become as one'. Together, *loto fa'atasia* encourages the health professional, the therapist or the researcher to be of one heart and one mind with the participants or clients in their journey, and to place the needs of these communities above their preconceived ideas and expert notions they may bring with them into the engagement.

This concept is imperative in the role of supporting and championing Samoan and Pasefika communities' epistemological foundations. That is, these families are experts of their lives, their experiences and

their environment. As outsiders, we are privileged and honoured to be invited into their sacred space, and it is to our detriment to treat it with disrespect or *solu* their trust and dignity. The collaborative approach is about the *aiga* and communities being respected as owners of their healing and restoration. It is therefore impervious for the health professional to assume expertise and authority on what is deemed 'the best' or 'right solutions' for these communities.

The 'we' approach as an integral component of the collective self for Samoans, is seen as the core ingredient that knits Samoan people together. This connection in turn creates a strong sense of affiliation, loyalty and community. Further, this way of living and relating is foundational when it comes to Samoan peoples' place and status in the *aiga*, *nu'u*, *atunu'u* and *ekalesia* (church) (Seiuli, 2004). The Samoan person is always part of the collective unit, the *aiga*, never an independent entity unto one's own self. This is a foreign and western concept as Tamasese, Peteru, and Waldegrave (1997) reported where they emphasised that:

...there is no such thing as a Samoan person who is independent of others, [tuto'atasi]. We can try and explain the Palagi concept of self, but this is futile. We will eventually return to the connection between people [va fealoalo'ai]. You cannot take a Samoan out of the collective context. (p. 28)

*Mana/Mamalu* or *honouring* represents the final step of the *faletalimalo*. For Samoan people, the core values of *mamalu* and *mana* are intrinsically connected to the foundational practices of honouring and maintaining dignity. With this as a premise, it is of utmost importance that before one enters into the sanctity of the *aiga potopoto*, one need to enter with a spirit of humility; deferring honour and dignity to the family or community who have

availed themselves to the engagement. One also needs to be mindful that in the process of opening their doors to the engagement, these families and their communities are vulnerable and exposed, and many in past times have taken advantage of this vulnerability, which may have resulted in the trampling (*solu*) of the sacred relational space. It is therefore imperative as health professionals and researchers to not repeat these same mistakes, and to uphold the honour and dignity of these communities before, during and after the engagement is completed.

When the *mamalu* and *mana* of the *aiga* or community is upheld throughout, it is then a reflection of health research that is done *with* people and *for* people, not *on* people (Hodgetts, Drew, Sonn, Stolte, Nikora, & Curtis 2010; Jovchelovitch, 2007). Historically, health research of Samoan life was fundamentally research done *on* people. The outcome of these observations often resulted in representations and interpretations common of the period. We need not make the same mistakes. Needless to say, it has been sometimes reported that it is people from within these same communities who should know better, but who are amongst the culprits who dishonour families and communities they should be protecting.

The final component of the *mamalu* and *mana* concept is about supporting and validating expressed life narratives of individuals, their *aiga* and their communities. The validation process can be contextualised in three distinct ways. Firstly, the validation of expressed life stories is therapeutic in and of itself, and one which ultimately supports valuable steps to healing. Secondly, the validation of expressions is inextricably linked to the recovery and preservation of Samoan epistemological foundations. This foundation speaks about who we are: our struggles, our challenges and our emergence within our renegotiated existence as communities in western localities. Shared stories can provide a sense of community

similar to those experienced within a Samoan village. We can interpret our experiences less as isolated and exclusive incidents, and more as shared similarities with others in the wider community. Thirdly, the process of validation is about reconciling and reprioritising the important practices about our traditions, customs and cultural expressions. A clearer understanding of these priorities better equips us to continue in the process of handing on the *meaalofa* (gift): the gift of our journeys; the gift of our stories; the gift of our emergence; the gift of our struggles; and the gift of our lived experiences. The Uputaua Approach is an attempt to contextualise these gifts, as living legacies, ones that we can share and pass on to our loved ones, and to future generations (Seiuli 2004, 2010). *Fa'afetai lava*.

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### Notes

<sup>1</sup>Pasefika (Pasifika or Pasifiki) is a term of convenience to encompass the diverse range of peoples from the South Pacific living in New Zealand. Pasefika people's ancestry homes are located in the Polynesia, Melanesia, and Micronesia groups. These are people from the island nations of Samoa, Cook Islands, Tonga, Niue, Fiji, Tokelau, Tuvalu, Kiribati, Vanuatu, Solomon Islands and Papua New Guinea.

<sup>2</sup>Therapeutic is about making beneficial contribution that maintains and supports the overall health and well-being of individuals and their communities. Therefore, great care and sensitivity is maintained throughout the engagement processes, and just as importantly, the responsibility to safeguard and honour the sanctity of the participants' information that was shared. Uputaua as a therapeutic approach is purposeful in building and maintaining a trusting relationship that is mutually beneficial; one that offers opportunities for healing to take place, as well as working towards the retaining and restoring of the sacredness of people's identities and cultural imperatives.

<sup>3</sup>Meaalofa concepts are discussed in more details in Seiuli (2010).

### Author Biography

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## Out from the margins: Centring African-centred knowledge in psychological discourse

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*This article examines the marginalisation of indigenous psychologies of African peoples of the Diaspora by critically interrogating the privileging of dominant Anglo-American knowledge within psychology. It argues that African-centred psychologies may, in some cases, offer a useful model for understanding and articulating the psychological orientation of African peoples of the Diaspora who are suffering from mental health problems. By embedding indigenous knowledge within a broader anti-colonial framework, the paper interrogates the dominance of Anglo-American knowledge in general and in psychology, more specifically. In doing this, it presents African-centred Psychologies and other indigenous knowledges as a counter-stance to colonising dominant Anglo-American models. Consequently, the article argues that African psychologies may offer important insights to the psychological orientation of African peoples of the Diaspora and, consequently, for the treatment of mental illness. The article concludes with a discussion on the various healing approaches utilised by African peoples of the Diaspora that are informed by indigenous and various Euro-Western approaches.*

Scholars who are becoming increasingly concerned with the failure to acknowledge the histories, cultures, and knowledges of marginalised peoples consider the ‘indigenous knowledge’ framework useful for interrogating why and how certain knowledges get validated in the academy. As scientific development and research and development activities gained in importance, Anglo-American society constructed a hierarchy of knowledge whereby diverse, but equally valid forms of knowledge were ranked unequally based on their perceived value. Dei (2000a, 2000b) argues that indigenous knowledge seeks to examine the process of knowledge production by questioning and challenging how imperial ideologies about legitimate and non-legitimate knowledges serve to marginalise and silence subordinate voices. Consequently, non-dominant Anglo-American knowledge systems that are evaluated based on a dominant Anglo-American epistemological frame of reference are often devalued and delegitimised (Dei, 2000a, 2000b; Waldron, 2002a, 2002b, 2010).

The inherent power inequities between

indigenous and dominant Anglo-American knowledges are illustrated in the production, reproduction and dissemination of discourse within various disciplines, including health, medicine, sociology and psychology. It is important here to clarify the distinction between illness and disease. While the assessment and treatment of ‘disease’ is primarily the domain of biomedicine, illness is often dealt with by some variants of psychology, public health, population, social medicine and complementary (alternative) medicines. Biomedicine understands disease as being rooted in biological and genetic disruptions (i.e., internal malfunctioning). African-centred psychologies and other indigenous or ‘folk’ models, on the other hand, are more likely to consider how factors external to the individual (e.g., punishment by an angry spirit, witch or ghost) contribute to illness. Illness in many of these societies is often perceived as ‘culture-bound’ because the explanations given for it are often based on personal understandings of health and illness that reflect the symbolic structure of specific cultures and societies, as well as local histories, and environments. Conversely, explanations for disease that are

embraced by biomedicine are not tied to personal or symbolic structures. Rather, they are applied universally under particular methodological conditions that are often independent of the health practitioner's beliefs or the socio-cultural realities of individuals (Clement, 1982). Parks (2007) observes that the 'folk psychologies' that characterise the beliefs and healing practices of some African-American families and communities and that is passed down through generations encompasses a wide range of beliefs. These beliefs include personal agency, human understanding, capacity for inner healing, self-image, personal security and moral lessons.

This article examines the marginalisation of indigenous psychologies of African peoples of the Diaspora within the broader discipline of psychology by critically interrogating the privileging of dominant Anglo-American knowledge within psychology. It suggests that African-centred psychologies may be useful for understanding and articulating the worldviews and psychological orientations of African peoples of the Diaspora and for helping them cope with and resolve mental health problems. It should be emphasised, however, that the paper is not suggesting that African-centred psychologies should be seen as the only way forward for all African-Americans or African-centred psychologists. What it does seek to do, however, is to centre African-centred psychologies within the broader psychology framework as valid and useful frameworks for understanding the histories, cultures and experiences of African-Americans. In other words, while the paper critically interrogates the peripheralising of African-centred psychologies, it recognises and validates the considerable diversity that exists within African-American culture and among African-centred psychologists. For example, it is important to point out that the term 'African-centred psychologies' denotes the heterogeneous nature of African-centred approaches and broader movements in indigenous psychology globally. It also

highlights the considerable diversity and complexities that exist within cultures. This is exemplified by the range of holistic approaches that are in use in North America by diverse communities. In resisting the homogenising of indigenous approaches, the paper refrains from invoking dominant and colonising ideologies that are inherent to the Anglo-American (positivist) tradition.

The paper begins with a discussion on how indigenous knowledge can be used as an avenue through which to give power to the ideologies and experiences of subordinated and marginalised voices. It presents the anti-colonial framework as useful for capturing how indigenous knowledge can offer an avenue to resist the dominance of Anglo-American knowledges. This is followed by a discussion on the effectiveness of using an African-centred conceptual framework to understand the psychological orientation of African peoples of the Diaspora. Next, the paper demonstrates how African-centred psychologies may be used to articulate the production of mental health problems experienced by African peoples of the Diaspora that are the direct result of being subjected to oppressive conditions that arise out of past and present-day colonial encounters. Consequently, the paper highlights a social causation model that understands mental illness as being produced from the psychological, mental and spiritual violence that continues to be perpetrated against racialised peoples in Anglo-American societies. The paper concludes with an examination of the healing approaches used by African peoples of the Diaspora that are informed by a variety of indigenous and scientifically-based approaches.

### **Indigenous Knowledges: A Counter-Hegemonic Stance for Rupturing Dominant Discourses**

The term 'indigenous' describes specific groups of people who are grouped under the criteria of ancestral territory, collective cultural configurations, historical

location in relation to the expansion of Europe, and knowledge that emanates from long-term residence in a specific place. Since the 1980s, 'indigenous' has been used alongside the term 'knowledge' to signify a social science, philosophical, and ideological perspective that acknowledges the significant role that knowledge plays in the power relations that emerged from the expansion of Europe (Dei, 2000b; Purcell, 1998). Moreover, unlike scientific discourse, indigenous knowledge makes no claims to a universal truth. Roberts (1998) conceptualises indigenous knowledge as knowledge "accumulated by a group of people, not necessarily indigenous, who by centuries of unbroken residence develop an in-depth understanding of their particular place in their particular world" (p. 59). When 'indigenous' is used alongside discussions on health or psychology, it characterises what is often referred to as ethno-medicine, 'folk' medicine or 'folk psychologies' and is thought to differ in significant ways from dominant Anglo-American psychology and biomedicine.

Hooks (1990) argues that marginality is a site of deprivation as well as a space for resistance because it simultaneously reveals the material, spiritual, and psychological destitution that oppression engenders, as well as the many opportunities for resistance that exist for rupturing hegemonic structures and discourses. The anti-colonial framework has often been put forward as useful for articulating counter-hegemonic consciousness and actions of marginalised histories, knowledge, cultures and peoples. It is a framework that values the knowledges that are produced from the daily experiences and cultural histories of marginalised groups. It acknowledges how various structures and processes within societies stratified by socially-constructed markers of difference (e.g., race, culture, gender, and class) impact on social relations and human interaction. It also demonstrates how individuals and groups are positioned differently within hierarchies

of power (Dei & Asgharzadeh, unpublished; Waldron, 2002a). The anti-colonial framework also seeks to reveal the processes through which inequalities are produced and reproduced within institutional structures and questions the power, privilege, and dominance that result from unequal relations. Finally, in recognising how deeply relations of power are embedded in our lives, the anti-colonial framework articulates the processes through which marginalised and oppressed peoples can engage in counter-hegemonic activities that question, challenge and dismantle dominant ideologies and structures.

Decolonisation has been taken up by anti-colonial theorists as an important process through which the colonised (i.e., marginalised communities) can acknowledge the colonial past by recalling, remembering, and revisiting it. Decolonisation interrogates the processes and structures of colonialism in order to examine the process through which the indigenous knowledges of colonised subjects get constructed as illegitimate and worthless (Dei & Asgharzadeh unpublished). Although the subversion of dominant Anglo-American hegemonic discourses and systems are at the heart of the decolonisation project, it is also concerned with validating indigenous forms of knowledge that marginalised communities bring into the existing dominant knowledge frame. For example, Fanon (1963, p. 63) argues that decolonisation should always be viewed as an ongoing process that progresses to some sort of societal transformation. It arises initially from the conflict that ensues when two opposing forces – one dominant and the other subordinate – collide in a highly tenuous and combative environment. It also examines the possibilities and limitations for rupturing the hegemonic systems within the academy and other social spaces. African-centred psychologies is one example of a decolonisation project that has at its root the intellectual, spiritual and psychological liberation of African peoples.



### **Understanding the Psychological Orientation of African Peoples of the Diaspora**

Perhaps what most distinguishes biomedicine, psychiatry and dominant Anglo-American psychology from the traditional healing systems (i.e., indigenous) of non-Europeans is their tendency to separate the material from the non-material in explaining illness causation and in treating illness. The material includes those tangible explanations that can be seen concretely, whereas the non-material includes those psychic, spiritual and mystical explanations that may not be visible in a concrete way. Whether we use the terms 'mind-body', 'mind-body-spirit', or the more inclusive 'mind-body-spirit and emotions', we are describing the truly whole and integrated nature of ourselves and our beings.

African indigenous knowledge, in particular, is predicated on an African conceptual framework that is concerned with generosity, compassion, humanity, community, and relationships. Unlike in Anglo-American societies, where an emphasis is placed on gaining control over the environment, an African conceptual framework values cooperation and harmony with each other and with nature. It is also premised on the interrelationship between the living and the nonliving, natural and supernatural elements and the material and the immaterial. The emphasis on spiritual phenomena is an important aspect of this world view, particularly the belief that deceased individuals transform into invisible ancestral spirits and involve themselves in all aspects of life. These include assisting individuals in obtaining good fortune, assisting with interpersonal relationships, and promoting good health and preventing illness (Bojuwoye, 2005). Asante (1991) asserts that:

Centricity is the location of students within the context of their own cultural reference so that they can relate socially and psychologically to other cultural

perspectives and view all group contributions as significant and useful. (p. 171)

This conceptual system is considered optimal by African-centred scholars (Akbar, 1979; Asante, 1991; Dei, 2000a; Dickerson, 1995) because it is couched in a holistic African-centred world view that perceives reality as both spiritual and material. African-centred scholars and other individuals understand the concept of self as being comprised of the concepts 'I' and 'We', with both concepts perceived to be part of an integrated whole. The notion that 'I am, because we are' means 'we are, therefore, I am' in the African-centred world view. Unlike in Anglo-American cultures, where an emphasis is placed on the individual, the African-centred world view sees the 'I' (self) and the 'We' (community, nature) as interdependent. It is a holistic approach to knowledge and an optimal world view in which normalcy is defined in terms of health and well-being and is predicated on a world that is manifested by an infinite spirit (Myers, 1988).

Fanon (1963) argues that it was inevitable that colonialism would provide a fertile ground for the production of psychiatric and behavioural problems among the colonised. He suggests that individuals who are subordinated in ways that force them to abandon the particularities of their culture and to assimilate into a dominant culture may live an existence that is at odds with their psychological and spiritual make-up. Fanon was less concerned with the superficial particularities of racial stereotypes that were at the centre of dominant Anglo-American discourse than with the exploitation of racial difference for economic and political gain. He integrated theories of phenomenology, existentialism, and Marxism to construct a unique theory that articulated how mental pathology may be produced from feelings of alienation and marginalisation among colonised subjects (Ashcroft, Griffiths, &

Tiffen, 1989).

Similarly, Akbar (1979) argues that African peoples of the Diaspora who live in environments where they are subjected to controlling behaviours by European peoples will be inculcated with dominant Anglo-American ideologies and values. He suggests that this often results in the adoption of the personality structure, behavioural patterns, and 'disorders' of Europeans who live in Anglo-American societies. He identifies female frigidity, sexual perversions, and extreme anxiety as disorders that are rare in cultures with different value systems and social organisations from those of Europeans. He also states that mental health professionals who treat African peoples of the Diaspora must acknowledge the distinctions in the dispositions and values of Africans and Europeans. In addition, he cautions these professionals to acknowledge the significant role that oppression plays in producing mental health problems among African peoples of the Diaspora. Memmi (1965) argues that colonialism uses psychological violence to keep the colonised in a state of perpetual ignorance, hopelessness, and helplessness. Colonised peoples, according to Memmi, are inculcated with the values and ideologies of colonisers that are rooted in racist ideology. Consequently, the coloniser is able to justify his oppression of the colonised by imbuing the colonised with negative traits and qualities that are thought to warrant that kind of treatment.

It is important to note that Fanon (1963) did not confine the problem of colonialism simply to the violent colonial encounter of the past. Rather, he suggests that the violent colonial encounter is still in evidence today in the relationship between marginalised and dominant populations, within the structures and institutions of Anglo-American societies and in the production of mental health problems that are a product of oppressive structures, institutions and actions. This understanding of pathology or mental illness

suggests that African peoples of the Diaspora have a heightened vulnerability to developing 'colonial pathologies' because they are subjected to consistent and persistent psychic injury that is typical in Anglo-American societies that uphold White supremacist and dominant Anglo-American ideologies. These ideologies hold privileged status in educational institutions, the workplace, media and in society in general. These 'colonial pathologies' are the mental health problems that are experienced by non-European and racialised peoples who suffer from feelings of subordination, subjugation, and oppression within colonial relations and imperial structures in these societies (Waldron, 2002a, 2005).

In discussing African Americans in particular, Azibo (1996) and Parham, White, and Ajamu (1999) suggest that the behaviours, attitudes, feelings, values, and expressive patterns of African Americans emerge from a psychological perspective that can be said to be uniquely African American. It influences the way that African Americans interpret reality, relate to others, and live their lives. This is not to suggest, however, that all African Americans as a group share a particular experience. Rather, these authors are arguing that a shared history and culture, both of which continue to be regenerated inter-generationally, shape the relationships that African Americans have with social institutions, other communities, other African Americans and themselves. Consequently, the psychological perspective that the authors suggest is uniquely African American and is a product of the unique relationships that African Americans experience.

Psychologists who adhere to an African-centred perspective argue that, since most of the basic principles of dominant Anglo-American psychology are designed to understand personality structure and behaviours and were not designed with non-Whites in mind, they are not useful for understanding how African heritage (as well

as a European one) has influenced the dispositions of African peoples worldwide. Consequently, they fail to understand how the experience of social, economic and political inequality and oppression provide African peoples with a unique standpoint or worldview and how those issues impact on their psychological, mental and emotional status.

### **African-Centred Psychologies**

African-centred psychologies offer conceptual models for understanding and assessing the personality structure and psychological orientation of African peoples within Anglo-American societies. They move beyond the emphasis on the self or individual in the dominant Anglo-American model of psychology to examine how mental illness may be attributed to wider historical, structural and institutional structures and processes (Waldron, 2002a, 2005, 2010). African-centred psychologies originate from an organised system of knowledge that emerged from the philosophy, definitions, concepts, models, procedures, and practices of an African cosmology. It predates the European Renaissance and the founding of Greece and originated as far back as the ancient Kemet, which was the Blacks' Nile Valley civilisation of what is today Egypt. The Kemet system used theoretical and practical constructs to create a system for describing the human psyche (Azibo, 1996). The three key concepts in African-centred psychologies are: (a) cosmology; (b) social theory; and (c) African self-consciousness. Baldwin (1986) defined the present-day model of African-centred psychologies in the following way:

African (Black) psychology is defined as a system of knowledge (philosophy, definitions, concepts, models, procedures, and practice) concerning the nature of the social universe from the perspective of African Cosmology (meaning that). . . African (Black) psychology is nothing more or less

than the uncovering, articulation, operationalization, and application of the principles of the African reality structure relative to psychological phenomena. (p. 243)

African-centred psychologies challenge dominant Anglo-American ideologies that perceive the world as material as opposed to spiritual, that consider the Black man inferior to the White man and that perceive the individual and the environment as independent of one another. It also challenges the notion that the behaviours of all individuals can be accurately assessed in the same way, despite racial and cultural differences (Khatib, Akbar, Nobles, & McGee, 1979). The main weakness inherent in dominant Anglo-American psychology pertains to assumptions that the dominant Anglo-American model of normalcy is relevant to the experiences of non-White peoples. Dominant Anglo-American psychology emerged within the context of a social reality that reflected and still reflects a dominant Anglo-American world view. In this world view, difference and diversity are downplayed and individuals who deviate from established rules and norms are often considered abnormal. Consequently, non-White peoples who deviate from a dominant Anglo-American behavioural norm may be mistakenly identified as pathological by mental health professionals who are unfamiliar with the personalities and behavioural patterns of culturally diverse peoples. In dominant Anglo-American psychology, a person who is considered to be mentally healthy is one whose behaviours and personality traits most closely resemble those of the White middle-class, urban male, that is, affectless, individualistic, competitive, controlling, and future-oriented (Azibo, 1996; Waldron, 2010).

Moreover, dominant Anglo-American psychology is primarily reductionist in its concern with categorisation, mental measurement, establishment of norms, the

study of the individual and the early years of child development. Despite the discipline's claim that the measurement of ability is based on scientific principles, the findings that emerge from these measurements have continued to support a belief in the intellectual superiority of Europeans (White, 1984). This has had its most damaging impact on the lives of African peoples worldwide because it is inherently anti-African and in contradiction to the survival of African peoples as a collective (Azibo, 1996).

African-centred psychologies offer an alternative epistemology that reflects the historical, philosophical, and cultural realities of African Americans and other African peoples worldwide. It is based on an understanding of and appreciation for 'the Black family,' its African roots and the historical development, evolution and socialisation of its members. African-Centred Psychologies have sought to organise and explain the behavioural patterns of primarily African Americans peoples within the context of an African worldview. It is important to point out that putting forth broad claims about the personality structures and behavioural patterns of African Americans is problematic in its essentialist and universal stance. The usefulness of an African-centred approach in understanding the perspectives of African American peoples, however, lies in its attention to the 'psycho-social,' particularly how marginalisation, inequality, discrimination and oppression impact the psychological, mental and emotional health of African Americans and other Africans worldwide (Baldwin, 1992).

Several African American psychologists (Akbar, 1979; Azibo, 1989; Baldwin, 1992; Wright, 1974) have responded to the inadequacies of dominant Anglo-American psychology and the social ills affecting African American communities by developing a theory, research, and practice base that is African-centred and that speaks to the social realities of African peoples of the

Diaspora – social realities that are shaped by historical, structural, institutional and everyday inequalities. For example, Baldwin (1992) developed a theory of Black personality that consists of a complex biophysical structure comprising of two core components: (a) the African self-extension orientation and (b) the African self-consciousness. According to this theory, the African self-extension orientation, which is the foundation of the Black personality system, is considered to be bio-genetically determined and represents the psychological disposition of Black people. The African self-extension orientation is based on the notion of a shared spiritual essence in which the African person is perceived to be a direct extension of the Divine (Creator, God). Baldwin (1992) points out that African Americans can only be considered psychologically healthy when they have reached a level of self-consciousness where they recognise themselves as African biologically, psychologically, and culturally, perceive the survival of Africans as a priority and where they respect, engage in, and foster all things African.

While I disagree with Baldwin's (1992) argument that psychological health for African Americans can only be realised when African Americans reach a particular level of self-consciousness, I share his view that an important aspect of being psychologically healthy for African Americans is in recognising and accepting themselves as African biologically, psychologically, and culturally. This is particularly crucial to their emotional, mental, psychological and spiritual well-being in light of social institutions and media images that specifically seek to damage African Americans' healthy view of their histories, cultures and of themselves.

