Culture, Theory, and the Practice of Occupational Therapy in New Zealand/Aotearoa

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In the context of contemporary New Zealand, this paper discusses the need for occupational therapy to substantiate its claims of being a holistic profession with particular reference to the Maori, the indigenous people of New Zealand (referred to by the Maori as Aotearoa). In this era of accountability and consumer choice, occupational therapists need to more effectively meet the cultural needs of their clients through an understanding of both the material and nonmaterial aspects of their cultures. However, for New Zealand occupational therapists, cultural sensitivity is not enough to contribute to changing the diminished life chances of the Maori. It is proposed in this paper that the Model of Human Occupation (Kielhofner, 1985; Kielhofner & Burke, 1980), when combined with the work of radical community educators such as Freire (1972), could provide the sociopolitical dimension to New Zealand practice. The Model of Human Occupation is examined in light of current occupational therapy practice in New Zealand. It is argued that this model, when accompanied by a broader understanding of the sociopolitical processes informing multiculturalism, could be seen as a suitable framework for understanding cultural differences in New Zealand and could assist in the move toward providing culturally appropriate occupational therapy for indigenous peoples such as the Maori.

Occupational therapy has prided itself on being a holistic health care profession. However, in New Zealand, there is little evidence that the cultural needs of our clients, particularly of Maori, are being addressed in occupational therapy practice. A review of the occupational therapy literature from a variety of Western countries reveals that occupational therapy is only beginning to consider the implications of cultural differences in treatment planning and implementation (Dyck, 1989; Hill, 1986; Hume, 1984; Levine, 1987; Weiriga & McColl, 1987). Little of the work that has been done discusses the broader sociopolitical aspects of working with people from other cultures or the potential role of occupational therapists as agents of change for community action or community development with indigenous peoples. Shawski (1987) commented on this paucity of analysis and stated that the relationship of cultural background to treatment planning is not well articulated in the occupational therapy literature, where evaluation and assessment of functioning are based largely on the sociocultural norms of a white middle-class population. Much of what has been written about cultural differences relates to immigrants rather than to indigenous populations (such as Maori, Aborigine, or native Americans), where the impact of colonization has frequently eroded or undermined a culture, resulting in an alienated and marginalized group of people (Spooner, 1988). Serious cultural inequalities exist in New Zealand between Maori and non-Maori people with high levels of unemployment, substandard housing, poverty, poor educational achievement and overrepresentation in penal institutions, and are important reasons for the disproportionately high levels of sickness and shorter life expectancies of the Maori people (Pomare & De Boer, 1988).

It is in this context that Maori leaders, as Tangata Whenua (people of the land, the indigenous people of New Zealand), have called for a renewed pride and awareness of Tikanga Maori (Maori culture) to prevent further loss of the language and culture and to improve the life chances of Maori people. However, this responsibility must not be seen as solely Maori. At the center of any consideration of cultural perspectives on occupational therapy practice is the Treaty of Waitangi, an agreement between the British Crown and the Tangata Whenua of Aotearoa (the Maori name for New Zealand) and signed by both parties in 1840. History has shown (see Orange, 1987) that neither the specific rights of Maori to control the natural resources of New Zealand and their own culture, language, and traditions; nor the promised political autonomy was honored. This has led the Maori to become a political minority in their own country, and grievances from the past underlie much of the tension between Maori and Europeans.

This paper presents an overview of some of the key issues around culture and the practice of occupational
therapy in New Zealand and draws on sociopolitical and anthropological literature and analyses as well as on occupational therapy theory. Central to the argument is the contention that before any multicultural initiatives can succeed, biculturalism (i.e., the equal partnership, cooperation, and sharing of power and resources between the two main cultures, Maori and European) espoused by the Treaty of Waitangi must be an accepted and integral part of New Zealand social and organizational life. Biculturalism is a vital movement toward multiculturalism, "the first step towards relationships with cultural groups other than Maori. Multiculturalism is the logical progression from biculturalism but it cannot be espoused without further expense to the indigenous people of this country" (Ramsden, 1988, p. 3). This paper focuses on Maori issues with the understanding that knowledge and experience gained from the indigenous people of New Zealand will ultimately lead to multiculturalism. Knowledge of another culture can benefit occupational therapists both professionally and personally, enabling them to become more culturally sensitive so that their services are equally effective for all clients.

