TALKING THERAPIES FOR PASIFIKA PEOPLES

BEST AND PROMISING PRACTICE GUIDE FOR MENTAL HEALTH AND ADDICTION SERVICES

Te Pou o Te Whakaaro Nui
Ministry of Health Manatū Hauora
LeVa Pasifika within Te Pou

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Web **www.tepou.co.nz** and **www.leva.co.nz**
Email **info@tepou.co.nz**
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FOREWORD

Fofola e fala kae alea e kainga – roll out the mat for kin to dialogue.

A wise Samoan orator-chief likened the process of effective engagement to the meeting of two family groups for the first time. In a traditional Samoan setting, the parties would use *fa'atalatalanoa.* Despite the literal meaning of 'talking about nothing', *Talanoa* is widely used to cover anything from general through to more meaningful conversations at many different levels[1]. *Fa'atalatalanoa* however is more purposive, deliberate and action-orientated dialogue, which often has an end-goal in mind.

When frontline workers meet Pacific clients for the first time, they must not only engage positively with them, they must also take the opportunity to switch from a *talanoa* to a *fa'atalatalanoa* process. This is facilitated by positive and appropriate engagement at this critical first point of contact.

An effective analogy for this is the *paepae* or surrounding pebble courtyard of the Samoan *fale* (house), which also includes the space in front of the *fale*. In traditional Samoan custom, this is the space where formal engagement mostly begins when two parties meet for the first time. Here is where the introductory speeches and *gafa*[2] connections are made, often by a skilled orator or *tulafale* bearing his *to'oto'o* and *fue*[3]. The purpose here is clear – to connect, establish a *va*, and define the purpose of the visit.

When therapists and front-line workers meet Pacific service users, they will need to be aware of the *paepae* effect. This is where pre-engagement is crucial, for it is here that the preparations are made to create a relationship or *va*.

I would like to thank our contributing authors Denise Kingi-Uluave and Epenesa Olo-Whaanga who have likened this process to rolling out a metaphorical mat or *fofola e fala*. This is essentially where the building of *va* begins, but does not end. The success of the ensuing *fa'atalatalanoa* will then be dependent on how you nurture the relationship or *tausi le va.*

It is my hope that this manual will be your *to'oto'o* and *fue* as you seek to serve our people through the nurturing of the *va*.

Soifua

Dr Monique Faleafa *(DClinPsy)*
National Manager, Le Va

1. Tala means to tell or talk and noa means nothing or void. Hence, talanoa literally means to 'talk about nothing' in Tongan, Samoan and many other Pacific languages (Fa'amatuainu Tino Periera, 30 May 2010, Presentation at Le Tautua Emerging Leaders Fono).
2. Genealogical connections or hohoko in Tongan.
3. Samoan orator's staff and fly-whisk, symbols of prestige and skilled office.

Lastly, we would like to thank Tupu Pacific Alcohol/Drugs and Gambling Services, Takanga A Fohe at Waitemata District Health Board, and the Pasifikology executive members: Sue Mafi, Michael Satele, Siautu Alefaio, Monique Faleafa, Ailaoa Aoina and Tansy Brown.

EXECUTIVE SUMMARY

Pasifika world views and identities are based on a collective approach, with health and well-being relying on safe and balanced relationships. Given the holistic nature of these relationships, any disturbance or imbalance may be associated with mental health difficulties. This guide predominately presents ways of working with Pasifika individuals and their families. Consideration should also be given to the complex set of inter-relationships that exist between Pasifika communities and to the important role of spirituality in Pasifika people's lives.

The New Zealand Mental Health Survey – Te Rau Hinengaro[1], identified that Pasifika peoples carry a higher burden of mental disorder than the general Aotearoa/New Zealand population, but that use of mental health services for Pasifika peoples with a serious mental disorder is only 25% compared to 58% for the total Aotearoa/New Zealand population. A major challenge for Pasifika communities is stigma and the need to demystify mental illness and psychological issues. Talking therapies have strong potential to address these issues, provided the initial engagement process is a positive experience for Pasifika families

It is also important to acknowledge the cultural and intergenerational diversity that exists among Pasifika people. The level of acculturation of individuals and families will determine the extent to which the recommendations in this guide apply. While each family will be unique, and families will vary in their level of acculturation, pre-engagement approaches recommended in this guide can help build understanding of how Pasifika families are positioned within a social, historical and economic context.

Within Pasifika cultural world views, considerable significance is placed on developing and maintaining relationships. As a result, the importance of understanding the context in which Pasifika peoples operate, and of establishing a solid and trusting therapeutic relationship, cannot be underestimated when working with Pasifika peoples. Particular emphasis has therefore been given to cultural considerations in the engagement section of this guide. It is likely that unless cultural considerations are addressed at the first point of contact, then effective assessment and therapy are unlikely to eventuate.

Throughout this guide, processes are presented that may help the therapist build rapport and maintain engagement with Pasifika populations. This process is likened to 'rolling out the metaphorical mat' and inviting the person to come sit, before entering into therapy – the *vaka/va'a* (a raft or vessel). Much of the knowledge, skills and attitudes identified in this guide align and support the principles identified in the Ministry of Health's *Let's get real* framework and *Real Skills Plus Seitapu.*

It is important to highlight that no systematic research on talking therapies with Pasifika populations has so far been published. Due to this limited research on evidence-based psychological interventions for Pasifika people, a practice-based observations approach was employed in

producing this guide, involving consultation with therapists (both Pasifika and non-Pasifika) and people who have used mental health and addiction services. Information collection involved a national consultation process, using a multi-method approach, which included a brief literature review, focus groups held in Auckland, Wellington and Christchurch, and interviews with key informants. While the information and recommendations in this guide could be seen as best (and promising) practice for talking therapies when working with Pasifika peoples, we emphasise that some suggestions may or may not be applicable in individual situations.

While therapists interviewed for this guide identified several talking therapy models that were useful when working with Pasifika people, they strongly identified that in their practice, they modified, adapted or used parts of these models eclectically. It appears that having several models to draw on as a therapist helps to meet service users' needs more holistically. Therapists also did not believe that 'manualised'-type approaches were flexible enough to allow for this. Hence, it appears that a high level of sophistication, confidence and competence is necessary when working with Pasifika peoples.

In general this guide is written to provide information for people working in and using mental health and addiction services. It therefore has a clear clinical focus. It may also be useful for non-government organisations and other agencies involved with counselling Pasifika families.

A successful outcome in therapy will depend on many factors. It will be reliant on the most appropriate and effective therapeutic intervention being tailored to meet the particular needs of the individual. It also depends on the experience (clinical and cultural) of the therapist and their confidence in the interventions they are delivering.

Pasifika peoples need to have trust and confidence that their cultural and clinical needs will be acknowledged and respected.

The lack of talking therapies research points to the critical need for culturally appropriate research to build Aotearoa/New Zealand's evidence base for 'what works' for Pasifika peoples.

ACKNOWLEDGEMENTS

Denise Kingi-Uluave and Epenesa Olo-Whaanga were the major contributing authors and researchers of this guide. Like our ancient skilled navigators, they have navigated unchartered waters on behalf of our entire Pacific mental health and addiction sector and mapped out the beginnings of an exciting journey.

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CONTENTS

INTRODUCTION

BACKGROUND

Mental health and addiction services in Aotearoa/New Zealand need to reflect a recovery approach when working with people accessing these services. While there is no single agreed definition of recovery, in this country it is often referred to as 'living well in the presence, or absence of mental health problems.'[2]

Recovery as part of a person's journey to wellness will often require a combination of biological, social, cultural and psychological interventions. As evidence continues to grow for, and society becomes more aware of, the effectiveness of talking therapies, people who use mental health and addiction services are requesting better access to quality talking therapies.

In response to these requests, Te Pou is working to improve access to talking therapies for service users of mental health and addiction services. Te Pou has produced a number of reports (**www.tepou.co.nz**):

a) *We Need to Talk*[3] – examined the most commonly used therapies in Aotearoa/New Zealand mental health and addiction services. This report also identified which therapies, if introduced more widely, could produce more positive change for those accessing this sector.

b) *We Need to Listen*[4] – summarises the issues raised during the feedback process on We Need to Talk and proposed a more formal consultation process.

c) *We Need to Act*[5] – provides a summary of the results from the feedback process, and information on a literature review that explored evidence for cognitive behavioural therapy, motivational interviewing and dialectical behavioural therapy. This report also outlines a framework for introducing talking therapies and recommends action points.

d) *Action Plan for Talking Therapies 2009 to 2011* – describes the actions, timeframes and processes to increase the quality, sustainability and spread of talking therapies for users of mental health and addiction services in Aotearoa/New Zealand.

In addition, Te Pou has produced *A Guide to Talking Therapies in New Zealand*[6], which focuses on providing information to service users and families who want to increase their knowledge on the talking therapies available in Aotearoa/New Zealand. (This guide can be downloaded from the Te Pou website www.tepou.co.nz.)

The *Action Plan for Talking Therapies* identified the need to develop a best (and promising) practice guide for mental health and addiction staff who provide talking therapies for Pasifika people and their families. Taking action on this recommendation is critical, given the results reported in the *New Zealand Mental Health Survey: Te Rau Hinengaro*[1]. This research identified that Pasifika people carry a higher burden of mental disorder than the general Aotearoa/New Zealand population, yet the use of mental health services by Pasifika peoples with a serious mental disorder is only 25% compared to 58% of the total Aotearoa/New Zealand population.

It is theorised that one of the reasons for the low uptake of mental health and addiction services by Pasifika peoples may be associated with the way they perceive health and mental health. The more traditional Pasifika perspectives of mental illness, particularly amongst older generations, view mental illness as spiritual, in that you are either possessed or being punished for past sins

committed by family members[7]. The use of traditional healers and an alternative traditional aetiology to frame mental illness experiences are some of the issues that may need to be considered when delivering talking therapies.

This project

This guide was collated using several methods. A literature review specifically related to Pasifika and talking therapies was carried out. It was acknowledged at the outset that there would be a dearth of specific research in this area. To compensate for this, the views and experiences of therapists working with Pasifika peoples in the mental health and addiction field were sought. Consumer representatives were also consulted.

Participants were recruited via a snowball sampling strategy, using clinical and Pasifika networks. Participant selection was based on identifying those people who could most inform this project ('information-rich' participants[8]) and their availability within the allocated timeframes.

Focus groups or *fono* were held in Auckland, Wellington and Christchurch, with both Pasifika and non-Pasifika participants. Key informants were also interviewed either in person or by telephone. *Fono* group interviews were taped, transcribed and thematically analysed. Themes were cross-validated between the researchers.

Limitations of the guide

- Given the limited research available on evidence-based talking therapies with Pasifika peoples, information presented in this guide is reliant on practice-based observations elicited from therapists and service users of mental health and addiction services.
- As Pasifika peoples under-utilise mental health and addiction services, very few are referred for talking therapy. A greater pool of participants, would have further increased confidence in the recommendations of this guide.
- There are a very limited number of Pasifika therapists trained to deliver the extensive range of therapeutic approaches now available to service users. Consequently, it is difficult to confirm which types of therapy, if delivered by a Pasifika therapist, would be effective with Pasifika people.
- The Pasifika population in Aotearoa/New Zealand encompasses a diverse range of people, each with their own specific beliefs, values, language and customs. Further research into talking therapies with ethnic-specific groups is necessary to ensure appropriate and effective therapies are provided.
- Older Pasifika peoples are less likely to access mental health and addiction services. As a result, limited information was acquired on talking therapies with people from this age group, making it difficult to extrapolate which therapeutic approaches are helpful for them. Possible reasons for not accessing therapy include:
  - most were born in the islands and therefore may prefer to access traditional healers, as there is often a view that mental illness is caused by a breach of tapu or spiritual possession
  - mental health and addiction services may not be culturally appropriate for the needs of Pasifika populations
  - these people may prefer to be cared for by family members due to issues related to stigma and shame.

PURPOSE AND TARGET AUDIENCE

This guide assumes that readers are familiar with the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services, as described in the Ministry of Health *Let's get real* framework.

The *Let's get real* framework explicitly states the expectations for people who work in mental health and addiction services, irrespective of their role, discipline or position in an organisation. Further information on *Let's get real* is discussed in Section Two – Principles of Engagement.