According to Baldwin (1986), Black personality malfunctions when the relationship between African self-extension orientation and African self-consciousness

becomes impaired by the superimposition of the alien reality structure. The concept of African self-consciousness, the second core component of Black personality, derives from the African self-extension orientation and represents the conscious level of the spiritual component. Baldwin (1992) argues that this component considers the psychological and behavioural conditions of African Americans within the context of their own cultural heritage and acknowledges the role that nature (genetics) and nurture (environment) play in the personality and behaviours of African Americans. He (1984) blames the weakening and distortion of the Black personality on the imposition of an alien or non-African (European) influence on African American peoples. He perceives the socio-cultural and mental health problems of African Americans as being the result of the unnatural influence of a dominant Anglo-American cosmology that is substantially at odds with an African cosmology. Baldwin also argues that African Americans have adopted a false sense of consciousness as a result of being socialised and indoctrinated by an alien influence that is not only Anglo-American, but inherently anti-African. This influence produces negative self-concepts in African Americans that result in destructive behaviours and that, consequently, threaten the survival of the group.

Akbar (1979) proposed the following classification system of mental disorders among African Americans that relates directly to Baldwin's (1992) model: (a) the alien-self disorders; (b) the anti-self disorders; and (c) the self-destructive disorders. This classification system views the mental health problems experienced by African Americans as being the result of their having being stripped of their optimal world view, inculcated with an alien world view, and as a result of their adoption of a false sense of self. Alien-self disorders, the first category, refers to African Americans who have rejected the spiritual dimension of their being, preferring

to define themselves based on material possessions and external rewards. These are individuals who value materialism and social prestige over moral virtues and negate the relevance of race, racism, and oppression in their lives. They also become alienated from themselves through a process of indoctrination that distorts or rejects their cultural and historical identities.

Anti-self disorders refer to African Americans who engage in self-hating behaviours by demeaning and rejecting their ancestral roots. These individuals' behaviours and goals are motivated by a reliance on the approval of the dominant White group. Unlike those individuals in the alien self-disorder group, these individuals are considered to have adapted quite successfully to the European cosmological system. Their 'cultural dissociation' from their African heritage is considered complete when they are thought to have successfully rid themselves of their cultural and historical memories and now function at a level that would be defined as healthy by European cosmology.

Finally, self-destructive disorders are perhaps the most visible consequence of living in an oppressive environment. African Americans who belong to this group have either not had the opportunity to identify with European cosmology or have rejected many of its basic principles. This group comprises those African Americans who engage in negative behaviours, such as prostitution, drug dealing, and substance abuse.

Putting forth any classification system of personality for racial and cultural communities is problematic in its potential to homogenise cultures and races. It also has a tendency to undermine and ignore the complexities of human experience and confine behaviour to pre-determined, fixed and stable categories that serve to further stereotype cultural and racial communities and individuals, as Akbar (1979) does in discussions on negative behaviours (e.g.,

prostitution, drug dealing, substance abuse). However, unlike other classification systems of personality in Anglo-American psychology, the classification systems put forth by Baldwin (1984, 1992) and Akbar (1979) are most concerned about how structural and systemic inequalities impact on personality structures.

Baldwin (1984) and Azibo (1989) both use the concept of 'psychological mis-orientation' to refer to African Americans who are subjected to a cognitive definitional system that is alien, non-Black, and at odds with the survival of African peoples and things. African Americans are said to be psychologically mis-oriented when they operate out of a dominant Anglo-American state of consciousness that they consider to be neither alien nor dysfunctional according to the Euro-American social reality. Baldwin also argues that this psychological mis-orientation is supported by institutional systems that support a European survival thrust and that reinforce a disordered psychological functioning among African Americans. Wright (1974) coined the term 'mentacide' to refer to the silent rape of a people's collective mind by the penetration and perpetuation of alien culture, values, belief systems, or ideas for the purpose of group destruction. He argues that mentacide occurs when marginalised communities accept and internalise the culture, values, and belief systems of the dominant group, resulting in the damage to African self-consciousness and the adoption of the behavioural characteristics of the oppressor. Similarly, Azibo (1989) uses the term 'alienating mentacide' to refer to the process of indoctrination that commands acceptance of and respect for a dominant Anglo-American value system and that promotes negative depictions of African peoples.

African-centred psychologies underscore how important it is for African peoples to recover their sense of identity, humanity and power in societies that subject

them to experiences of intense trauma and dehumanisation. As Pajaczkowska and Young (1992) so succinctly put it:

The psychoanalytic emphasis on the complex and often painful transactions between the psychic and social can reveal how deeply racism permeates not only the institutions of post-colonial societies, but also the ways in which we experience ourselves and others. (p. 198)

### **Holistic Healing Approaches: Integrating African Indigenous and Dominant Anglo-American Knowledges**

Various healing systems around the world are predicated on knowledge systems that are often at odds with rationalist and positivist ideologies upon which the biomedical model and dominant Anglo-American psychology are based. For example, Durie (2004) observes that Maori perspectives on health in Aotearoa, New Zealand embrace holistic conceptualisations that perceive good health as a combination of mental (hinengaro), physical (tinana), family/social (whānau), and spiritual (wairua) dimensions. Maori researchers have challenged existing measures that are grounded in biomedical models by developing the Maori Mental Health Outcome Framework (MMHO) to measure mental health outcomes for Maori.

A study conducted by the Center for Addiction and Mental Health (1999) in Toronto found that some African Caribbean peoples are suspicious of dominant Anglo-American approaches for treating mental illness, such as psychiatry, therapy, and counselling. There is, however, a greater tendency to embrace the idea that mental health problems can be more successfully resolved through more informal routes, such as spirituality, faith healing, religion, church, social networks and self-help strategies (Waldron, 2005, 2010).

Early studies on mental illness among African peoples of the Diaspora (Asuni, Schoenberg & Swift, 1994; Baker, 1994; Barbee, 1994; Bulus, 1996; Center for Addiction and Mental Health, 1999; Fontenot, 1993; Foster & Anderson, 1978; Madu, 1996; Sow, 1980) found that conceptualisations of 'mental illness' stem from people's own observations, understandings and interpretations of specific symptoms, the behaviour of persons who are affected and how those symptoms are uniquely experienced and explained in a particular society or culture. They found that for African peoples of the Diaspora, medical traditions are shaped by the makeup of the physical environment, the occurrence of specific diseases or the disease experiences of the people, the level of exposure and access to biomedicine, levels of literacy, social class and the beliefs that people hold about diseases and cures that are inherited from past generations.

Several authors (Carrington, 2006; Schnittker, 2003; Schnittker, Freese & Powell, 2000; Waldron, 2010) describe conceptualisations of mental illness among Black women specifically. Carrington found that the ways in which African American women present symptoms of depression are often culturally determined, resulting in their failure to seek treatment for a number of reasons, including the belief that depression is indicative of a weak mind, poor health, a troubled spirit, and lack of self-love. She also pointed out that these women are often reluctant to seek treatment because of a lack of trust in healthcare providers, denial that they have depression, lack of knowledge about the causes of depression and the stigma associated with mental illness in their community.

Religion, belief in a higher power and spirituality are used to explain mental illness in Caribbean, African American and African communities. They are important sources of strength for these individuals, playing a

significant role in offsetting the stresses and anxieties that may lead to depression and other health problems, particularly in the face of racism and other forms of discrimination and oppression. For example, Waldron (2003, 2005, 2010) and Heath (2006) suggest that spirituality plays a significant role in the recovery of mental health concerns among Black women who must cope with gender, race and class inequalities. Schnittker (2003) found that African American women are sceptical about embracing the biomedical model as the cause of depression and reluctant to use psychiatric medications, believing that these medications were experimental or mind altering. They were, however, more likely to rely on their spiritual connection to God and maintaining a positive ideology as means of transforming feelings of depression.

While some African peoples of the Diaspora are often sceptical about the appropriateness and effectiveness of dominant Anglo-American approaches for helping them cope with and resolve spiritual, emotional, mental, and psychological difficulties, several authors (Bojuwoye 2005; Waldron, 2002a, 2005, 2010) argue that many African peoples of the Diaspora embrace a holistic approach to mental health care. This approach often integrates a variety of African indigenous and Anglo-American practices. For example, Waldron (2002a, 2003, 2010) found that Black Canadian women who were born in Africa, the Caribbean and Canada seek support for mental health problems through a variety of approaches and methods. These include formal/professional resources, such as family doctors, psychiatrists, psychologists, hospital emergency wards, counselling, and psychotherapy. They also include more informal (and non-psychiatric) resources, such as social support networks of friends and family, church and other religious and spiritual activities, meditation and relaxation, solitude, and diet regulation). Bojuwoye

(2005) points out that help-seeking for emotional and psychological issues among individuals in Africa and the Caribbean is informed by the biomedical model, dominant Anglo-American psychology and African indigenous methods. Moreover, education level, social class, religious background and residence in urban or rural environments are some of the factors that determine the type of treatment or support that individuals seek out.

It is important to point out, however, that these activities have been occurring within the context of the increasing influence of Eastern, Aboriginal and other non-Anglo-American knowledges on dominant Anglo-American approaches, resulting in a broader range of therapeutic approaches to health and mental health. These include 'complementary medicine', 'homeopathy', 'holistic medicine' and 'behavioural medicine'. Today, a considerable number of North Americans are using complementary or holistic medicine for physical and mental health concerns. It is a phenomenon that illustrates the increasing propensity to embrace more holistic conceptions of health and treatment that acknowledge the interrelationship between mind, body and soul (Poulin & West, 2005).

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### Author Biography

Dr. Ingrid Waldron is a Montreal-born woman of Trinidadian heritage. She is a sociologist who is currently employed as an Assistant Professor in the School of Occupational Therapy in the Faculty of Health Professions at Dalhousie University in Halifax, Nova Scotia, Canada. She holds a Ph.D. in Education from the Sociology and Equity Studies in Education Department at the Ontario Institute for Studies in Education, University of Toronto, a MA in Intercultural Education: Race, Ethnicity and Culture from the Institute of Education, University of London (England) and a BA in Psychology from McGill University.

Dr. Waldron's research and teaching interests are in the sociology of health and illness. She is a critical theorist who uses critical feminist, anti-racist and other anti-oppressive research methods to conduct policy-relevant social action research aimed at improving the health, social, economic and political conditions of culturally and racially diverse communities in Canada. She is particularly

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## Practitioners' experiences of collaboration, working with and for rural Māori

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*To understand the unique experiences of collaborating across health and social services in a rural setting with and for Māori with substance use and related problems, two focus groups were undertaken. This preliminary study used qualitative methods, following theory and practice informed by Māori values. Three culturally relevant themes were identified: collaboration as a tikanga (practice informed by Māori values) based practice, whanaunga (relative) or kupapa (traitor)?, and whanaungatanga (relationships) as collaborative practice. These themes highlighted the importance of Māori values in collaborative relationships, and the positive benefits for clients and practitioners collaborating to meet the holistic needs of whānau (family). Several unique experiences of Māori practitioners working and at times living in small rural communities were identified; these included the tensions associated with practitioners who may have existing relationships with clients through roles as family members, tribal members or within the wider community. Enablers to collaboration were argued to exist within the dynamic of whanaungatanga. Understandings and skills in applying tikanga, whakapapa (genealogy), confidentiality, and connecting clients with broader community activities were identified as important aspects in the practice of whanaungatanga.*

Addressing the cultural beliefs and practices of Māori with substance use problems has been referred to as the 'crux' of effective treatment (Huriwai, Robertson, Armstrong, Kingi & Huata, 2001) and the 'path to wellness' (Huriwai, Sellman, Sullivan, & Potiki, 2000). Contemporary Māori models of health and wellbeing, such as Te Whare Tapa Whā (Durie, 1994), Te Wheke (Pere, 1984), and Ngā Pou Mana (Henare, 1998), highlight the symbiotic relationship between the individual, the collective (whānau, hapū and iwi), the environment, and te ao Wairua (the spiritual world) (Huriwai, 2002). An attempt to encapsulate these principles can be seen in the recent major health initiative 'Whānau Ora' (family wellbeing). The initial task force report noted that "assurances will be required from a number of government departments and a spirit of collaboration must be

embedded between funders, providers, practitioners and whānau" (Whānau ora Taskforce, 2009, p. 5).

In its most basic form, collaboration is "the act of working with another or others on a joint project" (Collins English Dictionary, 2009, p. 338). Craig and Courtney (2004) suggest that collaboration exists as part of a Partnering Continuum that spans coexistence through to partnership (Figure 1). Partnering was proposed to differ according to the purpose, focus, governance, range of participants, timeframes or funding arrangements. This Continuum has been used widely within the voluntary and community social service sector (Public Health Advisory Committee, 2006; Walker, 2006).

Despite the popularity of the model, Craig and Courtney identified that for many Māori, the term relationship was preferred to partnership, which was seen as akin to the

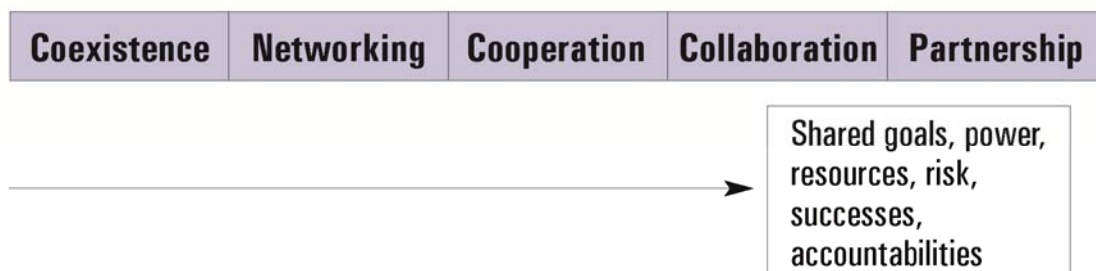


Figure 1. Partnering Continuum (adapted from Craig & Courtney, 2004, p. 38).

partnership principle within the Treaty of Waitangi (the original treaty signed between Māori and representatives of the British crown). Therefore the term partnership was seen as more relevant to relationships between Māori and the crown, as opposed to relationships between agencies and communities.

The Māori concepts and terms most closely aligned with the basic definitions of collaboration are mahi tahi (working together) and kotahitanga (unity). As collaboration is a social concept, a wide range of Māori values inform and guide behaviour around relationships, these include what is and is not appropriate in certain contexts and relationships, engaging in new relationships, status within relationships, behaviour that enhances relationships, and practices that address problems in relationships. Ritchie (1992) argued that it was difficult to portray Māori values in simple or analytic terms. This reflects the interrelated and symbiotic nature of Māori indigenous beliefs. Collectively the beliefs and concepts inherent in Māori values and the practices informed by these values are termed tikanga (practice informed by Māori values) (Mead, 2003). These values both transcend the material world (Ritchie, 1992) and provide the central tenant for maintaining the socially mediated model of health. Māori values relevant to relationships include whakapapa (geneology), whanaunagatanga

(relationships, kin and non-kin), manaakitanga (hospitality), wairuatanga (spirituality), rangatiratanga (status) and kotahitanga (unity). Each of these values and concepts also include and relate to other values and concepts. As an example, Mead (2003) identified that the terms tika (right/correct) and pono (honest/true) were important concepts that underpinned values, and were important evaluative principles for behaviour. Whanaungatanga (relationships) has been cited as the “the basic cement that holds things Māori together” (Ritchie, 1992, p. 67), in fact understanding the dynamics of whanaunagatanga and whakapapa (genealogy) have been cited as integral for working with Māori in substance abuse treatment although Huriwai et al. (2001) cautioned that “not all Māori have been raised or live in a ‘customary’ context and the relevance of ‘traditional’ values is not the same for all” (p. 1035). This highlights the diverse realities that Māori live in, and the importance of understanding that Māori practitioners and those Māori accessing services may have different understanding, experience and comfortableness with the use of tikanga (practice informed by Māori values).

While the value of collaborative relationships in a therapeutic environment are widely acknowledged, there is a lack of research identifying the specific barriers and enablers to effective collaborative

relationships between substance abuse treatment and ancillary health and social services, particularly for Māori, and Māori in rural communities. A study by Holdaway (2003) on collaboration across primary health and mental health providers captured the unique experiences of Māori community support/health workers in rural and urban areas. Māori community support/health workers reported several barriers to collaboration, including a lack of recognition or respect for “our knowledge and skills from mainstream and others” (Holdaway, 2003, p. 13); a lack of information sharing within and across the sectors, contributing to whānau “falling through the cracks” (Holdaway, 2003, p. 13), and a lack of commitment from all parties in integrating care. This study identified the importance of “partnerships to solve the problems of resources, communication, and coordination in health and social care” (Holdaway, 2003, p.18).

According to the literature, and current national service provision models (Whānau ora) there are strong arguments for addressing the interrelated social needs and cultural needs of those with substance use and related problems. This research project aims to extend upon Holdaway’s (2003) work by documenting and discussing the experiences of practitioners from a range of social services that work with Māori with substance use and related problems in a predominantly Māori rural community in New Zealand.

### **Methods**

This study uses qualitative methods that are guided by Kaupapa Māori Research (KMR) principles. KMR was developed by Māori, as a transformative process in order to assert self-determination in responding to the negative health, education and social outcomes of Māori (G. Smith, 1997; Walker, Eketone, & Gibbs, 2006). KMR is beyond a simple description or definition as it has been described as a philosophical framework and theory, a set of methodological principles and processes, and as an intervention strategy (G.

Smith, 1997; L. Smith, 1999). KMR does not preclude other methodologies, in fact G. Smith (2000) argues for the utilitarian value of western research practice, arguing for being “open to using any theory and practice with emancipator relevance to our Indigenous struggle” (p. 214). Therefore KMR can be used to shape and inform different research methods. As a theory, KMR engages in a rigorous critique of western theories and practices impacting on Māori, and has the explicit goal of improving outcomes for Māori (L. Smith, 1999). As a guide to research practice, tikanga (practice informed by Māori values) can be seen in each step of the research practice. This includes, the research being undertaken for Māori by Māori; Māori direction, guidance and participation across the focus, design, application, analysis and dissemination of research; and the use of Māori rituals of engagement and hospitality within the research.

### *Participants*

The host Iwi (tribal) service provided a list of key stakeholders (personnel and agencies) operating within the local rural community to be invited as research participants. The stakeholders came from within its services, and collaborative partners from statutory, district health board and non-Governmental health, mental health and social service providers that operated within the local community. Stakeholders were sent an introduction to the study and an invitation to participate. Participants were required to work as paid or volunteer staff members of health and/or social services that work directly with adults 18 years and older who have substance use problems and/or their family members. By recruiting groups with a history of working together there was the opportunity to observe naturalistic exchanges (Freeman, 2006) which underpin collaborative relationships.

Participants completed a group demographics form at the start of each focus

group which included a range of questions related to their demographic status, roles, workplace and length of service in the community. The majority of the 21 participants were either in the 36-50 year old age band ( $n = 10$ , 48%) or 50-65 year age band ( $n = 9$ , 43%), female ( $n = 16$ , 76%), and identified as Māori ( $n = 13$ , 62%). The largest proportion of participants identified their profession as 'whānau/family support' ( $n = 12$ , 57%), with an even spread of small groups within nursing, counselling, and education ( $n = 9$ , 43%). Most worked in non-governmental organisations ( $n = 13$ , 62%), with the remainder working in public health ( $n = 3$ , 14%), an Iwi based social service ( $n = 3$ , 14%), and an alcohol and drug service ( $n = 2$ , 10%). Participants could identify more than one work role, with most engaged in direct client contact ( $n = 17$ , 81%), and small numbers providing supervision of other staff ( $n = 6$ , 29%) and management roles ( $n = 4$ , 19%). Participants identified a significant history of working in the geographical area, with 33% ( $n = 7$ ) reported working in the area for five to ten years, and 29% ( $n = 6$ ) for more than ten years.

#### *Data Collection*

Two focus groups were held at the local Iwi providers offices, for approximately one and a half hours each, co-facilitated by authors AM and RH. There were 15 participants in the first focus group and six in the second. Digital audio recordings were made of both focus groups. Each session, following the principles of tikanga was facilitated by a staff member from the host Iwi (tribe) service provider chosen by the host organisation due to their knowledge and skills in Māori protocol. This process was termed a whakatau (settling), and included practices at the opening and closing of each session, such as acknowledging the important spiritual and cultural features and people of the area (whai korero); greeting the participants and researchers (mihimihi); prayer (karakia), song (waiata), and a shared

meal.

We utilised a semi-structured interview format to guide discussions. Questions were developed in response to the literature reviewed and the experience of the primary researcher who has a 20 year history of working in community development and clinical settings in the capacity of a youth worker and then alcohol and drug clinician. This included five years working within the geographical area the study was conducted in.

Questioning followed a logical progression starting from (1) a general discussion in response to 'what is collaboration?'. This was scribed on the whiteboard; (2) Participants were then asked to categorise the data on the whiteboard according to whether they viewed them as values or practices. Additional prompt questions were used in these discussions to identify participants' views on any issues which may have been specific to living or working in a rural community, and working with whānau/family with substance use and related problems; and (3) In each focus group, a small group exercise was conducted, with participants forming groups of between two and three people, and discussing and writing a group response to the following three questions:

- What are the barriers to collaboration?;
- What are the barriers to collaboration in relation to working with whānau with substance use problems?; and
- What are the barriers to collaboration for staff and agencies in rural communities?

Groups reported back to the larger group, and written responses were handed to the researcher. All whole group discussion was audio recorded and transcribed verbatim.

#### *Data Analysis*

Our analysis of data followed that suggested by Marshall and Rossman (2011). All focus group data (audio transcripts and participant notes) were read and reread

(organising the data and emersion in the data). This was followed by generating categories and themes, coding the data, offering interpretation through analytical memos, and searching for alternative understandings. A constant comparative method was used (Glaser & Strauss, 1967) with authors AM and RH comparing comments for similarities and differences over a series of three meetings. This process was strengthened by undertaking a member checking process which included forwarding typed audio transcripts and preliminary key themes to participants for comment. The acts of peer debriefing, member checking and reviewing national and international literature on collaboration supported the process of triangulation; that is, using multiple methods to “generate and strengthen evidence in support of key claims” (Simons, 2009, p. 129). Finally, a written report and physical presentation was provided to the host organisation and participants.

### Findings

There were three key themes identified from the focus groups that represented the participants’ views of and experiences with collaboration. These were: Collaboration as a tikanga (practice informed by Māori values) based practice, Whanaunga (relative) or kupapa (traitor)?, and Whanaungatanga (relationships) as collaborative practice. *Collaboration as a Tikanga (Practice Informed by Māori values) based Practice*

It was evident that participants viewed collaboration through the lens of relationships established and maintained through Māori values, as opposed to collaboration being a simple set of practices, such as having a meeting. The beginning of each focus group involved a brain storming session on what collaboration was. Principles of aroha (love), tika (doing what is right) and pono (honesty) were proposed as cornerstones of collaboration. Whakawhanaungatanga (creating relationships) was also used to express

collaboration. These values were proposed to have been handed down through whakapapa and from nga atua (gods). “Nga kete e toru iho mai no Rangiatea” (The three baskets of knowledge passed down from the heavens) (Participant Focus Group 1, PFG1). These values were also proposed to be interrelated to spirituality and Māori worldviews.

“Something that we haven’t got up there is spirituality, and when you talk about a Māori...a lot of those things had to do with a Māori world view” (PFG1). Participants related collaboration to a social model of care, and an holistic approach. One participant reflected this in her comment “It’s that saying of, it takes a village to raise a child” (PFG1).

This social model of care was argued to provide positive benefits for both the workers and the whānau (families) they work with. “I’m not sure how to say it succinctly, but the work that you can do together has a bigger effect than the work that you can do separately or apart from each other” (PFG1). Collaboration was argued to require concerted effort “We’re stronger as a group, so there’s strength in numbers essentially” (PFG2) and planning:

Planning for the whānau should be together, not as individual agencies or me. Because collaboration can only work for the whānau ... if you’ve got 60 organisations banging on your door, I’d be pretty pissed. I would rather meet with the organisations that are working with the whānau, plan together, go with one plan to the whānau and work it that way. (PFG2)

The act of planning was also proposed to contribute to improved outcomes “and maybe when it comes together it’s stronger too, because the focus is common” (PFG1).

