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**Te mana o te wāhine:**  
**Māori women's experiences of mental health services in New Zealand**

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Tainui, Ngāti Maniapoto, Ngāti Mahuta, Ngāti Hari, Ngāti Pou

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## Abstract

This research examines the lived experiences of Māori women who had engaged in recent years with mental health services in New Zealand. This research heard the stories of 12 Wāhine Māori (Māori women) using semi-structured qualitative interviews to allow participants to share their unique experiences.

A thematic analysis was used to identify categories and themes that represented participants' experiences before, during, and after using mental health services. Participants made sense of their mental health problems as a response to violence and harassment at the hands of men, difficulties with roles as wāhine (women), and struggles with their cultural identity. Participants described how they managed before engaging with mental health services by continuing in the face of adversity and relying on whānau (family) support. Participants shared their reasons for delaying contact with mental health services, including that it was hard to ask for help, they did not know or trust mental health services, and they engaged only in a crisis. They highlighted important factors in building a relationship with mental health services, including building a genuine relationship, finding understanding, being able to trust professionals to maintain confidentiality, not feeling pressured, looking for acknowledgement, and looking for familiarity. Participants also described seeking help outside of mental health services by going back to whānau support, and seeking Māori healing outside of mental health services. Finally, participants gave their own recommendations for improving mental health services, such as coming to meet people halfway, seeking more Māori professionals, healing, and worldviews, and moving toward collective support.

Key findings in this research highlight the need to acknowledge mental health problems as an understandable response to difficult life experiences, the mana (strength) and tapu (sacredness) of Wāhine Māori, and the struggles Māori may face in relation to their own cultural identity. This research also highlights the value of whānau support for tāngata whaiora (service users), the importance of whakawhanaungatanga (establishing relationships) and familiarity, the importance of cultural competency in mental health services, and the general need for increasingly more Māori input, professionals, methods of healing, and worldviews offered within mental health services in New Zealand.

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*My success and strength is not mine alone, but that of many.*

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**Whāia te iti kahurangi ki te tūohu koe me he maunga teitei.**

*Pursue excellence – should you stumble, let it be to a lofty mountain.*

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## Glossary of Māori Words

*Readers may refer to this glossary for assistance with Māori words*

*Additional translations have also been noted throughout the thesis to enhance readability*

<b>Atua wāhine</b>	Goddesses
<b>Hā a koro ma, a kui ma</b>	The breath of life from ancestors
<b>Haka</b>	A specific cultural dance, vigorous dances with actions and rhythmically shouted words
<b>Hapu</b>	Sub-tribe, pregnant
<b>Hei konā</b>	See you soon
<b>Hineahuone</b>	The First Woman
<b>Hinengaro</b>	Mind
<b>Hinenuitepō</b>	Goddess of Death
<b>Hinetītama</b>	First Daughter of Hineahuone and Tāne
<b>Hinu</b>	Oil/fat
<b>Iwi</b>	Tribe
<b>Kai</b>	Food
<b>Kaitiaki</b>	Guardians
<b>Kaka</b>	Shit (slang)
<b>Kanohi kitea</b>	The known face, having familiar faces around
<b>Kanohi ki te kanohi</b>	Face to face
<b>Kapa haka</b>	Traditional song and dance
<b>Karakia</b>	Prayer
<b>Karanga</b>	To summon, call out
<b>Kaumatua</b>	Male elder
<b>Kaupapa</b>	Topic or agenda
<b>Kaupapa Māori</b>	Māori approach, topic, or agenda
<b>Ko te ahua nei</b>	As it would appear
<b>Koha</b>	Gift, offering, or donation
<b>Kohanga reo</b>	Māori language preschools



<b>Kuia</b>	Female elder
<b>Mahi</b>	Work
<b>Mana</b>	Strength
<b>Mana ake</b>	The unique identity of the individual and their family
<b>Manuhiri</b>	Visitors
<b>Mauri</b>	The life force in people and objects
<b>Mihimihi</b>	Speech of greeting
<b>Mirimiri</b>	Māori (healing) massage
<b>Mōteatea</b>	Traditional chants
<b>Pākehā</b>	New Zealander of European descent
<b>Papatūānuku</b>	Mother Earth
<b>Pēpe</b>	Baby
<b>Pōwhiri</b>	To welcome, rituals of encounter
<b>Raruraru</b>	Problem or dispute
<b>Rongoā</b>	Traditional Māori medicines
<b>Taha tinana</b>	Physical health
<b>Tāngata whaiora</b>	Mental health service users (Māori)
<b>Tāngata whenua</b>	People of the land
<b>Taonga</b>	Treasures, gifts
<b>Tapu</b>	Sacredness
<b>Te Reo Māori</b>	The Māori language
<b>Te Taha Hinengaro</b>	Mental health
<b>Te Taha Tinana</b>	Health in the bodily dimension
<b>Te Taha Wairua</b>	Health in the spiritual dimension
<b>Te Taha Whānau</b>	Health in the family dimension
<b>Te Tiriti o Waitangi</b>	The Treaty of Waitangi, founding document of New Zealand
<b>Te whānau</b>	The family
<b>Te Whare Tapa Whā</b>	The four walls of the house – The four cornerstones of Māori health

<b>Te Wheke</b>	The octopus
<b>Te Whetu</b>	The star
<b>Tikanga</b>	Correct procedure or custom
<b>Tinana</b>	Body
<b>Tuākana</b>	Older sibling, mentor
<b>Tūpuna</b>	Ancestors
<b>Tūpuna wāhine</b>	Female ancestors
<b>Wāhine Māori</b>	Māori women
<b>Wahine Māori</b>	Māori woman
<b>Waiata</b>	Song
<b>Waiora</b>	Health, soundness
<b>Wairua</b>	Spirit or spiritual
<b>Wairuatanga</b>	Spirituality
<b>Whakamā</b>	Feeling of shame
<b>Whakanoa</b>	Removing tapu or sacredness
<b>Whakapapa</b>	Genealogy
<b>Whakawhanaungatanga</b>	Establishing relationships
<b>Whānau</b>	Family, extended family
<b>Whanaunga</b>	Relative/Family member
<b>Whanaungatanga</b>	Extended family
<b>Wharekai</b>	Dining hall
<b>Wharenui</b>	Meeting house
<b>Whatumanawa</b>	An open and healthy expression of emotion
<b>Whenua</b>	Land, placenta

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## **CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW**

The purpose of this research is to highlight Māori women's experiences of mental health services in New Zealand, from the beginning of the difficulties that lead them to engage with services, through to their experiences with mental health services, and their ideas to improve mental health services in the future. It focuses on how Māori women make sense of mental health problems, how they manage mental health problems, why they delay contact with mental health services, how they build a relationship with mental health services, support they seek outside of mental health services, and their recommendations to improve mental health services in the future. The intent of this research was to give voice to the stories and unique experiences of participants as users of mental health services in New Zealand. It aims to highlight these experiences and give voice to their recommendations to improve mental health services. Although the primary objective of my research is to understand these women's experiences, it is hoped that my investigation into these experiences may also provide vital information needed to improve mental health service provision for Māori women.

My own position as a Māori woman, a clinical psychology student and a feminist have all helped to shape my approach to this research. I will consider my own position and its implications for the research in more detail in the methodology chapter.

In reviewing the literature that informs my research topic, I will first briefly discuss mainstream definitions of mental health and mental health services. I will then move into a more critical discussion of user perspectives on mental health and mental

health services. Next, I will look at Māori mental health and mental health services, including incidence of mental health problems, models for understanding mental health problems, and engagement with mental health services. I will then look at women's mental health and mental health services, before considering the intersectionality of Māori women's mental health and mental health services.

### **Mainstream definitions of mental health and mental health services**

In this section I first briefly present some statistics on mental health problems, arguing that mental health is considered a concern worldwide, in New Zealand, and particularly for marginalised groups, such as Māori and women. I then explore dominant Western definitions and discourses of mental health, and consider critiques and developments in these over time.

The World Health Organisation (WHO) reports that mental health problems are a prevalent and growing problem across the world. In a 2001 global report, the WHO provide statistics suggesting that over 450 million people worldwide suffer from mental health problems (WHO, 2001). In their 2016 depression fact sheet, they also provide statistics highlighting the impact of mental health problems. Combined with substance use disorders, mental health problems are the leading cause of disabilities worldwide. Worldwide, 800 000 people commit suicide each year, and suicide is the leading cause of the death in 15 to 29 year olds. The WHO also report that mental health problems increase risk factors for other diseases and illnesses (WHO, 2016a). Depression, for example, is often comorbid with that of other chronic physical health conditions, and can result in worse health outcomes overall (Moussavi et al., 2007). The WHO also argue that those with mental health problems also suffer from stigma, discrimination, and human rights violations (WHO, 2016b).

Mental health is clearly recognised as a pressing issue worldwide, and local researchers and policy makers also argue that it is a significant problem in New Zealand. Data from Te Rau Hinengaro, which is still the most recent, comprehensive New Zealand Mental Health Survey, suggests that about 40% of New Zealanders will meet criteria for a mental disorder at some time in their lives (Oakley Browne, Wells, Scott, & McGee, 2006). Data from the Ministry of Health suggests that since the 1980s, New Zealand has consistently had one of the highest youth suicide rates (especially for young men) in the Organisation for Economic Co-operation and Development or OECD (Ministry of Health, 2015). The New Zealand Mental Health Survey also suggests that the prevalence of disorders in the 12 months prior to the survey was higher in younger people, people with less education, people with less income, and people living in more deprived areas (Oakley Browne, Wells, Scott, & McGee, 2006). Thus, there appear to be groups of people who are disproportionately affected by mental health problems.

Although mental health has the potential to affect people from all walks of life, marginalised groups are particularly vulnerable. In New Zealand, for example, mental health problems are understood to affect Māori, the Indigenous people, significantly and disproportionately. Data from the Ministry of Health suggests that the Māori suicide rate was similar to the non-Māori rate up until the mid-1990s, after which Māori suicide rates were consistently greater than non-Māori, and this was the case for both male and female Māori suicide rates. This report also notes that this relatively higher suicide rate for Māori is similar to the relationship between Indigenous or First Nations groups and the majority populations in both the USA and Australia (Ministry of Health, 2015). The New Zealand Mental Health Survey, Te Rau Hinengaro, provides data that suggests Māori have a higher likelihood of meeting criteria for a mental disorder at



some time in their lives, with anxiety disorders and mood disorders most common. The survey also indicates that Māori have a higher prevalence of disorders (though these differences are reduced after adjustment for sociodemographic correlates), and are less likely than other groups to access mental health services when severity is taken into account (Oakley Browne, Wells, Scott, & McGee, 2006). Overall, data from New Zealand suggests that mental health problems are of particular concern for Māori. In order to begin to look at why this might be the case, I next consider how mental health might be defined.

Western definitions of mental health tend to be dominant in university trainings and amongst service providers (Kirmayer, 2006; Kleinman, 1977). The Western discourse of mental health: the psychiatric model, has been criticised in numerous ways. It has often been criticised for having a biomedical focus (Engel, 1980). Critics have argued that it tends to ignore the psychological and social aspects of mental health and portrays a narrow view of mental health, and what it means to be mentally healthy. Having come from a medical model, it is also said to be a model of illness; focusing only on when people are ill, and not when they are well (Pilgram & Bentall, 1999; Lilja & Hellzén, 2008; Lacasse, 2013; Deacon & Cleary, 2013). This is evident in the Diagnostic and Statistical Manual (American Psychiatric Association, 2013, 2000, 1994, 1987, 1980, 1968, 1952), which, despite decades of criticism, appears to become more biomedical in its approach as it is revised (Lafrance & McKenzie-Mohr, 2013; Lacasse, 2013). Diagnostic tools like the DSM-5 are set within a realist epistemology of standardised diagnostic criteria, and have been criticised as being a “professional reification about human misery, not a fact” (Pilgram & Bentall, 1999, p. 271).

Some groups, like psychologists, have typically adopted an approach which is more sensitive to social and psychological issues, such as the biopsychosocial model

(Engel, 1980). The WHO also appear to support a broader definition of mental health which acknowledges both social and psychological factors, and claim that “multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time” (WHO, 2016b, para 5). The WHO reportedly recognise that "persistent socio-economic pressures" (WHO, 2016b, para 5), including poverty, along with "rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations" can all affect mental health (WHO, 2016b, para 6). The WHO define health in general as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2014, para 2). The WHO define mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2014, para 1). Given this, mental health is described by the WHO as more nuanced than the absence of mental disorders or disabilities, and seems to imply a good quality of life. However, even the WHO definition of broader health has been criticised for its use of the phrase '**complete** physical, mental and social well-being' because it would render nearly everybody as 'unhealthy' much of the time (Huber et al., 2011). In this way is said to continue to support the pathologisation which is said to be so prominent in the psychiatric model.

The psychiatric model of *treating* mental health problems has also undergone revision as it has been challenged and criticised. It moved away from institutionalisation as the dominant form of intervention in the 1960s, towards de-institutionalisation in the 1970s, and further towards community support in the 1980s (Cohen, 2008). By the 1990s it had shifted to recovery focused service delivery with integrated community support (Anthony, 1993; Cohen, 2008). Additionally, there have been shifts in New

Zealand which have been positive for mental health service users. This includes the development of a Code of Ethics for Psychologists Working in Aotearoa/New Zealand 2002, and the Health Practitioners Competence Assurance Act (HPCA) 2003. The Code of Ethics for Psychologists sets out standards for ethical practice and is based on principles of Respect for the Dignity of Persons and Peoples, Responsible Caring, Integrity in Relationships, and Social Justice and Responsibility to Society. The HPCA seeks to ensure that the public are protected by setting standards for qualifications, competence, and accountability of health professionals, as well as guidelines for complaint procedures should health service users feel these standards have not been upheld. However, despite developments in definitions and treatment models, many would argue that the dominant Western model of mental health has failed to move on from the psychiatric model in a meaningful way.

A product of the dominance of the psychiatric model is that it becomes taken-for-granted as the only definition of mental health (Lafrance & McKenzie-Mohr, 2013). Despite the barriers faced by vulnerable groups, these dominant definitions have not remained uncontested. They have been extensively critiqued, particularly from cultural and gender perspectives (Brown, 2008; Lafrance, 2009). I discuss these criticisms and some alternative definitions of mental health and its treatment below, in regards to service users, Māori, and women.

### **User Perspectives on mental health and mental health services**

In this section, I consider the marginalised position from which service users critique mental health, and present research on perspectives from or on behalf of mental health service users, including challenges to the psychiatric model, and experiences and narratives of mental health service users in general.

Service user research has not always been valued or sought. The WHO acknowledges that mental health service users are a vulnerable group (Chan, 2010). As a vulnerable group, they are affected by mental health problems, yet have traditionally been unable to contribute to defining it. Thornicroft and Tansella argue that service users' perspectives are an essential part of expertise in mental health, and that as a group, service users can make vital contributions and add valuable insights (2005). Listening to service users can reveal how they manage their own mental health problems and this knowledge can be used to develop strategies in services. They can also indicate how relationships between service users and services may be improved (Walsh & Boyle, 2009). Involving service users in decision making helps to provide a service that is more responsive to their needs, and users have a right to be involved in decisions that affect them. Furthermore, there is therapeutic value in being involved in decision making (Hickey & Kipping, 1998).

However, mental health service users' ideas have been less valued because they are not seen as being able to offer a rational opinion. Furthermore, those who are articulate enough to give their opinion have not been considered representative of the majority (Goodwin, Holmes, Newnes & Waltho, 1999). These arguments have been refuted, however, and research indicates that service users' ideas are both rational and representative; while they highlighted a need to exercise caution when generalising, Crawford and Rutter (2009) found that the views of mental health service users do not differ significantly from those of 'ordinary' people.

Despite doubts about the value of service users' views, there still exists a growing body of research that seeks to highlight service user perspectives. While user involvement is not new, incorporating their ideas into mainstream mental health provision is fairly recent, and they have not been quite yet fully realised (Truman &

Raine, 2002). In recent years, service user research has become more popular, and the wealth of knowledge gained from this growing field of research is shaping up into a useful resource for critiquing the psychiatric model. In the United Kingdom, for example, service users have been increasingly given the opportunity to have their voices heard (Barnes & Shardlow, 1997; Peck & Barker, 1997). As a result, mental health service users are beginning to have a greater voice in the running and development of mental health services (Pilgrim & Waldron, 1998; Repper, 2000; Gilbert, Rose & Slade, 2007). However, some have argued that service user involvement has remained as a “rhetoric rather than a reality in many clinical settings”, acknowledged as something that *should* be important but is not often utilised effectively (Borg, Karlsson & Kim, 2009, p. 285).

Research which focuses on incorporating user perspectives into the way we define and treat mental health problems has examined the lived experiences of mental health service users. Although service users do not have a single identifiable definition of mental health, service user research has highlighted some key ideas and critiques which help to frame mental health in a more helpful way. Service user research has highlighted the way that service users take a holistic approach to mental health (Agar-Jacomb & Read, 2009). In this way, they directly challenge the psychiatric model by highlighting the importance of other aspects such as social and psychological factors. In one study participants felt they were seen as a disease (Lilja & Hellzén, 2008). In another, they appreciated being seen as a whole person, and not just the illness (Hodgetts & Wright, 2007). Service users have described how a focus on the psychiatric model meant social and environmental factors were ignored, when acknowledgement and treatment of these areas may have improved their mental health experience (Lovell, 1995). Service users often understood their onset of illness as situational (Koivisto,

Janhonen, & Vaisanen, 2003), with service users in New Zealand sharing understandings of mental health problems that often stemmed from abuse, loss and abandonment (Lapsley, Nikora, & Black, 2002). Broadly, service users seem to make sense of their mental health problems as a response to difficult experiences. Cohen's study on mental health user narratives highlighted family/relationship problems, bereavement, education/work problems, financial problems, and other issues as precipitating factors (Cohen, 2008). Service user research has also challenged the assumptions of the psychiatric model in terms of preferred methods of healing and recovery. As an alternative to psychiatric medication, treatments such as Bach flowers, St John's Wort, massage, relaxation techniques, and spiritual practices are often seen as helpful (Lapsley et al., 2002). The support of family and friends is also seen as meaningful and important in recovery (Koivisto et al., 2003; Lapsley et al., 2002) and some users want family involved as part of formal treatment (Rydon, 2005). This again highlights a service user preference for a holistic approach to mental health; one than the dominant psychiatric model appears to conflict with.

Service user research overwhelmingly appears to highlight the importance of the quality of the relationship between clients and professionals who work in mental health services. In one study, it was thought to be the most important element of good service experiences (Gilburt et al., 2007). In another, building a relationship was considered a treatment in itself (Hopkins, Loeb & Fick, 2009). Feeling understood (Gilburt et al., 2007; Johansson & Eklund, 2003; Nilsson, Svensson, Sandell, & Clinton 2007; Wood & Pistrang, 2004), and being listened to and feeling heard were considered important in the relationship (Agar-Jacomb & Read, 2009; Gilburt et al., 2007; Johansson & Eklund, 2003; Mörtl & Wietershelm, 2008; Nilsson, Svensson, Sandell, & Clinton 2007; Rodgers, 2002; Walsh & Boyle, 2009; Wood & Pistrang, 2004).

Professionals who were caring (Hodgetts & Wright, 2007), empathic (Hodgetts & Wright, 2007; Johansson & Eklund, 2003; Walsh & Boyle, 2009), warm (Hodgetts & Wright, 2007; Johansson & Eklund, 2003), accepting (Hodgetts & Wright, 2007), and non-judgemental and respectful of clients were also appreciated (Agar-Jacomb & Read, 2009; Gilbert et al., 2007; Goodwin et al., 1999; Hodgetts & Wright, 2007; Nilsson, Svensson, Sandell, & Clinton 2007; Rodgers, 2002; Rydon, 2005; Walsh & Boyle, 2009). Developing a trusting relationship was also seen as important (Gilbert et al., 2007; Walsh & Boyle, 2009). For those in therapy, the modality used was less important than these relationship factors (Rodgers, 2002). Service users also appreciated feeling as though they were given the time they needed for treatment, talking, or recovery in general (Goodwin et al., 1999; Johansson & Eklund, 2003; Rodgers, 2002; Walsh & Boyle, 2009). Service users also valued being cared for (Katsakou & Priebe, 2007); they liked staff who were approachable, kind, and noticed when they were upset. However, staff who showed little interest, were dismissive, and ignored them when upset were felt to be unhelpful and made service users feel worse (Goodwin et al., 1999). When professionals took the time to interact with users and build close relationships, making users feel that they were personally interested in them and cared about them, users felt less fear and uncertainty, which they felt helped their recovery significantly (Katsakou & Priebe, 2007).

