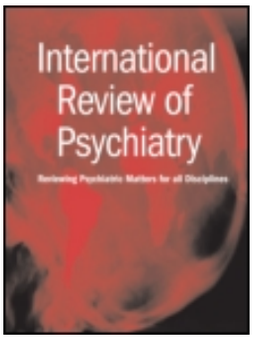

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Which family – What therapy: Maori culture, families and family therapy in New Zealand

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Abstract
New Zealand is a relatively young and small country which has seen steady migration for nearly seven centuries. Despite a long history of rivalry and hostility between Maori and European values, the country has also seen some significant synergism between the two cultures. For the last three decades Asians have also migrated at a significant pace. The country faces the challenge of delivering quality mental health services to such cultures which are bifurcated in being socio-centric (Maori, Pacific Islanders and Asian total 32% combined) or ego-centric (European total 68%). Significant progress has been made in including families of the mentally ill in their treatment and care planning. Legislative requirements have been introduced for the family to be consulted in the treatment of those who are being compelled to receive psychiatric care under the Mental Health Act. Models of family therapy developed through innovation meeting the unique local needs or adaptation of existing models from overseas are being used. An overview of such family therapy modalities is presented.

Introduction

New Zealand is a relatively small country with a population of 4.37 million (Statistics New Zealand, 2011). It has seen a modest estimated population growth of 1.2% during 2010. The median age of the population rose from 33.0 years in 1996 to 35.9 years in 2006 (Statistics New Zealand, 2011). Similar trends are also seen in its closest neighbour, Australia, which has experienced an increase in median age by 4.8 years over the last two decades from 32.1 years at June 1990 to 36.9 years at June 2010 (Australian Bureau of Statistics, 2010). Both countries, like many in the world, are experiencing ageing populations. One corollary is that children now only make up 20% of New Zealand population, down from 23% in 2000 (Statistics New Zealand, 2011). With a small, ageing population base, ethnic complexity and changes in family and other societal structures, the country faces significant challenges in delivering high quality mental health services, though according to recent reports the standards of health service delivery in New Zealand are comparable to many developed nations (Ettelt et al., 2008) and in fact New Zealand has developed some unique aspects of delivering mental health services to its population (Bale, 2002).

Sociodemographics

Broadly speaking there are four ethnic groups in New Zealand: European, Maori, Asian and Pacific Islanders. European migration in New Zealand began approximately two centuries ago. They colonized the land inhabited by the earlier settlers, the Maori, who began arriving in significant numbers in the fourteenth and fifteenth centuries as part of a continuing trans-Pacific, Polynesian spread. As settler migration began to gain momentum in the 1830s and 1840s, a treaty was signed in which Maori ceded the sovereignty of New Zealand to Britain in return for the retention of rights over their lands, forests and fisheries amongst other things (Orange, 1987). Although there are inconsistencies between the English and Maori language versions of the document, current statements frequently subsume the three articles of the Treaty of Waitangi under the headings of partnership, participation and protection. The Treaty retains considerable political and social significance for Maori (Poata-Smith, 2004) while providing a launching pad for ideas around self-determination and realization. Of particular relevance to this paper is the fact that the Treaty's principles are reflected in a number of documents and codes that prescribe the activity of the health sector. Moreover, the country

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has relatively good statistical data on many issues as they relate to ethnicity partly as a consequence of the commitment of the government to delivering on the Crown's Treaty obligations.

In New Zealand ethnicity is a matter of self identification and is more or less defined as such in the official 5-yearly census. The country has a population comprised of many different ethnicities with people of European descent dominating at 68%, followed by New Zealand Maori at 15%. The remaining 17% of the population is composed of people of Asian (8%), Pacific (7%) and other (2%) origins (Ministry of Health, 2006a). It is noteworthy that the Asian population is the fastest growing population subgroup in New Zealand with an increase of almost 50% over a 5-year period from 2001 to 2006, closely followed by Pacific Islanders with an increase of 14.7% (Statistics New Zealand, 2006). The growth in the Asian population could have been fuelled by some changes in migration legislation that occurred in 1987 and 1991 removing a bias in favour of British and western Europeans, who were check dateconsidered 'preferred sources' of migrant population in New Zealand (Brooking & Rabel, 1995), and the mental health implications of this trend were reviewed recently (Kumar et al. 2006). Another noteworthy characteristic of the country's population is that the Māori population is much younger than the total population (Statistics New Zealand, 2011). The median age of the Māori ethnic group was estimated to be 23.0 years of age at 30 June 2010 which is 13.7 years younger than that of the total population (Statistics New Zealand, 2011).

