What does mental illness mean for Maori?
In particular, Maori women diagnosed with a mental illness, during the period of pregnancy and childbirth

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Abstract

This paper will look at the appropriateness of the management of mental illness for Maori in general. It is also the beginning of a study about the impact that ‘mental illness’ has on Maori women during pregnancy and childbirth.

As a matter of course in New Zealand, the management of severe mental illness is accessed by way of Western treatment service, typically in a state funded and managed hospital environment. Discussion will revolve around the appropriateness of these Western treatment approaches, and whether they serve the wellbeing, cultural values and beliefs of Maori in health settings.

History

The premise of healthcare for all is a basic tenet of past and present New Zealand governments. Indigenous peoples like Maori, live their day-to-day lives on the perimeter between the indigenous world and a set of norms assembled by the dictates of wider society of the dominant culture. In New Zealand that culture is descended from a European paradigm.

Subsequently in New Zealand, a ‘bicultural’ approach (implying partnership) was promoted, as the concept that would best accommodate the needs of Maori and Pakeha alike. The struggle to implement this utopian state continues in the political, economic and social arenas. The impact of government policies and the provision of appropriate health, educational and social services for Maori have resulted in a mishmash of service delivery. In the mental health arena this is evidenced by the fact that, differences of opinion exist about cause, and appropriate assessment and treatment procedures based on differing cultural constructs of mental illness, which means that those delivering services are often at loggerheads with the intended recipients.

Diagnostic and Statistical Manual (DSM IV) – Defining mental illness

Regardless of the topic, individual social attitudes endure in a particular culture, and an even wider divergence of attitudes between cultures (Sainsbury, 1976). This is true of the term ‘men-
tal illnesses’. Through the ages, causes of mental illness and those afflicted with this ‘diagnosis’ have been perceived in various ways – from possession by demons through to enlightened beings, vilified or venerated depending on the belief systems of the culture and times.

It has been argued that categorising illness imposes a ‘treatment barrier’, thus removing responsibility for certain situations from a person, in turn facilitating ‘... a process of converting political and social problems into those of medical treatment’ (Bowers, 1988). Consequently, issues could be ignored. Thomas Szasz was most vociferous about the term ‘mental illness’ and charges that it could conceal difficult moral and social problems (Szasz, 1972). Nonetheless, categorisation of mental illnesses or psychiatric disorders exists in a Western diagnostic form, and is defined by two main texts; the International Classification of Diseases (ICD), and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Reference in this paper will be made to the latter and specifically to the 4th Edition (American Psychiatric Association, 1994). ‘New Zealand clinicians typically use DSM-IV criteria for symptom classification...’ (Read et al., 2003).

The DSM IV has a specific medical model approach to diagnosis and the treatment of mental disorders. This is reflected in the current nosology (classification) that emphasises the irreplaceable role played by systemically collected, replicable empirical data. Like other sectors of medicine, psychiatric nosology is perpetually evolving as a mixture of etiologic theory and symptomatic description, with the comparative contribution of each shifting as knowledge has accumulated (Kupfer, First and Regier, 2002).

The DSM-IV defines a mental disorder as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability or an important loss of freedom (American Psychiatric Association, 1994: xxi).

**Culture bound syndromes**

Cultural unawareness is feasibly responsible for misapplication of diagnostic criteria. Where the medical workforce is predominantly Western, it is conceivable that interpretation of clients’ verbal and body language will be based on their own values and beliefs. The DSM-IV allows for cultural bias by describing cultural divergence in relation to clinical presentations. Nevertheless, schizophrenia in particular has been over-diagnosed, especially with patients who meet the criteria for an affective disorder with psychotic features. This is evident in data collected on Hispanics and African Americans in the United States of America. African-Americans with bipolar disorder or psychotic depression are often misdiagnosed as having schizophrenia (Herrera, Lawson and Sramek, 1999).

