

Counselling Maori Clients

He Whakawhiti Nga Whakaaro i te Tangata Whaiora Maori

Paul Hirini

Department of Psychology, Massey University

The present paper discusses several issues central to both training and practice in the counselling situation, including client identity, the social context of the client and the ideological assumptions or world views of the client and counsellor. These central issues are explicated within the specific context of working with Maori clients. In addition, a particular counselling perspective that has gained ascendancy in recent times, the Cognitive-Behavioural approach, is also discussed in reference to working with Maori. The effective integration of new co-operative relationships with Maori consumers and community resources in local practice is suggested to be an imperative if Maori mental health needs are to be effectively met. This will require a degree of openness to challenge and change on part of New Zealand counsellors.

Relative to other New Zealanders, Maori people presently experience high rates of inpatient mental health service utilisation (Pomare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson, & Watene-Haydon, 1995; Te Puni Kokiri, 1996). Durie (1994a) has documented trends in comparative utilisation rates of Maori since the conclusion of the second World War, highlighting an alarming rise in the prevalence of mental disorders among Maori as reflected in admission data since the mid-1970s. It is of much concern to Maori, as an indigenous people striving to realise their full potential, that they continue to endure a disproportionately high rate of psychiatric hospital admissions (see Maling, 1996; Mason, 1996; Pomare et al., 1995; Te Puni Kokiri, 1996). Mental illness has been identified as the single most insidious

threat to the health status of Maori people as they enter the twenty-first Century (Durie, 1994c, pers. com.). Durie recently remarked that "poor mental health is the most serious health problem facing Maori and it calls for innovative public health measures, as well as the development of appropriate clinical interventions." (1997, August, p.2). As an outcome of increasing recognition for the need of appropriate community services and effective service delivery for Maori, counselling practitioners have become interested in ways to address the special needs of Maori clients.

A modest amount of literature has been written regarding the counselling of Maori people (e.g., Awatere, 1982; Durie, 1985; Herring and Jespersen, 1994; Jones, 1993; Laven, 1993; Medland, 1988; Rankin, 1986; Sachdev, 1989a, 1989b). The present paper provides some views regarding commonly raised questions and issues, heard in both the training and practical settings, concerning the practice of counselling Maori clients. It is by no means intended to be an exhaustive or conclusive exposition of the topic, rather, it is viewed merely as a contribution to the developing literature and practice, and in that context is intended for consideration by both Maori and non-Maori practitioners in their efforts to work effectively with Maori clients.

The mental health field appears to be ever diversifying. The range and number of mental health service providers is growing exponentially to meet expanding community demands. Mental health professionals are numerous in kind, and those now engaged in counselling exchanges include the categories of psychiatrists, psychologists, social workers, nurses, community health workers, counsellors, therapists, psychotherapists and mental health workers. Maori, however, are all too often poorly

represented in such occupations (e.g., Ministry of Health, 1996).

The inclusion of a number of fundamental guidelines or 'basics' are common to all trade or professional training endeavours. When trained to conduct an interview or counselling session within a mental health service setting, those in a counselling role (as traditionally defined by Western models) are introduced to a number of general guidelines. The present paper discusses several issues central to both training and practice in the counselling situation. These topics involve client identity, the social context of the client and the ideological assumptions or world views of the client and counsellor. These central issues are explicated within the specific context of working with Maori clients. In addition, a particular counselling perspective that has gained ascendancy in recent times, the Cognitive-Behavioural approach, is also discussed in reference to working with Maori.

Client identity

Cultural heritage and identity remain important considerations when working with Maori, especially in times of illness (Durie, 1977). It is preferable not to immediately ask Maori clients to reveal personal information without first taking some time to develop rapport (National Health Committee, 1996; Tipene-Leach, 1978). A desirable level of trust may need to be established before a Maori client is willing to disclose information regarding their Maori identity, this may not necessarily occur during the first interview.