As a part of building a meaningful relationship, research with service users has also indicated the importance of being treated like a human being (Walsh & Boyle, 2009; Rodgers, 2002). Simply being treated as ‘ordinary people’ by staff meant users felt ‘normal’ and self-confident (Katsakou & Priebe, 2007). They also appreciated staff allowing themselves to be human, sometimes via humour or appropriate self-disclosure

(Agar-Jacomb & Read, 2009; Goodwin et al., 1999; Hodgetts & Wright, 2007; Lilja & Hellzén, 2008; Rydon, 2005; Timulak, 2007).

The research also highlights a desire by mental health service users to participate and be involved in treatment, including being able to make choices and decisions about their treatment. There is a need for control, agency, and autonomy (Agar-Jacomb & Read, 2009; Elstad & Eide, 2009; Goodwin et al., 1999; Katsakou & Priebe, 2007; Lapsley et al., 2002; Rodgers, 2002; Thomas, Wilson & Jones, 2010; Walsh & Boyle, 2009) through an experience that is often alienating and frightening (Lilja & Hellzén, 2008). In one study, when participation in decision-making for treatment was restricted, service users felt like their rights had been taken away, and even felt physically or emotionally coerced at times (Katsakou & Priebe, 2007). When professionals allowed for more freedom and flexibility, as well as participation in treatment planning, users felt respected, which helped with their recovery (Katsakou & Priebe, 2007). Service users want to be listened to, have their views taken seriously, and their expertise and knowledge on their own life recognised (Thomas, Wilson & Jones, 2010). In a complementary way, this also indicates the importance of a lack of feeling coerced or controlled, or feeling like services were pushing their own agenda (Gilburt et al., 2007). In one study, participants felt coercion had a significantly negative effect on being able to build a relationship (Sheehan & Burns, 2011).

The experience of coercion has often been described by mental health service users in regards to medication being forced upon them (Hodgetts & Wright, 2007; Walsh & Boyle, 2009) In particular, service users often express concerns about lack of information and choice about treatment options (Goodwin et al., 1999; Lovell, 1995; Walsh & Boyle, 2009), with medication often being the *only* treatment option given (Katsakou & Priebe, 2007). The majority of studies indicate that service users generally



do not like medication or its side effects (Lapsley et al., 2002; Gilbert et al., 2007; Goodwin et al., 1999) and have voiced concerns that taking medication is incapacitating and isolating (Lapsley et al., 2002). In one study participants expressed feeling as though they were offered pills instead of listening, and felt medication was a repressive form of ‘care’ (Lilja & Hellzén, 2008). However, some research has indicated that service users can view medication both positively and negatively (Kartalova-O’Doherty & Doherty, 2010).

Service user feedback has also highlighted the importance of the environment in mental health services. Overwhelmingly, service user research in inpatient settings has emphasised the importance of feeling safe (Hopkins, Loeb & Fick, 2009; Lovell, 1995; Wood & Pistrang, 2004). Beyond safety, users in general have expressed wanting the environment to have the comforts of home (Gilbert et al., 2007) and be home-like (Agar-Jacomb & Read, 2009).

Somewhat related to a holistic approach, service users have also indicated the importance of cultural competency and cultural responsiveness (Agar-Jacomb & Read, 2009; Gilbert et al., 2007; Hodgetts & Wright, 2007). Users appreciated interacting with staff with the same cultural background, and an approach that acknowledges culture with respect and honour (Hodgetts & Wright, 2007). When racism was experienced, this resulted in both negative interactions and a lack of understanding, which undermined the quality of the relationship (Gilbert et al., 2007).

Lastly, some research with service users has also indicated that identity is important in recovery, and encouragement and fostering of this development by mental health services was appreciated. In one study, participants described their struggle with mental health problems as struggle for identity (Lilja & Hellzén, 2008). In another,

repairing a sense of identity was seen an important to recovery (Katsakou & Priebe, 2007). In New Zealand, identity was also highlighted as important in recovery, including cultural identity and sexual identity (Lapsley et al., 2002).

Overall, service user research appears to highlight the importance of taking a holistic approach to mental health problems and recognising the significance of the social context in which mental health problems occur. The research also emphasises the importance of how services relate to clients, and reaches far beyond the constraints of the psychiatric model of mental health. This body of research is significant because it provides mental health services with clear evidence and guidance on how to improve services from the perspective of service users, which may help to address the worldwide concern of mental illness. This research also demonstrates the value of qualitative research in capturing in detailed accounts of service users' experiences. As these accounts, however, come from service users in general, it is not clear whether the same would be helpful for Māori. Thus, I next examine Māori mental health, and mental health services.

### **Māori mental health and mental health services**

In this section I briefly look at the history of Māori, the incidence of mental health problems in Māori, and possible reasons for this. I then look at Māori models for understanding mental health problems, and consider these in relation to the dominant psychiatric model. Finally, I look at Māori engagement with mental health services, including research on Māori user experiences.

Māori experiences of mental health problems need to be understood in light of their history of colonisation. Like most Indigenous peoples, Māori (the Indigenous people of New Zealand) have experienced a history which is considered to have had

severe impacts on population, loss of land, loss of language and culture, as well as impacts on traditional ways of life. Like other Indigenous groups, Māori experienced rapid population declines because of new diseases brought by settlers, which they did not have immunity to (New Zealand State Services Commission, 2005). Land was dubiously purchased, confiscated, and acquired in the process of settlement, wars, and unjust laws (Ward, 1993). Te Tiriti O Waitangi (The Treaty of Waitangi), signed in 1840 and considered the founding document of New Zealand, is a contentious document (with both Māori and English language versions) that has been used to both marginalise and support Māori throughout history. With loss of land came deprivation, and alienation from homelands; as a result, Māori became marginalised both economically and socially in their own country (Ward, 1993). The population continued to fall, with the idea of Māori as a ‘dying race’ gaining traction, owed much to the ‘fatal impact’ theory of Darwinism (Belich, 1996).

As of 2015, Māori are estimated to make up 15% of the New Zealand population; numbers have grown steadily and considerably since 1918 and the share is predicted to increase in the future (Statistics New Zealand, 2015). The effects of colonisation, however, are thought to remain in effect. The loss of language and culture is reflected largely in the negative statistics regarding Māori health and mental health in modern times (Rochford, 2004). The socio-cultural history of Māori is important because it provides a context for understanding how Māori present today, and how we might think about mending the suffering of the past in order to improve Māori mental health.

Māori health has been consistently recognised as an area of disadvantage, particularly for women, both in the past and more recently. In the area of mental health, Māori are hindered in nearly every aspect when compared to their non-Māori

counterparts (Armstrong & Armstrong, 1991; Bushnell, 2005). Rates of treatment at Mental Health Services are also disproportionately much higher for Māori than for other ethnic groups and are on a sharper rise than non-Māori ethnic groups (Oakley Browne, Wells & Scott, 2006). Anxiety, depression, and substance use have been reported as higher for Māori compared to non-Māori (Bushnell, 2005; Tapsell & Mellso, 2007). Overall, mental health has been identified as a specific concern for Māori as early as 1998, when the Mental Health Commission at the time stated that “mental illness is now the number one health concern for Māori” (Mental Health Commission, 1998, p. vii). Although survey data in New Zealand is limited, comparisons of statistics between Māori and non-Māori in New Zealand also highlight this concern (Baxter, Kingi, Tapsell, Durie, & McGee, 2006). Below, I explore some possible reasons for these differences, including colonisation and its after-effects, as well as considerations of a mismatch between the dominant psychiatric model, and Māori models of mental health and service preferences.

The socio-cultural history of Māori as Indigenous peoples may shed some light on mental health as a contemporary concern. Māori are not alone in bearing negative health and mental health statistics, with Indigenous populations in Australia, Canada, the United States of America, and many other countries, suffering the same. The similarities across the world in Indigenous health and mental health statistics may help us to understand why these populations might experience higher rates of mental health problems. Research from Australia suggests that Indigenous Australians are 1.5 to 2 times more likely to be hospitalised for a mental disorder, and up to 3.5 times more likely to commit suicide (Hunter, 2007). It has also been suggested that Indigenous Australians in rural areas are even more likely to be at risk of mental health problems. As a result of living in remote areas, they are generally not recognised or treated in the

mental health system, and thus statistics like the above are likely to be under-representative (Hunter, 2007). Similarly, research from Canada suggests that First Nations youth are about 5 to 6 times more likely to die from suicide than non-Indigenous youth. Suicide rates for Inuit are reportedly among the highest in the world, and are at 11 times the national average (Health Canada, 2016). Research from the United States of America suggests that statistics on Native American mental health are scarce; however it is estimated that the suicide rate among Native Americans is 1.5 times the national rate (Mental Health America, 2016).

Many have argued that remaining effects of colonisation have something to do with poorer mental health for Māori today. Despite a “political and public policy rhetoric” that Māori are politically, culturally, and linguistically equal to non-Māori, Māori remain disadvantaged in all areas of society, including health and mental health (Walker, Eketone & Gibbs, 2006, p. 332). Durie argues that Indigenous groups who have been subjected to colonisation still suffer from injustices of the past, including Māori, whose traditional values have been largely replaced by Westernised values (Durie, 1985). Given that other Indigenous groups experience similar disadvantaged positions in their own countries, it is likely that shared Indigenous experiences, such as colonisation, are a factor in Māori health discrepancies (Durie, 1999). It has been acknowledged that Māori might be more likely to suffer from mental health problems because of the destruction of social infrastructure, rapid urbanization, poverty, cultural alienation and loss of identity, family dislocation, traumatisation, and increased alcohol and drug use (Kumar, Ng, Simpson, Fischer & Robinson, 2008, p. 1). As a result of what Kingi (2007) terms ‘cultural decay’, many of the traditional social practices and structures that had protected and promoted Māori health were abandoned. Thus, the effects of colonisation appear to be active today.

Another major factor linked to colonisation has been thought to be the effects of discrimination. As the WHO outlines, discrimination can negatively affect mental health for marginalised groups in society (Chan, 2010). In further analysis of data from the New Zealand Mental Health Survey, Harris and colleagues found that self-reported racial discrimination and deprivation was much higher in Māori compared to Pākehā (New Zealanders of European descent), and was also correlated with poorer mental health as well as poorer self-ratings of mental health (Harris, Tobias, Jeffreys, Waldegrave, Karlsen & Nazroo, 2006). The authors therefore argue that both interpersonal and institutional racism correlates with, and perhaps contributes to, poorer mental health for Māori.

Trauma as a result of colonisation may also play a role. Although Māori do not disproportionately present with trauma, for example, in hospital statistics (Koea, 2008), qualitative research suggests that Māori experience high levels of personal trauma (Hirini, Flett, Long & Miller, 2005; Wirihana & Smith, 2014). The impact of trauma and difficult life experiences on mental (and physical) health can be severe (Read, van Os, Morrison, & Ross, 2005; Schnurr & Green, 2004). The collective Indigenous trauma of Māori is likely to be a key part of the over-representation of Māori in our mental health services. This type of trauma has been termed intergenerational, transgenerational, or historical trauma, and was originally coined to describe the over-representation of the children and grandchildren of holocaust survivors in mental health services in Canada (Fosson, Rejas, Servais, Pelc, & Hirsch, 2003). There is a lack of research in New Zealand regarding the intergenerational impacts of trauma on Māori (Pihama et al., 2014). However, Māori and other Indigenous scholars have argued that the cumulative impact of Indigenous trauma like colonisation, land loss (Reid, Taylor-Moore, & Varona, 2014), and other genocidal and ethnocidal acts, have a similar impact

to the trauma of holocaust survivors (Brave Heart & DeBruyn, 1998; Duran & Duran, 1995). The intergenerational impact, therefore, is seen as a "direct outcome of unresolved trauma which manifests in a range of dysfunctional behaviours that then inform the learning environment of, and are passed on to, subsequent generations" (Pihama et al., 2014, p. 249). In this way, previous trauma events for Māori as a people are likely to continue to impact today, even in the generations who did not experience this trauma first hand. This may help to explain why Māori appear to present with poorer mental health than non-Māori.

In order to reflect on the possible impact of colonisation and its related effects, I first look at models of Māori mental health, and then consider how the contrast with the psychiatric model might affect how Māori mental health is viewed, the appropriateness of service delivery, and how Māori engage in mental health services.

Māori have, and have always had, their own views on health and mental health, though they may not always be acknowledged as such. They are "not widely written about, yet are understood and assumed by Māori, and acted upon and expected" (Nikora, Levy, Masters & Waitoki, 2004, p. 2). Nikora (2007) aptly summarises the contemporary climate of Māori defined mental health, or a Māori Indigenous psychology, as such:

Māori have their own approaches to health and well-being, which stem from a worldview that values balance, continuity, unity and purpose. The world view is not typically thought of as 'psychology', yet it is a foundation for shared understandings and intelligible action among Māori. Māori behaviours, values, ways of doing things and understandings are often not visible nor valued. However, through these opening years of the twenty-first century, psychologists

are slowly turning their attention to addressing this invisibility with the explicit agenda of building 'indigenous psychologies'. (Nikora, 2007, p. 80).

The invisible and undervalued dimension of things Māori mean that it is difficult to put forward a Māori definition of mental health that has the same influence and power as the psychiatric model. There has been a movement since the 1980s to grow the field of Indigenous psychologies, which arose out of discontent with Western views of mental health that were established largely in North America and Europe. The objectives of the movement are "to develop psychologies that are not imposed or imported; which are influenced by the cultural contexts in which people live; are developed from within the culture using a variety of methods; and result in locally relevant psychological knowledge" (Nikora, Levy, Masters & Waitoki, 2004, p. 2). With these objectives, Indigenous peoples the world over could hope to redefine health and mental health for themselves in a self-determining way, in order to push back against the dominant psychiatric models which have for so long been experienced as unhelpful.

Unlike many Western models of health, Indigenous peoples' notion of health is often not individual, but one that encompasses the health of the whole community, and the health of the ecosystem in which they live. For Māori, as is the case for many other Indigenous peoples, mental health is usually defined as part of the broader definition of health, as a holistic view of health does not compartmentalise mental health on its own. Because of this holistic view of and approach to health (Mark & Lyons, 2010), Māori and other Indigenous peoples have "pluralistic and holistic solutions to their health problems" (Stephens, Nettleton, Porter, Willis & Clark, 2005, p. 10). Family, whānau (extended family), and whakapapa (genealogy) are also important in Māori models of mental health (Mark & Lyons, 2010). Indeed, Durie (1985) has argued for the need for



the family system to be the *real* place of support, rather than a psychiatric model and service-provider. Māori healers have also claimed that wairua (spirituality) and a connection to the whenua (land) are essential to Māori mental health (Mark & Lyons, 2010). Durie has emphasised that “the development of a positive cultural identity is necessary for optimal mental health” (Durie, 1997, p. 24). While a secure cultural identity does not necessarily protect against mental illness, it can be an important factor in the recovery process, and recovery itself can contribute to a secure identity (Pere, 2006). These aspects important to Māori wellbeing may help to inform appropriate services to improve Māori mental health.

Although there is no single stated definition of Māori mental health that stands above all others, several models of health have been proposed in recent decades to attempt to capture the uniqueness of Māori mental health. One of the most well-known is Te Whare Tapa Whā, which was developed by Māori health workers at a hui (meeting) in 1982 and later described by Mason Durie. Using the metaphor of the four walls of a house, which cannot stand if all four walls are not in order, a holistic view of Māori health is presented. The four walls are represented by a component of health, and cannot be separated from one another: Te Taha Tinana (health in the bodily dimension); Te Taha Wairua (health in the spiritual dimension); Te Taha Whānau (health in the family dimension); and finally Te Taha Hinengaro (mental health) (Durie, 1994). Another popular model that captures the holistic Māori view of health is known as Te Wheke (meaning octopus), defining family health (Pere, 1988). The head of the octopus represents Te whānau (the family), while the eyes represent Waiora (total wellbeing for the individual and their family); the eight arms then represent eight essential components of health: Wairuatanga (spirituality), Hinengaro (mental health), Taha tinana (physical health), Whanaungatanga (extended family), Mauri (the life force in

people and objects), Mana ake (the unique identity of the individual and their family), Hā a koro ma, a kui ma (the breath of life from ancestors), and Whatumanawa (an open and healthy expression of emotion) (Pere, 1988). Māori healers have also proposed a model called Te Whetu (The Star), with the 5 points of the star being mind, body, spirit, family, and land (Mark & Lyons, 2010). Although these are only brief overviews of just three of the many models of Māori health proposed by Māori and for Māori, they illustrate the stark contrast between the dominant Western definition and Indigenous definitions. The Western, compartmentalised view of mental health is in direct and obvious contrast to the holistic concept of mental health that both Māori and other Indigenous groups subscribe to (Westerman, 2004). In Australia, for example, the Social and Emotional Wellbeing Model has been coined to describe the holistic model of health of Aboriginal and Torres Strait Islander people (Social Health Reference Group, 2004). A distinction is drawn between the Western definition of mental health, used in non-Indigenous contexts, and the concept of Social and Emotional Wellbeing, which highlights the importance of culture, community, connection to land, spirituality, ancestry, and family (Kelly, Dudgeon, Gee, & Glaskin, 2009; Zubrick et al., 2010); concepts which are also integral to Māori. It seems clear from an Indigenous and holistic perspective that the psychiatric model nor the WHO definition of mental health would be able to incorporate the meaning of mental health for Māori, or indeed for other Indigenous peoples.

In addition to these models, Māori also have traditional treatments for health and wellbeing, including mental health. Māori methods of healing such as waiata (song), mōteatea (traditional chants), haka (a specific cultural dance), whakanoa (removing tapu or sacredness) and whakawhanaungatanga (establishing relationships) are, and always have been, used within Māori communities to sustain wellbeing

(Wirihana, 2008). Māori rongoā (Māori medicines) have also been highlighted as having importance in mental health, and although the usage of traditional Māori treatments decreased with colonisation and has evolved over time, they are still considered important today (Mark & Lyons, 2010).

Māori and other Indigenous groups have also proposed models of cultural safety and cultural competency (Papps & Ramsden, 1996). For Māori, the idea of 'cultural safety' has drawn from the principles of Te Tiriti O Waitangi and requires that health professionals must examine and recognise their own cultural attitudes, and acknowledge that their views, combined with the power they hold as health professionals, allow them to influence their clients/patients and their health outcomes (Wilson, 2008). Māori service users should therefore experience that their personal, social, and cultural wellbeing is acknowledged, even if not fully understood (Fulcher, 2001). This goes hand in hand with being able to provide a culturally appropriate mental health service, as a culturally safe service should improve Māori engagement and participation in mental health services at the very least, and, ideally, legitimise Māori models of mental health and integrate them into a culturally appropriate mental health service. Cultural safety and cultural competency are challenges to the ethnocentrism of the mental health system, and draw attention to processes and practices which may be rendered invisible to those in the dominant culture. Although many health and mental health professions now include cultural competency in their policies and practice in some form, it is not an end goal that can be completed but an ongoing journey for mental health services in which improvement is always possible and desirable (Dunn, 2002).