In New Zealand similarities exist, evidenced by the high committal rates which emerge to suggest that health professionals are apprehensive about less rigid forms of treatment for Maori, and have a propensity to commit ‘disturbed’ Maori, more often than any other groups, of disturbed patients (Durie, 2000).

Trying to accommodate Western classifications of mental and behavioural states of indigenous cultures can lead to misdiagnosis. However, incorporating the influences of
culture bound syndromes can provide a much more accurate diagnosis and subsequently a more appropriate treatment approach; although culture bound syndromes as such are not readily recognised by Maori (Durie, 2000).

What is interpreted as pathological behaviour in one culture, can be deemed normal and even appropriate in another. For example, by using a judgmental standard – that of society and psychiatry – pathology can be classified within the ‘criterion of result’. This rests on the premise that a person strives to attain a certain goal, by behaving in an organised manner. When this behaviour becomes dysfunctional or disorganised, when it prevents someone from reaching their goal, disrupts the group, causes self-harm or harm to others, this behaviour and the mental condition associated with it is labeled pathological. The opposite of this state is referred to as ‘normal’ (Wittkower, 1970: 219).

Culture-free certainties are rare in psychiatry. Organic brain syndromes, such as psychotic delirium and psychotic hallucinations are pathological by definition. There was once collective agreement defining disorders transculturally from a biological viewpoint, thus reflecting the medical model of the profession (Rinder, 1964). Furthermore, this belief brought about a climate in which the major form of treatment (and often, the only one offered) has been medication (The British Psychological Society, 2000: 22). However, this pattern is changing. There is a trend toward focusing on social issues and the examination of psychological causes (shaped by psychology) of a person’s distress, which is now seen as truly relevant (The British Psychological Society, 2000).

However, whether either school of thought seriously considers the impact of a person’s culture a valid variable, in terms of appropriate management, is doubtful (Durie, 2001).

**Postpartum psychiatric disorders**

Childbirth is a complex event, brimming full with somatic and psychological milestones. It is a period of rapid biological, social and emotional transition. During pregnancy physical discomfort is apparent, there can be changes in social networks, along with financial pressures. Relationships can be strained and boredom can set in. After delivery there may be a period of excitement and elation, as well as exhaustion (Brockington, 1996). Some women may also experience an unconscious connection to other worldly states, with an emphasis on religious or spiritual matters. Religion and spirituality are gaining legitimate importance as cultural variables operating in all stages of the diagnostic and treatment processes. It is therefore, imperative that they be acknowledged, and examined in the history-taking and cultural formulation processes. Spirituality becomes a significant component of ‘...self-identity, self-care, insight, self-reliance and resiliency in the treatment arena’ (Kupfer, First and Regier, 2002: 262).

Some researchers and clinicians view postpartum depression and postpartum psychosis as no different from depression and psychotic illnesses, despite there being evidence that psychiatric disorders specific to this period have been identified. Others cite lack of societal support and the lowered status of motherhood during pregnancy and the postpartum period as the originators of ‘depressive illnesses’ and abhor the over-medicalisation of it (Paffenberger, et al., 1996). Nonetheless it is generally recognised in clinical practice and in most recent research publications that the first 12 months postpartum are considered to be
a period in which psychological and psychosocial problems are most likely to occur (Pitt, et al., 1996).

**Cultural differences and some Maori customs associated with women and childbirth**

In order to give an appropriate diagnosis of a mental disorder for Maori, one must first discern what the term ‘mental illness’ means for Maori. Western psychiatry does not acknowledge that ill health, both mental and physical, and accompanying afflictions can be influenced by spiritual causes. Maori culture does acknowledge this, however.

The term for this is Mate Maori.

The term refers essentially to a cause of ill health or uncharacteristic behaviour which stems from an infringement of tapu (a tribal law) or the infliction of an indirect punishment by an outsider (a makutu) (Durie, 2001).