Introductions are considered an important part of any initial or assessment interview. The introduction has specific relevance in gaining an appreciation of a client's identity. This point is particularly important in terms of the cultural dimension for all clients. An appreciation of a client's developed level of awareness regarding their Maori identity may help reduce chances of making erroneous assumptions, and may further assist in matching counselling style with a client's current needs. Conservative Maori culture has well-established preferences in terms of interpersonal introductions. As a collective culture, in order to facilitate the establishment of rapport and a therapeutic alliance from the outset, collective identity will often need expression for many Maori people. Family involvement, particularly in times of illness, is an important notion for Maori (Durie, 1977). The expression of collective identity can take on a number of forms, from others attending interview to verbal recital of whakapapa or familial and tribal connections. The latter may be a particularly important consideration for Maori mental health professionals working with Maori clients.

Nevertheless, as modern Maori live in diverse realities (Durie, 1995) many Maori are not actively involved in the affairs of conservative Maori social institutions as *iwi*, *hapū* and *whanau*. For example, the proportion of the Maori population who are active members of their descent-based *whanau* is not known, although it is generally assumed to be less than half (Metge, 1995). It is therefore important to avoid making assumptions of homogeneity in terms of such involvement, and the personal meaning attributed to a Maori client's identity or self-concept. Stereotypical assumptions are a pitfall when counselling Maori, as indeed they are with all clients. Counsellors should exercise care in discussion of identity with Maori, being sensitive to both verbal and non-verbal signals of discomfort or reluctance to respond or elaborate during interview. A Maori client may feel less threatened in this situation when working with a Maori counsellor responsive to Maori interactive nuances.

A person's identity is a multifaceted and dynamic construct. According to cultural identity theory, people have varying levels of awareness regarding their ethnic or cultural backgrounds (Ivey, 1995). One's level of awareness regarding identity with a particular reference group is continually changing as a function of their social experience. As one's sense of personal and collective identity is dynamic in an ever-changing social context, it is important to appreciate that it is not the counsellor's role to impose or conclusively define any client's sense of cultural identity. One view maintains that a Maori identity can only be developed through experiential contact with other Maori. Conventionally, and where possible, this has taken place within *whanau* and been the responsibility primarily of family members.

For reasons such as the above, some flexibility is required in counselling practice with Maori. Provision for others to attend interview, and regard for appropriate timing and cultural responsiveness in discussion of identity with Maori clients are examples of potentially important considerations.

Client context

A thorough assessment is widely regarded as the cornerstone of any effective therapy. Akin to the introduction, another fundamental guideline repeatedly stressed in counselling practitioners' training is that of making a sound assessment of a client's social context. In practical terms this may also equate to making oneself aware of potential helping agents or agencies that exist within the client's natural environment. However, awareness alone does not ensure changes in one's counselling practice. The utilisation of community resources can enrich therapy, as

conventional counselling practice is but one approach of many theoretical and technical approaches available to the helping professional (Cheatham, Ivey, Ivey, Pedersen, Rigazio-DiGilio, Simek-Morgan, and Sue, 1997). Making use of traditionally trained Maori *tohunga* when the need for such intervention is indicated, for example, can promote progress or healing in areas unfamiliar to the trained counselling professional.

An informed appreciation of an individual's cultural context requires the development of a sociological eye, which often translates to moving beyond traditional disciplinary or sectoral boundaries. Some understanding of historical and socio-political context is therefore valuable when working with Maori. However, a preferable aim in service provision is surely to develop practices that are more competent or effective with Maori, rather than merely informed or sensitive. Cultural competence involves working collaboratively with natural supports in communities and promoting client self-determination (De La Cancela, Jenkins, & Lau Chin, 1993). Self-empowerment in advancing the health of given communities was an overriding theme proposed by the Ottawa Charter in 1986. With respect to contemporary Maori mental health service needs, Tino Rangatiratanga was the guiding theme of the inaugural hui of Maori mental health workers held at Wainuiomata marae in 1993 (Keefe-Ormsby, Watene-Hayden, Maniapoto, Taumata-Bishara, & Potaka, 1993). Obligations and responsibilities as contained in both the provisions and principles of the Treaty of Waitangi have direct relevance to mental health services being utilised by Maori. The principles of partnership, participation and protection recommended by the Royal Commission on Social Policy, for example, have been applied to the health arena (1988; Durie, 1989; 1994b).