While Pacific Islanders share with Maori a Polynesian ancestry and a number of culturally based values, they, like Europeans and Asians, are regarded as migrants. People of Indian ancestry along with those from nearby countries are also included under the 'Asian' heading in New Zealand.

New Zealand has also experienced a drop in the general marriage rate which is currently 13.2 per 1,000 per year in 2009 which is less than one third of the peak of 45.5 per 1,000 per year recorded in 1971 (Statistics New Zealand, 2010).This drop has been attributed to a number of factors including growth in de facto unions, a general trend towards delayed marriage, and increasing numbers of New Zealanders remaining single. The median age of men and women who married for the first time in 2009 had increased by seven years from 1971. Furthermore, women continued to marry men older than themselves although the gap between the median ages at first marriage has narrowed. Some 89% of those remarrying in 2009 were previously divorced, up from 67% in 1971 (Statistics New Zealand, 2010).

As in many parts of the developed world including Australia, North America and Europe, many people in New Zealand live together without legally formalizing their union. This trend continues to rise. For instance, in 1996, about one in four aged 15–44 years who were in partnerships were not legally married. By 2006, this figure had increased to around two in five. Since the enactment of the Civil Union Act in 2005, many same sex unions have also occurred. Rates of divorce have varied though it is recognized that annual divorce statistics do not give a complete picture of the number of marriages ending in divorce. The Family Proceedings Act (1980), by permitting divorce on the grounds of irreconcilable differences, was seen as being responsible for a sharp rise in divorce rates in the two subsequent years.The divorce rate (divorces per 1,000 existing marriages) has ranged between 10.2 in 2009 to 12.5 during the late 1990s and early 2000s. Age at divorce tends to be increasing possibly due to the marked trend toward later marriages, which began in the early 1970s.The median age at divorce in 2009 was 45 years for men and 42 for women (Statistics New Zealand, 2010). Couples with children make up 42% of all families in New Zealand, while couples without children make up 40%; 18% of families in New Zealand are one-parent-with-children families (Statistics New Zealand, 2010).

Ethnicity, health and families

Important differences in family structure and the shape and function of social networks are widely recognized between Maori, European and Asian sectors in the New Zealand population.Typically Maori and Asian populations in New Zealand are viewed as being socio-centric (Kumar & Oakley-Browne, 2008; Kumar et al., 2006) whereas European are considered to be egocentric (Kumar & Oakley-Browne, 2008). Utilizing descent, seniority and extended family as the primary determinants of Maori social structure, power and authority is seen to reside with the group rather than the individual. The internal workings of Maori social networks are based upon the concepts of whänau (family), hapu (extended family), iwi (tribe) and waka, with the last term (literally meaning canoe) signifying unification around a common ancestor. The whänau is the centre of day-to-day decision making and is formed by individuals born within it who have close familial and reciprocal contacts, although still extending well beyond the western concept of the nuclear family. Hapu operates as a basic political unit consisting of a number of whänau. Hapu protect the local resources and support the land; the land being a critical component of Maori identity. A number of related hapu

constitute an iwi which serves to support its members and subgroups. Finally, identity is intimately linked to the seven waka from which all Maori have common ancestry enabling related iwi to share their history and form common connections. The constructs of whänau, hapu, iwi and waka collectively define a person's whakapapa (genealogy) alongside the elements of the land from whence they came. Based on the principle of descent, whakapapa is central to Maori society because it defines kinship, determines the rights of people and governs the patterns and significance of their interrelationships (Henare, 1988). A fundamental difference is observed between the Maori and European concept of kinship. In anthropological terms, Maori have ambilateral affiliation because an individual person can attach themselves to a kin group from either the paternal or maternal lineage. Europeans, on the other hand are often considered to have had a propensity to mainly follow paternal lineage, although in practical terms this feature is moderated through changes in legal and social frameworks.

