

“Just Therapy” with Families on Low Incomes

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This article addresses the inadequacies of counseling, therapy, and social work that occurs with low-income families. The author argues that many families who seek help arrive with problems that are usually assessed separately from their socioeconomic and cultural contexts. Careful questioning will often lead to the discovery that the onset of many family problems are located in events external to the family, such as unemployment, bad housing, and racist, sexist, or heterosexist experiences. They can be extremely depressing ongoing experiences that eventually lead parents and children into a state of stress that opens them up to physical and mental illnesses. This article argues that a wide body of research supports such a view and that counseling, therapeutic, and social work practices should address these issues much more directly. It also argues that practitioners have an important role to play in social and economic policy development out of respect for their clients' struggles.

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When we speak of families and therapy, we tend to think in mental health or relationship categories. In this article, the term *families* refers to any primary intimate group, who either through genealogy or intentional commitment identify themselves as family. The term *therapy* in this context refers to the healing and problem-solving discourses that the helping professions carry out, including those of psychologists, social workers, counselors, psychiatrists, and nurses. A family in need of therapy may require help because of the unpredictable behavior of one or a number of household members, or because relationships between members have become disrupted in some way. If, instead of referring simply to families, we refer to *poor families*, we are triggered into issues of context.

Addressing the Context

What is good therapy when families are poor? How does a therapist address relationships when parents who struggle to feed their families are not able to access decent housing? Do current clinical and therapeutic courses adequately prepare students to address the therapeutic issues of poor families? The words *families* and *therapy* tend to elicit a reasonably predictable set of expectations, but if one uses the adjective *poor* to describe a set of particular families, those expectations become challenged.

Consider for example, how a group of therapists are likely to answer the question, "What is absolutely basic to a family or family life?" They would probably answer along the following lines: There must be at least a minimal commitment to relationship among members. There must be some evidence of emotional warmth among members. There must be some cooperative patterns of behavior that order at least some of their life together, and one would hope that there would be some evidence of what is referred to in the non-social science world as love.

Consider now how a group of community workers may answer the same question concerning what is absolutely basic to a family or family life. They would probably answer along the fol-

lowing lines: Families require adequate and safe housing. They require sufficient income to live out of poverty. They need to be able to access affordable health care, and they need to be able to live free from fear and harassment.

Both views, of course, are correct in as far as they go, but their emphases are quite different. One is focused primarily on family dynamics, whereas the other is focused primarily on social and economic context. The same divergence of views would probably occur if therapists and community workers were asked a further question: "What causes the problems of poorer families who visit therapists for help?"

Many therapists, when referring to particular stresses poor families face, would probably still make a list characterized by the following sorts of problems: inadequacies in communication, the loss of emotional warmth, tensions in relationships, an inability to make decisions, and difficulties resolving conflict. Community workers, on the other hand, would be more likely to refer to an alternative list of problems, such as poverty; bad housing; inadequate financial resources; and ongoing racist, sexist, and heterosexist experiences, for example.

For many therapists, the problems of all families relate primarily to individual or family dynamics. Such a view provides a contained space in which to work effectively, and that which is beyond those boundaries is the work of other professionals. Although this view limits and defines therapists' work, it unfortunately also ensures that work will be ineffective, and possibly detrimental to poor families, because it treats the symptoms of larger scale social problems as though they are the result of internal family dysfunction. The context named by the community workers is largely dismissed.

Many families who come to therapists arrive with problems that include psychosomatic illnesses, violence, depression, addiction, delinquency, marital and partnership stress, psychotic illnesses, parenting problems, relationship stress, and the like. If the therapists are sufficiently patient and persistent, they will discover after some questioning that the onset of many, although

certainly not all, family problems are located in events that are external to the family. These could be events such as unemployment; bad housing; homelessness; racist, sexist, or heterosexist experiences; and the like—the same problems, in fact, that the community workers identified. These can be extremely depressing, ongoing experiences that eventually lead parents and children into a state of stress that makes them vulnerable to physical and mental illnesses.

When people come to therapists depressed and in bad housing, and therapists treat their clinical or social problems within the conventional clinical boundaries, they are simply made to feel a little better in poverty. Quite often, competent therapists are able to quite effectively help move people out of depression, but then simply send them back to the conditions that created the problems in the first place. Unintentionally, but nevertheless very effectively, they simply adjust people to poverty.

Furthermore, by implication, the therapists encourage families in the belief that they, rather than the unjust social, economic, and political structures, were the authors of their problems and failures. They do this despite the knowledge we have today of structured and cyclical unemployment in most postindustrial countries, the physical and psychological pathologies associated with inadequate housing, the same pathologies associated with ongoing racist experiences, and the patriarchal determinants of physical and sexual abuse.

Further still, such therapists can be guilty of silencing the voices of poor people. Low-income families often share their vulnerability and pain with therapists, who then, because of their professional commitment to confidentiality, never pass it on to the forums that could do something about it. The therapist is often one of the only people in mainstream middle-class society to whom poor people outline their difficulties. If they feel no compulsion to address the causal factors by bringing the repeating themes of poor families (not the individual confidential stories) into the public debate or to the institutions that can change them, then the cry for help has been silenced.

Inequalities and Health

A substantial body of literature associates low-income households and inequality with physical and mental ill health. One of the most significant early research projects on the subject was carried out by Harvey Brenner (1973) at Harvard University. His research focused on unemployment and societal health. He led a large-scale study on the effects of economic recession in the United States from 1936 into the 1970s, and his results indicated that a 1% rise in unemployment is followed by 6% more admissions into psychiatric hospitals, a 4% rise in suicides, a 4% rise in state prison admissions, and 6% more homicides.

Further research by Brenner (1979) confirmed the same findings in England and Wales. Researchers tested the relationship between unemployment and suicide in eight different developed countries and again demonstrated the close link between annual variations in unemployment and suicide rates (Boor, 1980). Another study found the same relationship in New Zealand (Macdonald, Pearce, Salter, & Smith, 1982).

Since the 1980s, many local and national studies have followed Brenner's (1973; Acheson, 1998; Benzeval, Judge, & Whitehead, 1995; Crampton, Salmond, & Kirkpatrick, 2000; Dunn, Hayes, Hulchanski, Hwang, & Potvin, 2003; Kawachi & Berkman, 2003; Kawachi & Kennedy, 2002; National Health Committee, 1998; Waldegrave, King, & Stephens, 2003). They each show a distinct relationship between inequalities in society and physical and mental ill health. Poorer people die earlier and consistently have the poorest health and the highest hospitalization rates. Furthermore, when a country's population health status improves overall, the health inequalities do not decrease.

The evidence is so overwhelming that a number of major governments have set up inquiries to study the evidence and recommend new directions for national health services to address health status from the perspective of inequalities. The famous Acheson (1998) *Independent Inquiry into Inequalities in Health* report in the United Kingdom and the *Social, Cultural and Economic Determi-*

nants of Health in New Zealand (National Health Committee, 1998) are two such examples.

Given the substantive evidence of the relationship between inequality and physical and mental ill health, it is reasonable to suggest that many of the problems that families present in therapy result from poverty, inadequate housing, unjust economic planning, unemployment, racism and so on. As such, where this is the case, one can conceive of the problems as the symptoms of inequality.

From this perspective, these symptoms, which are usually construed in mental health or social categories, should not be considered as simply personal, intrapsychic, or intrafamily disorders if they arise in association with broader structural problems in society. They can be more accurately viewed primarily as the symptoms of those structural social problems. The tighter clinical categories are secondary and only useful if viewed in relation to the primary focus.

This suggests a notion that many, although obviously not all, of the mental health and relationship problems people have are the consequences of power differences and injustice. Such a notion seldom appears in clinical literature or as a major theme in therapeutic conferences. If it did, however, researchers would do considerably more exploration and analysis regarding ethics and social justice themes as they relate to family context and would focus less exclusively on the bounded space of individuals, couples, or families.

Therapists as Thermometers of Pain

Therapists, be they psychologists, social workers, counselors, psychiatrists, or nurses, have a critical role in postindustrial and largely secular states. They are the predominant professional group who listen to the pain of individuals and families. They work in the institutions that address pain in these societies, such as the health, welfare, and justice services. They work in the non-governmental and community organizations that provide fam-

ily support and services for abuse, poverty, housing, general counseling, mental and physical ill health, and so on. They also work privately, but are often contracted into the work of these larger organizations.

Therapists, as a professional group, are the most informed “experts” of the collective grounded levels of hurt, sadness, and pain in modern countries. Those who live in deep pain are of course the primary experts in the sadness and hurt they and their communities experience, but therapists are the professional helpers who continually witness that pain with many individuals and families and across a variety of communities week after week. As such, they carry a substantial responsibility to identify, quantify, and describe the severity and causes of it. This is ethically essential if they are committed to honoring their client group. They have a responsibility to publish and publicize the causes and outcomes of people’s pain so they may be addressed in the public debate and affect policy. Good policy in this sense can address issues of well-being and inclusion in informed and effective ways.

Therapists, in this view, can be seen as the “thermometers of pain” in modern countries. Instead of withholding their knowledge in clinical vacuums, they can quantify, describe, and identify causality for all to see. If issues of housing, poverty, or race become dominant in caseloads, for example, their descriptions can inform the public by adding reality and depth and providing a more helpful basis for intelligent public discussion. One can find a good example of this in the public work many fine therapists have carried out highlighting the levels of abuse occurring in many countries, the causes of that abuse, and the policies and laws required to stop it. A parallel level of action and commitment is required in a range of other pain-causing factors therapists identify.

There are a number of critical issues along these lines that therapists could usefully ponder at professional conferences, in professional organizations, and at staff meetings that may be more useful than the endless string of case study presentations and focus on therapeutic techniques. They would center on the im-

portance of developing record systems of the numbers of individuals and families they meet in therapy who are below the poverty income threshold in their country, for example (or in inadequate housing, or being subject to ongoing racist experiences, etc.). The summaries of those, and their colleagues' in other organizations, could be written up and placed in the public arena.

Therapists could write up the stories they see and hear in therapy for popular media outlets and advocate for social changes that will address the therapeutic problems they identify. They could also identify the failure of certain social and economic policies as the prime cause of pain and ill health to many low-income families, rather than the failure of individuals and families, as many in society often view the situation. When therapists know that certain social and economic conditions prolong ill health, they could be active in creating public awareness concerning these issues, out of respect for the needs of their clients not to have their sicknesses prolonged.

Actions like these would require a fundamental institutional shift of attitude and responsibility in the profession. To begin would not be difficult, however. For example, keeping the statistics would simply involve a few more columns in case-note sheets after some sensitive questioning. Reflective and careful analysis, however, would be required to address the social critique, based on those statistics, for placement in academic and popular media outlets. Success in achieving these goals would go a long way toward ridding the profession of the fair accusation that practitioners often silence the voice of poor people as they unintentionally help make them happy in poverty.

The profession may also choose to address some uncomfortable and more personal questions. These include:

- Has the profession of therapy been captured by a group who believe in low taxes and minimal social policies?
- Are therapists paid off to be silent, given the profound knowledge many of them have about the lives of poor people?
- Do therapists make money off people's misery and thus have no interest in reducing their problems at root?

These are tough, reflective questions, but they are the sort a professional who is entrusted with the vulnerability of people during some of their most fragile periods should be asking. It is perhaps excusable to admit one's naiveté and unintentional behavior when first addressing these questions, but once admitted, it is surely unethical not to change. Societies need their reliable thermometers of pain, the mercury readings provided by the therapists.

"Just Therapy" in Poor Communities

For therapists to successfully work in poor communities, they have to take the critical context beyond the family into account. Those most in need of the health and welfare resources in most societies and communities are those who experience the most trauma, the greatest stress, and, as a consequence, the most ill health. They are usually those with low incomes, people in cultures that have been marginalized in the societies in which they live, and, most frequently, they are women. Unfortunately, therapeutic resources are spread rather thinly for this group because they are outside the mainstream and have less money.

Waldegrave, Tamasese, Tuhaka, and Campbell (2003) created Just Therapy to help therapists address the critical socioeconomic, cultural, and gender contexts of therapy. This article has focused predominantly on the socioeconomic aspect and therapists' interactions with and responsibilities to their societies. Each of these contexts, however, are very important.

It is equally important to address the context in the therapeutic process as well. A full development of this is not possible in an article of this length, however, some pointers may be helpful. It is beneficial when questioning low-income household members to sensitively address their stories about accessing necessities. Unfortunately, therapists seldom refer to this in therapeutic discourse. The adequacy of household income, quality of housing, and access to good health care are critical contexts. Families in these situations struggle and are often highly motivated to share

coping strategies and survival skills. These in turn offer genuine stories for the therapist to admire, honor, and, in a sense, be in awe of.