Creating a network of potential community support to individual or familial counselling endeavours can improve the quality of service delivery for Maori, as well as enhancing the efficacy and credibility of mental health professionals among the Maori community. At times this will require a deviation from what might be considered 'standard practice'. However, it is well noted that past standard practice in terms of formal mental health care has not proven particularly effective for an unacceptably high number of Maori service consumers (Pomare et al. 1995; Te Puni Kokiri, 1996; Mason, 1996). Increased appropriate utilisation of non-conventional mental health services such as *tohunga* or Maori social services will require a level of tolerance for differences in terms of theoretical approaches and methodologies on part of most New Zealand mental health professionals. Yet

not making use of such resources within a client's community environment and cultural context contravenes a fundamental principle of sound therapeutic practice. The imposition of disciplinary boundaries or restrictive practices, and a failure to incorporate contextual resources effectively into counselling practice among Maori communities will only perpetuate the record of poor mental health outcomes for Maori.

Historically, the New Zealand health system has been characterised by generations of staunch guardianship or gatekeeping of perceived health professional responsibility, and active suppression of indigenous healing practices (Durie, 1996). Only in recent times has it become the expectation in the health service environment that where considered appropriate health professionals will enlist the services of *tohunga*, Maori clergy, pertinent Maori social services, and *whanau*. It remains to be seen to what degree a collaborative or complementary relationship might develop between Maori community-based and Western-trained mental health service providers. The co-operative endeavour is the expectation at least in policy (National Advisory Committee on Health and Disability, 1996; Shipley, 1996) if not in practice. The pilot Bicultural Therapy Project (McFarlane-Nathan, 1996) is one contemporary example of a programme developed within an existing mainstream service to facilitate more effective co-operative management with Maori community providers.

The proviso 'where considered appropriate' is expected to be the stumbling block for many. The national guidelines for the treatment and management of depression written for primary healthcare providers (National Advisory Committee on Health and Disability, 1996) gives explicit indicators for suggesting the involvement of "Maori health workers and/or Maori elders adept and experienced in Maori mental health and spiritual issues" (p.27). Such referrals ought to be viewed as referrals to specialist service providers as with any other type of specialist referral. Some counsellors may be reluctant to refer to a *tohunga* due to inadequate familiarity or understanding of theoretical and methodological differences in approach. The concept of healthy suspicion among indigenous healers is a world-wide phenomenon. The *Tohunga Suppression Act of 1907* is a particularly poignant reminder of why attitudes of suspicion continue to exist toward conventional medicine or health professionals among some Maori *tohunga*. The suppression or appropriation of indigenous medicine by Western trained health professionals or academic researchers remains a perceived threat (Duran and Duran, 1995). Many Maori

would argue that it is inappropriate for Western trained mental health professionals to usurp or practice indigenous Maori medicine, in the same sense that it would be for traditional healers to engage in the practices of Western psychiatry or psychology.

One obvious suggestion to discern the potential value of consultation, referral or a co-operative form of intervention would be to seek a directive from the client concerned based on his or her preferences and the perceived value of enlisting such help. Yet one should be mindful of differences in the decision-making process between individual Maori clients, as whanau preferences may also need to be considered (Waldegrave, 1985) granting issues concerning confidentiality.

Client and counsellor world views

An important guiding principle in counselling involves refraining from making assumptions about individual clients. As modern Maori vary widely in terms of their social learning and world views, it is important not to stereotype. Counsellors must be open to learning of individual differences among each of their clients, particularly if the client is from a different culture to their own. If a counsellor does not begin an exchange by learning from a client, their 'culturally aware' helping may be more stifling than if they knew nothing about cultural differences at all (Cheatham, et al., 1997).

While learning about the content of a client's culture is important, it is often not sufficient to enable counsellors to establish a therapeutic alliance (Chin, 1993).