In addition, *Real Skills Plus Seitapu* provides a framework for the essential and desirable knowledge, skills and attitudes of any person in the mental health and addiction workforce who is working with Pasifika people or families. This document can be downloaded from the Le Va website (**www.leva.co.nz/page/14-projects+seitapu**).

Real Skills Plus Seitapu is intended to better inform staff in mental health and addiction services who work therapeutically with Pasifika peoples and their families about culturally safe practices and talking therapies that are particularly appropriate for the Pasifika population. It may also be a useful resource for general practitioners and therapists who are not engaged in therapy as it provides helpful suggestions for building rapport and engaging with Pasifika people. Le Va, Pasifika within Te Pou also support Pasifika Engagement training.

It is strongly recommended that staff have access to regular cultural supervision when working with Pasifika service users.

PASIFIKA PEOPLES IN AOTEAROA/NEW ZEALAND

The information presented in this section has been sourced from Statistics New Zealand[9].

The demographics of Aotearoa/New Zealand are rapidly changing, resulting in an increasingly diverse and multi-cultural society. The Pasifika community makes up 6.9% (265,974) of the total population and consists of people from a variety of Pacific Island nations who celebrate and maintain their own specific languages, beliefs, values and traditions. Samoan's make up 49% of the Pasifika population followed by Cook Islands (22%), Tongan (19%), Niuean (8%), Fijian (4%), Tokelau (3%), and Tuvalu (1%). By 2051, the Pasifika population is projected to increase to 599,000.

- 58% of Pasifika peoples residing in Aotearoa/New Zealand were born in this country.
- The majority of Pasifika peoples (almost 93.4%) live in the North Island, with the largest numbers (66.9%) living in the Auckland region.
- Nearly 40% of Pasifika peoples in Aotearoa/New Zealand are under the age of 15 years, with increasing numbers of these younger people identifying with more than one ethnicity and speaking more than one language.
- The median age for Pasifika peoples is 21 years, compared to 35.9 years for the total population.
- Just over 8 in 10 Pasifika peoples identified with the Christian religion.

COMMON HEALTH ISSUES FOR PASIFIKA PEOPLES

Pasifika peoples experience poorer health outcomes than the general Aotearoa/New Zealand population. The Ministry of Health reports that Pasifika peoples die younger and have higher rates of chronic diseases. Social and economic factors are known to contribute significantly to Pasifika people's relatively poor health status. The Ministry of Health reports that (www.moh.govt.nz/pacific):

- Cardiovascular disease is the principal cause of death for Pasifika peoples and cardiovascular mortality rates are consistently and significantly higher than for the general population.
- Mortality rates for cerebrovascular disease (stroke) are higher for Pasifika peoples than for any other ethnic group.
- Ethnic disparities in cancer survival have increased in the past 25 years and are a major cause of premature mortality and disability.
- The prevalence of diabetes in Pasifika populations is approximately three times higher than among other New Zealanders.
- Pasifika men have higher rates of lung cancer and primary liver cancer than other New Zealand men.
- Pasifika women have higher rates of breast and cervical cancer than other New Zealand women.
- Pasifika children have higher rates of hospitalisation for acute and chronic respiratory and infectious diseases than any other group in Aotearoa/New Zealand.

Te Rau Hinengaro concluded that:

> **These poor physical health outcomes will constitute both acute and chronic life stressors for Pasifika peoples, thereby also placing them at greater risk for poorer mental health outcomes[1].**

In fact, research shows that those with chronic physical conditions experience higher rates of mental disorders, particularly for anxiety and mood disorders, than people without physical conditions.

MENTAL HEALTH ISSUES FOR PASIFIKA PEOPLES

Te Rau Hinengaro[1] identified that Pasifika peoples experience higher levels of mental disorder than the general population. The survey also reports that:

- Pasifika people experienced higher rates of mental disorder (25%) compared with the general Aotearoa/New Zealand population (20.7%).
- The most commonly reported lifetime disorders were anxiety disorders (16.2%), mood disorders (8.6%) and substance use disorders (5.3%).
- Pasifika people have a higher 12-month prevalence of suicidal ideation (4.5%) and suicide attempts (1.2%) than the general population.
- Younger Pasifika peoples (aged 16 to 24 years) have higher rates of mental disorder than their older Pasifika cohort.
- People's age at migration was significant, as those who migrated to Aotearoa/New Zealand before 18 years of age had a lower prevalence of mental health disorders.
- Males have higher rates of substance use disorders and females have higher rates of anxiety and mood disorders.

ADDICTION ISSUES FOR PASIFIKA PEOPLES

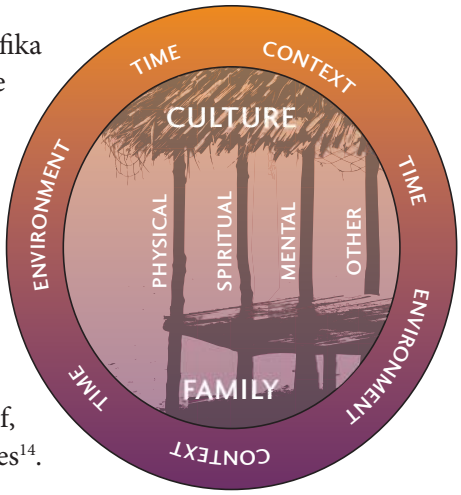
Although there are proportionally more non-drinkers in Pasifika communities than the general population, those who do drink tend to do so to harmful levels[10].

Te Rau Hinengaro[1] found that Pasifika peoples have higher rates of alcohol abuse than the general population. In addition, a study by Haukau et al[11] identified:

- 57% of Pasifika peoples were drinkers (males 61%, females 51%), compared with 85% of the general Aotearoa/New Zealand population (males 88%, females 83%).
- Pasifika peoples report higher incidents of violence and injury from other people's drinking.
- Pasifika drinkers report more problems from violence and serious arguments as a result of their own drinking compared with the general Aotearoa/New Zealand population.
- In general, the use of drug and alcohol services by Pasifika peoples is very low, at 27% less than the national average[12].
- However, Pasifika youth (aged 15 to 19 years) appear to use these services as frequently as any other New Zealand young people.
- The Pasifika population has been identified as being the most at-risk ethnic group in Aotearoa/New Zealand for developing problem or pathological gambling behaviours.
- A 1991 study reported Pasifika peoples made up to 14% of pathological and problem gamblers in Aotearoa/New Zealand[13].

CULTURAL WORLD VIEWS FOR PASIFIKA PEOPLES

There are some unique elements in the world views of Pasifika peoples. A few of these key differences are highlighted here for Samoan and Tongan world views.



A Pasifika world view and identity is described as being based on a collective approach, which is governed by a complex set of inter-relationships between individuals, their families and their communities. These relationships are often upheld through adherence to a set of core values and practices. Western world views and paradigms usually centre on the notion of individualism. The focus on self, rather than others, is highly regarded in individualist cultures[14].

Tongan world view

The traditional Tongan social structure is based on a hierarchical system of commoner (*kau tu'a*), nobles (*hou'eiki*) and royalty (*ha'a tu'i*), with strong social rules that determine the level of power and authority one has in the community. As Mafile'o says, "Tongans are entwined with a matrix of multiple and complex inter-relationships. There are principles and values which govern the operation of inter-relationships and which in turn constitute well-being within a Tongan worldview perspective"[15].

Samoan world view

Oral traditions as opposed to written traditions are usually given different levels of significance in the Samoan world view. The Samoan self is described as a relational being, not an independent being. Therefore, a Samoan person is legitimised by their relationships with others. This has a bearing on the sacredness of relationships both to people, land and spirituality. It guides the use of language, proximity and appropriate boundaries. This can be at odds with the modern western world with its notions of free-will, choices and independence[16].

In a Pasifika view of health, a positive and balanced relationship between the three elements of *Atua* (God), *tagata* (people) and *laufanua* (environment) is required in order to maintain well-being[17]. Several core values are identified that are common to Pasifika groups and underpin relationships in a Pasifika context. These include, amongst others, notions of *tapu* (scared bonds), *alofa* (love and compassion), *tautua* (reciprocal service), *fa'aaloalo* (respect and deference), *fa'amaualalo* (humility) and *aiga* (family)[7].

STIGMA FOR PASIFIKA PEOPLES

Traditional Pasifika approaches to mental illness will often differ from the Western medical notion of illness as a result of 'chemical imbalance'. In a Pasifika context, the cause of mental illness may be viewed as spiritual or inherited, and thus treated by 'spiritual healers' or traditional methods of healing. The presence of mental illness may be shaming for Pasifika families due to traditional spiritual explanations (e.g. as punishment from God, or a curse due to a family wrong) [18].Therefore, it is important to acknowledge traditional Pasifika beliefs and to be cognisant of the stigma surrounding mental illness, particularly among the older Pasifika population.

NATIONAL EVIDENCE

Extensive evidence exists on the effectiveness of talking therapies for many mental health and addiction disorders. However, to date there is a paucity of research both nationally and internationally on evidence-based treatments for Pasifika peoples. Studies have generally omitted descriptions and analyses of cultural, spiritual and ethnic data. In addition, due to a lack of minority group representation, studies have been unable to produce sufficient statistical power to demonstrate the interventions' effectiveness with minority populations[19].

Most psychotherapies are based on Western philosophical frameworks, which are individualistic in focus and in fundamental discord with the Pasifika worldview. The Pasifika view is based on a holistic collective approach grounded in notions of spirituality, connectedness and a complex set of inter-relationships between individuals, their families and their communities. This discrepancy in theoretical frameworks presents a challenge for the acceptability and applicability of the evidence-based talking therapies for Pasifika peoples.

Southwick and Solomona state that, "Little research has occurred to begin to mediate this polarity", referring to "a cultural difference of understanding between the body of knowledge that constitutes a western bio-psycho-social explanation of mental health and mental illness and Pacific people' holistic world views."

They go on to suggest that:

> **Pacific mental health requires the development of a pedagogical approach that makes explicit the competing epistemologies so that practitioners can be guided to develop their practice in a coherent and measurable way. This process would aid the articulations of 'best practice' [21].**

Healing in the Samoan culture necessitates working with a Samoan person's community and regard for their communal practices [22]. This is often not taken into account in psychiatric services that work with an individual Samoan person (which is in fact an impossible construct).

Past research has examined treatment interventions and practices for Pasifika alcohol and other drugs (AOD) services in Aotearoa/New Zealand. The findings from this study revealed that:

> **The most effective worker for Pacific people is someone who has sound knowledge of AOD, Pacific cultures and processes, and has the ability to integrate both Palangi (European) and Pacific knowledge to help their client [23].**

Research conducted in Aotearoa/New Zealand demonstrated that a culturally adapted 'manualised'-type CBT programme could be effective for use with adult Maori service users with depression[24]. Reductions in depressive symptoms and negative cognitions, as well as increased well-being in four culturally relevant dimensions were reported. This study also highlighted the importance of building rapport and developing a positive therapeutic alliance, including 'therapist self-disclosure, exploration of whakapapa, the establishment of connections and engagement with relevant whanau'.

INTERNATIONAL EVIDENCE

On an international level, there is a growing amount of research emerging that investigates the use of talking therapies with minority or indigenous groups. In particular, cognitive behavioural therapy (CBT) has been modified and trialled with some success[25].

In a study that adapted a CBT intervention for depression with Haitian American youth, the researchers argued that, if done without regard for their culture, implementing an evidence-based treatment could further alienate young people[20]. After following a consultation process to adapt talking therapies for this population, certain changes to the CBT manual were suggested, such as using more culturally relevant examples, language, metaphors, pictures, spirituality, cultural rationale for the onset of depression, and the use of traditional remedies. There were also structural issues identified such as time, place, and agenda setting that required attention.

The importance of the therapeutic alliance was also identified in research examining the utility of CBT for the Latino population[25]. This research highlighted the importance of building rapport through self-disclosure (sharing background information) and integrating religious aspects (prayer and church attendance) into the therapeutic intervention. The report concluded that,"Decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship"[26]. Many experienced therapists, regardless of theoretical orientation, acknowledge that the therapeutic relationship is a vehicle by which therapeutic change occurs.