Institutions view so many of these families in a pathological light. They are often referred to as “dysfunctional” or “multiproblem” families. This consistently negative view, combined with the sense of social failure and lower status conferred by mainstream society, can quickly become self-fulfilling. It is critical to this work to recognize where families’ strengths lie and honor them. Strengths are usually found in their resilience under the sort of stress middle-income households are seldom required to endure.

Nothing is more basic, for example, to a family than a house. As such, housing can usefully become a central context in the therapeutic process. Without adequate, safe, secure housing, all families are at risk of mental or physical sickness. The meaning therapists assign to poor families’ housing problems determines whether the therapist will locate the problem internally or in its socioeconomic context. If the therapist takes the former route, he or she will encourage feelings of inadequacy and self-blame. If the therapist chooses the latter, contextual route, then the focus will move toward understanding the socioeconomic context and developing smart survival strategies. It is very important to challenge the failure meanings that so many poor families adopt as a result of their constrained circumstances and the reactions of others to them.

In our work, for example, we often congratulate families for surviving overcrowded living conditions with their families still intact. Their ability to survive a housing crisis not of their own making, but of that of the housing planners, can be recognized as courageous, committed, and extraordinarily competent. Having explored their stories of resilience, resistance, and survival, we often indicate that we are not at all confident our families would have survived those circumstances as well as the clients’ have. In this positive context, we are able to address the symptomatic presenting problems in context, enabling families to identify the broader structural issues that have been imposed on them. We can then help them recognize their strengths as the stepping stones to either surviving without self-blame or developing smart strategies to move to a more secure social place.

We also use metaphor to encourage a positive perspective. For example, we may say to a single parent who has struggled through many difficulties with his or her children as a result of rejection and poverty that we are amazed at the parent's ability to steer his or her canoe through the stormy waters of loss and rejection that they have experienced. "All your cargo and paddlers are still on board and you have kept them in rhythm despite the odd upset. You will reach the calm waters you have been searching for, and when you do, we are sure you will recognize just how much you have achieved." The metaphor gently recognizes the parent's achievement in what has been his or her prime life task, despite the current and past problems. It externalizes and contextualizes the difficulties that would pose serious obstacles for any family, at the same time as it encourages and touches the parent's hopes.

Focusing the Problems of Current Practice

The therapy community has served poor families badly in three ways. First, although such families are those most in need of therapeutic resources, they seldom receive such resources on their own terms. A combination of middle-class capture and preference for therapists to work above the poverty line constrains the resources available to low-income households.

Second, therapists working with poor families typically constrain themselves in narrow clinical boundaries that avoid the prime contextual factors that are so basic to the families' daily survival. This encourages the internalizing of their problems and the consequent self-blame during therapy and subsequently, if the family relapses.

Finally, this article strongly suggests that therapists would better serve poor families if they took their role in social and economic policy development seriously. As the key profession most in touch with grounded pain in society, therapists would contribute substantially more to disadvantaged families if they were active in the public debates and policy discussions that affect these families in modern democratic societies.◆

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Samoan and psychiatrists' perspectives on the self: qualitative comparison

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Objectives: To compare psychiatrists' perspectives on the meaning of self, in general adult public practice psychiatry in the Wellington region of New Zealand, with a Samoan view of self and to discuss the implications for the practice of psychiatry with Samoan people in New Zealand.

Method: A focus group of psychiatrists was convened for three sessions. A Samoan view of self was presented to the participants. Transcripts of the focus groups were analysed using inductive content analysis and a process of cultural accountability was included in the research design.

Results: Individual and secular notions of self dominated the psychiatrists' perspectives and contrasted with the primacy of relational and spiritual notions of self in Samoan culture. Psychiatrists experienced a sense of cultural 'dissonance' on first exposure to the Samoan views. The Samoan notion of self was considered to challenge the universalist assumptions of Western psychiatric theories as understood by the participants. The Samoan relational notion of self had implications for clinical interviewing, understanding of phenomenology, formulation and treatment planning with Samoan patients and their families.

Conclusions: Dedicated Samoan or Pacific Island mental health services would allow culture-specific concepts central to an understanding of mental health to be embedded in service delivery. The process used in this study and the notion of dialectical tension could be used in the cultural education of mental health clinicians. The cultural accountability process models an important aspect of such training.

Key words: cross-cultural, cultural accountability, Samoan, self.

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Human identity is at the heart and soul of our endeavours. Our task is not to negate cultural identity or to squeeze others into straitjackets of cultural neutrality. The challenge is to understand cultural identity as a keystone for healing, for living and eventually for dying.

Mason Durie, College address RANZCP Congress 1996 [1]

Differences between Western and non-Western views of self have been highlighted by many writers [2–5]. In Western philosophy there is a tradition of debate about whether the self is a unitary phenomenon [6]. However, most psychiatrists do not engage daily with philosophical debates, rather they bring to their practice a 'working

model' of self which is likely to be based on a combination of personal and professional cultural inheritance, knowledge of theory, spiritual belief and individual experience of their own psychological world. If common elements can be identified among the working models of self that psychiatrists bring to their work, and if there is a difference between these and the notion of self shared by an identified cultural group, there are implications for the provision of culture-specific mental health services for the group in question [7,8].

Pacific Island people form about 6% of the New Zealand population and over half of them are of Samoan descent [9]. Mainstream New Zealand mental health services do not serve Pacific Island communities well [10,11] and improving mental health services for these groups has recently become a focus of research and government policy [12,13].

Understanding the Samoan concept of self is considered by Samoan people to be crucial to understanding mental wellbeing. The Samoan self is a relational self, having meaning only in relationship to others [14]. It is 'a total being comprising spiritual, mental and physical elements which cannot be separated', deriving its 'sense of wholeness, sacredness and uniqueness from its place of belonging in family and village, genealogy, language, land environment and culture'. The Samoan concept of self is considered an appropriate theoretical foundation for the development of mental health services for Samoan people in New Zealand [14]. This can only be achieved if those providing the services are aware of the centrality of the Samoan notion of self to Samoan mental health and are able to use the construct in their formulations of the mental health problems presented by Samoan people.

This study was designed as part of an ongoing discourse between local service providers and the Wellington region's Samoan community.

Method

The enquiry was informed by a social constructionist perspective. In this epistemological framework the values, beliefs and customs making up social reality are considered to be constructed by members of a culture as they interact over generations [15]. This perspective acknowledges the importance of power relationships and social forces in determining which values gain dominance in a society.

Research questions

In a New Zealand setting:

1. What are common views of self as understood in everyday adult psychiatric practice?
2. What are the main domains of contrast to the sense of self as understood by the Samoan people?

3. What are the implications for psychiatric practice with Samoan patients?

Sample and recruitment

Using a purposive sampling strategy we approached psychiatrists with over 5 years experience of public practice in the lower North Island of New Zealand, who had exposure to Pacific cultural issues in clinical settings. The psychiatrists were chosen on the basis of their relative homogeneity of training and experience. Following the ethics committee approval, eight participants were recruited by telephone, followed by a letter. All the participants were of Western European descent, either New Zealand or UK born. Most completed specialist psychiatry training locally and occupied senior non-academic positions in adult community psychiatric practice. Two psychiatrists worked part time in a specialist Maori mental health service. There was an even gender mix and we planned for a minimum of six participants attending all three focus group sessions, allowing for unforeseen absences.

Procedure

A series of three focus groups was held at two weekly intervals. They were moderated by Allister Bush (AB) and observed by Sunny Collings (SC) and addressed the research questions in sequence. Focus group questions were developed in draft form before the first session and revised in light of new material as sessions progressed.

In the first session participants explored their personal perspectives on the self, ideas about self dominant in psychiatry and the relevance of these to their clinical work. The Samoan mental health study *Ole Taeao Afua: The new morning* [16] was given to them to read before the next session. The second session was preceded by a presentation of this study by its principal researchers. This included a detailed account of the Samoan view of self. Participants discussed contrasts with their personal views of self and between the Samoan view and what they considered as the dominant views in psychiatry. The final session focused on the implications of these differences for their clinical work with Samoan patients. The focus group questions are available from AB.

Sessions were audiotaped and transcribed and the transcripts were sent to participants within 1 week for verification and to remind participants of the issues discussed.

Cultural accountability

In cultural research there is an ethical obligation to ensure that no harm is done to the communities being studied and to minimize further stereotyping of and prejudice against these communities [17]. In order to maintain cultural accountability, a Samoan member of the *Ole Taeao Afua* research team was involved in each stage of the development of this project including analysis, interpretation and report writing.

Analysis

An iterative inductive content analysis process was used. The unit of analysis was segments of text pertaining to identifiable themes in the participants' talk. The process was one of constant comparison, iteratively classifying and grouping the material to identify preliminary

themes and subthemes [18]. Two researchers (AB and SC) independently analysed each transcript and then met to compare and confirm findings. Attention was paid to corroboration and divergence within the data. Coded text segments were entered into a Microsoft Access database. This facilitated refinement of the domains of broad themes and subthemes which was done jointly by AB and SC. A draft report was reviewed by the other members of the research team. This was then reviewed by the participants to verify the authenticity of the findings.

Results

In the interests of space, we have conflated the description of the key themes in the participants' views of self with the four major contrasts identified between participants' and the Samoan perspective on the self. We considered these distinctions as *dialectics* as this term captures the potential for change that can occur through the dynamic interplay of opposing viewpoints.

1. Individual versus collective notions of self

This was the most prominent dialectic. From a personal perspective, the majority of the participants identified their core self as individual. For example:

Participant: 'I would see the self as the middle of the wheel, as the hub. And the spokes I wouldn't include in self'

Moderator: 'So what would you exclude from self?'

Participant: 'Everything beyond here' (gesture indicated outside of his head and body).

Some participants considered collective identity and family history as aspects of self, while still describing their core self as individual, for example:

I suppose there is me, however I just see myself sometimes within this whole context of all my forefathers, forebears and it is very kind of diffuse . . .

With reference to dominant ideas in psychiatry there was a consensus among participants that the idea of self as individual was dominant, for example:

It is based on the idea that I am an isolated alone being and what is me is kind of inside my head or inside somewhere in me.

It was agreed that these influences came from Western European and North American schools of thought. The following two examples contrast participants' views with the Samoan relational self:

It is a different sort of relatedness to my sort of relatedness. I define myself in terms of my relationship with you or with her or whatever. I don't define it in terms of my family with your family which is much more what I thought (the Samoan presenter) was trying to put across.

I still think that I tend to start from myself when I'm thinking about my sense of self. I still tend to start with myself and then work out whereas I think from what I've heard today in the Samoan view there is much more of a sense of starting from relatedness to other people and then working away from that.

A number of participants reported feeling confused by the Samoan concept of a relational self as it was described.

I realised how little I understood. I was confused after I read the document and I just got more and more confused and the more I listened the more I realised that this was cognitively dissonant.

The idea of the 'individual' self dominant in psychiatry was considered quite different from the Samoan view and it was suggested that the Samoan idea of relational self had implications for a number of aspects of psychiatric practice.

2. Spiritual versus secular notions of self

The issue of spirituality was not raised by the participants until the second session. Although some felt uncomfortable discussing religion and spiritual issues, a number of the participants considered spirituality personally important. The fact that they had chosen not to discuss it earlier may reflect a tacit assumption that in psychiatric settings such conversations have little place.

Participants perceived a major difference between the dominant psychiatric view and the Samoan perspectives on religion and spirituality. Here is an example:

I think predominantly psychiatric thought is secular and it does not have notions of spirituality and sacredness well knitted in . . .

They noted that religion was commonly examined in psychiatry from a non-spiritual perspective, for example:

even when we talk about religion, we begin to talk about it in secular . . . kinds of ways.

It was felt that mainstream services could benefit from an acknowledgement that spirituality is an important part of mental health for many non-Samoan people. However, to adequately meet the spiritual needs of Samoan patients and their families, a dedicated Samoan or Pacific Island mental health service was considered necessary.

3. Reductionist versus holistic notions of self

This was discussed in response to the Samoan idea of self as holistic in nature. A number of participants described aspiring to a holistic approach in their work. However, this was constrained by characteristics of the health system such as large caseloads, under-resourcing and the climate of legalistic accountability.

I still think that one of the tensions is that as individual psychiatrists we may want to use a holistic approach, but the pressure of 'the system' and the funding is to perform quite reductionist psychiatry.