However, mere cultural sensitivity is not enough. It alone does not address the effects of colonialism and the power dynamics between health professionals and their clients, nor is it working toward changing the life chances of Maori people. Ramsden et al. (1990) have put forward the notion of cultural safety in health care on the part of health care providers. This idea of cultural safety "ensures the non-violation of all those attitudes, values and actions which implement the obligations of the Treaty of Waitangi" (Ramsden et al., 1990, p. 4) and involves the education of health professionals so they do not blame victims of historical and social processes for their plight. As long as Maori people perceive the health service as alien and not meeting their needs in treatment, service, or attitude, it is seen as culturally unsafe, that is, dangerous.

Culture Defined

Culture may be defined as a blueprint for human behavior. It is more than the arts, crafts, music, and other tangible aspects of material culture. Metge (1976) described Maori culture as

a matter of present experience, a living and lived in reality either for themselves or for others well known to them. It encompasses a wide range of behaviour, including everyday practices as well as ceremonial. Most importantly, it includes not only outward visible forms but also deep inward feelings and values, which are relevant to and expressed in all they do. (p. 45)

Culture is therefore an abstraction, a complex idea in the minds of people and a group possession passed on to successive generations. Culture is transmitted in a variety of ways, the most important being language, which is the main medium through which knowledge and an understanding of one's cultural reality may be learned. The death of a language means a loss of the culture: the values, attitudes, beliefs, ways of doing everyday tasks, and notions of health and illness as well as a group's very reality.

People's perceptions of and responses to health and illness tend to be culturally determined, with a person's own culture being the reference point for other views. In New Zealand, the dominant culture has as its main reference point a reductionistic Western model of health and illness and either sees other realities as being merely perspectives in addition to their own view or ignores colonial New Zealand would demonstrate how early paternalistic attitudes of colonizers have molded subsequent generations into believing that European culture is superior.

The arena of health care has not been exempt from such monoculturalism to the extent that health care in New Zealand is considered unhealthy by the Maori (see Ramsden et al., 1990). Maori people have a shorter life expectancy than Europeans and are more likely to die from respiratory disease, diabetes, rheumatic diseases, and hypertensive heart diseases (Pomare & De Boer, 1988). Maori are only too aware of the "appalling health status in which they find themselves" and that "poor Maori health statistics are a health service delivery problem, not a Maori problem" (Ramsden, 1988, p. 1). Explanations for such poor health statistics vary from the idea of a constitutional weakness on the part of the Maori contributing to their poor health to monocultural organizational structures and the limitations of Western-style bureaucracies. This situation is not limited to New Zealand. Dyck (1989), a Canadian occupational therapist, has written of the social and economic disadvantages (e.g., housing, access to health care) that immigrants in Canada experience, along with being of low-income, working class status and downward mobility.

Historical Overview

For many years, New Zealanders have perceived themselves as living in a country free of racism and conflict, a country in which everyone is treated equally and opportunities are available for all. The 1980s have seen this supposed harmony shattered by the violence and conflict arising out of the 1981 South African Springbok Rugby Tour (where anti-apartheid demonstrations led to the country being divided) and by increasing Maori demands for more self-determination and control of the resources in their own country, as promised by the Treaty of Waitangi (Orange, 1987). New Zealand has entered a turbulent adolescence as race consciousness expands and the "golden age" of perceived racial harmony, in which minority peoples (especially the Maori) "knew their place," is over (Spoonley, 1988). It is beyond the scope of this paper to expand this history, but a historical analysis of
them completely. Western constructs such as the medical model do not readily encompass social and spiritual phenomena or the notion of health and well-being resulting from all elements of people's lives being in harmony. For Maori, such balance is achieved through the interrelatedness of all aspects of people's lives, including close affiliation with the extended family, respect for the land, or the relationships with ancestors. The place of wairua (the spirit) and relationships with the spiritual world are frequently ignored by the Western health service, which often feels ill at ease with such concepts in a medical context (Ramsden, 1990).