Māori mental health as outlined above, and the contrast this presents with the psychiatric model, might affect how Māori mental health is viewed, judged, and approached. Tapsell and Mellsoop (2007) suggest that health practitioners, who are

trained under Western values, may form invalid opinions of Māori based on the psychiatric model. They also consider that systemic factors may affect the way Māori are diagnosed and treated in mental health services, which again may be influenced by the dominant psychiatric model. Wilson (2008) has argued that mainstream mental health does not examine itself critically enough, and does not consider how contesting definitions may affect how Māori mental health is interpreted. From the view of the health practitioner, “when interventions ‘go wrong’ or outcomes are not achieved, it is not unusual for clients to be blamed and labelled ‘non-compliant’” (Wilson, 2008, p. 173), locating blame with the (Māori) person, and not considering that the system itself could be at fault. This could also be reflected in the statistics, which are gathered, presented, and interpreted under the psychiatric model. For example, schizophrenia in Māori, may appear overrepresented because spiritual gifts are sometimes confused for mental illness (Lapsley et al., 2002). In this way, Māori mental health statistics could appear poorer than if they were interpreted from a framework of Māori mental health.

The contrast between Māori mental health and the psychiatric model might also affect the appropriateness of service delivery, which could result in a ‘real’ worsening of mental health problems due to absent or inefficient treatment. The overrepresentation of Māori in our mental health services has for some time raised questions around the adequacy of the service that is provided to Māori (Sawrey, 1993). In Australia, Fredericks (2007) attributed the gap between service provider and service user as a factor in the poor mental health of Indigenous Australians, explaining that mental distress is often unnoticed and untreated because the health system does not recognise Aboriginal values and beliefs (Brown, 2001). One Australian study suggested that service users who are part of the Western and dominant group in their country tend to describe symptoms in a way that matches well with services’ language, which yields

appropriate intervention. However, Indigenous people with a holistic view of mental health instead speak more vaguely, giving no clue of physical or mood symptoms (Westerman, 2004). This mismatch in understanding or defining mental health problems may mean that Indigenous service users do not receive the same quality of service delivery.

Another factor that may account for the lack of fit between mental health services and Māori service users is the relatively low number of Māori mental health professionals compared to service users. Levy (2002) argues there are barriers that prevent Māori entering the field of mental health as a professional and gaining senior positions, which results in fewer Māori professionals working for Māori clients, and fewer opportunities to promote change from the top. Reid and Robson (2006) have suggested that Pākehā, as numerically dominant, demand and attract resources that result in appropriate service provisions for the majority, which may not be appropriate for Māori, hence the mismatch in funding, resources, and cultural appropriateness (Reid & Robson, 2006). The effect of this may be poorer mental health statistics for Māori.

Differences between Māori mental health, and the dominant psychiatric model, may also affect how Māori engage in and experience mental health services. Tapsell and Mellsoop (2007) suggest that Māori are less likely to access mental health services in community settings, and present later than non-Māori to mental health services and with more severe symptoms. Durie has also noted that historically, “Māori felt excluded from a health system that emphasized Māori pathology and Māori deficits” (Durie, 2011, p. 29), and there has been movement since to reformulate concepts of health in New Zealand to better fit with Māori views. The body of research, however, on the experiences of Māori mental health service users is limited. Nevertheless, I now present a small number of studies that share these experiences.

Service user research with Māori appears to highlight the importance of many of the same areas that general service user research does. Māori service users also highlight the need to establish a meaningful relationship (Harris, 2014; Wilson, 2004). Harris (2014), who interviewed Māori women with bipolar disorder, and Wilson (2004), who interviewed Māori women in regards to health in general, found that there was also value in the importance of choice, trust, advocacy, being listened to, being human and acknowledging clients as real people, being caring, being non-judgemental, having enough time, and having familiar faces around (Harris, 2014; Wilson, 2004). Some also highlighted a need to have access to early intervention and prevention services (Harris, 2014). Service user research with Māori also highlights a number of areas that seem to be uniquely important to Māori; these are discussed below.

Service user research with Māori seems to place high importance on receiving culturally appropriate mental health services (Harris, 2014; Lapsley et al., 2002; Semmons, 2006; Wilson, 2004). Lapsley and colleagues (2002), who interviewed a number of mental health service users in New Zealand, found that for Māori, dedicated Māori mental health services were particularly appreciated (Lapsley et al., 2002; Wilson, 2004), and were experienced as respectful, culturally safe and responsive (Harris, 2014). In one study, participants expressed a particular appreciation of staff engaging in *whakawhanaungatanga* (relating to others), for example by simply sitting down, talking, and eating with the clients (Harris, 2014). Users also appreciated encountering Māori staff within mainstream services (Lapsley et al., 2002; Wilson, 2004), and Māori staff (as well as Pacific Island staff) were also experienced as more understanding (Harris, 2014). The comfort of a Māori environment and *kanohi kitea* (the known face; having familiar faces around) was also experienced as helpful in recovery (Wilson, 2004). In contrast, when (particularly mainstream) services were

experienced as culturally inappropriate, service users felt their recovery was impeded. Some felt that their holistic views of mental health contrasted strongly with the Western psychiatric view of mainstream services (Wilson, 2004) and others lamented the lack of Māori professionals and Māori tikanga (correct procedure or custom) in their service (Semmons, 2006). Some felt alienated within the mental health system, felt like their behaviour was misinterpreted by mental health professionals and that they had never actually been mentally ill, and felt that they could recover their tinana (body) and hinengaro (mind) but not their wairua (spirit), which they saw as imperative (Lapsley et al., 2002). Similar ideas have been also echoed in research with Indigenous Australians (Fredericks, 2007) and First Nations Canadians (Baker, Daigle, Biro & Joe, 2000). Research with New Zealand professionals has also acknowledged the need for Māori-centred health services, more Māori professionals, and the need for non-Māori clinicians to liaise with Māori staff when working with Māori clients (Johnstone & Read, 2000). The mental health service user perspective is particularly valuable in this case because a major criticism of earlier research which looks at 'cultural inappropriateness' is that it seldom fully defines what 'cultural inappropriateness' in services actually means, and does not go further into how health professionals can adapt their practice to become 'culturally appropriate' (Westerman, 2004). Mental health service user research, on the other hand, appears to be able to detail this quite articulately, when sought, and could therefore be valuable in creating these definitions.

As an adjunct to services being culturally appropriate for Māori, mental health service user research with Māori highlighted the importance of Māori treatments being offered. Some narratives highlighted the usefulness of Māori healing such as rongoā (Māori medicines), mirimiri (Māori massage) and relaxation techniques, as well as wairua practices (Dyall et al., 1999; Lapsley et al., 2002; Wirihana, 2008). Cultural

teaching was also identified as an aide to recovery (Lapsley et al., 2002). In another study, kapa haka (traditional song and dance) experiences included as part of sensory modulation in mental health services, for example, were experienced as helping service users feel safe, helping them feel grounded in their bodies, and enhancing their cultural identity (Hollands, Sutton, Wright-St. Clair, & Hall, 2015). Thus, access to Māori treatments appears to be an important part of offering a culturally appropriate mental health service, and enhancing identity as Māori. In some studies, identity, and having many roles was thought of as a dilemma of figuring out oneself in a contemporary world (Semmons, 2006; Wilson, 2004). In another study, users defined recovery as coming to terms with mixed Māori and Pākehā identity, and felt Māori identity and increased self-pride was particularly important in recovery. They placed importance on valuing that identity, and sometimes, contact with monocultural (mainstream) mental health services had made matters worse (Lapsley et al., 2002). Mental health service users sometimes felt their identity was judged by staff; sometimes felt judged for being Māori and at other times felt judged as ‘not a real Māori’ (Semmons, 2006). Services therefore appear to have the power to either help with or exacerbate this dilemma. Previously mentioned arguments from Durie and colleagues also support this notion, albeit from a researcher rather than a user perspective.

Research with Māori service users also highlighted the importance of whānau in both recovery and treatment, and users appreciated when services acknowledged and fostered this need (Dyall et al., 1999; Lapsley et al., 2002; Harris, 2014; Jahnke, 2002; Wilson, 2004). Sometimes this was something as basic as having appropriate areas for visiting whānau within the service, or having staff recognise that family support was helpful in recovery (Lapsley et al., 2002). Some considered whānau connection as important for intergenerational wellness and pathways to recovery (Harris, 2014). For



others, whānau intervention was crucial; sometimes just experiencing their support and love was healing, and even just wearing taonga (treasures, gifts) and feeling like they were not alone was helpful for service users (Lapsley et al., 2002).

The research presented demonstrates the value of qualitative research in capturing the qualitative accounts of Māori service users' experiences. As these accounts, however, often emerged in the broader context of health services, and with all Māori service users, it is not always clear whether there are specific meanings for Wāhine Māori (Māori women) within these. Next, I look at women separately, before focusing on the intersectionality of being Wāhine Māori.

### **Women's mental health and mental health services**

In this section I first consider the incidence of mental health problems in women. I then consider possible reasons for women's mental health problems. Finally, I look at previous research on women's engagement with mental health services, including previous research on women's service user experiences.

Mental health has been recognised as an area of disadvantage for women worldwide (WHO, 2015). In New Zealand, there is a limited availability of recent mental health survey data, so while the 2006 Mental Health Survey, Te Rau Hinengaro is referenced here along with other data, this is done so with an acknowledgement of their age. Mental health statistics in New Zealand suggest that, when compared with men, women have a higher prevalence of anxiety disorders, especially posttraumatic stress disorder (PTSD) and specific phobias (Oakley Browne, Wells & Scott, 2006), major depression (Bushnell et al., 2001; Bushnell et al., 2003), suicidal ideation, and eating disorders. Overall, women have been noted to be more likely to make a mental health visit or experience any mental health disorder when compared to men (Oakley

Browne, Wells & Scott, 2006). Although men in New Zealand have a higher reported suicide rate, women are more likely to be hospitalised for self-harm (Dye, Rossouw & Pacheco, 2012). Over the last few decades, the subjective wellbeing of women is also said to have dropped internationally, both in 'real terms' and relative to men (Blanchflower and Oswald, 2004). Below, I explore some possible reasons for these differences, including disadvantage and discrimination, gender roles and experiences, and trauma, as well as considerations of a mismatch between the dominant psychiatric model, and feminist models of mental health.

Some researchers have argued that the disadvantages and discrimination that women face might account for women's poor mental health (Klonoff, Landrine, & Campbell, 2000). Discrimination affects mental health (Dambrun, 2007), and in the USA, poverty, inequality, and discrimination have been identified as sources of poor mental health among women (Belle Doucet, 2003). Gender discrimination has been identified as a major form of stress for women (Klonoff & Landrine, 1995). A study by Moradi and Funderburk (2006), for example, observed links between the frequency of perceived sexist events and psychological distress, and some studies suggest that self-reports of recent and lifetime sexist discrimination can entirely account for observed differences between women and men in depressive, anxious, and somatic symptoms (Klonoff, Landrine, & Campbell, 2000). This discrimination may also be evident within mental health itself, and might also explain the discrepancies between women and men. Ussher (2011) argues that women have always been disadvantaged in mental health, "from the 'hysteria' of the eighteenth and nineteenth centuries, to 'neurotic' and mood disorders in the twentieth and twenty-first" (Ussher, 2011, p. 1), and that women have often been incarcerated for being 'difficult' or 'deviant', and regulated through 'treatment' (Ussher, 2011). First person accounts from women in overseas asylums

between 1840 and 1945 share the horrors of ‘treatments’ including restraint, isolation, enforced bed rest, and submersion in freezing water (Geller & Harris, 1994). While much has changed in terms of mental health models, provisions and delivery of service, there are still concerns that these subtly discriminate against women (Bondi & Burman, 2001). In summary, different forms of discrimination could account for relatively poor mental health statistics in women, from broader disadvantages such as poverty, inequality, and sexism and the risks these seem to pose to wellbeing, to specific discrimination within mental health services which might position women as simply more ‘mad’ than men (Ussher, 2011).

The social roles of men and women have also been said to contribute to gender differences in rates of mental illness (Sachs-Ericsson & Ciarlo, 2000), and the experience of gendered roles have also been considered as a factor particularly in higher reported rates of women’s depression (Ussher, 2010). Experiences unique to women, which have the potential to be distressing, might account for differences in experienced stress and therefore poorer mental health statistics. The specific needs and stressors of mothers have been highlighted in mental health literature (Montgomery, Tompkins, Forchuk & French, 2006; Mowbray, Oyserman, & Bybee, 2000), and one study specifically highlighted the way in which mothers with poor mental health mask their ‘illness’ and carry on at detriment to themselves, usually delaying asking for help until a crisis point (Montgomery et al., 2006). Postnatal depression has also been identified as a problem for women (Dennis & Chung-Lee, 2006; Sword, Busser, Ganann, McMillan, & Swinton, 2008). Miscarriage is said to be the most common adverse outcome in pregnancy, and can often be traumatic (Simmons, Singh, Maconochie, Doyle, & Green, 2006). Studies have indicated that experiencing miscarriage heightens the risk of mental health problems in women, particularly anxiety and depression

(Broen, Moum, Bodtker, & Ekeberg, 2006; Cumming et al., 2007; Rowlands & Lee, 2010). However, some researchers have found that this risk resolves in the year following miscarriage (Lok, Yip, Lee, Sahota, & Chung, 2010; Lok & Neugebauer, 2006). The topic is controversial, and New Zealand research is scarce, but suggests that abortion in young women may also be associated with an increased risk of mental health problems such as anxiety and depression (Fergusson, Horwood, & Ridder, 2006). While these experiences unique to women do not necessarily indicate compulsory mental health problems for *all* women who experience them, it is important to acknowledge their existence and the potential distress that accompanies them. These unique opportunities for distress might explain some of the differences in reported rates of mental illness between women and men.

Just as intergenerational trauma might play a role in increased mental health problems for Māori, elevated levels of personal trauma, particularly as a result of gender-based violence experienced by women, may have the same effect. Statistics suggest that intimate partner violence is the most common form of violence against women worldwide, and approximately a third of women will experience physical or sexual violence in their lifetime (United Nations, 2016). Although data is scarce, it is believed that women in New Zealand face relatively high levels of domestic and sexual violence, with one in three women being victim to physical assault, more than half when psychological and emotional abuse is included (Ministry of Justice, 2016), and one in four women being victim to sexual assault (Fanslow & Robinson, 2011). In a review of women's wellbeing in New Zealand, Dye, Rossouw and Pachecho (2012) note the gendered nature of family violence statistics provided by the Ministry of Justice; a large majority of serious cases of physical partner violence are committed against women, and statistics regarding sexual offences towards women are on the rise. A WHO multi-

country study found significant associations between lifetime experiences of partner violence (including physical and sexual violence) and higher levels of emotional distress, suicidal thoughts, and suicide attempts, compared to non-abused women (Ellsberg, Jansen, Heise, Watts & Garcia Moreno, 2008). The long term mental health consequences of childhood sexual and physical abuse have long been acknowledged in New Zealand (Mullen, Romans-Clarkson, Walton, & Herbison, 1988) and worldwide (Banyard, Williams, & Siegel, 2001; Coker et al., 2002; Cutler & Nolen-Hoeksema, 1991; Edwards, Holden, Felitti, & Anda, 2003; Springer, Sheridan, Kuo, & Carnes, 2007), with a particular focus on depression and anxiety in later life. Adult experiences of intimate partner violence, both physical and sexual, have also been acknowledged as a risk factor (Campbell & Lewandowski, 1997; Cortina & Kubiak, 2006) particularly for post-traumatic stress. In one study, gender on its own had little impact as a determinant of poor mental health, but experiences of sexual violence were key (Cortina & Kubiak, 2006). Like intergenerational trauma for Māori, it could be that these difficulties contribute to poorer mental health reported in women.

Although it has been suggested there may be a ‘real’ mental health difference between women and men, there is no reliable evidence for a simple biological reason which explains gender differences in depression, for example (Blehar, 2006). Critics like Ussher would argue that we need improvement to mental health services, yet we also need social and political change so that women are not living in a context of inequality, violence and abuse (Ussher, 2010). Broader models of mental health that incorporate social and psychological aspects might be more helpful than the dominant psychiatric model in improving mental health for women. Like Māori, women do not have a single identifiable definition of mental health, but feminist theory and critics inform a way of thinking that frames the poorer mental health of women in a more

helpful way. Ussher (2011) has often critiqued the dominant psychiatric model, and prefers to use the term ‘madness’, as she sees the term mental illness as “problematic, as it suggests an internal pathology that can be incontrovertibly categorised and cured by biomedicine; a disease state that occurs within the individual and is separate from culture, values, and politics” (Ussher, 2011, p. 4). For some time, feminist critics have also incorporated narrative therapy and metaphor with which women can be empowered to re-author or re-story their life in the context of discrimination, gender roles, and trauma (Gremillion, 2004; Lee, 1997). Regarding motherhood, for example, as a potentially distressing experience as described above, Medina and Magnuson (2009) explain how feminist approaches to mental health allow clients to explore meanings given to motherhood and question the origins of these beliefs. Working with a feminist therapy approach empowers women, is focused on strengths instead of deficits, and views women's symptoms as their best attempts to cope with a restrictive and oppressive environment (Medina & Magnuson, 2009). In this way, feminist models of mental health directly challenge the dominant psychiatric model by offering critical social and psychological elements in addition to a biomedical approach. Next, I look at the experiences of women service users of mental health. Again, the body of research that focuses solely on women is small, but substantial enough to provide some information about what women find helpful and unhelpful when engaging with mental health services.

The importance of relationship has been highlighted by women service users, and across several studies women have expressed a preference for professionals who are non-judgmental, non-directive, compassionate, understanding, sensitive, and respectful of maintaining confidentiality (Feder, Hutson, Ramsay & Taket, 2006). The importance of being caring and feeling cared for was also highlighted in a review of

women's service user experiences (Dennis & Chung-Lee, 2006), and a key component of being able to show this was allowing enough time with clients and being unhurried. This review also highlighted specific needs for women, including wanting to be given permission to talk in-depth about their feelings, to be able to talk with someone who was non-judgemental, would take time to listen, take them seriously, to understand them, and to accept them for who they were. Reassurance was also appreciated, but to be effective it had to be from other women with similar experiences, such as motherhood (Dennis & Chung-Lee, 2006). Suggestions have also been made not just about accessibility but about the willingness of mental health services to make an effort to relate, branch out into the community and reach out to women in need. Goodman and Epstein argue that mental health professionals should demonstrate a willingness to leave the confines of their offices and go out into the spaces that women frequent (Goodman & Epstein, 2008). Reaching out to build meaningful relationships between mental health services and women service users might have a positive impact on the reported mental health of women.

Studies with women service users have also highlighted a preference for therapy over medication, preferring to have talking therapies with someone who was non-judgmental rather than just receive pharmacological interventions (Dennis & Chung-Lee, 2006). In another study, service users expressed higher confidence in psychological treatments compared to pharmacological treatments (O'Mahen & Flynn, 2008). For some, emotional support in general was the most preferred method of healing, though medication was also seen as helpful (Gammell & Stoppard, 1999; Woolhouse, Brown, Krastev, Perlen, & Gunn, 2009). Medication, such as using anti-depressant drugs to treat depression, has benefits such as alleviating distress, but does not seem to be compatible with personal empowerment because it helps to define

depression as a solely medical problem, and takes away a service user's power to define the nature of their problems for themselves (Gammell & Stoppard, 1999). Inappropriate medicalisation, of miscarriage for example, meant that service users felt unable to build good relationships with services (Simmons et al., 2006).

Studies have also suggested that women frequently seek help from informal sources, such as friends and family (O'Mahen & Flynn, 2008), and would like for family to be involved in their healing and recovery (Dennis & Chung-Lee, 2006). Another study also highlighted that women expressed trying to ignore their feelings and carry on in the face of adversity, usually in order to protect their family from disruption or distress (Gammell & Stoppard, 1999). This might point toward a sort of strength in women to carry on even when distress levels are high. Because of the nature of these studies, it is likely that these factors are important to women service users in addition to those discussed in the service user section above, such as other elements important in building a relationship, being treated like a human being, autonomy and making choices and decisions, lack of coercion, feeling safe, a holistic approach, and cultural competency.