4. Universalist versus relativist notions of self

Participants believed that universalist views were dominant ideas in psychiatry. The following exchange illustrates this universalist view:

A: 'so (the Jungian model) would be a construct that I would use in my everyday work, or have it in the back of my mind, whether I use it or not'.

B: 'If you are seeing a traditional Maori patient how do you modify that?'

A: 'I don't. I would see the psyche as being the same no matter what the race or the cultural background of the person. The same structures would still be there. The cultural heritage of the person would be one of the mediating mechanisms for manifestation of those structures so I would need to take that into account if I could'.

In a different part of the same session, 'A' described his experience of being perplexed by the concept of 'we-ness' in Maori culture.

... this discussion reminds me of practising in an area with a large Maori population, where the 'I/we' dichotomy and the focus on the individual was almost a polar opposite to how it is for European psychiatry where the focus is on 'I'. And to experience patients who had less of a concept of 'I-ness' and more of 'we-ness' was incredibly difficult and even after ten years there I still hadn't got my head around it, and being away from it now I know that I haven't got my head around it.

In light of the confusion this participant experienced when faced with a very different cultural view of self, doubt is cast on the universal applicability of the European model referred to. The opposing relativist view would be that different models of self may be required to understand and work with patients from disparate cultures.

This illustrates an essential dilemma in the practice of psychiatry in specific cultural settings.

Implications for psychiatric theory

Participants had several suggestions about how psychiatric theory might be influenced by the Samoan notion of self.

The dominance of secular and reductionist ways of thinking in psychiatric models in general did not fit well with Samoan views of mental health. In particular, Samoan ideas of self were seen as challenging the universalist assumptions underlying Western developmental theories, especially those where states of individuation and separation are considered more important or more healthy than interdependence. In the light of the Samoan perspectives, Western normative views of family structure and the nature of intrafamilial roles and relationships were also viewed as culture specific.

It was suggested that the analysis of culturally specific power issues was an important part of the process of new knowledge being accepted into the body of psychiatric thought. Otherwise, even if non-dominant ideas were incorporated into psychiatry, they could still be distorted by tacit Western ethnocentric assumptions:

we only incorporate components of their ideas that are attractive to us.

It was noted that these ideas came from a Palagi (European) perspective. Samoan or Pacific Island mental health clinicians were considered the most appropriate group to assess the implications of these ideas of self for the theory and practice of psychiatry with Samoan patients.

Implications for psychiatric practice with Samoan patients and families

Participants stated that the Samoan concept of a relational self raised issues that should be addressed in clinical interviews. These included appropriate greeting rituals, family involvement at all stages and consideration of the culture-specific roles and relationships in the lives of Samoan patients. They suggested that history-taking practices might require review, in that questions which emphasized individual development might be less relevant and questions which focused on roles and responsibilities in family relationships may be more relevant in a Samoan context. Similarly, spirituality was seen as an important area to address with Samoan patients. The need for sensitivity and an inclusive attitude on the part of psychiatrists and other non-Samoan clinicians was noted.

Participants viewed phenomenology as the same across cultures, but noted that in practice some phenomena were difficult to interpret because of differing notions of self. An example given was that of 'hearing voices' in the context of the spiritual dimension described as part of the Samoan self:

For us, we're going to have schizophrenia fairly high on the list. But for a Samoan patient hearing voices, there may be other explanations for it, just as there are with Maori patients.

Participants felt that consultation with other family members and appropriate cultural workers in these circumstances would be necessary.

In treatment planning, they stressed the necessity of working with the wider family and community and speculated that some individual therapies might be less relevant for and less acceptable to patients from the Samoan culture because of the relational nature of the Samoan self:

Another fascinating thing for me is that I've been in New Zealand now for 12 years and I'm yet to be referred a patient, or see a patient from any non-Caucasian culture for individual psychotherapy.

The problem of coping with unfamiliarity with another culture's concepts and norms of communication was a common theme. It was agreed that Samoan cultural workers had an important role in guiding Palagi (European) clinicians in their work with Samoan families. The need for a dedicated Samoan or Pacific Island mental health service to meet adequately the needs of Pacific Island communities was highlighted.

Implications for mental health service development and delivery

Participants suggested that Palagi (European) mental health clinicians in mainstream services needed training on the Samoan concept of self and the relevance of this in clinical work in order to improve mental health care for Samoan patients and their families. They also suggested that sensitivity to spiritual issues, while essential in a Samoan context, was often relevant with Palagi patients as well.

At least two services dedicated to the mental health of Pacific Island people in New Zealand were in early stages of development at the time of this study. Participants made a number of comments about the need of such services. They emphasized the need for resourcing and planning to allow time for the development of culturally relevant ways of working and to address challenges that might arise in a service attempting to meet the needs of a range of different Pacific Island communities.

They supported the view that such a service would be ideally staffed solely with personnel from the relevant Pacific Island communities, with Palagi staff such as psychiatrists employed only if appropriate staff from those cultures were unavailable.

Culturally acceptable processes would be required for appointing staff. Such a service would require an appropriate blend of cultural knowledge and clinical skills and need strong links with local Pacific Island communities. Participants suggested that the Samoan concept of the relational self had implications for design of clinic space to cater more for family groups and budgets for food and time for appropriate greeting rituals. Multiple staff and home visits would be more frequently required for assessment and follow-up interviews. Boundary issues such as the appropriateness of sharing a meal with a patient and their family might be viewed differently in such a service. Such practices might not fit with Palagi values and funding practices, but participants suggested that the Samoan relational self helped to illuminate the need for such differences from a conceptual point of view.

Discussion

To our knowledge this is the first study to examine the response of psychiatrists to the mental health perspectives of Samoan people. In continuing the dialogue that began with *Ole Taea Afua: The new morning* [16] these findings will contribute to improvements in psychiatric practice and mental health service delivery for Samoan and other Pacific Island communities.

Historically, Western researchers have felt justified in evaluating the values and perspectives of other cultures with some authority, an approach we did not consider appropriate for our study. Throughout the design, execution and reporting of this study the choice of a social constructionist framework legitimized our reflection on the relevant power relationships and the primacy of the views of the Samoan researcher on the team.

The use of a cultural accountability process to address issues of cultural safety is a key strength of this study. The use of the focus group method yielded a rich dataset, encouraged the participants' exploration of ideas and was considered a positive learning experience by them. The parallel analysis of the data, corroboration of findings by participants and the cultural validation process support the credibility of our findings.

The study was limited to a relatively homogeneous professional group in one location. Although this relative homogeneity is a strength in allowing the data to be placed in context, other mental health professional groups would have brought other perspectives to the issues and enhanced this study.

Our findings highlight distinct cultural differences between the Samoan world view and the dominant ideas in psychiatry as practised by our participants. The idea of the dialectic is a useful way of raising awareness among Palagi (European) mental health professionals of divergent underlying cultural values. Responses from

participants in this study indicated that the process of the research was a valuable cultural learning experience. The dialectics raised by our study and the process we used could serve as a model for cultural education of Palagi psychiatrists and other mental health professionals.

Quantitative research has highlighted the individualist–collectivist distinction in cross-cultural ideas of self [19,20]. Participants in the present study described their core sense of self as individual. They considered this to be a dominant theme in Western psychiatry, distinctly different from the Samoan relational view of self. Although we cannot claim that our participants are representative of psychiatrists in New Zealand or further afield, our results indicate the likely importance of the individualism–collectivism dialectic for the practice of psychiatry in Samoan communities, with possible implications for other Pacific Island cultures.

Participants experienced confusion and cultural 'dissonance' in trying to understand the Samoan relational self. We have not found reference to this concept in the literature. Understanding that this phenomenon may be an expected part of the learning experience may enhance cross-cultural communication. It may be an essential step in reaching a greater understanding of another culture's perspective. However, whether Palagi mental health professionals are able to learn to truly understand the relational view of self through a process of training is still an open question. Similarly, the universalist view of self was described by participants as dominant in Western psychiatry in contrast to cultural relativist views. Theoretical models based on European and American values may not fit the experiences of people from other cultures. However, they offer clinicians a way of making sense of the experiences of those they work with and may offer a sense of security analogous to a map in difficult terrain. To abandon such a map may leave clinicians with a loss of this security, but attempting to adjust such models to fit another culture risks invoking a form of colonialism. From the social constructionist perspective the best judges of whether a model fits for a different culture are members of that different culture.

There was a major difference between the dominant views in psychiatry on spirituality and religion and the Samoan perspectives. In general, the psychiatrists felt ill-equipped to address these issues with their Samoan patients, yet a recent survey in New Zealand has found spirituality to be an important issue for patients from a variety of cultures attending mainstream mental health services [21].

This study also emphasizes practical constraints which limit psychiatrists from achieving a holistic approach in their work. Holistic practices are highly valued in many

non-Western cultures including Samoan, Maori and other Pacific cultures [1,5,14]. However, when resources are limited these holistic values may not receive priority.

Conclusions

Our findings support the call from Samoan and other Pacific Island communities for the further development of dedicated Pacific Island mental health services in New Zealand. Ongoing cross-cultural dialogue will allow an exchange of ideas and incorporation of more culturally based practices into mainstream services. These findings also demonstrate the need for the development of education programs to assist Palagi (European) psychiatrists and other mental health professionals who work with Samoan patients and their families to gain an understanding of the Samoan concept of self and its relevance to mental health and ill-health.

To further the cross-cultural dialogue in our local services, a Samoan response to this study will be sought. Further research should include other mental health professional groups. A quantitative study could establish whether the psychiatrists' perspectives on self outlined here can be generalized to the wider group of psychiatrists in New Zealand. Exploration of the implications of the Samoan concept of self for understanding of processes of grief, response to trauma and the clinical presentation of depressive, anxiety and psychotic symptoms and the involvement of consumer participants are further avenues for enquiry. There is also scope for further study into effective ways of educating Palagi mental health professionals about the Samoan concept of self and its relevance to the mental health care of Samoan patients and their families.

The importance of further research to improve our understanding of the issues raised by this study is perhaps best expressed in the words of one of our study participants:

So if we don't have an idea about self in psychiatry, and identity and difference, then there is a risk of kind of mindless or soulless psychiatry, practising to people who have had one of the biggest traumas to their souls that they may ever have encountered, making it very meaningless or empty, or false . . . for the patient.

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CONTRASTING NATIONAL JURISDICTIONAL AND WELFARE RESPONSES TO VIOLENCE TO CHILDREN

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Abstract

This paper describes some approaches to addressing maltreatment of children in OECD countries and explores whether these approaches could be used to improve outcomes in New Zealand. Comparisons are made between the Anglo-American model of *child protection*, which New Zealand uses, and the Continental European model of *family services*. The child protection model is based on the adversarial legal approach, where social workers' focus is on removing the child from potentially harmful family situations and gathering evidence for legal proceedings. The family services model is focused on maintaining the family unit wherever possible, and the social workers work with families to sort out their problems. This model uses the inquisitorial legal approach, where specially trained judges lead teams of social workers to help the child by enabling changes in family circumstances to equip parents to meet their obligations to their children. New Zealand's use of Family Group Conferences, which is developed from an indigenous Māori structure, is more akin to the family services approach. This is because it encourages early intervention, with a wide whānau/family focus, without the need for gathering legally admissible evidence. However, if New Zealand wanted to adopt a more holistic family

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services approach to child protection, there would need to be a substantial theoretical and procedural shift from seeking to punish “unsafe” families to ensuring parents are assisted to meet their obligations regarding the wellbeing and safety of their children.

INTRODUCTION

The Social Report (Ministry of Social Development 2005), which records New Zealand’s official indicators of social wellbeing, referred in its “international comparison” section to “a UNICEF study of child maltreatment deaths in rich nations in the 1990s [which] reported that New Zealand had the third highest maltreatment death rate (1.2 per 100,000) behind only the United States and Mexico” (p.107). The report noted that care should be taken with this finding because of the small numbers involved and the possible differences in the ways in which countries classify death by intention. Nevertheless, the result is sobering. In a second league table in the same UNICEF document, the figures for children under 15 years intentional death and death of “undetermined intent” were combined, and the results were not much different: New Zealand moved from third highest death rate to sixth highest out of 27 OECD nations (UNICEF 2003).

The UNICEF league tables are interesting because they offer one of the only accepted international comparative outcome data sets for violence to children, crude though they may be. In fact, apart from road deaths, the league table is the only international comparative database cited in the entire “Safety” section of the Social Report. This is because violence and abuse reporting systems and processes vary so widely in countries that comparisons lack credibility. Child deaths identify an objective outcome at the extreme end of the violence continuum, and they may or may not reflect the levels of abuse in a particular country.