Culture, therefore, encompasses the nonmaterial world through attitudes, values, and the social and cultural meanings giving structure to the beliefs and practices of everyday life; and the material world through the artifacts giving form and expression to the beliefs that are held. Both the material and nonmaterial aspects of culture relate clearly to occupational therapy practice: first, through the early part of our heritage—arts, crafts, and the things people do or make and how they fill their time—and second, through an understanding of the cultural values and beliefs that influence professional practice.

### Occupational Therapy and Culture

Arts and crafts are aspects of material culture involving much more than the manufacturing of an end product. The process of making something involves the learning and transmission of attitudes, values, and traditions of spirituality and essentially represents a group's understanding of both its spiritual and physical worlds. For Maori, arts and crafts have been a well-understood and supported means of transmission of culture. Mead (1987) wrote on Taaniko weaving:

> Taaniko provides one vehicle, among others in the culture, by which and through which cultural ideas are expressed and objectified. It has been used both consciously and unconsciously by Maori to express their individuality as people and to provide some visual concrete manifestation of their concept of Maori culture. (p. 74)

Through participation in crafts, tribal patterns and traditions can be learned so that young Maori can develop a strong grounding in the cultural pride of race, self-respect, and confidence. So, too, for any culture, arts and crafts can be an important form of cultural maintenance, cultural transmission, and cultural development (for both indigenous and immigrant populations) and is especially important for people who have nearly lost their distinctive way of life through colonization.

Learning through arts and crafts engages all aspects of one's being, "involving heart as well as head, emotion as well as intellect" (Metge, 1984, p. 29). Through the signs, symbols, and design styles of arts and crafts, the concepts of reality, the meaning of the universe, and the interpretations of the cycles of human life are made explicit. The process of making and doing and the use of traditional tribal designs, symbols, and techniques result in artifacts (and actions) that can mediate between the inner and outer worlds of a people. For Maori, such exploration has resulted in the restoration of pride in their cultural heritage, both at an individual and at a wider group level, as traditional crafts (e.g., carving, weaving) and performing arts (e.g., oratory, song) are rediscovered and fostered.

Fidler (1981) described the critical function of doing—that is, of involvement with the world—and the effect of purposeful activity in shaping a person's sense of competence, mastery, and efficacy. Through interaction with the environment and materials, persons learn to know their potential and limitations and develop a sense of competence and real worth. Such a belief in doing has been an integral part of occupational therapy philosophy and practice and has informed and underpinned occupational therapy theory in many areas.

A review of the literature addressing culture and occupational therapy reveals that potential problems exist between the cultural dimensions of practice and the value system of the therapist as well as between the values and beliefs of different cultural groups and the theoretical framework selected and treatment program implemented (Dyck, 1989). This is supported by Levine (1987), who contended that the effectiveness of therapy depends on "three levels of beliefs: the patient's perception of illness and health, the patient's perception of therapy and the patient's belief in the meaning of his (or her) own life and activities" (p. 9). Culture has a pervasive influence on a person's values, goals, interests, roles, habits, performance, and how people determine their direction and degree of involvement in self care, work and leisure activities" (Levine, 1984, p. 734).

However, as Shawski (1987) pointed out, time spent learning treatment theories is useless if the therapist is unable to establish a therapeutic relationship in which this information can be used or is unable to communicate because of problems of language and cross-cultural communication (see Kinloch & Metge, 1976). Once a relationship is established, it is important to select activities that have meaning to the client. Levine (1987) stated that few people are interested in activities that have little or no personal meaning. As occupational therapists, we search for activities that will stimulate and interest our clients as well as promote functional abilities. Many areas that occupational therapists deal with have meaning in many cultures, for example, areas of food preparation, bodily care, touch and personal space, the notion of time, and age- and gender-appropriate activities (see Hume, 1984 and the Spring 1987 issue of *Occupational Therapy In Health Care [Staff]*).
The Model of Human Occupation

Although much of occupational therapy theory and practice acknowledges a cultural dimension, the Model of Human Occupation (Kielhofner, 1985; Kielhofner & Burke, 1980), includes a conceptual structure that integrates data about the patient’s values, goals, interests, habits, and roles into occupational therapy (Levine, 1987). Despite the underlying Anglo-American concepts of role acquisition and expectations and the cultural differences in understanding what constitutes appropriate tasks and roles, the Model of Human Occupation has been found to be a particularly flexible and useful tool in guiding the occupational therapist in the definition of goals and the provision of appropriate therapeutic environments for the culturally different client (Levine, 1984; Weiringa & McColl, 1987).