Though these studies demonstrate the value of qualitative research in capturing the qualitative accounts of women's service user experiences, there is a relatively small amount of research which has a specific focus on women service users. In the next section, I explore the intersectionality of being Wāhine Māori.

### **Māori women's mental health and mental health services**

In this section I consider the intersectionality of Māori and women, or being Wāhine Māori, particularly in regards to mental health. I first consider intersectionality as a framework, and what this might mean, and then look to theories and previous



research specifically with Māori women, including that which relates to mental health experiences.

Intersectionality refers to the way in which being both Māori and a woman, or Wāhine Māori, might combine together for those with a dual identity. Māori, other Indigenous peoples, women, and, in an intersecting sense, Māori women, are subject to discrimination and marginalisation in society. That is, there are different ways in which discrimination and marginalisation work against Māori women to worsen their mental health problems. Being both Māori and a woman is a considerable disadvantage in mental health. Despite the fact that literature on race and gender disparities in the mental health system seldom focus on both, and usually on one or the other, the oppression of women within mental health has also been acknowledged to intersect with other “marginalised positions of disadvantage” (Bondi & Burman, 2001, p. 8), such as race and class. Although few statistics reported in previous sections focus particularly on Wāhine Māori, they suggest that Māori women are twice as likely to have a diagnosable disorder as non-Māori women (Bushnell, 2005), and depression is also higher in Māori women compared to non-Māori women (Tapsell & Mellsop, 2007). Broader health differences have been reported too. Bramley, Hebert, Tuzzio and Chassin (2005) have found that there is a glaring gender and ethnic gap in terms of life expectancy, with Māori women having a life expectancy of 9.4 years lower than their non-Māori counterparts. This suggests that there may be some particular disadvantage in being Wāhine Māori, and that being Māori and a woman might bring with it the poorer mental health statistics of both groups in a ‘more than the sum of its parts’ type of way.

The ways in which Māori, women, and mental health service users are discriminated against and marginalised might affect both the actual and perceived mental health problems of these groups. The first is the direct effect of discrimination,

which manifests as stress, and can increase the risk of mental (and other) health problems. The second is the indirect effect of discrimination from mental health services (as previously discussed regarding women), which might exacerbate this stress for Māori. The former is an experiential risk factor for mental health problems, and the latter is a skewed interpretation of Māori women being more problematic than other groups (as suggested by Tapsell & Mellsop, 2007). In addition to the reasons explored for both Māori and women separately, this intersectionality of discrimination could explain some of the mental health discrepancies for Wāhine Māori.

Just as colonisation, discrimination, trauma, social roles and experiences, and conflicting models of mental health could explain differences in mental health statistics for Māori and women, when combined they could explain differences for Wāhine Māori. Additionally, traumatic experiences have been noted to be high in Māori women, particularly sexual abuse as a child or adult, physical violence at the hands of a family member, or traumatic death of a loved one (Hirini, Flett, Long & Miller, 2005). Research with Māori women has also highlighted motherhood as a potential struggle, and children as important to recovery (Harris, 2014; Semmons, 2006).

In addition to the important factors highlighted by research with Māori and women service users, such as building a meaningful relationship, receiving culturally appropriate services, the importance of Māori healing, the importance of family and whānau, the importance of identity, and preference for therapy over medication, there are some additions to mention regarding Wāhine Māori. Just as a positive cultural identity has been argued as important for Māori mental health, a positive and secure identity as Wāhine Māori seems to be important for Māori women's mental health (Jahnke, 2002). However, intergenerational differences complicate the idea of a sole Māori identity, and should be considered when engaging with Māori and evaluating

and investigating service users' experiences in the mental health system (Houkamau, 2006).

In spite of these disadvantages, however, Wāhine are also recognised to possess considerable strengths. Reference is often made to the dignity and self-determination of Māori women (Herd, 2006), and Mana Wāhine Māori, or the status of Māori women as embodying both tapu (sacredness) and mana (strength). Traditional Māori perspectives construct women as connected to the Atua (gods), and as powerful, sacred, and life-giving (August, 2004; August, 2005). Previous health research with Māori women has highlighted the motivation and self-determination of Wāhine Māori (Harris, 2014), as well as a 'resigned acceptance' of life as the way it is (Wilson, 2004). This 'resigned acceptance' is not self-sabotage, but meeting their own needs by prioritising the needs of others, with the full knowledge of the risks of delaying seeking help. It is putting others ahead of the self, putting whānau ahead of the self, and being accepting of situations, yet being resilient, resourceful, and doing everything possible to self-care. This style of managing speaks to the unique endurance of Māori women (Wilson, 2004).

Jenkins and Pihama (2001) argue that the status of Māori women has been seriously misrepresented and our voices have been silenced for too long, which has meant a silencing of our theories and worldviews. It is important that Māori women take control of spaces where our stories can be told, including theoretical space via academia. Service user research in general is rich and clear in its direction and consensus, and Māori service user research appears to offer a smaller yet still valuable insight into how mental health services might better serve the needs of vulnerable groups. However, research focusing on women or Wāhine Māori in particular is sparse, and those studies that do are more broadly focused on health in general (for example,

Wilson, 2004) or hone in on particular diagnoses (such as Harris, 2014). It is hoped that my research can fill this void by offering a focus on Māori women's mental health user experiences, to find equally rich information as that found in the general service user or Māori service user research.

## **Summary**

A broad glance across the literature regarding service users in general, as well as Māori service users, women service users, and Wāhine Māori service users, highlights some key points. There are potential conflicts between service user research and the frameworks of mainstream mental health. This highlights the importance of considering why mental health discrepancies may exist for these groups, and the value of considering their voices in order to improve their experiences of mental health and mental health services.

In this research I will explore the key research question: **what are Māori women's experiences of mental health services in New Zealand?** The aims of this research are to give voice to the stories of participants as users of mental health services in New Zealand, to highlight their unique experiences, and to give voice to their recommendations to improve mental health services. Although the primary objective of my research is to identify and understand these women's experiences, it is hoped that highlighting these experiences may also provide vital information needed to improve mental health service provision for Māori women, in the same way that previous service user research has done for service users in general.

## CHAPTER 2: METHODOLOGY

In this chapter I outline the methodology of this project. I will first provide an account of the overarching framework within which I developed the research. I adopt a qualitative approach to this research and argue that Kaupapa Māori research, feminist research and service user research all helpfully inform my orientation. In the second part of this chapter I describe the design and methods used in the research as well as ethical issues and the steps I took to ensure the rigor of the research.

### **Kaupapa Māori Research**

Kaupapa Māori research has called into question some of the positivist assumptions of traditional empirical research (Pihama, Cram & Walker, 2002; Smith, 1999; Walker et al., 2006). Kaupapa Māori research emerged from a move by Indigenous peoples worldwide to increase their self-determination (whether over land, culture, or language), a greater commitment to the Treaty of Waitangi, and from the growth of movements such as kohanga reo (Māori language preschools) (Walker et al., 2006). It marks a change for Māori shifting from the 'researched' to the 'researchers' (Mahuika, 2008). In other words, research is done by and for Māori, and a key priority is that the research is culturally safe for Māori (Henry & Pene, 2001). Kaupapa Māori research gives full recognition to Māori values and systems, challenges dominant Pākehā constructs of research, aims to ensure Māori methodological and interpretive control over research, and aims to ensure Māori protocol is followed during the process of research (Walker et al., 2006). The definition of Kaupapa Māori research, and what is and is not Kaupapa Māori research, is still the subject of debate and discussion (Barnes, 2000).

Within Kaupapa Māori research sits Mana Wāhine Theory, a Māori feminist discourse and methodological approach that explicitly looks at the intersectionality discussed previously, of being both Māori and female (Pihama, 2001, 2015; Simmonds, 2011). Mana Wāhine Theory remembers both tūpuna wāhine (female ancestors) and atua wāhine (goddesses), attributing the mana of wāhine to cosmological narratives such as Papatūānuku (Mother Earth), Hineahuone (The First Woman), and Hinefītama/Hinenuitepō (First Daughter of Hineahuone and Tāne/Goddess of Death) (Simmonds, 2011). Like other feminist theories, Mana Wāhine Theory also advocates for the affirmation of women, particularly Māori women in Māori society (Pihama, 2001). Mana Wāhine Theory, like many things Māori, had not been written about previously (Te Awēkotuku, 1991), but in recent years has benefited from a growing body of literature (Pihama, 2001, 2015; Simmonds, 2009, 2011). With Mana Wāhine Theory and research, "the silencing of Māori voices and experiences, specifically Māori women's, can be addressed and the dominance of Western masculine scientific knowledge can be unpacked" (Simmonds, 2009, p. 35). As a feminist extension of Kaupapa Māori Research, the spirit of Mana Wāhine Theory was implicit in both my own positioning in this research, and in the essence of this research and its aim to give Wāhine Māori service users a voice.

While there were restrictions on the extent to which I was able follow Kaupapa Māori research guidelines within the constraints of the thesis, I felt it was important to abide by its key principles in my overall orientation to the research. I have labelled my approach a Māori-centred one, and in it I endeavoured to remain as close to the spirit of Kaupapa Māori research as possible.

To approximate the spirit of Kaupapa Māori research I first created this research with Te Tiriti O Waitangi in mind (outlined below). I initially consulted primarily with

my cultural supervisor Erana Cooper, but also informally with a number of Māori in both academic and mental health networks throughout the course of the research. As the research progressed, ongoing cultural consultation was provided by Pikihiua Pomare (Te Rarawa, Ngāpuhi, Ngai Te Rangi, Ngāti Pukenga), who also kindly translated the Participant Information Sheet and Consent Form into Te Reo Māori. For my participants, I provided consent forms, and participation information sheets in both Te Reo Māori and English. I endeavoured to offer a kanohi ki te kanohi (face to face) approach as often as possible with potential participants and those helping to recruit or host interviews via networking. For this reason, face to face interviews were chosen. Where possible, participants were interviewed in safe spaces, and karakia (prayer), kai (food), and whakapapa (genealogy) were shared. I was also upfront with participants about how I identified as Māori and how my research aimed to benefit Māori.

This research has also been considered in light of Te Tiriti O Waitangi (The Treaty of Waitangi) and focuses on and acknowledges cultural differences and ways of knowing. Te Tiriti O Waitangi is the founding document of New Zealand, signed in 1840 by representatives of the crown and Māori iwi (tribes) and hapu (sub-tribes). With myself (Tainui, Ngāti Maniapoto, Ngāti Māhuta, Ngāti Hari, Ngāti Pou) and supervisor Erana Cooper (Ngāpuhi, Ngāti Hine) being Māori, this research was an opportunity for Māori to be in control of the research, while also working in partnership with non-Māori (with supervisors Virginia Braun and Kerry Gibson). The research also intends to give Māori women a voice and opportunity to share their knowledge in an area that is of importance to Māori. These factors are particularly relevant to Articles 1 and 2 of the Treaty, which are focused on both autonomy and partnership.

Consideration has also been given to the way in which this research will help to address issues of equity, which is of most relevance to Article 3 of Te Tiriti O Waitangi.

The inequity between Māori women and other populations has been highlighted earlier in the literature review. This research hopes to gather information about the experiences of Māori women, with the intention of using this information to address these inequities. It is hoped that, out of this research, will be the opportunity to develop improved service provisions for Māori women. It is important to myself and my supervisors that the research is able to benefit Māori, and this was one of the main goals in its conception.

### **My Research Perspective**

I chose qualitative research for this study for a number of reasons. The explorative nature of qualitative research (Patton, 2002) is particularly useful for understanding issues and groups which are not well researched. As outlined in the literature review, research with Māori women in mental health is sparse, therefore an exploratory approach seems most appropriate this point in time. Qualitative research also enables rich data to be collected, and allows for thick, deep, dense, and detailed accounts of the participants' stories (Denzin & Lincoln, 2000). This allows one to examine in detail how participants engage in making meaning or sense of experiences for themselves. Given that one of my main aims is to give Māori women a voice as service users of mental health, qualitative research is also appropriate because it allows participants to speak about their personal experiences in their own words (Willig, 2008). Not only does qualitative research help to give participants a voice, it also seeks to empower participants. This is particularly important for marginalised groups as it provides an experience of being able to express their experiences and opinions, and not only have them listened to but purposefully sought. This is in contrast to the ways in which Māori in particular may have felt about their (lack of) ability to contribute to mental health services in New Zealand in the past (Durie, 2011). A qualitative approach can help marginalised groups to feel that their views are useful and valuable, as well as



provide opportunities to contribute to decision-making (Marshall & Rossman, 2011). For Māori women as mental health service users, this might mean opportunities to contribute to mental health service provision. I also consider qualitative research appropriate for this study because I wanted to make sense of participants' experiences in a way that would be suitable for sensitive topics. Qualitative research methods are fluid and flexible, allowing one to understand the subjective experiences of vulnerable peoples (Liamputtong, 2007). In this way, I hope that a qualitative research approach allows participants to feel safe whilst expressing potentially upsetting or difficult experiences.

Qualitative research can be conducted from a variety of epistemological and theoretical approaches. I choose to look through a lens of critical realism (Willig, 1999), in which I intend to try and capture as much of reality as possible, whilst acknowledging that it can never really be fully understood or even identified (Denzin & Lincoln, 2000). In this way, critical realism sits between essentialism and constructionism, and allows researchers to acknowledge how individuals make meaning of their experiences, while simultaneously acknowledging the significance of material 'reality' (Braun & Clarke, 2006). I chose critical realism so that I can acknowledge that my interpretation of the data is just that, an interpretation, but also respect my participants by acknowledging their realities, without simply reducing them to text (Willig & Stainton-Rogers, 2007). As a Māori researcher, this allows me to take a position in the spirit of Kaupapa Māori research that is both non-judging of my participants but also acknowledging of the 'realities' they experience. This helps me to avoid the pitfalls of placing myself in the (culturally) inappropriate position of dismissing the lived realities of marginalised peoples. In the same way, it also allows me to take the same position with women. Just as Ussher (2002), in her interviews with women on pre-menstrual dysphoric disorder

(PMDD), delicately balances the very positivist notion of PMDD with the lived realities of her participants, I also hope to acknowledge the ‘realities’ of my participants whilst maintaining a critical lens.

**Feminist and Critical Gender Research.** I am also informed by the theoretical frameworks of Feminist and Gender research. Below, I outline how feminist and critical gender research influenced the way I approached and shaped my study.

Since the 1980s, feminist and critical gender research has been identified with qualitative research (Gergen & Gergen, 2008). Feminist and critical gender psychology researchers have often been dissatisfied with traditional male-oriented research, which was seen to disadvantage women and perpetuate stereotypes (Gergen & Gergen, 2008). To contrast this, I aimed to approach this study from a feminist position that values women and their experiences, positions participants as experts on their own life, and views the concept of ‘gender’ critically. It has been claimed that using qualitative research as a base for feminist psychology allows women as participants (and actually, as researchers) to become active in the process of research, rather than passive observers (Kasper, 1994), and feminist research seeks to ensure this is the case. For example, as a feminist interviewing ethic (Fontana & Frey, 2000), the interviewer and participant are transformed into two equals who are having a conversation, usually about the participant's life. Given this, I aimed to approach my own interviews from the same perspective, in order to empower my participants. Feminist research challenges the traditional research interview, minimising the power difference between the researcher and the researched, and, like much qualitative research, forms a collaborative relationship between participant and researcher (Fontana & Frey, 2000). This allows women in research to explore the female voice, and look beyond dominant male understandings in order to empower women and give them a voice. In this way, we get

to hear and experience the non-dominant perceptions and understandings; ones we did not get to hear in an academic context before feminist and critical gender psychology, and these are the types of voices I hoped to be able to encourage in my study.

**Research with and for Service Users.** Despite being in its infancy, and in emergent debate (McLaughlin, 2006), research that gives a voice to the service users of mental health is beginning to be more widely utilised (Thornicroft & Tansella, 2005) and acknowledged as important (Bailey, 2005). User involvement in research has been found to benefit both the research and the users (McLaughlin, 2006); providing the research with valuable information and issues that are often overlooked by the researchers. Levels of service user involvement can range from giving a voice, to consultation, to collaboration, to fully user-controlled research (McLaughlin, 2006). Involving service users can narrow the gap between theory and practice, providing health professionals with information to help them place service users at the centre of care (Cooper & Spencer-Dawe, 2006).

My study aimed primarily to give service users a voice (Faulkner & Thomas, 2002), however it is also hoped that this study can both advocate for service users as well as provide them with agency in determining the future of mental health services for Māori women in New Zealand. Indeed, as I was interviewing participants, I noticed they often expressed a gratitude at being given a chance to have their say, not just to tell their story and get it 'off their chest', but to have space to contribute to something that might be useful to other service users in the future, and might improve mental health services. In this way, participating in this research, and research like it, could be empowering for participants. Therefore, I hope to encapsulate a sort of empowerment agenda in my approach to this research.

In sum, the overarching framework within which I developed this research draws on a number of paradigms which were specifically chosen to address the uniqueness of participants' identities and experiences. By taking each element into consideration my intention was that this broad framework would allow me to step into this research alongside my participants, and create something that valued them and their unique experiences as Māori women, and as mental health service users in New Zealand.

In addition to being influenced by these theoretical frameworks, my perspective is also shaped by my identity. In this research I am reflexive about how I am positioned relative to the participants I am studying (Mullings, 1999). Being a Māori woman means I take an insider role with my participants in this study. However, I realised as I began to talk to them that many of my participants were mothers, and at the time of writing I am not yet a mother, so in some ways I was an outsider to their experiences as women with children. In being Māori and researching other Māori, I am an insider, yet not having grown up close to my wider whānau, and not being fluent in Te Reo Māori makes me feel different to many other Māori, and I often feel like an outsider within my own ethnic group. However, many Māori I meet are in the same position as myself, so I often share insider status with other Māori who do not feel as Māori as they would like to. Within my own culture I can be both an insider and an outsider, and sometimes both at the same time.

Being an insider (sharing a social position with your participants) is seen as preferable in qualitative research as it allows researchers to work collaboratively with participants (Dwyer & Buckle, 2009); whereas being an outsider means there is a risk of approaching participants as an 'Other' or 'subject' to be studied (Fine, 1994). This, of course, is not preferable, as especially when conducting interviews on sensitive topics,

participants would not want to feel 'researched', but instead would want to feel that they are being listened to, and perhaps that their participation will make a difference. Being an insider in many regards in this research also allows me to be actively collaborating and participating in creating research for Māori women (Thomas, Blacksmith & Reno, 2000), which also enhances my ability to work within the spirit of Kaupapa Māori research. Being a Māori researcher working alongside Māori participants also means I can engage in Māori research for Māori and by Māori, and hopefully help participants feel self-determining and contributing value to the research and to our people as a whole.

In short, because I wanted to attempt to make sense of and understand the experiences of Māori women using New Zealand's mental health services, I chose an approach which is both practically and theoretically suited to my study. Its suitability for rich and detailed data, sensitive topics and vulnerable groups; and its openness to reflexivity mean that I feel I can do my research, and participants, justice.

### **Design of the Study**

This study is a qualitative interview study of Māori women who have had previous experiences using mental health services. This section describes the methods I used in the study, including participants and how they were recruited, how data was gathered and analysed, the quality of the study, and the ethics process and approval.

**Participants.** I aimed to recruit Māori women aged 18 and older who had previous experience(s) as a service user of mental health services in New Zealand within the past two years, but were considered well at the time of interview and no longer actively using a service. I wanted participants to be recruited independent of any particular mental health service in order to allow for more open expression of their

views. I also wanted them to be currently well in order to ensure their emotional safety in the research interview, and so excluded people who were currently psychotic or distressed. The period of time between when they had used a service and when I interviewed them was later extended to three years to allow some interested participants to share their stories. Twelve participants were recruited. In qualitative research it is recommended that recruitment continue to the point of saturation of the data. This refers to the point at which the same themes tend to be repeated in the data and new information is not forthcoming (Sandelowski, 1995). Morrow (2005) suggests that this often occurs at around 12 interviews in qualitative research. Although ‘service user’ was largely self-defined, I excluded participants who had alcohol and substance abuse as their primary difficulty and recruited those who saw themselves as having a mental health problem. The emphasis was also on *past* experiences, so although some participants were still healing from current experiences, or had long term involvement with mental health services over their lifetime, they were only talking about the experiences from the past which they were now no longer distressed about, and could look back on retrospectively as a completed experience.

