3. Stories from New Zealand.

Introduction.

In this chapter I will tell several stories from my professional life in New Zealand. I include them here to illustrate some of the issues I was grappling with in my practice over the years which led me to the question at the heart of my entering research - 'What was it I did that contributed to successful outcomes in practice?' This question did not seem to be in a form which lent itself to being easily researched, at least not within the forms of research that I was aware of. It was also a question which was more often implicit than explicit, being intertwined within many other questions in a buzzing confusion.

The stories I present here are only several of the many I carried which were 'alive' for me as I entered the research field. As I searched for clarity of focus in those early days, through reading literature on research theory and methodology, through noticing my current practice, through discussion and through keeping reflective diaries, I found these stories from the past stayed with me, seeming to either resonate or contrast with current experience. As I began to start writing about my research, for discussion with fellow researchers and supervisors at Bath, I wrote of some of my New Zealand experiences at the same time.

I wrote intuitively in storied form although I had no explicit sense at that stage of what constituted a 'quality' story. I also discovered the potential for story telling as a form of inquiry, as in the telling about prior experiences I became more fully aware of their significance for me in my current professional life and how they were informing the sense I made of current experience. Whilst these stories must be seen as reconstructions, influenced by the current context in which I was writing them, they nonetheless seemed 'present' with me at the time of writing. In Narrative Inquiry terms, they represent some of the stories I was 'living' as I entered the research field. Writing about experiences in storied form was the beginning of a process which emerged to become increasingly explicit over the course of the research.

In the stories presented here I do not attempt to tell of experiences in all their complexity, but rather I select those dimensions which hold together as one or more threads connecting experience together over time in a pattern which contain particular meaning for me. In the telling of them I attempt to give just sufficient background information about the setting and the people involved so that the reader can see how I take meaning from them. It is a difficult balance to achieve and these stories have come through many re-craftings in an attempt to convey 'essences'. I have successively 'thinned' them out so as to not leave the reader wandering through dense detail unsure of what they are meant to be noticing. This process of re-crafting can go on indefinitely, so the stories I present here are in the form of 'this is good-enough' to carry what I want to say. I have had to resist strong temptations to make the descriptions 'thicker' to convey complexity as I experienced it. These stories represent my first attempts at writing in a form which I did not recognise formally as 'story-telling' therefore I have resisted the temptation to embellish them further from within my later-arrived-at appreciation of Narrative Inquiry. I include them as written in the earlier stages of the research journey, although no doubt they have received some 'polish' from my later knowledge in the final draughting of this research account.

These stories remained alive for me in a second way as I entered the research. Jan and I had shared many professional experiences together and had used each other for personal support in talking through difficult or challenging times. This was particularly so in relation to working with the Maori people where we had both been involved, although in different roles. Now that we had some distance in time and space from New Zealand we 'de-briefed' together frequently about these experiences, making new sense from our new vantage points provided by another setting in another country.

I would like to present several of those stories now as experiential grounding for later writing and as analogical or metaphorical representations of the practice and research issues I was struggling with. *The core theme of these stories which I wish to highlight is how I was implicitly searching for a way of understanding and accounting for what I did in practice.* I found myself in many roles and situations for which my training had not equipped me, for which I had only very limited theoretical or practice frameworks informing what I did. Those frameworks I used came from therapy frameworks, often family therapy. The rest came from my own personal values, from intuition and guesswork, and from discussion and analysis with those in personal and professional networks who shared similar interests. It was the need to find a more coherent set of frameworks to account for what I did which provided one of the motivations for research. I am hoping that these stories will embody this for the reader in a richer way than a mere statement of 'fact' or intent. I will pause at the end of each story to describe what I take from it.

The first story is an account of looking for ways of practising authentically, attempting change in the way I and others practised in a multidisciplinary team setting, and failing in this. It is also about encountering the different interests and world views of the professional groups in a mental health service and my beginning awareness of how they influence relationships.

Lessons in initiating change.

The setting for this story is an acute admission ward in a psychiatric hospital in Auckland, New Zealand. I had been qualified for three years and I had not long moved to this job from a one in a community service for people with alcohol and related problems. Although I had worked before in acute admission wards, it had been during training and hence in a very junior role. I had moved to this job because of the connection it offered with a community mental health centre which served the same catchment area as the ward. This centre provided a complementary service to the hospital by seeing clients in crisis in order to minimise inappropriate admissions. The staff there had developed a network of statutory and voluntary workers and agencies, and together they provided support to people with mental health problems within their own family and community settings. They had been successful in reducing hospital admissions with the result that very few came into the ward from there. Their other role in relation to the ward was to provide follow-up care after discharge for patients who lived in the area.

Several staff at the centre were family therapists and had started training a small group of mental health professionals, of whom I was one. Taking the position on the ward allowed me to negotiate a small role in following up patients at the centre after discharge from hospital. In this way I could get live supervision from the family therapists as part of my training. Jan was the co-ordinator of the centre, being the person who had set it up from scratch, and so it was also an opportunity to find a small niche in which we could work together with families.