The strength that participants gained from collaboration, that is working together, was argued to come from the sharing of



expertise and the sharing of responsibility. “It’s less stressful I think, sharing that responsibility, because you don’t have to try and be an expert at everything” (PFG1). Whereas another practitioner identified that sharing was a key value for Māori. “Yeah, shared burden or shared load, because that’s the basis in some ways of kotahitanga [unity] and manaakitanga [hospitality], is around sharing loads” (PFG2). A participant highlighted the practical challenges of working with whānau (families) with complex problems, and the benefit of this sharing for improved outcomes for whānau:

I have 24 hours in the day and even then I struggle to make it through, and so if I’m the only person dealing with that one whānau and yet .... might have 16 or 17 or 20 whānau, how am I supposed to do everything for them without some help essentially? It’s kind of... I know what I know, but I also know what I don’t know and by collaborating.... in the real sense of the word, for me it’s about I can’t do everything because I don’t know everything. (PFG2)

It was evident from the above discussion that collaboration was a strongly endorsed, and culturally relevant approach to working with whānau experiencing complex difficulties. However, when the participants in focus group two were asked what the costs of collaboration to them as practitioners were, several participants stated that there were no costs, just benefits. However one participant stated “There must be a cost because it’s not happening...there’ll be a trade-off” (PFG2). This highlights the dichotomy between wanting to collaborate, and actually collaborating. This provided the rationale for exploring the barriers to collaboration. *Whanaunga (Relative) or Kupapa (Traitor)?*

This theme reflected several unique challenges of rural Māori communities, in

which service users and staff members interact, live in close proximity and are often whānau (family). Therefore these staff can wear many hats in the community, that is, they have roles within whānau (family), services, marae (meeting area of local sub-tribe, made up of communal buildings), and sports clubs. The question a service user is potentially faced with is; are you (the staff member) here as a family member focused on the best interests of the whānau? Or will you be a traitor (kupapa) and breach my trust and confidentiality?

One of the positive implications of being related to a client was that this relationship could provide a foundation for engagement: “It gets you in the door” (PFG1). These relationships can also place workers in positions of discomfort when working with a whānau whom they may interact with and have responsibilities to within the broader social and cultural context. The term tau kumekume (tension) was presented by a participant in the second focus group, acknowledging the tensions inherent when having the responsibility to manage commitments in personal and professional worlds.

A participant in focus group one stated that one of the discomforts faced by practitioners when entering collaboration was related to the cultural concept of kupapa (traitor):

Every time I keep thinking collaboration, I keep thinking kupapa [traitor]. Kupapa [traitor] was in the times of war, that’s what they used to do is they used to use their own people to work out how they could beat them. That’s what I always looked at as what collaboration was about. (PFG1)

This sense of being a traitor represents a real challenge for practitioners, as they may be in a position where sharing information is disallowed, (even if sharing this may address

a problem), or conversely where sharing information may contribute to further distress for the whānau.

Another participant identified that negative past experiences can contribute to the ongoing fears and apprehension inherent with practitioners not wanting to be a traitor, and in turn this can act as a barrier to collaboration.

It's doing things that are close to you that you've shared with people that you thought you trusted that have absolutely been destroyed .... So you may have gone in to the collaboration with an open and honest... but suddenly that kupapa thing comes in too, because you don't want it to be as collaborative as... and it might be a personal or it might be a provider organisation or whatever, because you keep things close to you. (PFG2)

This experience was also proposed to be a real problem for service users: "If people have let you down in the past because of not carrying out their end of the deal or breaching confidentiality, you're not going to have that trust, so you're not going to be able to move forward" ( PFG2). Addressing the existing issues between agencies and the past experiences of service users was seen as a first step in developing a platform of trust with whānau (families) and other services:

Yeah, because it is our 'take'<sup>1</sup> [issue/problem] and if we take our 'take' [issue/problem] to the whānau, the whānau's already messed up. They don't need us to be messing their heads again. So collaboration for me is doing things together and what's best for our community and our whānau. (PFG2)

Confidentiality was argued to be another challenge to addressing issues of mistrust in collaborative relationships with

whānau (family) and other services: "Because often we will talk around it, but we won't actually say that this is what we won't be confidential about and so everybody's just skirting on the outside and nobody's actually saying anything" (PFG2).

#### *Whanaungatanga (Relationships) as Collaborative Practice*

A range of issues in working collaboratively with people with substance use and related problems within a rural context were identified. It was stated that many of the people with complex substance use and related problems in the area came from outside of the area: "Connectiveness in the community. Not knowing anyone, no whānau" (PFG1). This could leave this group feeling isolated from important factors of wellbeing, including whānau (family), hapū (sub-tribe) and whenua (land). Another participant summarised many of the common rural barriers identified by participants:

... it's a number of things that are sort of interlinked where we've got lack of services, this is talking rurally, distance, staffing levels or qualified staff, coming through lack of knowledge across to no ability to change by the whānau, shared information; all these things, sort of looking in and just putting up huge barriers. (PFG2)

The comment 'no ability to change by the whānau' within the above quote reinforced comments from participants in both focus groups that people with substance use problems were either not able to change or "not ready to change" (PFG1). Participants related part of this inability to change to the ingrained nature of substance use problems in families, proposing that there is a "normalisation of substance abuse" (PFG2) in families. This normalisation was proposed to impact on the fabric of the values of families that have substance use problems and sometimes acted as a barrier to collaboration:

And it becomes a value [substance use]. It becomes what a whānau instilled value into, which can distort other values, and we see that a lot. Their children's health is no longer a priority. Or their children's education. It's just no longer a priority to send your kids to school because the whole value system changes. (PFG2)

One participant identified that engaging with whānau in relation to substance use and related problems was a sensitive issue, and that there were important steps to take place before discussing confidentiality and before attempting to collaborate with other agencies involved with a particular family:

One that we had was whakamā [shame]. .... it's quite intense and painful.....you've got mamae [hurt] in there and they won't feel comfortable to divulge that information anyway.....before you begin to even start talking about confidentiality. You know, it's about working first, what's happening for the... not just that individual, but also in the whānau as well. (PFG1)

As has been identified, there are several barriers to collaboration, including the multiple and complex relationships held between staff and service users in this Māori rural community, confidentiality, the ingrained nature of substance use and related problems in families, practical barriers related to rurality, such as transient families, travel and staff recruitment, and the sensitive nature of engaging with families about substance use and related problems. Solutions to several of these barriers were also located within or associated to the barriers, that is whakapapa (kin relationships) and the natural resources and cultural history of the area.

One of the key barriers to collaboration involved the proposed ingrained nature of substance use in families. The following comment identifies how practitioners and families can engage with the broader family

system in order to access activities that can encourage and support wellbeing, and re-connect families:

... in the substance abuse area, is actually using the kaupapa (issue) in terms of other members of that whānau who may be either connected to a religion or connected to a sports club where there's not that usage, but the usage has actually moved them apart and so it's the actual substance that's actually moved the whānau apart, and trying to look, trying to move, I guess, move that to the side and saying, "Hey, we're still whānau. (PFG2)

One participant identified that even those Māori families with substance use and related problems that come from outside of the area, have a cultural and family history that can be used to connect them to the area and people within it:

And that comes back to what ..... said... certain people get certain things, and that's where him and I fit in terms of our, how we can make the connections. And you know, if they're from Kahungunu [a tribe located on the central eastern shores of the North Island], we talk about Mahinarangi [name of a female ancestor from the Kahungunu tribe] and Turongo [name of a male ancestor of the Tainui tribe], when we make that connection through the whakapapa [genealogy] lines, then they feel comfortable enough to start sharing... (PFG1)

This highlights the importance of practitioners having an understanding of the whakapapa of the area, and of other tribal areas in order to effectively build these connections through whakapapa (genealogical) lines. Another practitioner extends upon this theme by highlighting the specific cultural history of the

area, and the importance of exploring how this history can be used to inform practitioners practice:

They know their history from around here with regards to what their tupuna [ancestors] went through with regards to kingitanga [the history of Māori kingship], the wars, confiscation, the awa [river]... I think one of the questions is, how do we as social service practitioners operate in a model of a kingitanga framework? (PFG1)

The above themes reinforces the complex interrelated nature of history, context and people; and how these factors can influence both staff and those with substance use and related problems in engaging in collaborative practice. The responses to these barriers reinforce the indigenous beliefs of the participants around individual wellbeing coming from collective relationships, and that healing comes through making connections between service users, the community and the environment – a process of connection guided by culturally competent practitioners.

### Discussion

This research project set out to identify the unique experiences of practitioners from a range of health and social services that are engaged in collaborative relationships for and with Māori with substance use and related problems in a predominantly Māori rural community in New Zealand. Qualitative data were collected from two focus groups involving a total of 21 participants. Participants predominantly self-identified as Māori, female, with a significant service history of working in the geographical area. These participants were in the most part engaged in direct client contact in whānau/family support roles. A limitation of the current research project was that there were no mental health or primary care general medical practitioners that were available to

attend the focus groups. This reduced the input of two particularly important sectors involved in collaborative practices with those with substance use and related problems.

The focus group methodology, guided by tikanga (practices informed by Māori values) provided the opportunity to see how cultural processes such as a whakatau (settling) contributed to an atmosphere of safety and unity, a necessary foundation for open discussion within the focus groups, an activity in itself which is collaborative in nature. The findings from the study identified three broad themes. The first of these revealed that collaboration was viewed by participants through the lense of Māori values, that is, viewing collaboration as relationship guided by values such as aroha (love), tika (doing what is right) and pono (honesty). These values were also proposed to be interrelated to spirituality and Māori holistic and socially mediated views of wellbeing. Collaboration was proposed to be a preferred model of practice that contributed to benefits for practitioners such as strength in numbers, shared responsibility, and shared resources. These benefits were proposed to in turn contribute to better outcomes for whānau.

Whanaunga (relative) or kupapa (traitor)? revealed a unique set of experiences under-reported in the literature, that is, the benefits and challenges of living in a predominantly Māori rural community. Participants revealed how working, and in some cases living, in a small rural community increased the likelihood that service users and staff would be either related or have interacting community roles. As a result some service users avoided local service providers due to fears of confidentiality. In a reciprocal nature, these shared relationships were proposed to place staff in a precarious position of kupapa, that is, a potential traitor due to holding information that may be beneficial or harmful to one or more of the groups or persons that they have relationships

with and in some instances responsibilities too (i.e., whānau or employers).

Healing through whanaungatanga (relationships) also highlighted the shame and embarrassment that some whānau (family) experience when talking about their problems, further complicated by fears of confidentiality. Several barriers to working with people with substance use and related problems were identified in addition to confidentiality concerns. Some of these were related to rural realities, such as lack of service options and difficulties in attracting qualified staff, and people moving into the area with little social or cultural connections in the area; whereas other barriers related to the impact of the negative experiences of staff working with people with chronic and complex substance use and related problems.

The strategies to respond to several of these barriers were in many ways found in the location of the barriers, that is, through relationships. Acknowledging the sensitive nature of substance use and related problems with whānau, and the underlying fears associated with confidentiality and past negative experiences with services, was argued as a first step in working towards collaboration. Reconnection through whanaungatanga (relationships) reflected what Huriwai and colleagues (2001) called 'the path to wellness'. Knowledge of community resources, whakapapa (genealogy), and tikanga (practices influenced by Māori values) were argued to be important skills that enabled practitioners to connect people that have moved in from outside of the area to make cultural connections to the area, and to reconnect people with whānau (families) and community based activities that can contribute to wellbeing.

Of particular note in this research was the observation that the host Iwi (tribe) organisation had staff from a range of services participating in the focus groups, including social workers, educators and

addiction therapists. This organisation reflected Māori models of health, taking a holistic approach, one focused on the broad needs of whānau. The staff also had long histories of working in the area, increasing the likelihood that staff were in tune with the social and cultural context their clients lived in.

The findings of this research can assist agencies and practitioners working with Māori experiencing substance use and related problems, and those working in rural communities to understand some of the unique barriers to collaboration, and culturally relevant responses to these barriers. This research project provides a platform to further explore, understand and interpret key factors associated with collaboration for and with Māori with substance use problems in rural communities. Areas that warrant further exploration include: the strategies used to increase the awareness, knowledge and skills of non-substance abuse specialists in working with people with substance use problems; the strategies used to increase the awareness, knowledge and skills of practitioners in working with Māori; the strategies used to develop shared inter-agency understandings and processes in relation to working with the privacy code when sharing information; and the perspectives of those with substance use and related problems and their whānau of collaboration with health and social services.

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#### Note

<sup>1</sup>In this statement the Māori term 'take' is used with reference to an 'issue or problem' as oppose to the English term take.

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## The Waka Hourua Research Framework: A dynamic approach to research with urban Māori communities

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*In this paper we present a methodological framework for research involving urban Māori, developed as part of a community-driven, cultural intervention at a State secondary school. The Waka Hourua Research Framework situates research exploration at the interface between Māori knowledge, and Western science (see Durie, 2005). The framework incorporates core Māori values, guiding principles, and contextual research considerations in a dynamic framework that allows for adaptations to be made throughout the research process. This framework enables researchers to affirm the legitimacy of Māori knowledge, and to use Māori knowledge as a platform for generating new knowledge, without dismissing Western knowledge bases. The utility of the framework is that it enables resulting research to reflect diverse Māori realities and respond to Māori research priorities, particularly within the discourses of Indigenous Psychology.*

When researching Māori social and psychological phenomena, an in-depth understanding of Māori knowledge systems is necessary in order to produce informed, accurate, and useful research. However, Māori and other Indigenous knowledge systems have often been dismissed or overlooked in Western research (Durie, 2005). This paper responds to this issue and contributes to the diversity of Indigenous research by presenting a framework for psychological research involving Māori, founded on Māori realities, knowledge systems, and research processes. This framework was developed as part of a community-driven intervention at a low-decile State secondary school. The intervention was designed to increase the engagement of Māori students and their whānau (family) with the school. In this context, it was necessary to develop a framework that could reflect the realities of diverse Māori community members, and respond to their research needs. In this paper we present a novel research framework, describe how this framework was developed and applied in a community setting, and give

insights into some of the research findings that were generated using this approach. This paper has been developed from the PhD thesis of the first author under the supervision of the second author.

*Western Psychology and Mātauranga Māori (Māori Knowledge)*

The purpose of psychology is to explain mental functioning, to make sense of behaviour, and to enhance mental wellbeing. Achieving these goals often requires an understanding of socially constructed, culturally specific value and belief systems. Despite the cultural specificity of value and belief systems underpinning psychology, psychology produced in Western settings is often applied uncritically to other cultural settings, resulting in a Western hegemony within the discipline that Allwood and Berry (2006) label 'ethno-centric'.

Lawson-Te Aho (2002) states that psychology is ethno-centric due to its construction within the culturally bound knowledge system of Western science. Although Western science is positioned as objective, culture free, apolitical, value free, and universally applicable, as with all



knowledge systems, it is culturally bound (Lawson-Te Aho, 2002). As a culturally bound knowledge system, Western science includes features that are not shared with many other knowledge systems, such as reductionism (i.e. separating objects under study into constituent parts to gain a greater understanding of the whole) and isolationism (i.e., studying objects in isolation; see Harris & Mercier, 2006).

Evidence of isolationism can be seen in Western psychology, as the individual is most often the basic unit of analysis, with little consideration given to wider social and environmental factors. Evidence of reductionism can also be seen in Western psychology, as psychological problems are considered to arise within the individual, often due to some structural or functional defect (Duran & Duran, 2002). Treatment is, therefore, directed at the individual, or some part of the individual. In contrast, Indigenous approaches to both scientific inquiry and healthcare identify the interconnectedness between all things and emphasise the importance of social and environmental relationships (for examples, see Pitama, Robertson, Cram, Gillies, Huria, & Dallas-Katoa, 2007; Williams, 2001).

As is common of Indigenous knowledge systems, mātauranga Māori (Māori knowledge) is founded on the unity of people and the environment, developed over successive generations (Durie, 2005). According to Māori, all things living and non-living, mental, physical, and spiritual are connected through whakapapa (genealogy), and descend from a common tapu (sacred) origin (Roberts & Wills, 1998). In a Māori sense, "... 'to know' something is to locate it in time and space," thereby identifying its whakapapa (Roberts & Wills, 1998, p. 45). For Royal (1998), whakapapa is the research methodology used to understand the world, and mātauranga Māori (Māori knowledge) is the theory that is generated from the whakapapa process. In this way, mātauranga

Māori results from a holistic approach, where knowledge and understanding is enhanced by considering the wider relationships of the object of study. This holistic research approach common to Indigenous communities incorporates analyses of social relationships, connections with the physical environment, and historical events.

#### *Interface Research*

Innovative approaches have been developed that combine Indigenous approaches with Western approaches. These research approaches are able to draw on two value systems, two knowledge systems, and two traditions of scientific inquiry, while retaining the ability to address issues of dominance within Western knowledge systems. Durie (2005) describes this type of approach as 'research at the interface of Indigenous knowledge and Western science'. The science produced by this approach is not strictly Indigenous Knowledge, nor Western Science. Rather, this research approach generates new and distinct knowledge that is able to enrich both knowledge bases (Durie, 2005). It is this interface between Indigenous and Western sciences that The Waka Hourua Research Framework presented in this paper is designed to explore.

### **Method and Results**

#### *Developing the Framework*

Navigating the largely uncharted space between Māori knowledge and Western knowledge can be challenging. The methodological framework presented in this paper was based on interactions between the Māori community, and the research team. During interactions the research priorities and preferred processes of community members and researchers became clear. Although centred on a State institution, and located in an urban context, this community of Māori students and their whānau placed value in Māori principles and practices. Therefore, these principles were incorporated into the methodological framework. Descriptions of the community intervention

and the researcher-community engagement processes are presented as follows.

#### *Intervention Background*

The intervention project grew out of community concerns with Māori students' outcomes at a particular State secondary school. Māori students at this school were disengaged with the educational process, were leaving school early with little or no qualifications, and were over-represented in negative school statistics (such as stand-downs and exclusions). In response to these concerns, a hui (meeting) was called to bring together Māori students' parents, and the school. Attendees identified the need to strengthen relationships, and to increase the cultural relevance of the school environment. The school and community initiated a novel intervention, without funding, to meet these objectives.

The intervention project had a number of components. Firstly, a Māori community liaison was appointed to improve relationships between Māori students, their whānau, and the school. This intervention activity demonstrated that the community valued whanaungatanga (connectedness). Secondly, regular meetings with Māori students' whānau were established. Matters affecting Māori students were discussed in these meetings, and recommendations were passed onto the school board. A member of this group was later put forward to sit on the school board. This intervention activity exemplified community-driven action, designed to increase Māori power in school decision making processes, and built-in a reflexive component to the intervention, as community feedback on the intervention was gained during these meetings. Thirdly, the intervention activities included increasing student access to the school marae (meeting house), thereby providing an institution that supported Māori cultural expression. In the marae context, wairua (spirituality) is acknowledged and expressed, the domains and attributes of the atua (deities, natural

elements) are clearly defined, and references are made to tīpuna (ancestors). Marae protocols guide actions around that which is tapu (sacred, prohibited) and that which is noa (profane, safe). Finally, the intervention activities also included offering Māori curricular and extra-curricular activities, such as te reo (Māori language) classes, kapa haka (Māori performing arts), mau rākau (Māori martial arts), and marae trips, which served to promote tikanga Māori (Māori laws, protocols), te reo Māori (Māori language), and mātauranga Māori (Māori knowledge).

Eventually funding was secured and independent evaluators were sought to fulfil funding obligations. At this stage, the first author was contacted through University networks and asked to evaluate the project.

#### *Community Engagement*

Many different groups were invested in the project, and maintaining respectful relationships with these groups was crucial. Meetings were held with key stakeholders including whānau members, board of trustee members, school staff, rūnanga (Māori council) employees, the school principal, and other researchers. Through these hui (meetings), a mutually beneficial arrangement was made, whereby the research team would gather information and evaluate the intervention, giving feedback and suggestions to the community, and fulfilling requirements stipulated by project funders. In exchange, the information gathered could also be used to produce academic reports. In this way, the research would generate both action and theory.

#### *Pōwhiri*

During initial hui (meetings), stakeholders stated that it was necessary for the research team to be welcomed formally through the pōwhiri (formal welcome) process before beginning research at the School. The pōwhiri process recognises the tapu (sacred, prohibited) nature of outsiders entering a new environment, and involves the ritualised removal of that tapu. This process

makes it safe for the tangata whenua (people of the land) to receive visitors, and safe for the visitors to enter the new environment.

The pōwhiri (formal welcome) process affirms the mana (authority, power, prestige) of atua (deities, natural elements), tīpuna (ancestors), and tangata whenua (people of the land). The pōwhiri process also allows those involved to exchange whakapapa (genealogy) and to whakawhanaunga (build relationships). While bringing two groups together, the process also positions the two groups as tangata whenua, and manuhiri (visitors), and there are clear behavioural expectations for members of each group.

Being welcomed through the pōwhiri (formal welcome) process enabled the research team to adopt the manuhiri (visitor) position, which facilitated the research. As manuhiri, we understood that, although invited in, we were outsiders (see Te Huia & Liu, 2012). Although we shared whakapapa Māori (Māori genealogy), and had some experiences in common with the community members, we were outsiders as we were not directly associated with the school. In addition, many of the experiences and challenges faced by community members had not been experienced by members of the research team. As manuhiri, it was our responsibility to be respectful, to acknowledge the authority of the hosts, to follow their processes, and to position their realities as central.

#### *Whakawhanaungatanga (Relationship Building)*

As manuhiri, we visited with the students and their whānau (families) on a regular basis in a number of settings, including during regular classes, school intervals, kapa haka (Māori performing arts) practices, mentoring sessions, and fundraisers. These visits allowed the research team to become familiar with the research environment, and to strengthen relationships further with Māori students, their whānau, and project workers.

The earlier relationship building enabled the recruitment of participants for interviews and focus groups to occur in an organic manner. Often community members, whom researchers had already met informally at an earlier date, would approach members of the research team and asked to be interviewed. As trust had been established between researchers and the community, interviews were free-flowing, and uninhibited, and the participants provided rich descriptions of their observations, issues, and ideas concerning the intervention.

The free-flowing nature of interviews was also facilitated by the fieldworkers' knowledge of tikanga (laws, protocols) and te reo (Māori language), which enabled fieldworkers to conduct themselves appropriately in the marae (meeting house) setting, and allowed participants to use te reo during interviews. The Māori research assistants were also gender balanced, so Māori students were able to approach gender matched interviewers, if they desired.

#### *Reflexivity*

Ethnographic notes were made during all visits, and following our visits the research team would reflect on our experiences. We reflected on how community members' patterns of behaviours might have been influenced by our presence, for example by possibly censoring criticism towards other parties involved in the project. We also reflected on how our own behaviours were being influenced by the context. For example, we noticed that although certain members of our research group were accustomed to introducing themselves solely in te reo (Māori language) at formal and semi-formal hui (meetings), they tended to deliver their introductions at the school in English. This was due to their awareness that in this urban environment (where the rate of te reo fluency is low, and where many Māori are dislocated from their traditional tribal territories), many of the Māori students and their whānau (families) had limited access to te reo. These

researchers used English as they were conscious of making themselves understood, and wanted to avoid flaunting their knowledge of te reo.

### *Analyses*

Based on the analysis of information gathered over successive school visits, a methodological framework evolved. This framework will be outlined in the following section. Field data was also used to generate reports for the community, and the funding entity. In addition, an inductive thematic analysis was performed to generate theory on increasing Māori student engagement with State secondary schools. Following these analyses, stakeholders at the school were visited and asked to provide feedback, which was then incorporated into the reporting. The findings from this thematic analysis also guided further studies looking at Māori identity development in State schools, and the relationships between cultural engagement, ethnic identity, and psychological wellbeing.

### **The Waka Hourua Research Framework**

In this section we present a novel methodological framework developed in the context of a community-driven action research project, located within the discipline of psychology. The metaphor used to communicate this framework is the waka hourua (double-hulled sailing vessel). Waka hourua were used by the ancestors of modern Māori to migrate throughout the Pacific Ocean. The craftsmanship and navigational skill required to achieve such a feat serve as an example of the excellence in research, science, and technology demonstrated by these ancestors. The migratory waka (vessel) that Māori ancestors arrived in continue to hold central importance to Māori identity today. For these reasons the waka hourua is an appropriate metaphor to draw on in the construction of an analytic framework for researching with urban Māori communities.

In this framework, the waka hourua (double-hulled sailing vessel) sits within a

wider environment (refer to Figure 1). Key parts of the waka (vessel) itself represent core values, celestial bodies represent guiding principles, and environmental elements that are crucial to way-finding represent wider contextual considerations that are crucial to research (refer to Table 1). A description of the components of the framework will be given to communicate an epistemic worldview, followed by an example of research that weaves these components together.