The study was advertised via Māori networks, via email advertisements in newsletters, and posters (see Appendix A) in places such as Māori spaces within the University of Auckland, and other Māori spaces. Those interested in taking part were able to contact me via email (which was provided on the advertisement) and were then sent a Participant Information Sheet (see Appendix B). They were asked to contact me again by email to confirm that they wished to participate. Informal consultation was also sought with various Māori mental health professionals and services whom I connected with whilst completing my clinical psychology placements. They overwhelmingly suggested more face-to-face recruitment, and in some cases facilitated

this in person. Patrick Mendes, then Cultural Coordinator of Kari Centre, was particularly instrumental in arranging meetings for recruitment. As a result of his input, I began to use my networks more actively to make contact with possible participants and also initiated a form of snowball sampling by which those who participated were able to tell others about the study and they were then able to contact me for details, or provide me with their phone number or address so I could then speak to them on the phone or visit them in person.

Table 1

*Participant Demographics*

Attribute	Data
Age Range	19 – 64 years
Average Age	36 years
Māori identity only	5 participants
Māori/Pākehā identity	4 participants
Māori/Other identity	3 participants
Range of number of services engaged with	1-5 mental health services
Average number of services engaged with	3 mental health services
Participants with children or grandchildren	7 participants
Participants without children or grandchildren	5 participants
Participants living with family	8 participants
Participants living alone	4 participants

Participant demographics have not been specified to the individual level to preserve anonymity. The ages of the 12 participants ranged from 19 to 64, with an average age of 36 years old. Participants identified as either just Māori (n=5), Māori and Pākehā (n=4), or Māori and another ethnicity (n=3). Participants acknowledged whakapapa from around the country, with those who specified affiliating to Ngāpuhi, Tainui, Waikato, Ngāti Whatua, Ngāti Awa, Ngai Te Rangi, Te Whakatōhea, and Te Rarawa. Participants reported experiences with between one and five services, while

the average number of services experienced across all participants was just over three. Just over half of participants had children or grandchildren (n=7). Two thirds of participants reported living with family at the time of the interview (n=8) while the other third lived alone (n=4). At the time of interviewing, all participants were living in the Auckland region.

At the conclusion of the interview, participants were given an option of whether they would like to receive a summary of the research upon completion. Nearly all of the participants wanted to hear about the findings and provided an email or postal address for a summary to be sent to. These participants will be provided with a brief summary of the research once it is completed. Those Māori networks and individuals who provided consultation and advice will also receive a summary of the research once completed, along with any other relevant bodies who may find the information helpful.

**Data gathering.** This study used semi-structured interview design (see Interview Schedule in Appendix C) which consisted of some open-ended questions to invite discussion of particular topics, and left room for further questions to be asked as each participant shared unique experiences. To capture the emotional subtleties of the interviews, I conducted them myself as a researcher (Hollway & Jefferson, 2012). The interviews were conducted at a place mutually suitable to both participant and researcher (sometimes at The University of Auckland in a meeting room, other times in a local community space, or marae). Participants were provided with a \$20 grocery or petrol voucher koha (gift) of their choice, though some refused to accept. Each interview was planned to take between one and one and a half hours to complete. The longest interview was two hours, and the shortest interview was 46 minutes. The average time across the twelve interviews was one hour and ten minutes. The length



depended on how much the participant wanted to share, and sometimes how long they were able to stay.

Individual, semi-structured interviews were chosen to focus on one person's telling of their own story. A semi-structured design was chosen to enhance the breadth of responses (Fontana & Frey, 2000), and although questions were written down they were used primarily to guide the interview rather than as a rigid set of questions. Open-ended questions and prompts were used to evoke further responses and elicit stories from participants (Hollway, 2009).

The main aim of data collection was to hear the participants' stories of their experiences of being a Māori woman in New Zealand mental health services, and as such, very broad questions were asked, and were followed up by prompts to continue the telling of the story by the participant (see Interview Schedule in Appendix C).

Before the interview participants were welcomed, made comfortable, and, when appropriate, engaged in sharing *karakia*, *kai*, and *whakapapa*. Informal talk about shared *whānau* and *whakapapa* was often engaged in before recording which started to establish connections between the interviewer (myself) and the participant. This is also known as the process of *whakawhanaungatanga* (establishing relationships). At this time the consent form was also explained and completed (see Appendix D). The interview was framed for participants as a conversation in which they would be able to share as much or as little as they wanted about their experiences with mental health services. Participants were then asked if they were happy for the audio recording to be turned on and for the interview to begin (Braun & Clarke, 2013). The beginning of the interview often consisted of the participant speaking about their *whakapapa* and history, before moving onto their engagement with mental health services. In general,

participants were asked to talk about their experiences beginning from how they became to be involved with mental health services, and further prompts lead them through a telling of their experiences. As the story was told, participants were asked about their positive, negative, and neutral experiences, and asked whether anything could have been done differently to change that experience for them. During the interview process, some participants became visibly upset due to the nature of topics discussed. When this happened, participants were reminded that they could stop the interview at any time and did not have to answer any questions they did not want to.

In keeping with my empowerment agenda, I made a point to position the participant as the expert on their life and their experiences, but also on the subject of having been a mental health service user. Through the interview I endeavoured to ensure that participants were able to construct the story of their experiences in their own way. In conducting these interviews I recognised that people told stories about their lives and that this took a narrative form. Narrative, it is argued, is a ‘basic property of the human mind’ that ‘dominates human discourse’ and plays a role in ‘sense-making’ and constructing identities (Hiles & Cermak, 2008), and so naturally, when asked to talk about their experiences, participants will respond in narrative form. Often this narrative follows a temporal sequence within which events unfold over time. Overall, I aimed to meet the needs of the participant, rather than the needs of the research, in the name of equity but also because I agree that it produces better ‘science’ (Kasper, 1994).

After the recording was stopped, participants often engaged in less formal talk about their experience of the research. This was not transcribed, but noted by myself in a research diary, as I felt it served extra information about the study (Silverman, 2013). It was often helpful in noting how the interview process could be improved in the future,

and sometimes provided more candid insights into participants' experiences that they did not wish to be recorded.

**Data analysis.** The interviews were digitally recorded and then transcribed by myself or by a transcriber who had signed a confidentiality agreement, and then checked by myself.

The method of analysis used was thematic analysis, as outlined by Braun and Clarke (2006). A deductive form of thematic analysis, driven by my theoretical and analytical interest in the area of Māori women's mental health, was used to provide a detailed analysis of participants' experiences in regards to mental health services. Theory, and my own life experiences, played an important part in framing my interpretations (Braun & Clarke, 2013). In this sense, themes do not 'emerge', but are, in a sense, created or chosen by the researcher, and shaped by who I am and where I come from as an *active* participant in *doing* the research (Braun & Clarke, 2006). However, I was also interested in finding out what I did not know or understand about the participants' experiences of reality. It was hoped by examining these in detail that I would gain an understanding of the phenomenon in question (McLeod, 2001). I also tried to keep an open mind in recognising novel ideas, including those that did not easily fit in my own frameworks of understanding. I discuss this below in regards to the quality of the study and consensual discussion (Hill, Knox, Thompson, Williams, & Hess, 2005).

As recommended by Braun and Clarke (2006), the data were first experienced in the interview, live, and audio-recorded at the time. They were then transcribed verbatim by the interviewer or transcriber, checked, read, and re-read several times, so I could familiarise myself with the data. The data was then run through several stages

of analysis and manually coded several times, in order to identify, analyse, report themes, and interpret patterns in the data. Initial codes were generated to organise the data into meaningful groups (Tuckett, 2005); and the search for themes followed. Identified themes were refined over multiple analyses of the data. As demonstrated by Clarke and Kitzinger (2004), the prevalence of each theme was not necessarily dependent on quantity but rather whether it captured something important. The themes were then defined, named, and sometimes renamed several times in discussion with my supervisor, as well as classmates and colleagues with similar research interests. I then attempted to move from description to interpretation, in an attempt to look at the significance and broader meanings of the themes identified (Patton, 1990). This analysis was developed over a long period of time (Ely, Vinz, Downing, & Anzul, 1997) and was not carried out step-by-step, but in a fluid sense of being able to move backwards and forwards in the process as necessary (Braun & Clarke, 2006).

One advantage of thematic analysis is that it is flexible, and as such as well-suited to projects in which one of the aims is to give participants a voice. However, giving voice is not as simple as repeating the words of participants, but actually "involves carving out unacknowledged pieces of narrative evidence that we select, edit, and deploy to border our arguments" (Fine, 2002, p. 218). I hoped to identify latent themes in the data to get at the underlying ideas and ideologies of the participants' experiences in New Zealand mental health services (Braun & Clarke, 2006).

**Quality of the study.** Just as quantitative research relies on concepts such as reliability and validity to judge the quality of itself (Denzin & Lincoln, 2000), qualitative research has a developing set of criteria that lend quality to the study. Internal validity in qualitative research reflects how accurately the account by the researcher reflects the participants' realities (Creswell & Miller, 2000). This can be

ensured via disconfirming, researcher reflexivity, and thick, rich description (to create a sense for readers that they could have experienced what is described in the study) (Creswell & Miller, 2000). These concerns were addressed by searching for data that disconfirms the themes selected, self-disclosing the researcher's beliefs and assumptions, and seeking to retain the rich descriptions of participants. Themes were also discussed in supervision in order to challenge my perspective (Morrow, 2005), as well as informally with Māori and non-Māori classmates, colleagues, and whānau, to check whether I had captured the possible meanings in the data and to subject my ideas to critical discussion with others (Hill et al., 2005).

External validity in qualitative research refers to the generalisability of the results (Morrow, 2005). Validity in qualitative research is also sometimes known as trustworthiness or credibility (Morrow, 2005); however, some group reliability into the same definition (Madill, Jordan & Shirley, 2000). The distinction of reliability, however lies in the consistency of meaning (Madill et al., 2000), and the re-coding of data solidifies this. To address this, data were re-coded a number of times, and checked each time for consistency. Reflexivity in qualitative research is “the process of a continual internal dialogue and critical self-evaluation of researcher’s positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome” (Berger, 2015, p. 220). Reflexivity is not just reflection, and in writing this, it is often the consideration of how to write more of myself into my work without silencing my participants (Fine, Weis, Weseen, & Wong, 2000). I hope that in this process I have managed to be reflexive about my involvement in the research, the advantages and limitations of my methodological choices, the ethical judgements I have had to make, and the hopes I have for this research (Gergen & Gergen, 2008).

**Ethics.** This research was approved by The University of Auckland Human Participants Ethics Committee (details of this approval are included on the Participant Information Sheets and Consent Forms for the study - see Appendices B and C). The ethics of this study were considered carefully both in the approach and inception and in the ethics process itself. Although ethical issues are always important in research, I felt it was particularly important to conduct this study as ethically as possible, for several reasons. Firstly, as a people Māori have often been greatly wronged as the ‘subjects’ of research in the past (Bishop, 2011). Secondly, participants are particularly vulnerable as mental health service users (Liamputtong, 2007). Thirdly, they are also being asked to open up about potentially distressing experiences, and talk about sensitive moments in their life (Liamputtong, 2007). Given this, the intent to avoid or reduce any harm to participants seemed vital.

In particular, I recognised that talking about past mental health experiences may re-evoke emotional distress. This was handled sensitively by myself as the interviewer (as I am a training clinical psychologist and have some experience with talking to people about sensitive issues). Additionally, two of my supervisors (Kerry Gibson and Erana Cooper [Kaupapa Māori lecturer and Māori clinical psychologist]), who are both qualified clinical psychologists, were available to advise on distress and refer participants to other mental health services if need be.

Confidentiality and anonymity was ensured by restricting knowledge of who has participated to myself only, keeping consent forms separate to transcripts and data, and changing names and other identifying information when participants’ quotes were used in the write up (or not quoting them when identifying information could not be omitted). Participants were informed of how their confidentiality and anonymity would be ensured, and were fully informed of how their data would be used (such as potential

use of quotes in publications or presentations arising from the project). Although whakapapa was often talked about with participants during or before the interview, this has not been recorded in any official way, because the potentially unique mixes of iwi and hapū combined with the small sample size in this study meant that a participant's whakapapa could be identifying.

Participants were also able to withdraw their data at any time, without giving a reason, up to a month after data collection. The data will be stored for up to 10 years. Electronic files are protected by encryption, transcripts are password protected, and final backups will be made to a secure, encrypted, external hard drive kept at the University. At the end of the project, electronic files will be deleted and hard copies of the data shredded or otherwise securely destroyed.

### **Summary**

In summary, twelve participants were recruited for this research, and varied in age, background, whakapapa, and experiences with mental health services. Data were gathered via semi-structured qualitative interviews which took just over an hour on average to complete. Data were then transcribed and analysed via thematic analysis and processes were put in place to ensure the quality of the study.

## CHAPTER 3: FINDINGS

This chapter presents the findings of the thematic analysis. A total of 19 themes are presented across six categories, as shown in Table 2. These categories and themes have been arranged into an order that aims to present a story of participants' experiences, from the time prior to engagement with mental health services, through to their experiences with mental health services (and help sought outside of services during this time), and finally through to a retrospective look back on these experiences and ideas for the future. This temporal narrative account was chosen to reflect the way in which nearly all of the participants' stories captured a distinctly time-based beginning, middle, and end. It is hoped that arranging themes in this way will allow the reader to walk alongside participants in their collective narrative, to gain a richer understanding of their experiences.

### **Making sense of mental health problems**

Under this category I present themes which captured the way that participants made sense of their mental health difficulties. Their experiences have been grouped into three themes: experiencing violence or harassment at the hands of men, contending with roles as wāhine, and struggling with their cultural identity. While the difficulties of participants reflected some differences, there were similarities present in their experiences that are reflected in these three themes. Participants sometimes spoke about diagnoses they had been given by mental health professionals, however these were not considered in the thematic analysis unless they were congruent with the struggles participants identified with themselves.



Table 2

*List of categories and themes in findings*

Categories	Themes
Making sense of mental health problems	As a response to violence or harassment at the hands of men As a response to struggling with roles as wāhine As a response to struggling with cultural identity
Managing without mental health services	Continuing in the face of adversity Relying on whānau support
Delaying contact with mental health services	Because asking for help is hard Because we don't know or trust them Because we engage only in a crisis
Building a relationship with mental health services	A genuine relationship Finding understanding Being able to trust them to maintain confidentiality Not feeling pressured Looking for acknowledgement Looking for familiarity
Looking beyond mental health services	Going back to whānau Seeking Māori support outside of mental health services
Improving mental health services	Coming to meet people halfway Seeking more Māori professionals, healing, and worldviews Moving toward collective support

**Making sense of mental health problems: As a response to violence and harassment at the hands of men.** Of the twelve participants, nearly half made sense of their mental health problems, at least partially, as a product of their struggles as victims of violence or harassment at the hands of men. Participants spoke about being hurt physically, emotionally, and sexually, and it was common for participants to refer to both childhood as well as more recent experiences in adulthood. Although

participants spoke of events occurring in the past, they often also spoke of the continued effects of these experiences in their lives since.

A number of participants shared their experiences of physical violence in childhood. One participant described how her father had given her severe hidings as a child:

And I got a hiding kind of thing [...] I had black eyes, my face was beaten up. I had to tell everybody [...] that I'd walked into the door, but my father had given me a hiding for something, you know, but just overboard, overboard. (P12)

Not only did this participant describe being physically beaten, she also explained that she was scared into lying about her visible injuries in order to 'keep the peace' at home. Like a number of other participants, this woman went on to recall her experiences as a victim of physical violence in adulthood. She provided this vivid account of her first violent experience with a partner:

I angered him. First time and he picked me up and was throwing me into the walls. So yeah, that was my life for about, with him for about seven years, six going on seven years. So the culmination of like at the ends of it he tried, that was my second death experience I suppose. So he tried to batter me to death, drown me in the bath. (P12)

Some participants, like P12, spoke about being subjected to overt violence from the men around them, but others spoke of more subtle verbal or emotional abuse. A number of participants recalled experiences of being harassed, talked-down to, or belittled by men. One participant described various incidents of sexual harassment from her then-partner's male friends immediately prior to her first engagement with mental health services. This was also at a time when she was geographically isolated from her

immediate family, and felt she was severely outnumbered and overpowered by these men.

I was in a pretty... not a very good relationship at the time. Umm, he was very much invested with his blokey mates, and I kinda was on the periphery a lot, umm, they were very misogynist about women, and very like blatantly in front of me, and his friends would always make derogatory comments about me, and, directed at me, and, but made in a way that was supposed to be funny, or supposed to be like y'know 'oh hey you know, it's supposed to be a compliment' you know, but, he just ignored me as if I didn't even exist, and my partner was sort of 'oh don't worry about them, you know they're just dicks' but of course he'd go along with what they're saying. (P01)

This participant also spoke of being harassed by a man her place of adult education, which was then legitimised by other students and educators, who did nothing to stop the harassment, even when the participant laid a complaint and asked for help:

So, there was a, male, in a position of power over me, who, took a fancy to me, and, this was picked up and noted by my colleagues, who hassled me about it and suggested that I was doing it in order to incur some benefits, and umm, it was hurtful in an environment where I wanted to make friends with people.  
(P01)

Although this participant also identified other difficulties which lead her to seek help from mental health services, experiences of being belittled and harassed by men became a prominent feature in her distress. Sexual abuse by men also featured significantly in many of the participants' accounts of the origin of their difficulties. As the following participant described it:

Cos I was abused when I was 8 years old. Oh no 7, 7 years old and that happened until I was 13. It was my uncle, he used to sexually abuse me, yeah and my parents didn't know about that. But that affected me, and I didn't have a boyfriend when I was growing up. Yeah, I was scared of men, I was petrified of them. Yeah, but I ended up going with men that, that needed sympathy, yeah, and they didn't treat me very well, yeah. I got used a lot, yeah and that made me unwell, yeah. (P09)

Not only was her experience of sexual violence as a child distressing at the time, it continued to affect her relationships with men as she grew up, from being frightened of men, to again experiencing violence from them. This sentiment was expressed in a similar way by another participant, who, as an adult, was able to recognise how these early experiences of sexual violence had affected her later experiences of "women's stuff".

So I was sexually abused, raped for the first time probably before I was five anyway. I think it was around about four, which gave me all sorts of lifetime kind of issues with anything to do with women's stuff. You know, periods, childbirth, pregnancies, anything like that. Female, male relations, yeah. (P12)

One participant was dealing with a current accusation of sexual violence within her extended family, and recalled her own childhood experiences of being sexually abused:

Cos I was a victim of sexual molestation, so I know, and I'm watching, I'm constantly watching. I'm hypersensitive when it comes to things like that. (P02)

Interestingly, although this participant's experiences of sexual abuse as a child were highly distressing, she described feeling empowered in later life to take charge of her current difficulties with a more honed and critical eye. She felt these early experiences

allowed her to feel powerful and knowledgeable in similar situations as an adult. A number of participants echoed this sense of empowerment as a result of their experiences:

But it was because I said to him no more. I don't want to be your punching bag any more. I don't want to be anyone's punching bag any more. (P12)

Here P12 describes how she was able to gain some retrospective understanding of her experiences and realisation that she should not be treated this way. Like other participants, she spoke about her experiences not just as part of the cause of her mental health difficulties, but as something that empowered her, and made her stronger.