I was apprehensive about working again on an acute psychiatric ward. I did not relish being back in the 'institution' where the focus was more likely to be on 'controlling the symptoms' and 'treating the illness' from a medical perspective, and less on developing an understanding of the person in the context of their life and involving family and significant others in the process of change. I was worried about how I could contribute a psycho-social viewpoint in this setting and also be seen as useful. More generally I was seeking ways of developing my identity as a psychologist: respecting the needs of individuals while at the same time addressing issues in their social context which seemed to contribute to their problem. Family therapy, with its emphasis on seeing problems as occurring within the social context of the family, seemed a way of partly resolving this dilemma. So, going to work in a hospital setting both gave rise to contradictions for me, but paradoxically also offered a way of doing 'both/and' by allowing me to have access to family therapy training and experience.

After being on the ward for a few months, I realised that there were few clear expectations about what was required of me as a psychologist. It was a relatively short-stay ward, patients staying no more than three to four weeks on average before moving on. On admission the focus was on arriving quickly at a medical diagnosis, starting medication immediately and

then monitoring symptoms. This process involved doctors and nurses who then had a primary role in shaping what sort of service patients received. It was only towards the end of the patient's stay that nursing and medical staff began to think about wider psycho-social issues and start involving myself, social workers and others in preparation for discharge.

This left little time for the rest of us to do anything effective towards the patients stay before they were discharged, and had the more subtle implications that the patients' problems were due solely to illnesses for which the only or major treatment was medication. This was not to deny that many patients did not require or benefit from medication. Many arrived at the hospital in floridly disturbed states, highly agitated, unable to think clearly, deprived of sleep and with families and carers at the end of their tether. However, the process by which patients were dealt with left me feeling on the 'outside', and also concerned that it promoted a passivity in patients who might be left feeling there was little they could do towards regaining self control over their lives. It seemed that increasing my role in providing follow-up help after discharge was the most pragmatic solution. However, the hospital staff were reluctant for me to do this, they were clear when I suggested this that I was needed on the ward to make the team "multidisciplinary". But, discussing patients at ward rounds seemed to be the only explicitly valued role. I did not enjoy feeling I was a 'token' psychologist. I wondered how I might get involved earlier in the patients' stay and bring a consideration of the psycho-social dimensions alongside the biological: to increase my feelings of effectiveness; to broaden the focus for the patient; and to give more time for the non-medical staff to do their work.

I talked this through with Jan who had long experience as a senior nurse in in-patient psychiatric settings earlier in her career, and she suggested I talk with another psychologist she knew who had faced a similar problem in another hospital. I met with him and learned about how he had started a 'Goal-oriented Assessment Scheme', which involved meeting with the patient on or shortly after admission and gaining their view of the problems they faced in the various domains of their lives. Then, from this assessment, goals were derived with the patient in specific and concrete terms which would represent a resolution of these problems. Once the goals had been prioritised, then staff members with relevant skills and resources would be assigned to work with patients as 'therapists', according to the nature of the particular problem. The patient also had a 'mentor' whose job it was to monitor and review this process regularly and to advocate for the patient if changes were needed in the process, or if new goals emerged.

This scheme seemed to offer all that I was looking for and I began preparing to try it in my own setting. I read around the subject in the professional literature, shared the ideas with the social worker and occupational therapist on the ward and gained their agreement. I next approached the nurse in charge of the ward and several of the medical staff. They could 'see no objections' to the idea. I seemed to have a mandate, so arranged to give an in-depth presentation of the whole process to a staff meeting. In preparation I developed training materials, guidelines, processes and procedures so that I could demonstrate exactly what was required.

From that meeting I gained the agreement of the nursing staff to be a part of the process. There followed several long discussions which resulted in the nurses agreeing to be mentors because of their close involvement with the patients, but also taking therapist roles with any problems requiring their particular skills or interests.

The scheme failed. A considerable amount of time was needed for planning and monitoring after the initial assessment, to ensure that needs were matched with appropriate resources, and to ensure that we co-ordinated our activities with each other. This could not be done in ward rounds which was the existing forum where members of different disciplines met to discuss patients. There the process was organised around consultants training their junior doctors and the priority was to present information to assist decisions about diagnosis or prescribing of medication, leaving little time for other issues. The nurses were reluctant to challenge the way those meetings were organised and felt they had to give them priority. While the doctors agreed in principle to the assessment scheme and the multidisciplinary

involvement it offered, in practice they were indifferent to it and ignored the scheme as being peripheral to their work.

We had to meet outside the ward round. The nurses attended when they could but were frequently not there. The social worker, occupational therapist and I persisted for several months, meeting mostly on our own. We were identifying problems but did not have the necessary resources between the three of us to deal with them all. This created ethical difficulties in raising patients' expectations which could then not be met. Increasingly I felt the other two looked to me to supply the energy for success. I was not prepared to continue in this way and was frustrated and dismayed. At this point, the social workers in the hospital decided as a group to withdraw from playing a role on wards as integrated team members. They preferred to work from their own department and take referrals for any work the nursing or medical staff identified. This appeared to be their solution to the problems they saw inherent in multidisciplinary teamwork. I did not agree with this as a strategy, because I saw them as having even less influence on the way patients were treated or cared for. The occupational therapist and I agreed to stop the scheme and its demise went largely unnoticed by nursing or medical staff.

Lessons taken from this experience.

