RESEARCH ARTICLE

A Call to Wellness – Whitiwhitia i te ora: Exploring Māori and Occupational Therapy Perspectives on Health

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Abstract

The World Health Organization records that indigenous peoples throughout the world experience poor health. The concept of health was explored from a Māori world view and compared with occupational therapy perspectives. The aim was to understand and value indigenous knowledge and promote culturally safe responsive practice.

Māori methodologies were employed to protect the Māori knowledge shared in the study. This involved applying seven principles, including respect for people, be cautious, and look, listen, and speak. Perspectives on health and wellbeing were collected in 2008–2009 from indigenous occupational therapists, other occupational therapists and indigenous health practitioners using interviews and a questionnaire.

The findings are presented as a conceptual framework, depicting a whare, a Māori meeting house to show relationships between culture and health. Key concepts held by occupational therapists and Māori were spirituality, holistic views, client responsive practice, and environmental contexts. Areas of difference were the focus on occupations, the interdependence of indigenous relationships, and the place of the extended family in supporting wellness.

A strength was the respect for Māori methodologies and limitations were the number of participants ($N = 23$) and the small proportion of Māori therapists in Aotearoa/New Zealand.

Recommendations: Attention to culture is vital for appropriate, safe, and responsive practice. The conceptual framework provides a tool to inform, guide, and evaluate practice understandings. It acknowledges the importance of the individual within their extended family, their natural environment, and the historical, social, and political realities of living as Māori. Further research should explore the use of the framework and interaction between occupational therapy practice and specific indigenous cultures.

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Keywords

culture; indigenous health; occupational therapy; shared concepts

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Introduction

We begin with the traditional Mgāori introduction

Tuia te rangi e tu nei Tuia te papa e hora nei
Tuia te hunga tangata ki te tipu whenua
Tuia te tangata ki te iwi
Tihei mauri ora Unite with the skies
Unite with the earth
Unite people with their ancestral lands
Unite individuals with their people
Let life be lived (Durie, 2006).
Ko Takitimu te waka

Pukengaki te maunga
Ruamahanga te awa
Ko Ngāti Kahungunu te iwi
Ko Jane Hopkirk ahau Takitimu is my canoe
Pukengaki is my mountain
Ruamahanga is my river
Ngāti Kahungunu is my tribe
I am Jane Hopkirk

Ko Waiwhetu te Papatuawhenua
Ko Kotimana te iwi
Ko Gunn te hapu
Kei te noho au kei Otepoti inaianei,
i raro i te maru o KaiTahu Ko
Linda Wilson toku ikoa I was born in the Hutt Valley
I am descended from the Scots
From the clan of Gunn
I now live in Dunedin, under the
shelter of the tribe of Kai Tahu
My name is Linda Wilson

Māori, indigenous to Aotearoa/New Zealand, mirror other indigenous populations who are well documented as having the worst health presentation and being the least likely to have their health needs met (Harris, et al., 2012; Jansen et al., 2011;World Health Organization, 2007). Occupational therapy (OT) provision in Aotearoa is usually provided by non-indigenous practitioners (Jeffery, 2005), and only a few are providing interventions based on a Māori worldview (Te Rau Matatini, 2009).

Until indigenous peoples routinely have access to services provided from their own worldview, non-indigenous occupational therapists need to understand how both indigenous practitioners and indigenous clients may experience and see the world differently from them (Iwama, 2007; Gerlach, 2008; Kronenberg et al., 2011; Gilsenan et al. (2012); Najat Saif Mohammed & Borthwick, 2012; Hopkirk, 2013).

Within Aotearoa, the slowly growing number of indigenous practitioners (and clients) have shared some of their experiences to provide OT interventions appropriately (Carpenter & Sutherland, 2011; Davis, 2010; Emery-Whittington, 2010; Gilsenan, Whittington, & Hopkirk, 2012; Jungersen, 2002; Marino, 2010; Te Rau Matatini, 2009; Wilson & Hopkirk 2012; Wilson, 2010). Foundational to providing these has been acknowledging the place indigenous people and indigenous practitioners have in being a colonized or marginalized people in their own land, which adds barriers to their being effective members of the health care system and the profession.

Although located in Aotearoa/New Zealand, some of the issues raised in this research will have relevance to other countries, especially where there are indigenous peoples who may have been colonized or marginalized in their own lands.

Background

Durie (2003) describes indigenous peoples view of health as

> both a collective and an individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical, and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present, and future coexist simultaneously (Durie, 2003, p. 510).