Countries vary greatly in their jurisdictional and welfare responses to violence to children, according to their cultural conventions and political histories. Surprisingly, given the seriousness of the topic, there are few comparative studies that systematically explore the differences in terms of both their processes and outcomes. It is extraordinary when one considers the costs of violence to countries financially and in the loss of wellbeing. Yet many similar countries have developed quite different philosophical, legal, organisational and operational responses to violence and abuse. Given that all these countries encounter many of the same problems, an analysis of the relative merits of the different aspects of each system should be a fruitful ground for research and evaluation in this vexed area.

New Zealand is an English-speaking country that has inherited its essential traditions of law and welfare from the United Kingdom. Until 1989, it practised, for the most part, a traditional *child protection* model approach common to the Anglo-American world. In

1989, with the adoption of the Children, Young Persons and Their Families Act (the Act), an indigenous Māori element was introduced into the heart of the jurisdictional and welfare system through the use of the family group conference. This approach, based on a traditional Māori “whānau hui” (gathering for meeting involving extended family members), was designed to strengthen family agency and participation, and mobilise community and government resources more effectively (Dalley 1998, Love 2000). It introduced a broader ecological dimension into the responses to the maltreatment of children.

Unfortunately, the Act’s early life was accompanied by a period of economic restructuring and substantial constraints on social expenditure during the 1990s. The Department of Social Welfare, like other social ministries, had its budget substantially reduced and along with it much of the early resourcing of the family group conferences. Thus, it can be argued that the mixed cultural approach never really had the opportunity to develop in the way it was intended. Important elements of the family group conference were incorporated, but its application is probably more fully practised outside of New Zealand (Burford and Hudson 2000).

The international comparative research studies in this area, small though they are, offer some important points of reflection for policy in New Zealand. Like almost all English-speaking jurisdictions (Cameron et al. 2001), New Zealand continues to experience dramatic increases in reported child abuse (Department of Child, Youth and Family Services 2004), high levels of stress and job turnover among front-line workers, some loss of public confidence in the ability of public services to adequately address the safety needs of children, and a primary legal and resource focus on detection that constrains its welfare ability to deliver ongoing services to the families where violence has occurred (Ministerial Review Team 1992, Brown 2000, Ministry of Social Development et al. 2003, Connolly 2004). By contrast the *family services* focus of many European countries, though facing the same problems of child maltreatment, do not report a similar set of difficulties (Cooper et al. 1995, Hetherington et al. 1997, Cameron et al. 2001, Cameron and Freymond 2003). This is not to suggest that the European countries have developed some utopian formula to the vexed problems of violence, but that their predominant focus on “families” appears to have prevented a number of the persistent problems experienced by Anglo-American countries whose primary focus is the investigation and assessment of risk to children.

The purpose of this paper is to explore a number of differing national jurisdictional and welfare approaches to addressing the maltreatment of children as they tend to operate in a number of OECD countries and tease out important implications for improving outcomes in New Zealand. The paper will initially summarise important comparative research between the contrasting approaches of the French and English welfare and legal systems as they relate to the maltreatment of children, and identify differences between

the Continental European and Anglo-American typologies. It will then explore the principles that underpin these contrasting models as they relate to the family services model of the Continental European countries and the child protection model of the United Kingdom, Canada and the United States. Finally, the paper will consider the significance of the findings of these comparative studies for New Zealand as they relate to strengths and weaknesses in the country's approach when responding to violence to children. Particular focus will be given firstly to the role of family group conferencing in as much as it captures aspects of both contrasting models, and secondly to the types of changes New Zealand would need to make to its welfare and legal structures if it decided to incorporate a family services approach.

The paper is not intended to be a comprehensive analysis of countries' welfare and jurisdictional approaches or a full description of their systems, but rather a window into some exploratory research that has begun to investigate the assumptions behind the systems in various countries, the way they operate and the public's mandate and expectations of services.

CONSENSUS AND CONFLICT IN FRANCE AND ENGLAND

The early comparative work in national jurisdictional and welfare systems involved research into child protection in England and France (Baistow et al. 1996, Cooper 1994, Cooper et al. 1995, Hetherington 1996). This research began at a time when British practitioners and policymakers were beginning to turn away from the United States as the primary role model for the development of child protection systems. Until the early 1990s, the United States was seen as being at the forefront of efforts to combat violence towards children, and European systems were seen as lagging behind the Anglo-American approach. However, it became apparent that the United States and the United Kingdom, along with other English-speaking countries with similar child welfare systems, were heading for crisis. Researchers, looking for new perspectives on the problems they faced in the United Kingdom, found a range of cultural, structural and operational differences between Anglo-American and Continental European systems of child protection.

The findings suggested that French social workers had not suffered the crisis of confidence of their English counterparts. Public perceptions of them were generally good and the media tended not to vilify them when abuse cases came to their attention. Client families, social workers and the judiciary displayed mutual respect and shared perceptions. The French child protection workers had consistently developed trusting professional relationships with families where abuse had occurred. Furthermore, they viewed those relationships as the medium of change for the families.

The English social workers, by contrast, were primarily (often reluctantly) focused on the guilt or innocence of parents and the work of collecting legally admissible evidence of abuse. The modern legalistic orientation of child protection work was seen to have disrupted the earlier consensus that existed between client families, the social workers and the judiciary. The social worker took on the role of legal assistant for the child, usually (by implication) against at least one parent, leading to a conflictual relationship with the family – almost the opposite of the French approach.

The structural relationship between social work and the law in each country ... plays a central role in encouraging and discouraging “consensus”, which in turn shapes the day to day experiences of social workers, parents and children involved with the system, tending in France to encourage co-operation and in England conflict. (Cooper 1994:2-3)

These differences were framed by the politico-legal culture in the two countries. The English system had become conflictual at root, and the work of a social worker as social worker was frequently at odds with the social worker’s legal role. Tensions existed between the various parties, their claims on “rights” and their legal representatives, and between the differing professional interest groups. The French social workers, in contrast, were able to prioritise the family’s needs and their working relationship with the family. The legal aspects of child protection cases were largely addressed by the *Juges des Enfants* (Children’s Judges) – whose interesting role will be referred to later in this paper – while the social workers could focus on principles such as cohesion, consensus and collectivism in their work.

There appeared to be much more consensus in France, than in England, between families and practitioners as to the general nature of the problem and possible solutions and little criticism on the part of French parents concerning strategies that professionals used or the type of assistance available to them. (Baistow et al. 1996)

The primary objective of child protection work in France is to keep children in their family of origin, even in some situations where there was a risk of maltreatment. The families are not left alone to deal with the situation, however. If a parent, or parents, did not fulfil their role adequately, the aim is to help them become parents who learn to provide a safe environment for their children. This may involve therapeutic work, parental education and/or community support. The resources of the system provide a major investment for this process. The concept of parents being enabled to fulfil their role as parents who protect their children is embodied within the French Civil Code (Grevot 1994).

The primary objective of child protection work in England is to protect the child and to safeguard their rights in an immediate sense, regardless of the impact this may have on their relationship with their parents. The focus is on identifying abuse and/or the

risk of abuse, and the social workers may enter into conflict with families in order to ensure the right of the child to protection from harm. Although social workers often referred to a “working partnership” with families, the norm involved contested legal proceedings.

In England, though the family of origin was seen as the preferred place for a child in the first instance, this quickly gave way to placement outside the family if the parents were assessed to be inadequate to provide the necessary care for a child. In such cases, the primary aim was to search for a permanent substitute for the birth parents. Court proceedings were used to separate children from their parents and adoption orders were sought in a majority of the cases. The concept of permanency was a significant influence throughout the process.

The most striking difference between the two countries’ systems lay in their differing approaches to the significance of blood and kinship ties. In French child protection work, the individual child was, and remained, part of the family and so the family became the unit of intervention, whereas in the English approach, the assessment of risk to the child and immediate actions to prevent further harm was primary, regardless of its impact on the family. Thus, in French social work practice methodologies, individual rights were subordinated to the obligations family members had to one another. Emphasis was given to assessment factors, the evaluation of relative strengths and weaknesses in families, with a focus on causes and constraints, and a strong weight on education. Social workers were enabled to take considered risks in the process of family change. Placement outside the family home did occur, but only temporarily.

The practice methodologies in England, on the other hand, focussed primarily on the assessment of risk to the child and actions to prevent further harm. Risk was assessed largely through observation of parent–child interaction and by the employment of quasi-objective “indicators” of risk. When compared with the French social workers, little attention was given to causal factors. The primary focus was on immediate short-term solutions and then permanent long-term arrangements. Social workers were not allowed to take risks. The entire child protection system strove to minimise risk.

The differences between the two countries were reflections of their different social, political and legal assumptions concerning the relationship between children, the family and the state. A rights-based legal culture predominated in England. The privacy and responsibility of the family was central to the British tradition and consequently the law sought to restrict state interventions. The French state was more paternalistic. The family existed within a Continental European conceptual environment of citizenship and solidarity in which the state had responsibilities for its children. When parents failed their children in England, a contested legal process ensued, whereas in France the Children’s Judge embodied the benign authority of the state.

The Children's Judge epitomised the different approach to law in the two jurisdictions. The Children's Judge's role was to gain an appreciation of family circumstances and difficulties rather than accord guilt or blame. They endeavoured to help the child and enable changes that would equip parents to meet their obligations to their children. They met in the Judge's office in an informal but respectful atmosphere, usually with the social worker in attendance and only in isolated cases with a lawyer. These judges had their own teams of social workers separate from the social work agencies. The Children's Judges could make legal orders and the child protection social workers, both the Judge's and those in separate social work agencies, were accountable to them. Social workers could request an "audience" with the Children's Judge if they were concerned about the safety of a child, without having to produce legally admissible evidence. Thus, in child protection work in France, the Children's Judge and the social workers worked together as a combined justice and welfare team. The legal processes were essentially inquisitorial, in sharp contrast to the adversarial approach across the Channel.

The participating English and French social workers in the study reacted differently to the findings. The English social workers noted the loosely defined powers of both the Children's Judges and the social workers in France. They were impressed with the ease of access to legal proceedings and the informal family-focused audience with the Children's Judge. They expressed concern over the lack of attention to individual rights and the lack of "due legal process", but this was offset by a recognition that the system delivered substantive rights to children and parents in a manner that the formalities of the English system did not. Interestingly, participants in both countries considered that while families in England were accorded more rights, professionals there intervened more than in France and, despite the fact that the French system was paternalistic, its decisions were more moderate. English participants observed far less hostility between client families and social workers in France. They felt the lack of representation by lawyers contributed to this.

Overall, many English participants felt that while parents and children in England may have more rights than their French counterparts, they actually had less power. (Cooper 1994:9)

The English participants came to believe that the rights of the French families to be included in decision making, to be consulted and to be properly heard in the legal context, might be greater and more real. (Hetherington 1996:103)

French social workers were very disturbed at the power English parents had if there was insufficient evidence to bring the case to court. To them, it appeared to contradict the central objective of protecting children from harm. It was noted that the French system delivered a family-focused problem-solving style of justice, which was not possible in the adversarial and rights-based approach of the English legal system, where the legal and social work responses were not integrated.

CHILD PROTECTION IN EUROPE

The comparative studies of child protection systems eventually explored other European countries (Hetherington et al. 1997, Hetherington 1998) and later included research on the welfare of children with mentally ill parents (Baistow and Hetherington 2001, Hetherington 2001, Hetherington et al. 2002). The eight systems of child protection studied were Belgium's Flemish and francophone communities, France, Germany, Italy, Netherlands, England and Scotland. The broad Continental European themes, as described above in relation to the French system, had many similarities with the other Continental European countries.

The studies identified nine critical underlying concepts of the Continental European systems as they related to child protection.

- **Subsidiarity** was particularly emphasised in Germany, the Netherlands and Belgium. In Germany, where the concept had considerable force, there was an obligation on the state to develop social capital through strong social networks and support for local and regional institutions. Those closest to or most involved in activities should be the decision makers; that power could not be moved to a higher institutional level or to the state.
- **Welfare pluralism** is the substantial involvement of community groups and other non-government organisations in the delivery of services. As with the concept of subsidiarity, it did not refer to the state as a non-participant, but rather an encourager of diversity and autonomy for social institutions. Germany, Flanders and France (as we have already noted) offered good examples of public and private partnerships and linkages in the delivery of child protection services. In these countries, there was also considerably less government control over social work practices, in sharp contrast to their British counterparts.
- **Solidarity and the family** was considered fundamental to Continental European thinking, but most particularly in France. It was substantially distinguished from the British concept of family in that it was understood to be the foundation institution of society rather than an institution in the private domain. Social solidarity recognised the family as the appropriate object of social policy, which ensured its support and wellbeing. Thus, the interests of the state and the family tended to coincide (Hetherington et al. 1997:86). The concept of solidarity was linked to that of subsidiarity, the hierarchy beginning with the family, then the community and lastly the state.
- **Republicanism** was a strong organising principle, even in countries like Belgium that have a monarchy. It referred to a mutual set of obligations between the state and families. The French Children's Judges embodied the benign paternalism of the state. Easily called upon, the Judges were obliged and committed to help and enable families. Although the Judges and the families did not have equal power, both had

ownership of space when there was an “audience”, and the law required a negotiated reciprocity in such meetings. This framed notions of public and private, intervention and non-intervention, very differently from countries without this tradition.