PASIFIKA MODELS OF HEALTH

Pasifika people's well-being is defined by the equilibrium of mind, body, spirituality, family and environment. To capture this holistic view of health and well-being, various ethnic-specific Pasifika frameworks have been developed[7]. These metaphoric frameworks capture a holistic view of health and well-being and can also assist in the process of developing meaningful dialogue between service user and practitioner. They have also been incorporated into research methodologies to ensure cultural exclusivity throughout the research process[27].

Three commonly referred to models are described further in this guide:

- the Samoan Fonofale model created by Fuimaono Karl Pulotu-Endemann
- the Tongan Kakala model developed by Konai Helu Thaman
- the Cook Island Tivaevae model by Teremoana Maua-Hodge.

The *Fonofale* model[28]

The *Fonofale* model is a Pasifika model of health for use in the Aotearoa/New Zealand context and depicts a visual representation of a *fale* (a traditional Samoan meeting house) with four main posts (*pou-tu*).

The model essentially identifies six dimensions of health. The foundation (*fa'avae*) that the *fale* is built upon represents the nuclear and extended family (*aiga*) and forms the fundamental basis of social organisation. The *pou-tu* represent four further dimensions of health, namely:

- fa'aleagaga (the spiritual dimension) – the sense of inner well-being, encompassing beliefs around Christianity, traditional spirits and nature
- fa'aletino (the physical dimension) – the well-being of the body, which is measured by the absence of illness and pain
- mafaufau (the mental dimension) – the well-being of the mind
- isi mea (the dimension of other) – encompasses variables such as finance, gender, age, education and sexual orientation.

Above the *Pou-tu*, the roof (*falealuga*) symbolises the sixth dimension of culture (*aganu'u*), the values, attitudes and beliefs of Pasifika culture.

Surrounding these six dimensions of health is the environment, context and time relevant to the individual, which have either a direct or indirect influence upon one another. As with the Maori model of health – Te Whare Tapa Wha – the dimensions are interwoven and interdependent, so that altered states of wellness only occur when one or more of the dimensions are out of balance[29].

The *Kakala* model [30]

The *Kakala* model is based on Tongan values and principles of reciprocity, sharing, respect, collectivism and context-specific skills and knowledge. It is an integrated framework used to describe the processes involved in research (gathering knowledge and information, analysing and organising the information, and dissemination of results) and is likened to the practice of making *kakala* (garlands). Some Pasifika therapists use this framework when working with Pasifika service users.

Making *kakala* involves three major processes *toli*, *tui* and *luv*a. *Toli* refers to the skills required when gathering the materials (flowers, leaves etc) needed to make the *kakala*, including knowledge and experience in gathering materials at the right time and right place. Gathering materials must be done with respect and requires certain expertise.

Tui is the actual making or weaving of the *kakala*. *Luva* is the final process that involves the giving away or presentation of the *kakala*. It is based on sacred values of *fa* (respect) and *ofa* (compassion) for the person for whom the *kakala* is made. In this Tongan perspective, the *kakala* is always made to be given away.

The *Tivaevae* model

This model, developed by Maua-Hodge, uses processes followed by Cook Island women to make a *Tivaevae* or quilt. One person has the design and allocates different roles and responsibilities to other women in the group. Each has specific tasks to accomplish. Working together as a team ensures all patterns and parts of the *Tivaevae* will be sewn together in the appropriate way and a high-quality garment is produced.

Under the model, within a team of diverse researchers, the principal researcher will allocate tasks to the individual researchers. When these tasks are completed, the data is returned to the team who work together to analyse the information and produce a final, high-quality report.

PRINCIPLES OF ENGAGEMENT

It is generally agreed that effective intervention for people accessing mental health and addiction services is reliant upon accurate assessment and formulation of the issues that a person is presenting with. These issues include life stressors, as well as historical, contextual and political struggles. Eliciting such pertinent and often sensitive information from Pasifika service users requires more than simply asking questions. It also entails connecting and engaging with them at a level that evokes hope, respect and a trusting relationship.

PRE-ENGAGEMENT

Pasifika peoples, particularly those born in the Pacific Islands, may be unfamiliar with the concept of mental illness and some may still perceive mental un-wellness as caused by a breach of *tapu* or more closely connected with the spiritual realm. Therefore, pre-engagement preparation is vital to facilitate a successful therapeutic engagement process and to avoid a potentially negative or embarrassing situations for both the therapist and the service user.

It is difficult for many families to admit that their family member needs professional help or care. It effectively says on one level that despite all their love, care, resources and networks, the person needs help. This is one of the most difficult steps to take, to trust strangers to care for their loved one and help them.

For Pasifika families a sense of guilt and shame can also be associated with an inability to bear the full burden of care for their family member. Consequently, they may have exhausted other channels (e.g. alternative treatments or traditional healers) prior to accessing mental health or addiction services, thereby making pre-engagement and engagement even more critical.

To assist with rapport building and developing a meaningful connection with Pasifika service users and their families it may be useful to consider the following.

PERSONAL AND PROFESSIONAL PRACTICE ISSUES

To build rapport and work effectively with Pasifika peoples, it is essential as a therapist to:

- convey compassion and genuine care[31]
- have self reflexivity (having an appreciation of cultural differences requires an understanding of one's own position or culture)
- understand that your position or cultural view may not apply to the Pasifika person (even if you are a Pasifika therapist).

If working with Pasifika service users on an ongoing basis, gaining rudimentary cultural knowledge (for example about world views, values, cultural protocols and nuances) is respectful and will most likely be warmed to. Those not conversant with cultural rules can unintentionally breach them and are at risk of missing rich information often conveyed verbally or through body language[32]. Draw on cultural expertise from others if you are out of your depth by seeking advice from a person belonging to the service users background, e.g. a *matua* (elder) or traditional healer.

If you continue to work with Pasifika service users, organise access to cultural supervision or advice on an ongoing basis.

An awareness of religion and spirituality in the lives of many Pasifika families is also important, as this is particularly pertinent for Pasifika peoples. Pasifika peoples are often as comfortable talking about matters of the spiritual realm, as they are about matters in the physical world.

Making an effort to greet people in their own language can be interpreted as demonstrating respect and as a display of genuine caring. Therefore, having an awareness of the Pasifika greetings can assist with rapport.

Hospitality is a practice valued in Pasifika cultures and ensuring the service has sufficient resources and flexibility to allow for the provision of food where needed is an essential aspect of an organisation's commitment to effective engagement with Pasifika peoples. The spirit of hospitality extends beyond the therapist to the culture of the service. If other staff members are disrespectful to Pasifika service users, all the efforts of the therapist may be undermined.

Many of the suggestions above are ways to demonstrate two of the foundation skills for working with Pasifika peoples, outlined in *Real Skills Plus Seitapu*. Workers may need to acquire basic language skills across a range of Pasifika ethnic groups. This means being able to greet a person using the correct pronunciation, and using respectful body language when building rapport with service users and their families.

Real Skills Plus Seitapu also emphasises the importance of being aware of the meaning of *tapu* for different cultures. This awareness allows the practitioner to be sensitive to the boundaries of *tapu* within the context of their own practice, while working with service users and their immediate families.

SERVICE DELIVERY ISSUES

Referrals

The quality and quantity of referral information received can vary significantly. Before engaging with the person or their family it would be helpful to determine whether the information received is correct and attempt to elicit as much detail about the context in which the individual belongs and operates. This may include ethnicity, background information about the family, whether they were they born in Aotearoa/New Zealand or in the islands, their church or faith, who is in the family and who will be the main spokesperson for the family, any language barriers and whether an interpreter is required.

Consent

A major issue for Pasifika peoples is that referrals are often made without the consent of the family or that families have not been adequately informed about the purpose of the referral. Be aware that some families are only told they are being referred for extra help and do not always understand that they will be involved with a mental health or addiction service. Thus it may come as a surprise to them when contact is made.

Appointments

The Pasifika paradigm where relationships are priveledged does not always fit comfortably into a western-based timeframe. When working with Pasifika families, a degree of flexibility with the timeframes allocated for the engagement and assessment process is required. It is recommended that time is taken to build rapport before starting a formal assessment.

Attendance at appointments may be difficult for some Pasifika families. Having a degree of flexibility and trying to limit the amount of assessment appointments people are expected to attend is likely to make it easier for families to engage with the service. Non-attendance may be due to a variety of reasons, in particular work commitments. Useful points to note are that:

- unless the service user and their family prefer to come into the service, home visits appear to be the preferred engagement option for many Pasifika peoples
- offering a choice of venues and appointment times, such as the choices presented in the Choice and Partnership (CAPA) model[33], may increase families' attendance and involvement with the service
- sending out appointment letters can reduce the number of non-attendances to appointments. Letters may be interpreted as the system showing respect or may simply act as a reminder
- on the day of the scheduled appointment, a telephone call or text message is a good method of reminding people of their appointment.

Matching

Cultural and intergenerational diversity exists not only between Pasifika nations but also within each ethnic group. Some Pasifika peoples born in Aotearoa/New Zealand are influenced by contemporary views and may not always adhere to traditional cultural perspectives[34]. For example, not all families will be comfortable with a prayer to begin a meeting or therapy session. However, it is important not to assume that culture is unimportant to all Aotearoa/New Zealand-born Pasifika peoples, as many are often still raised in families where Pasifika values, beliefs and traditions are strongly held and practised. Be guided by the person you are seeing.

Given the relational and sacred boundaries that exist within many Pasifika cultures between brothers and sisters, and fathers and daughters, it may be helpful to take into consideration factors such as age, gender, hierarchies, social place (titles, nobility etc) and identity when engaging with Pasifika families. In particular, when addressing sensitive matters consideration may need to be given to whether the gender of the therapist is appropriate. At times, both male and female therapists (Pasifika and non-Pasifika) may elect to step back and supervise their colleagues of the opposite gender (if required to work outside their level of experience) in order to maintain the therapeutic engagement.

Cultural advisor

To increase the likelihood of a respectful engagement process, it is imperative that the service has access to a cultural advisor or *matua*. Cultural advisors are not only a source of knowledge for the therapist, but pave the way for a respectful connection with the service user and their family, particularly for those families born in the Pacific Islands. *Matua* are well respected elders in the community, employed by a service and can facilitate the most appropriate protocols to enhance

and guide the engagement. In most circumstances, unless the cultural aspect of engagement is observed, then it is unlikely that therapy will commence successfully, as you will not have established the *va* (relationship), which is critical when working with Pasifika peoples.

In addition, having access to a therapist or cultural advisor or *matua* who is familiar with the service user's own culture and language can help facilitate a more open conversation without the fear of being misinterpreted. Service users and their families can also express and explain situations more fully in their language of choice and not feel embarrassed or frustrated when struggling to provide the equivalent English explanation. The use of interpreters can also help deal with these language issues. Naturally, this will require being guided by the service user and identifying what they will be comfortable with. Like other people, Pasifika service users may also value complete anonymity and not want to be identified by members of their own ethnic group.

ENGAGEMENT – RELATIONAL CONNECTIONS

"Unfolding of the metaphorical mat and honouring the va."

Maintaining respectful relationships is a central cultural tenet that exists across Pasifika cultures. An individual's health and well-being is reliant on safe and balanced connections with others. In understanding the nature of crisis or illness in a Pasifika person's life, the concept and relevance of *va* is pertinent. Literally *va* can mean 'space' – not the space that divides, but the space or relationships that connect. A *va*-centred approach to relationships emphasises that they are sacred and inclusive of harmony balance, reciprocity and mutual respect[35].

Sir Mason Durie also refers to this sacred space within the context of the marae atea (the space directly in front of the marae):

> **The use of space is a necessary accompaniment of encounters, providing not only physical territory but also the psychological space to rehearse identity and to confirm the relationship between self and others [36].**

Consequently, acting in a manner that upholds relationships is imperative for many Pasifika families. Additionally, caring for family members is considered sacrosanct in Pasifika cultures and there is a commonly held belief that this duty of care brings blessings (*faamanuiaga*) to the family[27]. While the responsibility for caring for loved ones can be extremely supportive, it can also act as a barrier to accessing services during the early stages of un-wellness.

Laying out the mat – "we are here to serve"

In that first encounter with Pasifika families, the therapist is encouraged to think about metaphorically rolling out a mat, a woven mat that the service user is encouraged to join. This is the creation of the *va*, a safe space, a space of encounter between therapist and service user, a relational space.