Māori health perspectives (as defined in this research) are traditional and customary knowledge patterns based on a Māori world view being

> that bank of information built up by generations of ... Māori upon which their survival was based ... a way of considering issues from a Māori cultural viewpoint (Mohi in Williams, 1997, p. 15).

A range of models of health developed from this worldview include the following: Te Whare Tapa Whā (Durie, 1998), Te Wheke (Pere, 2003), Te Pae Mahutonga (Durie, 2003), and Whanaungatanga (Milne, 2001) (see Glossary for explanations of these models). All of these see health in community and family-based ways. This contrasts with the World Health Organization definition of health that focuses on the individual's state of physical, mental, and social wellbeing.

An early description of OT conveyed the complexity of this profession's view, which was remarkably similar to Māori understandings:

> ...Our body is a living organism pulsating with its rhythm of rest and activity... an organism that maintains and balances itself in the world of reality and actuality by ... acting its time in harmony with its own nature and the nature about it (Meyer 1922a in Schwartz, 2005, p. 64). A

> contemporary definition of occupational therapy focus on 'enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life' (Townsend & Polatajko, 2007, p. 372).

In New Zealand, indigenous occupational therapists comprise 2%(44/2159) of the profession for 14% population of Māori with less than seven practitioners worked indigenous settings (Te Rau Matatini, 2009). There are few OT practitioners both strong in their indigeneity and skilled enough in Māori practices to develop and provide indigenous OT specific interventions. These could include assessment tools based on an indigenous worldview incorporating function and participation important to their cultural context, for example, use of creation stories to motivate engagement in activities of significance, participation in cultural healing practices that sit beside other interventions, and involving family and community.

Understanding what it might mean to have services embedded in a client's own culture was the genesis of this research. Culture can be defined in several ways, including 'common markers of distinction that people ascribe to categories of objects and phenomena [and the] dynamic process by which these distinctions and categories are created, maintained and transmitted' (Iwama, 2006, p. 8).

This study was framed around the question 'Do cultural perspectives impact on occupational therapy practice?' It set out to explore health perspectives of Māori and OT, and develop a conceptual framework to support effective cultural responsiveness to Māori. Given that this research was considering indigenous ideas on health, it was apposite to use Māori-framed research methods.

Māori methodology

Māori methodology was selected to protect the management of Māori knowledge shared and used in the research (Smith, 1999, 2006). Traditionally, Māori knowledge was held by few; it was sacred and required protecting (Mead, 2003; Mercier, 2007). Māori methods of inquiry are derived from philosophical bases that intertwine multiple strands of Māori history and culture, pedagogy, lore, cosmology, and epistemology (Mercier, 2007). As research methodologies, they are not amenable to being described in qualitative or quantitative terms (Smith 1999) but offer a holistic view, balancing multiple components, not necessarily scrutinizing, measuring, or quantifying in the same way western science does. Where Māori are apprehensive in their own home-land, and see their knowledge not honored, researchers need to address these issues, as has been performed here, through using Māori framed research.

The design, investigation, interpretation, and presentation of the results are underpinned by seven principles of Māori research (Smith 1999).

These have a practical and a deeper meaning applicable to the interpretation of the research. We explain how this model was applied: but the explanation is partial as giving a full explanation would share what is essentially Māori knowledge and for Māori understanding only.

(1) The first component is 'respect for people' (Smith, 1999, p 120). In a country with a history of colonization where indigenous beliefs and practices were belittled and even banned by law (Tohunga Suppression Act 1907 prohibiting indigenous healers from practicing), it is the essential validity of the participants which is core.The concept associated with this research is the legitimacy of indigenous knowledge as worthy or as equal to other knowledge such as scientific or western knowledge (Durie, 2006).
(2) In a Māori world view, 'face to face' contact (Smith, 1999, p 120) is vital and widely applied when consulting Māori. Māori assess the person they are speaking to and will only share significantly if they feel safe to do so. Analyzing data requires others of an indigenous view to support the analysis.
(3) 'Look, listen ... speak' (Smith, 1999, p 120) contains an implicit challenge to the researcher to not have preconceived ideas or assumptions and to open themselves to all that might be shared on multiple levels such as the words said, the feeling attached, and the spiritual connection.
(4) The next element is 'share and care for people' (Smith, 1999, p 120). In many ways, this could be seen in a western context to be compromising notions of objectivity when engaging participants as the researcher's view may influence the participant. However, from a Māori view, a process of assessing how safe a person is to relate to occurs and unless a real connection is made, little of significance will be disclosed to the researcher. In applying this to interpretation, it considers the purpose of the research. Māori are an over researched people group and results have not

always been for their betterment (Smith, 1999). Thus, the robustness of collecting and analysing data needs to be seated in the context of caring and sharing to ensure results enhance Māori wellbeing.