- **Intermediate institutions** is a concept closely related to subsidiarity and welfare pluralism, referring to a devolved institution that sits between the family and the state. An example was the Flemish Mediation Committee, which functioned as both an alternative to court proceedings and a filter for cases to reach court. It sat between the administrative and legal domains and, in a sense, it functioned to protect civil life from needless intrusion by the state or the courts. It could refer child care matters to community organisations for help or to the court system depending on their assessment.
- **Rights and social rights** in relation to society and government were ensured for individuals by the concepts of solidarity and subsidiarity. The family was conceived as the basic unit of society and children’s rights were expressed through the family, implying a more collective notion of family welfare and rights as opposed to an individual-rights approach. Because the vast majority of children continued to live with their families, engaging with the family was essential for ensuring their safety and wellbeing. As noted earlier in this paper, this was in marked contrast to the English practice of individual rights over and above those of the family.
- **Rights and family support.** The earlier French and English research found that French parents, though frequently unclear about their rights, often successfully negotiated for forms of help other than those originally offered by the social worker. English parents, by contrast, generally struggled to receive help and were often afraid of the social worker’s power. At the same time, they were well informed about the system and their rights, probably indicating the social worker’s concern to inform them. Interestingly, French and English parents were much more concerned about their and their children’s welfare than they were about their rights.
- **The citizen and the state** referred to a Continental view of the state as reflecting the will of the people, giving political expression to the best wishes of human beings, as opposed to being an external force that regulated human activity. The Children’s Judge embodied this notion and was required by law to acquire parents’ agreement to the judge’s orders. Again, this sharply contrasted with English legal practice.
- **Ideologies of training** referred to the organising principles of social work practice and training – a holistic social pedagogy concerning the individual as self and the individual as a social being. The social worker’s role related to the total social, emotional, developmental and family situation in a non-compartmentalised way, which was reflected in both the thinking and practice of social work.

As one would expect, the six Continental European countries had developed their judicial systems quite differently from the English one. Scotland lay somewhere in between. Every country apart from England had professionally trained specialist judges for all work with children. Likewise, all the countries possessed an inquisitorial

legal system, apart from England, which was fundamentally adversarial. England was also the only country that did not allow informal dialogue between the social workers and the judge, and in most countries, even the children and parents were able to speak informally with the judge. In all six Continental countries, the judge stayed with the family case throughout enabling development of an ongoing relationship with the family and regular review of progress. In Scotland, this occurred sometimes, but rarely in England.

Separate legal representation for parents and their children was necessary in the adversarial English legal system, but not used in any of the other countries. England was the only country that separated its child welfare and juvenile justice systems, indicating a different philosophy of child development and responsibility. In all countries apart from England, judges could intervene on the basis of a child's welfare needs alone. Only in England was it necessary to have evidence of significant harm at the parents' hands in order to take legal action (apart from short-term emergency legal action).

Recently, the British government attempted to address some of the shortfalls of the child protection and children's services systems. Following the report of the Laming Inquiry into the death of Victoria Climbié,² the government published the Green Paper *Every Child Matters* (Her Majesty's Treasury 2003) followed by the *Children Act (2004)*. These were attempts to change radically the structure and function of children's services in England. The main thrust of the Green Paper was to improve inter-agency communication, to clarify the lines of accountability and to move from crisis intervention towards prevention and early intervention.³ This is an ambitious agenda, which is only in its first stages of implementation, and it is not yet clear how effective it will be. The fundamentally adversarial court system, however, has not undergone significant change.

2 Victoria Climbié was a girl of West African origin who was killed by her aunt and her aunt's partner in 1999. Despite being known to many agencies in a number of local authority areas, no professional had assessed the risk to Victoria. The inquiry into her death was led by Lord Laming (Laming 2003). They found that inter-agency communication had been poor, and that no one had taken ultimate responsibility for ensuring her safety.

3 The main provisions of the Green Paper include:

- increasing accountability by appointing a Director of Children's Services in each local authority area, who is responsible for outcomes of all children in that area and for all agencies
- Children's Trusts – every local authority will have a Children's Trust, which brings together the various sectors (health, education, social services) which have the responsibility of coordinating services and meeting targets
- an outcomes framework which governs all the work of the Children's Trusts
- Local Children's Safeguarding Boards, which bring together the Children's Trusts and other relevant agencies to develop policies and interventions to safeguard children
- a common assessment framework which will be used by all agencies
- the development of Sure Start Children's Centres which will provide child care and family support in every neighbourhood in the country
- the development of Extended Schools which will provide a range of community services
- inspectorates from different sectors should be merged.

CHILD PROTECTION IN NORTH AMERICA

North American researchers (Cameron et al. 2001, Freymond 2001, Cameron and Freymond 2003) have joined the comparative study of child protection, and the “English approach” has been expanded into the “Anglo-American paradigm”. They saw Canada, the United States and England as developing similar child protection systems, which they call “threshold systems” because they all require minimum levels of dysfunction in order to qualify for entry. The North American countries followed a very similar pattern to that outlined above for England.

They described the familiar notion of the privacy of the family and the state’s right to intervene only when parents have failed to meet some minimal standards of care and protection of their children. Even then, social workers have had to gather sufficient evidence of maltreatment and prove such allegations in court before the family’s right to privacy could be overridden. Front-line social workers spent much time collecting this evidence for the formal legal proceedings. If the evidence fell below the minimum standard, their case was closed and the family usually received no further help. As was noted with the English system, the North American child protection services were not able to be accessed directly by social workers or the families themselves. This ruled out effective preventive services with families who had not reached the minimum care threshold so far, but who might nevertheless be at risk.

Child abuse reports in these countries continued to increase substantially and, because every report required a formal investigation, the child protection services had become overwhelmed with the procedures, paper work and time required, such that little space had been left to provide helpful assistance to the families. This had been followed by complaints from workers of stressful job pressures, high levels of frustration and a consequent high staff turnover. As with the English system, the front-line workers experienced conflict between their legal and their welfare roles, which they referred to as “a perceived imbalance in the functions of care and control” (Cameron et al. 2001:26).

It was reported that very little choice had been left in a risk-averse system. Social workers complained of having decreased discretionary power in their work with families and a lack of flexibility to provide the care and support required to address family problems. The increased reliance on standardised legal recording and risk-assessment instruments compounded these problems. Likewise, families whose needs were often multiple and complex were offered limited and relatively inflexible prescribed processes from child protection workers. The workers, complying with investigation protocols, were constrained in their ability to adapt to the families’ needs. For those families who did not meet the minimum risk standard, little was offered to help them despite the fact that they often required a range of supportive services. For those who did meet the minimum standard, instead of negotiating assistance with the social worker, they often

had to comply with a direction and in some cases had their children removed from their home.

The overall picture of the Anglo-American child protection systems was dismal indeed. Dissatisfied workers and client families have prompted questioning of the direction of these services. In particular, these systems have been criticised for their disregard of family relationships in both preventing and addressing child maltreatment. That these societies do not appear to be achieving higher levels of safety through their approaches, when compared with other countries, raises questions about the efficacy and value of such an orientation in child protection practice.

SOME REFLECTIONS IN THE NEW ZEALAND CONTEXT

Caution should be exercised whenever systems in one country are compared with those in another. Countries have differing cultural traditions, political processes and systemic structures. It would be foolhardy to import a system that grew in one environment and simply impose it on another. However, there is value in questioning critical services in terms of the efficacy of their processes and the quality of their outcomes in any country. International comparative research enables a fresh view of the way different jurisdictions address similar problems in their own settings. This becomes particularly important where services, such as child protection, are essential to the wellbeing of a society, are big-ticket budget items and are struggling under a loss of morale and public confidence. In such a situation, it can be very useful to explore the strengths and weaknesses of similar jurisdictions and compare them with those from different traditions with a view to constructive criticism of one's own system.

As noted at the beginning of this paper, New Zealand inherited its essential traditions of law and welfare from the United Kingdom and has much in common with other English-speaking countries. Like them, it continues to experience dramatic increases in reported child abuse, high levels of stress and job turnover among front-line workers, a loss of public confidence in the ability of public services to adequately address the safety needs of children, and a primary legal and resource focus on detection that constrains its welfare ability to deliver ongoing services to the families where violence has occurred (Ministerial Review Team 1992, Brown 2000, Ministry of Social Development et al. 2003, Connolly 2004). Nevertheless, serious and commendable attempts are being made to address these problems (Ministry of Social Development et al. 2003, Waldegrave and Coy 2005), including more realistic approaches to issues of funding and training in recent years.

However, there is a danger that the reform of child protection services in New Zealand may be too narrowly focused and end up reconditioning a faulty engine when there was the opportunity to consider an alternative model. The comparative research outlined in

this paper suggests the Anglo-American child protection model contains some serious deficiencies in terms of quality of service. The Continental European family services approach avoids many of the pitfalls of the child protection model, although it poses some new dilemmas of its own.⁴ Nevertheless, its consensual approach to families, which primarily focuses its resources on enabling parents to create safe environments for their children, and its coordinated cooperation of legal, welfare and non-government organisations, may offer valuable pointers to improving child protection work in New Zealand. Furthermore, its principles may also offer ways of improving services around domestic and other forms of violence.

Family Group Conferences

It is worth noting that the introduction of family group conferencing in 1989 through the Children, Young Persons and Their Families Act incorporated into the heart of child protection and youth justice work in New Zealand a process akin to the family services approach. Unfortunately, the downsizing of public investment in the 1990s stifled much of its early life, but it has survived and it has been successful enough to take root in North America and Europe.

The family group conference places New Zealand in a unique position to draw the best and extinguish the worst from both the child protection and the family services models, while adding a much-needed indigenous element authentically drawn from Aotearoa New Zealand. The first two principles in the Act stated that:

- (a) ... wherever possible, a child's or young person's family, whanau, hapu, iwi, and family group should participate in the making of decisions affecting that child or young person, and accordingly that, wherever possible, regard should be had to the views of that family, whanau, hapu, iwi, and family group.
- (b) ... wherever possible, the relationship between a child or young person and his or her family, whanau, hapu, iwi and family group should be maintained and strengthened. (section 6, the Act)

Family group conferences, formally introduced by the Act, were designed to empower families to resolve the majority of their family welfare and justice problems through their extended family members. The traditional whānau hui (Māori extended family meeting) was the model for the family group conference. Initially, these worked very successfully when they were properly resourced and competently managed. Resources were available to allow attendance of critical kin members who lived in other places

4 It has been suggested, for example, that children's rights may on occasions become lost with the strong focus on families and that there can be a higher level of risk for children when the presupposition in most cases is that they will remain within their families. These arguments are countered by reference to the serious problems created by multiple child placements and that removing children from their families often punishes them and does little to help parents learn new ways of relating to their children.

and to follow through on family decisions, be they further educational tutoring, counselling, sports, music, and so on. The family group conference model was introduced for children, young people and their families of all cultures. Many Pākehā (white New Zealanders) also benefited from the extended family approach.

The family group conference contains elements that are common to the continental family services approach (Love 2000, Waldegrave 2000, Connolly 2004). These include the primacy of children remaining within their families and living within their kinship groups wherever it is possible. In fact, the family group conference, with its emphasis on the extended family, offers more options and flexibility in terms of safety than the European model. Secondly, the family group conference is an intermediate structure that can be called early in child protection cases without having to amass legally admissible evidence. It certainly reflects the concepts of subsidiarity, welfare plurality and solidarity that are lacking in the Anglo-American model but central to the Continental European approach. Thirdly, it encourages a consensual process rather than a conflictual one. And fourthly, when it is competently facilitated and responsibly followed up, it enables problem solving and preventive strategies, agreed to by the family, to be planned and acted on early in the process. Even in situations where court proceedings ensue, the family group conference can be called and important decisions agreed to before and during the period of legal proceedings.