By offering the mat and being clear about the nature of the space, the therapist is creating connection between themselves and the other. The mat demonstrates the intention to form a relationship that is characterised by compassion, respect and uplifting. Then the service user is in a position to choose whether they join the therapist on that mat or not.

To extend this metaphor further, it is expected that the therapist will sit cross-legged at that mat, at the same level as the service user, but also in a spirit of humility. This requires navigating an equilibrium between instilling confidence in professional practice and genuine human warmth, care and humility.

A skilled therapist will reassure a person that they are accepting of, and can cope with, whatever the service user chooses to bring onto the mat.

The mat, ideally, will be able to function as a raft, from which the person is able to reflect on all that is beneath. If this metaphor is extended further, the mat acts as a vessel, or as a *vaka/va'a* over an ocean. It opens up a range of illuminative metaphors. For example, the idea of navigation skills, the holding of maps, and the abilities and confidence to weather any storms, currents and rough waters that may lie ahead.

In many ways the stages of engagement can be likened to whether a person can trust the therapist and feel brave enough to get aboard the same *vaka/va'a*, which may or may not be therapeutic. If the family and service user do not trust in the therapist or the service, then they will not get on board. If they do not even make it onto the *vaka/va'a* for the therapeutic journey, then therapeutic benefits are unlikely to occur.

The very first step however, is preparation so that the person and their family are willing to enter into a relationship and join the therapist on the metaphorical mat.

Attitude

This mat is offered with the understanding that it will engender a space of warmth, compassion and genuine care for the person, e.g. unconditional positive regard. Laying down this mat in the spirit of service, with humility, means being non-judgmental, respectful, displaying compassion and flexibility. These are attitudes that convey genuine interest and respect, thereby contributing to a meaningful relationship.

By instilling confidence and creating hope the beginning of trust is being developed. The person and their family feel assured that the therapist has the compassion and competence needed to help them navigate through this very difficult and often turbulent time.

Face to face

Spending time on the mat, face to face at first point of contact, is vital to a successful journey. At this stage any confusion or miscommunication can be addressed. This process can be complemented but not substituted by a telephone conversation or written communication.

> ***"Me being Pacific I know making the connection is vital whether it's a piece of paper with Talofa lava and a few mana enhancing words or a phone call, but more powerful and potent is the face to face contact. Making that extra effort to visit in the home displays a sense of genuineness."*** ***(Pasifika Therapist)***

As mentioned previously, many Pasifika service users and their families prefer home visits to being seen at a mental health or addiction service. The social reality is that transport, parking, child care and shiftwork can all be barriers to appointment attendance.

> ***"I think the extra effort alone, if you're not Pacific, and that persistence and genuineness, wanting to make a difference makes engagement much more likely, e.g. knocking on doors."*** ***(Pasifika Therapist)***

If a home visit has been identified as the preferred venue for contact, it is vital to have knowledge of basic cultural protocols and use existing relationships (for example the key worker or cultural advisor or *matua* could accompany the therapist to the home) to pave the way for a respectful encounter. It is not uncommon for therapists to take a small offering of food when visiting people in their homes.

During the first point of contact, the time allocated should be brief with the main focus on rapport building, breaking down barriers, explaining the reasons for the therapist's involvement and what the service has to offer, and most importantly, providing a chance for the service user and family members to ask questions. It's about setting the right scene, balancing questions with respect and honouring their story. Very few questions should be asked, as:

> ***"Once the metaphorical mat is rolled out, the wairua flows."*** ***(Non-Pasifika Therapist)***

The focus of questioning should not be directed so much towards the presenting problems, but at 'what sustains you', which leads towards conversations of hope.

If working with children or adolescents, it is respectful to seek permission from the parents to see the child or young person alone or at school. Sometimes the child may not speak in the presence of their parents.

Confidentiality

The mat will be a safe space, where confidentiality and professionalism is guaranteed in the best interests of the person and their family. Pasifika communities are relatively small and closely connected. Therefore, reassuring the service user that confidentiality will be upheld is paramount. Stigma and shame associated with mental illness continues to exist amongst Pasifika communities and there may be significant concern that information will be disclosed. Taking the time to ensure issues related to confidentiality are explained thoroughly and to stress that privacy covers all employees of the service can be invaluable. Also being very specific about who the information will and will not be shared with without the person's consent can be reassuring to the family. The limits of confidentiality should also be discussed and checked for understanding.

The 'uplifting' process

Pasifika communities are proud and may view involvement with mental health and addiction services with a sense of shame. Stigma and shame have been identified as likely contributing factors towards Pasifika peoples presenting late to mental health and addiction services. Therefore, it is crucial that the point of engagement must ignite hope that this will be a place of uplifting, of hope and of healing.

> ***"When a mental health service is involved with the family, they are most likely already looking down on themselves."*** *(Pasifika Therapist)*

Issues related to prior experiences with other services may exist, which can cause the person to be extremely anxious when joining the therapist on the mat. Therefore, a warm and inviting greeting opens the door for a meaningful relationship. Even a simple gesture, such as a smile, can set the scene for a positive connection. Attempting to greet people in their own language can be viewed as a very small but significant offering to the family. Validating the person's suffering, and praising their courage and strength in seeking help can also assist with rapport building.

> ***"Praising the family or person, I normally say something about the house, it feels peaceful, this sets the order for discussion."*** *(Pasifika Therapist)*

Self-disclosure – 'a sharing of life stories'

There is a sense of family and hospitality, and a welcoming manner in which Pasifika peoples conduct themselves. The concept of 'professional distance' is foreign to many Pasifika therapists and consequently, they walk a fine line between giving of themselves in the therapeutic process – being genuine which involves openness and honesty – and knowing when boundaries are being crossed in a cultural context.

Making connections through ancestral links, family, village and church can be effective in terms of relational connections. However, it may also act as a barrier for people not wanting to be identified in their social context. Maintaining engagement with Pasifika youth can be difficult if the young person is aware the therapist has ties with their family members.

"If you can't join with them without any significance, nothing significant will happen – it will have happened by chance." ***(Non-Pasifika Therapist)***

Language

"Like skillful orators who talk all around us - we have to talk around it (mental illness)." ***(Pasifika Therapist)***

Doing the utmost to maintain respectful relationships is valued in Pasifika cultures. Pasifika service users will often present as humble – listening and appearing to agree with what is being discussed, while all the time they may be suffering and not feeling they can be truthful.

Encouraging and empowering language, and presenting yourself in a way that invites service users to share is essential for meaningful connections. The therapist needs to quickly establish that he or she comes with a serving heart, with humility and a commitment to duty of care. The person must feel that the therapist will do their best for them while they are on the therapist's mat, in their *vaka/va'a*.

Communication is always difficult when speaking different languages. When working in the mental health and addiction sector, the challenge is associated with translating and ensuring that concepts are interpreted correctly. Consequently, misinterpretations and cultural misunderstandings can occur when engaging with Pasifika peoples who come from cultures unfamiliar with psychiatric terminology. While the majority of Pasifika peoples speak English, their comprehension can be limited. It will be helpful to check for correct understanding of meanings, and enlist the assistance of professional interpreters if a cultural advisor is not available.

There is still limited knowledge and understanding about Western concepts of psychological disturbances among Pasifika communities. While people who experience psychotic symptoms eventually come to the attention of mental health services, there is generally a limited understanding about stress, depression and anxiety, or what psychological interventions are available to help. Therefore a therapist who states that they are from a mental health or addiction service may cause confusion or avoidance from families.

Therapists working with Pasifika families need to strike a respectful balance between being clear about the purpose of the referral, while avoiding describing the service in a way that may result in the family not engaging with the service. For example, some therapists tend to avoid the term 'mental illness' or 'mental health service', particularly during the initial stages of engagement. By reframing in terms of health and well-being, or describing what the service does (for example, helping with struggles or difficulties) and referring to behaviours and symptoms, a greater acceptance from the family may be elicited.

The *Real Skills Plus Seitapu* framework recommends:

Every person working with Pacific people has an understanding of the importance of language, both spoken and unspoken, across a variety of Pacific contexts, and is able to either personally apply appropriate communication techniques in working with Pacific people, or know exactly where such skill is available[37]**.**

The role of psycho-education

While many younger, Aotearoa/New Zealand-born Pasifika peoples may have been exposed to mental health or addiction terms through the media, schooling and music, it may not be part of the discourse for many families who have immigrated to Aotearoa/New Zealand from the Pacific Islands. Therefore, there is often difficulty understanding and accepting a diagnosis of mental illness or addiction problems. Service users and their families can feel a sense of helplessness. Providing adequate education about the person's problems can help diminish some of the anxiety by de-stigmatising mental illness, providing hope, and subsequently reducing barriers to treatment. Interviews with Pasifika mental health service users has revealed that many of them have difficulty explaining their illness to family members, and this can be viewed as a significant hindrance to their recovery[31].

An important factor in maintaining engagement with Pasifika peoples in mental health and addiction services is including family in the psycho-education sessions. This enables them to feel part of the process and gain an understanding of what their family member is experiencing. Several ways of presenting information have been identified as being helpful during this stage.

- When explaining and presenting information related to mental illness, increased understanding can be achieved through visual representation (e.g. a whiteboard) and showing diagrammatically how various aspects are connected. This should include wider contextual factors.
- Providing written material to take home can be beneficial, particularly for psychosis and medications, as this can be a difficult concept to fully comprehend.
- Youth may relate to songs, art or well-known personalities when explaining the experience of mental illness.
- Referring to and providing information (written, videos, websites) related to Pasifika peoples who have experienced mental illness can assist with de-stigmatising mental illness and provide hope for the service user and their family. Such resources can be accessed through websites and sources such as The Lowdown, Like Minds Like Mine and Le Va.

Therapists working in both mental health and addiction services reported the effectiveness of the cognitive behavioural therapy, five-part model to explain psychological disturbance to Pasifika service users. The model explores five different aspects of a person's life – thoughts (beliefs, images, memories), moods, behaviours, physical reactions and the environment (past and present). All areas are interconnected and changes in one domain have a direct or indirect affect on the others.

Fishing for what is important – the 'round-about' or 'indirect' approach

Once the relational connection has been established, and the service user and their family are willing to step into the *vaka/va'a*, the journey can commence. The therapist needs to have the confidence and skills of navigation. It is recognised that this will involve making connections across space between the therapist and the service user, the throwing out of lines. Some of these will be lifelines, some will be missed and some will be picked up, but a genuine attempt to connect across space is important.

Ned Cook[38] refers to the Tongan process of *talanoa-po talanoa* – through talking or informal conversation there is a deliberate way of being indirect. This involves throwing out the lines and hooks, with the skill of the therapist being to catch what is being told.

The analogy of the Tongan fishing practice of *uku* (diving) around dangerous blow-holes has been used to describe this Pasifika 'round-about approach'[15]. In certain parts of Tonga, hollows in the reef cause sea water to gush up to 30 feet into the air. These are dangerous areas and yet those skilled in navigation and who have a comprehensive understanding of the terrain, are able to catch the fish located under the reef. The *vaka* cannot sail directly into these sites without being crushed and therefore a round-about approach is needed requiring knowledge, intuition and respect for the sea.

This round-about approach is indicative of the ways an indirect nature of seeking information may be more effective when working with Pasifika peoples[7]. Direct questioning related to self-exposure or self-assertion can be perceived by Pasifika families as intrusive and rude[39].

This round-about approach relies extensively on allowing the family to tell their story and may take time. It can be misperceived as 'avoidance' by a therapist who is unfamiliar with Pasifika ways of relating. Pasifika therapists generally know what they are listening to (and listening for) and can put this information into context, which enables them to assess if the presenting issues are pathological or culturally acceptable behaviours, thoughts and feelings. If a therapist doesn't have these culturally specific skills, things can become lost in translation. However, even a basic awareness of the fact that Pasifika peoples may choose to tell stories in an indirect manner may be helpful for non-Pasifika therapists.

During the therapeutic journey, disclosure of personal and often distressing information may be made. A respectful and culturally competent therapist, skilled in the 'round-about' approach and who uses metaphors and story-telling, can provide a safe environment for this to occur. Judy Matai'a[40] introduces a Samoan mode of 'cultural communication' that incorporates inferences and narrative metaphors as an effective practice tool for addressing unspeakable taboos such as sexual abuse. She refers to the mating rituals of the *laumei* (turtle) who after the mating season and birth of its offspring, returns to mate with its own. Although she has not named the act of incestuous relations, the content and meaning behind the *laumei* metaphor does not leave scope for misunderstanding.