The Model of Human Occupation picks up many of the themes of holistic health care. The person is seen as an open system who is influenced by the environment and who, in turn, influences the surrounding world. This view is shared by Maori, Samoans, native Americans, and many Asian cultures who see themselves as an interdependent whole with other people, nature, and their gods (Weiringa & McColl, 1987). For Maori and other groups, an individual is always seen in the context of a larger group or community. His or her iwi [tribe], hapu [sub-tribe], or whanau [immediate family] affiliations and kinship ties, rather than occupation, become the initial reference point. Distinctions between the human and nonhuman environment may become blurred, as land, language, and the relationships with gods and ancestors become crucial factors in ill-health and well-being (Rankin, 1986).

The problems associated with urbanization and the breakdown of traditional family and tribal roles have repercussions on the client’s habituation subsystem. This is especially so for those Maori who may have weak tribal links or do not know their tribal affiliations. There are few role models who are confident and competent in Maori culture, because as kaumatua (elders) die, so too does the knowledge and guidance. Many Maori and native Americans may experience role conflict between the aspirations of white society and the actual opportunities that may be open to them after a frequently unsuccessful education (Weiringa & McColl, 1987).

Culture also has a pervasive influence on the volitional subsystem. During intervention, the occupational therapist’s expectations may be at odds with those of the client in such areas as values regarding dressing independence or gender-appropriate activity. For example, the family or caregiver of an elderly and revered Kaumatua who has had a cerebrovascular accident may believe he should be fully cared for by nondisabled community members in the pensioner flat on the Marae (a Maori meeting house and environs). Therefore, rather than focus on the person’s performance of activities of daily living, the occupational therapist should focus energy for treatment on activities that the patient values more, such as teaching the young in the Kohanga Reo (the language “nest,” or school, established to revive the language).

The notion of productivity can also be open to wide interpretation depending on the culture. Interesting developments are emerging with contemporary Marae-based initiatives, where each member contributes according to his or her knowledge and expertise, much like a therapeutic community. In this form of environmental management, people engage in activities because of their value in life situations. Young Maori have blossomed in such caring, supportive, and meaningful environments, as opposed to the sterile, impersonal environments of many Western organizations, such as psychiatric hospitals.

Tapu Te Ranga Marae in Wellington, New Zealand, is one such example. Here, people of all ages and races, including persons both with and without mental illness and persons living on the streets, participate in practical, task-oriented group activities. These are not simulated activities but are an integral part of the day-to-day running of the Marae. The community emphasizes learning through doing, group rather than individual treatment, cooperative rather than competitive activities, and different teaching and learning styles. Bruce Stewart (1988), the founder of Tapu Te Ranga, believes that, through involvement in a cooperative venture and learning of and through traditional Maori principles, such as Manaakitanga (to show respect or kindness), people can change and learn to become more fully human. “They who build the whare [house] are built by the whare” (Stewart, 1988 [pg. no. unavailable])—they who build the place are changed by the process of building as they learn new ways of thinking and living.

However, the Model of Human Occupation has some limitations in the arena of culture. The distinction between disorder and dysfunction is influenced to a certain extent by cultural biases. The model defines dysfunction as “the inability to effectively accomplish daily tasks and to enact occupational roles” (Weiringa & McColl, 1987, p. 78), but the definitions of tasks and roles differ by culture. Daily implies a particular way of organizing time—with time and temporal adaptation being two of the most central concepts of industrialized Western society. In addition, if the occupational therapist seeks to promote maximum competence in occupational performance, the occupational therapist needs to know what competent performance is in the context of an individual culture.