Given the shared elements between family group conferences and the family services approach, it is perhaps surprising that New Zealand's Department of Child, Youth and Family Services has often been the focus of negative attention since the introduction of the Act. The reasons for this are probably not inherent in the processes of the family group conferences, but a range of other factors. Foremost among these is that the more family-services style of the family group conference has been imposed on an essentially Anglo system of welfare and law and that system often reverts to type, especially when it is under pressure. The weight of a huge increase in reported abuse (Department of Child, Youth and Family Services 2004), high stress and job turnover among front-line workers, and the demoralising impact of public exposure of casework failure when it has occurred, has probably contributed to a risk-averse, depersonalised approach that is more akin to its Anglo roots (Ministerial Review Team 1992, Brown 2000, Ministry of Social Development et al. 2003, Connolly 2004). Furthermore, the long period of low investment in funding and human capital during the first decade of its life (Ministerial Review Team 1992, Brown 2000, Ministry of Social Development et al. 2003) added to the pressure.

The legal structures around child protection essentially incorporate the family group conferences without fundamentally adopting a Continental European-style "family friendly" approach. Judges have not been specially trained for working with children at risk, court processes cannot be accessed without a certain level of evidence, and

the processes remain conflictual, with separate legal representation for the different parties involved.

As the Department of Child, Youth and Family Services became more risk averse, it tended to manage “abuse and neglect” cases itself, reducing the role of intermediary community and service organisations (Connolly 2004, Waldegrave and Coy 2005). This could be expected to have damaged the trust and goodwill inherent in stakeholder support. Furthermore, the Department’s performance data sets reveal that over the period 2001 to 2004, family group conferences were only convened for around 10% of the “abuse and neglect” notifications. Family/whanau agreements were formed for considerably fewer than that (Department of Child, Youth and Family Services 2004). Thus the family services processes in the system are only being employed sparingly.

The risk-averse behaviour of the Department is better understood in the context of their having primary responsibility for the care of children at risk, instead of this responsibility being shared to the extent it could be across ministries like health and education. The Department carries the bulk of protection and welfare responsibilities and is expected to budget for both. Critical rehabilitative services are not prioritised to the extent necessary to provide an efficient coordinated service by the ministries that carry those responsibilities.

As noted earlier, child protection services in New Zealand are being rebuilt. The 21st century finds these services better resourced and leadership determined to lift their game in light of the reports referred to earlier. The resilience of the family group conference process, despite the pressures noted above, has the potential to reinvigorate the whole child protection system if it could be accompanied by a more consistent family services focus across the legal, inter-ministerial and community and service organisations domains, as outlined in the research in this paper.

This is not a presentation of the family group conference as a utopian instrument, but rather an indigenous plant that has many more blooms than we have yet seen. Its great value to New Zealand is that it offers an approach that is consistent with some of the best practices in child protection work in the world. European cultural practices do not have to be imported because this “taonga” (treasure) is already established in the child protection system. It can offer a firm foundation for substantial improvements in the field if it becomes the centre of the new developments and is accompanied by similar approaches in the legal, ministerial, community and service organisations domains.

Changing the Model

Anglo-American approaches to child protection are being seriously questioned today in the light of the problems in those systems that are largely avoided by the Continental

European family services approach (Allen Consulting Group 2003, Connolly 2004). As the research outlined in this paper indicates, there is much to be commended in the cooperative, consensual approach of working with families to help them change their behaviour when it is unsafe, and preserve the family unit wherever that is possible. By contrast, the conflictual legal approach often antagonises parents and disengages them from their children. Furthermore, the resources in this latter approach are placed primarily into the legal arena, rather than into welfare and rehabilitation.

In the family services approach, the judicial and welfare roles work flexibly in partnership, allowing early interventions within a more preventive and holistic framework. The legal process is essentially inquisitorial, rather than adversarial, with a view to understanding causes and influences and how to change behaviour. The adversarial approach discourages early intervention and focuses more on legal assessment of guilt or innocence, often at the expense of family relationships. Children can become permanently separated from their parents, or at a later stage returned to their parents who very often have not received the welfare and rehabilitative support that would help them become better and safer parents. This is not to suggest that using one approach rather than the other will resolve all the problems in child protection work. There are, of course, a number of other important factors, like families' motivation to change, socio-economic circumstances, education services and so on.

The contrast between these two approaches, however, has considerable implications for New Zealand's child protection services and, beyond that, for violence-prevention services with adults. The analysis above highlights the problems when family group conferences are placed in a largely unchanged legal, cross-ministerial, community and service organisations environment. This points to the substantive change that would be required if New Zealand chose to adopt an holistic family services approach to child protection. It would involve employing an ecological, theoretical framework.

Firstly, the legal framework would require a different orientation. It would need to adopt a consistent, inquisitorial approach to the problems before it. Legal representation for each party would be replaced with social workers or other helping professionals. The focus would move to a "strength-based" approach of rehabilitating parents who were deemed to be unsafe. An assessment of the influences and causes of destructive behaviour would become central to this approach, with a view to addressing them with therapeutic and educational resources. Funding that was saved through the reduction in legal representation could be reinvested in the rehabilitative services. Judges in this area would undergo specialist training in working with children and families. They would have a central role in the process of ensuring parents were assisted to meet their obligations for the wellbeing and safety of their children. They would make legal orders and the social worker would, at least in part, become accountable to them. The total service would aim at early intervention with flexible access to the judges.

Secondly, the Continental European principles of employing strongly devolved social networks, the substantial involvement of community groups and non-government organisations, and use of intermediary institutions that sit between the family and the state, would encourage a broad range of differential responses. The principle of welfare pluralism would require the Department of Child, Youth and Family Services to involve and resource non-government service providers and community-based organisations to broaden its service base, enable strong preventive work and enhance the ability of communities to encourage safety in families. It would call for a conscious effort to build trust and predictability with key stakeholders in regions throughout the country. This approach has been advocated in New Zealand (Connolly 2004) and there are indications that the Department plans to adopt a “differential response model” to child protection services that will incorporate this principle (Waldegrave and Coy 2005).

Thirdly, it follows from this that social workers, psychologists, educationalists and other helping professionals will need to be trained for holistic, preventive and rehabilitative strength-based work as their primary mode. The gathering of legally admissible information will be of less significance. Specialised skills in family therapy, non-violence group work, social networking, parenting groups and child development will reflect the type of human capital required. Specialised, sensitive family facilitators and coordinators will be needed in senior positions, and a raft of experienced supervisors, who can support, nurture and lift the capability of front line workers, will also be needed.

Fourthly, it further follows that the greater bulk of child protection resources would be diverted from the “front end” of the system, which is focused on detection and the gathering of legally admissible evidence, to the “back end”, which is primarily focused on rehabilitation. While there must always be a commitment to some “front end” work, the emphasis in the family services model is predominantly in the “back end”, helping families to live safely through rehabilitative processes like counselling, education, support for their particular circumstances, help with social networks and so on. This will not remove the need for more legal processes in certain situations, but it will enable early preventive work, help for as many family members as require it and a vehicle for the learning of safer ways to parent children. A planned movement of the bulk of child protection resources to the support, education and rehabilitation of families is central to the family services approach. It would also be important to develop joint ministerial responsibility for child protection services so that health and education resources could be prioritised for families where violence has taken place.

The focus of this paper has been on jurisdictional and welfare responses to violence to children. Many of the principles, though, may well apply to responses to domestic violence, other forms of adult violence and elder abuse, although that is really the subject of another paper. It is not a central aim in responses to domestic violence to keep a couple together, but the emphasis on holistic, preventive and strength-based

responses, aimed at helping people fulfil their obligations to each other in safety, warrants investigation. The emphasis on inquisitorial and consensual approaches to violent offenders is reflected in the “men for non-violence” movement and restorative justice approaches. This is not to suggest there should be no punishment through the court system, but that the long-term safety of society will depend on the quality of the “back end” services of rehabilitation and behaviour change. Early interventions well before legal thresholds are crossed, well-resourced community and non-government service provision, and skilled social-work professionals capable of enabling therapeutic and educational change, could all lead to more effective responses to violence between adults, as well as that from adults to older people and children.

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Ole Taeao Afua, the new morning: a qualitative investigation into Samoan perspectives on mental health and culturally appropriate services

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Objectives: The first objective was to develop a culturally appropriate research method to investigate Samoan perspectives on mental health issues. The second objective was to apply this to identify cultural values and understandings important in the care and treatment of Samoan people with mental health problems.

Method: Gender-specific focus groups consisting of Samoan elders and service providers were facilitated by Samoan researchers in the Samoan language. Systematic analysis of the transcripts, adapted to the cultural context, were conducted in Samoan and later translated into English.

Results: A culturally derived method, referred to as *Fa'afaletui*, reflecting Samoan communal values and familiar institutional structures within the community, allowed each focus group to come to a consensual view on issues discussed. The Samoan self was identified as an essential concept for understanding Samoan views of mental health. This self was described as a relational self and mental wellness as a state of relational harmony, where personal elements of spiritual, mental and physical are in balance. Mental ill health was sometimes linked to breaches of forbidden and sacred relationships, which could be addressed effectively only within protocols laid down in the culture. Additional stressors contributing to mental ill-health were identified as low income, unemployment, rising housing costs and the marginalization of Samoan cultural norms in New Zealand. Participants identified the need for a culturally based mental health service for Samoan people to address key cultural factors.

Conclusions: The *Fa'afaletui* method is a new research method which is sensitive and responsive to Samoan cultural norms and is methodologically rigorous. Such an approach may be relevant for other Pacific Island cultures and other cultures, which have a strong emphasis on collectivity. The Samoan concept of self provides a theoretical foundation for understanding the mental health needs of Samoan people and a basis for developing appropriate services.

Key words: culture, mental health, Pacific Island, Samoan, self.

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In Samoan culture there are three perspectives. The perspective of the person at the top of the mountain, the perspective of the person at the top of the tree, and the perspective of the person in the canoe who is close to the school of fish. In any big problem the three perspectives are equally necessary. The person fishing in the canoe may not have the long view of the person at the top of the tree, but they are closer to the school of fish. This research represents the culmination of all three perspectives, as it sought a range of views both long and short, from women and men and from the Elders and those who work in the health field.

Tuiatua Tupua Tamasese Efi [1]

People of Pacific ethnic origin make up 6% of the population of New Zealand and represent at least 22 different cultures with a greater number of languages. The Pacific population is demographically young with higher fertility rates than the rest of the New Zealand population. Their numbers are expected to double over the next decades. Samoan people make up 51% of this population, living mainly in urban areas of New Zealand's North Island [2].

To date, research focusing on the mental health of this population has been limited. However, hospital admission statistics support the view that Pacific people delay or avoid seeking treatment from mainstream psychiatric services [3]. It has been suggested that one reason for this delay is that the values inherent in the 'western' mental health system may be viewed negatively by Pacific people [3].

This project had two aims. The first was to develop a rigorous research method, which would be relevant and acceptable in a Samoan cultural context.

The risks of cross-cultural research which is used to examine the experience of non-western participants from western psychiatric points of view, have been highlighted by a number of authors [4–6]. Kleinman has emphasized the importance of research approaches which examine data using analysis derived from concepts indigenous to the culture in question.

In the Samoan context, the nuances of the Samoan language hold the key to understanding the meaning of important cultural concepts [1]. As well as being the vehicle by which beliefs and values have been transmitted from generation to generation, a person's first language houses their sense of belonging and identity and best explains their world view [1]. The Samoan language, depending on the situation, is spoken either on an informal level or in a mode which is highly formal. The latter is the language with which knowledge is appropriately and most commonly imparted [1]. Protocol and etiquette are critical and allusive linguistic techniques

such as 'riddles and camouflage' play a key role [1]. Accounting for these factors is necessary in order to develop appropriate and effective research methods for the Samoan context.

The second aim in this study was to identify the views of Samoan people on issues pertaining to mental health and wellbeing. This included inquiry into Samoan explanations of mental health and ill health, identifying Samoan values, concepts and practices relevant to mental health, and seeking participants' views on the extent to which these concepts and practices may have been influenced by western models of health care. It included inviting participant responses to Pacific Island mental health data and seeking their experiences of mental health services in New Zealand, as well as Samoan opinion on effective and culturally appropriate mental health services for Samoan people.

In New Zealand there is a Ministry of Health policy commitment to addressing the specific mental health needs of Samoan and other Pacific Island people [7,8]. However while it is acknowledged that acceptable mental health services would need to be culturally appropriate, there has been no previous systematic and rigorous research to establish what would constitute acceptable mental health services for Samoan or other Pacific Island people. This research aims to address this gap.