Makasiale[41] also employs *heliaki* (metaphor) and an indirect approach when working therapeutically with service users. In a counselling session with a young Pasifika woman, Makasiale reveals how she includes metaphor when navigating sensitive issues. When she talks about the rain pouring within the person it elicits an emotional response from the young women who then feels able to tell her story.

For people, counsellor and client, who are not well known to each other – this use of metaphor is a strategy that avoids a possible humiliating route to shut-down. Makasiale draws on her own cultural knowledge and wisdom, avoiding direct language and therefore skilfully avoiding loss of face, 'no room to move' and a violation of the va between people who are not known to each other. Her choice of heliaki leaves the unspeakable unsaid, but opens up the possibilities of hearing and speaking 'truth' [42].

INVOLVING FAMILIES

The *Real Skills Plus Seitapu* framework outlines considerations for the mental health and addiction workforce when working with Pasifika populations. One of the key themes of this document relates to engaging with Pasifika families. The following information aligns and supports this framework.

The collective nature of Pasifika communities suggests that when working with Pasifika service users, the recovery journey is most likely to involve their families (including extended family members) and possibly others in the community (e.g. church ministers, traditional healers). If working with an individual alone, assessing the quality of the relationships the service user has with the extended family and community can provide crucial information in trying to understand their presenting life struggles[43].

While recognising the importance of engaging families in the recovery journey of the service user, it is also important to acknowledge the constraints of bringing the family together. For example, work commitments may prevent family members from attending appointments. As mentioned previously, non-attendance should not be perceived as a lack of interest or caring. Additionally, while family involvement is desirable, it may not necessarily be appropriate in all circumstances.

Pacific opinion leaders argue that service workers need to ensure that blanket assumptions or stereotypes are not unfairly adopted (pg x) [7].

Therefore, engaging the family does not necessarily require bringing them into the service, but it is important that they feel valued and are at least offered a home visit to ensure that the service user, particularly if they are a young person, remains engaged with the service. Having a cultural advisor or *matua* present, or available to consult with, can ensure cultural values are respected and that the family is treated appropriately and fairly.

Many ethnic minority families, including Pasifika families, experience difficulties when immigrating to another country[44]. They describe how the impact of immigration and cultural adjustment can be extremely stressful for some families, as they face not just physical, economical and language transitions, but also cognitive and psychological transitions. Conflict and emotional distance can arise, as children of immigrants discover freedom of choice and learn assertiveness. As a consequence, depression, anxiety, family violence and suicide may occur.

The therapist can be helpful in engaging families in what is referred to as 'externalising conversations' where the family provides accounts of the effects of migration which externalises the problem and does not place it within the individual or family [45].

Fono participants identified this narrative technique of externalising the problem as a respectful and effective approach when working with Pasifika families. Externalising the problem is consistent

with choosing to be indirect and not personalising the problem, or locating it exclusively within the person.

It is important to consider all the tensions, conflicts and fears that service users and their families may be facing when involved with a mental health or addiction service. This may be the fear of the therapeutic journey itself and what it may uncover and where it may lead. These pre-therapy suggestions may assist the therapist to help the service user and their family reach a point where they are willing to get into the *vaka/va'a* and embark on a therapeutic journey.

MEDICATION

Psychotropic medications (i.e. those that affect mental activity, behaviour or perception) are usually offered to Pasifika people either by their general practitioner or by a psychiatrist in mental health and addiction services. Such medications may be tranquilisers, sedatives, antidepressants or antipsychotics.

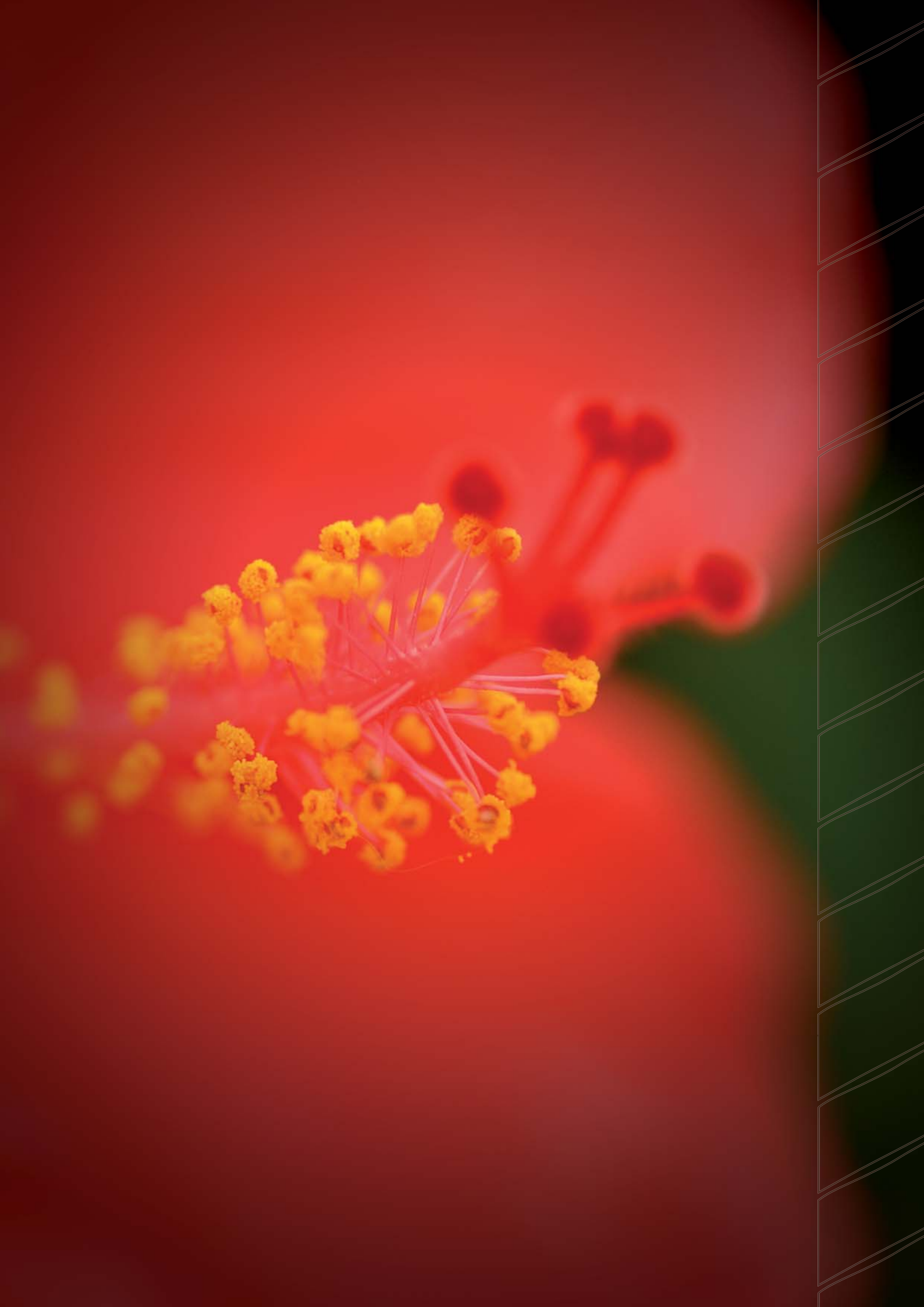
Traditionally, herbs are used throughout the Pacific for medicinal purposes to address a range of illnesses. Usually, use of these herbs has a prescribed time limit. A psychiatrist commented that he often used this fact to explain the purpose and usefulness of psychotropic medications, as it provided a familiar and useful framework from which families to make decisions about medications. Giving families different options for medications and using motivational interviewing and solution-focussed techniques could increase the likelihood of people being willing to trial medication[46].

The use of western medications in the Pacific Islands may impact on the decision to trial medications. There is a limited choice available in many Pacific nations and dosages can consequently be at non-therapeutic levels, limiting effectiveness. The concepts of maintenance medication or preventative medication may be unfamiliar. These factors can contribute to medication compliance issues. Pasifika service users may report that they are compliant with medication when they are not. They may stop using medication when they start to feel better and may not understand the importance of continuing or tapering off medications.

Most Pasifika service users who experience psychotic symptoms and who are seen by mental health and addiction services will be prescribed either oral or depo medications. Intervening at the earliest stage is important and this may mean starting talking therapies sooner. If service users are on medication, then they should be maintained on the lowest dose possible. Significant side effects can lead to further non-compliance. Maintaining the therapeutic relationship is still important, even in the context of administering medication.

> ***"You can never divorce the importance of the therapeutic relationship even when trying to get the person to take the depo every week."*** ***(Non-Pasifika Therapist)***

Consideration should also be given to the power dynamics that may occur, as often a doctor is looked upon as an expert. There may be a tendency to 'overpower', as opposed to 'empower', service users to make fully informed decisions.



It is important to ensure that the family understands how medication can be useful. In child, adolescent and family mental health services, families can be more reluctant for young people to take medication. Medication should be explained in a way that families and the service user understand. This may also mean working alongside traditional healers. Explaining the way medications work, the side effects and dosages are important. This could be provided using diagrams on a white board or with paper and pen. Handouts should also be provided. Explaining a trial of medication and when it will be reviewed is also important.

LET'S GET REAL

Let's get real is a framework that was established to increase the effective delivery of mental health and addiction treatment services throughout Aotearoa/New Zealand. This framework describes the essential knowledge and skills required by people who work in mental health and addiction services. The essential values and attitudes that underpin the framework are also expressed throughout this document.

The *Real Skills Plus Seitapu* framework is a companion document to the *Let's get real* framework and presents the essential and desirable knowledge, skills and attitudes required by the mental health and addiction workforce in order to work more effectively with Pasifika peoples and their families. The skills are considered to be fluid and transitional with the key themes being family, language and *tapu*.

Much of the knowledge, skills and attitudes identified in this guide align and support the principles identified in *Let's get real* and *Real Skills Plus Seitapu.*

TRADITIONAL PERSPECTIVES ON MENTAL HEALTH AND HEALING

Attributions for mental un-wellness may vary from an aetiology of an injury, to being possessed by spirits, or to breaches of *tapu* – the sacred bonds between people[16]. Intergenerational curses may also be named as causative factors. These causes can disturb the natural harmony of relationships or be viewed as spiritual issues that may manifest in a mental illness. Similar to other indigenous cultures, the use of traditional therapies or healers is a practice that is used among many Pasifika peoples to ameliorate these causes.

There are many different traditional methods available to families when they are facing difficulties with a family member. These include particular processes or rituals used by traditional healers who are especially gifted with particular presentations. These gifts are seen as *tapu*[43] and they can ameliorate or heal the sources of disharmony. Traditional therapies can include *fofo* (massage), herbal remedies prepared in a traditional way, or incantations and prayers by a traditional healer. Christian ministers are also used to help restore harmony.

Stressors that contribute to mental un-wellness from a Samoan perspective include low income, unemployment and the marginalisation of Samoan cultural norms in Aotearoa/New Zealand. Pasifika peoples tend to be over-represented in low socio-economic status populations and have financial collective cultural obligations such as weddings and funerals. Many also experience cultural adjustment issues, which can include racial prejudices. Continual adjustment to dominant cultural norms is also seen as contributing to destabilising relational harmony and the deterioration of mental health[16].

It is useful to include folk-healers in psychiatric treatment as this provides a meaningful collaboration for service users suffering from *avanga* (disease)[47]. If mental un-wellness is attributable to breaches of *tapu*, western medicine may be seen as insufficient intervention[16] and traditional healing will be required. Appropriate cultural services for mental health have been proposed that will address these factors more effectively. While Pasifika peoples may consult traditional healers for mental health issues in preference to western psychiatric treatment, concerns have been raised about the problems arising from delays in receiving effective mental health treatment and the impact on the long-term prognosis for individuals. However, there is no evidence to prove these concerns are valid.