### *Core Values*

Ten core values are represented in the Waka Hourua Research Framework. The first of these, tapu (sacred, prohibited), refers to the sacredness imbued by the atua (deities, natural elements) to all things living and non-living. Tapu is central to Māori beliefs and behaviour. Therefore recognition, and respect for tapu is necessary when engaging with Māori, and attempting to explain Māori social phenomena. In contrast, the second core value, noa, describes a state of balance and safety (Mead, 2003). Noa is highly pertinent to research, as, to conduct research ethically, it is important to consider safety.

Whakapapa is the third core value, and represents genealogical connections with atua (deities, natural elements), ancestors, relations, places, and histories. Whakapapa informs Māori identity, and produces diverse Māori realities. In order to understand social phenomena occurring at the individual level, it is important to have an understanding of who individuals are: where are they from geographically, who they are descended from genealogically, and what historical events shaped their reality? In short, what relationships do they have with people, places, and events?

Whanaungatanga, the fourth core value, is a Māori concept meaning close, warm, family-like connectedness with others. In research, the whānau (family) structure can be used as a model for research relationships, and the whakawhanaungatanga (relationship

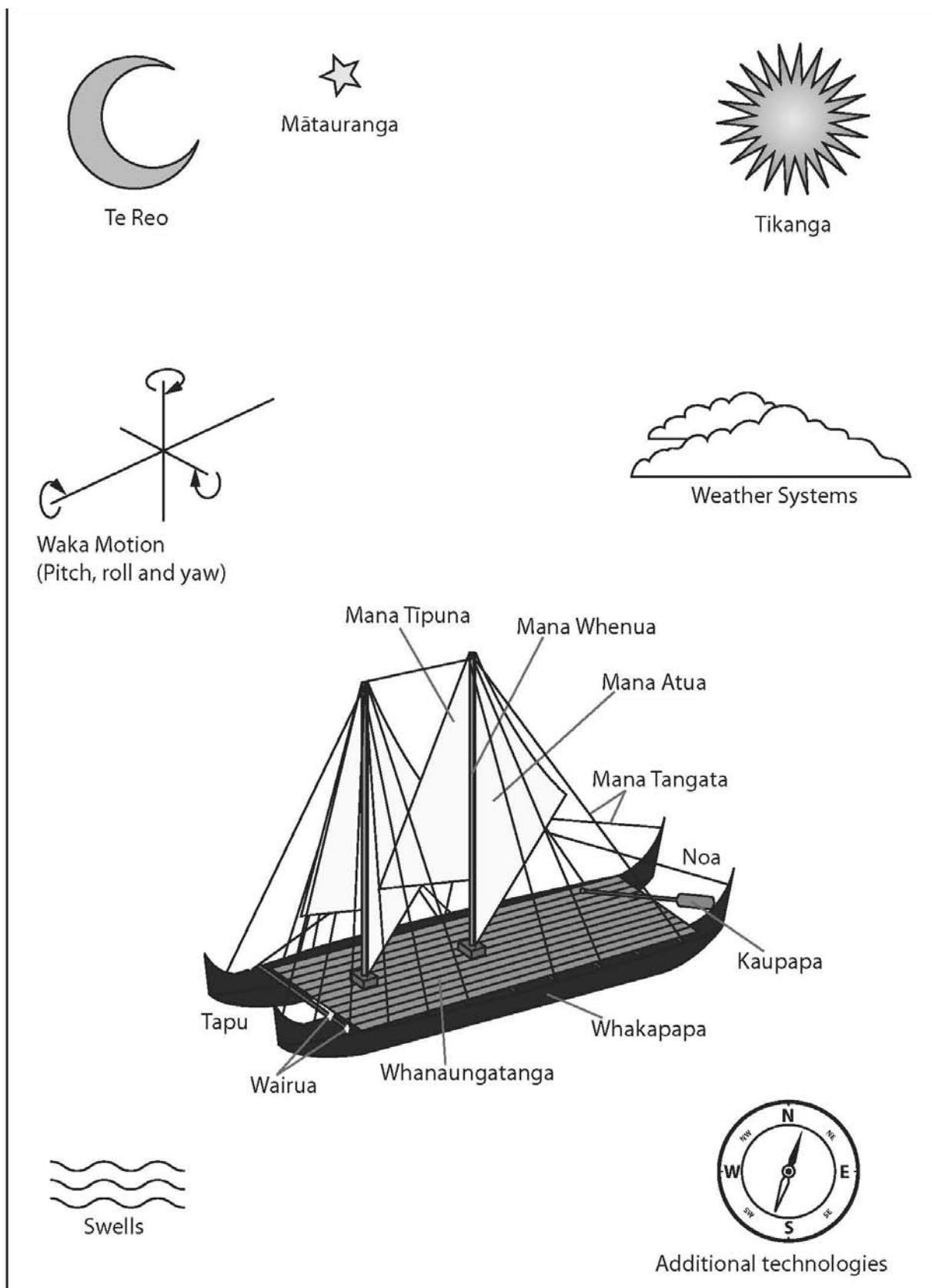


Figure 1. The Waka Hourua Research Framework

Table 1.  
*Components of the Waka Hourua Research Framework*

Waka component	Research component	Description
<i>Core values</i>		
Ihu (bow)	Tapu	Sacredness imbued in all things living and non-living
Tā (stem)	Noa	Balance and safety
Riu (hull)	Whakapapa	Genealogical connections
Kāraho (deck)	Whanaungatanga	Ongoing, warm, reciprocal relationships
Aukaha (lashings)	Wairua	Spiritual connectedness between all living and non-living things
Rā (sail)	Mana atua	Respecting atua
Rā ngongohau (staysail)	Mana tūpuna	Respecting ancestors
Maihi (mast)	Mana whenua	Respecting the environment
Taura (rigging ropes)	Mana tangata	Respecting people
Urungi (steering paddle)	Kaupapa	Collective research vision
<i>Guiding principles</i>		
Sun	Tikanga	Affirming Māori laws and protocols
Moon	Te reo	Affirming Māori language
Stars	Mātauranga Māori	Affirming Māori knowledge
<i>Contextual considerations</i>		
Weather systems	Diverse realities	Recognising social, cultural, geographical, political, and historical circumstances
Swells	Power structures	Recognising the effect of power structures on research
Waka motion	Reflexive awareness	Self-monitoring and adjusting the research approach where necessary
Additional technologies	Combining knowledge systems	Respectfully combining knowledge systems in an additive manner, where appropriate

building) process can be used to guide interactions with others, resulting in the establishment of ongoing, reciprocal relationships.

The fifth core value, *wairua* (spirituality), connects all living and non-living things in the Māori world. It is through *wairua* that we are connected to the *atua* (deities, natural elements), to the *whenua* (land), to our *tīpuna* (ancestors), *mokopuna* (descendants), and to each other (Pihama, 2001).

*Mana* is a concept incorporating authority, power, and prestige (Williams, 1957). *Mana* is intricately linked with *tapu* (sacred, prohibited), as the higher the *tapu* of a being, the higher the *mana*. As *tapu* is passed down through *whakapapa* lines, so too is *mana*. The more senior one's *whakapapa* (genealogy) lines, the greater one's *mana*. As the *atua* (deities, natural elements) represent the origins of all *whakapapa* lines, the *atua* are imbued with the highest *mana* and *tapu*. As ancestors are genealogically linked to the *atua* more closely than current generations, ancestors too have high *tapu* and *mana*. Honouring *atua* and *tīpuna* (ancestors) is central in Māori protocol. Therefore research with Māori should uphold *mana atua* (divine power) and *mana tīpuna* (ancestral power), the sixth and seventh core values respectively.

*Mana whenua* refers to territorial rights, or prestige sourced from the land one occupies, and is the eighth core value in the Waka Hourua Research Framework. Those who are *tangata whenua* (people of the land) hold the authority in their area such that when different Māori collectives come together, the protocols of the *tangata whenua* preside. For research to be conducted with Māori in an appropriate manner, proper recognition and respect should be given to *mana whenua*.

*Mana tangata* (personal authority, power, prestige) is the ninth core value in the framework. All people have inherent *mana*,

from conception, inherited through *whakapapa* (genealogy) from *atua* (deities, natural elements) and *tīpuna* (ancestors). For research to be ethical it must be respectful to people. In research involving Māori, the *mana tangata* of those involved must be upheld.

The final core value, *kaupapa* (agenda), is defined in this model as collective research vision. This component of the framework requires that research is directed towards Māori development, and approved by the community.

#### *Guiding Principles*

The celestial bodies depicted in this framework that make navigation possible are the sun, the moon, and stars, representing *tikanga* (laws, protocols), *te reo* (the Māori language), and *mātauranga Māori* (Māori knowledge) respectively. The guiding principles in this framework recognise the legitimacy, relevance, and utility of Māori culture and knowledge, and appreciate the capacity for new knowledge to be generated from Māori knowledge.

#### *Contextual Considerations*

When navigating the Ocean, it is crucial that environmental conditions are carefully studied, and responded to. Some of these environmental considerations are incorporated into this framework as important research considerations. The first contextual consideration in this framework is weather systems, which are likened to the diverse realities Māori experience. Just as *kaiwhakaterere* (sailors) must be responsive to weather systems, researchers must be acutely aware of the social contexts within which their research takes place. For participant based research, an understanding of the diversity of participant realities is crucial to all stages of the research process, and caution must be exercised when attempts are made to generalise results across populations.

The second contextual consideration is swells. Māori navigators use swells to maintain course in the absence of more easily

detected points of reference, such as stars. In research, power structures can affect progress, much as swells affect waka (vessel) voyages. Researchers must therefore be cognisant of power structures and focused on attaining research goals when plotting the research course.

The third contextual consideration is waka (vessel) motion. Careful study of the way in which the waka hourua (double-hulled sailing vessel) moves is necessary to complete successful voyages. The movement of the waka hourua indicates seaworthiness, and environmental conditions. By monitoring the movement of the waka hourua, adjustments can be made to the waka itself, and to the course steered. Reflexivity in research similarly allows for self-monitoring and adjustments to the research approach where necessary. Just as waka hourua may need to alter orientation, course, or, in extreme cases, destination, researchers may need to alter their approach, processes, or even their research objectives.

The fourth and final contextual consideration is additional technologies. While waka (vessel) voyages can be made successfully relying solely on traditional way-finding techniques, this by no means excludes the use of modern innovations aboard waka hourua (double-hulled sailing vessels). On modern waka hourua voyages, information and technologies such as the compass, GPS, ocean charts, and marine weather forecasts are often utilised. These technologies are useful. However, to ensure smooth sailing, it is important that reliance on these modern instruments does not subvert information gathered using traditional techniques, as was discovered by the crew of *Te Aurere*, on its maiden voyage to Rarotonga, in 1992 (see *Te Aurere Voyaging*, 1992). In research too, Indigenous knowledge is used to generate legitimate new knowledge, without recourse to non-Indigenous knowledge. Indigenous knowledge can also be combined with non-

Indigenous knowledge systems to generate new knowledge. Provided the knowledge systems being utilised are given appropriate consideration and respect, combining the knowledge systems can be an innovation that leads to new discoveries. What is critical to Indigenous researchers is that the new knowledge is able to make a contribution to Indigenous defined goals and outcomes.

*Te Ara Rangahau (the Research Path)*

Just as a structurally sound waka (vessel) is needed to make an ocean voyage, a sound methodology is necessary to complete a successful research journey. A description of research that adheres to the Waka Hourua Framework will be provided, as follows. The kaupapa (agenda) of the research will respond to research objectives that have been identified by Māori communities. Consultation with appropriate Māori collectives and authorities that promotes whanaungatanga (connectedness) and that affirms mana whenua (territorial rights), mana tangata (personal authority, power, prestige) and whakapapa (genealogy) will occur from the initiation phase of the research. Acknowledgement and respect of wairua (spirituality), mana atua (divine power), and mana tīpuna (ancestral power) will be evident in all stages of the research. This will be achieved through understanding tapu (sacred, prohibited) and noa (profane, safe), and by adhering to tikanga (laws, protocols), which allows for the safe navigation between that which is tapu and that which is noa. The starting point of inquiry will be based on tikanga, te reo (Māori language), and mātauranga Māori (Māori knowledge). Where researchers need guidance on these matters, research relationships with appropriate experts will be formalised. The research will show awareness of the diverse realities of Māori and the socio-political and historical contexts that produce these realities. Researchers will be cognisant of power structures that exert influence over the research process, the



research participants, and the researchers themselves. Researchers will also show reflexive awareness, monitoring the research process, themselves, and the research community, and demonstrating flexibility in adjusting the research process in light of their assessments of the research process, and community feedback. Finally, the research may or may not employ additional (non-Māori) knowledge and techniques. These additional research techniques could include qualitative and/or quantitative research techniques, applied in an additive manner to Māori knowledge and research methods, in order to add value to the research.

### Discussion

Interpreting psychological phenomena requires an understanding of underlying, culture specific value and belief systems. The Waka Hourua Research Framework is an attempt to incorporate a Māori community's values and beliefs into the research approach. In the ethno-centric discipline of psychology, founded on Western scientific principles including isolationism and reductionism (see Harris & Mercier, 2006; Lawson-Te Aho, 2002), the Waka Hourua Research Framework allows for a holistic approach to psychological research to be taken, recognising how people's social, political, historical, and geographic context influences their psychology.

It is important to note that this framework was produced in response to the research needs of a particular urban Māori community. The components of the framework reflect concepts that the members of the specific community and research team deemed crucial to the research. Therefore the utility of this framework is that it can be used as a starting point in formulating a tailored methodological approach to suit other Māori communities. It is likely that the application of this model will be most successful in similar urban Māori communities.

The Waka Hourua Research Framework described in this paper was used successfully

to guide research with an urban Māori community. The intervention project was successful, as key stakeholders reported satisfaction with the outcomes of the intervention activities. Information gained in the field was used in further studies that conformed to community members' research interests. In the first of these studies, a thematic analysis of community members' interview data was conducted, and a framework for increasing Māori engagement in State secondary schools was produced. A further study used the interview data to generate a process model of Māori identity development. Insights gained from community members also prompted further statistical studies using data from another research project. As an ongoing relationship has been established between the research team and the Māori community, results arising from these further studies will continue to be fed back to the community.

This paper explored one direction for psychological research involving Māori communities: researching the interface between mātauranga Māori (Māori knowledge) and Western science. The Waka Hourua Research Framework, positioned to explore this interface, is founded on core Māori values that enable research to reflect Māori worldviews. The guiding principles in the framework, tikanga (laws, protocols), te reo (Māori language), and mātauranga Māori (Māori knowledge), then provide the bases and processes of scientific inquiry. Finally, holistic, contextual considerations that influence and provide feedback into the research process are outlined. The result of incorporating these components is a dynamic framework, based on ancient Māori values, processes, and knowledge, that is able to respond and adapt to contemporary and diverse Māori research needs.

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**Glossary**

<i>Māori</i>	<i>Meaning in English</i>	<i>Māori</i>	<i>Meaning in English</i>
Atua	Deities, natural elements	Pōwhiri	Formal welcome/s
Aukaha	Lashings	Rā -	Sail
Hui	Meeting/s	Rā ngongohau	Staysail
Ihu	Bow	Riu	Hull
Kaiwhakatere	Sailor/s	Rūnanga	Māori council
Kapa haka	Māori performing arts	Tangata whenua	People of the land, territorial authorities
Kaupapa	Agenda	Tapu	Sacred, prohibited
Kāraho	Deck	Taura	Rope
Maihi	Mast	Tā	Stern
Mana	Authority, power, prestige	Tikanga	Laws, protocols
Mana atua	Divine power	Tīpuna	Ancestor/s
Mana tangata	Personal authority, power, prestige	Te reo	The Māori language
Mana tīpuna	Ancestral power	Urungi	Steering paddle
Mana whenua	Territorial rights	Wairua	Spirituality
Manuhiri	Visitor/s	Waka	Vessel
Marae	Meeting house/s	Waka hourua	Double-hulled sailing vessel
Mau rākau	Māori martial art	Whakapapa	Genealogy
Māori	Indigenous people of New Zealand	Whakawhanaungatanga	Relationship building
Mātauranga Māori	Māori knowledge	Whanaungatanga	Connectedness
Mokopuna	Descendent/s	Whānau	Family
Noa	Profane, safe	Whenua	Land

## Participatory action research in Aboriginal contexts: ‘Doing with’ to promote mental health

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*The resilience and creativity of Indigenous populations in the face of tremendous adversity serves as a great inspiration for Aboriginal community psychologists like myself to offer the best tools to communities in order to assist them to enhance the wellbeing of all their members. This paper brings in personal and professional elements of my journey as a Canadian First Nation’s researcher in community psychology working with First Nations of Canada and Aboriginal people of Australia. It aims to highlight the contributions of the Collaborative Research on Empowerment and Wellbeing (CREW) team to support Aboriginal-based mental health promotion. The CREW aimed to address the power-dynamics of research with Aboriginal people of Australia by systematically adopting a Participatory Action Research (PAR) process in which Indigenous partners are leading the research process from conception (identification of priority needs) to dissemination. It also presents the theoretical underpinnings and empowerment principles guiding our work as well as an example of a PAR project. In conclusion, I argue that this respectful way of applying rigorous methodologies to research issues affecting Indigenous people and communities could represent the ‘best of both worlds.’*

As Indigenous researchers, we can’t leave our Aboriginality at the door. It is an integral part of who we are and what we bring to our research. Quote from an Indigenous research workshop participant

Community psychology allows Indigenous practitioners to marry their cultural wisdom, respect, values and knowledge to mainstream psychology in order to creatively support their communities. Indigenous Peoples and cultures around the globe have survived despite many past and ongoing assaults to their integrity. This is a testimony to the resilience and creativity of their members. Although many differences distinguish Indigenous cultures, communities and individual experiences, the shared and similar histories of colonisation, assimilation and subjugation of Indigenous people all over the world unites us (Kirmayer, Brass, & Tait, 2000) and allows for Indigenous psychologists to contribute to the expansion

and adaptation of disciplines such as community psychology to better respond to Indigenous realities.

Jackson and Kim (2009) highlight the important contributions of community psychology to better understand the diversity and the valuing of Indigenous knowledge. However, these authors also draw attention to the lack of incorporation of cultural theories and research in community work. Williams and Mumtaz (2008) point to the resounding lack of Aboriginal-based mental health promotion initiatives in the published literature to highlight the Western epistemological hegemony in the area of Indigenous mental health promotion practices and approaches to evaluation. Indeed, this rejection of Aboriginal ways of understanding the world, perceived as myth, from mainstream Western knowledge perceived as scientific (Williams & Mumtaz, 2008) is evidence that colonisation continues to be present in modern forms (Wexler, 2009). Hence, the need for Indigenous psychologists is clear, as we walk in two

worlds: we possess a deep understanding and respect for Indigenous ways of knowing, being and doing and are able to use the tools provided by our scientific training to enhance the health and wellbeing of our Peoples.

According to King, Smith and Gracey (2009), the colonisation of Indigenous people is a fundamental determinant of health. There is no lack of evidence of Indigenous disadvantage across most all of the monitored indicators of health and social status, ranging from education, health, employment and economic status. Statistics highlight this disparity; for example, there is a life expectancy gap of an estimated 12 to 17 years for Indigenous compared to non-Indigenous Australians (Australian Institute of Health and Welfare, 2008; Vos, Barker, Stanley, & Lopez, 2008). Recent data suggest that Indigenous people are over-represented tenfold among Australia's imprisoned population (Willis & Moore, 2008). The high rates of suicide and self-harm experienced in Aboriginal and Torres Strait Islander communities is also a significant issue with suicide rates up to 72% higher than that of the whole of the Queensland population (DeLeo, Klieve, & Milner, 2006).

At the community level, these statistics represent struggles, pain and suffering of real people every day. This reality became apparent to me while researching my thesis on suicide in First Nations communities of Canada (Laliberté, 2007). Although this is not an easy subject to research, as an aspiring psychologist, I was determined to gain a better understanding of this experience and contribute to its prevention. I was welcomed in four Canadian First Nations' communities where, for varying lengths of time over a period of eight months, I listened. I sat with 25 suicide survivors who told me about their brothers, sisters, sons or nephews, the hardships they had endured, the ways they tried to cope, how they succeeded, how they failed, and what happened to make them decide they could not cope any longer

(Laliberté & Tousignant, 2009). When applied to suicide research, this method to study individual risk factors for suicide is called psychological autopsy. The results were shared back to communities to contribute to the design of their Life Promotion program.

However, during this period as a Canadian First-Nation's student of psychology, I came to realise that the discipline was inadequate to answer the complex psychosocial needs of Indigenous communities and be truly useful. At worst, the mainstream interventions proposed could harm Indigenous individuals, families and communities by its individual focus and often individualising outcomes (Williams & Mumtaz, 2008). Instead, I understood the importance of working upstream to promote health rather than redoubling efforts to treat problems that can often go unnoticed until it is too late. Indeed, working backward from death to look at experiences, missed opportunities for intervention become shockingly apparent. This realisation came from my research into suicide deaths of four young Canadian First Nations' girls who, through a rigidly honoured pact, decided they had enough with life. Going through similar stressful experiences directly related to the state of being an adolescent compounded with disturbing psychosocial realities, these girls found each other and acted on shared feelings of psychological pain, exhaustion and hopelessness (Laliberté, 2007). Had they been supported by empowered women of their community and provided with a safe place to share these feelings, a very different outcome may have been possible.

Not surprisingly, this realisation is shared with numerous Indigenous people. Indeed, Australian Aboriginal community leaders, members, Elders, youths and health workers suggested addressing issues affecting their communities that almost invariably started with the recognition and development of individual, group and

community strengths to promote positive collaborative actions and foster a sense of belonging, self-worth and achievement. Intuitively and almost unanimously, they were referring to empowerment.

Empowerment can be described as an active, participatory process through which the individuals themselves gain greater control, efficacy and social justice (Peterson & Zimmerman, 2004; Zimmerman, 2000). It is 'doing with' as opposed to the top-down 'doing for,' a practice synonymous with government interventions. Major global support for empowering initiatives was exerted through the Ottawa Charter (World Health Organization [WHO], 1986) and have proven effective in demonstrating sustainable changes in a wide range of disadvantaged populations (Wallerstein, 2006). A growing body of literature supports innovative, culturally sensitive, empowering methods of research to study and address the social disparities that lead to detrimental health and wellbeing outcomes (Campbell, Pyett, & McCarthy, 2007; Chino & DeBruyn, 2006; Labonte & Laverack, 2001; Quantz & Thurston, 2006; Reilly et al., 2008; Salmon, 2008; Tsey & Every, 2000).

With my doctorate in hand, I wanted to apply my skills to support empowerment and promote the health and wellbeing of Indigenous communities. I also wanted to expand my understanding of indigeneity as well as learn more about the practical applications of empowerment theory to health promotion. The Collaborative Research on Empowerment and Wellbeing team (CREW) had been working with Australian Aboriginal communities to promote health and wellbeing of these groups for over 15 years. I joined them for a three-year postdoctoral fellowship.

The objective of this paper is to highlight the contributions of the CREW to support Aboriginal-based mental health promotion. The first section presents the CREW, the theoretical underpinnings or framework guiding our work, and the

Participatory Action Research (PAR) process used as a way of working with community. The second section presents an example of a PAR project entitled Building Bridges: Learning from the Experts, which used an Aboriginal-developed empowerment and leadership program, The Family Wellbeing program, as well as Men's groups and Men's Knowledge Sharing Forums to support empowerment.

### **CREW: Theoretical Underpinnings, Who we Were and How we Worked**

Through long-standing working relationships with several Aboriginal community leaders and service providers in Far North Queensland (FNQ), the CREW aimed to support 'bottom-up' solutions to improve the health and wellbeing of Indigenous people from the 'inside-out.' Situated in Cairns (FNQ) and attached to the University of Queensland's North Queensland Health Equalities Promotion Unit (NQHEPU), this research team included five full time academic researchers – four of whom are Indigenous (three Aboriginal Australians and myself, a First Nations Canadian) – and a varying number of lay 'community researchers' including members, leaders and elders active in the communities participating in the various CREW projects.

The CREW adhered to the principles of the widely recognised Ottawa Charter (WHO, 1986) which urged nations to improve health by reducing disparities. It established the goal of health and wellbeing in an ecological as well as a strength-based perspective, recognising the impact of social determinants on the wellbeing of individuals who have the capacity to think and do for themselves, despite the difficult conditions that they endure. Health promotion then, is not the sole responsibility of the health sector, but goes beyond healthy life-styles to wellbeing. It advocated for health to be seen as a positive and holistic concept and emphasises social and personal resources, as well as physical capacities. This definition of health is

consistent with the holistic worldview of Indigenous people who describe health as the social, emotional and cultural wellbeing of the whole community (National Health and Medical Research Council, 2003).

