

# The Socially Constructed Nature Of Psychology And The Abnormalisation Of Maori

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*Pardon him, Theodotus: he is a barbarian, and thinks that the customs of his tribe and island are the laws of nature.* (G.B. Shaw, Caesar and Cleopatra)

Just as it is a perfectly natural assumption to make that cultural realities offer a brand of truth for those who subscribe to them, it is a logical progression to identify that 'truth' is relative and, that no one body of knowledge can be considered to offer the 'truth' since 'truth' must be located within the cultural context of those who generate it live by it and therefore accept it as real (Anderson, 1990).

Historically and indeed contemporarily, western derived science has captured the market on the manufacture of 'truth'. Other forms of knowledge which are not arrived at by empirical definition and quantification may be readily dismissed as 'too subjective' 'primitive' fanaticism' 'a minority view', the only limitation on the labels is that which resides in the minds of those who would have the non believers dismissed in some way.

Psychology as a 'social science' has adopted the methodology of science and applied it to the understanding of human behaviour packaged in the grandiose claim that psychology can actually offer some understanding about why people do what they do. Some branches of psychology even proffer solutions for the problems that confront people (behavioural modification, psychotherapy, cognitive therapy, behavioural/cognitive therapy). Others are content to wrestle with the problem of exposing (by experimental method) the link between sense data and experience in the continual attempt to solve the 'mind/body' problem (psychophysiology) (Goldstein, 1989).

What psychologists by and large, fail to recognise is that psychology is a socially constructed reality just as the scientific method which it has so readily adopted is a socially constructed reality (Berger & Luckmann, 1984). Science is a fabrication, the product of creative minds and is no more the bearer of 'truth' for those who do not acknowledge it as such, than any other body of knowledge. Western culture seems however to credit science

with an almost godlike capacity to unlock the mysteries of the universe and psychology which is grounded upon the tenets of science and the scientific method has been content to claim credibility by basking in the reflected glory of the 'pure sciences'.

Culturally specific knowledge such as that which is a part of my reality as a Maori woman, is generally treated as 'additional to' what is already known about human existence from science or is always contrasted against the realities of Western culture, almost like 'the bit on the side'. While I choose to teach in psychology, I find myself continually in a reactive position commenting on and reacting to the application of Western derived psychology to Maori people.

The flaws in the underlying philosophies and methodologies of science and, by extension, of psychology and these have been documented elsewhere (Capra, 1982; 1992; Gould, 1981; Masson, 1988) are dismissed or ignored or disguised. The body of knowledge Maori is marginalised or othered while Western derived knowledge is treated as the norm.

Nowhere is the constructed nature of psychology more salient than in clinical psychology. The fact that definitions of abnormality seem remarkably attuned to changes in social mores bears testimony to the socially constructed nature of the labels which characterise clinical psychology. The link between social norms and definitions of abnormality form the basis of a process which categorises then treats on the basis of the categorisation, those individuals who do not fit conventional definitions of normality. Many clinical psychologists seem to recognise this fact and yet few seem to act on it. It appears they exonerate themselves by casting blame on psychiatrists for the maintenance of the Diagnostic Services Manual and all the labels contained therein encased in a 'we don't

make the rules we only follow them mentality'.

In more recent years, the use of behavioural techniques to facilitate the management of illnesses such as asthma have become a popularised part of clinical practice, particularly as practices such as psychological testing which have been identified as both racist and elitist (Awatere, 1984; Gould, 1981; Innes, 1976) are now largely obsolete.

The emphasis in clinical psychology seems to have shifted to assisting individuals to modify their behaviours and, to assist those in the social environment of the individual to also modify their behaviours so that behavioural changes may be maintained. At least the recognition that people 'behave' in a social context is a step in the right direction.

The identification of those contingencies of reinforcement operating in the environment of the individual which result in the maintenance of the certain maladaptive behaviours on the part of the individual and, subsequently changing the contingencies, seems a plausible panacea. However, the entire process of behavioural modification no matter how plausible, is devoid of politics where Maori people are concerned.

Culturally bound definitions of adaptive and maladaptive behaviour like the culturally bound definitions of normality and abnormality are precisely that, culturally bound. The labelling of environmental contingencies and adjudgement of their significance are also culturally bound acts. These definitions which guide treatment processes reside within a cultural reality which Maori people have not created or indeed been a party to other than, in the latter case, being on the receiving end of.

The assumption with the use of behavioural treatments appears to be one of universalism, that is, that behaviourism is somehow culturally neutral. There are other specific anomalies and inconsistencies in a behavioural approach to treatment in terms of culturally derived understandings (such as time) but these will not be discussed in this paper.

The point is that psychology and clinical psychology in particular, has created the mass abnormalisation of Maori people by virtue of the fact that Maori people have been on the receiving end of psychological practice as the helpless recipients

of Pakeha defined labels and treatments. The practice and teaching of clinical psychology are invariably political acts behind which, reside human intent, not to mention employment for large numbers of people to maintain, control, label, describe and treat those who don't fit the 'norm'.

Friere (1976) states that one of the characteristics of oppression is that the oppressors define the thought and reality of the oppressed. They name the world on behalf of others and they define how others should live in that world.

Jackson (1992) also states that those who hold the power to define hold the power of reality construction. In Aotearoa, Maori have had their reality consistently defined and redefined since colonisation. As Smith (1985) states, Maori culture has been defined, evaluated and packaged to suit the reality of the Pakeha. The numbers of Maori people on the receiving end of psych. services in mental institutions, prisons and other institutions of the state, continue to bear testimony to the social and political position of Maori people in Aotearoa.

I recall a statement made by one of the people on the interview panel when I applied for entry into the clinical psychology diploma programme here at Waikato after I had made a statement about the majority of those on the receiving end of psychological services in organisations such as justice being Maori. He replied "only half of our clients are Maori". Still half is too many when the politics of clinical psychological practice and the socially constructed nature of the labels and treatments are considered, not to mention the fact that Maori people comprise only 12-15% of the total population.

Maori misery has become a marketable commodity. The brutality of colonisation did not cease in 1840, it just took on new disguises and has been packaged in more socially acceptable ways. Clinical psychology is just one more of these ways.

Clinical psychology, like psychology, like science are constructed realities nothing more and nothing less. They are forms of social control derived from human intent and human action and offer no more 'truth' about the realities of Maori people's lives than a regular reading of the horoscopes page in the local newspaper.

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The corruption in clinical psychology which Innes (1976) in his wisdom identified a long time ago occurs for Maori people, when the labels and treatment processes are imbued with some supernatural capacity to deliver understanding about the realities of Maori people and the conditions of their lives.

The corruption in clinical psychology occurs when hundreds (perhaps even thousands) of Maori people are redefined as abnormal because they do not fit Pakeha defined notions of 'normality'.

The corruption in clinical psychology occurs when Maori misery is created in order to make a buck.

It is about time that psychology, and in particular clinical psychology, had it's worth reassessed. It is about time that psychologists acknowledged the relative nature of 'truth' but most of all, it is about time that psychologists recognise that they do not have the premium on solving the problems of Maori people. In fact, for many Maori people at their mercy, they are the problem.

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