(5) To 'be generous, be cautious' (Smith, 1999, p 120) is an attitude during the collection and analysis of data. Research on Māori has at times been an inspection of the minutiae – a dissecting of culture (Smith, 1999). There is more than the dissected in a Māori view where meaning, spirituality, and connections have far more significance than the actual components. Balancing this with the cautious element is linked to the assessment of relationships with participants, the research itself, and the analysis. In this study, it meant having a Māori supervisor, Māori occupational therapists to discuss elements with, and using Māori methods to guide and support the conclusions.

(6) 'Do not trample over the mana/authority of people' (Smith, 1999, p 120), directs Māori researchers to uphold these elements and to also reminds them of the spiritual connection that links it all together. There can be repercussions on the researcher themselves spiritually if they do not treat the informants and the information with respect.

(7) The final element 'don't flaunt your knowledge' (Smith, 1999, p 120) places the indigenous research participant at the forefront of the research. This is again contrary to some western views holding the knowledge where it belongs in the participants hands not the researcher's.

Data collection

A questionnaire survey of occupational therapists and interviews with experts were the primary data collection methods. These were supplemented by an analysis of literature, discussion with some in Māori health, and consultation at hui/culture specific meetings. The data was collected in 2008 and 2009. The research was approved by the Massey University Human Ethics Committee (July 7, 2008).

A two-part questionnaire was distributed, face to face and then forwarded to interested participants, at a national cultural workshop. Demographic details and views on culture and OT health perspectives were sought[1]. Seven of the 18 respondents identified as Māori. Part two was for Māori only with open questions about barriers to integrating the Māori and OT perspectives and continued professional development needs.

Selecting practitioners to interview was difficult because there were so few indigenous occupational therapists and fewer still who worked in a 'by Māori, for Māori' organization.

Five health experts were interviewed. There were two Māori occupational therapists, one New Zealander occupational therapist and two Māori health specialists.

Participants were ethnically diverse with 17 identifying themselves as New Zealanders and 11 as Māori. Eight reported more than one ethnicity and one reported seven. Five identified themselves as Māori only and six said Māori/New Zealander.

Most were employed in a university setting with hospital employees next. Most Māori practitioners worked in hospital services. The Māori practitioners had lower qualifications and were younger than the other participants on average.

Interestingly, Maori therapists reported they had less than a 25% chance of working on a daily basis with Maori, other therapists reported that they were 38% likely to work regularly with Maori.

Interviews were undertaken in an organisation promoting indigenous health. Interviews were recorded and transcribed, and notes were made during the recorded interviews. The interviews amplified and explored the data from the questionnaires, literature search, and consultations to confirm their fit with the framework presented here. Sources are referred to as 'Participants (numbered)' when they are a questionnaire respondent; 'Workshop Participants' when from the workshop forum or 'Interviewees (alphabetical order of interview)' when interviewed by researcher. Minor editorial changes have been made to quotes for reading ease.

Findings

Consistent with the Maori research approach, we present our findings using an indigenous view of the data collected and the meanings ascribed. We acknowledge that in many Western paradigms, it is conventional to present results in a linear way. However, research from an indigenous view can be liberating when it returns the research to that of an indigenous worldview and holds its validity in this context (Smith, 1999, 2006). Here, indigenous ways of knowing are the primary focus.

Every participant saw culture as an essential enabler of health for indigenous clients. This finding facilitated

[1]Questionnaire is available from researchers.