Our team espoused the cultural holistic worldview of the populations it worked with by adopting an ecological theoretical framework. According to Bronfenbrenner (2005), the ecology of human development is the scientific study of the mutual and progressive adjustment of a human being and of the milieu that he/she inhabits, considering that this process is also modified by the interactions between these different environments and by the larger context in which they take place. In other words, this ecological perspective proposes to consider the contexts in which the individual evolves and with which he/she interacts as having an impact on his/her development. Not unlike the holistic view of health and wellbeing of a majority of Indigenous groups, the ecological perspective considers the individual as an integral part of his/her surrounding contexts. At the same time, the environments are inextricably linked to and shape the development of the individual. Hence, like the biological and the cognitive development (growth, intellectual ability) impact on the individual through the passing of time, the dynamics, values, beliefs, attitudes and so on of the family, the school, the community, the culture, will have a necessary impact on the personal values, attitudes and beliefs of the individual which will shape their choices, behaviours, life-style and ultimately their wellbeing. Being a two way relationship, positive actions from groups of empowered individuals can serve to change the larger environment by shaping attitudes, beliefs and influencing behaviours of those who surround them and can, eventually become embedded in the mentality of the larger community.

To achieve its goals, the CREW employed a Participatory Action Research

(PAR) approach in which the university-based researchers worked side by side with the community-based researchers throughout the implementation of all the PAR activities. The PAR process is an empowerment research technique aimed at raising critical consciousness through ordinary people generating relevant knowledge in order to address the issues that are of priority concern to them. It involves researchers assuming roles of peer facilitators to generate broader systemic frameworks for understanding given situations. These frameworks are then used to question the situation and identify alternate courses of action. From here, the process itself is spiralling as knowledge and understanding informs strategy development, followed by action, reflection and new understanding with ongoing change and improvement being the goal (Tsey, Patterson, Whiteside, Baird, & Baird, 2002; Tsey et al., 2007). The PAR process thus compels the incorporation of cultural and local theories of wellbeing and research in community work.

The PAR activities of the CREW aimed to inform and explore ways to make the services and community resources more responsive to the needs of the Aboriginal communities. It recognised the value and leadership of community organisations, thus supported the empowerment of these groups and strengthened collaborative relationships. The PAR projects also aimed to contribute to build personal capacity and support community wellbeing. One way of achieving this was to systematically employ Aboriginal community-based researchers.

The community-based team members represented a significant gain to the PAR studies. Indeed, in addition to their practical positioning to identify, engage and support participants, they brought essential cultural, experiential and local knowledge to inform the projects thus insuring appropriateness and relevance. The community-based researcher also ensured empowerment activities of participating groups and informed community

service providers and stakeholders in meaningful and timely ways, with the support of the university-based researcher. The specific engagement activities remained flexible to be relevant to each community. Word of mouth, social gatherings and classroom visits were techniques that were employed.

Health promoters need three levels of knowledge, namely instrumental, interactively derived and critical knowledge (Keleher MacDougal, & Murphey, 2007). As researchers with different Indigenous backgrounds, we, the members of the CREW, used our heritages as much as our academic experience and knowledge to inform our health and wellbeing promotion efforts. We worked sensitively and respectfully. We considered that Indigenous ways of knowing, being and doing represent considerable strengths to the promotion of Indigenous health and wellbeing and we systematically employed empowering approaches to research, implement and evaluate health promotion initiatives.

#### **Building Bridges: Learning from the Experts project**

An example of a project in which these principles were applied is Building Bridges: Learning from the Experts, which was funded by the Australian Government's Department of Health and Ageing through the National Suicide Prevention Strategy. Stemming from the CREW's earlier work (Haswell-Elkins et al., 2009), the project brought together members from the University of Queensland, James Cook University, University of Southern Queensland, Griffith University and the Centre for Rural and Remote Mental Health Queensland. The participating communities included two remote communities which were closed off during the wet season, a rural community easily-accessed and close to a large town, and a mixed Aboriginal and non-Aboriginal community close to a large urban centre. In addition to the academic researchers of the

CREW, the project employed four community-based researchers. I was responsible for the formative implementation evaluation of this project. I thus was able to work side-by-side with all the community researchers throughout the entire project in both support and research roles.

The main tools used in this project are the Family Well-Being program, to foster empowerment and positive relationships and the community Men's groups and Men's Knowledge Sharing Forums to support networking and working together toward positive solutions to community issues. The Family Well-Being Program (FWB) was initiated in 1993 by Aboriginal people who were part of the Stolen Generations – children who were forcibly removed from their Aboriginal families and raised in non-Indigenous Australian institutions and foster families. The understandings of what this group needed to survive traumatic experiences and chronic stressors, as well as come to terms with their own shortcomings and gain enough strength to become leaders in their communities formed the basis of what would become the FWB program (Tsey & Every, 2000). It aims to empower participants, their families and community to take greater control and ownership of circumstances that influence their lives, including meeting their basic physical, emotional, mental and spiritual needs. The program is divided into five stages of approximately 30 hours. Each stage comprises 10 sessions. Stage 5 is facilitator training and is an accredited undergraduate program. As described in the systematic review of the underlying components of the program (Laliberté, Haswell, & Tsey, in press), FWB is delivered to small groups and each session starts with a brainstorming activity, making it an action learning and empowering process.

The first stage of the program aims to bring people together and establish that change starting with oneself. It is based on



the premise that individuals are responsible for their own wellbeing and have the capacity to take charge of their lives and make positive changes to enhance their environment. It aims to support psychological empowerment and to enhance interpersonal skills to build healthier interactions and relationships. The second stage examines the process of change, and imparts skills to cope with different types of losses (e.g., through death, alienation, estrangement, divorce, separation, etc.) and the resulting grief. In stage three, participants are invited to explore the issue of family violence, during which information is provided on the cycle of abuse and strategies for dealing with family violence and creating emotional health are shared. Stage four invites participants to revisit the important learnings of each stage and reflect on the changes that have already occurred in their lives since the beginning of the program.

During the duration of the project, 11 participants became program facilitators. Of these, four, including myself, were academic CREW researchers and four were community researchers. The skills and insights gained were applied to engage community members, advocate for more equity within Aboriginal communities and social justice for these groups.

The other main tool used to support empowerment was Men's Groups. The purpose of Men's Groups is to bring local men together to discuss priority issues and is about men supporting each other to find ways to manage conflict and crisis, develop strategies to deal with loss and grief, deal with family violence and anger issues, among others. Men's Groups is also about creating emotional health and fostering positive relationships and interactions. The men usually met once a week to discuss these issues, but they also went on camping and fishing trips, often to teach traditional ways to the younger men of the community. In essence, the Men's Groups message was

about being role models in their communities and supporting each other to providing alternatives to alcohol and drug abuse. As university-based researchers working side-by-side with the community-based researcher, I had the great privilege to be invited to several Men's Groups activities and was able to see first-hand how an active Men's group can initiate community changes such as better school attendance, a larger number of social and family activities and a greater transmission of cultural and historical knowledge.

The Knowledge Sharing Forums was to bring the Men's Groups from the four participating communities and their surroundings together to discuss general issues affecting Aboriginal men, families and communities. In all, there were at least one Forum in each community and approximately 200 men in total from all over Queensland participated.

An external evaluation of the project conducted by the Australian Institute of Suicide Research and Prevention (AISRAP) concluded:

The FWB training and the opportunities provided by Men's Groups empower people and communities to understand dysfunctional behaviours and gives them the ability to change coping strategies and other behaviours for the better. These types of activities enhance their ability to see that there was a great deal of potential in people becoming active in addressing these issues. There was energy in people's descriptions about a better future where people come together, are listened to, take responsibility and make good choices. They could envision their community as a place where there are jobs, good relationships ...[and] well spent resources and where people's strengths could be

recognised and built on. (McKay, Kölves, Klieve, & DeLeo, 2009, p. 87)

In essence, these types of activities have the great potential of creating hope for a better future.

### Conclusion

The PAR projects were designed to allow the research team to gather the three levels of knowledge needed by health promoters, namely instrumental, interactively derived and critical knowledge (Keleher et al., 2007) while building the capacity of the community leaders to advocate for services and service delivery to meet their needs. In so doing, it enables research done with Aboriginal populations to address the immediate concerns by benefiting participants and community partners directly. Thus being guided by 'what works' with this specific group (Banister & Begoray, 2006; Chansonneuve, 2007; Oliver, Collin, Burns, & Nocholas, 2006) and, to a certain extent, simplifying the knowledge transfer pathway from adopt, adapt, and act (Waters, Armstrong, & Doyle, 2007) to understand, plan and act.

The knowledge and skills gained are readily transferable to other disadvantaged populations in diverse cultures and settings. Indeed, the information provided from this intense sample and the demonstration that empowering initiatives and research methods can have an impact in re-engaging severely disconnected and voiceless groups represents a broad ranging potential for health promotion that is widely applicable among a variety of cross-cultural settings across the globe. Not only do indigenous peoples have analogous histories of colonisation, the remarkable resilience and profound wisdom of these millennia peoples are undeniable strengths that need to be part of the solution.

We cannot undo the history of colonisation responsible for these devastating social and health consequences; however, addressing these issues with problem focused,

top-down initiatives represent history repeating itself. The health, incarceration, suicide, education and socio-economic statistics describing the circumstances of Aboriginal communities in Australia translate to everyday struggles of regular people; they do not, however, characterise them.

As a Canadian First Nations' woman, I have an intimate understanding of the pride and responsibility this heritage carries as well as of the everyday struggles indigenous peoples must face not because of this heritage, but due to the socio-economic circumstances in which too many of us evolve. I appreciate the strength and flexibility it takes to walk in two worlds, as the path seems perilous on both sides. What does it mean to be an Aboriginal person/woman in the twenty-first century? Where do I fit? As those questions impact on one's own quest for identity, the collective answers impact on the future of an entire people. Research with Aboriginal communities must respect their objectives of self-determination as well as address the pressing problems faced by several individuals through rigorous, responsive, strengths focused culturally sensitive and locally relevant participatory studies. As an Indigenous community psychology researcher working with Aboriginal communities, I am guided by the wisdom of those who have walked the path before me and of those who are walking alongside me now, both Indigenous and non-Indigenous.

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## Exploring the nature of intimate relationships: A Māori perspective

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*The 2002 World Report on Violence states that violence occurs in about 70 percent of intimate relationships (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). New Zealand research indicates that more than a quarter of relationships have experienced intimate partner violence (IPV), with Māori (Indigenous people of New Zealand) women three times more likely to experience IPV in their lifetime. Utilising Kaupapa Māori (Māori-centred approach) and narrative methodologies, this paper explores the nature of intimate relationships from a Māori perspective, investigating how Māori initiate intimate relationships, attempt to maintain positive intimate relationships and when applicable, exit intimate relationships. The findings from two case studies reveal that intimate relationships involve identity negotiation and an incorporation of cultural values. Communication processes are highlighted as a facilitating factor of intimate relationships.*

Intimate partner violence (IPV) is a significant social and economic issue in New Zealand, similarly highlighted by the international community as a major public health threat (McHugh & Frieze, 2006; Moffit et al., 1997). Internationally, the prevalence of IPV is estimated to be between 10 and 69 percent (Krug et al., 2002). In New Zealand, McHugh and Frieze (2006) reported that more than 25 percent of intimate relationships have contained physical assault. More recently, McMurray and Clendon (2010) found that Māori women were three times more likely to experience IPV in their lifetime in comparison with non-Māori women.

Krug and colleagues (2002) define violence as:

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death,

psychological harm, mal-development or deprivation (p. 5).

The New Zealand Domestic Violence Act 1995 classifies IPV as a form of domestic violence which involves perpetrating violence against past or current partners or spouses (*Domestic Violence Act 1995, New Zealand, 1995*). Recent studies suggest that IPV includes verbal and psychological abuse that can take many forms, such as threats, intimidation and coercion (Robertson & Oulton, 2008).

To understand IPV within the context of New Zealand, we consider the impact of colonisation on Māori. In traditional Māori society, women were commonly referred to as “Te whare o te Tangata – the only source from which all new life flows” (Robertson & Oulton, 2008, p. 6). In accordance with these conceptualisations, the sexual assault of any female within the iwi (tribe) was regarded as an assault on whānau (family) and whakapapa (genealogy, ancestral connectedness), provoking punishment of banishment or death (Mikaere, 1994). The arrival of colonialism in

New Zealand brought patriarchal ideologies that conflicted with Māori values and beliefs (Mikaere, 1999). Imperial domination and its accompanying legislative systems sought to exploit the abundant natural resources contained within these shores. Colonisation stripped Māori of their land, culture, language, identity, access to natural resources, and their traditional way of life (Jackson, 1992). Furthermore, the patriarchal ideologies that underpinned British colonial systems countered and removed the importance of women in te ao Māori (Māori world-view). In contemporary New Zealand, the pervasive impact of colonisation has resulted in immense socio-economic disadvantage for Māori. These consequences are regarded as a major contributing factor to the high rates of IPV within the Māori population (Koziol-McLain, Rameka, Giddings, Fyfe, & Gardiner, 2007; Robertson & Oulton, 2008).

In considering the impact of colonisation upon IPV amongst Māori, this paper is situated within the context of preventing IPV. The aim of this research is to explore the nature of intimate relationships in relation to three core issues: initiating intimate relationships; maintaining positive intimate relationships; exiting intimate relationships. Research by Hamby (2009) that focused on relationship dynamics found that during the initiation phase of intimate relationships, the interaction process between couples is noted as a contributing factor to IPV and dating victimisation. In addition, communication styles used between intimate partners play a crucial role in the long term quality and maintenance of intimate relationships (Overall, Fletcher, Simpson, & Sibley, 2009). For example, indirect, passive or covert communication approaches may lead to a lower long term relationship satisfaction, whereas, direct or explicit communication approaches are likely to result in higher long term relationship satisfaction in couples (Overall et al., 2009).

Considerations are also made in regards to the sense of identity that people take into intimate relationships and how identity changes over time. Nikora (2007) proposes that social identity consists of an individual's self-perception which is drawn from knowledge associated with a social group he or she identifies as being a part of.

Traditionally, Māori identity is rooted in whakapapa, tikanga (custom) and kawa (protocol) (Nikora, 2007). Māori, as a social group, underwent social change during colonisation (Jackson, 1992), which has significant impacts on Māori identity construction (Nikora, 2007). Māori identity and how it had changed over time is important for understanding intimate relationships because it speaks to the issue of who Māori are. That is, the cultural and social groups from which Māori draw their identity help to shape the values Māori consider important and use those values to negotiate intimate relationships.

#### **Method**

A Kaupapa Māori methodology offered a means by which research could be conducted in a way that adheres to Māori tikanga and tradition. Kaupapa Māori approaches challenge the norms of mainstream research methodologies, stands to benefit Māori and allows Māori to interpret collected data in an appropriate way (Pihama, Cram, & Walker, 2002). This methodology had a strong emphasis on whanaungatanga (relationship through shared connectedness) which features that research is conducted *with* Māori, rather than *on* Māori. A narrative approach to this research was employed to capture Māori individuals' experiences. The narrative approach allowed research participants to recount their experiences in a story-like format that could appropriately consider the cultural context in which they are situated (Breakwell, Hammond, & Fife-Schaw, 2003). The findings of this research were part of an undergraduate directed study conducted by

the lead author.

Two participants were recruited through the researchers' social and university networks. To ensure anonymity, pseudonyms are used: Ruru, a Māori man in his early thirties; Tui, a Māori woman in her early forties. Once the participants consented to take part in the research, information sheets were then provided and the interviews were arranged at a time and venue that suited the participants.

The interviews were conducted utilising a semi-structured interview process with each participant being interviewed once. Interviews began with a shared meal, in line with traditional Māori customs surrounding hui (meeting) (Walker, 1990). Sharing a meal assisted to establish rapport between the researcher and participant and allowed the sharing of whakapapa and tribal ties. The interviews were recorded in an audio format once consent was given by the participants. The interview guide included five broad themes for discussion which were tikanga, te reo Māori (the Māori language) and te ao Māori; the initiation of intimate relationships; the maintenance of relationships; exiting relationships; and a general discussion. At the conclusion of the interview, participants were presented with a koha (gift) in appreciation of the time that they had given.

Following the transcribing of interviews, a summary of the interview was compiled and forwarded to the participants for review from which no amendments were necessary. A thematic analysis (Breakwell et al., 2003) was conducted from which three major themes emerged: intimate relationships within culture; intimate relationships and identity negotiation; and communication as facilitators of intimate relationships. These major themes identified are presented in the following section.

### **Findings**

#### *Intimate Relationships within Culture*

The first case study was conducted

with Ruru. Ruru was adopted into a Pākehā (non-Māori) family whilst maintaining a positive relationship with his biological Māori family. Through his biological father, Ruru was active within te ao Māori, including partial fluency in te reo Māori and established a strong understanding of the tikanga of his iwi. His connection with te ao Māori carried through into his adult life. Weka was Ruru's long term intimate partner which he primarily spoke of during the interview. She also had a strong upbringing in te ao Māori. Tikanga Māori then became a cornerstone of their relationship together. For example, Ruru asserted: "We'd actually set up our relationship to honour our ethnicities... everything that we've done was about being successful Māori... in a successful relationship".

Ruru and Weka first met in a professional setting. They were set up on a date through a mutual friend. Once a committed, intimate relationship had begun, te reo Māori and tikanga became a process of intimate bonding – through establishing whakapapa (ancestral connectedness) – and an eventual way of life that they would share through marriage. During the early stages of their relationship, a concern was raised by Weka's family regarding Ruru's ethnicity. Ruru explained:

Funny enough, this is my partner we're talking about, she's part Māori, and her mother didn't like the idea of her partnering with another Māori, and that was communicated quite effectively. It was a perspective of her family that Māori men don't get out there and perform and provide for their families the same way that non-Māori men do.

This perception of Māori men reflects the hegemonic notions perpetuated by colonial ideologies in mainstream institutions to actively disadvantage Māori (Jackson, 1992) which could provide an explanation for



Weka's parents' perceptions of Ruru as a Māori man. However, in Ruru's account, Weka's parent's animosity was not aimed towards the Crown. Rather, it seemed to have turned Māori against Māori in that negative stereotypes that have resulted from colonisation are being held by people at the centre of disadvantage. Ruru took this as a challenge to prove that Māori men can be successful and worked hard to change this perception.

Ruru and Weka came from different iwi. As the relationship developed, they both saw the importance of learning the specific tikanga, karakia (prayer) and waiata (song) of both their iwi in order to participate appropriately when visiting each other's marae (tribal meeting place). Not only did this serve a practical purpose to the inner workings of the relationship, but also it served as a close and personal form of intimate bonding. Ruru explained:

We did a trade and exchange thing around waiata because we thought well, if we're going to make this in the long term, you're going to be spending time on my stomping ground, I'm going to be spending time on yours so let's do that in a way that we could participate.

Ruru's account indicates that much of their social life together consisted of attending Māori based events, such as Te Matatini (the bi-annual National Māori performing arts competition), Te koroneihana (the coronation of the Māori King or Queen) and Poukai (annual visits by the Māori King or Queen to marae in the Waikato area) from which they would enjoy Māori performing arts, socialise and acquire pieces of Māori art to decorate their home and reaffirm their Māori identity. Ruru and Weka also spent a lot of time caring for their loved ones in palliative care, which reaffirmed their commitment to each other. They actively encouraged each other to use te reo Māori in

a traditional way, free of transliterations. The primary reason that Ruru gave for this was that the meanings of traditional Māori words could be traced back through proverbs and chants for a deeper understanding of their language, where transliterations could not. These actions demonstrate that te reo Māori and tikanga were both an active expression of cultural identity, and also a set of tools used to develop, strengthen and maintain a positive relationship together.

In the second case study, Tui had very little influence of te ao Māori from her parents. Her father was brought up immersed in te ao Māori but in an era when children were punished at schools for speaking te reo Māori. Through this process as well as societal pressure to conform to Western ideologies, he disregarded Māori knowledge, as being the old way, and adopted te ao Pākehā (non-Māori world-view) as the new way forward. As a result of this, Tui did not learn te reo Māori from her father. Tui also described her father as having problems relating to alcohol that would result in him becoming verbally abusive towards her mother which she personally witnessed on a number of occasions as a child. As a child, the contact Tui did have with te ao Māori was through a close bond with her grandmother with whom she was able to participate in hui, tangihanga (traditional Māori funeral) and other such gatherings on her marae. Tui stated: "I still don't feel like a Māori... I don't have the language." Tui's statement suggests that there seemed to be an inability to connect with her cultural identity due to her perceived language deficiencies. She felt that she had missed out on her own culture. This is consistent with Durie's (2003) notion of te reo Māori being a key component of Māori cultural identity. For these reasons, she strongly encouraged her children to learn te reo Māori at kōhanga reo (Māori pre-school).

Tui's ex-husband Kererū has Māori heritage, but was raised in a family that held Western values. Although he was close to his own family, he had never experienced the

Māori concept of whanaungatanga the way that Tui had introduced it into their relationship together. Tui stated:

The three major relationships that I've had, they've started out not really with a basis of whānau, and whanaungatanga. So they've all been, and I don't mean to sound racist, but they've been white guys, white people and so they don't have the same philosophy. Basically I've had to train them to accept the fact that if people show up at my door, I'm going to feed them, and that you know, it's ok to do that and it's ok for people to come in and out of your house, and yea ok sometimes you get a little sick of it, but it's all about whānau and being accepting of everyone and I've managed to change their ideas about how they see whānau and family... My grandmother used to actually say that her house was her marae.

Tui incorporated the Māori concepts of whanaungatanga, tautoko (support) and awhi (aid) into her relationships and into their whānau. Both Tui and Kererū held their whānau in far higher importance to their individual selves. This demonstrates the concept of manaakitanga (hospitality, kindness), whereby the caring of others is central to being part of a social group, which is a cornerstone in te ao Māori (Nikora, 2007). Tui's excerpt shows that she was able to incorporate fundamental concepts from te ao Māori that she had learned from her grandmother. Whanaungatanga served as a bonding agent that allowed Tui and Kererū to integrate their lives together.

As we have illustrated, culture plays a major role in Ruru's and Tui's relationships through acts of tautoko, awhi and whanaungatanga. Culture is important in the way that they express themselves, bond with

each other and incorporate cultural practices into their daily lives. We have shown that cultural identity has been negotiated within our participants' intimate relationships. In the next section, we will show how our participants negotiate personal identity within their relationship.

#### *Intimate Relationships and Identity Negotiation*

Ruru discussed the multiple layers of identity that he negotiated with his partner Weka, such as: cultural identity, a Māori male who was adopted into a Pākehā family and a victim of child abuse. Ruru's cultural identity was easy to share with Weka because she too came from a Māori family. She understood and embraced this part of Ruru in their relationship.

As a Māori man who was given up for adoption and experienced years of sexual abuse as a child, Ruru found it hard to share "who he was" with Weka. These past experiences affected Ruru's perceptions of relationships, in that relationships can be unsafe and end in an instant. As a result, Ruru became protective and was generally defensive to physical touch. Although they attempted to work through these problems together, Ruru was never able to resolve the issues pertaining to his experience of sexual abuse as a child. As conflicts within the relationship escalated, Weka resorted to physically assaulting Ruru. Ruru was hospitalised and received stitches to his face. When seen by a doctor, he felt that he had to, and did, lie about how he had sustained his injuries due to his own, and Weka's, professional careers. Ruru reflected:

Without looking too deep bro, you can see that they don't believe your story and I don't believe the story and that's a huge cost, spiritually, on your wairua (spirit), that's a huge cost. It can split you in two depending on how often you have to tell that story. Privately, I've absolutely

ripped myself to shreds. It's hard to look people in the face.

Ruru's account suggests a stigmatisation associated with male directed IPV. Allen-Collinson (2009) argue that men generally do not report IPV to police or social services. The reasons for this include: embarrassment, shame and social norms associated with masculinity such as the feeling of not being a 'real' man (Allen-Collinson, 2009). Following the assault, Ruru felt a sense of loss and loneliness. Ruru questioned his abilities to take control of his own life and was filled with self-doubt and low self-esteem:

It's promoted to us as Māori people that there is no sense of yourself within a collective, there's no such thing as the individual. Well actually there is, and when all of those, iwi, hapū (sub-tribe), whānau structures break down, like in a relationship break up or something like that, then the Māori individual does find themselves by themselves for a little bit.

Ruru's reflection raises the issue of the loss of identity. Ruru felt that he had lost a degree of his professional identity through having to lie about the assault, and further, the collective nature of his cultural identity brought in to question who he was when he was alone. It was not until Ruru exited his relationship with Weka that he was able to begin rebuilding his own sense of identity through reaffirming connections with his family and close friends.