It seemed that for a number of participants the experience of violence and more subtle harassment at the hands of men was seen as central to their understanding of their difficulties. Experiences of physical violence, sexual abuse and harassment by men were woven through their lives and were seen as cumulatively contributing to their mental health problems. However, for many of those participants who shared experiences of violence, the outcomes seemed to be more complex than simply being bad events that caused their mental health difficulties. As well as being understood as contributing to later difficulties, these experiences were also framed as strengthening and empowering. Overall, participants' stories seemed to reflect a common thread that meant their experiences of being hurt by men played a role in understanding both their problems in mental health, and sometimes their strengths.

**Making sense of mental health problems: As a response to struggling with roles as wāhine.** This theme attempts to capture the difficulties participants struggled with regarding roles as wāhine. Two thirds of participants shared experiences related to their roles as women, including pregnancy, childbirth, raising children, miscarriage, or

termination. In particular, participants shared stories about the impact of changes to their identity as wāhine, such as coping with motherhood and the loss of children (whether they had passed away or been removed from their care), and framed these experiences as contributing to, or exacerbating their mental health problems.

A number of participants spoke of struggling with growing into the role of becoming a mother. One participant recalled how she became involved with mental health services when, feeling largely unsupported by her then husband, she struggled immensely with motherhood, which culminated in her child being placed into care:

He went straight for a while, [...] when we had our first child, but I wasn't; coping with him using while we were having our first child and I just, just didn't feel that I was getting the support from him to help me, help me cope. Yeah. So I lost my child to Child, Youth and Family. They stepped in because I was getting ill. [...] I wasn't coping very well with my son, yeah and I was hitting him, I was trying to suffocate him, I was doing things that weren't right. Yeah, I knew, knew they weren't right but I was struggling to find some help to, to cope with being a Mum. (P09)

Not only was she struggling with a lack of support in finding her role as a mother, she began to struggle further at the distress of having him taken away from her:

They've got, they've got my son [...] when he left I was, I felt, empty and lost without him [...] (P09)

She then reflected further on how being without her son contributed to her difficulties. In times when she had been particularly “unwell”, she had been unable to visit her son, and in this conundrum, became more “unwell” without contact with him. She also

blamed herself for this situation as she felt it was her fault that she was not strong enough to cope with her difficulties in order to be deemed well enough to visit her son:

That's what was making me ill, making me get depressed and out of control was I wasn't seeing my son back in 2010 for, for a long time. It was so many months. Because I wasn't, I wasn't, I wasn't strong enough to cope, yeah... (P09)

A number of participants also experienced difficulties with feeling low, sad, or lost after childbirth, sometimes through multiple births. One participant recalled how her journey into mental health services began with being told she had postnatal depression, after losing a baby to miscarriage soon after the birth of her previous child:

I was diagnosed with postnatal depression. I lost a baby after my daughter and that sort of triggered it, yeah, so. (P08)

She commented on how distressing the entire medical process of dealing with the miscarriage was:

And um, it was real intimidating who I went to, you know, to confirm that it was dead that, um, I had to sit with all these pregnant women to wait for my scan sort of thing. And they were having babies, kind of thing. (P08)

She also reflected on how she had been immediately discharged with no follow up after confirming the loss of her baby, and had realised after a month or two of not being able to stop crying that she needed some support:

I, I had just, you know, lost the baby and then they just confirmed it and just let me go kind of thing. And then I went back and I thought oh, there's something wrong with me, I can't, I can't stop crying sort of thing. Because it wasn't like

a month later, a month or two later that I had gone back and I had been basically crying all the time. (P08)

Another participant felt substantial loss after losing a child via termination. She felt that her difficulty around this was not recognised by medical professionals at the time, but in retrospect she felt it contributed to her first “breakdown”:

I was also struggling with the fact that I’d had a termination. Um, and, which, and it’s only after having kind of these last two breakdowns that I’ve had over the last two years, I have ended up wondering whether I suffered, or had something kind of similar around that time but it kind of went undiagnosed. (P07)

For these participants, and others who shared experiences of miscarriage and termination, they seemed to feel unsupported, or that their grief was unresolved or unacknowledged. It seemed that while the event itself was difficult, feeling unsupported and unacknowledged throughout meant that the difficulty, and impact, was even greater.

In summary, a number of participants understood their mental health difficulties as a response to some of the challenges of being wāhine. For some, this was a central difficulty, and for others, it is was a small contributor. Participants expressed difficulty with the actual events, such as becoming a mother, raising children, miscarriage, termination, or losing care of children. Participants also expressed that there was added difficulty in the aftermath of these events. Coping with children, a lack of follow up after medical procedures, ongoing custody disputes, lack of acknowledgement of distress, or themselves or others not recognising they were not coping, seemed to compound this difficulty. For these participants, their mental health problems were



understood not just as a result of struggling with being wāhine, but the ongoing struggle that came with the lack of support.

**Making sense of mental health problems: As a response to struggling with cultural identity.** Nearly all participants described how their struggles with their identity as Māori had in some way contributed to their mental health problems. Participants expressed struggling with developing a Māori identity for themselves, and having their Māori identity ignored or denied by others. It was common for participants to speak of difficulties with their cultural identity both in childhood and more recently in adulthood, and participants often gave a narrative of how this had evolved over time for them.

Some participants described how this struggle began early in childhood. One participant recalled how growing up in a largely Pākehā school meant that her identity as Māori felt restricted from a young age:

I think I was the only Māori in my year, at that school. There was a couple of years, there was some Māori people that came in, just for a short time, but they'd left soon after cos it wasn't, they sort of, it was the kind of primary school where they would teach, y'know 'this is how you count in Māori and we'll do, a stick game, but the attitude was very much of umm, you're you're playing in our game now, like, you play by our rules, you know, this is how we're gonna learn, this is how we're gonna do things, and none of this sorta feeling sorry for yourself crap. (P01)

This participant also recalled, as an adult, how angry she felt when members of her adult education class judged her, denying her a Māori identity and at the same time

discriminating against Māori by associating negative attributes with the identity. She described her experience:

[...] and it was at a time when I felt that nobody in my class believed that I was Māori, no one gave me any, umm, everyone said I was too white to be Māori, everyone said I was too smart to be Māori, in my class, fuck you know if that's not a fucking double-ended fucking slap I don't know what is, but, one of those things, my whole aspect of being Māori was being pushed down, like being stifled [...] (P01)

Not only did this cause her anger, she felt as though an entire aspect of herself was being denied and devalued. A number of other participants also struggled with being denied a Māori identity because they were seen as 'too white'. Another participant lamented her fairer complexion and the judgement passed on it by others, which she felt hindered her journey of finding her identity as Māori:

I was still struggling with my own identity. Because obviously with the way that I look I encountered kind of, um, well I guess a lack of acceptance or what have you from some Māori people and my family also couldn't understand why I was wanting to express, um, or be part of things Māori. (P07)

For this participant, this lack of acceptance, particularly from the Pākehā side of her family, meant that she felt isolated in her attempts to "be part of things Māori", at a time when she felt she needed to create a Māori identity in order to heal. Many other participants also saw developing a Māori identity as crucial to their wellbeing. One participant described how her mixed identity was responsible for her difficulties that lead to her engaging with mental health services:

I guess being both [Māori and Pākehā] has been related to the issues I've had with mental health. Like identity issues... (P10)

She explained how being brought up both in a largely Pākehā environment, and without her Māori parent, affected her:

I think cos I went to like a very Pākehā school, and there was no Māori presence at all yeah the culture kind of taught me oh you're just that, just be Pākehā, but then I realised I can't, because I can't deny half my family. I was kind of brought up – my Pākehā family had something against my Māori side, because my parents split up, so they had a prejudice against it, and I have a big family, on my Pākehā side. All my relatives they're all just Pākehā, so they kind of had to point it out all of the time: "It's cos you're half Māori". (P10)

Like others, this participant identified her distress as being associated with feeling unsettled about her Māori identity (or lack thereof). This was compounded by having to justify herself at times:

I have to keep talking, and keep justifying. Oh yeah and then they were well what percent are you? And I was like, it doesn't matter how my family are Māori. (P10)

Despite being able to assert herself in some situations, the constant questioning and judgement of her Māori identity caused distress for this participant.

These participants described how struggling with their cultural identity caused them difficulties. They recognised retrospectively that these struggles had led to their engagement with mental health services, even if they were not aware of this at the time. Sometimes this struggle was expressed as being within oneself, with participants coming to terms with or trying to create their own identity as Māori. Other times this

struggle was created or exacerbated by others who judged or restricted participants' Māori identity. Experiencing others aggressively questioning their identity or associating negative attributes to it caused participants to feel unsure of themselves and discriminated against. Although a few participants expressed this was their main difficulty, many felt this to be an extra source of difficulty in addition to other sources of distress.

In summary, participants understood their mental health problems as a product of their experiences of violence at the hands of men; a product of their struggles with their roles as wāhine, and the outcome of their struggles to establish their Māori identity, and have this accepted by others.

### **Managing before mental health services**

This section looks at how participants were managing and coping with their difficulties before engaging with mental health services. Almost all participants described a period in which they tried to manage with their distress without seeking formal professional support. This seemed to capture the period of time in which participants first recognised that they were experiencing difficulties but before they began to think about seeking formal support. Two common ideas expressed by participants were managing by continuing in the face of adversity, and managing by relying on whānau support.

**Managing before mental health services: Continuing in the face of adversity.** Almost all participants described trying to be strong and keeping going on, even when times became tough, in the period before they engaged with mental health services. Participants spoke of the strength of Māori women and how they just keep

going when things become difficult. They expressed the idea that though this was usually seen as a good thing, there were also downsides.

Many participants provided an account of how Māori women were tough and strong. One participant summarised it aptly while laughing:

My experience as a Māori woman has been “Fuck life is really fuckin’ hard sometimes life is not fair” and you just fucking get on with it (laughs). (P01)

One participant used a metaphor of a broken down car to describe how Māori women keep on going in the face of their difficulties:

Yeah, yeah, and, and we have to remember that okay the car breaks down and they get repair and they’re on the road again. And I think that’s, that’s what it is with, with Māori women. (P06)

Several participants spoke about how they drew strength from the idea that Māori women were strong in the face of adversity. As one participant put it:

Umm, I think being a Māori woman, we’re pretty tough (laughs) umm, my grandma is a pretty, both my grandmas actually, are very influential on me in the ways in which they are pretty hard people, they don’t take much crap. Umm, but that’s, that’s something that, I’ve been told I’ll grow into, that’s something that, that comes, I’ve been told that’s something that comes with time. (P01)

She theorised that it was something Māori women developed as a result of facing hardships throughout their lifetime, and explained that this was a strong idea passed down in her whānau:

I can imagine that over time it’s made me stronger, and stronger, and stronger. So I think it’s, it’s been good to have role models who have- who have role

modelled that, that when the going gets tough, you just get stronger (laughs).

(P01)

For this participant, it meant that although she had been through difficult times, these would empower her by increasing her strength to be able to deal with difficult times ahead, layering in a cumulative way to make her stronger and stronger as she grew and matured. This sentiment was echoed by other participants. An older participant wondered about strength being ingrained in the role of women:

Well, what I'm saying is that the women are, um, I guess in, in many ways we're stronger because we're the nurturers and the... and the men have another role.

(P06)

Some explained that this strength had been modelled by other women in their family and they learnt from this:

Because my Mum was pretty staunch about it too, she was like oh no, you, you just harden up. Harden up and get over it sort of thing. And I'm like oh, okay then, I won't tell anyone, try and hide it the whole time. (P08)

Although participants described being strong as a form of coping, some conceded that continuing on in the face of adversity was sometimes a negative thing, particularly when they isolated themselves and their feelings. As one participant put it:

I like to think I was a bit staunch and wasn't, and was kind of detached from my feelings [...] so I kind of didn't communicate some of my feelings as best as I could because I always felt like I took after my mum. (P11)

Another participant also acknowledged that being “tough” and putting on a brave face was not necessarily a good thing, even though it helped her cope. She reflected on how skilled she thought Māori women were at maintaining this facade:

They thought I was pretty fabulous up here but just ‘ko te ahua nei’, you know, in Māori is like ‘as it would appear’. I think that Māori are really good, Māori women are very good ‘as it would appear’ people. So you know what I mean? So on the outside. Inside you're dead or you're dying. Yeah and nobody knows, yeah. (P12)

This was echoed by another participant who spoke of how Māori women just carry on, however she also conceded that not talking enough was problematic:

[...] so a big factor aye with Māori women, you don't talk about it enough and get the help you should do, and just seem to take the world on and passing everything by. (P04)

As well as being a way of managing before mental health services, being strong could also mean that participants did not receive the help they needed soon enough.

Overall participants expressed a key idea of Māori women being tough and strong, which allows them to carry on in the face of adversity and manage without support. However, participants also expressed that hiding vulnerability might be a bad thing, and delay or prevent them getting the help they needed. They seemed to express there being an expectation from others for them to be strong, simply because they are Māori women, and this was often expressed in family beliefs and expectations. Continuing in the face of adversity, for these participants, was expressed as an empowering and positive way of managing their difficulties, and also had the potential for simply being a facade which allowed them to hide their distress. Overall,

participants expressed that being expected to be strong could be positive, but could also be problematic.

**Managing before mental health services: Relying on whānau support.** All twelve participants spoke about the importance of whānau and whānau support, and nearly all participants spoke of relying on this support to some extent before seeking professional help. Participants spoke of the close support from whānau, that things were generally kept and dealt with within the whānau, and of relying on help from whānau as the first point of call before seeking professional help. They spoke about how this meant that difficulties were kept and dealt with within the family, but also that sometimes the guidance of a family member was used to encourage them to engage with mental health services.

A number of participants spoke about how they relied on family relationships to help them when they were feeling stressed. For example, one participant spoke at length about the closeness of her family, and how she depended on them for support with just about anything:

We've always been a close whānau. [...] we ring each other up all the time and just say how are you, we'll talk for hours on the phone, and that's my brothers too, they'll ring up like hi sis, just ringing to see how you are [...] And it's like, oh thank god you rang [...] and it's about seeking advice from them without having to ask them for advice. (P02)

This participant also explained how this support went both ways and was provided without having to ask. Others described a similar strong sense of family support. One participant described how, in her wider whānau, there was a sort of system in place for how difficulties were managed:



There was this sort of, a sense, within, umm, my family that things were kept within the family, and that was how things were dealt that, you know, mum would always talk to or consult with her mother, and aunties, and uncles, and, there was always someone to consult with [...]; the whānau was to manage those sorts of situations. (P01)

She explained that she had assumed that her family would always be able to help her and that engaging with mental health services was not something she had considered. This was also echoed by other participants who recognised that things were dealt with within their whānau:

So yes, no we don't always seek assistance because we deal with it in the whānau, or in the extended whānau. (P02)

While relying on family seemed to make using mental health services a less obvious alternative, some participants described how family members had been active in encouraging them to seek professional help. One participant explained how her mother had courageously over-ruled her reluctance to seek professional help and insisted she do so:

Um, and um, my mum was like oh I think we should talk to someone. I think you need to think about medication. She was really brave, she brought all that up because I just completely negatively reacted and was like I don't need to be medicated, there's nothing wrong with me you know [...] I just thought I was normal and she was like well will you at least talk to someone? (P03)

Although the precise form family support took varied from one participant's account to another, most explained that they had relied on their family to help them with their difficulties, particularly in the early stages of experiencing mental health difficulties.

Some families remained the primary method of support for participants, while others encouraged participants to engage with mental health services. Either way, family support was described as being a vital resource to participants in managing their difficulties.

In summary, participants described managing by being strong and keeping their struggles to themselves, but also by relying on whānau support. Some participants expressed the idea that having whānau support meant that they felt that they did not need to seek professional help at times. For others, they spoke of seeking professional help only when recommended, or encouraged by, whānau members. This, in itself, was described as another form of support from whānau.

### **Delaying contact with mental health services**

This group of themes are focused on engagement, or rather, delayed engagement, with mental health services. All participants gave accounts that emphasised difficulties such as finding it hard to ask for help, feeling that they should only engage in “an absolute crisis”, and a general distrust of mental health professionals. Although all participants did eventually engage with some sort of professional help, these barriers made it more difficult to do so.

**Delaying contact with mental health services: Because asking for help is hard.** Almost all participants explained that approaching mental health services and asking for help was very difficult. They provided a number of reasons for this difficulty including that they found it shameful to seek help from strangers, and because it was hard to acknowledge that they were not coping.

Participants described how asking for help was hard because of shame. In many cases participants associated the shame with sexual abuse experiences and spoke of the difficulty in sharing these experiences with others, as one participant said:

But of course I'm not gonna tell anybody because it's something that is private to all Māori women. They don't wanna tell the whole world oh yes, I've been sexually abused, oh yes, I've been badly abused. (P06)

Other participants echoed this sentiment with their own individual experiences. One participant also added that the "privateness" of it all exacerbated the shame because although she wanted to speak to a professional in 'private' about something 'private', doing so seemed to reinforce that it should be kept 'private':

[...] things that, y'know I felt ashamed about, and y'know, or wanted to speak to someone privately but, in a sense, working with that, privateness kind of, reinforced the fact that it was a private matter, made it harder to talk to other people about. (P01)

Another participant added that it was having to ask strangers for help that increased the feeling of shame:

It is, the thought of having to ask strangers for help is really shameful, you know, oh they're just going to think I'm a useless person, and I can't cope but I don't know how to manage my life properly, and they're just going to think the worst of me. (P02)

This participant also expressed an element of fearing judgement from professionals if they acknowledged they were not coping. Other participants expressed how difficult it was to acknowledge their struggles. One participant described it frankly as "bloody hard":

But I know that the first time I ever went it was really hard for me. Just to acknowledge that I wasn't coping, that's bloody hard, you know what I mean?  
(P02)

Several other participants also spoke about a reluctance to acknowledge they could not cope. One participant found it hard not only to engage with her doctor for help, but to utilise the support available to her, because she found it difficult to accept that she was struggling:

And at the time when I was first diagnosed I didn't wanna accept it, and I didn't want anybody to know about it. And so I, um, denied the medication and all the help and for [...] three years I just tried to wait for it to go (laugh). (P08)

For these participants, the reluctance to acknowledge they were not coping may be linked to the previous theme of Māori women being expected to be strong and just 'get on with it'. Acknowledging they were not coping, for these participants, may have conflicted with their commitment to continue in the face of adversity.

Participants described many factors that made it difficult for them to seek help. In some case they were reluctant to seek help because of the shame of talking to a stranger about sensitive issues, such as sexual abuse, and their lack of familiarity with opening up to a professional outside of their community. However they also expressed their own reluctance to acknowledge they could not cope. This seemed to be twofold in that it was difficult to ask for help because that would mean admitting to a stranger (mental health professional) that they could not cope, but also meant acknowledging this for themselves.

**Delaying contact with mental health services: Because we don't know or trust them.** Another reason participants often gave for not engaging with mental health

services was related to a caution, suspicion, or distrust about approaching mental health services. This was separate to a general difficulty in asking for help, and was more specific to not wanting to engage with mental health services in particular, despite being willing to accept help from other resources, such as whānau members. Participants described being held back by a lack of familiarity with mental health services, a mismatch between the individual nature of services and their own collective values, and whānau beliefs that fostered a suspicion of mental health services.