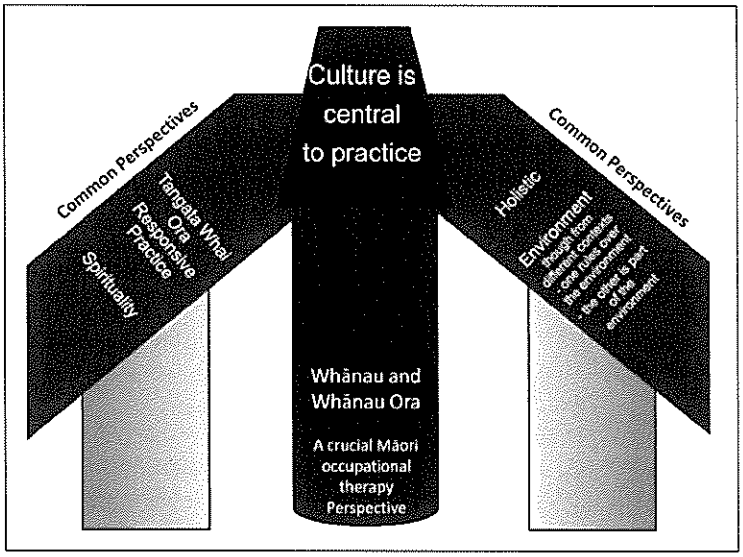

Figure 1. A framework for practice.

the development of a conceptual framework that can be used to guide understanding and practice. This framework (Figure 1) also presents our findings: we describe the framework using a common image – a whare, a Māori meeting house, and then elaborate its components and interconnections.

The framework, based on the traditional Māori community building or meeting house is used to frame, shelter, and position the findings in three interconnected sections:

(1) culture is central to effective practice;
(2) shared OT and Māori health perspectives;
(3) whānau/extended family and Whānau Ora (well Māori family and communities of meaning (Ministry of Health, 2002)).

A framework for practice

Indigenous self-determination in health encounters was strongly supported by occupational therapists and indigenous practitioners alike. People need and have the right to be 'able to live as Māori, that is actually live, and not die early, and be able to be full citizens of the world with choice: Māori should be no more bounded or restricted than anyone else' (Interviewee A). This is only possible with 'Whānau (extended family) knowledge, which is crucial to supporting the healing of whānau. 'Health is Māori development that is whānau development' (Interviewee D). Māori aspirations are 'Māori want to be productive, participate and contribute to whānau, hapū and iwi' (hapū/sub-tribe, iwi/tribe) (Interviewee E).

The image used to build the conceptual framework is a representation of the Māori whare situating the framework where traditions and the Māori worldview are paramount. This framework was developed in consultation with an elder of the researcher's tribe and confirmed by the Māori supervisor of the study. As a conceptual framework, it depicts the elements the research generated, rather than a model. The links indigenous peoples have with each other are the connection we have to the environments we live in and go beyond the realm of the physical to encompasses the spiritual (Durie, 2005).

The meetinghouse is a sacred place where cultural practices are supreme and integral to tribal, sub-tribal, and family life. The top of the whare is usually a head of a significant ancestor with arms coming down either side that extend past the walls, with a central ridge post (Buck, 1952).

Culture in OT practice is situated in the central overriding place of the head of the house to illustrate its importance. Either side of the head are the two arms that hold the jointly held OT and indigenous health perspectives. These include spirituality, tangata whaiora/client responsive practice, holism, and environmental context.

The vital ridge pole, supporting the structure, is whānau/family and whānau ora/well Māori families and communities.

Indigenous OT practitioners did not think occupation itself was significant: instead, relationships and family were. As occupation was not identified in this context, despite its permeating other aspects, it is not part of this culturally constructed framework.

Culture is central to effective practice

Participants saw that clients should be protected and enabled by their cultural outlook when seeking wellbeing. 'Cultural perspectives are often central, whether recognized or not, to a person's involvement in occupation and the world around them' (Participant 18), because 'culture influences who we are as people and the meaning we give to our occupations' (Participant 10).

A Māori view was that

> Culture is a living entity made up of all the experiences from home ... contact with my whānau/family, discussions on iwi/tribal politics, hui/cultural meeting, waiata/singing are all a part of my life and keep me close to my Māori cultural roots' (Participant 15).

Most respondents described being culturally safe in practice (Ramsden, 1991) as important:

> Cultural perspectives are the lens through which I view my practice. I am aware that another perspective exists and I look for differences to ensure I am not assuming things for clients. My own cultural perspectives help me feel confident in my personal commitment to my profession and to my responsibilities to people in my community" (Participant 15).

Indigenous practitioners stated that their indigenous view was paramount and OT perspectives were secondary, developed through dual cultural and clinical practice. There is a

> philosophical challenge to merge Māori concepts into western health models. It is putting less into bigger (culture being the bigger in this case). Both are hybrid.
>
> Practitioners must use both i.e. the best OT practice ... Things Māori are completely ordinary so merging seems strange. When accessing OT services Māori shouldn't feel strangeness (Interviewee C).