Tapu is a key skill identified by the *Real Skills Plus Seitapu* framework. It states that every mental health worker needs to be open minded to the cultural, spiritual and relationship environments and belief systems that may accompany Pasifika service users and their families. This skill can be demonstrated in a number of ways, such as acknowledging the belief that mental illness may be a result of a breach of *tapu*, and that this breach may be trans-generational, or by recognising that the concept of *tapu* is about ensuring cultural safety and enabling culturally safe practices.

THE THERAPIES

Te Pou has published a series of guides, which are intended to inform staff working therapeutically with specific population groups about the processes of engagement and therapies that are particularly appropriate. In addition, *A Guide to Talking Therapies in New Zealand* (**www.tepou.co.nz**), may be useful as a general source of information on therapies that are widely used throughout Aotearoa/New Zealand and how to access them.

However, there is limited documented research on the effectiveness of talking therapies with Pasifika populations[5]. Consequently, data gathered to inform this section is based on anecdotal evidence and practice-based observations from both Pasifika and non-Pasifika therapists who are providing therapy for Pasifika peoples accessing mental health and addiction services in Aotearoa/New Zealand. Focus groups were also held in Auckland, Wellington and Christchurch, and key informant interviews were held with key stakeholders in the mental health and addiction sector.

TALANOA

Talanoa is a concept familiar to Samoa, Tonga and Fiji. It simply means talking or having a conversation[48]. *Tala* means inform, relate, story or tale, or command and *noa* translates as nothing, ordinary or void. Despite the literal meaning of 'talking about nothing', *Talanoa* is widely used to cover anything from general through to more meaningful conversations at many different levels.

Talanoa is an oral tradition where ceremony and protocol is as important as the actual process of relating[49]. *Talanoa* is non-linear, usually carried out face to face and is reciprocal without time restriction. The values of *Talanoa*, where the relationship between people is privileged, and flexibility and adaptation occurs naturally, lends itself to Westernised ideas of therapeutic conversations. "*Talanoa* is a good conversation: one listens to the other"[48]. It has also been proposed as an appropriate research methodology for Pasifika peoples, especially for social and education purposes.

Talanoa does not have a preconceived agenda and it is not about consensus[50]. While the outcome is not predetermined, if you have faith and "respect and trust the people you are talking with, you will get the outcome". However, the critical factor involved in the *Talanoa* process relates to effective facilitation and being able to extract and reflect back the important points. Ultimately, *Talanoa* is based on a respectful and trusting relationship.

Accordingly, therapy cannot be seen in isolation, but is an extension of relationship building. Once the metaphorical mat has been rolled out and the relationship has been established, it is time to journey in the *vaka/va'a*. Once the relational connection has been made and the service user and their family is willing to step into the *vaka/va'a*, the therapy (or fishing journey) can commence. There are times that this journey may lead to unexpected horizons and times when the journey experiences whirlpools and there is danger of the *vaka/va'a* capsizing. Western types of interventions help to focus inwards and find answers within yourself. It was suggested by *fono* participants that many Pasifika peoples tend to process outwards, focusing on relationships. However, like every other ethnic group, there is a wide variety of responses and individual diversity. It was also reported that Pasifika service users may prefer practical solutions and strategies.

Therapy often has its challenges and progress can either be slower or quicker than anticipated. Perhaps what is important for therapists to consider is that there are many cultural maps that can be applied to the same terrain. Be aware that a Pasifika person may see the same territory very differently. Therefore, there may be cultural nuances, signposts and markers that do not appear on the therapist's map. This means that alongside the frameworks and tools that have been part of a therapist's training, there is a need to be trained to see what is not on their own map.

Ultimately, the service user must be able to map their own way in recovery. This cannot be super-imposed upon them. The therapist is not the captain of the therapeutic journey, but merely one of many guides. Pausing to try and see what is there (particularly with regard to cultural nuances and issues) that does not feature on the clinical map, yet exists for the person, is an important skill.

NARRATIVE APPROACHES

There is no empirical evidence for using narrative approaches with Pasifika peoples in mental health and addiction services, yet they are utilised extensively.

Narrative approaches historically developed as a response to behaviourism and cognitive approaches, as they were believed to be more respectful of cultural differences. Narrative approaches were also seen as more useful in terms of externalising difficulties and for re-storying or constructing alternative realities[51].

Using storytelling is a familiar cultural practice across the Pacific. There is also an acceptance in narrative approaches of meanings and significant events as opposed to a linear or logical time frame. Hence, these approaches appear more effective in exploring these events, rather than relying on the semantic meanings of words. This approach builds on the service user's strengths and helps them to re-story their struggles into a strengths-based narrative. This approach shares similarities with the process of *talanoa* and may fit well with both island-born and New Zealand-born Pasifika peoples.

Adult mental health services

Narrative therapy was being used by therapists who saw it as a useful way of working with their Pasifika service users to support re-authoring of stories and build collaboration with service users. The non-linear approach of narrative therapy and its fit with the use of storytelling was seen as particularly effective.

> ***"Narrative approach – sometimes not as linear as palangi process – [one] can talk about [an] incident as if in the present but [it] actually happened 20 years ago –[there is] more about the significance of the event as opposed to logical time frame as we know it – [this] goes back to knowing [the] nuances of culture."*** ***(Pasifika Therapist)***

Child, adolescent and family mental health services

Sharing stories is seen as a Pasifika way in which families can connect and is suitable for relating to young people as it is a medium familiar to them. Their use in externalising difficulties is useful, rather than difficulties being seen as a problem with the person.

> ***"Sharing and telling stories is a very Pasifika way – families can connect with you and kids can relate."*** ***(Pasifika Therapist)***

The personal stories co-constructed were understood as heart connections as opposed to intellectual ones.

Narrative family therapy appears to be useful in the child and adolescent mental health setting. Narrative approaches also appear to be effective when talking to parents. This included identifying strengths through others, as a person may not talk about themselves as culturally this may be considered inappropriate. An example of this may be asking a young person about their strengths in a culturally appropriate way like, "What would your grandmother have been proud of about you?"

> ***Narrative family therapy (is) most effective, relational, spiritual, most respectful of cultures. A manualised approach [in contrast] – does not address relational aspect system, or context adequately.*** *(Pasifika Therapist)*

Addiction services

Narrative approaches do not appear to be used by therapists from addiction services surveyed in the *fono*.

MOTIVATIONAL INTERVIEWING

There is no empirical evidence for this approach with Pasifika peoples in mental health and addiction services, yet is widely used.

Motivational interviewing (MI) is a therapeutic technique that has been shown to be useful in helping to engage people in changing their behaviour[52]. MI is brief and client-centred. It uses four key principles: express sympathy, develop discrepancy, roll with resistance and support self-efficacy. The emphasis is not to challenge people directly, but to help them see other alternatives. It also appears to be a useful technique for both engagement and working therapeutically, as it accommodates Pasifika service users at all levels of behaviour change. It has been used for joining with Pasifika service users and drawing on their motivation for change. It is also used for helping people with their medication compliance. MI is seen as useful for both adult and adolescent age groups.

Adult mental health settings

MI is particularly useful when assessing service users. Often Pasifika peoples do not like being confronted directly and using MI can be helpful. It also helps engage the service user in their reasons for change.

Child, adolescent and family mental health services

MI does not appear to be used in this area, according to those surveyed, but it may be useful to engage young people for the reasons already outlined.

Addiction services

MI is used extensively within addiction services according to the therapists surveyed in the *fono*. It is used to help service users work out if they have a problem issue to deal with. The framework provides an opportunity to discuss the impact of issues on a person's family and lifestyle.

This in turn can greatly aid motivation to change and also move people from a pre-contemplative to contemplative stance, and then into action. This appears to be particularly useful in changing health behaviours when service users are given some psycho-education and an opportunity to reflect on how they can make changes themselves with the support of a therapist.

SOLUTION-FOCUSSED BRIEF THERAPY

There is no empirical evidence for using this approach with Pasifika peoples in mental health and addiction services, yet is widely used.

Solution focussed brief therapy (SFBT) is a therapeutic strengths-based intervention[53]. It moves a service user from a problem-dominated perspective to a solution-oriented perspective. This model fits well with *talanoa*, to "ask people to generate their own solutions". It also fits well with using a service user's own knowledge about themselves and their context, and is a strengths-based perspective, rather than one of pathology.

SFBT was used by many therapists for a variety of issues, particularly to support engagement. The emphasis on 'brief' intervention should be considered in light of engagement issues. This is due to the period that needs to be taken to build engagement with Pasifika clients. However, this approach may also fit with a service user's time constraints, such as the identified barrier to therapy of needing to take time off work to attend appointments.

Adult mental health services

SFBT did not appear to be used by therapists from addiction services surveyed in the *fono*.

Child, adolescent and family mental health services

SFBT appears useful for young people in that it focuses on finding solutions rather than being problem focussed. Identity and connections for young people are especially important in this developmental stage, so being solution-focussed may appeal more to them.

> ***"For young people talking about identity – we look at maps, who am I? Where do I belong? Not focus on me and my problems but where I am in the world and get grounded/rooted (so) they can do lots of things. [It is important to have a] holistic approach to understanding the person in the context in which they operate."*** ***(Pasifika Therapist)***

Addiction services

Some of the therapists from the *fono* used SFBT with their Pasifika service users and reported how useful it had been for service users. The 'Miracle Question' (e.g. What would be different if you woke up tomorrow and the issue you are dealing with is gone?) had been particularly poignant for service users. It appears that this helps with motivation to change and provides hope that things can be different for them and their families.

COGNITIVE BEHAVIOUR THERAPY

There is no empirical evidence for this approach with Pasifika people in mental health and addiction services, yet it is utilised to some extent by those trained in it.

Cognitive behaviour therapy (CBT) is a therapy that is often favoured because of the substantial evidence base of its usefulness for a range of mental health issues. CBT assists people to monitor their thoughts, increase behavioural activation, and challenge erroneous thinking and core beliefs by looking for evidence.

While there is no current Pasifika-specific research to support this, feedback from both Pasifika and non-Pasifika therapists suggests CBT can be an effective therapeutic intervention. However, there were conditions associated with its application. A strict adherence or a rigid CBT approach was reported to be not well received by Pasifika service users. In particular, those who are more traditional need a more flexible therapy.

However, for New Zealand-born Pasifika children, youth and adults who are more acculturated into Aotearoa/New Zealand society, CBT with some cultural adaptations was said to have produced positive therapeutic outcomes. The acknowledgement or inclusion of the spiritual component was helpful in presenting this model to Pasifika service users.

It was also reported that the five-part model in its written form was useful. When applying problem solving, particular considerations for therapists included being mindful of the context and how solutions may impact on family and community relationships, as well as being mindful of cultural consequences.

CBT is regarded as effective for anxiety-related presentations and depression, which have been identified as the most common mental health issues for Pasifika peoples[1]. However, it appears that the therapist's level of experience and training in applying this approach, as well as their cultural knowledge and competence, are important factors in the success of this model. It is unclear if Pasifika and non-Pasifika therapists differ in their delivery of CBT and this could be investigated in future research.

Adult mental health services

One Pasifika therapist commented that CBT was more useful when it started with examples then presented concepts and said, "Pasifika (people) don't usually think from concept to example but build concepts from the ground up".

Some Pasifika therapists discussed the importance of addressing the 'B' in CBT, or the behavioural component, as this was a familiar concept and more tangible.

It was recommended that, if using a CBT approach, commencing with behavioural activation would fit with the way that people who were not well would be supported in the Pacific Islands. That is, they would still be given achievable tasks to complete as part of their family. These tasks were seen to help build confidence and achievement and give them a useful role, even if it was a small practical task like raking the leaves. It was also suggested that:

> ***"CBT needs to be turned upside down – look at historical and current narratives through story telling first then introduce CBT concepts – then the client has something to hang concepts on – practical life examples."*** ***(Pasifika Therapist)***

The feedback from therapists interviewed for this guide suggests that CBT is useful when working with Pasifika adults. It is seen as useful for relapse prevention and maintaining wellness. It has also

been identified as a collaborative approach where time is taken to build a therapeutic relationship. It is useful to help service users monitor their thoughts for early warning signs.

Child, adolescent and family mental health services

Some Pasifika therapists used CBT with young Pasifika people, with all elements of the therapy employed. These service users did tend to be Aotearoa/New Zealand-born young people. Using the whiteboard to draw diagrams when explaining the principles and the model and providing written materials supplemented therapy. Homework appeared useful to reinforce the concepts learnt and discussed in therapy. The ABC's of CBT for young people were deemed useful, especially around consequences, as these seemed to provide tangible factors that young people could relate to.