Important differences also exist between the Asian and European sectors of New Zealand population. The Asian world view is described as being based on collectivism, whereas the European view is based on individualism (Hsu, 1971; p. 34): 'Western Man' holds the 'individual human animal as the center with the rest of the world around him', while Asian peoples define the 'human individual as part of a set of relationships with no assured starring role' for the individual. Citing Hsu's work, Yee (2003) has argued 'Hence the maintenance of immediate and extended family ties are given central importance in many Asian cultures and are reflected in notions of filial piety' (p. 3). This significance of involving families in the care of Asians with mental illness was highlighted in the Mental Health Commission's Recovery Competencies for Mental Health Workers (O'Hagan, 2001) stipulating that a competent mental health worker ought to have knowledge of the importance of family, religious traditions, duty, respect for authority, honour, shame and harmony.

Help-seeking behaviour is often determined by the way a society conceptualizes health. Traditionally, Maori and Asian peoples have had associated with them a holistic model of health and wellness which may appear even broader than that once proposed by the World Health Organization (WHO, 1947). This can result in a mismatch between traditional healing methods and modern western medicine, sometimes resulting in failure of conventional services to provide a welcoming environment to engage these populations. However, notwithstanding such differences, both western and non-western models of health share an emphasis on a 'state of complete well-being' and 'not merely the absence of disease or infirmity' in terms of physical, mental and social functioning. Added dimensions in one of the most widely accepted Maori models of health are those of family and spiritual well-being. (Durie, 1999b). This model has been termed 'whare tapa wha' (a four-sided house) in which health status is described in terms of the balance between physical, mental/emotional, spiritual and family well-being. A standardized assessment questionnaire and outcome measure has been developed in New Zealand based upon this particular paradigm (McClintock et al., 2011a). This research tool employs the concepts of taha wairua, the spiritual wall having the capacity for faith and wider communion with unseen and unspoken energies; taha hinengaro, the mental wall enabling people to communicate, think and feel; taha tinana, the physical wall enabling physical growth and development; and taha whanau, the extended family wall that gives the capacity to belong, care and to share with one's family (Durie, 1999a, 1999b). For a state of optimum health, these four components must be equally strong, stable, integrated and in balance with each other because the individual's health is perceived as an integral part of a wider system of spirit, body and mind, that includes the extended family. Any disruption in harmony between these four elements is said to manifest itself in the form of poor health or disease. With regard to taha whanau, two important considerations need to be made. First, family as opposed to the state is still seen to be the main support system for Maori as the sense of identity and purpose is derived from the concept of family. It is the inclusion of an emphasis on the well-being of the family and spirituality in order for an individual to be in a state of optimum health that fundamentally distinguishes a Maori from a non-Maori perspective on health. The key importance of whanau to health services utilization has been highlighted in other recent publications (McClintock et al., 2011b).

Like many non-western cultures, interdependence as opposed to independence is perceived as a healthier goal (Durie, 1999b). Therefore Maori cultural identity and values support the whanau (extended family) taking on the roles of nurturing, disciplining and supporting individuals in distress. Indeed in Maoridom the whanau may have more responsibility for determining the appropriate care provision than the individual themselves (sometimes leading to clashes with mainstream healthcare providers). Disconnectedness from whänau or impaired relationships within it indicate incomplete health – a view that confirms that the nature and quality of a person's social network is an important determinant of health in a Maori context.

A recent study has developed and examined the applicability of outcome measures for mental health using the construct of hua oranga which is derived from the framework just described (McClintock et al., 2011a). This study compared different versions of a standardized assessment developed from the te whare tapa wha model of health. The version finally accepted, based on its psychometric properties (including particularly the level of reliability and utility) utilizes perspectives, those of the three key stakeholders that influence the configuration of health service delivery. These agencies are tangata whaiora (mental health consumers), treating clinicians and whanau (family). However, despite the development of such innovative, family inclusive models of healthcare and service delivery, it is also recognized that kaupapa maori services are, so far, available to only a minority of Maori mental health service users.

As a way of explaining this observation, it is clear that the advent of modernization has promoted two key changes which have caused stress to traditional social structures and progress. First, indirect relationships have taken precedence over direct ones with the advent of information technology, the bureaucratization of organizations and political and legal support for self-regulating systems such as markets. Secondly, postmodern societies have also produced complex 'imagined communities' so that individuals are connected to larger 'collectivities' through shared values and not direct relationships such as in nations, races or classes (Calhoun, 1991). These changes have occurred globally and New Zealand is not immune to them. In the context of New Zealand however, it has been suggested that the increased highlighting of indirect relationships has been antithetical to a Maori world view (te ao maori). Such fundamental and massive change in the properties of primary relationships may have become a breeding ground for social distress (Kumar & Oakley-Browne, 2008).