Shared occupational therapy and Māori health perspectives

Four aspects were congruent between OT and a Māori worldview. These were spirituality, the centrality of the client, understandings of holistic care, and the relationships between the environment and health.

Spirituality

Spirituality was common in OT and Māori views. In OT, it was expressed as we 'value spirituality – though this does depend on the model used' (Workshop Participant). The centralizing of spirituality in the person in the COPM© model, is the essence of the being and a determinant of occupation (Law, et al., 2005). It is also recognizable in responsive practice where 'Occupation, spirituality, doing things that are meaningful to the person' (Participant 10).

Māori health perspectives considered spirituality vital to wellbeing:

> Spirit is unique – the life force – I can't describe it, but it drives all people the way we 'do'. It is the fire within – what you feed it will depend on what you do with it ... It is a journey, spirit, activity, meanings all combine (Interviewee A).

Examples of applied spirituality were described:

> Western cognitive interventions do not necessarily heal Māori spiritual issues. We need to see more recovery through the use of healing the spirit. Link back to the land, to the beach – where Māori go to restore, to heal (Interviewee B).

Tangata whaiora/client responsive practice

Placing the tangata whaiora/client (see Glossary) in the center of care, driving the services they receive was another shared view and crucial to effective outcomes. An occupational therapist's view was

> If we are providing client-centred practice then the cultural perspective of the client is essential to recognise.... or the intervention won't be successful (Participant 15).

This view was also held by Māori practitioners who saw that 'Tangata whaiora are the expert' (Interviewee B).

In order to be effective, practitioners need to understand the cultural biases they hold. Therapists were clear that when you 'provide culturally safe and client- centred practice you need to be aware of possible differences in values/beliefs' (Participant 7).

Responsive practice included the concept of self-determination of empowering Māori to be Māori. Māori aspire to be fully engaged in the world: 'reaching

full potential – community participation/citizenship is enabling occupations via increase of a person's capability' (Participant 17) and part of a

> Community which is participating and contributing to community/whānau, give back to whānau/ family and participate in relationships. It includes the upholding and building of mana/ inherent worth and status (Interviewee B).

Understanding of holistic care context

This perspective of health, found in Māori culture prior to European settlement but still relevant today was described by Interviewee C:

> pre models of Māori health had a holistic view of health. Health was joined by occupation and function and a holistic perspective. A holistic view meant different things 100 years ago. Today we see kids wanting to use play station and middle aged women wanting to use internet, this doesn't alter that they are Māori (Interviewee C).

New Zealand occupational therapists identified holistic care as including spirituality and family and

> 'looking at the context the person is living/working/playing within and how this influences meaningful occupations for each person considering the physical, emotional, spiritual, and psychosocial aspects of each person I work with' (Participant 8).

Relationships between the environment and health

Occupational therapy's use of the environment to enable occupation was allied to an indigenous view. Occupational therapists saw the environment as able to be modified, occupied, and controlled by 'enabling occupations via increase of a person's capability and environmental accommodations' (Participant 17).

In contrast, indigenous practitioners identified themselves as being part of, belonging to and negotiating with the environment, as in being 'connected to nature and environment and land to sustain, to meet basic needs – in flow. Your being was taken from around you' (Interviewee B).

Whānau and Whānau Ora/family and well communities

Māori health and Māori OT practitioners identified whānau/extended family as the most common perspective across all data. Whānau/family were crucial to a Māori view, because 'Māori want to ... contribute to whānau, hapū/ sub-tribe and iwi/ tribe' (Interviewee E).

Whānau/family is significant in different ways, being described as crucial to belong to, to participate in, and to contribute to. It is one of the cornerstones of 'Te Whare Tapa Whā' (Durie, 1998) a holistic model of health that holds spirituality, whānau/extended family, physical, and mental wellbeing as a four walled house, as noted by Participants 13 and 16.

As a tool to heal 'Whānau knowledge is crucial to supporting the healing of whānau/family'(Interviewee D). This incorporates knowledge from family relationships, the understanding of how healing can occur in a family, and how it can occur in a particular family's context. Whānau/family need OT services, for where one in the whānau/family group is unwell, the whole group is unwell.

This is understood in whānau ora (well Māori family and communities of meaning), (Ministry of Health, 2002). Whānau ora is crucial to any Māori services as demonstrated by this comparison of a Māori children's health service to a mainstream service:

> kids are managed differently; we start with needs not being as honed in as mainstream on illness/ disability but we work more holistically starting with whānau/family first then the child, compared to mainstream who may only use a social skills group as an intervention, whereas the Māori team still do a full assessment and intervention (Interviewee E).