Chin argues that more critical than knowledge of a client's culture is an awareness of the underlying assumptive frameworks or world views used by counsellors to guide the counselling endeavour. Spector (1991) contends that trained health service providers have been socialised into a distinct provider culture. For this reason, irrespective of a counsellor's ethnic background, gaining an awareness of 'counsellor culture' is vital in facilitating the level of self-awareness that Chin proposes. Sue (1992) argues that conventional counselling practice was designed to transmit a particular set of (dominant) cultural values, and has therefore functioned to the detriment of minority cultural groups.

To achieve a therapeutic alliance, counsellors need to examine how their assumptive frameworks differ from those of their clients'. Attending to the client's perceptions of the process throughout the counselling interaction is a necessity for nurturing a collaborative relationship, and empowering a client. Akin to

clarifying a client's statements in terms of interview content, the counsellor also ought to frequently check out a Maori client's perceptions of the counselling process. This is particularly important in terms of ensuring a sufficient rationale is given for any suggestion or form of intervention, as withdrawal from counselling or 'non-compliance' may result from a Maori client being ill-informed about the counselling process itself.

The Cognitive-Behavioural approach and Maori

An introduction to the Cognitive-Behavioural approach and its variants is generally considered to be a fundamental given of any modern counsellor training endeavour. Essentially concerned with the analysis and modification of a client's thoughts and actions, Cognitive-Behavioural approaches have been widely researched internationally, and are considered particularly effective for some classes of mental health problems such as certain forms of anxiety and depressive disorders. However, as with all theoretical approaches in the field, cross-cultural limitations are evident in the Cognitive-Behavioural approach. For one, translation difficulties occur when one considers the concept of logic, of central importance to all variants of the Cognitive-Behavioural approach. It might be argued that Cognitive-Behavioural strategies are effective among all cultures if suitably adapted to the belief system of the cultural group concerned. However, many so-called rational or logical beliefs innate in the approach are only considered so within a specific cultural context (i.e., Western world views) and may not translate comfortably to other cultures. The following examples of such translation difficulties pertain to counselling Maori in particular, yet may also apply to other cultural groups.

Assertiveness training is a strategy often used in Cognitive-Behavioural interventions. Individualist cultures promote independence and individual assertion of one's individual rights, this is perceived to be a logical and functional counselling goal within a Western ideological framework. Yet collectivist cultures may view this line of thought as irrational, and even dysfunctional. An insistence on independence is regarded by Maori as a sign of immaturity. Interdependence, rather than independence is viewed as an indicator of healthy social functioning for Maori (Durie, 1987; 1994b).

Conversely, some beliefs that continue to have relevance for Maori in times of illness may be viewed as irrational from a Western world view. Belief in the ill-effects of breaching cultural protocols, such as the

laws of tapu, may precipitate mental health problems for some Maori presenting in counselling practice. In regard to the notion of rationality, the implicit exclusion of the spiritual dimension in the Cognitive-Behavioural approach is a considerable limitation when working with Maori. Te taha wairua or the spiritual dimension is considered a significant determinant of healthy functioning in a Maori world view (eg., Durie, 1987; Sachdev, 1990). For many, spirituality is encountered as experiential, rather than a domain to be understood at an intellectual level. Some counsellors may view work in the area of spiritual beliefs as a Cognitive-Behavioral oriented activity, or in the sphere of a client's faith. Yet many would argue that spirituality and spiritual experience is not bound by intellectual reasoning (the notion of timelessness is a case in point), and that any attempt to do so would be arrogant and fruitless.

Finally, the Cognitive-Behavioural traditions do not account for situations where a client's issues of concern are not internal or person-bound. For example, community racism and consequent discrimination are often more important than internal cognitive structures in the counselling situation, and cannot be adequately addressed solely by internal change on part of the client (Cheatham et al., 1997). Indeed, in relation to the world view of the counsellor, Pedersen (1987, cited in Baruth and Manning, 1991) warns that not examining professional assumptions may consequently result in unintended institutional racism and other forms of cultural bias on part of the counsellor.

The above considerations are offered in hope of stimulating further discussion and reflection among those working with Maori in counselling professions. Although Maori themselves currently comprise a small proportion of the counselling profession, it is imperative that those presently charged with delivering such services to Maori continue to question the effectiveness of existing counselling practices. The effective integration of new co-operative relationships with Maori consumers and community resources is suggested to be an imperative if all Maori mental health needs are to be effectively met. This will require a degree of openness to challenge and change on part of New Zealand counsellors. This very attitude, after all, is what counselling professionals attempt to foster in clients themselves.