Despite the presence of philosophical differences between the European and Maori cultures in New Zealand, some significant synergies have appeared as the two civilizations have lived together for the last two centuries. Maori narratives on the prime importance of family seems to have positively influenced the way service planners and developers have conceptualized recovery of the mentally ill and the significance that has been attached to family members in the provision of compulsory care to those in receipt of treatment.

Involving families in the treatment of the mentally ill

As indicated above, effective delivery of health services to Maori particularly centres on recognizing the role of the extended family (whanau and hapu) in both the health of an individual (tangata whaiora) and in the utilization of services (Laird et al., 2010; McClintock et al., 2010, 2011b; Moeke-Maxwell et al., 2008). That research has clearly established and confirmed that Maori whanau have views on how their family designated patients should be diagnosed, managed and communicated with. Above all, the importance of the views of family/whanau has been illustrated by the specific and legislated requirement to consult them when considering the need for, and appropriateness of, compulsory treatment (Spencer & Skipworth, 2007) The responsible clinician providing compulsory treatment to someone under the provisions of the Mental Health Act 1992 is required to consult with the family (Ministry of Health, 2006b). The legislation in some ways overrides an individual's right to exclude their family from treatment planning. This requirement was introduced in 2000 and a recent audit of a representative sample of districts found broad compliance with the legislative intent for family/whanau consultation in at least 93% of cases (Spencer & Skipworth, 2007). The audit also found that 88.6% of clinicians were aware of the legislative requirements about consultation and encouragingly the audit found that a significant percentage (54.7%) believed their practices had altered following legislative change (Spencer & Skipworth, 2007).

In general, as much is known about the distribution of psychiatric disorders within Maori as is known globally where studies have been done based on ICD-10, DSM-4, or CIDI methodologies. Importantly, there are also a number of culturally specific findings in such research which have become matters for speculation rather than empirical knowledge (Wells et al., 2006; Mellsop & Tapsell, 2011; Tapsell & Mellsop, 2007). The role of families in decision-making in relation to service access have been highlighted in the research of McClintock (2011b) and are reflected in relation to diagnostic perceptions contained in the views of both services users and their families (Laird et al., 2010; Moeke-Maxwell et al., 2008).

Family therapy in New Zealand

In New Zealand, the focus of families and their involvement in treatment has arisen in the context of the development of the Families Commission in 2004, a crown entity legislated by the Families Commission Act 2003 (Families Commission, 2004). In addition, the National Mental Health Standards includes, as Standard 10, Family/Whanau participation and Objective 3.3 in the National Mental Health Strategy to improve the responsiveness of mental

health services to families and caregivers (Ministry of Health, 2005). The Mental Health Commission (MHC) (2009) emphasizes the importance of inclusion of families in the care of children and youths with psychiatric illness and describes how it is codified in various acts, codes and standards. Many District Health Boards (DHBs) have appointed family facilitators or advisers to ensure that the interests of families are adequately considered in the assessment and treatment of an individual at the recommendation of the MHC.

There is a documented history around the development of family therapy techniques in New Zealand, in particular, behaviour family therapy for high expressed emotion in the families of patients with schizophrenia (Falloon, 1984). According to its website, the *Australian and New Zealand Journal of Family Therapy* is reputed to be the most-stolen professional journal in Australia (ANZJFT, 2011). Despite this, family therapy is not currently a recognized or regulated profession within New Zealand and there is disagreement as to whether it should be (Werry Centre, 2009).