I was most powerfully aware at that time of the mutual dependence between doctors and nurses in a hospital setting. The doctors' priority was to diagnose and prescribe treatments. This meant they relied on nurses to observe patients, dispense medication and gather information for them. This delegated role meant that nurses became limited in the degree to which they could exercise their own independent roles in carrying out nursing care. The bulk of their work relied on the sanction of the doctor and so they became dependent on them for decisions. In turn this meant that they were even more limited in carrying out inter-dependent work with other disciplines. The resulting relationship struck me at the time as a 'dance' between doctors and nurses which left other disciplines as 'wallflowers', required to be there as occasional partners, but largely onlookers.

My later experience at the community mental health centre gave me a contrasting view as I worked with nurses who had a strong sense of their independent and inter-dependent roles. So I came to see that the hospital setting, and the primacy of a medical viewpoint which prevailed there, created a context in which those particular 'dance' relationships between the disciplines survived.

In relation to my own role, I was clear that I had failed to convince others of the efficacy of what I had proposed. I had relied on my position as a psychologist to introduce a programme which seemed to meet all the requirements. It met patient needs, used the resources of all the staff, had a theoretical rationale and was supported by the research literature. Yet that was not sufficient. Despite my analysis of staff relationships in that setting, I was still left feeling as if I had personally failed. I had not been persistent enough or worked hard enough, and nor had I been skilful enough.

However, I must also acknowledge a personal agenda which no doubt contributed in some way. I was keen on working more closely with the community centre and developing my skills as a family therapist. Over the succeeding year I spent increasing amounts of time working at the centre with patients and their families. As patients neared discharge from the ward and were identified as needing psychological treatment on follow-up, I would arrange family meetings on the ward and negotiate their involvement for on-going work. I felt able to do this because, after all , I had tried to do it differently, had had a go at being an effective member of the ward multidisciplinary team. But this did not feel a fully authentic conclusion. I did not feel comfortable with the climate of alienation which existed in psychiatric wards.

Caught between cultures.

This story follows on from the first, but several years on in time. I had left the job in the hospital to work in a voluntary agency which had hired me as its Assistant Director, to set up a family therapy service and train several of the staff there to work with me. There were other responsibilities which went with the job, including provision of some of the more mainstream services expected of a psychologist such as group and individual therapies. I saw this job as offering several opportunities: to contribute to a widening network of community mental health services which offered alternatives to institutional based care; to work in a more flexible organisation; to practice more explicitly as a family therapist; and to develop some management skills.

This story is about one management task I was asked to take on as part of the new job. It was to co-ordinate a project to produce a cross-cultural handbook for health and welfare workers. This had been started by the previous incumbent in the job but needed considerably more work to complete. It was intended as a guide to help people in health and welfare organisations become more knowledgeable about, and hence more sensitive to, the beliefs and practices of the different cultural groups living in Auckland. These included the indigenous Maori people, most of the Pacific Island peoples, and people from Asia.

The handbook was a response to increasing awareness within New Zealand society that minority cultures were disadvantaged in getting an effective service from health and welfare agencies. The handbook project had been based on an assumption that increasing the 'cultural awareness' of individual workers about health beliefs and practices of different cultural minorities would improve the services delivered.

The more I learned about what had been developed so far, the more I became worried about the likelihood of success. I had been developing an analysis of New Zealand society which was very influenced by radical Maori groups who were gaining in voice. Their view was that as 'people of the land' they were the host culture, but through colonisation had lost sovereignty over their land and their culture. The Europeans ('Pakeha'), although the dominant culture, were visitors. So too were Pacific Islanders, even though they shared the same cultural roots as Polynesian people. All visitors had a homeland in which their culture was intact. If they were to stay in this country, then they must allow the Maori people to regain sovereignty and work in partnership with them. Otherwise, went the more radical of the Maori groups, 'go back home!'. Failure to change would result in the death of the Maori culture and with that an even greater increase in the growing tragedy of illness, alienation, violence and crime among Maori people.

Stemming from that analysis, the target for change was not so much individual racial prejudice, but instead, institutional racism. The challenge was issued for Pakeha people to become aware of the fundamental assumptions about the world which made them blind to the ways of the Maori, and hence informed practices which contributed to continued oppression. This must lead to Maori people being given their share of resources and access to decision making on terms which fitted with their culture. This was not an analysis accepted widely by either Maori or Pakeha people at the time. For most, the Maori had been given equal opportunity in this society and failure to thrive must be laid at the feet of the individual.

However, I was part of a growing segment of Pakeha society which found the sovereignty analysis both compelling and challenging. While I could not be responsible for one hundred and fifty years of history, I could at least accept responsibility at a personal level for remedying this in the present. I did not know clearly how that would translate into practice at that stage.

Against this background I took on completion of the hand-book. At the outset I thought in principle I could support its production as potentially part of a wider change. However, I rapidly developed misgivings. For a start, it seemed it had been initiated on the wrong basis. My predecessor was originally from Hawaii and had based this current project on an identical one developed there. He thought the idea could be transplanted to our local setting with very little adaptation. He had enlisted the support in Auckland of the director of a local Pacific Island Education centre, a Samoan with european educational qualifications. This man had

promised to edit the book while my agency had agreed to obtain government funding to employ workers from the different cultural groups to write a section each on their own culture. Funding had been obtained on a non-recurring short-term contract from the Labour Department, under a scheme to support unemployed people to re-skill in order to return to paid employment. My job was to recruit the workers and support and resource them in collecting the data and writing up. The job of the Director was to edit the work on completion and publish it, using the resources of his centre.