Method

In recent years there has been an increasing recognition of the value of qualitative studies in healthcare research [9]. This is particularly the case in the mental health context when addressing the meaning people from different cultures create to describe their experience and understanding. Cultural meaning that differs from mainstream definitions often becomes marginalized in formal discourse and theory [1].

This research is culturally based as noted in the aims above. The *fa'afaletui* methodology that was adopted, is set out below. It avoided the danger of Western interpretation and meaning construction and enabled an authentic Samoan based approach. From a Western perspective, postmodern critical theory offers a rationale for this approach to mainstream theorists and practitioners, because it identifies differing constructions of meaning and power differences between them [10]. This study has sought to explore the experience of Samoan people and the meaning they construct around critical mental health issues and definitions. Cultural information of this type seldom features in formal mental health literature.

Data collection

In Samoan culture, issues of importance are always discussed collectively [1]. Therefore a focus group method was chosen for this study. This method provides an opportunity for more in depth discussion than other research techniques, encourages the exploration of meaning and allows systematic comparisons of an individual's experience with those

in their group [11]. Of further relevance to the Samoan context, focus groups also allow the development of consensus views around issues of importance [1].

Participants

All participants were of Samoan descent and living in urban areas in the lower North Island of New Zealand. *Tumua ma Pule*, the traditional oratorical body that is representative of all villages in Samoa, selected participants from as many villages of origin as possible, aiming for a balance of participants from the two larger islands of Samoa, Sava'i and Upolu. This was intended to increase the breadth of perceptions and experiences of mental health issues.

Fa'afaletui method

Fa'afaletui is a Samoan concept, that was brought to the notice of the researchers by the Elder men and women's focus group participants, to explain the process in which they viewed themselves to be a part. Essentially, *fa'afaletui* describes a method which facilitates the gathering and validation of important knowledge within the culture.

Gender and relative status within the cultural community were selected as the most appropriate ways to apportion the focus groups. The gender separation allowed relationships and the appropriate cultural protocols to be addressed and permitted issues considered *tapu* (or sacred and forbidden) which could not be spoken of across gender groups, to be openly discussed. The relative status separation allowed recognition of the roles and responsibilities of elders on the one hand and their particular knowledge of traditional 'health models' prior to the Western public health system in Samoa, on the other.

In this study, an Elder men's and an Elder women's group, with a minimum age of 50 years were selected. A women's and a men's provider group were also selected. They represented a range of disciplines within the mental health field. Informed consent was obtained from all participants after personal approaches by Samoan members of the research team, supplemented by written material.

These groups or houses (*fale*) met separately to address the research questions with a facilitator, who enabled their sharing of knowledge and consensus building. The *fa'afaletui* process then involved delegations from each of the houses meeting each other and going through the same process together to build a new consensus. The information was threaded and rethreaded among the relational houses until all were agreed that the specific knowledge pieces were valid and authentically reflected the collective experience of the participants. *Fa'afaletui* is the critical process of weaving (*tui*) together all the different expressions of knowledge from within various groupings.

Development of focus group questions

In preparing the questions to put to the focus groups, it became apparent to the Samoan researchers that in the Samoan context, issues of health and wellbeing without regard for a Samoan view of the self, have little meaning. In order to discuss what might constitute a mentally well self, participants would need to address the more fundamental issue of a Samoan perspective on the self. This distinction became the basis for the development of the focus group questions. Details of the focus group questions are provided in the Appendix.

Group facilitation

Samoan researchers facilitated all sessions. It was anticipated that the main medium of communication would be the Samoan language and expected that Samoan protocols would be observed. The facilitator's role was to loosely guide discussion, attempting to gather clear and useful responses while encouraging a divergence of opinion and allowing participants to use their own concepts and meanings. In all 14 focus group meetings took place, four for both Elder groups and three for both service provider groups. The Elder groups had an extra meeting that focused on questions about their memory of the treatment of mental health problems prior to the Western public health system in Samoa.

Analysis

Audiotapes of the focus group sessions were transcribed and proof-read to ensure accuracy. Specialized terms and vernacular usage were verified.

It was initially planned to translate the transcribed interviews into English prior to the data analysis. However during this process the Samoan researchers became concerned that important concepts discussed in the Samoan language were difficult to translate precisely, resulting in the loss of the essence of some of the information. At this point a decision was made to proceed with the data analysis in the original language of the participants.

The data was coded and categorized into themes manually. The themes consisted of clusters of the subject areas that consistently recurred. These theme areas were then classified and subcategorized in a manner that highlighted the consistently repeating knowledge pieces. A manual approach was employed, because much of the data was given in metaphorical and allusive language, as is common in serious Samoan discourse, and digital theming techniques proved inadequate.

The primary report was completed in Samoan. Copies of this report were given to authoritative participant members from each of the groups to check for coherency, appropriate use of terms and concepts, and an appropriate observance of written protocols and etiquette. The Samoan report was considered to be important both because it represented the initial gathering of primary source data and because it was accessible to Samoan readers. An English report was prepared based on the Samoan report, to be accessible to English speaking health professionals.

Results

There were 12 participants in each of the Elder men and women's groups and ten and eight members for the men and women's service provider groups, respectively.

The results are presented in sections according to the major themes that emerged in the data analysis. Each theme is illustrated with quotations taken from the text.

The Samoan world view and the importance of the relational self

Participants considered that it was not possible to understand Samoan concepts of mental health and ill health without first understanding the Samoan concept of self.

A relational self

Participants explained the nature of the Samoan person as that of a relational being:

It is difficult because there is no such thing as a Samoan person who is independent (of others). You cannot take a Samoan out of the collective context.

I cannot say that I am a person, just me; (because) then I will be nothing without my other connections . . .

The idea that a person can be an individual unto him/herself is a new concept which was introduced with Christianity. Christianity introduced the notion that one looked to oneself first. The Samoan belief is that in need, we look to each other. You cannot prosper on your own, by yourself . . .

The self is identity and tofi [responsibilities, heritage and duties].

The Samoan self was described as having meaning only in relationship with other people, not as an individual. This self could not be separated from the 'va' or relational space that occurs between an individual and parents, siblings, grandparents, aunts, uncles and other extended family and community members.

In the context of psychiatric services, it was pointed out that individuals who receive treatment without regard for their communities and communal practices were denied a most important source of meaning and life support in their process of healing.

Tapu and sacredness in relationships

Tapu in its fundamental sense means 'that which is forbidden to the ordinary', as expressed in cultural protocols and etiquette. *Sa* has its nearest English equivalent in the word 'sacred'.

Within *va fealoaloa'i* (particular relationships of mutual respect) there exist *tapu* and *sa* which define by way of . . . etiquette how one ought to relate to the other. There exist such relationships for example between *matai* (titled heads of families and villages), between brothers and sisters. These relationships are especially sacred.

Within the physical and spiritual domains, there are *tapu* whose purpose is to ensure that human wellbeing is protected and (given prominence), through its sacred nature. For example, a basic premise of cultural protocol is, it is forbidden (*Sa*) to stand in the presence of people (while they are seated). There exist protections around Samoan wellbeing because of the relational arrangements with others.

These quotations were typical of the comments of all the groups and emphasize the fundamental importance of language, Samoan etiquette and protocol in protecting the sacred nature of relationships, and maintaining wellbeing in Samoan society.

The Samoan self was described as drawing its sense of worth from its ability to carry out its appropriate roles and responsibilities. Mental ill-health among Samoan people was reported as often understood to be the result of breaches of forbidden or sacred relationships (or breaches of 'sa' and 'tapu'). These cultural notions were clearly

viewed as being effectively addressed only within the protocols laid down in the culture.

It was noted that although young people brought up in New Zealand were less influenced by these concepts they were still relevant when the young person faced a crisis in their life.

Spirituality and the self

Prior to the arrival of the 'good news', Samoa had her Gods; each island had their Gods; there were Gods of districts, Gods of villages; families also had their own Gods.

. . . our Gods were Gods whom we could see but from 1830 we have been worshipping a God that cannot be seen.

. . . if both (physical and spiritual) natures are not in balance, wellbeing cannot be in balance . . .

In Samoan culture, Gods were traditionally embodied in the environment in which people lived and genealogical ties could always be traced back to a God. Despite the change in emphasis following the arrival of Christian missionaries to Samoa, a person's relationship to land, sea, ancestors and God remain central to the Samoan sense of self.

Participants described spiritual and mental aspects as being so closely related for Samoan people that psychiatric treatment processes that did not address the spiritual aspect were considered unlikely to be successful.

The whole self cannot be divided

Samoan people believe that the person is 'itu lua', that is the person has physical, mental and spiritual aspects.

We view ourselves as whole beings. In other words the spirit, the body, the will. I include the spiritual because there is no Samoan person who . . . exists outside of a spiritual existence.

In fact the Samoan term for spiritual, 'fa'aleagaga' was frequently used by participants to include the mental faculty. It was emphasized that the Samoan self is seen as a total being comprising spiritual, mental and physical elements which cannot be separated.

If I become mentally unwell, everything else is not well. If I become physically unwell, everything else is not well. I cannot say, 'I will leave my spirituality while I go and get on with my physical function', or 'I will put aside my mental function while I undertake my spiritual duty'. The whole person is all parts. The person cannot be divided by anyone.

Participants viewed this being as deriving its sense of wholeness, sacredness and uniqueness from its place of belonging in its family and village, its genealogy, language, land environment and culture.

Causes of mental illness

All the focus groups expressed the view that mental ill health among Samoan people is often understood as being the result of breaches of forbidden or sacred relationships.

Breaches of tapu and sa

Participants considered that prior to 1920 rare cases of mental illness had usually been attributed to breaches of 'tapu and sa'. Such breaches were viewed as grave transgressions of family, village or district relational boundaries. They could often result in a curse (malaaumatua) being placed on the offending person or persons.

If a person has been cursed, it is because something has been dealt with irreverently or desecrated. In other words he or she has been assigned the consequences of desecrating sacred protocols.

Curses could be intergenerational. They would frequently condemn the person to a life outside of family and village relationships, and hence a life without purpose.

An example would be the relationship between sisters and brothers. In the Samoan context, this relationship is viewed as especially sacred and it is the role and responsibility of a brother to ensure the safety and welfare of his sister or sisters. As part of this feagaiga (covenant) a sister has the power to curse a brother whose conduct is extremely untoward or neglectful of her.

There are cultural processes that facilitate healing after breaches of 'tapu and sa'.

The Samoan way of healing is for the family to establish why there has been a curse put on this person and to seek reconciliation through appropriate processes.

Additional pressures in New Zealand

The participants stated that sometimes mental illness results from an inability to fulfil responsibilities and obligations to their families, villages and districts of belonging:

For many Samoans who have migrated here, the reason has been because of family and their responsibilities towards family.

There is not enough financially to meet obligations and fulfil responsibilities.

(There is) no money, not enough money.

The needs from Samoa become a pressure . . . it becomes difficult for young people to provide (financially) for the family, church obligations, to send remittances (home to Samoa) . . . these become heavy burdens, the mind tries to cope, then it breaks down.

Pressures of cultural adjustment were also highlighted as possible precipitants of mental ill health:

There are different values and priorities between Samoan culture and the dominant culture, and these values conflict.

(Young people) . . . don 't know if they are Palagi (European) or Samoan, they're confused.

One of the biggest reasons especially for the younger generations is the different cultures and trying to live in the European way . . . as well as keeping your identity as a Samoan and playing your role in the family. You've got two (areas) putting

a lot of pressure on you to function out in the community and function in here.

There are conflicts of cultural identity causing shock and trauma. (Whether the child) was born in New Zealand or brought up in Samoa, there are conflicts with cultures within schools.

These pressures were noted particularly in shifting family relationships. In some families older members become depressed as senior members are accorded lower status, both in earning power and recognition in New Zealand:

. . . Where we come from, our status is determined by the titles our families hold. In this country the status is determined by our earning power. A senior ranking matai (titled elder) who comes from Samoa finds that he is not employable; he cannot make decisions or undertake his responsibilities. Eventually his mental health will be affected.

For younger people, the push to succeed in a Palagi (European) environment at school, where they are seen as different and often from a low income family, could lead to the development of psychological problems:

. . . parents have high expectations of their children. There are many things that they are wanting but these are not appropriate to where the mind of the child is at. The child will therefore try their best to realize the parents' expectations.

Racial stereotypes and prejudices held by non-Samoan peers and teachers were also thought to create pressure on young Samoan people in the school setting.

Other factors identified as precipitants for mental ill health included: drug and alcohol abuse, unresolved grief, physical and sexual abuse, and isolation due to the breakdown of traditional collective support systems.