Toward Bicultural Practice

Although the Model of Human Occupation provides a working model for planning and implementing culturally
appropriate programs, it is essentially a Western model based on Western premises and realities (Weirniga & McColl, 1987). What is needed for New Zealand practice is a more sociopolitical overview that encompasses the notion of partnership espoused in the Treaty of Waitangi and more say for Maori and other minority groups in New Zealand about the way in which they wish to receive health care. Also needed is an understanding of the cultural and social processes that perpetuate monocultural practice. For these overviews, we need to read the work of radical and critical educators, such as Paulo Freire (1972). Freire was concerned with the liberation of oppressed people through education. Freire stressed the importance of the nature of human reality, which is created through the person’s dynamic and reciprocal relationship with the physical environment. Persons making their own environment humanize the world, resulting in culture (Colins, 1982). This perspective is compatible with what many occupational therapists perceive themselves as doing.

This perspective of education can be applied to a variety of community contexts and with different oppressed peoples. For psychiatric patients, this framework could be applied, in a somewhat abstract fashion, to therapy and through arts, crafts, and other activities. For many patients with mental illness or who are chronically ill, the experience of hospitalization—being labeled and treated as a patient—can be likened to the process of colonization described by Freire (1972), when one person’s reality is defined by another. For many Maori, this kind of redefinition is a daily reality (see Ramsden et al., 1990).

The work of many health professionals and the cultural invasion that such work involves frequently perpetuates dependence, further disabling those who are already sick or disabled. Through tangible involvement with their environment, using a variety of activities, and interacting with their peers, people can come alive and work toward reaching their potential. Central to being able to reach this potential is the process of teaching and learning where people can either liberate or oppress learners. To liberate is to empower with a therapeutic process that requires clients to make choices about activities and intervention, working with people as partners rather than doing things for or to them. These are key components of occupational therapy practice. Without these experiences, it is difficult to achieve a self-aware, independent mind, which is the hallmark of the true liberation that Freire envisaged (Shallcrass, 1988).

Through the Freirian notion of interacting with and effecting change on the environment, individuals and groups can gain control of their lives by being active producers rather than passive consumers. Empowerment of people through activities creates community interaction—the potential for excellence, individual achievement and recognition—yet still acknowledges the importance of cultural freedoms for cultural minority groups as well as the cultural freedoms for people who are disadvantaged. Such a philosophy of therapy would greatly change the power dynamics of working with Maori and would supply a sociopolitical overview that the Model of Human Occupation does not clearly articulate.

For many occupational therapists, adopting such a philosophy will mean stepping back and giving away some professional power and control to people who may not have Western qualifications (e.g., tribal authorities, tohunga [traditional healers]) and who may work in alien contexts, such as Marae. Bicultural health initiatives may need to be developed, which involve planning and working with experts from both cultures to overcome the ever-present Eurocentric bias. Bicultural programs must be pursued with total commitment and total integration across the health care system and have to be seen as relevant, important, and valuable in their own right. Above all, the philosophy of a bicultural system in health care would have to acknowledge the integrative nature of the Maori view of health:

Giving unity to spiritual, emotional, psychological, bodily, family and environmental dimensions, it rises above the divisions created by narrow professional roles, by the sickness/health polarity and the mind/body dichotomy. (New Zealand Board of Health, 1987, p. 2 [see also Rankin, 1986])

To facilitate bicultural or culturally sensitive practice, continuing professional education and staff development are vital. However, any education in the area of culture, and especially Taha Maori (Maori culture), must encompass more than merely learning about Maori (i.e., focusing on life-styles) to include learning for and through Maori. The latter acknowledges the need for experiential learning and attitude change, which ultimately leads to an awareness of the limited life chances that many Maori experience. As there are few Maori professionals who are able to integrate occupational therapy theory with Maori knowledge, the onus for developing bicultural practice must lie with the European working closely with Maori, who may not have Western professional qualifications, but instead have the necessary respect and mana (prestige) in the Maori world.

Conclusion

The benefits for both the health care system and society in general of adopting a bicultural approach are immeasurable. They include exposure to different styles of teaching and learning; recognition of individual differences, strengths, and skills; increased understanding of different conceptions of knowledge, health, and sickness; and, ultimately, for the occupational therapist, a chance to effectively meet the needs of our clients and a chance to offer a more holistic service.
With your basket of knowledge
And my basket of knowledge
The people will be assisted. (cited in Puketapu-Hetet, 1989, p. 1)

References