I immediately saw problems with this. There had been no consultation with the various cultural groups who were going to be represented in the book and I worried about how it would be received and whether they would have a sense of ownership over the information presented. I also knew that the education centre was held in suspicion by most cultural groups. The director was Samoan and was seen to favour his own people over other pacific groups, so this mitigated even further against any eventual broad acceptance of the hand-book. Even within his own people, he was not seen as widely representing them. He was a western trained anthropologist, not someone who held leadership by virtue of tribal or church position.

There appeared to be no planning for involving the indigenous Maori people who I believed ought to have the major role in this. They were the 'host culture', they were by far the largest and most complex group with many different tribes, and were most in need in terms of health and welfare problems. With this in mind I set about finding out who the leaders were in the local communities. This was easy enough for some of the smaller pacific island groups who had formed relatively cohesive urban communities since arriving in Auckland over the last twenty years. It was much less easy for the Maori people. They had been a rural people who had drifted into the cities as rural employment and housing had dwindled over the last fifty years. As a result they were alienated from their tribes which were linked to specific geographical areas. Their historical inter-tribal rivalry and conflict mitigated against them reforming into cohesive urban communities. They were also isolated from extended family structures which were part of the bedrock of their identity and well-being. The tribes which were historically connected to the land around the Auckland region had fared worst through the last century and it was many of their people who were over-represented among welfare recipients and occupants of local prisons, psychiatric hospitals and children's' homes. I had to turn not to tribal leaders, but to those individuals, such as Maori welfare workers, who had assumed leadership in the city by being spokespersons for the most disadvantaged groups. I knew of one such person already and turned to him as a support and as someone who could locate researchers on behalf of local Maori people. He nominated his niece.

I started with a small group of people, one Maori and several from the different Pacific Islands. Immediately there were difficulties. There were problems with written literacy as all came from oral cultures. They did not gel as a group because of cultural rivalries so I worked with them individually. They had different senses of priority and time and so it was hard to retain regular contact with them within my time frame. I believed that if the product was to be owned by them, then I had to respect cultural difference and go with the process by which they seemed to work. Privately, I was unsure what the outcome would be, but as I had accepted the task and had embarked on it this particular way then I had to follow it to its natural conclusion.

Shortly after we began, I was approached by the Director of the Pacific Islands Education Centre. He wanted to know what progress I was making and wanted to suggest people he knew who could write the book. He did not envisage that the Maori people should have any greater space than the other pacific groups. I told him of my views and of what I had done so far. If the people he wished to recommend had the confidence of their own people then I would be happy to employ them.

The director then told me I was "foolish" and there was no way that I would ever get the book published under those conditions. Furthermore, the Maori people had had their chance in this society and had "blown it" because they were "lazy". It was now the turn of the Samoan people and they would succeed and take their rightful place as the strongest group. It was

they who would succeed in educating their children and get the jobs and take leading roles in business. I was taken aback - I knew of tensions between the two peoples but had never heard it stated so baldly. I thoroughly disagreed. He said I would fail in producing the hand-book because I would find no one who was capable of writing it. I partly suspected he was right but was absolutely clear in my mind that unless we started from a basis of consultation, the end product would be useless. We parted on unhappy terms but I was convinced I had to do it according to the principles I had started with. I kept my employers informed about developments and fortunately they were able to support what I was trying to achieve.

Concerned about the director's attitude and the effect it may have on the project, I sought guidance from the Maori leader and he contacted others in his network. I met with them and faced their anger that they had not been told of the existence of the book at the very outset of its inception. In particular, they believed as 'people of the land' that they should be exercising leadership over any such project. Eventually, they arrived at a solution. 'Leave him to us, if he causes any fuss, we will deal with him! Let him take charge of the Pacific Island chapters if he insists.'

I proceeded with the project, but inevitably it ground to a halt. Two chapters had been completed about small island groups but I had lost contact altogether with the Samoan and Maori researchers. After discussion with the two remaining researchers we agreed they should seek guidance from their community and I would do what I could to assist. So while I had failed to meet the original agenda of my employers in providing a hand-book for which they could take credit, I felt I had done all I could to maximise the involvement of the different groups. At the same time I felt I had also honoured as far as I could at a personal level the Maori regaining sovereignty over their own culture. I was sad at how fragmented they had become.

Six months later, the young Maori researcher came to visit me. She explained she had been ill for a long time, ending up in hospital with a mysterious illness for which there had been no clear diagnosis. After many weeks in hospital, she had received a visit one night from an old Maori man, a stranger to her. He told her that the knowledge she had been collecting for the book was sacred knowledge and should be kept secret from the pakeha lest their people lose even more of their 'Mana' (roughly equivalent to power, status or prestige, in both a social and a spiritual sense). She was shaken by this, particularly when upon asking the nursing staff about her visitor was told no such person had been there. She realised it was a vision and that she had met one of her ancestors. She shortly became well enough to leave hospital and was now letting me know that she would no longer be working on the book. From now on she was to live with her grandmother up north and learn the old ways of healing. I was very moved by her story and felt this outcome alone vindicated the process we had gone through.