Sometimes the hesitation to engage with mental health services was simply put down to unfamiliarity, with the service, the people there, and sometimes also the mode of engagement. As one participant put it:

Yeah initially when I used the services there, I felt uncomfortable, I didn't know what to do, what to talk about, I didn't know how to talk about anything. (P02)

For this participant, the gap between her usual way of talking and expression was so different to what was expected by mental health services that she felt uncomfortable. Another participant commented on her Māori view of the self as a collective, and theorised that this might be why she, and other Māori, do not want to engage with services, which are traditionally focused on the individual:

I used to feel uncomfortable even just talking about myself to shrinks. Just that whole thing of like focussing on you and what you want and how you feel. Like it's quite like daunting I think if you grow up Māori. It's very like, there is no you. It's everyone. [...] So even just seeing a shrink in itself is kind of going against how I grew up. Going there to talk about your own issues and oh, you know what I mean. So that needs to be, I think, taken into consideration. (P11)

The concept of going alone to a service to engage and talk just about her own difficulties seemed such a foreign concept that she recognised it was one of the reasons she did not ask for help sooner from mental health services. A number of participants described how their family were generally suspicious of mental health services, preferring to resolve their issues within the family, by utilising the help of family members. As one participant explained:

Very deeply suspicious... we were umm. There was this sort of, a sense, within, umm, my family that things were kept within the family, and that was how things were dealt that, you know, mum would always talk to or consult with her mother, and aunties, and uncles, and, there was always someone to consult with. But that, umm, the whānau was to manage those sorts of situations? Umm, you know that we don't go and sort of talk about, you know, and raruraru [problem or dispute] with other people, and there was a - there was a reason for that, and that was because we would get judged, umm, mum was very aware of judgements from other people, she was very aware of racism. (P01)

For this participant, like many others, keeping things within the family was the safest and most effective way of dealing with any difficulties.

Overall, participants largely expressed being wary or distrusting of mental health services in general. The lack of familiarity, and unwillingness to engage with professional help, seemed to be in direct contrast to the closeness of whānau, and the willingness to accept help from their families. Participants' concern that mental health services would be based on an unfamiliar and individualist approach seemed to add to their reluctance to engage.

**Delaying contact with mental health services: Because we engage only in a crisis.** Many participants spoke about only considering engaging with mental health services at the point at which they found themselves in crisis.

One participant captured this in her response to a question about when she would consider approaching mental health services for help, she replied:

Only in an absolute crisis. (P02)

She explained how, in her most recent experience of engaging with professionals, she had tried every available resource in dealing with her difficulties before deciding to engage with services, and reflected on how this was normally the case for her:

Yeah, if things had been different, probably because every time I've gone to get [professional] help, it's been for me a real crisis, an absolute crisis. (P02)

She clarified that by absolute crisis she meant one that she could not deal with using any other resource, whereas a manageable crisis would still be handled by her, within, and with the help of, her family. She spoke of only engaging with mental health services when all other avenues had been exhausted, and she was left with little choice:

To me, I'd gone down all the avenues that I'd normally use to help me. But even that wasn't quite enough, you know what I mean? It might have been 90 percent or 80 percent, but I still needed something, another avenue to help me. (P02)

Other participants also spoke about how the severity of their situation meant they had no choice but to engage with mental health services. One participant described how she reached a serious point before she engaged with mental health services, which meant that she was admitted straight to hospital:

So I actually went straight to hospital, because I rang my family. And, um, my sister came to get me and she's a doctor, so they took me straight into hospital (laugh). (P07)

Another participant expressed how she waited until she had no other choice but to get professional help:

Like, and I feel like for me I went there because I felt like I had, like I felt like I had to. Like I felt, I was in that place where I just had to get help [...] There was no other option but to do something drastic or to get help and for me I just had to get help. But if I, you know, I felt like I didn't have a choice. (P11)

For these participants there was no other choice or support to turn to; engaging with mental health services was the only thing that was going to help. Some participants managed their difficulties for long periods of time before engaging with mental health services:

It took a few years before I ever sought help. (P12)

One participant thought it may have been seven years that she struggled before engaging with support, and was at the point of "losing it":

Um, well it took me five years, five years, five years. And yeah, by that time my daughter was at school and I had, oh no it was six years, six, yeah, six, seven years to actually get help. (P08)

Another participant recalled how somebody had warned her about the possibility of having a breakdown, but she thought by that stage, she had already experienced one:



And so therefore, yeah okay, someone said oh you could end up having, you know, a breakdown. I said no, I possibly have already transgressed that road.  
(P06)

These participants again reached a point of crisis where engaging with mental health services was the only option left for them.

In summary, participants explained that they would only seek professional mental health support in a crisis. For some this meant that they exhausted all other avenues for help before they sought professional help. For others it was when their struggles became so severe that they had nowhere else to turn, and felt like they had no choice. There was a sense of only engaging with mental health services when absolutely necessary, perhaps even only as a last resort. For these participants, it could be because whānau is considered the first (and maybe most acceptable) option.

Overall, participants expressed a reluctance to engage with mental health service unless absolutely necessary. The factors that play a role in delaying engagement with mental health services included the difficulty of asking for help, a lack of familiarity and trust of mental health services, and the idea that help should only be sought from mental health services in a crisis.

### **Building a relationship with mental health services**

Presented below are themes that convey participants' accounts of their experiences of engaging with mental health services. Participants highlighted the importance of a genuine relationship with mental health professionals, the importance of being able to trust mental health professionals, seeking and receiving acknowledgement from mental health professionals, and finding familiarity within mental health services.

### **Building a relationship with mental health services: A genuine relationship.**

All participants stressed the importance of the relationship between themselves and mental health professionals in some way. Participants explained the importance of different elements of this relationship, such as professionals being real, being upfront and honest, and not being judgemental.

Most participants spoke about the value of feeling that they had a real, honest relationship with a mental health professional, and had positive experiences with mental health services when professionals allowed themselves to be human. As one participant explained, sensing that the professional was “being real” was important:

[..] say how's it goin y'know or something like that and just be real with them, I think, that's what, myself as a Māori woman really wants from health professionals and health services. Just a sense of being real. (P01)

She went on to clarify that “being real” could be as simple as:

[...] just a umm, a sense that the other person is speaking to you as a human with umm, yeah maybe they're cooking something for dinner that night, you know what I mean, just something just to make it kind of, make you feel like you're talking to someone who gets what it's like to be a human and just live in an ordinary world rather than a kind of lab (laughs). (P01)

Another participant spoke of the genuineness of her therapist, noting how, among other things, she swore:

Yeah, nah, she's really cool. She swears, that's really cool, you know what I mean? Just real, it's just real. (P12)

Participants also expressed an appreciation of honesty, particularly when mental health professionals were honest about their own skills and limitations, instead of pretending to know things or be capable of more than they actually were. One participant was particularly impressed by a Pākehā staff member whom she thought worked well with Māori, but did this without presuming to be Māori:

Pākehā guy. Understood Māori, was not trying to be Māori or anything like that but yeah. That I could say anything, do anything, not do anything but you know what I mean. So and it wasn't like insensitive, culturally insensitive or whatever.  
(P12)

For participants who shared this experience, meeting professionals who were honest about their own cultural competency resulted in positive experiences, regardless of the level of competency.

Participants also described how being treated with respect was an important aspect of their relationship with mental health professionals. This was often described as being treated like a human being. One participant reflected on the importance of this:

I think, it's so, important [for professionals] to know that, y'know you're working with another human being and another human being's sharing their life with you and they'll hope that you can help them and they wouldn't be there otherwise. (P01)

Another participant explained how she was able to be her true self with her therapist, who treated her like a human being:

And I felt like I could, yeah, that I was really being me. (P11)

Participants also described the importance of not being judged in the relationship. As one participant put it, an unassuming stance from her therapist made her feel comfortable:

It's like acknowledging that things might feel differently for you depending on how you came, not how you came up, how you grew up. Which is really important because I feel like the main reason why I was scared to seek help was because I thought I was going to be categorised like instantly. [...] I felt like they were going to be like you are this, you are that and we're all the same and I was just like freaked out about that. But when they acknowledged that we were different in that way it was quite cool. It made me feel comfortable. (P11)

Initially fearing labelling, judgement, or categorisation, this participant felt relieved and comfortable when she was met with a lack of judgement. Another participant echoed this appreciation:

I guess another positive was that, uh, there was a sort've open curiousness that a lot of the therapists took in relation to what was going on for me. (P01)

On the other hand, participants spoke about how relationships suffered when they felt judged by professionals. One participant recalled a particularly unpleasant experience with a nurse she had never met before at a respite facility:

I had all these different nurses coming into see me at different times, and one nurse came in and said to me you, she said something like... "You silly girl..." she was an odd woman, "You silly girl, you've taken all these drugs and you've ruined your career chances, you've ruined your life, look at where you are now". (P01)

This participant was shocked at the audacity of this mental health professional, and felt harshly judged, particularly because her recreational drug use was something she felt she had managed responsibly.

I'd never met her before in my life and this is what she delivered to me in terms of her two cents and her, from looking at my case notes. It was awful and I remember thinking, thank you, you can leave, y'know. And these are people that were supposed to be coming to help. (P01)

Another participant recalled a similar experience where she gained access to her notes and was disheartened to see what her therapist had written about her after meeting her once:

And I felt that for her to write and say oh, this Māori woman was a, ah, I think she put down that I was ignorant or had no education or something and I, I and at that time I'd only just begun a course at the university (laugh), as far as I'm concerned I, I'm a woman that's going up not down. (P06)

For these participants, feeling judged impacted heavily on the relationship and its potential to develop.

Overall, the importance of building a genuine relationship was paramount for participants. Feeling as though they were being respected, not judged, and treated like a human being, and experiencing professionals as human and as real people, was imperative in allowing participants and services to build a good relationship.

**Building a relationship with mental health services: Finding understanding.** Another important aspect of building a relationship with mental health services was finding understanding. Their preferences and concerns often related to the extent to which they felt the mental health professional understood their culture. Nearly

all participants explained that feeling understood by a mental health professional was important for them. Participants expressed the idea that an unspoken understanding was the most effective at helping to build a relationship. However, they also explained that in lieu of unspoken understanding, finding professionals who made an effort to understand also helped to build this relationship. Finally, their accounts also suggested that it was sometimes difficult for them to form a relationship when they felt that professionals or services ‘just didn’t get it’, despite their efforts to explain themselves.

Some participants explained how they had a sense of being understood with Māori mental health professionals with whom an unspoken cultural understanding took place. One participant recalled how she was effortlessly understood by a Māori professional without having to explain or justify herself:

I said something about umm cooking with hinu [oil or fat], and umm, she knew straight away what I was talking about, straight away. (P01)

Another participant commented on her non-Māori therapists’ understanding of whakamā (feeling of shame) as a concept:

Okay so the whakamā, that she understood that, that I didn't have to define or describe that, [...] she totally understood that and I think she'd been to a workshop or something so, you know, that felt like wow, I didn't have to, yeah, no that was cool anyway. (P12)

Other participants also spoke of this sense of ease in understanding, which came without having to provide explanations:

Um, I think there was just, well there’s just an ease there because you don’t have to be mindful of trying to, um, explain things. (P07)

This participant also drew a comparison between trying to explain herself to non-Māori, and the understanding that occurred without her needing to do so when the kaumatua (male elder) came to assist:

So um, I mean, you can try, and you can try to explain, but I guess that's what I mean about, you know, when the kaumatua came over from the Māori service, it was just like things were instantly understood. (P07)

The understanding experienced by these participants, which happened in an apparently natural and unspoken way, meant that a relationship was easily built.

Some participants recalled experiences where they initially had to explain themselves or their situation to mental health professionals, however this was still a positive for the relationship when it resulted in participants feeling they were being understood. When simple efforts to understand were made by professionals, participants seemed to experience a better relationship. One participant appreciated her therapist backing down on a particular issue, even though she did not fully understand it:

I think again it is understanding a different world view. And as much as she, she understood, I don't know if she could truly understand, but it was sufficient for her to not push things that go down that view. (P02)

Although experiences like these were not described as fondly as those which featured unspoken understanding, participants seemed to express the idea that as long as professionals made efforts to understand, a meaningful relationship could still be built.

On the other hand, participants shared experiences in which despite their best efforts, they did not feel there was understanding between them and mental health professionals, and as a result, the relationship suffered. Several participants commented

on the lack of understanding from some non-Māori professionals. One participant recalled having to explain Māori worldviews to one professional who did not ‘get it’ even after the explanation. As a result this participant seemed to theorise that understanding Māori was a distinct type of understanding, however, and preferred that professionals know when to step back and let somebody with that understanding take the lead, rather than putting the client through a hefty explanation or translation process:

Or yeah, either assumptions about Māori, stereotypical type stuff about Māori [...] so then that person who’s in that position has to explain to them or translate to them what it means in there and it gets lost in that. So it's understanding and if you don't have an understanding, send somebody in that does. (P12)

Another participant echoed this sentiment. Although there were many positive experiences in which participants felt understood, there were clearly experiences where an understanding could not be reached.

Oh, I’ve dealt with them before. It’s not their fault but they just don’t get Māori, they just don’t get us. It’s, it’s, it’s not about prescriptions, it’s not about the specialist and do it this way. It’s about, like, culture and it’s about feelings, you know, and our environment, we’re more like that kind of thing. (P08)

Overall it seemed that participants overwhelmingly found it easier to build a relationship when effortless understanding happened, but also appreciated professionals who made efforts to understand them. Finding this understanding appeared to help in building a relationship with mental health professionals. However, when understanding could not be found, the quality of the relationship appeared to suffer.



**Building a relationship with mental health services: Being able to trust them to maintain confidentiality.** Another key component to building a relationship with mental health services for participants was feeling that they could trust professionals to respect their privacy and maintain confidentiality. One participant detailed her concerns after she visited a counsellor to discuss her experiences of sexual abuse:

You know, so going through the sensitive issues thing and that you have to put it on paper for the world to see kind of thing and that I know that these records out there with my information on that, I don't know who can access but I bet somebody can that shouldn't. You know, it's a government department. I've worked in government departments. You know. And how is my information being used by them? I don't know. (P12)

Other participants experienced breaches of confidentiality which shattered their confidence in the professionals and services. One participant described an experience where she initially had a good rapport with a counsellor but when she went back to the waiting room to retrieve a forgotten item, she heard the counsellor talking about her to the receptionist:

I'd forgot something in the waiting room and I went back and she was talking to the receptionist about my story and what I'd told her (laughs). So I was like, she kind of looked at, like she was looking at the receptionist like this and I was like, you have that kind of moment of like 'are you...' and that was it., for me and it was like I'm not telling anyone else, this is, y'know I've, no thank you [...] my first emotions in at the time, were of, I'm not important, no one cares, this has just reinforced that nobody cares, them gossiping about me in the

waiting room, it was quite useless actually, I was not happy with that at all.

(P01)

Another participant experienced a situation where she did not feel confidentiality standards were being met:

I complained because, ah, oh, I, I felt that, ah, first of all I went to this room and the room was wide open. And I said oh, don't you think you should have, you, you know, privacy cos, I mean, she's only just met me and I wanted the, I wanted everything, ah, like, but she had the curtains, blinds wide open and everything. (P06)

She then spoke about how she complained and was met with even more disrespect:

When I went and told the doctor the doctor laughed like nothing cos I said to the doctor she had blonde hair and blue eyes and she looked down at me as if I was, just came out of a, you know. And of course the Indian doctor went hahahahaha, really, yeah, and thought it was funny. And I said no, it's not funny, because I expect them to show respect to me when I go in to get counselled because it was, ah, sexual abuse thing see. (P06)

For this participant, not only were her privacy needs not met, she was laughed at when she made a complaint. For these participants, experiences of not being respected had a negative impact on the relationship. Breaches of confidentiality meant that trust was broken or could not be established, and a relationship with mental health services was unlikely to form.

**Building a relationship with mental health services: Not feeling pressured.**

Participants often described experiences in which power, or pressure, was present in their interactions with mental health professionals. They noticed this could be used to

pressure them into things they did not want, or could be eased off or turned around in order to empower the participants. This pressure was felt when the professional was felt to push their agenda over that of the participant. On the contrary, relationships were built more easily when participants felt that professionals generally 'didn't push it'. Some participants also described situations where there was pressure get them 'out the door'.

Many participants described how they felt pressured, particularly regarding treatment focus and options. Several participants spoke of their dislike for medication and the processes by which they came to be taking it. One participant particularly disliked the way in which medication was the main focus of her treatment:

Yeah, well they wanted me to take the pill. I just thought it, I just seen it that way. You want me to take your medication you can come out and bring it to me, you know, even though you say oh this is gonna help you and this is gonna, it's gonna help, help you with your thoughts and, um, yeah. (P05)

She felt as though medication was the only treatment option offered, and felt the only reason she was visited at home was so mental health professionals could make sure she was taking it. This meant that she felt her needs were not being met or acknowledged; ignored in favour of medication as a singular approach, or at least an approach with such focus and pressure that she felt it was their only contribution to her recovery:

Oh, it just felt like, it just felt like all good for yous to come out and get me to take your medication but you can't help me with one simple thing. You know, that's all I wanted [...] I sometimes left there wondering too, that's all they wanted me to, they, they're just checking up on me cos they're asking me, you know, what do you do in the day during the week. And I just say oh, I take my

medication. Oh pardon me. And they, you know, I just felt like sometimes when I was leaving there I felt a bit funny, like, um, yeah, well you got your, got what you wanted out of me so it's see you later, see you next month, you know. (P05)

This pressure to adhere to medication, combined with a lack of additional or alternative interventions, meant this participant felt her views were not respected by the service. Another participant spoke of her negative experiences with medication, and felt her very identity was subdued by having to take it:

I, yeah, I wasn't myself, I was on heavy medication, I kept to myself a lot, I hardly spoke, I, I couldn't identify myself as being Māori, yeah because I didn't have that in me. (P09)

At a time when she most needed to have a solid and stable identity, and get to know herself better, the medication she was pressured into taking meant she was effectively denied access to that part of herself. For these participants, pressure to take medication impacted negatively on their relationship with mental health services. Participants also described a type of pressure felt, particularly in therapy and counselling, when the topic focused on or discussed was not what they considered important. One participant lamented the focus on the negatives in her counselling sessions, and generalised this out to talking about problems or struggles in general:

When you talk about your problems, you only normally talk about the horrible things that's going on. You don't normally get a balanced view, or at least some positive things, that's probably the hardest thing about it. (P02)

For this participant, the counsellor's problem-focused approach meant that she felt she only knew the bad things about her, and not the whole person. Another participant

spoke of how her wants and needs were not attended to, in favour of the therapist's agenda:

What the therapist decided was more important for me was to focus on my relationship with my mother. Which of, I was like what the? Y'know, I'm not coming to you with questions about my relationship with my mother! Like, where's that coming from? I wanna talk about this. But... none-the-less, we discussed my relationship with my mother and actually, that aspect of the therapy, my relationship with my mother improved. No question. No question... But it wasn't what I wanted therapy for! (P01)

Many participants echoed the idea that it was difficult to move forward when they felt forced to follow the agenda of the professional, and easier when the professional gave them options and choices. Nearly all participants spoke positively about being given choices. One participant reflected on how her keyworker encouraged her to meet in public in order to address her social anxiety:

It wasn't forcing me but you know, she sort of showed me a different way to work with me. And she was, you know, real, real down to earth kind of person. And she taught me about, like each time I met up with her she'd get me to read this, read a book or read part of a book. (P08)

Even though this participant felt anxious about doing this, the way in which it was presented to her as a choice meant she engaged. Another participant echoed this appreciation of being given a choice:

Um, so when I first met her I found her very open and honest um and she sort of said we can have this first session. It's just sort of a test drive and if you don't feel comfortable here or I don't feel comfortable treating you then I can refer

you on to someone else who I think would be great. And feel free to take it or leave it there's no pressure on you to come back. (P03)

As well as being given a choice of therapist, she also appreciated being given choices about what to work on in therapy. This was evident even in the structure of each session she attended:

She would be like today we're going to do this and then check with me like is that, how do you feel about that? Do you reckon that would helpful? (P03)

Another participant experienced a major contrast between two professionals and felt it was a cultural difference, though they were also from different professions. While she experienced the social worker as easy-going and friendly, she found the doctor pressured her into answering questions.

I remember the social worker who I saw before I went there was Pacific, and she just had a different attitude, like different approach. She was a bit more relaxed, less rigid, not just wanting answers to the questions – that's what I found they wanted. They just wanted you to answer their questions. (P10)

As a result she felt the social worker had her interests at heart, and the doctor did not. Ironically, and perhaps predictably, this meant she revealed more information to the social worker and was not keen to speak to the doctor at all.