For Tui, the two relationships she was in reflect the different ways she negotiated her own sense of self. The first relationship was with her ex-husband Kererū. This relationship began in her late teenage years and they shared a close social life together. Tui and Kererū's relationship underwent changes when they had their first child. This change was marked by high levels of stress

which, at times, they did not deal with well. This stress was attributed to Kererū being unemployed and their newborn's erratic sleep patterns. Tui would become physically violent towards Kererū and her children. Kererū detested the violent touching of his children and would verbally lash out at Tui. In time, Tui changed the way that she dealt with stress by not resorting to violence with her children. However, Kererū did not change; he became increasingly verbally and psychologically abusive towards Tui. Tui stated:

As time went on, he just wore me down and wore me down and wore me down till basically there was nothing left of me. I was just a walking dead person, so I wasn't interested. I wasn't interested in helping myself. I wasn't interested in helping us. I wasn't interested. My focus was my kids and that was it. I lived for them.

Tui avoided interaction with Kererū and withdrew within herself. Allen-Collinson (2009) stipulates that avoidance, withdrawal and self-blame are common coping mechanisms for victims of IPV. Tui described a strange sense of attachment to Kererū, whereby she felt that she had no value without him. Her sense of self diminished; the only thing that kept her strong was her children. The relationship ended when Kererū left Tui for another woman. At this point, they were living in a different town from where they had met and Tui had made friends independent of Kererū. The support and whanaungatanga that her friends offered her was essential to the recovery of her sense of self. This indicates that for Tui, whanaungatanga was a dynamic concept that spans the domestic, whānau, hapū and iwi realms.

Tui's experience also suggests that intimate relationships are a process of self-development and growth. This is evident

when she reflected on her second relationship with Tītī:

This new relationship that's just broken up, it was my decision. I just needed to be in charge of my own life. I don't need someone telling me how to run my life. To finally get a sense of self and I think, when three papers I was doing on women and gender studies just smacked me upside the head and everything became really clear and I suddenly saw things for what they were and I suddenly woke up and I thought that I've been asleep for the last 40 years. What the hell have I been doing?

Tui's account suggests that she has experienced two pivotal shifts in self-concept. The first took place after her relationship with Kererū ended, leaving her disempowered and depressed. This second shift was a result of higher education which empowered her. Furthermore, this move to attend university was motivated by Tītī. One of the primary differences between these two relationships was the way that Tui and her partners communicated with each other. With Kererū, she employed an implicit and indirect form of communication, while with Tītī she used a more explicit and direct form of communication. Yet both relationships exhibited issues of power and dominance that affected Tui's sense of self. In the next section, I will focus on the role of communication in intimate relationships.

#### *Communication as Facilitators of Intimate Relationships*

At the beginning of his relationship, Ruru responded well to Weka's communication style. Before he had met Weka, Ruru had never directly initiated a relationship; most of his previous relationships were limited to one night stands or were initiated in very indirect ways. Ruru explained:

My soon to be ex-partner turned around and just said "Oh, look I'm interested in you, you're interested me." It was just a lot more, had a lot more strength behind it than anything I had expected or experienced in the past. It was exciting.

The reason Ruru responded well to Weka was that she was able to use a direct approach in a way that he had not experienced before. From his past history of sexual abuse, he did not respond well to direct approaches. However, as Ruru described, Weka was able to be direct in a safe and comfortable way. This communication style continued throughout their relationship and served as an effective maintenance tool. For example, Weka would neutralise arguments that could not be resolved in the immediate future and would deal with it at an appropriate time and place.

Through their employment, they acquired a vast range of communication skills which they applied in their relationship. For example, they used a three minute rule, which gives each of them an opportunity to express themselves uninterrupted for three minutes when they got home after work. The aim of this was to share positive experiences of each other's day, and to prevent the unloading of stress on each other. However, strategies like this were not enough to deal with the wide range of problems that they experienced. Ruru said: "If all you're doing is identifying problems and then trying to identify solutions, then that becomes your relationship." This suggests that their roles were now as professional facilitators rather than a couple, which resulted in less enjoyment in their relationship together. Ruru reflected:

If there's hope, then there's a chance for something better, but when the change doesn't walk, that dashes hope against the rocks. We were great organisers,

but we're not great, I don't know, love passed us by.

As a result, the relationship ended although they thought they had the resources and skills required to make the relationship work. This suggests that it is not enough to just have good communication skills; formulating effective ways to practice what is communicated within a relationship to invoke change is just as important. In comparison, the communication used in Tui's relationship with Kererū was different. Tui recalled:

It [communication strategies] wasn't even needed to be discussed. He would wake up one morning and say "where should we go?" and then we'd just go. I don't know, we just had a really nice rhythm for quite a long time and things just happened.

Later in the interview, Tui expressed how this style of communication transpired during times of conflict with Kererū, she said:

Just put a sticky plaster on it and kiss it better. Or I would give in and allow him to win. I would just agree with whatever it was that he wanted to fight about. To my own detriment, I would just swallow it back down again.

Tui's excerpts suggest that they did not discuss strategies to deal with conflict. As Tui asserted, at the start of the relationship this approach worked well and the relationship was good. This changed following the birth of their first child. Tui described:

After the first two kids were born, things started really going downhill and he became really, he just became more and more abusive, putting me down, belittling me, psychological abuse. Everything that you could of, but not physical. By the time he was actually wanting to try to

set something up to get it working again, something inside me had died. He [Kererū] yelled at me: "Why can't you argue with me? Why can't you just say one thing back?" At the time, I could not say anything, I totally froze... I think I have an instilled fear of arguing and I think that seeps back to my early childhood. My father was an angry Māori man with a drinking problem.

Tui's account suggests that the abuse she experienced from Kererū triggered emotions associated with the abuse she witnessed as a child. She withdrew herself from verbal conflict with Kererū as an adult, the same way she would with her father when she was a child. Riggs, Cusimano and Benson (2011) have suggested that victims of abuse develop "poor self-concept, low self-esteem and disorders of emotional regulation and impulse control" (p. 127) which may result in negative coping with IPV.

The participants' experiences suggest that, in intimate relationships, communication strategies and skills, and emotional engagement are mutually important in order to achieve the desired change within their relationships together. Despite the participants having experienced difficulties in the dissolution of their relationships, our analysis suggests that the participants not only cope with challenges and conflicts, but also consider that their everyday situations foster their growth and positive changes. The positive changes the participants experience include new possibilities of their lives and a greater sense of personal strength. In this sense, living with adversity can be harmful for the participants both emotionally and physically, but these situations can also encourage them to rethink their lives, re-evaluate what is important and develop strategies to achieving a future free from IPV.

### **Discussion and Conclusions**

The presented research has explored the

factors that influence our participants to initiate, maintain and exit intimate relationships. The findings suggest that culture plays an important role in the way that our participants negotiate and maintain intimate relationships through acts of whanaungatanga, awhi and tautoko. They honour their ethnicities by using their culture to build what they consider to be better quality relationships. In this sense, cultural values provide a framework to bond, negotiate and interact with each other. This suggests that a focus on the strengths within te ao Māori can be used to incorporate Māori values into intimate relationships. For example, the collective nature of Māori emphasises the importance of iwi, hapū and whānau over the individual self (Walker, 1990).

The analysis demonstrates that self (re) construction is a crucial aspect during the dissolution phase of relationships. When the participants moved towards the end of their relationships they redefined themselves as autonomous beings. The analysis suggests that a holistic view of self and identity construction that considers the cultural context is needed in order to examine identity within intimate relationships.

For our participants, communication is important through different stages of their relationships. If there is open and honest communication along feeling, sharing and emotional engagement, the couple's ability to deal with conflict might be better resolved. When communication is manifested in an abusive way such as put downs and insults, our participants internalised their emotions and refused to engage in communication. As a result, the couples experienced breakdowns in communication that lead to an inability or an unwillingness to resolve relationship issues.

As the stories of Ruru and Tui indicate, intimate relationships do not exist in isolation. Rather, they are developed and constructed within the relational, cultural,

social, historical and political contexts. Individuals' cultural values, personal and cultural identities and communication styles collectively influence how they interact with intimate partners and the way they perceive themselves within the relationships. Developing this research out of a concern for IPV in Māori communities, we believe that understanding the nature of intimate relationship can provide us a window into preventative approaches to establishing more loving, compassionate and most of all, violence free intimate relationships.

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**Glossary**

<i>Māori</i>	<i>Meaning in English</i>	<i>Māori</i>	<i>Meaning in English</i>
Awhi	Aid, help	Tautoko	To support
Hapū	Sub-tribe	Te ao Māori	The Māori world view
Hui	Gather, meeting	Te ao Pākehā	The Pākehā world view
Iwi	Tribe	Te koroneihana	The coronation of the Māori King or Queen
Karakia	Prayer	Te Matatini	The bi-annual National Māori performing arts competition
Kaupapa Māori	Māori-centred approach	Te mea te mea	And so on and so on
Kawa	Protocol	Te reo Māori	The Māori language
Kererū	Pigeon (used as a pseudo-name)	Tikanga	Custom
Koha	Gift	Tītī	Muttonbird (used as pseudo-name)
Kōhanga	Māori pre-school	Tui	Parson bird (used as pseudo-name)
Manaakitanga	Hospitality, kindness	Waiata	Song
Māori	Indigenous people of New Zealand	Wairua	Spirit, soul
Marae	Tribal meeting place	Weka	Wood-hen (used as pseudo-name)
Pākehā	Non-Māori	Whakapapa	Genealogy, ancestral connectedness
Poukai	Annual visits by the Māori King or Queen to marae in the Waikato area	Whānau	Family
Ruru	Morepork (used as pseudo-name)	Whanaungatanga	Relationship through shared connectedness
Tangihanga	Mourning, Māori death ritual		



## Māori healers' perspectives on cooperation with biomedicine

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*In Aotearoa/New Zealand, Māori use of both general practitioners and rongoā Māori (traditional Māori medicine) services for health treatment continues, although traditional healing has gained little acceptance from medical practitioners. This research explores issues of cooperation between doctors and Māori healers from the perspective of the traditional Māori healer. Semi-structured interviews were conducted with 17 rongoā Māori healers. Data were analysed using a narrative analysis approach. Findings reveal that some healers promote cooperation between the 2 systems, arguing that they are complementary and could work side-by-side. Other healers resisted cooperation as a consequence of general practitioners' limited understandings and rejection of rongoā, and concerns about maintaining the integrity of rongoā. A model of pluralism is discussed as a way to address Māori healers' concerns and promote cooperation between traditional Māori healing and medical health treatment in Aotearoa/New Zealand.*

Traditional healing has been the basis of health treatment used for many generations in indigenous cultures (Tangwa, 2007), but traditional healing methods have often been under-estimated or dismissed by the scientific and medical communities (Marks, 2006). This may be due to differences in the conceptual framework between biomedical and traditional medicine (Sexton & Sorlie, 2009; Struthers & Eschiti, 2005), a lack of clear understanding about the limitations of the biomedical model, how indigenous healing functions (Janes, 1999), or a lack of knowledge sharing between health practitioners and traditional healers (Calvet, Reyes-Garcia, & Tauer, 2008). The different issues arising from both the medical fraternity and the traditional healing community indicate significant difficulties in reconciling their differing perspectives on health treatment. This paper focuses on exploring ways that practitioners of medical and indigenous healing systems could work together.

Traditional healing is often placed under the umbrella of complementary and alternative medicine (CAM, Tataryn, 2002).

Like traditional healing, CAM covers a variety of therapies that are not based on the biomedical model (Leckridge, 2004; Struthers & Eschiti, 2005). Literature about the integration of CAM into mainstream health care is abundant and reveals similar issues to these faced by traditional healing. There are concerns that biomedical practitioners are unable to give sound advice on CAM therapies because they lack knowledge about its uses, benefits and limitations (Giordano, Boatwright, Stapleton, & Huff, 2002). This lack of understanding of CAM by physicians would have negative impacts on possibilities for establishing collaborative and integrative practices (Hollenberg & Muzzin, 2010). This is important because integration of alternative and conventional medicine may require a blending of practices, and it is often the underlying worldview of practitioners that facilitates or hinders the success of integrative efforts (Barrett, 2003).

Rongoā Māori is part of a traditional system of healing that has developed out of the cultural traditions of the Māori indigenous population of Aotearoa/New

Zealand (Jones, 2000). Rongoā Māori is described as encompassing herbal remedies, physical therapies and spiritual healing (Ahuriri-Driscoll, Baker, Hepi, & Hudson, 2009; McGowan, 2000; Mcleod, 1999). This involves the use of Māori cultural values on health such those advocated by the Whare Tapa Wha (four sides of a house) Māori model of health. This encompasses the taha hinengaro (mental), taha tinana (physical), taha wairua (spiritual), taha whānau (family) (Durie, 1998). An additional factor of Māori health that is important in rongoā Māori healing is a connection with whenua (land), and Māori healers seek to provide a holistic healing treatment to address these factors of Māori health (Mark, 2008). However, McGowan (2000) maintains that the power of rongoā Māori is healing through taha wairua, reflecting the importance of spirituality to the Māori worldview (Valentine, 2009).

Rongoā Māori was once the exclusive domain of tohunga (traditional Māori priest) only, people who were specifically chosen for the role. Tohunga held prestigious positions in Māori society and helped to maintain the lawful and spiritual upkeep of Māori society. However, the Tohunga Suppression Act enacted in 1907 was intended by the government of the time to base health care solely on biomedical concepts and methods, and to restrict healing activities of tohunga (Durie, 1998). Although the Tohunga Suppression Act weakened confidence in Māori healing, tohunga represented a link with the past. With the authority of tradition behind them, Māori continued to consult with tohunga despite their practices being driven underground (Lange, 1999).

Tohunga are now rare and the status of Māori healers has changed to being a secondary and alternative form of health treatment in Māori society, with the biomedical system now providing the main form of health treatment for Māori (Durie, 2001). Māori healers today may not be specifically chosen or trained in the same

way as tohunga in traditional Māori life. Rongoā Māori classes are now taught at universities in Aotearoa/New Zealand and healers are often taught Māori medicine from within their families (Kominik, 1993; Tipene-Leach, 1994; Tito, 2007). The reduced status of Māori healers, now an optional form of health treatment, is one likely effect of the Tohunga Suppression Act. Despite this reduced status, Māori healers continue to practice rongoā Māori.

The Treaty of Waitangi is a document of agreement signed in 1840 between indigenous Māori and the Crown government of Aotearoa/New Zealand that granted Māori citizenship rights and full protection of their interests and status (Waitangi Tribunal, 2011). The Treaty of Waitangi is significant for rongoā Māori because it grants Māori the right to their own perspectives of health, the right to engage in their cultural traditions, and therefore the right to protect rongoā Māori is an obligation to be upheld by the Crown government of Aotearoa/New Zealand (Jones, 2000). The renewed focus on rongoā Māori can be seen as part of a worldwide agenda for indigenous efforts at decolonisation and to legitimise traditional knowledge and healing systems (Jones, 2000).

Research with tauīwi (non-Māori/European) general practitioners (GPs) has shown that most acknowledged their ignorance of traditional Māori health practices and regarded rongoā Māori with tolerance, as either harmless or of limited efficacy (McCreanor & Nairn, 2002). Although these GPs could name a few remedies or practices from Māori tradition, they felt that acquiring such knowledge was neither their responsibility nor in their interest (McCreanor & Nairn, 2002). In another study, Māori GPs were questioned about their patients' use of traditional healers' services and traditional forms of medicine. These practitioners understood the use of traditional Māori healing to be on the

increase and as able to be used in association with orthodox medicine (Jones, 2000). However there was very little interaction between healers and doctors, with referrals between the two types of service being the exception. These Māori GPs also concluded that the development of this partnership would be beneficial for both healers and patients (Jones, 2000). In further research, Sporle (1994) argued that many patients may find it difficult to reveal to GPs that they also use rongoā Māori, and that it would be beneficial for GPs to check on this to assess for possible interactions and side effects (Sporle, 1994). In light of all this, more interaction between the two types of practitioners could be beneficial for both their practice and their patients. This paper seeks to understand the possible linkages between these two forms of practices from the perspective of traditional Māori healers.

#### **Methods**

Seventeen rongoā Māori healers, with experience in the use of traditional rongoā Māori healing practices, were approached to participate. Healers were recruited through snowballing techniques through friends and family networks of the first author. Healers were located in a range of locations, from Auckland to Christchurch. Six were male and eleven were female, with ages ranging from 43 to 76 years. Ethical approval for the research was gained through the Massey University Human Ethics Committee. Semi-structured interviews were conducted with the healers, and aimed to encourage responses in storytelling form. Stories are an intrinsic part of Māori culture, providing multiple ways of sharing knowledge through mythology, history and nature (Metge, 1995; O'Connor & Macfarlane, 2002). Data were analysed using narrative inquiry techniques that allowed for an in-depth analysis of the identification of relevant themes and the healers' views. This began by examining the detailed stories of participants, both seeking to emphasise the content and meaning of their

stories, and to discover the themes that unify stories as well as differing perspectives between them (Josselson, 2011). This paper presents a specific analysis of these stories, focused on providing an account of the healers' views on cooperation between healers and doctors.

#### **Findings and Discussion**

When we examined the data, we were surprised to find that healers focused on the concept of cooperation, rather than separation or integration. However, healers' views on cooperation were mixed with some supporting cooperation and others resisting it. Findings are presented separately for these differing perspectives, illustrating how support and resistance respectively were achieved.

##### *Promoting Cooperation*

Arguments that supported cooperation held that medical practitioners and traditional healers could work together. Healers argued that cooperation could work and may be possible, even though healing processes involve different forms of health care, they may be able to work effectively side by side in a parallel manner. For example, Aroha stated:

I believe the future of health is where you have a clinical doctor with all that scientific and academic area with a healer or tohunga working together side-by-side. Um, you know, that is the future for me, of health and it's exciting...

The benefits of cooperation between traditional healers and health professionals are that this could lead to co-management of health (Calvet et al., 2008), the provision of culturally competent care, where traditional healing practices are respected (Broome & Broome, 2007), and create greater client adherence to combined health treatments (Courtright, 2009). As one healer stated, rongoā and conventional medicine are complementary, and could work out of the

same hospital or from the same marae (Māori meeting place), with a doctor and a rongoā healer functioning in a cooperative, side-by-side relationship, and each having access to the other. Perhaps if these benefits were advocated to both rongoā healers and GPs, then mutual professional respect would be fostered, and the complementary nature of the two systems encouraged (Al-Krenawi & Graham, 1999). Advocating the complementary, rather than the competitive, nature of traditional healing and mainstream medicine would promote a cooperative environment for health care. Jones (2000) found a positive reaction from Māori stakeholders to the idea of incorporating traditional Māori healing into primary health care, although the suggestion there was for rongoā Māori to be situated within a Māori primary health organisation rather than for client collaboration between healers and doctors. The healers in this study supported cooperation, and indicated a desire to see the provision of health treatment that encompasses the best of both worlds, with both indigenous and medical practitioners working together to provide health treatments in parallel to patients.

#### *Resisting Cooperation*

Other healers voiced a range of resistances to cooperation. They cited experiences where referral of patients to health professionals was not reciprocated, and where GPs had rejected their forms of treatment and training. These healers also argued that the health system was not a suitable site for rongoā Māori practice.

The tension between doctors and healers is shown when reciprocation of patient referral is non-existent, and especially when this is due to a lack of respect for professional boundaries impacting on patient management. Healers stated that they would refer patients to medical doctors, but that their referrals are typically not reciprocated. It appears that this is because medical practitioners often do not respect the

knowledge or healing methods of traditional healers and are not willing to share information or be open to learning from rongoā practitioners (Dagher & Ross, 2004; Ross, 2007). The practices of the two systems were perceived as incompatible because of healers' concerns about rejection of their healing treatments. As Kororia recounted:

So you see, that was really, you know, heart breaking to see. You know when you work and ... he was getting better. And what happened, he stubbed his toe and his blood got infected and he went to the doctor and he said, oh, that I been doing it [*treating this person with rongoā*] and he was stopped from seeing me. So ... I said, well that's me, I'm out of here. Can't work with the doctors 'cause they don't work with me. They want it their way.

This dismissal of healers' indigenous knowledge by the biomedical professionals may arise because this knowledge and training was not acquired in a recognised academic institution. However, indigenous healers do go through a rigorous apprenticeship with a practicing healer, a process that is overlooked by health professionals (Marks, 2006). Rongoā Māori is also now taught in universities in Aotearoa/ New Zealand which may assist in gaining legitimacy for the training of Māori healers. However, it is unlikely that this would be recognised as a parallel qualification with medical training by medical practitioners. Janes (1999) argues that the professionalisation of indigenous healers may be necessary to maintain the integrity of the medical system, but also that integration of biomedical and traditional medicine should not minimise traditional identities, and reduce traditional healers into poorly-qualified health workers in the biomedical system. Rather, professionalisation would ideally result in a reconciliation of the two health

care systems with mutual respect for differing values (Gessler, Msuya, Nkunya, Schar, Heinrich, & Tanner, 1995). The alternative indigenous process of training healers would need to be respected by medical practitioners in order to ensure that traditional healers are not submitted to professionalisation standards dictated solely by biomedical systems.

Healers also raised fears that the mainstream health system could not maintain the integrity of rongoā Māori. Traditional healers may be reluctant to seek cooperation due to fears of threats to their cultural heritage that may force them into a subordinate role with loss of independence. They may prefer to see a dual system of medicine promoted rather than an integrated system (Ramesh & Hyma, 1981). Therefore, it becomes particularly important to consider the challenge to indigenous medicine around whether indigenous cultural values and beliefs can be maintained in healing while at the same time incorporating medical concepts of health treatment and practices (Janes, 1999). In relation to this, Native American Elders felt it would be best not to transform Native American traditional medicine into a biomedical model by reducing it to the moment of interaction between healer and individual and to a 'treatment' (Hill, 2003). They believed that protection of the spiritual foundation of traditional medicine as an on-going healing journey for individuals was paramount (Hill, 2003). In our study, some healers felt that the only way the cultural integrity of rongoā Māori could be maintained is by keeping it out of the public health system. For example, Atawhai said:

Actually, doesn't belong, no it doesn't actually belong in public health system. It actually belongs back with our people so our people can have autonomy to give it back and give it the, the mana (prestige), integrity that it so deserves. Yeah, because I don't believe actually that the public

health have got a, a philosophy of hiha which is honesty, integrity and honouring the kaupapa (philosophy) as well as appreciating us as Māori. What I do believe is that those who take our kaupapa or, or be um, engaged in our kaupapa is for their own means. Which doesn't serve the purpose of rongoā Māori.

The danger of integration is that it may seek to promote subjugation of indigenous values. Consequently, indigenous healers challenge notions of integration because indigenous healing will not maintain its integrity. This group of healers largely resisted cooperation between the two systems and argued for some degree of separation between the two. These viewpoints indicate considerable difficulties in establishing any cooperation between rongoā healers and mainstream health professionals. However, healers also voiced a willingness to cooperate with medical health professionals, as long as that does not reduce the cultural integrity of rongoā Māori. Protective mechanisms against cultural integration, or loss, of indigenous healing into biomedicine are vital.

#### **Towards Cooperation**

These findings demonstrate mixed views on cooperation. Similar findings were documented in this study with Black South African healers (Dagher & Ross, 2004). In this study, some healers were open to learning concepts from medical treatment and had experienced some collaboration with doctors over patients. However, it was also found that doctors did not acknowledge or respect the beliefs and capabilities of healers. Therefore, some healers did not believe they would be able to collaborate with doctors due to this lack of belief (Dagher & Ross, 2004). It is important to highlight that the values and practices of healers and doctors will be fundamentally different, but cooperation implies that the two systems require some

form of alignment to work on the same health issues for a patient in the same way.

One way to address these issues of cooperation and collaboration may be for doctors and healers to become better informed about the philosophies, values and practices of the others' form of treatment, as Mere proposed:

... into the future we should be able to have a Māori provider who is working alongside general practice and gathering two ways, general practice to be able to give us Māori who may require this service, which means they need training in what that may be, and secondly, rongoā Māori providers, once people are on their road to wellness, to be able to access general practice services, in whatever shape or form that may be.