Lessons taken from this experience.

There were many occasions during this experience when I felt out of my depth and unsure of what to do. It was like taking a journey blind folded. I felt bruised by tripping over the multiple and conflicting expectations I perceived from different groups. I wished to help with a product which gave everybody a voice, but I also wished to honour what I had heard the Maori asking for. I believed strongly in the 'truth' that the Maori people must be allowed to take control over their own destiny and that provided me with the strength to continue in the face of criticism and possible lack of success in terms of my own culture. To do otherwise would have compromised my own integrity and made it hard to live with myself.

I learned of the difficulty in coming into projects without being in on the beginning, and so having to work with agendas and expectations I had not taken part in negotiating. I learned also that there were many 'realities' at work of which I was only dimly aware. This necessitated 'letting go' in a way which I might not have been so willing to do within my own culture.

Most poignantly, I realised how, in the process of wishing to support a marginalised young woman, I had inadvertently placed her in a position of dissonance with her own culture.

Fortunately, I believed the outcome was positive for her. I was later to learn more about the role of gender among Maori people. It was not the place of women to speak on behalf of their culture!

Finally, the metaphorical communication to me of the young woman's story was that my role as a pakeha was not to find out more about the Maori culture. That could only happen when they had regained their knowledge and spirituality and could give it to me from a position of strength. I was left with two voices echoing : the Director's 'The Maori have had their day and have blown it'; and the radical Maori Sovereignty group's 'We must regain sovereignty over our land and our culture or else we die'.

Going with the chaos

This third story follows from the last, but three years on in time. It is about 'knowing' yet 'not knowing'. It is about following what I believed was 'right' but at the same time taking risks through participating in events in which I lost my sense of moment to moment purpose, leaving me wondering about the effectiveness of what I was doing. It is about 'hanging in' without knowing what was going to emerge. It is also about discovering that dialogue contains different meanings for the different participants.

I will take some time sketching the background to this story because the wider social context in which it occurred is important to the understanding of my experiences. Over the intervening years since the 'Cross-cultural Hand-book', I had become progressively more involved with the radical Maori groups who were pushing for change within health and welfare services. They were either workers themselves or members of 'watch dog' groups, monitoring and commenting on the institutional racism inherent in services as they saw it. This involvement was sometimes invited, sometimes uninvited. On several occasions I had sought their support for changes I was seeking within services for which I was responsible - to advise on appointments of Maori workers, or to run an institutional racism awareness workshop for the staff.

On other occasions it was uninvited. They would turn up unexpectedly at various sites within the city, as a small group, to challenge a particular incident or decision which they saw as being detrimental to their people. This was not a tightly organised cohesive group, but rather a network with a loose and changing membership organised around a small core of key individuals. On several occasions the services I was a part of received such visits. Sometimes the challenges seemed just to me, at other times not. However, I was beginning to learn how difficult it was to create a space in an organisation for Maori workers and clients when that organisation had been originally conceived and set up on Pakeha principles, assumptions and inter-personal processes.

In parallel with these developments, Jan had been working with the Maori people in her own organisation. At that time she was Director of Nursing Services for a large metropolitan mental health service, comprising a wide range of hospital and community services. She had initiated a process of extensive consultation with Maori people in Auckland which resulted in the formation of a Maori Advisory Group. This group appointed a co-ordinator who, with Jan's facilitation and support, developed a Maori Assessment Unit within the main psychiatric hospital (the one in which I had previously worked).

The role of the unit was to provide a cultural assessment of all Maori patients admitted to the hospital and was intended to complement the existing service provided. In addition to the co-ordinator, it was staffed by several Maori nurses from elsewhere in the hospital together with non-professional Maori people from the community. Their assessment attempted to understand presenting mental health problems in the context of their own culture, language, extended family and tribal structures and relationships, and spirituality.

I got to know the staff in the Maori unit through participating in the consultation process which led up to its inception, and through continued informal contact after it opened. There were

many teething troubles as the unit and the hospital attempted to find a way of coupling together. The difficulties were not only due to culture but also due to a closed institution being challenged to accommodate to the informal practices of groups of people from the surrounding community. For example, hospital routines did not meet the needs of visiting families who came from far away and needed to be provided with accommodation over several days so that they could participate in the assessment.

There were many cycles of reciprocal challenges, accommodation and adaptation, followed by further friction and challenge, and so on. I dropped in informally whenever I could to give moral support and to also support pakeha professional colleagues who had perhaps tried to find ways of interacting with the unit and had been stung by the 'straight talking' they had received. I had been on the receiving end myself and knew they needed support as well as challenge. I also knew that Jan was standing in the middle of this, trying to support the unit and at the same time trying to support her organisation in managing the change. A brief visit to the unit to say 'hello' sometimes extended to several hours when the staff would ask me to stay and eat with them, or take part in discussions with patients and families with whom they were working. Although I felt I had much to learn from them I realised they were also interested in learning from me.