Addiction services

CBT was not used routinely in addiction services. However, many therapists highlighted the effectiveness of using the CBT five-part model when providing psycho-education to the service users and their families. Service users are provided with a visual framework and can make their own connections with the material.

DIALECTIC BEHAVIOUR THERAPY

There is no empirical evidence for this approach with Pasifika peoples in mental health and addiction services and was utilised by a few therapists with Pasifika peoples.

Dialectical behaviour therapy (DBT) is an evidence-based approach originally formulated by Linehan for working with women with a diagnosis of borderline personality disorder[54]. Its use has extended to work with adolescents and in the justice sector with offending behaviours. Pasifika peoples often do not access a DBT programme, due to the limited availability of DBT and the commitment required on behalf of the service user.

The few therapists who used some of this therapy primarily employed it to teach DBT skills, such as practical Mindfulness activities, that are useful for Pasifika service users.

Adult mental health services

Therapists surveyed were not using DBT. However, DBT is available in various forms in adult mental health services. To date, DBT has not been modified for Pasifika service users.

Child, adolescent and family mental health services

DBT appears promising for groups in which the majority of members are of Pasifika descent and where the therapy is being delivered by an experienced Pasifika therapist. The reasons for its success may be attributed to the cultural matching of the therapist and the group. DBT's delivery was highlighted as useful when engaging Pasifika youth, as it takes an active learning approach that incorporates practical everyday life events that youth can relate and connect with. As with other groups, it would be important to have at least one other youth of Pasifika descent in a DBT group.

Addiction services

This approach was not being used by therapists from addictions services surveyed. However, aspects of mindfulness (which is a key concept of DBT) were being used successfully with Pasifika service users.

FAMILY THERAPY

There is no empirical evidence for this approach with Pasifika peoples in mental health and addiction services.

Family therapy is an approach that includes the family of an identified service user. Formal family therapy was used cautiously by the therapists surveyed. In some cases family therapy can be hard to implement because of the *va* or sacred relationships between generations, especially between father and daughter, and brother and sister.

The intricacies that exist in relationships between Pasifika peoples are extremely important and should be treated with caution. An example of this is *mehikitanga*, or the role and status that an elder sister or cousin has over her brother's children in Tongan culture[43]. This can be easily misinterpreted as an unhealthy alliance in structural family therapy. It is imperative that any family therapy be done with an awareness of these issues.

Adult mental health services

Family work or sessions can be useful in a recovery framework. This is not family therapy per se. A consumer advocate reported that it was only when he felt his cultural practices were taken into account and respected by the therapist he was seen by, that he asked his family to be involved in his treatment.

While the inclusion of family members is ideal in intervention and recovery, the reality of family members having transport and the time during office hours to attend appointments can be difficult and can place more stress on a family system. Careful consideration can help identify and work around these issues.

Child, adolescent and family mental health services

While the family is very important in a young person's presentation, traditional family therapies may not always be suitable. Asking a Pasifika young person to comment on a family member who is older is problematic for a number of reasons. This may include the relationship boundaries that exist, as commenting on how a parent or other family member may see a situation can transgress these boundary[14].

Addiction services

Family therapy was not used routinely in this sector by those interviewed.

OTHER THERAPEUTIC TECHNIQUES

Socratic questioning

Aspects of therapies like Socratic questioning were identified as useful to help Pasifika service users identify what their issues were.

> **Socratic questioning is important and if you're doing it well you'll be getting to the core issues, self statements about the person. I don't think there are exclusive ways of doing it. The best therapists in probably any mode of therapy will get to it in their own way [55].**

Socratic questioning is seen as more useful than direct questioning in both assessment and therapy. A risk of using more direct questions is that they may elicit responses from the service user that indicate agreement with professionals, when actually they do not agree. Both Pasifika-born and Aotearoa/New Zealand-born service users are unlikely to challenge the therapist in order to remain respectful.

Humour

Humour is important to use in the therapeutic relationship at appropriate times, as it can provide some temporary relief[56] and help to avoid the service user leaving the appointment feeling worse. However, when and what you can laugh about is important. Therefore non-Pasifika therapists should be cautious using humour, as it is easy to offend if they are unaware of cultural nuances.

Physical interventions

Adjunctive physical interventions can enhance talking therapies. Young people can feel uncomfortable with face-to-face, one-to-one talking. Boys tend to be more active. Therefore using incentives such as a game of touch rugby at the end of a talking session may help them remain focused. Other ideas that were discussed included gardening, weaving, *umu* (traditional cooking method) and having conversations while working. These are all natural activities for Pasifika peoples that could be extended to a group therapy context. Relaxation, prayer, meditation, breathing and music were also identified as useful to incorporate into therapy.

Concretisation

'Concretisation' or using items that represent something meaningful (e.g. sand-tray objects and photos) was identified as a useful technique for therapists. One therapist used 'the empty chair' technique as a way of externalising – by talking to an imagined person sitting on an empty chair as though they were present. Pasifika people can be very visual so using visual aids, such as photos, pictures, artefacts, diagrams and the whiteboard, can be useful. Using resources that are culturally connecting and that service users can relate to and identify with can also aid therapy. Symbols can also be used, such as mats and the kava bowl where water symbolises cleansing. These aesthetics are seen as important[57].

Group therapy

Groups were mentioned throughout the *fono* as an appropriate way to deliver therapy, but certain factors must be considered. Groups appeared useful if there was more than one Pasifika service user in the group. If a Pasifika person attends a mainstream group, a Pasifika therapist advised that

non-Pasifika therapists should be aware that it could take time for them to open up and trust the group, and not to expect they will open up straight away. The principles in section two of this guide on engagement would still apply. Other issues such as ethnic matching, or variables such as gender and age may also need consideration for group therapy. One reason for this is the appropriateness of discussing issues with people of the same gender, so as not to breach *tapu*[7].

LESS WIDELY AVAILABLE EVIDENCE-BASED THERAPIES

Acceptance and commitment therapy (ACT)

There is no empirical evidence for this approach with Pasifika peoples in mental health and addiction services, but it shows potential as a promising therapy.

Acceptance and commitment therapy (ACT) has only recently been introduced into Aotearoa/New Zealand as a therapeutic approach, and therefore the number of therapists skilled in this approach is not as extensive as those trained in more established therapies. Consequently, it is difficult to comment on ACT's effectiveness with Pasifika populations.

However, ACT's inclusion of metaphors and values, and its focus and emphasis on life domains that are important to Pasifika peoples (e.g. spirituality, community, recreation, family, work or career, parenting, friends and social life, education, physical well-being and relationships) would suggest this approach could have potential appeal and usefulness for Pasifika populations.

Bibliotherapy

There is no empirical evidence for using this approach with Pasifika peoples in mental health and addiction services.

Given possible language difficulties, and a preference by many Pasifika peoples for face-to-face engagement, while this approach may be a useful adjunct to talking therapies for those service users who are competent in the English language, it is not recommended as a stand-alone intervention. However, it may be an option for Pasifika peoples experiencing mild mental health or addiction problems who are reluctant to engage with mental health or addiction services because of stigma.

Computerised cognitive behaviour therapy

There is no empirical evidence for using this approach with Pasifika peoples in mental health and addiction services.

Given the importance of relationships for Pasifika people, this approach may be useful to complement talking therapy, but at this stage would not be recommended as a stand-alone intervention. It may also be more useful for Pasifika people who have access to computers and the internet and who are more technology literate.

Counselling

There is no empirical evidence for using this approach with Pasifika peoples in mental health and addiction services.

Interpersonal psychotherapy

There is no empirical evidence for this using approach with Pasifika peoples in mental health and addiction services. No therapists interviewed for this project identified this approach as one they used with Pasifika service users.

Multisystemic therapy

There is no empirical evidence for using this approach with Pasifika peoples in mental health and addiction services. No therapists interviewed for this project identified this approach as one that they used with Pasifika service users.

Problem-solving therapy

There is no empirical evidence for using this approach with Pasifika people in mental health and addiction services. No therapists interviewed for this project identified this approach as one that they used on its own with Pasifika service users. However, it is used as a technique within other therapeutic approaches, such as CBT.

Psychodynamic therapy

There is no empirical evidence for using this approach with Pasifika people in mental health and addiction services. No therapists interviewed for this project identified this approach as one that they used with Pasifika service users.

Psychotherapy with children

This is addressed within each of the models under the Child, Adolescent and Family Mental Health Services sub-heading.

CONCLUSION

Talking therapies

Therapies currently being used most successfully with Pasifika service users include those that encourage a strengths-based approach. A recovery focus is also important and this sometimes includes the use of medication. Recognising and attending to a holistic model is also important for therapists working with Pasifika service users.

While all the therapists interviewed believed that the mentioned talking therapy models were useful, they strongly identified that in their practice they modified, adapted or used parts of these models eclectically. It appears that having several models to draw on as a therapist helps to meet service users' needs more holistically. The therapists interviewed were more senior practitioners and although they knew the therapeutic underpinnings of each model, would not exclusively use one with Pasifika peoples. They also did not believe that 'manualised'-type approaches were flexible enough to address Pasifika people's holistic needs.

Hence, it appears that a high level of sophistication, confidence and competence is necessary when working with Pasifika people. This is consistent with ideas proposed in *We Need to Act*[5], with those service users presenting in secondary mental health services needing comprehensive service, including a range of therapeutic modalities.

RESOURCES

www.tepou.co.nz
www.leva.co.nz

Other helpful websites

www.104.6planetfm.org.nz
Planet FM - giving a voice to those with mental illness, disabilities, of different sexuality, beliefs, culture and language, or supporting the desires of many to build community, based on meaningful and relevant communication.

www.depression.org.nz
The National Depression Initiative (NDI) aims to reduce the impact of depression on the lives of New Zealanders, by aiding early recognition, appropriate treatment, and recovery.

www.familiescommission.govt.nz
The Families Commission provides a voice for New Zealand families and whānau. They speak out for all families to promote a better understanding of family issues and needs among government agencies and the wider community.

www.familyservices.govt.nz
A Family Services Directory.

www.mentalhealth.org.nz
The Mental Health Foundation of New Zealand.

www.pasifikology.co.nz
Pasifikology is a network of Pasifika psychologists, graduates and students of psychology who support, promote, inform, educate and mentor the practice of psychology for Pasifika peoples.

www.sfauckland.org.nz
Supporting Families in Mental Illness. Supports families and whanau to provide the best possible quality of life and recovery to their loved one who has a mental illness; peer support networks, support groups including Pacific Island Family support.

www.thelowdown.co.nz
An interactive website helping young kiwi's understand and deal with depression.

www.tepou.co.nz/page/501-Knowledge-Exchange
Te Pou's Knowledge Exchange supports the translation of knowledge into action by igniting a passion for learning, embracing information sharing and research collaboration.

Additional recommended reading

Culbertson, P., Agee, M. & Makasiale, C. (2007). *Penina Uliuli: Contemporary Challenges in Mental Health for Pacific People*. Honolulu: University of Hawaii Press.

Kingi-'Ulu'ave, D., Faleafa, M., & Brown, T. (2007). A Pasifika Perspective of Psychology in Aotearoa, in Evans, I.M., Rucklidge, J.J., and O'Driscoll. M (Eds.). *Professional Practice of Psychology in Aotearoa New Zealand.* New Zealand.

Health Research Council (2004). *Guidelines on Pacific health research*. Auckland NZ: Health Research Council of New Zealand.

Mila-Schaaf, K. and Hudson, M. (2009). *Negotiating Space for Indigenous Theorising in Pacific Mental Health and Addictions.* Auckland: Le Va, Pasifika within Te Pou. www.leva.co.nz/page/9-publications.

Ministry of Health. (2008). *Pacific Peoples' Experience of Disability: A paper for the Pacific Health and Disability Action Plan Review.* Wellington: Ministry of Health.

Ministry of Health. (2008). *Pacific Youth Health: A paper for the Pacific Health and Disability Action Plan Review.* Wellington: Ministry of Health.

Ministry of Health. (2008). *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review.* Wellington: Ministry of Health.