References

- Awatere, D. (1982). Maori counselling. In *A time to talk: Counsellor and counselled*. Donnelly, F. (Ed.). Sydney: Allan & Unwin.
- Baruth, L., & Manning, M. (1991). *Multicultural Counseling and Psychotherapy. A Lifespan Perspective*. New York: Merrill.
- Cheatham, H., Ivey, A., Ivey, M., Pedersen, P., Rigazio-DiGilio, Simek-Morgan, & Sue, D. (1997). Multicultural Counseling and Therapy I: Metatheory - Taking Theory into Practice. In Ivey, A., Ivey, M., & Simek-Morgan. (1997). *Counseling and Psychotherapy. A Multicultural Perspective*. (4th ed.). Boston: Allyn and Bacon.
- Cheatham, H., Ivey, A., Ivey, M., Pedersen, P., Rigazio-DiGilio, S., Simek-Morgan, L., & Sue, D. W. (1997). Multicultural counselling and therapy II: Integrative practice. In Ivey, A., Ivey, M., & Simek-Morgan, L. (Eds.). *Counseling and Psychotherapy. A Multicultural Perspective*. (4th ed). Boston: Allyn and Bacon.
- Chin, J. L. (1993). Toward a Psychology of Difference: Psychotherapy for a Culturally Diverse Population. In Chin, J. L., De La Cancela, V., & Jenkins, Y. M. *Diversity in Psychotherapy. The Politics of Race, Ethnicity, and Gender*. Connecticut: Praeger.
- De La Cancela, V., Jenkins, Y. M., & Lau Chin, J. (1993). Diversity in Psychotherapy: Examination of racial, ethnic, gender, and political issues. In Chin, J. L., De La Cancela, V., and Jenkins, Y. M. *Diversity in Psychotherapy. The Politics of Race, Ethnicity, and Gender*. Connecticut: Praeger.
- Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. New York: State University of New York Press.
- Durie, M. (1977). Maori attitudes to sickness, doctors and hospitals. *New Zealand Medical Journal*, 86, 483-485.
- Durie, M. (1985). *Counselling Maori people*. A presentation to the New Zealand Counselling and Guidance Association hui, Tu Tangata urban marae, Palmerston North, May 1985.
- Durie, M. (1985). A Maori perspective of health. *Social Science Medicine*, 20, 2, 483-486.
- Durie, M. H. (1989). The Treaty of Waitangi and health care. *New Zealand Medical Journal*, 102, 283-285.
- Durie, M. (1994a). Maori psychiatric admissions: Patterns and policy implications. In Spicer, J., Trlin, A., & Walton, J. (Eds.). *Social dimensions of health and disease: New Zealand perspectives*. Palmerston North: Dunmore Press.
- Durie, M. (1994b). *Whaiora. Maori health development*. Auckland: Oxford University Press New Zealand.
- Durie, M. (1994c). Personal Communication.
- Durie, M. (1995). *Nga matatini Maori. Diverse Maori realities*. Unpublished document, Department of Maori Studies, Massey University. Palmerston North.
- Durie, M. H. (1996b). *Identity, conflict, and the search for nationhood*. Royal Australian and New Zealand College of Psychiatrists College Address. Unpublished document. Department of Maori Studies. Massey University. Palmerston North.
- Durie, M. H. (1997, August). *Puahou. A five part plan for improving Maori mental health*. Paper presented at Oranga Hinengaro Maori - Maori Mental Health Summit '97. Wellington.