Several major themes emerged from this part of the focus group discussions. Firstly, participants maintained that mental illness was more likely to occur when extended family relationships were disrupted and traditional relational arrangements weakened. Secondly, conflicting values between Samoan culture and the dominant Palagi (European) culture in New Zealand were viewed as a significant ongoing stressor.

A third theme was that mental ill health could be triggered by feelings of failure associated with the inability to meet financial responsibilities within the extended family.

Finally, when traditional Samoan structures of support were fragile or absent, healing and the restoration of emotional and relational harmony were seen as much more difficult to achieve.

Effectiveness of psychiatric services for Samoan people

Strengths of mental health services

There was recognition that there were mental disorders which could only be treated by Western medicine:

. . . hospitals have their purposes because there are many types of illnesses, and many causes . . .

Hospital facilities also helped to relieve the burden of care faced by some families, enabling other family members to seek paid employment:

... we have a child who is mentally unwell. The positive aspect is that she is able to be placed in hospital care. The family structure in New Zealand (nuclear families) makes it difficult to work and leave her at home on her own. It is not like Samoa where there is the extended family who are able to care for her.

There was also acknowledgement of the emerging role of Pacific people who were employed as cultural advisors in mainstream mental health services. This was seen as a significant first step in bridging identified cultural gaps.

Weaknesses of mental health services for Pacific Island people

Participants reported that psychiatric treatment of Samoan people in New Zealand was based on Western medical beliefs. This primarily focused on physical modes of treatment:

It is not that the hospital is of no use. The work of the hospital with regards to the treatment of physical illnesses is important. The problem arises where there is a need for holistic treatment, and this is not undertaken ... This is true of the treatment for mental unwellness where doctors have separated the whole into three parts, treating only the physical. You cannot divide a Samoan person because if my mind is unwell, everything else becomes unwell ...

Language and a lack of familiarity with important cultural issues, were identified as problems with the current mental health services:

Language is one barrier which is creating difficulty for our people. If the Palagi (European) cannot understand a Samoan patient, they treat our people differently (from others). If the patient does not understand (the Palagi), they are treated in a manner which indicates that the Palagi may not be happy with the patient. It is only when they see their own that they sense relief ...

The Palagi does not understand the Samoan. Our culture and traditions are different ...

There are no Samoan psychiatrists. Samoans are being diagnosed by people from other cultures who define normality from their own perspective.

Participants emphasized that these issues led to crucial communication problems. For example details regarding symptoms and the frequency and nature of particular psychiatric experiences may be misunderstood by psychiatrists who speak English when interviewing patients whose primary language is Samoan.

References were made to established Maori mental health services in New Zealand which provide culturally appropriate care for Maori patients:

The Maori have made the health system effective for themselves, yet we are lumped with the Palagi (European).

It was stated that where the cause of the unwellness originated from breaches of Tapu and Sa, and where this had a history of being intergenerational, then Western treatment was not effective:

The doctors will try in vain to apply treatment to heal the person, but they will not be successful because the cause of the unwellness is outside of their medical experience.

... medication and injections cannot treat this type of illness; it can be healed through appropriate traditional healing.

Culturally appropriate Samoan mental health services

Key cultural factors

Participants considered the Samoan view of self to be a crucial concept in developing culturally appropriate services for Samoan people. This view was of a relational self in which spiritual, mental and physical aspects were considered together as a whole and not treated as separate entities.

They highlighted the important role of Samoan relational arrangements in the healing process and the critical role of the family in nurturing them. The importance of involving the extended family in treatment was emphasized.

Service issues

Participants identified a need for a specific Samoan service for mentally unwell Samoan people combining aspects of both Western and traditional Samoan models of care:

... early recognition of symptoms and causes, changes in behaviour and intervention at an early stage would increase the likelihood of recovery

... there should be a hospital service for Samoan people where they can be taken care of

... Samoan people are best employed because they understand the needs of Samoan people ...

... there will be Samoan people who will work there with commitment because they will look after their own people as if they were their mothers or fathers ...

Family involvement

Within this service, the participants stated that there should be people trained to provide support and counselling for families of the mentally unwell:

... there need to be family and community education programmes; families need to be supported where needed in therapy and counseling, financial (budgeting) ...

... it may be that the treatment has not worked and the families are at their wits end. The only thing left is to provide a service within the context of aganu'u (sacred Samoan customs and traditions). In this way, there needs to be an understanding not only of the way of life but also of the culture ...

Participants noted different cultural conceptions of confidentiality, and considered that clients of a Samoan service should be able to choose to have their rights to confidential information extended to their

families, rather than restricted to individual rights. They pointed out that the family, which provides most of the support and has its own recognized boundaries can be marginalized through current institutional processes and legal requirements for confidentiality and privacy.

Community support services

Participants emphasized the need for community based services:

The focus is out in the community. We need to set up a place where we can cater for the needs of our people.

Therapy and counseling that connects people to their places and gives a sense of belonging should be made available.

. . . we need a mental health service to cater for the needs of Samoan people run by Samoan people . . .

Employing Samoan healers

Traditional Samoan medicine and healing knowledge should be valued in the treatment of Samoan people . . . *taulasea* (Samoan healers) should be recognized because there are illnesses which can only be treated by *fofo* Samoa (Samoan healing methods); there are also illnesses which can only be treated by Western medicine . . .

There needs to be education of Samoan psychiatrists and Samoan cultural consultants . . .

Participants stated that they wanted *taulasea* and *fofo* (Samoan healers) to be employed in the mental health services alongside other clinicians. They wished to see the status of traditional healers recognized along with appropriate remuneration.

Enhancing the mental wellbeing of Samoan people

While offering suggestions regarding changes to New Zealand mental health services to improve care provided for Samoan people, participants also identified a need within their own communities to strengthen family relationships and the role of the church.

Participants identified the importance of preventing mental ill health through the strengthening of critical cultural concepts and structures. The emphasis was placed on strengthening of spirituality and relational arrangements within the family, in recognition that the family is the first place of relational harmony, belonging and identity. It is also the primary site of education and nurturance of language and cultural knowledge.

Where families were unable to provide this secure foundation, the churches were identified as being the next most important source of support, providing both a spiritual dimension as well as pastoral care and support for families.

Medical scholarships and research

Participants recommended that medical scholarships be made available for Samoan students to enable a greater proportion to complete medical training and proceed with specialist training in psychiatry. This would enable better recognition of Samoan approaches at a senior level.

They also stated that there was a need for Samoan researchers to undertake qualitative and quantitative research that relates to Samoan people and that this research should be more accessible to Samoan people.

Discussion

Despite recent acknowledgement of the specific mental health issues facing people from cultures indigenous to the South Pacific region, few if any studies have attempted to systematically investigate the views of members of these cultures. Furthermore, research methods traditionally used in the mental health field have not been well accepted by Pacific Island groups [1].

The present study is unique both in terms of the method used as well as the findings. It has developed an innovative research method known as *Fa'afaletui* which weaves in established qualitative research principles with the values and processes indigenous to Samoan culture. During this research there was an extraordinarily high level of cooperation by the participants, and the breadth and depth of knowledge that was shared, suggested a high degree of acceptance of the research process. Participants raised deeply spiritual material during the course of the research and clearly expected that this would be treated as sacred by the researchers. The trust shown by participants suggests that the research method was found to be culturally relevant and safe. In addition, the Samoan leadership of the project, and focus group facilitation by Samoan researchers in the Samoan language were further factors in the cultural acceptability and validity of the method. The validation of key cultural concepts was strengthened by verification of findings by participants.

Although participants were all Samoan and represented a range of villages in different parts of Samoa, it should be noted that they were all resident in the greater Wellington region of New Zealand, and some findings could be subject to regional differences, for example varying experiences of mental health services. In addition although similarities in cultural values have been described between different Pacific Island cultures, it is not possible to generalize these findings to other Pacific Island communities.

This study found that from a Samoan point of view, understanding the Samoan sense of self is crucial to an understanding of what constitutes mental wellbeing for Samoan people.

The Samoan self described in this study is a relational self. Other collective views of self have been described for a range of diverse non-Western cultures [12–15]. These authors state that it cannot be assumed that developmental theories, therapeutic interventions and mental health service practices that have evolved in cultures

with individual concepts of self, will necessarily be relevant for people from collective based cultures. Other authors have highlighted aspects of the phenomenology of major mental disorders such as depression and schizophrenia arguing that differences in presenting symptoms across western and non-western cultures may be accounted for by fundamental differences between individual and collective concepts of self [4–6].

The results of this study challenge a number of prevalent presuppositions about the nature of self in modern psychiatry and raise questions about the assumption that such dominant western views of self are applicable across cultures. In particular the Western notions of the self as being primarily individuated rather than relational, and secular/scientific rather than spiritual, differ substantially from those identified by participants in this study.

In the New Zealand context, specialist Kaupapa Maori mental health services have been established, which have developed whanau (family) centred practices to address collective values in Maori culture [16]. Participants in this study called for similar Samoan or Pacific Island services to specifically address these issues for Samoan patients and their families.

According to the participants in this study, spirituality must be addressed if the mental health care of Samoan people is to be effective. This is consistent with the findings from other cultures indigenous to the Pacific region. For example, Maori authors have described spirituality as integral to a Maori model of mental well-being [17].

In order for a mental health service to adequately address relational, spiritual and holistic aspects of the Samoan self, they would need to transform current approaches to mental healthcare. In this study a range of recommendations of how to do that were put forward by participants. These involved the provision of services that incorporate the beliefs and customs of Samoan people, the use of traditional healers alongside mental health clinicians, and closer links in the healing process with extended families, the churches and the communities in which Samoan people live.

The study also noted the added pressures many Samoan households experience that can lead to mental ill health. Samoan families as a whole tend to occupy a lower socio-economic status than the majority of New Zealanders and the combination of the financial worries low income households experience and the added pressures associated with cultural collective obligations create added stresses for many. Racial stereotypes and prejudices from the mainstream cultural groups contributed further tensions along with the cultural adjustments many immigrant families were undergoing.

Further research is required to establish whether there are themes in common between Samoan perspectives outlined here and the views of other Pacific Island groups. The Fa'afaletui method may well be an appropriate and acceptable research design for investigations with other Pacific Island communities. A current development of this study is involving a similar enquiry into the perspectives of Samoan consumers of mental health services.

Tupuola [18] has emphasized the predicament that young Pacific Island women face growing up in New Zealand, straddling cultures with very different values. Participants in this study also highlighted this point. Similar qualitative research would shed further light on particular psychological stressors faced by New Zealand born people of Pacific Island descent.

A further area for enquiry would be to seek a response from Palagi (European) mental health professionals to the Samoan concept of self and how they would view this as relevant for the mental health care of Samoan people and their families.

There is little epidemiological data available regarding the mental health status of Pacific Island people either in New Zealand or in their countries of origin. Qualitative research using the Fa'afaletui method could be expected to contribute useful information towards finding culturally acceptable methodologies, in order to maximize participation of Pacific Island groups in epidemiological research. Furthermore, future research that adopted this methodology would usefully test the validity of such an approach.

Durie has called for 'the development of a type of psychiatry which is firmly grounded in a New Zealand identity' in order to best meet the mental health needs of the Maori community [19]. In a similar way, understanding cultural identity in the Pacific Island context is the key to beginning to address the mental health needs of Pacific Island communities. A collaborative approach to this endeavour can only enrich the development of psychiatry in the South Pacific region.

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Appendix

Focusing questions

(questions were asked in the Samoan language)

Samoan perspectives on mental health and the self

- *What is your understanding of the Samoan self?
- *What is your understanding of a well self?
- *What is your understanding of a mentally well self?

Causes of mental unwellness among Samoan people

(Elder Men and Women's groups only)

*Before Western mental health practices, when a self was not mentally well, how did the elders and people know?

*What sort of things did people do that showed others that their self was not mentally well?

*How were these people helped to become well?

Additional causes of mental unwellness in New Zealand

*What do you think happens when people lose their state of mental wellness?

*Do you think there are any particular reasons why some Samoan people lose their state of mental wellness in New Zealand?

Effectiveness of mental health services for Samoan people

*In light of the discussions on the mentally well self, how effective do you consider the Public mental health services for Samoan people to be?

*What are the strengths of the current mental health services?

*What are the weaknesses of the current mental health services?

A successful mental health service for Samoan people

*What are the most significant changes to the mental health system in New Zealand that you would like to see introduced, that would benefit and heal Samoan people who have a mentally unwell self?

*Create for us a picture of the sort of mental health service that you consider will be consistently effective for Samoan people in New Zealand?