This healer's quote shows a way that GPs and healers could work together by training GPs in recognising patients who may benefit from rongoā treatment. This training could be expanded to include in-depth knowledge sharing about healing and health treatment practices. Health professionals could also become informed about indigenous health care beliefs and practices, and each group of practitioners could acknowledge and learn the worldviews and practices of the other (Dagher & Ross, 2004; Madge, 1998; Parks, 2003; Ross, 2007). In particular, the importance of holistic care involving spirituality for Māori healers during rongoā healing (Mark, 2008; McGowan, 2000; Mcleod, 1999) could be shared with doctors. It may also be useful for healers to become informed about basic concepts of biomedical practice such as recognising the need for patients to be referred for biomedical treatment.

In a South African study, despite a lack of appreciation from medical practitioners, traditional healers were open to receiving

training in biomedical approaches to establish a collaborative relationship and improve patient care (Campbell-Hall, 2010). This would help to improve communication between patients and both healers and medical practitioners, who would understand the contributions of the different forms of health treatment, and be able to provide respectful and critical feedback, guidance and coordination between the systems. Physicians would then be able to participate in informed discussion with patients about alternative medicine options and allow them to seek alternatives, which would open communication between the patient and physician. Similarly, healers could understand allopathic treatments and their relation to healing treatments. Active cooperation between the two modes of treatment could occur, with practitioners referring patients between modalities. Health care facilities where the different systems coexist may facilitate greater cooperation and less fragmented patient care (Kaptchuk & Miller, 2005). This mutual and transformative process would be beneficial for both systems.

The model of pluralism described by Kaptchuk and Miller (2005) could be seen as a potential way to address Māori healers' concerns. This model calls for cooperation rather than integration between CAM and medical systems. A pluralistic approach encourages cooperation, open communication and respect between practitioners, despite the existence of honest disagreements, and preserves the integrity of each treatment system. This model tolerates epistemological differences and recognises that both allopathic medicine and CAM have potential to offer valuable treatment options for patients, while maintaining integrity for those participating, and offering improved communication and better patient choices (Kaptchuk & Miller, 2005). This could provide a framework for a mutual and transformative process by which practitioners of both rongoā Māori healing and biomedical

health care could collaborate, and provide a way to ensure that Māori healers' worldviews and practices are acknowledged and respected in a spirit of cooperation, not separation or integration. This approach emphasises the patient's freedom of choice and shows how the two systems could complement one another while allowing the integrity of each to be maintained.

Primary health care is most often delivered to Māori by doctors and therefore, the interaction between Māori healers and doctors is a key factor in health treatment for Māori who choose traditional healing alongside medical treatment. While Māori healers' views are mixed on matters of cooperation, the views of medical practitioners in Aotearoa/New Zealand about cooperation with indigenous healers are uncertain as this has not yet been researched. Further research needs to be conducted on the most effective way to promote cooperation between doctors and Māori healers. This effort may even contribute to a more cooperative approach across medical, traditional Māori healing and CAM modes of health treatment, and lead to the ideal possibility of all New Zealanders receiving the benefits of a variety of coordinated and parallel health treatment options.

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#### Glossary

<i>Māori</i>	<i>Meaning in English</i>	<i>Māori</i>	<i>Meaning in English</i>
Aotearoa	New Zealand	taha tinana	physical
hiha	honesty, integrity	taha wairua	spiritual
kaupapa	philosophy	taha whanau	family
mana	prestige	tauwiwi	non-Māori/European
marae	Māori meeting place	tohunga	traditional Māori priest
mea	way	Whare Tapa Wha	Māori model of health (Four sides of a house)
rongoā Māori	traditional Māori medicine	whenua	land
taha hinengaro	mental		

## Zimbabwean medication use in New Zealand: The role of indigenous and allopathic substances

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*Over millennia, indigenous communities have developed distinct health systems and a range of medications. Many of these traditions have been disrupted, delegitimised and changed through processes of colonisation. Changes to medicative practices also occur for groups who move from their places of origin to new countries. This article explores understandings of medications and their storage and use among 4 Zimbabwean households in New Zealand. Our findings highlight some of the ways in which allopathic medications have become acculturated as familiar objects within the everyday lives and health-related practices of these households.*

Groups throughout the world have long utilised their indigenous knowledge to assign meaning and respond to illness.

Understandings of the causes, diagnoses, and treatments of illness are social constructs that often differ across groups as reflections of shared cosmologies, narratives, values and norms (Castillo, 1997; Kleinman, 2004; Ryder, Yang, & Heini, 2002; Swartz, 1998). Culture enables people to formulate ways of treating and coming to terms with illness as a physical, social and cultural construct (Castillo, 1997; Helman, 2001; Ngubane, 1977). Of particular interest in this article is what happens to indigenous forms of knowledge regarding medications and health care when the groups who have developed their own medicative practices move from their homelands to another country; in this case from Zimbabwe to New Zealand. We consider the ways in which Western<sup>1</sup> biomedical technologies (pharmaceuticals) are embedded within daily life and kuchengetedza utano (familial healthcare practices) within four Zimbabwean migrant mhuri (households). We explore how biomedical substances are related to

householder conceptualisations of illness and medication uses (*cf.*, Swartz, 1998).

Zimbabwe lies in southern Africa and derives its name from historical stone structures, called Great Zimbabwe 'house of stones'. Zimbabwe was colonised by the British in 1890 and became independent in 1980. There are many tribal groups although the Shona and Ndebele people are the major tribes. Familial and traditional care practices are the primary means through which healthcare is conducted in Zimbabwe (Embassy of Zimbabwe, n.d.). The majority of the population live in rural areas and most of them continue to consult vanaChiremba (traditional healers) or use highly accessible and cost effective herbs for treating a range of ailments (*cf.*, Last & Chavunduka, 1986). Many believe that vanaChiremba are culturally attuned, operate within close kinship networks, build close bonds and explain illness in terms that are familiar and understandable (*cf.*, Kazembe, 2008). Traditional treatments are diverse and complex and involve some aspects of mind-body intervention and the use of animal and plant-based products (United Nations

Environment Programme, n.d.). It is not only the symptoms of the disease that are taken into account, but also psychological, sociological and mweya (spiritual) elements of patient lifeworlds (*cf.*, Waldron, this issue). The national flower of Zimbabwe, the kajongwe or *Gloriosa Superba* (Flame Lily) is a traditional medicinal plant. The tuber juice of the kajongwe is used for pain relief, to aid kurapa (healing) and to treat zvironda (bruises), colic, mudumbu (chronic ulcers) and kushaya mbereko (infertility).

Two health care and medicative traditions are in operation in Zimbabwean mhuri (households), and these reflect two differing approaches (Ross, 2010). The first is the tsika nechivanhu chedu (traditional approach) which is based on indigenous belief systems. The second is the chirunga (Western approach) which is incorporated within an allopathic medical paradigm. With the colonisation of Zimbabwe and the creation of a Westernised professional class in urban centres, negative attitudes towards indigenous medications have developed (*cf.*, Waldron, this issue). vanaChiremba (traditional healers) have been denigrated by the settler society and supplanted by Western medications and associated practices. Traditional medications were officially designated as being 'backward' and 'African medicines' (Kazembe, 2008). According to Kazembe (2008), younger generations residing in urban settings in Zimbabwe have lost contact with indigenous marapiro echivanhu (medicative practices), ruzivo (knowledge) and healthcare systems. These Zimbabweans prefer western biomedical understandings and medications. This change has its origins in colonial practices that involve the subjugation of indigenous knowledge and traditions and the legacy of successive colonial governments and missionaries who promoted the view that anything African was inferior to their own ways of responding to illness (*cf.*, Hodgetts, Drew, Sonn, Stolte, Nikora, & Curtis, 2010).

We explored New Zealand-based Zimbabwean householder understandings of medications, where these households obtain and store medications, and the cultural and familial relations that shape their use of medications. It is important to point out that whether tsika nechivanhu chedu (traditional approach) or chirunga (Western approach), medication use involves risk. Medication can be the source of unintended ill-health, particularly when substances are taken in concert, not as directed or when substances pass their used by dates (Johnson & Bootman, 1995; Lisby, Nielsen, & Mainz, 2005; McDonnell & Jacobs, 2002). Presently, we are less interested in issues of risk and more on householder understandings and uses of medications.

This is an important focus because health care reforms in many countries such as New Zealand have led to a shift in the delivery of health care away from formal places such as hospitals towards more informal domestic settings (Dyck, Kontos, Angus, & McKeever, 2005; Hodgetts, Hayward, & Stolte, unpublished). This shift transforms the home into a 'therapeutic landscape', encompassing not only practices of healing and recovery from sickness, but also those employed for the maintenance of health (Gleeson & Kearns, 2001). Medication practices, and associated understandings, form a significant component of the care practices that take place within domestic dwellings today (Hodgetts, Chamberlain et al., 2011; Hodgetts et al., unpublished). Exploring medication practices within domestic settings reveals understandings of 'proper' usage, risk, adherence, sharing and the relationship between biomedical and traditional indigenous medications (Hodgetts, Chamberlain et al., 2011; Hodgetts et al., unpublished; Sorensen, Stokes, Purdie, Woodward, & Roberts, 2006).

The cultural patterning of how medications are understood and used by different groups of people in their homes

presents an exciting new avenue for research. Nikora, Hodgetts, Carlson, and Rua (2011) illustrated how medications take on important culturally-patterned meanings for Maori householders, enabling them to manage illness and assert some agency over family healthcare in accordance with everyday Maori cultural practices. The present article explores how medications become acculturated into four Zimbabwean households in ways that shape the meanings and use of these technologies in accordance with existing cultural relationships and practices of care.

#### *The Present Study*

We took a broad ethnographic approach to capture the complexities and fluidity of the use of various forms of medications, including pharmaceuticals, herbs and dietary supplements (Hodgetts, Chamberlain et al., 2011). Data collection focused on four Zimbabwean households in Hamilton, New Zealand over a three week period in January 2011, using a variety of methods (interviews, photographs, diaries, mapping, material objects, media content) to capture the complex and fluid nature of popular understandings and use of medications.

The recruitment process began by approaching indigenous Zimbabwean households who were known to the first author. Pseudonyms were used in this research to protect privacy and to ensure confidentiality. Participants were informed that they could withdraw from the research at any time. The respondents are referred to in this research as the Sibanda, Rugare, Gumbo and Moyo households. The Sibanda household is comprised of four members and these include Themba a male aged 48 who is married to Ruth aged 38. The couple has two sons Rob (16) and Jack (12). The Rugare household is made up of four members who immigrated to New Zealand four years ago. Joe (43) is male and is married to Ann (39). They have two children, a girl, Rungano (17), and a boy, Tim (13). The Gumbo

family includes Mark (42) who is married to Edith (34). The couple have two children, a boy, Tongai (15) and a girl, Thembe (6). The Moyo family is comprised of two adults and three young children. Matt (42) is married to Sue (34) and they have two boys whose names are Simba (12) and Jeff (2). Molly (7) is the only girl in the family. These households contain professionals who grew up in urban areas in Zimbabwe and had jobs which enabled them to choose to access a chirunga (Western style) medical aid scheme, but who were often dislocated from tsika nechivanhu chedu (traditional systems).

The research process was carried out in four stages over a two week period: pre-data collection, initial household discussions, tasks and individual interviews and the exit interview (see Hodgetts, Chamberlain et al., 2011). All recorded research interactions were conducted in Zimbabwean and later translated into English by the first author. Contact was made frequently either through telephone calls, household visits or mobile phone texting. In the pre-data collection stage the four households were introduced separately to the research. Participants were given the option to consider the various forms of medications they consumed. During the initial household discussion stage a general conversation about medications, their meanings and uses took place. Maps were drawn of each house that illustrated the specific places where medications were normally stored. The third stage required that data be gathered by one member of each of the participating households using diaries and photographs. Participants diarised their daily encounters with medications whether within or outside of the home, workplace or through media. They also photographed medications, their storage areas and anything that they felt was relevant to the study. Each interview took approximately 50 minutes. Diary entries, photographs and the maps were used during interviews to discuss their entries, images, thoughts and reflections. In the final stage,

exit interviews were conducted. Participants reflected on the research and were asked to give any other comments which they thought may not have been discussed in the original interviews. Throughout the process, the first author took notes reflecting the nature of the discussions and emerging themes.

The analysis involved a number of steps including transforming, coding, collating, determining and organising empirical materials. We concentrated on exploring the socio-cultural life of medications and how these substances were integrated into home life, often taking on taken-for-granted status as things that belonged and which were implicated in personal histories of illness. The analysis also looked at the use and placement of medications within caregiving relationships. The main themes identified through the research were the acculturation of chirunga medications into the existing patterning of everyday household life; and the sourcing, storage and safe use of medications in the home.

*Combining Chirunga (Western) and Tsika Nechivanhu Chedu (Traditional) Traditions in the Home*

These households occupy a hybridised domestic space for care in which categories of knowledge are not mutually exclusive and are in actuality churned up together in the daily reproduction of cultural life (*cf.*, Blok & Jensen, 2011). Having come from middle-class and urbanised backgrounds in Zimbabwe, all four households are familiar with the biomedical pharmaceuticals that are in common use in Zimbabwean cities. They are also aware of their own indigenous traditions, but these no longer hold centre stage. The householders reported using traditional medicines when these substances are available. It is difficult to obtain these substances in New Zealand.

In defining medications, participants invoked both chirunga (Western) and tsika nechivanhu chedu (traditional) approaches. For example, Edith gave her own definition of

what she thinks medication is:

Medication is any drugs, according to my understanding, that gets given to me or prescribed by a doctor for the conditions I would be requiring the medications for. But as Zimbabweans we also have our own traditional medications, which we do not have here in New Zealand, but back home we could definitely choose either to go to a medical doctor or a traditional doctor or even to faith healers.

Edith goes on to reflect on the influence of chirunga medications over indigenous medication practices and their origins for many Zimbabweans. One reason given for the use of allopathic medications is that they are familiar internationally and can be accessed in different countries; thus providing continuity in caregiving practices across nation states. Further, householders recognise that such medications draw on and incorporate substances from indigenous traditions. This means that allopathic medications are seen as an extension of traditional knowledge and practices, rather than as a totally separate tradition. Chirunga medications have become part of the cultural landscape as medicinal objects within these Zimbabwean households.

Factors such as accessibility, affordability and trust influence family choices regarding chirunga and tsika nechivanhu chedu medications. Choosing between chirunga and tsika nechivanhu chedu medications depends on a number of factors including the cost of each type of treatment, accessibility, and knowledge of the probable effects of different treatments (Kazembe, 2008). In New Zealand, allopathic medications are cheaper and easily available. The Moyo family felt that availability and affordability of medications in New Zealand made it easier to respond to illness than when

they lived in Zimbabwe:

Ann: Medication is expensive in Zimbabwe because of the dollar issue and some people cannot afford to buy them. Even if you go to the public hospital they might not have certain drugs because they are expensive for those public hospitals to have medicines in stock. So at times you will find that you might not get the medications because of that. And if you compare with New Zealand, I think the medications are always available. Medications in New Zealand are subsidised so anyone can buy the medications unlike in Zimbabwe where they are not subsidised and it's expensive and they cannot afford most of the medications.

Both over the counter and prescribed allopathic medications were not easily obtainable in Zimbabwe. Costs were very prohibitive for those who depended on chirunga medications.

Chirunga (Western) substances were brought into households and enculturated into an existing system of relations and customs. In this way, biomedical substances became Zimbabwean cultural objects through which relationships of care and responses to illness were manifest. The taken-for-granted use of allopathic pharmaceuticals in these households was reflected in the casual snapshots of medications. Figure 1 shows chirunga medications that were in the household at the time of the research. Discussing this image sparked the following account, which reflects the taken-for-granted nature of engagements of these households with the chirunga approach in New Zealand.

Joe: I go to the doctor or if it is something minor, I go and buy the medication over the counter, say if it is a headache... I will go and get it in the supermarket. If I have a headache and I take Panadol and there seems to be no change, there might be an underlying problem so I have to visit the doctor... I wouldn't say I



Figure 1: Joe's photograph of Panadol

am doing away with traditional medications because back home I didn't visit traditional healers.

Only when the elders would give me a few herbs and I would be treated. So my first port of call is the doctors.

The routine use of allopathic medications is associated with familiarity and perceptions of scientific proof of safety. After taking medications for a period of time, people become familiar with the effects of medications on their bodies, what works and what has side effects (McClellan & Shaw, 2005). New substances and those who administer these become acculturated into daily responses to illness and to some extent relied upon for a trusted effect. As Edith stated:

I trust the medication given to me by the doctor. Because that is something that I have grown up knowing that it is there. I trust it more than the new things that I have heard of. The doctors offer services that have been proved scientifically unlike our traditional medications that some people use.

These householders were not totally convinced about the safe use of tsika nechivanhu chedu (traditional) medications. Although they continue using tsika nechivanhu chedu medications in their homes, they relied primarily on chirunga (Western) medications.

It would be misleading to infer that issues of scientific proof for effectiveness and safety are rigid points of comparison or that, in fact, these householders compare chirunga and tsika nechivanhu chedu medications in a dualistic manner. For example, Ruth gave a summary of how she viewed key differences between chirunga and tsika nechivanhu chedu approaches to treatment, which contextualise the use of medications associated with each tradition. In the process, such participants

invoke nuances and complexities around dualistic distinctions between chirunga and tsika nechivanhu chedu health systems:

Medical doctors are able to treat broken limbs. I could have surgery performed on me and be given a diagnosis of the problem. They have equipment like x-ray machinery to carry out extensive examinations on their patients and come up with an informed diagnosis. Traditional healers lack such machinery and cannot tell what is wrong with my liver for example. I am sure that they may be good at treating spiritual problems. They look at the person as a whole and have interest in a person's family or the environment surrounding the patient. Medical doctors might not be interested in all that stuff. I like them because they use scientifically proven methods of treatment and there is no guess work.

It appears that a pragmatic approach to using medications from different cultural traditions is in operation in these households. Daily medications use transcends the dualism between biomedical and traditional indigenous knowledge and substances (*cf.*, Blok & Jensen, 2011). For the householders biomedical and indigenous medications have different, yet complimentary functions. Householders proposed that the emphasis chirunga (Western) trained doctors place on treating malfunctioning parts of the body was in many respects compatible with the emphasis vanaChiremaba (traditional healers) placed on treating the whole person, including spirit aspects.

Householders were aware that biomedical constructions<sup>2</sup> present disease as a form of biological malfunction manifesting in chemical and physiological changes within the physical body (Ross, 2010). In a pure

form, the biomedical approach looks at isolated disease agents and attempts to change and control them. The approach is based in the Cartesian separation of mind and body, and separates physical illness from psychological illness (Hodgetts et al., 2010). Strictly speaking, spiritual illness does not exist according to the biomedical approach. Our participants do not accept such a rigid understanding of disease. They recognise the benefits of biomedical science where doctors used diagnostic tools like x-ray machines which helped them make informed diagnoses and prescriptions for medications. Whilst drawing on effective medications from this tradition, our participants preserved a more traditional emphasis on people that does not rely on the mind and body dualism. Emphasis is placed on looking at relationships surrounding patients. In a similar vein, Ross (2010) proposes that mind, body and spirit are part of a larger whole and no distinction is made between physical and psychosocial problems within traditional methods of healing that seek to alleviate physical symptoms and reintegrate the person with his or her community, the earth and the spirit world. This reflects writing on the development of African centred psychologies and medicine that draw on knowledge systems developed over millennia and which focus on interpersonal relations, mind, body and spirit as part of a coherent whole (see Ngubane, 1977; Waldron, this issue). It also reflects how colonial and indigenous knowledge can become interwoven within daily life.

#### *Storing and Using Medications in the Home*

Despite the broader societal context in New Zealand reaffirming the use of Chirunga (Western) medications, these households also maintained their unique way of life, daily routines and broader indigenous understanding of illness and care. An important element of this research was to consider what happens to chirunga medications once they are brought into such

culturally-patterned domestic settings. For example, where are medications stored, who administers these substances and how do these practices relate to indigenous assumptions and practices?

Women were the key dispensers of medications and regulated storage and access for the family. Ann keeps medications considered hygienic to be stored with food in the kitchen pantry because they were easily accessible and whenever she is in the kitchen she is always reminded to take them. She does the cooking and prepares her food there. Placement of medications in certain areas was done to aid all participants in remembering to take medications herself or to administer these to family members. Edith also recounted such considerations when she discussed the storage of medications in the refrigerator:

I put them in there (Figure 2) to remind myself that I have to take my medication. They are easily reachable so that if anyone is sick they can reach them. I don't keep medication in the pantry because the hot water cylinder is in the pantry. It is hot in the pantry and can alter the medication because of the heat. The kitchen cupboard is also a cooler place and that is what the medication instructions say, to be stored in a cool place. If I keep the medication in the bedroom I might forget to take them.

Our participants emphasised the need to keep the medications away from any hot spots within the home as heat could have an effect on the medications, and to store medications under certain conditions prescribed by her chirunga (Western) trained doctor. The storage and consumption of medications is implicated in the patterning of the households (Nikora et al., 2011). For example, bathrooms and bedrooms are common places where



orally-consumed medications are stored. This marks a separation between bodily functions and food consumption.

The storage of medications appears to be influenced by many factors, including their accessibility to different family members, cultural assumptions regarding hygiene and the need to remember to consume these substances and to administer them to other householders (*cf.*, Nikora et al., 2011). Medications that were ingested were stored and consumed in food eating spaces, which included kitchens and dining rooms. Externally applied and inserted medications are kept away from eating places. The exception is medications like insulin which needed to be refrigerated. Such medications are retrieved from the refrigerators and injected away from food eating places.

Most medications were administered before or after meals. Meal times functioned as reminder moments and instances when parents enact parental responsibilities, including the regulation of familial medication use. Figure 3 depicts the cultural patterning of such mundane occasions in everyday household life. During meals the

family in the picture adopt particular seating arrangements where males sit on the couch whereas females sat on the floor. The youngest in the family, Tim (13) is male, yet he is elevated to the same status as that of his father. Culturally, Tim represents his father in any family related matters in the event of his father's absence. On such occasions, parents act as mediators in their children's relationships with medical professionals, as 'prescribers' of substances, and how they supervise their children's treatment and ensure compliance with and changes to medication regimens (*cf.*, Hodgetts et al., unpublished).

Sharing medications during such communal occasions is a feature of household life today that allows family members to demonstrate care for one another and to tackle the issue of sickness together (*cf.*, Hodgetts, Chamberlain et al., 2011; Hodgetts, Nikora, & Rua, 2011). Panadol and paracetamol, as well as tsika nechivanhu chedu (traditional) medications were shared among family members. These householders were reluctant to experiment with the use of medications in familial relationships in a



Figure 2. Edith's medications stored in the refrigerator.



Figure 3. Rugare family sharing their dinner.

manner evident in the household practices identified as occurring within other cultural groups (Hodgetts, Nikora et al., 2011). As Themba states:

...unless it's been advised by the doctor. Medications like paracetamol which are just plain painkillers yes but not specific medications. After assessing you the doctor gives you maybe an antibiotic. It doesn't mean that if I have say, tonsillitis, and the doctor gives me a particular antibiotic and my wife contracts tonsillitis and she also goes to consult a doctor, it doesn't necessarily mean she'll get the same antibiotic that I was given. So for that reason, wisdom will tell us no, you go and get your own. Chances are you might be given the same, chances we will get it in different doses, so we don't share, we don't unless it's over the counter medication like paracetamol where you just walk

in and buy it.

All households were conscious of the need to adhere to a chirunga (Western) trained doctor's advice when taking prescription medications in order to ensure each family member's safety. Medications that were obtained over the counter without a prescription were considered safe to share. Through sharing these medications social relationships among the Zimbabwean households were sustained and nurtured. Culturally, parents as custodians of their children had the responsibility of sourcing medications from various places including from doctors, pharmacies and supermarkets (cf., Hodgetts et al., unpublished). The administration and safety matters of medications remained in the hands of the parents.

### Discussion

Zimbabwean migration to New Zealand involves the movement of not only physical selves, but also the knowledge of groups regarding illness, treatment and care. Such movements raise questions surrounding the continuation of indigenous Zimbabwean

health-related knowledge and practices in a new place. We have begun to explore familial understandings of and socio-cultural practices surrounding the use of medications in everyday lives of four Zimbabwean households. As a key location for care, the home spaces plays an important role for maintaining each family's health as the main place where medications are stored, administered and used (Sorensen et al., 2006). In this place, the use of medication occurs within the context of householder efforts to respond to and manage illness, and to preserve their familial relationships and cultural traditions (Hodgetts, Chamberlain et al., 2011; Hodgetts et al., unpublished). Through taking or giving others medications, people demonstrate care for themselves and others close to them (Whyte, Van der Geest, & Hardon, 2002). The consumption of material objects such as medications can also reaffirm familial bonds and culturally patterned relationships of care. Zimbabweans come from a background of interdependence where sharing, unity, respect and love dominate much of their lives. In the event that any member of their family or immediate family falls sick, they are there to support each other by sourcing a cure and making sure that the member takes the medication as prescribed by a doctor.