A review of family therapy services and opportunities in New Zealand was conducted by the Werry Centre for Child and Adolescent Mental Health (Werry Centre, 2009). This centre was established to improve the mental health of the country's young people by providing training of a high quality to mental health professionals, promoting research in child and adolescent mental health, advocating for mental health needs of children and adolescents in New Zealand, and supporting the child and adolescent mental health workforce nationally (Werry Centre, 2011). The review noted that courses in family therapy are provided across New Zealand and Australia in a variety of university post-graduate courses (for example Canterbury, Waikato, Otago and Massey in New Zealand, and state universities in Queensland and New South Wales in Australia) and there are a number of private providers (Werry Centre, 2009). Study programmes range from a 5-day course with an additional DVD self-study component, to a four-stage course of 40 weeks per stage (a total of 1902 hours of study). Although post-graduate diplomas are being developed in polytechnics, the majority of the training for the family therapist takes place 'on the job'. It is reasonable to state that the range of family therapies offered in New Zealand is limited and faces challenges. Limited training and educational opportunities exist, resources are limited, the majority of practitioners have their core training in another discipline such as psychology, nursing, social work or occupational therapy. Of concern in this context is the lack of opportunity for trainees to be observed in practice during the training programmes (Werry Centre, 2009).

Despite the resourcing issues identified above, several examples of innovations in family therapy and attempts to deliver high quality services exist. A programme is described by Schaeffer (2008) of Multi-Family Group Therapy in an alcohol and drug rehabilitation service in New Zealand (Higher Ground) which includes an analysis of the advantages and disadvantages of multi-family therapy drawn from the literature and reported by staff and clients. The Choice and Partnership Approach (CAPA) (Kingsbury & York, 2006), a service delivery approach initially developed in the UK, is currently offered by the Werry Centre in Auckland. Evidence-based family therapy programmes available for externalizing disorders in New Zealand include multidimensional family therapy (MDFT), functional family therapy (FFT) and multi-systemic therapy (MST) (Werry Centre, 2009). MST has support in the literature as being one of the best available treatments for youths who have mental health needs and are involved in the juvenile justice system in order to reduce recidivism rates (National Mental Health Association, 2004). The therapist collaborates with the family to determine the factors in the youth's 'social ecology' that are contributing to the identified problem and to design interventions to address them (National Mental Health Association, 2004). FFT has also been shown to reduce recidivism. This is a brief therapy focusing on the development of strengths, enhancing self-respect and motivating families and youth to positive change (Sexton & Alexander, 2000). MDFT (Liddle, 2005) is recognized by the US Substance Abuse and Mental Health Services Administration (SAMHSA) as a model therapy. It is a manualized treatment for adolescent drug abuse which focuses on reducing psychological symptoms and facilitating change across four behavioural domains (Hogue & Liddle, 2006). The Werrry Centre report (2009) identified this as a treatment modality being used by some centres in New Zealand. Just Therapy is a family therapy programme developed by the Family Centre (Lower Hutt, New Zealand) in 1979. The programme was developed to include the broad cultural, gender, social, spiritual, economic and psychological influences which underlie the problems experienced by families (Waldegrave & Tamasese, 1994; Waldegrave, 2005) . Family therapy is also offered in New Zealand for the internalizing disorders – depression, borderline personality, obsessive–compulsive disorder and eating disorders due to an emerging evidence base, with strong evidence for therapies for eating disorder (Werry Centre, 2009). The Maudsley model has a non-pathologizing approach to families, standardization of treatment techniques, and has demonstrated long-term effectiveness of outpatient family therapy treatment for families of young people with

eating disorders (Rhodes, 2003). Attachment-based family therapy (ABFT) focuses on helping families to identify and resolve conflicts which have contributed to young people lacking trust in their parents and not using them as a source of emotional support (Diamond & Josephson, 2005).

The review of family therapy in New Zealand (Werry Centre, 2009) made the following recommendations for the future development of the profession and workforce:

- a symposium for key stakeholders,
- working with services to develop role descriptions and career pathways,
- funding for tertiary education postgraduate courses,
- development of a National Family Therapy Association,
- web-based clearinghouse for the dissemination of research and training opportunities,
- promotion of national training programmes,
- promotion and provision of family engagement and support training for all CAMHS & AOD workers,
- promotion and training for leaders in family therapy for mentoring and supervision,
- further research into indigenous models and the applicability of models that are introduced into the New Zealand setting.

It is unclear at this stage how many of these recommendations have been implemented and we are not aware of any data on the impact of their implementation if they have occurred.

Conclusions

Acceptance of the centrality of family to individuals' mental health, their service access and treatment utilization is quite uniquely emphasized in New Zealand. It is emphasized in policies, legislation, clinical practice guidelines and much actual clinical practice. Specific or formal family therapy does not have the same primacy and is not so pervasively practiced. Nevertheless there are many pockets of relevant training, practice, and increasing advocacy for its more widespread delivery.

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