Pacific Health Dialogue, Journal of Community Health and Clinical Medicine for the Pacific (2009), *Pacific Mental Health and Addictions*, Vol 15, 1. www.leva.co.nz/page/9-publications.

Pulotu-Endemann, K., Suaalii-Sauni, S., Lui, D., McNicholas, T., Milnes, M, & Gibbs, T. (2007) *Sietapu Pacific Mental Health and Addiction Clinical and Cultural Competencies Framework.* Auckland: Te Pou.

Waldegrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. (2003). Just Therapy- a journey. A collection of papers from the Just Therapy Team. Adelaide: Dulwich.

The following readings have been accessed from the Bibliography in Cultural Diversity: Issues for Social Work in New Zealand – 1990-2008 by Tricia Bingham 2009:

- Robinson, G. (2006). (Vol. 119). Pacific healthcare workers and their treatment interventions for Pacific service users with alcohol and drug issues in New Zealand. New Zealand Medical Journal: Journal of the New Zealand Medical Association, 119(1228). Retrieved October 30, 2008, from www.nzma.org.nz.ezproxy.auckland.ac.nz/journal/119-1228/1809/content.pdf.
- Huakau, J., Asiasiga, L., Ford, M., Pledger, M., Casswell, S., Suaalii-Sauni, T., et al. (2005). New Zealand Pacific people' drinking style: Too much or nothing at all? New Zealand Medical Journal, 118(1216). Retrieved November 5, 2008, from www.nzma.org.nz.ezproxy.auckland.ac.nz/journal/118-1216/1491/.

- Bridgman, G. (1997). Mental illness and Pacific people in New Zealand. Pacific Health Dialog, 4(2), 95-104.
- Lima, I. (2004). Tafesilafa'i: Exploring Samoan alcohol use and health within the framework of fa'asamoa. Unpublished PhD thesis, University of Auckland, Auckland, New Zealand.
- Finau, S. A. (1999). Alcohol and young Tongans: A FOBI perspective for change. Pacific Health Dialog, 6(2), 320- 325.
- Foliaki, S. (1999). Mental health among Tongan migrants. Pacific Health Dialog, 6(2), 288-294. James, K. (1999). Alcohol: A threat to Tonga's time-honoured values? Pacific Health Dialog, 6(2), 261-264.

REFERENCES

(ENDNOTES)

1. Oakley-Browne, M.A., Wells, J.E., & Scott, K.M. (Eds). (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
2. Mental Health Commission (1998). Blueprint for Mental health Services in New Zealand. How things need to be. Mental Health Commission: Wellington.
3. Te Pou, (2008). *We need to talk*. tepou.co.nz.
4. Te Pou, (2009). *We need to listen*. tepou.co.nz.
5. Te Pou, (2009). *We need to act*. Auckland: Blueprint.
6. Te Pou (2009). *A guide to Talking Therapies in New Zealand*. Auckland: Blueprint.
7. Agnew, F., Pulotu-Endemann, F.K., Robinson, G., Suaalii-Sauni, T., Warren, H., Wheeler, A., Erick, M., Hingano, T., & Schmidt-Sopoaga, H. (2004). *Pacific models of mental health service delivery in New Zealand.* Auckland NZ: Health Research Council.
8. Patton, M. Q. (2002). Qualitative Research and Evaluation Methods. California: Sage.
9. Statistics New Zealand (2006). 2006 Census Statistics. Downloaded from www.stats.govt.nz/Census/2006CensusHomePage.
10. Alcohol Advisory Council of New Zealand. (2010). *Pacific Action Plan – 2009-2012.*
11. Huakau, J., Asiasiga, L., Ford, M., Pledger, M., Casswell, S., Suaalii-Sauni, T., et al. (2005). *New Zealand Pacific peoples' drinking style: Too much or nothing at all? New Zealand Medical Journal, 118*(1216). Retrieved November 5, 2008, from Beasley Institute Inc.
12. Ministry of Health, 2005. *Te Orau Ora: Pacific Mental Health Profile.* Wellington: Ministry of Health.
13. Abbott, M.W., & Volberg, R.A., 1991. *Gambling and problem gambling in New Zealand. Research Series No. 12*. Wellington: Department of Internal Affairs.
14. Waldegrave. C. (1998). The challenges of culture to psychology and post-modern thinking, in M. McGoldrick (Ed.) *Re-visioning Family Therapy: Race, Culture and Gender in Clinical Practice*, NY: Guilford.
15. Mafile'o, T.A. (2005). *Tongan metaphors of social work practice: Hange ha Pa kuo Ta'u.* PhD dissertation, Massey University, Palmerston North, New Zealand. p145.
16. Tamasese,K., Peteru, C., & Waldegrave, C. (1997). *O le taeao afua: The new morning: A qualitative investigation in to Samoan perspectives on mental health and culturally appropriate services. Report for the Health Research Council of New Zealand.* Wellington: The Family Centre.
17. Lui, D. & Schwenke, L. (2003). Soul searching. In *From Rhetoric to Reality*: *Proceedings of the 12th Annual TheMHS Conference 2003.* (pp. 175-178). Wellington NZ: The Mental Health Services Conference of Australia and New Zealand.
18. Huakau, G. & Bray, A. (2000). *Talking disabilities' from a Pacific perspective*. Dunedin NZ: Donald Beasley Institute Inc.
19. Miranda., J. Bernal, G., Lau, A., Kohn, L., Hwang, W. C. & La Fromboise, T. (2005). *State of the Science on Psychosocial Interventions for Ethnic Minorities.* Annual Review of Clinical Psychology. Vol. 1: 113-142.

20. Nicolas, G., Artnz, D. L., Hirsch, B., & Schmiedigen, A. (2009). Cultural Adaptation of a Group Treatment for Haitian American Adolescents, *Professional Psychology: Research and Practice*, 40:378-384.
21. Southwick, M., & Solomona, M. (2007). Improving Recruitment and Retention for the Pacific Mental Health Workforce: Feasibility Study Auckland: Te Pou o te Whakaaro Nui, p. 22.
22. Tamasese, K., Peteru, C., Waldegrave, C., & Bush, A. (2005). O le taeao Afua, the new morning: a qualitative investigation in to Samoan perspectives on mental health and culturally appropriate services. *Australian and New Zealand Journal of Psychiatry*, 39: 300-309.
23. Robinson, D. & Robinson, K. (2005). *Pacific ways of talk- hui and talanoa*. Social and Civic Policy Institute: Wellington.
24. Bennett, S. (2009). *Te huanga o te ao Maori: Cognitive Behavioural Therapy for Maori clients with depression - Development and evaluation of a culturally adapted treatment programme.* Unpublished PhD dissertation, Massey University, Palmerston North, New Zealand.
25. Organista K & Muñoz RF. (1996). Cognitive-behavioral therapy with Latinos. *Cognitive & Behavioural Practice*, 3: 255-270.
26. Lambert, M., Barley, J., & Dean E. (2001). Psychotherapy: Theory, Research, Practice, Training. Vol 38(4), p 357.
27. Kingi, D.A., Faleafa, M. & Brown, T. (2007). A Pasifika Perspective of Psychology in Aotearoa in Evans, I.M., Rucklidge, J.J., and O'Driscoll. M (Eds.) *Professional Practice of Psychology in Aotearoa New Zealand.*
28. Pulotu-Endemann, F. K., Suaali'i-Sauni, T. D., Lui, D., McNicholas, T., Milne, M., & Gibbs, T. (2007). *Seitapu: Pacific mental health and addiction cultural & clinical competencies framework*. Auckland, New Zealand.
29. Durie, M. (2002). Is there a distinctive Maori psychology?" In Nikora, L., Levy, M., Masters, B., Waitoki, M., Te Awekotuku, N. & R. Etheredge (Eds.), *The Proceedings of the National Maori Graduates of Psychology Symposium.* Hamilton: University of Waikato. pp. 19-25.
30. Thaman, K. (2004). LE'O E PEAU: Towards Cultural and Cognitive Democracy in Development in Pacific Islands Communities. In *Changing Islands – Changing Worlds: Proceedings from Islands of the World VIII International Conference*. 36-47 Kinmen Island (Quemoy), Taiwan.
31. Malo. V. (2000). *Pacific People in New Zealand talk about their experiences with mental illness*. Wellington: Mental Health Commission.
32. Henare, K., & Ehrhardt, P. (2004). *Support of Maori, Pacific and Asian Family, Whanau, and Significant Others who have been bereaved by suicide: Findings of a literature search*. Commissioned by the Ministry of Youth Development.
33. Kingsbury, S & York, A. (2007). *The 7 helpful habits of effective CAMHS and the Choice and Partnership approach.* UK: CAMHS network.
34. Foliaki, S. (2001). *Pacific mental health services and workforce: Moving on the Blueprint.* Wellington: New Zealand.
35. Mila-Schaaf, K. (2006). Vā-centred social work: Possibilities for a Pacific approach to social work practice. *Tu Mau II, Social Work Review, Autumn 2006, Vol.XVIII.8-13* Aotearoa New Zealand Association of Social Workers.

36. Durie, M. (2002). "Is there a distinctive Maori psychology?" In Nikora, L., Levy, M., Masters, B., Waitoki, M., Te Awekotuku, N. & R. Etheredge (Eds.), *The Proceedings of the National Maori Graduates of Psychology Symposium*. Hamilton: University of Waikato. pp. 19-25.
37. Te Pou, (2009). *Real Skills Plus Seitapu*, Auckland: New Zealand, p. 23.
38. Ned Cook, Personal communication, 2009.
39. Waldegrave, C. (1990). Social justice and family therapy: A discussion of the work of the family centre, Lower Hutt, New Zealand. *Dulwich Centre Newsletter, 1,*5-47.
40. Matai'a, J. (2006). It's not what you say, it's how you say it: Cultural ambiguity and speaking without naming the unspeakable. *Tu Mau II, Social Work Review,* Autumn 2006, Vol. XVIII.37-41 Aotearoa New Zealand Association of Social Workers.
41. Makasiale, C.O. (2007). Symbol and Metaphor in Pacific Counselling. In Culbertson, P., Nelson Agee, M. & Makasiale, C.O. (Eds), *Penina Uluiuli Contemporary Challenges in Mental Health For Pacific Peoples* (pp109-121). Honolulu: University of Hawaii Press.
42. Mila-Schaaf, K. & Hudson, M. (2009). *Negotiating Space for Indigenous Theorising in Pacific Mental Health and Addictions*. Auckland: Te Pou.
43. Samu, K. S. & Sualii-Sauni, T. (2009). Exploring the 'cultural' in cultural competencies in Pacific mental health. *Pacific Health Dialogue*: 15:120-130.
44. Ho, M.K., Rasheed, J.M. & Rasheed, M.N. (2004). *Family Therapy with ethnic minorities 2nd* Edition – Sage Publications, Inc.
45. White, M., & Epston, D. 1990. *Narrative means to therapeutic ends*. New York: W. W. Norton & Company,
46. Agnew, personal communication, 2010.
47. Puloka, M. H. (1999). 'Avanga: Tongan concepts of mental illness. *Pacific Health Dialogue* 6: 268-275.
48. Vaioleti, T. M. (2006). Talanoa Research Methodology: A developing position on Pacific research, *Waikato Journal of Education* 12:2006, 21-34.
49. Robinson, G. (2006). (Vol. 119). Pacific healthcare workers and their treatment interventions for Pacific clients with alcohol and drug issues in New Zealand. *New Zealand Medical Journal: Journal of the New Zealand Medical Association*, 119(1228).
50. Halapua, S. (2007) Talanoa – Talking from the Heart. Interview with Dr. Sitiveni (**www.sgiquarterly.org/feature2007Jan-4.html**).
51. Morgan, A. (2000). *What is narrative therapy?* Adelaide: Dulwich Centre.
52. Miller, W. R. & Rollnick, S. (2002). *Motivational Interviewing 2nd Edition*. NY:Guilford.
53. Miller, S. Hubble, M. and Duncan, B. (1996). *The Handbook of Solution-Focussed Brief Therapy*. San Francisco: Jossey-Bass.
54. Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* NY: Guilford.
55. Agnew, Personal Communication, 2010.
56. Efi, T. (2009). *He who rallies in my hour of need is my kin*, Keynote Address. NZ Families Commission Pasifika Families' Fono: Auckland.
57. Alefaio, S. Personal Communication, 2010.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