The vital part of this story came with an invitation from the Maori people to work formally with them. It came at a time of crisis. Jan and senior colleagues had been working over the last year to close and de-commission a special forensic hospital nearby which housed psychiatric patients who had come from the prisons. By this time, all of these forensic patients had been carefully assessed and re-located in various other hospitals or mental health settings according to their needs and according to the varying degrees of risk they posed to themselves and the public. All that remained was a group of about twelve men who required a special environment in which they could develop more appropriate social and living skills in order to survive outside a less secure environment. They were all detained under special sections of the mental health act for people who had committed crimes but were also thought to have mental illnesses or mental handicap contributing to some presumed diminishing of personal responsibility. Within the setting of the old forensic service these men had demonstrated disruptive, violent and sometimes bizarre behaviour and were seen as very difficult to work with and manage. A significant number had committed sexual crimes and one had committed murder.

The plan had been to move this group of patients into a purpose-built building on the hospital site. At the last minute, the health service unions went on strike and refused to work with this group. This created a very difficult dilemma for health managers and the Health Authority as the patients could not continue to stay in their original building which was inadequate and due for demolition. At this point, the Maori Unit stepped in. They reasoned that as nearly all the patients were Maori, it should be their responsibility to look after them. This offer was indeed inspired by genuine caring and concern, but it also contained other agendas: extending their influence for Maori psychiatric patients; and moving to large premises and gaining more resources, for example. In turn, the acceptance of this offer by the governing Health Authority also contained a mix of agendas, including the breaking of the strike. There were wider and complex political agendas at play also, connected with closures of hospitals, changing working conditions, conflict over provision of psychiatric services to prisoners, and so on. This group of men connected with all of these.

At this point I need to introduce something of the character of the Maori co-ordinator as she was central to the service. Titiwhai was a complex person. She was a passionate advocate of her people who would challenge fiercely and unhesitatingly if she felt compromised or blocked in her purpose. She spoke the 'truth' as she saw it if she felt the situation required it, passionately and sometimes recklessly, irrespective of the risk to her reputation. She came from one of the few tribes which allowed women equal speaking rights in their protocol for formal occasions. She assumed this right in all formal settings, independent of which tribe was hosting the event. She was offended by the sexism she saw in much of her culture's practices, but at the same time fought to claim her culture's rightful place in the contemporary world. Equally she was very compassionate with people she saw as vulnerable. She was also

supportive and welcoming of anyone she saw as genuinely trying understand her cause. And often she was very vulnerable herself as she contemplated the enormity of what she was trying to achieve. She was well known as a radical and inspired strong reactions either way, from Pakeha and Maori alike. Such reactions mirrored the increasing split in New Zealand society over the Maori sovereignty issue.

For the purposes of my story, what matters is that the patients were moved into the new building and the Maori Unit took responsibility for caring for them. This required two things to happen quickly. Firstly, an increase in Maori staff numbers, and secondly the formation of a small group of Pakeha health professionals to provide support. The first was solved by Titiwhai getting together a group of young men from where ever she could at short notice. They all had inevitably been unemployed, some had been in prison themselves, and all but a few had been alienated to varying degrees from their own culture and language. But in the circumstances at the time, this was the only pool of people Titiwhai could draw from.

The second was solved by Jan and members of the Health Authority Executive negotiating with medical and nursing staff within the hospital who were not part of the unions involved in the strike. A consultant psychiatrist and several senior nurses offered to provide support. The Maori staff were accepting of this offer but wanted a psychologist. None came forward from within the hospital, so they asked me to work with them.

This placed me in a dilemma. I could not see how I could easily do this from my current job. Although by now I was back in the statutory mental health services run by the Health Authority, I was in an entirely different sector. I was acting head of psychology services to a large general hospital (which also contained a psychiatric wing attached to the local university), and to specialist child and adolescent mental health services for the Auckland area. On the other hand I felt that the Maori unit had placed themselves in a very vulnerable position as they could not deal with this very challenging group of patients without professional and moral support. I had been powerfully influenced by the work I had seen them do so far, but there was a naïveté about their analysis of professional politics in health which rendered them vulnerable to sometimes unnecessary conflict with the 'status quo'. I wanted to work with them to help the venture succeed and allow the fragile beginnings of an alternative mental health service for Maori people to survive and grow.

After rapid but extensive negotiations I arrived at the new unit to work part-time for a six month period. I felt I had gained the support of my psychology colleagues in my own service, together with that of the Executive group of the Health Authority. But others in my service were less understanding and supportive and thought I was "committing professional suicide". One colleague, a doctor, saw me as making a self-interested career move into becoming an expert in "cross-cultural psychiatry". I was unclear about what the future would hold and felt vulnerable about leaving junior psychologist colleagues less supported in their work than I felt happy with. But on balance I felt this was the 'right' thing for me to be doing in relation to the future of health services.

The philosophical basis for the new unit, called the Whare Paia ('House which makes well'), was that of a partnership under the Treaty of Waitangi. This treaty was signed by the Maori over a century ago in the belief that they were signing governance of their land over to Queen Victoria and her government, but retaining sovereignty for themselves. The radical Maori movement wished the treaty to be honoured in the original spirit in which they had signed it. In practice for the Whare Paia, this meant that the day to day care of the patients would be the responsibility of the Maori people within the context of their own cultural beliefs and practices. This care was to be supported by the team of pakeha professionals, who would provide guidance over the need for european nursing care, medical treatments, and psychological interventions. Together we would share the decision-making.