Consequently, in these cases, a traditional healer (tohunga) could be a more appropriate practitioner than a psychiatrist. There is reluctance, however, on the part of many Maori to discuss Mate Maori in a clinical environment, because of the fear of ridicule or pressure to choose the psychiatric/Western treatment approach. Durie explains that Mate Maori does not necessarily mean that there cannot be a co-existing mental disorder and that the term is an explanation on perceived causes of abnormality rather than the emerging symptoms or behaviour (Durie, 2000).

For women whose heritage is non-Western, there are often cultural issues relevant to presentation postpartum with psychiatric illness. For Maori women their cultural expectations may not be met, or may even be opposed by Western health professionals and services.

There are customary rituals related to childbirth that are crucial to the physical and mental well being of Maori women. Spirituality may be linked with childbirth that is quite different from that experienced (or experienced but ignored) in Western cultures (Buist, 1996). The significance of culture to Maori in everyday situations may not be apparent. However, Durie concludes that although Maori are more often than not Westernised, or at least appear to be, cultural heritage continues to delineate ideas, attitudes and reactions, particularly during periods of illness (Durie, 2001). Moreover, the concepts of tapu are central to much of the anxiety and depression which beset the Maori patient while in a hospital setting.

There are many dimensions to health, and it is important to note that Maori consider any ‘diagnosis’ or treatment of a person is seen as a whole, rather than just the parts that are unwell. In 1947 the World Health Organisation defined health as being greatly influenced by social and cultural factors: ‘Health is a state of complete physical, mental and social well-being not merely the absence of disease or infirmity’ (Durie, 2000: 68).

Understanding Maori health is to realise that it is more complicated than illness and lifestyle. People belong to families and communities, and are representative of the values and policies therein. They are part of the fabric of society. The notion of collective accountability is a cornerstone of Maori well-being. There is a greater need to strive for standards
of health, which exceed physical dimensions and encompass those aspects which have been relatively neglected, such as wairua, hinengaro and whanau (Kelsey, 1990). Durie explains that kaupapa Maori services should:

...provide a treatment environment which is based on Maori cultural values, processes and beliefs. The use of traditional invocations (karakia), counseling by tribal elders, cultural assessment, customary remedies from native plants and berries (rongoa), the use of Maori language and the services of traditional healers (tohunga) characterise Maori services (Durie, 1997?).

Although not all Maori subscribe to the same cultural values and beliefs, due in large part to the alienation from culture and whanau during preceding policies of institutionalisation, and through the medium of imposed colonial laws (Durie, 1997?). Nonetheless, specialist Maori mental health teams have the ability to reshape mental health services in ways that will strengthen cultural identity.

Incorporating cultural assessments as part of a mental health status exam, in order to gain a better appreciation of cultural identity and its relevance to mental health, will provide an opportunity to formally assess participation in, and access to, Te Ao Maori. When cultural assessment is used collaboratively with conventional clinical and social assessments, the opportunity to facilitate a more comprehensive and relevant treatment plan is likely to emerge (Durie, 1997?).

**Culturally effective treatments**

Indigenous cultures generally view a ‘psychotic person’ as being possessed by evil spirits. Traditional treatment often consists of a restorative period of rest, sympathy, as well as increased social support with particular types of traditional healing rituals (Castillo, 2003: 1).

The World Health Organisation studies of functional psychoses worldwide have made it plain that psychoses generally have a better course and outcome in traditional cultures (Jablensky, 2003). Some theorists surmise that this is because there are fewer demands made on patients in agrarian economies of underdeveloped nations. On further examination, countries such as Japan, Hong Kong and Singapore have shown a better course and outcome for psychoses than those in Western cultures (Lee, et al., 2003). However, while these are all societies with well-developed economies, they also retain traditional belief in spirits (Lee, et al., 2003).

Providing culturally appropriate services for Maori is an ongoing developmental process that will do much to improve the plight of Maori at the hands of Western treatment approaches. It is imperative that the issues of high Maori admission and readmission rates to psychiatric acute units are reduced (Sachdev, 1989).