Within these households, medications are embedded in complex cultural, familial, social and health care relations. Householders view medications from a culturally hybridised standpoint encompassing both tsika nechivanhu chedu (traditional) and chirungu (Western) perspectives (Blok & Jensen, 2011). Although these Zimbabwean participants emphasised their use of chirungu (Western) medications in their day-to-day lives in New Zealand, these substances were transformed socially into cultural objects through their use in daily household life, particularly in parental responsibilities to care (*cf.*, Hodgetts et al., unpublished). Both tsika nechivanhu chedu (traditional) and chirungu

medicines provided a meaningful way for families to achieve treatment objectives in daily life and the exertion of control over illness (*cf.*, Leontowitsch, Higgs, Stevenson, & Jones, 2010).

This study has raised more questions than it has answered. We have only scratched the surface in relation to the use of chirungu medications among this indigenous group and how the presence of different cultural traditions of healthcare are integrated within everyday life in their domestic dwellings. Future research needs to contribute to the development of an indigenous Zimbabwean psychology, within the context of recent work on African indigenous psychologies (Waldron, this issue). The development of such psychologies is crucial to address the continued marginalisation of African knowledge within our discipline and the privileging of Anglo-American traditions as normative and somehow culturally free. Concepts and psychologies germane to particular groups are invaluable in understanding their healthcare practices and use of both tsika nechivanhu chedu and chirungu medicines. This article comprises a tentative contribution to this broader agenda of indigenising and pluralising psychology.

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**Notes**

<sup>1</sup> We are aware of the problematic and homogenising nature of the term 'Western'. We use this term to denote developed and European dominated societies, including those in the global south. At the same time it is important to acknowledge diversity within and across European cultures.

<sup>2</sup> We acknowledge that Western medicine contains a range of biomedical, social medicine, population health and complimentary approaches. We are reiterating a distinction our participants made between the biomedical approach and their indigenous approach.

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## Maori children and death: Views from parents

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*Research about Maori children's experiences and perceptions of death and tangi (Maori death rituals) is sparse. What is available tends to be generalised and stems from Western paradigms of knowledge. In this study we explore Maori children's experiences of death and tangi through the eyes of Maori parents. Through semi-structured interviews with 17 Maori parents, five areas were explored: a) the childhood experiences of parents and how they learned about death and an afterlife; b) what their adult beliefs about these matters are; c) how they have communicated the death concept to their children; and d) whether their children are likely to do the same in the future. From this study we learn that death was not hidden from children, that parents talked with their children in very open and age relevant ways, and considered their children's participation in tangi an important way to grieve and ensure continuity with kinship networks and support. This study suggests that the challenge now is to ensure that these practices continue to persist between parents and their children, and future generations.*

In this paper we report our study of how children come to know of and understand death. In presenting this work, we realise that we write about kinship relationships, bereavement and death rituals in a general and perhaps idealised way that for many may not fully capture the range, complexity and depth of emotion that one may feel in response to a death. There is simply not enough space to explore these exciting and critical aspects of the field. Nonetheless, we are ever mindful of different ways of being together and that the nature of kinship relationships, functional and dysfunctional, may well lead to different and sometimes unanticipated bereavement experiences and outcomes. With this limitation in mind, we begin this paper with a review of the literature that informs our thinking in the field.

Most children will experience grief and bereavement in their lifetime when someone close to them dies. Some will mourn the death of a parent, a sibling or grandparent and grieve for the loss of that relationship (Dyregrov, 1991; Heaney, 2004). They have lost the love and security that was given by their parent; they have lost a friend, a playmate, a rival sibling and

family member (Gill-White, 2006; Parker, 2003). Children can find the death of a loved one difficult, overwhelming and at times traumatising (Rosner, Cruse & Hagl, 2010). Nevertheless, explaining and helping children understand the concept of death can significantly reduce fear, anxiety and other emotional or behavioural responses associated with anticipating or mourning the death of a loved one (Turner, 2006).

How children understand and conceptualise and respond to death varies from culture to culture (Rosenblatt, 1997). Some theorists suggest that children cannot acquire a mature understanding of death until they have a basic understanding of certain foundational concepts (Feifel, 1977; Kane, 1979; Lansdown & Benjamin, 1984; Nagy, 1948; Speece & Brent, 1992). These include the notions of *universality*, *irreversibility*, *non-functionality* and *causality* (Cuddy-Casey & Orvaschel, 1997). *Universality* refers to the fact that eventually every living thing is destined to die and it cannot be avoided. *Irreversibility* is about death being irreversible. *Non-functionality* implies that the deceased person is no longer

living and life is non-existent. The concept of *causality* involves understanding the possible causes and circumstances of how the death occurred.

On from the need to understand these conceptual ideas, Piaget (1960) and many researchers after him (e.g., Childers & Wimmer, 1971; Ellis & Stump, 2000; Kane, 1979; Lansdown & Benjamin, 1984; Nagy, 1948; Speece & Brent, 1992; Wenestam & Wass, 1987) argued that children's thoughts and reasoning develop gradually over time and as a function of age. For example, up until about five years of age, children tended to deny death (Nagy, 1948); up until about 9 years of age, children tended to personify death (e.g., the bogey man), and beyond that age, children realise that death is final and universal (Lansdown & Benjamin, 1984). Though these studies showed parallels with Piaget's theory of cognition, findings also show that children can understand and comprehend death at a young age if they are exposed to it.

In New Zealand children are exposed to numerous accounts associated with dying and death. Death is taught as part of the schooling curriculum, it is portrayed in art, music, literature, observed in television shows and news media reporting and engaged through electronic gaming. Children see animals that are dead on the road or brought in by the family pet; they hear about death in fairy tales and/or act it out when playing imaginary games (Heaney, 2004). In contrast to New Zealand's relatively peaceful environment, children in less settled societies are often exposed to the raw reality of death much earlier because of war, civil conflict, sickness or natural disasters (Marten, 2002). In countries with high mortality rates, children are more likely to learn about real, rather than imagined death, much earlier in life.

In cultures of European origin including Pakeha New Zealanders, parents and adults have often avoided talking about the death of a loved one with children with some finding it an extremely difficult task (Granot, 2005). Some suppress their own emotions and feelings in the

presence of children to shelter them from the pain, hurt and anxiety associated with the grief of losing a loved one (Granot, 2005; Smith, 1999). Parent's grief reactions, like anger, shock and crying, are often concealed and hidden from children, for example, through prohibiting children from attending funerals (Drewery & Bird, 2004) or visiting dying family members (Dyregrov & Yule, 2008; Granot, 2005). Children come to learn that powerful emotions should be withheld and not expressed (Smith, 1999), in turn developing a disposition that may extend into adulthood, where adults may continue to struggle to express and regulate their emotions (Dyregrov & Yule, 2008; Granot, 2005).

Token (2003) suggests that when questions are left unanswered or there is an absence of information about the death of a loved one, or delays in receiving it, it can lead children to make up their own stories about what happened, allowing fantasies of the imagination and magical thinking to play upon their mind. While there may be more, Dyregrov and Yule (2008) have, rather simplistically, identified two ways that children understand death. The first is the truth which is constructed from the information they have received about it; the second version is a construct of the child's own fantasies that does not necessarily represent reality. When children begin to believe their own fantasies, rather than accepting that someone close to them has died, their perspective can become distorted as to what is the truth (Granot, 2005; Smith, 1999). The two kinds of 'truths' identified by Dyregrov and Yule (2008) help us to understand the possible imaginings of children, but denies the possibility that death for children, as it is for adults, may well have multiple narratives that may all contribute to an overall truth narrative. None of the narratives are necessarily wrong, but some may well be more privileged than others. This way of thinking provides space for the possible coexistence of the factual and fantastical truths.

Too often bereaved children have been put to one side and left to cope with their grief

alone. As a result, many are deprived of the opportunity to grieve the loss (Heaney, 2004). Adults who have experienced grief in childhood report that the failure of their parent or other adult to include them in the mourning process contributed to their increased difficulty in coping with grief (Granot, 2005). Studies have found that unresolved childhood grief, combined with their perceived loss, contributes to the development of adult psychopathology and impairment in interpersonal adult relationships (Edmans & Marcellino-Boisvert, 2002; Mireault & Bond, 1992).

Cultural and religious explanations often address themes of death and/or questions of an afterlife. Both constructs frequently help adults to explain difficult questions asked by children after the loss a loved one. These beliefs provide comfort for children, much like they do for adults (Cuddy-Casey et al., 1995; Granot, 2005). Children absorb the beliefs and culture they are raised in and are readily accepting of the answers provided to them concerning death (Fiorini & Mullen, 2006). For Maori, the indigenous people of New Zealand, traditions and cultural beliefs mingle closely with Christian ideologies (Salmond, 1976). Though many Maori have converted to Christianity many often still retain and pursue Maori cultural practices that to an outsider may look somewhat contradictory. This apparent contradiction is consistent with what Ritchie (1992) terms 'both/and' logic; the Maori world and its cosmological beliefs sitting in a complimentary way with that of Christianity (Salmond, 1976). According to Rosenblatt (1997) the blending of cultural traditions with religion is not unusual, in fact, there are many instances where people seek guidance, comfort and understanding from both sources.

While the literature points to the presence of children and their involvement during tangi (e.g., Dansey, 1992) there is no comprehensive examination of their thoughts and responses to death, or how Maori parents or adults talk to Maori children about death. Nikora et al. (2010, p. 401) noted that "...there is no definitive

historical or contemporary published account of tangi and the Māori experience of death, which captures its fluidity, transformation and effect". Regardless of this, there is some agreement across the literature of the general pattern that constitutes a Maori ritual response to death. Nikora et al. (2010) summarise the arising pattern as follows:

Death takes place; sometimes the ceremony of *tuku wairua* or sending the spirit on occurs. Family and friends are alerted and if required there is an autopsy. The deceased is prepared by an undertaker, often with assistance from family members. He or she then proceeds to the *marae* [tribal meeting place] sometimes via the family home, for viewing, mourning, remembering and celebrating. *Marae* rituals are enacted over a few hours or a few days before burial and associated rites or cremation. They include the performative elements of *powhiri* (rituals of encounter), *tangi* (mourning), *whaikorero* (oratory), *haka* (posture dances), *waiata* (dirges), *whakapapa* (recitation of genealogy), *poroporoaki* (speeches of farewell) and *karakia* (prayer). These proceedings are enhanced by the display of significant artefacts that ... adorn the casket. Portraits of deceased relatives are exhibited. Closing the casket generally occurs before the final church or memorial service. *Takahi whare*, or the ritual cleansing of the deceased's house, usually follows internment. *Hakari* (feasting) completes the process; this releases the family to everyday life. (p. 401)

The institution of tangi is a persistent cultural practice that has largely resisted the ravages of colonisation and remains deeply embedded within Maori communities. As the authors are constantly involved in the Maori



world, we know that children are present at tangi, are exposed to tupapaku or the deceased, and that they engage their peer group and adults in conversations about death. This study seeks to document and explore the communication of the death concept between Maori parents and children. Specifically, we examine: a) the childhood experiences of parents and how they learned about death and an afterlife; b) what their adult beliefs about these matters are; c) how they have communicated the death concept to their children; and d) whether their children are likely to do the same in the future.

### **Method**

Maori parents who had conversed with their children about topics relating to death and tangi were recruited to participate in this study. There were no restrictions placed on age or gender or ethnicity of partners although most had partners who identified as Maori. The sample size was determined on the basis of theoretical saturation (Bloor & Wood, 2006), that is, we continued recruiting and interviewing participants until a commonality of responses was apparent and that it was unlikely that further interviewing would give rise to any new information. The saturation point for this study was reached after interviewing 17 participants. The interviews were conducted by the first author in the second part of 2010 as part of her graduate studies, with the study receiving ethical approval from the Psychology Department's Research Committee at the University of Waikato.

Interviews with participants followed a semi structured interview schedule (available from the first author) with questions directly related to the research objectives. Participants were keen to talk about their experiences and expressed no reservations about doing so. Each interview took about an hour. They were audio recorded, transcribed, thematically analysed and summarised into a report for verification by participants. When each participant was satisfied that their report

represented their views accurately, it was added to the pool of 17 reports for overall thematic analysis. Pseudonyms were assigned to all participants in this study except those who explicitly asked for their true identities to be associated with their information.

### **Findings**

Participants in this study recalled numerous childhood memories and experiences of death and tangi. They remembered tangi as an event that drew families together to farewell a loved one and to provide support for the bereaved. Death and tangi were a part of everyday life even if it was a departure from everyday life routines. Because of this, they remembered a sense of excitement, novelty and anticipation, of being reunited with cousins and relatives they may not have seen for some time. As children, none of the participants found the presence of a tupapaku disturbing because the deceased was conceived of as someone familiar and precious. They were family members. As children, they remembered participating in the formal rituals of encounter on the marae, where they paid their respects and greeted the deceased and the bereaved, as did adults. They were expected to help with the many tasks to be completed and when proceedings were slow, they recalled finding delight and excitement and sometimes mischief with relatives of their own age. In later life and as parents, they included their own children in tangi, they exposed them to tupapaku, encouraged them to express themselves and to take part in marae activities. Participants supported being open and honest when talking to their children about death and tangi. They all believed in an afterlife, some subscribed to Christian beliefs, some to Maori cosmological beliefs, and some to both. To varying degrees they drew from these belief systems to explain death, tangi and an afterlife to their children. These themes are elaborated in the sections that follow.

*Parents Remember*

Our conversations with participants ranged across many experiences including the death of grandparents, parents, siblings and extended family or whanau members. Some deaths were sudden, sometimes accidental and unexpected, while some were preceded by illness and anticipated. When deaths were of people close to a participant, their accounts were deeply personal and moving as they remembered and relived their experiences of mourning, grief and support. All talked of their childhood memories of a grandparent, parent, sibling, cousin, uncle or aunt passing. Some remembered in detail how the news came to them through telephone calls or people visiting or through visiting others, but most memories related to going to the marae, to prepare and participate in mourning rituals, an event that was more frequent than that of close and deeply felt deaths. As Rangi mentions, attending tangi “was just part of what we did”.

Death has always been related to how we do tangi and that. Even as a child growing up it was just part of what we did. You wake up one morning and someone’s dead; someone took them (the deceased person) off somewhere; we went to the [marae] and got the [marae] ready; they came back in a casket. (Rangi)

Most participants had childhood memories of being well supported through significant bereavements by their immediate family or whanau, by their broader clan (hapu) and iwi (tribe), and by friendship and work networks lending weight to Ngata’s (2005) assertion that in times of illness and death these networks pull together and act as a source of strength and support for those bereaved. While Heeni Poutu described her experiences of tangi as a child as a break from routine and mundane daily life, her account also illustrates how children are part of the ‘pulling together’ to offer strength and

support:

I know that this may sound strange, but we thought that attending tangi was wonderful! When we were children we just loved going to tangi because we saw all our relations...Wherever we went the rest of our relations would be there, so it was a great holiday experience for us. (Heeni Poutu)

Dianne also picks up on the theme of vacation and also reinforces Rangi’s view of tangi being part of everyday life, familiarity overcoming any fears that may have been apparent:

Tangihanga, death and dying were a natural part of my childhood. It was something that we commonly did or attended...it was not something that was fearful. It was just what we did...When a tangi occurred in the family the car got packed up, everyone hopped in ... kind of like a holiday really because you knew you were going to see your cousins and your aunties. (Rangi)

At most tangi the corpse or tupakaku is presented in a casket and the immediately bereaved and close relatives keep a continuous vigil over a period of about three days while people come to pay their respects, that is, “...so that the dead may be properly farewelled, his or her virtues extolled (and, quite often, faults and failings almost brutally enumerated), the bereaved comforted, [and] the ties of relationship renewed” (Dansey, 1992 p. 110). All participants spoke of times when they touched, kissed, viewed or were in close proximity to a tupakaku as a child. No one expressed any fear, distaste or discomfort, but rather an opposite view held. Rehua told us:

I don’t know that it was scary and I suppose when I look back on it I don’t remember anyone saying to

us “Ok when you go there, there’s going to be a dead body. We didn’t view it as a dead body, that’s our whanau, somebody that we knew and loved and spent time with and we cared about...It’s an awesome experience to be able to say your final goodbyes... They’re not scary! (*Rehua*)

While the tupapaku is the object of greatest significance at a tangi, and the focus of much attention, participants also told us about the expectations and responsibilities they felt as children. At tangi, the bereaved need to be fed, as do the waves of visitors. There is food to be gathered, prepared, cooked and served, tables to be laid and dishes to be cleared and washed, beds to be made, facilities to be cleaned, the grounds of the marae kept tidied – there are a multitude of tasks. And children are expected to share in this load according to their ability, sometimes gender, interest and initiative. Ivy explains:

My number one job was doing dishes and table setting... You just go and start helping in the kitchen to see if there’s anything you can do to make things easier... We would just help out where we could... We would stay around the marae and play the number one game “Bull Rush” and catch up with cousins; but you always knew that once manuhiri turned up you were back in the kitchen setting up and getting something ready for them to eat and prepare things for the next big meal. (*Ivy*)

As Ritchie and Ritchie noted (1979), in Polynesia children are often trusted to mind other children and are responsible for each other while their parents and other adults engage in ‘adult’ activity with children being quite capable of being accountable to and for

each other. Even so, as Dianne told us, children can also get up to mischief.

We kids would skedaddle off the marae. ...we would sneak around, and do things we weren’t allowed to do... We set a mattress on fire one time and chucked it down the bank hoping it would get down to the river but it only got half way down!

As Dansey (1992) asserted, maintaining relationships with kin is significantly important for Maori, and attendance at tangi is one way these relationships are maintained. For many participants, maintaining and strengthening kinship ties primarily with their cousins while at tangi was of most importance, while maintaining other kin relationships with aunties, uncles and elders came secondary.

#### *Parents, their Children and Death*

The parents in this study were in agreement about the need to be honest and open with children about death and tangi. For them it was about allowing their children to ask questions freely, bringing their feelings out in the open as opposed to hiding them away. It was about listening and reassuring children, and letting them know that their parents were there for them:

I believe in open communication and being honest with my children and letting them see things for what they really are and not disguising it or making things look pretty or giving them a false sense of reality. Our children learn a lot better when it’s all open and I believe that’s how I’ve communicated with them. (*Dianne*)

We speak to them about it all the time. I share with them the same things that I was told when I was a kid, as much as I can remember. I wouldn’t say that we are blunt and brutal, we just tell it

as it is. For example, what's happened and what we think is going to happen next... (Sam)

This openness and lack of inhibition about talking of death with children and their inclusion at tangi and exposure to tupapaku supports children to come to know that death is an irreversible condition and that the cultural-emotional response is one of sadness. Sam told us about how his young children reacted when, on the death of his mother, they returned to the family home to visit with her and their extended family before she was removed to the funeral home.

Both of them were really shocked at the news because they had just finished talking to their grandmother the night before... We had dad visiting with us at the time so we had to break the news to him too....and they saw his reaction to that news. They were scared for a little while. They felt really saddened; you could see that in their faces and in their own persona and how they talked. They knew something wasn't right. Their whole character changed... When we got there [to the family home] all the families were there, ...and the kids came with us and they saw their grandmother lying there and they knew we were upset and they openly showed their emotions just like we did, and we had time with her... (Sam)

The involvement and exposure of children to conversations about death, to adult reactions to death, and how adults interact with tupapaku and with each other, serves to model appropriate and expected social and emotional behaviour (Alegre, 2011). It provides a learning context for children's enculturation (Grusec & Hastings, 2007) much like how knowledge was transmitted to the parents in this study.

Religious and cultural beliefs about death, bereavement, mourning and an afterlife are beliefs that are enculturated. They are absorbed by children as they engage, think about and are affected by events and influences around them. When asked about their beliefs about an afterlife, the parents in this study explained that they came to know and believe in a Christian afterlife, a Maori afterlife, or some combination of both, as Sam explains below:

They [his parents] usually said they went to heaven. That was one side of it... Well, from the religious point of view they both said they went to heaven... Mum and Dad are Anglicans and we were brought up in the Anglican church. I'm not too sure why, but I suppose it's because the Anglicans were the first to get a church in our part of the tribe... But from a Maori point of view they knew that the bodies were going back to Papatuanuku. That was part of the Maori tradition of what we believed. For example, the bodies went back to the ground but the spirit returned back to Hawaiki. Those were the same stories that came through, through the tangihanga process. But through the religious process, and if we were to draw parallels, I suppose you could say that the spirit was heading somewhere upwards. Mum and Dad always believed in some sort of afterlife of some sort. Whether it was either religious or through Maoridom, they'd talk about that...

According to Rosenblatt (1997) it is quite common for many traditional societies to blend culture and religion without it being terribly problematic finding comfort and understanding of death and ideas of an

afterlife from both perspectives. From the accounts given by participants, we learn that they can hold strong to their cultural beliefs as well as incorporate religious perspectives without feeling conflicted (Salmond, 1976). The participants in this study learned their beliefs and values from their parents. In turn, they communicated these ideas to their children. Whatever the beliefs held by participants, two common ideas were expressed. First, that on death, they would be reunited with family who had died earlier, and secondly, that those who had died were never far away. Matiu and Frank illustrate these ideas in the follow comments:

This is what I think will happen to me. I'd simply go and see my uncles who have just recently passed away, my koroua and my immediate whanau and there I'll be connected with the older/elder ones that I don't know of. This to me is what I think will happen when I pass on... There have been a lot of events I have witnessed that suggest to me that they're still watching over us.... (Matiu)

To me, afterlife is never anywhere; it's always there in you, the wairua of that particular person, your beloved one. Yes they've passed away, but they're still there and it will never go away... The wairua is still there and still around. That was my parents' belief and that sort of belief was handed down to me... (Frank)

#### *Implications*

Kinship networks are becoming more fragmented. Kin are now widely scattered in New Zealand and abroad, with the nuclear family more and more becoming the norm. Increasingly, it is only for tangi and whanau reunions that these networks endeavour to reunite (Nikora, 2007). Many have written of the challenges of urbanisation and the

barriers, like the competing demands of work, education, finances, transport and distance, that Maori continue to negotiate to engage in Maori world activities like tangi, unveilings and other episodic events (*cf.*, Nikora, 2007). For these reasons, extended kinship networks may well be shrinking with priority shifting to relationships within the nuclear unit rather than extended whanau. If this trend continues with resulting isolation and fragmentation, then increased stress within parent-child relationships may well be the outcome; meaning that children have only their parents and siblings to support them through crises rather than a much broader network of many parents and cousins.

The process of transmitting knowledge of death, dying, mourning and culturally defined responses from parent to child is clearly a 'within whanau process' rather than one assisted by knowledge gained from books, counseling or the internet. Parental knowledge came from participants own childhood experiences that they in turn drew on to inform their conversations and experiences with their own children. While Maori parents have prioritised honest and open dialogue about death and the life after, there is no guarantee that this will continue. This transfer of knowledge between generations cannot be taken for granted.

Maori move with ease between Christian and Maori beliefs about an afterlife. All parents interviewed believed there was life after death bringing them comfort and reassurance which they, in turn, communicate to their children. Death is not an end, but rather, a transition to a new life with relatives, ancestors and friends who had passed before. Therapists need to bear this in mind and be careful of pursuing an 'either/or approach' to thinking about what Maori believe and be aware of a 'both/and' way of thinking, a process insightfully described by Ritchie (1992).

The marae served as a therapeutic space to mourn in an appropriately emotional and

cathartic manner; a space in which family could reunite and children could play, and where oratory and emotional expression is balanced with song, dance and laughter. The marae, its environment and stage, its rituals and protocols have been harnessed over generations to soften the sting of death. But not all tangi are held at marae. Domestic dwellings, educational institutions and funeral homes (Edge, Nikora, & Rua, 2010) have also been sites for death rituals and mourning. Whether or not they afford participants, adults and children alike, an adequate therapeutic space is yet to be explored and awaits further research.

From this study we gain valuable knowledge into Maori children's experiences of death and tangi through the eyes of Maori parents. Even though these experiences have not come from Maori children themselves, by no means does it infer that the information gained from Maori parents is less relevant or insightful. What we have learnt from this study is foundational in understanding the relationship that Maori parents have with their children at times of death and tangi and the importance of transparency that is needed during these times. Most importantly, Maori parents talk with their children and involve them in all aspects of death and tangi. The challenge now is to ensure that these practices continue to persist between parents and their children, from this generation to the next.

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