This is how I came to spend the next year immersed in a bewildering kaleidoscope of changing time frames, values and realities. It is hard to know which aspects of this kaleidoscope to present here in writing, but I will attempt to capture the essence of it for my purposes in as brief a way as possible.

Titiwhai assumed a very strong and charismatic leadership with the Maori staff. First and foremost, they refused to see any of the patients as mentally ill. They either had "sickness of the spirit" or alternatively they were "being naughty" The patients were given straight and uncompromising messages: "We will treat you like men, and expect you to behave like men". Violence or aggressive behaviour was also dealt with uncompromisingly: "We will never throw the first punch, but if you hit us we will hit you back". This in fact happened, but what was very interesting to me was how they then dealt with the aftermath. Two or three would sit in close physical contact with the patient, holding him, stroking him, talking to him. This would go on for as long as twenty four hours and he would not be left alone until it was resolved.

Titiwhai pushed toward normalising patients in every aspect of their lives. This meant visits out to local swimming pools; use of the hospital gymnasium and other recreational and leisure facilities; visits home to families; ensuring they were appropriately dressed and groomed; cooking their own meals; and participating in any meeting or gatherings in the unit where a large room was set up as a traditional meeting house and where traditional protocol held sway.

This placed many demands on the young staff, many of whom were as alienated from their own culture as they were from that of the Pakeha. Many faced problems in their own lives which surfaced in their work. They were supported to some extent by a small number of the male elders from the advisory group, but many of these elders were as conspicuous by their absence as the few were by their presence. There were jealousies and tensions within the group, and although they had corporately selected Titiwhai, many of the men believed it should have been a man leading the Whare Paia.

The push for normalisation and for the resources to support this created much conflict and friction with the wider hospital culture. Many hospital staff had previously seen these patients as highly dependent, dangerous and needing institutional care. They were unwilling to accommodate to their change in status. Similarly, giving patients more freedom, even if closely monitored, required a change in their status under the Mental Health Act. To achieve this required the consent of central government Health department officials and so cases had to be made for this by the pakeha professionals.

So, where did we fit in? For myself, I became unsure what role I was playing. I 'mucked in' according to what seemed needed on a day to day basis. Sometimes I washed and shaved several physically disabled patients, played volley ball, accompanied the group on outings, helped with meals. At other times I spent hours with angry pakeha colleagues from the hospital who had felt affronted by the behaviour of Titiwhai and her staff in advocating for the patients. I made myself available to talk through with them and offer perspectives on what the Maori staff were trying to achieve, and where they were 'coming from'. This was not always accepted. At other times I played 'go-between', translating back and forth between the two cultures, explaining each to the other when it seemed possible to achieve conciliation.

However, there were times when the Maori staff would not settle for this and insisted on confrontation. I sat through some meetings with my heart in my mouth, not knowing what would be said or how events would turn out. Their challenges could be incredibly confrontational and sometimes the tension was almost more than I could bear. I was often confused about the meta-communications. Theirs is a culture based on oratory and so verbal interchanges held many complexities which were not immediately apparent to me. Did they mean what they said, or were they just establishing a position, or both? The culture was historically predicated on 'men as warriors' where warfare was highly ritualised and seen as a spiritual activity. Was this what I was seeing played out in those meetings?

Sometimes my values were affronted by the way they would use violence, yet I could not gainsay the results as over a six month period the level of violent and aggressive behaviour from the patients dropped by a truly remarkable level. Power-over or empowerment? I had long discussions about the extent to which I was prepared to support them and where my personal limits lay.

As the Maori staff got to know the patients better, they were more willing to hear the views of the pakeha professionals - that some patients could not achieve what they were asking of them because of neurological, educational, intellectual and mental illness factors. "Yes", we agreed, "many can be seen as naughty, but some are also disabled by other factors".

As we got to know each other better, I heard of some of the pain in the lives of the young staff and how the work was stressing them. Arthur was Titiwhai's son and took over leadership with the young men. He was many people - a proud orator, a warrior, and a healer. Yet he was a very wounded young man too and there were many stories hinted at but untold about past shames in his family and tribe. His marriage was under stress as he spent days and nights on end in the unit making it work. He started drinking and became violent to his wife. I felt helpless as I watched this and made myself available to him whenever we were there together. Sometimes we would talk directly about himself and his problems. Sometimes we would share life stories, but most often we would talk about problems to do with the work at hand. I would offer my perspectives from a pakeha point of view. I felt very close to him yet very distant.

There were times when I stayed for several days and nights on end to relieve the staff or to fill in when someone did not turn up for work. I became disoriented in moving between this world and that of my own professional world, trying to keep up my commitment to one or two days per week in my original role in the other service. I lost track of time as the familiar markers were no longer present.