- Herring, R., & Jespersen, S. (1994). International counselling: An opportunity for culture-specific counselling with the New Zealand Maori. *Journal of Multicultural Counseling and Development, 22*, 17-27.
- Ivey, A. (1995). Psychotherapy as liberation. Toward specific skills and strategies in multicultural counseling and therapy. In Ponterotto, J., Manuel Casas, J., Suzuki, L., & Alexander, C. (Eds.). (1995). *Handbook of multicultural counseling*. Thousand Oaks: Sage Publications.
- Jones, R. (1993). Cross-cultural psychology. Some implications for psychological practice within New Zealand. In Department of Justice. *Proceedings of the department of Justice Psychological Services Division annual conference, 1993*. Wellington: Department of Justice.
- Keefe-Ormsby, V., Watene-Hayden, N., Maniapoto, W., Taumata-Bishara, G., & Potaka, H. (1993). *Tino Rangatiratanga and Maori Mental Health. Report of First National Hui for Maori Mental Health Workers. 28-30 June, 1993*. Wainuiomata marae, Wainuiomata. Wellington: Mental Health Section, Department of Health.
- Laven, H. (1993). Cultural consultants. In Department of Justice. *Proceedings of the Department of Justice Psychological Services Division annual conference, 1993*. Wellington: Department of Justice.
- Maling, N. (1996). A crisis in Maori mental health. *The Evening Post*. Magazine. Saturday, November 16, p.14.
- Mason, K. (1996). *Inquiry under section 47 of the Health and Disability Act 1993 in respect of certain mental health services. Report of the Ministerial inquiry to the Minister of Health Hon. Jenny Shipley*. Wellington: Ministry of Health.
- McFarlane-Nathan, G. (1996). The bicultural therapy project. Auckland: Psychological Services, the Department of Community Corrections (cited in Glover, M., and Robertson, P., (in press).
- Medland, J. (1988). Therapy with the whamere. *Australian and New Zealand Journal of Family Therapy, 9*, (1), 33-35.
- Metge, J. (1995). *New growth from old. The whanau in the modern world*. Wellington: Victoria University Press.
- Ministry of Health. (1996). *Maori health workforce development. A discussion document*. Unpublished draft document. Wellington: Author.
- National Advisory Committee on Health and Disability. (1996). *Guidelines for the treatment and management of depression by primary healthcare professionals*. Wellington: National Advisory Committee on Health and Disability.
- Pomare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Haydon, N. (1995). *Hauora. Maori standards of health III. A study of the years 1970-1991*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare/Eru Pomare Maori Health Research Centre.
- Rankin, J. (1986). Whaiora: A Maori cultural therapy unit. *Community Mental Health in New Zealand, 2*, 2, 34-47.
- Royal Commission on Social Policy. (1988). *The April report. Volume I and II*. Wellington: Author.
- Sachdev, P. (1989a). Mana, tapu, noa: Maori cultural constructs with medical and psycho-social relevance. *Psychological Medicine, 19*, 959-969.
- Sachdev, P. (1989b). Maori elder-patient relationship as a therapeutic paradigm. *Psychiatry, 52*, 393-403.
- Sachdev, P. (1990). Whakama: culturally determined behaviour in the New Zealand Maori. *Psychological Medicine, 20*, 433-444.
- Shipley, J. (1996). *Policy guidelines for Regional Health Authorities 1996/97*. Wellington: Office of the Minister of Health.
- Spector, R. (1991). *Cultural Diversity in Health and Illness*. (3rd ed). Connecticut: Appleton & Lange.
- Sue, D. (1992). Derald Wing Sue on multicultural issues: An interview. *Microtraining Newsletter*. Cited in Ivey, Ivey & Simek-Morgan.
- Te Puni Kokiri. (1993). *Nga ia o te oranga hinengaro Maori. Trends in Maori mental health. A discussion document*. Wellington: Te Puni Kokiri. Ministry of Maori Development.
- Te Puni Kokiri. (1996). *Nga ia o te oranga hinengaro Maori. Trends in Maori mental health. 1984-1993*. Wellington: Te Puni Kokiri. Ministry of Maori Development.
- Tipene-Leach, D. (1978). Maoris: Their feelings about the medical profession. *Community Forum* (November issue).
- Waldegrave, C. (1985). Mono-cultural, mono-class, and so called non-political family therapy. *Australian and New Zealand Journal of Family Therapy, 6*, 4, 197-200.

Address for correspondence:

Paul Hirini
 Department of Psychology
 Massey University
 Turitea Campus
 Private Bag
 Palmerston North