**Whakawhanaungatanga**

Whakawhanaungatanga (family-like relationship building) is pivotal in Maori culture and was identified by Wi Keelan as one of the six characteristics essential to the provision of appropriate Maori mental health services (Durie, 2001). He also advocates management by
Maori for Maori, the integration of tikanga Maori (Maori custom), the inclusion of whanau, hapu and iwi, the implementation of Maori healing practices and the provision for cultural assessment and cultural practice.

The fundamental meaning of whanau is ‘to give birth’, although it is a word that has undergone change in parallel to the changes in Maori society. One traditional interpretation is that whanau members are all descended from the same ancestor and therefore possess a shared history and a common genetic endowment (Keelan, 2001). Relatives from the same whanau could expect support from each other, unbidden, for the care of children, and could likewise assume care of other parents’ children within the whanau. The whanau represents the group’s common interest and their commitment to a distinct cause as well as to each other.

Metaphorical whanau developed after the disruptions caused by urbanisation (post-World War II), when many Maori were isolated from kinship whanau yet felt the need for closeness and support (Keelan, 2001: 192).

Since the focus is on the group, rather than the individual, whanau programmes are often perceived to be unresponsive to the needs of particular members, and preoccupied with group comfort, disregarding the personal distress of a member. Accomplishing balance between the welfare of the group and the well being of the individual is vital to the integrity of the whanau as a whole. Indeed, whanau alliance offers a raft of opportunities for good health, including a secure identity, intergenerational transfers of knowledge and experience, and the consummate transference of cultural heritage as well as socio-economic improvements.

Whilst the onset of serious mental illness cannot be totally prevented, positive whanau development can have outcomes at three levels:

1. Universal prevention – better health for all whanau members
2. Selective prevention – targeting those that might experience problems because of risk factors.
3. Indicative prevention – early detection and management of those who are likely to develop a disorder or who have prodromal signs of a mental illness (Mrazek and Haggerty, 1994).

With this in mind the application of interventions for women’s health during pregnancy, and after childbirth can be shaped more appropriately, assisting the healing process so those women can resume their valued role in the whanau.

**Linking paradigms**

The statistics available on mental illness for Maori are notably limited. The majority of published data is hospital based. No complete population surveys have been conducted from an ethnic viewpoint, with the exception of studies of alcohol abuse, and women’s health, which were restricted in their aims (Richie, 1964). Richie completed a (limited in scope) study of Maori families, particularly women, in the Wellington region to determine the impact of urbanisation. She concluded that, on the whole, adjustment of women was
good and they did not require much participation in Maori activities to maintain good psychological adjustment in the urban environment (Richie, 1964). However, a health survey study that included information on life style, attitudes toward health care and delivery, and the importance of Maoritanga to one’s reality, conducted by the Maori Women’s Welfare League in the Bay of Plenty, South Auckland and Waikato, identified common problems of depression, asthma and bronchitis. The study, with a response rate of 95%, showed a strong correlation between socioeconomic status and social problems; women with economic difficulties registered poorly on a number of indices. Smoking and obesity emerged as primary problems. The urban group was also identified as being at risk of losing its ‘Maori identity’ through non-adherence to Maori cultural practices (Murchie, 1984).

Tensions between cultural perspectives can partially be resolved by consonance between paradigms, which should not be seen as opposing but as complementary. Positive implementation of cultural collaboration is essential to the provision of appropriate health services for Maori. Clearly, the diagnosis and treatment of mental illness should not be isolated from its cultural paradigm. The manifestation of illness, and subsequent treatment, needs to be inclusive of relative worldviews, in order to ensure optimal outcomes. To base the management of care, using a diagnostic interview schedule and treatment approach that universally assumes only one interpretation of a particular human experience across all cultures, can only be considered folly.

References