The spiritual work was done by the visiting elders and Titiwhai, and often patients would be taken back to their tribal land to resolve issues arising out of transgressions of the 'tapu' or the sacred. This work was not visible to us as pakeha, but we would hear of the outcomes and learn of very harrowing tales which had never been, or could never be, resolved because of irreparable changes in their social and cultural fabric. It was clear that sacred knowledge was now a precious resource held by the few and not to be given to the pakeha. This was their work, not ours.

The making of decisions became problematic for me. I could not make out how decisions were arrived at. On one occasion I became angry because it appeared a decision had been made on an issue about which I felt strongly. I did not feel I had been in on the decision and said as much. The reply came back: "But David, you have. We have listened to everything you have said and taken it into account" I then reflected on that. It was true, the issue had been around for a while, it had been aired in meetings and people had given their views. It was true, I could recognise my viewpoint implicit in the decision. But I could not find out how a decision had been arrived at. No one could offer an explanation at the time. I learned gradually that it seemed to be an intuitive and implicit process. Sometimes it appeared that a decision had been made, then at a later point it appeared as if it had not.

There was increasing interest from the wider world in what was happening in the Whare Paia, not all kindly or well meant. There were many critics from both races who made much of any incident which could be interpreted as evidence of mistakes or poor practice. As time went on, the Maori staff relied increasingly on the small group of pakeha supporters to provide a buffer against pakeha challenges to the unit. This was not always possible.

The more I became involved, the more admiring I became about what they had achieved, and the more appalled I was at the shaky foundations on which they stood as I learned of how divided they were against themselves. I became both more connected to them and at the same time more alienated, as I recognised ways in which our cultures were so fundamentally different. I simultaneously became more alienated from my own culture while at the same time recognising the need to connect more with it at a fundamental level. I did not know how to resolve the paradox except to leave. I had done as much as I could and they needed to learn to fly themselves. Jan had been a fellow traveller but in a more public and vulnerable way as a manager in the organisation trying to meet the needs of both cultures. We both needed to leave

Lessons taken from this experience.

For much of the time in the Whare Paia, I could not account for what I was doing as a Psychologist. I was not using my professional skills in the way I had been used to doing, within the formal structure of therapy sessions, teaching, supervision, service planning, administration and so on. There were many times I wondered if I was being useful at all. I just seemed to 'be around' and 'spend time with' people. Occasionally I would use formal skills, but not often. Yet I knew that they valued having me there, even though at times it felt it was only as a road-block against my own culture or as an extra pair of hands.

So I was taken by surprise when on leaving they told me of the things I had done for them that I had not been aware of. One of Arthur's comments stayed with me. "You taught me a lot about how groups worked and that helped me understand what was happening." I had not been aware in any way of transmitting this to Arthur. We had never discussed groups or group dynamics and this had not been a conscious intention of mine.

I had no language to describe to pakeha professional outside the small group of us in the Whare Paia what I was doing there as a Psychologist. Even within the group, we did not develop a common language. We were all there for different reasons with different values about what was happening. I could only account for what I was doing in terms of social justice and some deep personal connection. I felt isolated and out on a limb. I had moved away from my professional base and it would have been very difficult to return back to it in the form of my existing job. All I knew was that I needed distance and time in order to make sense.

This is a very difficult story for me to tell, to do it justice and yet not let it crowd this research account. Eight years on I can still feel strong emotions which have no name but feel like grief, love, pain, welling up as I write. Jan and I left New Zealand immediately to come to England. We left for many reasons and it had always been something we planned to do. The particular timing was influenced by our exhaustion and by a strong feeling that the Whare Paia had made a start and now needed to see if it could survive on its merits. It is still functioning.

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Summary.

In some fundamental ways these stories informed the research. For me they demonstrated the increasing importance I placed on the social context in which I worked and the questions this raised about creating conditions for renewal and change. They also represented an increasing isolation and movement away from my professional roots as a Clinical Psychologist and my own cultural base, leading to me feeling out on a limb. They contained the seeds of seeking a place to belong; to stay around for a while and see things through over a longer time; to see if there was a more comfortable relationship possible with Psychology; to account for what it is I do and see if there is a language for it; and to find room for the personal.

The stories also contain the seeds of what I was to confront later in the research. In the first two stories there are issues about my coming into situations and wishing to change practices when the socially shared 'frames' governing the meanings of events have already been established. In the first story the competing frames are professional ones, in the second they are more broadly cultural. There are dilemmas about the degree to which change is possible without either introducing new frames for negotiating meaning at the outset, or alternatively accepting the initial frames and working to introduce or create new ones over the course of time. Within the second and third stories there are dilemmas about accepting the different world views of others and seeking to work within them, but needing to 'let go' and cope with the consequences. The challenge then becomes one of staying within one's own sense of what is ethical or 'authentic'.

Associated with the issue of 'meaning frames' or 'world view s' (either professional or cultural) are the issues of knowledge and power and how these are both exercised in and structured by the relationships and social practices in which individuals participate. These issues arise throughout the research and my dealing, or not dealing, with them becomes one of the narrative threads throughout the remainder of this research text.

Returning to my account of the journey, I needed to explore the research field further and gain some ideas about research methodology which would carry such questions and issues and enable me to find a starting point. In the next chapter I will take some time outlining the ideas which most appealed about theory and methodology and which came from my reading and from seminars and discussion at Bath in those early days.