Indigenous practitioners reported whānau/family wellness as crucial to successful intervention outcomes. The need to provide services to the client, to their family, and wider family/community for positive outcomes was the most frequently reported indigenous perspective. Yet, this was not mentioned or given status by non-indigenous occupational therapists.

Discussion

A conceptual framework using the Māori whare (Figure 1), represents the main findings about OT concepts and Māori world views of health and wellbeing.

Culture is significant, and although there were differences in emphasis, there is much that is similar in the areas of holistic care, spirituality, client responsive practice, and environmental contexts.

Indigenous peoples and occupational therapists both adapt environments to enable participation in occupations of their choice or for the development of their tribe or family. However, indigenous processes require a negotiation with the environment, of which they consider they are inherently linked to, before adapting it. Occupational therapists could work with clients and their extended family on the processes that are used to negotiate with and about the environment when discussing environmental modifications.

Such differences need attention by the profession to identify and support Māori occupational therapists as they develop their practice, and to assist non-Māori therapists to understand how to be effective with Māori families.

Therapists who identify as Māori need access to 'training in kaupapa/Māori research, cultural supervision and having other Māori staff linking together to strengthen one another and having a safe place to work and ... be Māori (Interviewee B)'.

The conceptual framework is intended to assist indigenous Māori students and therapists to understand the similarities between Māori health and practices and OT practice.

It may also help non-indigenous students and practitioners to examine ways these shared perspectives are applied and to develop them to provide effective services for whānau/extended family.

Occupation was not considered important by the indigenous participants, something noted by Iwama (2006). It may be that 'occupation' is a culture-bound concept, which is strongly represented in OT's culturally constructed context, or that indigenous practitioners and clients are more focused on addressing issues of daily life than talking about it. Māori do benefit from OT choosing to access OT more than other health professions (Hirini, et al., 1999). The findings indicate that what emerges from the research is that attention to holistic views, client centered practice, spirituality, and the environmental connection could be used as mechanisms to enhance practice with indigenous clients. OT practitioners in Aotearoa/New Zealand need to focus on recognizing the individual within the context of their extended family, their natural environment, and the historical social and political realities of living as Māori. Only by negotiating with family about how all these influence the person and their circumstances will practitioners be able to facilitate positive change for the person and thus the community.

We believe there is an urgent need to grow the workforce of indigenous practitioners, develop indigenous OT interventions, and to extend the cultural competence of indigenous and non-indigenous practitioners in Aotearoa and elsewhere.

Methodological other considerations

Limitations came primarily from a small number of indigenous occupational therapists, and of them, only a few were culturally strong and had practiced for a significant period of time.

Imperative in this research was the need to protect the indigenous knowledge shared with in it. Loss of indigenous knowledge was an integral part of the colonizing process that has occurred in Aotearoa where colonial or western knowledge was seen as more significant and continues to this day to challenge indigenous knowledge. The research process and participants were held tightly within the realm of the Māori worldview to avoid devaluing indigenous knowledge.

Future research

The development of this indigenous-based framework specifically links the culture of this land and OT practice. Conceptual frameworks that link culture and practice may help guide practice understandings for indigenous and non-indigenous therapists in other countries, too. However, they require research and evaluation with students and local practitioners. This framework needs to be evaluated by therapists who identify as Māori and to see if it is helpful as they establish practice in by 'Māori for Māori' services.

Further research into conceptual and practice interactions between OT practice and specific indigenous and non-western cultures are needed. This may also support the decolonising of OT practice, encouraging approaches based on indigenous knowledge.

Conclusion

Māori methodologies were used to explore the concept of health held by occupational therapists, indigenous occupational therapists, and indigenous health practitioners in Aotearoa/New Zealand. All identified culture

as a central to effective practice. Common elements were working holistically, with spirituality and from a client centered view.

Indigenous practitioners considered these to be a strength of OT. There were differences about occupation and the need to include the extended family and community in service provision: this was not appreciated by non-indigenous practitioners.

A conceptual model representing a whare, the traditional Māori community building, was developed to show the relationships between culture and health. The approach of creating an indigenous-based conceptual framework could be replicated in other countries. This framework, based on research with indigenous practitioners, is intended to assist occupational therapists to walk with indigenous clients and their families on their path to wellness in Aotearea.

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