Like the Pacific woman that asked me the same things, but she sat and listened, and it was okay. Like she had the time to sit there and listen. Yeah she kind of seemed to care more. Whereas this woman just wanted the words on the paper, or whatever. (P10)

In contrast, several participants also had experiences where mental health professionals allowed them some power in the relationship, which was greatly appreciated. For some, this was something as simple as articulating clearly and deliberately the power imbalance and giving participants permission to hold some of this power for themselves. For one participant, having her therapist acknowledge that she was the expert on her own life empowered her greatly in the therapeutic process:

Like certain people have certain authority and you just kind of don't question anything and that's just a normal thing. So even if, I mean I can imagine someone sitting there and maybe the therapist going off on a tangent which isn't, doesn't feel right to the person. Maybe the person won't say anything, just kind of won't turn up eventually and won't even interact. So you know, I reckon the fact that she said, you know, you're the expert or whatever, you tell me if this is not a thing that you can change, if this is a thing that means a lot to you, if it's a cultural thing. That was a huge thing for me, yeah. But the GPs and all that I can't yeah. I mean, I don't, it's not very good but it's not very easy to talk to them. (P11)

She imagined that without this empowerment and acknowledgement, Māori women in general would not feel able to say anything if the relationship or therapy was not meeting their needs, and would eventually disengage.

Participants also expressed a feeling of being 'pushed out the door' by being told they were better when in fact they did not feel like they were ready to finish therapy. As one participant put it:

Kind of like putting words in my mouth. Well you know this now, and you've written it down, so you can do it. Like I can see how it sounds positive recalling it, but it didn't feel that way at the time. (P10)

Her therapy ended without a satisfying conclusion and she did not feel like she was ready for discharge, however she did not feel she could speak to this. Another participant had a similar experience when she changed from a Māori to a Pākehā keyworker. She compared their approach:

Like the way she spoke and the way she addressed my problems with breathing techniques and stuff like that. Oh yeah, that helps but like, um, they do it from a different way, you know, a different angle. It, it was, um, more so forced, she pushed it more. And um, the Māori lady she's just like oh, we'll try this and we'll see how it goes. But then the Pākehā lady, she was just like oh, do this, do this it works sort of thing. It didn't work for me! (laugh) (P08)

Overall, participants expressed appreciation of not feeling pressured or coerced, particularly in regards to treatment options such as medication or therapy. Not only did having choices and autonomy help to build their relationship with professionals and services, it was also experienced as helpful in their recovery and healing, and was experienced as empowering.

**Building a relationship with mental health services: Looking for acknowledgement.** Participants described how being acknowledged was important in their experiences with mental health services and professionals. They spoke about how this was most keenly felt when their identity as Māori was acknowledged, and when professionals openly acknowledged Māori healing, values, and worldviews. When



these were ignored, disparaged, or not acknowledged, participants expressed disappointment and negative impacts to their mental wellbeing and recovery.

Many participants expressed that their cultural identity was not acknowledged, or was not meaningfully acknowledged by mental health professionals. Two participants recalled how their cultural identity was not acknowledged at all during her experience at the service:

Not really. My identity was never acknowledged. (P10)

Like it was never even brought up, like maybe they just, they may have seen me and just like ticked the box on their computer like Pākehā. Or like they're like this isn't relevant but um, nah it never came up aye. (P03)

They both wondered if the mental health professionals appearing to ignore this was due to their fair complexion. This experience meant that they felt like a specific part of them was being devalued or deemed not relevant, let alone in need of a specific treatment approach. As one of these participants explained:

I have an understanding of, you know, that they would look at me and not necessarily think okay she's Māori (laugh), you know, or we should involve Māori Services. (P07)

She then went on to describe the surprised reaction she was met with when she went on to specifically request Māori mental health services:

Um, yeah, but I just remember being in someone's office and being really insistent that, yeah, that I have Māori Services and, um, I think they regarded that as quite a strange request. (P07)

She elaborated on her struggle and wish for Māori mental health services to be provided for her:

I just felt that because of what I'd experienced that there needed to be someone Māori there, because otherwise these people weren't necessarily gonna be able to make sense of it, mmm. (P07)

Another participant reflected on how her ethnicity as Māori was not only not acknowledged, but was a fundamental part of her difficulties, and the discrimination she experienced was not helpful:

I think there's been times when my ethnicity hasn't been umm, noted in the way it should be, and the way it sort've deserves to be, umm, and the ways in which it's fundamentally been a part of some of the difficulties I've experienced y'know in terms of that some of what I've experienced has been because I've been in a more marginalised space and a disempowered position. (P01)

For this participant, engaging with mental health services, without her experiences as a Māori woman being acknowledged and held sensitively, might have meant that she did not experience these services as culturally appropriate. Another participant's story about her struggles with identity shared common themes with others, as she connected her experiences with mental health services with her identity struggles in wider life. She recalled how she had filled out the initial forms there, noting her ethnicity as Māori, however this was not acknowledged either:

I think ignoring that someone ticks a Māori box even though they appear to be European just by their features – I think there's a problem with that, because it's hard enough to assert that identity if you don't look like it. (P10)

She also reflected on how having to assert and justify her identity to mental health professionals was an added difficulty over and above having to do the same in daily life. At the most recent service she had engaged with, she requested, and was given access to, a Māori therapist, and reflected on how positive her experience was simply because she felt her identity was acknowledged and she did not have to justify herself to the therapist:

Yeah I guess not even within mental health services, just day to day people I have to keep talking, and keep justifying. Oh yeah and then they were well what percent are you? And I was like it doesn't matter how my family are Māori. Yeah so I didn't have to do that with him, like he was interested in my whakapapa stuff, but I didn't feel like I had to justify my identity. (P10)

Not having to justify her identity, as well being acknowledged as Māori, meant that she felt valued, respected, and legitimate. This included the nuanced difference in being badgered for evidence of being Māori versus being asked about her whakapapa out of genuine interest. Finally, she reflected on the reality of mixed identities:

I want to continue accepting that there's going to be Pākehā Māori, Asian Māori. Māori who were brought up on the marae Māori, you know, that rainbow Māori. (P10)

Given that many participants entered into mental health services already struggling in regards to their Māori identity, and having difficulties with others not acknowledging this, facing this struggle again from mental health professionals when seeking help was particularly unhelpful.

Some participants, however, experienced professionals who made an effort to acknowledge their culture and Māori identity. One participant described how, from

their first meeting, her therapist explicitly acknowledged her Māori identity, and then began her assessment by exploring the participants' background in a way that was culturally important to her:

Well a big thing for me was [...] she asked me where I was from. That was the first thing, you know, and that stuff is important. Like I mean, she asked me specifically what tribe I was from. She didn't just say, you know. Like that's like just this Pākehā lady with blonde hair and she wasn't young and for her to know that that's an important thing for me, straight away I felt comfortable with her, you know. (P11)

For this participant, it meant that she was immediately at ease with her therapist; she expressed feeling legitimate as Māori and felt acknowledged and valued as a person. Participants who found this acknowledgement, described how they remained engaged, and had a more meaningful relationship with professionals.

Nearly all participants also spoke about how they valued a broader acknowledgement of things Māori. This included acknowledging aspects of Māori values and how they might affect the way in which participants reacted to or handled difficult situations, or acknowledging that a Māori way of healing difficulties had a legitimate place in mental health services, or that participants had a legitimate right to ask for and receive Māori healing or access to Māori mental health professionals.

Participants explained how seeing Māori professionals meant a greater acknowledgement of things Māori. As one participant put it:

I guess spirituality and stuff is more acknowledged, and seeing it as a legitimate reason or something behind what's going on. [...] But yeah it was nice to have

the Māori counsellor like think that my ideas about spirituality and stuff were legitimate. (P10)

Another participant also appreciated the acknowledgement of Māori worldviews by mental health professionals, when her wairua experiences were positioned as legitimate, and were not simply labelled as psychosis:

I think positives I, experienced were, an acknowledgement of ancestors, present, wairua, as not being a sign of psychosis. There was no, no point in any of my interactions with umm, therapists that, talking to my ancestors were, was a sign of psychosis. I think that's great, like it's umm, come in leaps and bounds, umm, since, umm, I guess my grandmother's time anyway. (P01)

She also reflected her knowledge that this is something which has greatly improved over the period in which she has had contact with mental health services. For her it meant she did not have to contend with being mislabelled or mistreated. Many participants also expressed a lack of acknowledgement of anything Māori in their experiences with mental health services. Participants often lamented what they described as a complete lack of Māori mental health treatment offered. As one participant described it, she felt she was only rehabilitating her "Pākehā self":

[...] it would have been nice to have some like Māori mental health treatment, like something on Mana Wāhine or even like the pōwhiri [to welcome, rituals of encounter] process or something, something like that that actually connected to that part of me [...] So when that's not brought up like in therapy sessions I feel like I'm only really rehabilitating my Pākehā self. And that there's other parts of me that aren't. Like they're just not on the same wavelength you know. (P03)

This participant yearned for something Māori in her recovery options, but nothing was offered or even mentioned to her. At the most basic level, she felt that she was not even offered “a little bit of like token Māori treatment”, let alone a proper Māori approach to her recovery. Only being able to rehabilitate her “Pākehā self” meant that she felt the service could never offer her a full recovery. Other participants shared varying experiences between different services. One participant compared her most recent service with the one she attended before, described the lack of Māori ‘feeling’ or ‘connections’ at her previous service:

Yeah they didn’t have any Māori feeling toward, they didn’t have much Māori connections there as they do here, yeah. And I felt, I felt comfortable here than I did there, yeah. Cos there were more Māori connections here, yeah, for me to branch out to my culture again. Yeah, but there it was European mainly, yeah, and it was quite strict and, yeah. (P09)

For this participant, it seemed that being treated in a service where Māori ‘feeling’ was not acknowledged, and where she was unable to connect with things and others Māori, made her feel uncomfortable. However at the most recent service, which was Māori, she was able to ‘branch out’ to her culture again; something which has allowed her recovery to progress. Another participant shared a similar narrative about her experiences. She shared how non-Māori staff made an effort with things Māori and sought culturally appropriate assistance when they were unsure; showing an awareness of their cultural limitations.

The staff who aren’t Māori seem to have a pretty good appreciation, even understanding, of things Māori. Even the new guy [...] he’s made an effort, if he feels like he’s unsure of things, to bring in people, you know, to help him

out. Whereas I suppose at the last service I went to, it felt that, yeah, their people really didn't know what they were dealing with. (P07)

In contrast, at the previous service she was involved in, things Māori were largely unacknowledged, perhaps because of a lack of competency. When asked what could have been done differently by mental health services to change her experience for the better, this participant felt that even the basics needed to be provided:

Um, mmm and just, I mean they, yeah, I mean even just things as basic as mihimihi [speech of greeting] and knowing who you're talking to and, um, things like that before you start. (P07)

Like other participants, she recognised these 'basic' things as necessary for her, and legitimising and acknowledging the importance of these processes meant she felt comfortable, at home, and welcomed at the service. Without these processes in place, she felt awkward. However she had later engaged with a Māori mental health service, and spoke about what that meant for her. Like other participants, she was grateful of the existence of Māori mental health services:

I suppose one positive is just the fact that a Māori Mental Health Service actually exists (laugh). So that you are able, you know, even if it's not immediately, um, to make that connection and have that eventually. Um, I think it's great that they have the complex, you know, in terms of the whareniui [meeting house] and the wharekai [dining hall] and what have you. Although to be honest, when I first came I found it really upsetting, because I suppose, well for me anyway, the last time or every other time I've been in whareniui it's been for, well, different purposes. So I guess, um, yeah, it was just, um, I guess just

because of how I was feeling about coming to terms with, um, my illness and this idea that I might be tāngata whaiora (laugh). (P07)

However, even at the Māori service, she found herself wanting more Māori healing than could be offered, and this was a sentiment often echoed by other participants:

But that's, and whether it's just that that's not possible with the kaumatua because, you know, he has to go here, there and there, um, and I don't know if other people feel this way, but I just know for me, um, well I guess because, I mean I do, I've kind of got an enquiring mind as well (laugh), um, and because you know, I really want to understand what's happened, um, mmm. Yeah, or I certainly want, I guess, like a Māori explanation for what's happened and to weigh up for myself, um, the best way of having it explained for me. (P07)

She particularly wanted more access to the more Māori aspects of the treatment offered, and questioned why she could not have weekly appointments with a kaumatua or kuia as she was able to with, say, a psychologist. It was important to her to have adequate access to these services because she felt she needed a Māori perspective on her difficulties. Thinking back on her experiences as a whole, she had this to say:

It just feels like there's this, yeah, there's this gap between say the western medical interpretation of what's happening, um, and yeah, a Māori perspective. (P07)

For this participant, it was this gap that meant she felt she could not have the experience she would have considered ideal. Other participants found this gap was not as large. One participant described her struggles and gave a detailed account of how her therapist approached her therapy in a culturally sensitive way:



And so she used to be like, you know, if you get better they're going to be happy which just sold me automatically [...] she emphasised the fact that just having those feelings means they're, they're legitimate or they're valid because if you have them that's the way you feel. (P11)

It seems her therapist was very tactful in the way she approached problem-solving with this participant, knowing that the tension between individual focused therapy and the collective concern of the participant and her whānau was present. By weaving together the happiness of the participant with the resulting happiness of her family, the therapist was able to reconcile the participant's hesitancy to improve her own happiness, and at the same time acknowledged a Māori worldview.

Those feelings are just authentic because you feel them and if you go against them then you end up hurting or whatever, the people around you anyway in some way. Like for me it was resentment. Like I used to do a lot of things for people and most of the time it was good and I felt good about myself doing things but some of the time I used to resent it and then it would come out in other ways. [...] So [my therapist] really emphasised how, actually if you're okay then they're okay or they're happier and that you are doing something for everyone by looking after yourself which was really a big thing for me. (P11)

Instead of ignoring the Māori-ness of the participant's predicament, continuing with a traditional intervention of individual therapy, she felt that the therapist made an effort not only to resolve tension between two worlds but also validated and legitimised her Māori worldview. Resolving this tension was difficult for this participant, but having a therapist who was understanding of this difficulty meant that she had a very positive experience in therapy:

That is quite a liberating thing to say I'm important and this is how I feel but also, I can also be a part of the collective at the same time because there's quite a, there's quite a bit of dissonance between that. (P11)

It appeared that this professional did have some knowledge of Māori worldviews, but it was her acceptance of this view that affected this participant's experience. It seems there is a distinction between having cultural knowledge and **being** with clients in a way that is culturally sensitive, appropriate, and adaptable. It seems to be this **being** which made experiences positive for this participant. Despite the fact the therapist was not Māori, finding an appropriate way of being with Māori clients seemed to be key.

Overall, participants expressed appreciation of mental health professionals or services that acknowledged Māori worldviews, healing, and culture in general. While this experienced acknowledgement seemed to be higher when Māori mental health professionals were encountered, non-Māori professionals were also experienced as capable of finding a culturally appropriate way of being with the participants as clients, particularly when they also provided acknowledgement.

**Building a relationship with mental health services: Looking for familiarity.** Nearly all participants expressed an appreciation of familiarity in a mental health service. This familiarity was mostly keenly felt by participants when they felt they were being treated like a friend or whanaunga (relative, family member) by professionals, when they felt professionals made time for them and were working hard for them, and when there was some Māori presence to put them at ease.

For some participants, being treated like a friend or whanaunga meant that as well as being kind, they felt like professionals had time for them. One participant described the time pressure exerted by one of the professionals she encountered:

They didn't have time for me. They just threw me the tissue box, but they weren't sympathetic at all, they didn't want to relax and just let me cry. They just wanted their questions answered in their little one hour time slot or whatever. (P10)

She also described the contrast between two professionals at one service:

I felt that they didn't want to take the time – they just wanted their questions answered kind of thing. Whereas that Pacific woman yeah we went way over time when I was with her, but yeah she was nice. (P10)

When asked more about what the Pacific professional did that she appreciated so much, the participant elaborated:

But yeah she kind of just treated me, I don't know just like family or something. She didn't really try to box me into anything. (P10)

While Pacific people come from the islands around New Zealand, their cultural practices have something in common with Māori, and these similarities might mean that participants, as Māori, experienced Pacific professionals as closer to Māori than other non-Māori. This participant appeared to recognise that the professional's cultural identity played a part in her 'nicer' attitude.

Another way in which participants felt they were being treated like a friend or whanaunga was when they felt that mental health professionals were working hard for them. Participants felt cared for and cared about when professionals would 'go the extra mile' for them. One participant provided an account of a really positive experience with a particular service where she really felt all members of the team were working hard for her, and had her best interests at heart:

It's like you're, you matter, like I matter. (P12)

For this participant, feeling like the staff at this service were working hard for her was a positive thing; she felt they cared about her and were doing their best for her:

Him explaining or talking to me about stuff like him not making a big deal and being excited that oh it's your lucky day, you know, that kind of stuff. Like he was working on board for me, you know. So that felt really good. (P12)

She expressed feeling as though the staff were working hard for her, and elaborated on what she experienced as the professional's commitment to her:

He chased me all the time because I'd go into hiding and when I go into hiding he knew. So it felt like he loved me personally, you know, you know he didn't but you know what I mean? So he cared. Yes, you know, come visit him. Even when I was naughty and went in hiding and didn't make appointments he still loved me, still cared, still chased me. I love that. (P12)

Another participant had a similar experience where she felt the service she attended was willing to make time for her, right from the beginning of engagement:

No, no, they were all very positive. I must admit, when I say it was easy to get an appointment, it was probably because when I rang up I was in such a state and I could barely talk without crying, I need to see someone. [...] They kind of went, come in this afternoon straight away. (P02)

When she established a relationship with a professional at this service, she also felt she was working hard for her. Even when she was unable to help the participant resolve or change the situation, she described how the professional was willing to support her in any way she could:

She'd say to me what can I do for you, I can give you a letter regarding extensions for your assignment, that would help, and I'm happy to talk to your lecturers about the fact that you're going through some issues and you need the support, those sorts of things. (P02)

This sense of feeling like she mattered, and was worth putting in effort for, and worthy of being helped, meant that as a person she felt valued. Participants particularly felt like a friend or whanaunga when engaged with Māori professionals. One participant spoke fondly of when she first met her keyworker who was Māori, and instantly felt as though she was family:

Because as soon as I met her I was comfortable. As soon as I met her it was like she was one of my aunties. (P08)

Another participant contrasted her experiences with Māori and non-Māori workers, articulating the difference in how she felt, despite feeling that they were both professionally capable, she simply felt more comfortable with Māori staff:

Cos the actual doctor, she was like, I don't know, from another country, she was a foreigner but very intelligent I could take it. But you know, as soon as the Māori lady walked in I felt comfortable, we're at the same level now sort of thing. (P08)

For this participant, feeling at the same level would have been empowering in a situation where she was initially feeling like she was on the back foot as a service user. Sometimes participants expressed that all that was needed to create this feeling of familiarity was having somebody Māori in the room. One participant shared how the presence of somebody Māori was able to put her at ease in a situation where she would normally feel alone:

[...] just the presence of Māori people, um, well for me anyway, has been enough to put me at ease, mmm. (P07)

When the kaumatua entered the room and said his mihimihi and set the kaupapa (topic) for the meeting at the service, she felt more comfortable:

I think just because of the space that I was in at the time, the kaumatua, it was like I was instantly at ease simply because of the things that he said in his mihimihi. (P07)

Interestingly, this participant also found she was at ease even knowing that one of the women at the service was Māori, despite the fact she only met her in passing.

[...] one of the women at the service was Māori. I actually knew her because she used to be a fashion designer. An incredible, I mean yeah, change of, um, career, yeah. So that was great, um, and she came quite regularly so yeah, it was good. (P07)

Another participant echoed the appreciation of just having somebody Māori present and available:

[...] it was just about that, that there was a Māori person, sitting with me, who could say to me, when I said y'know made a joke about something, they'd get it, or they wouldn't look at me strangely for having a particular mannerism or, a particular way of speaking [...] Even if they don't necessarily identify with, umm, tikanga, just a sense of umm, having Māori whānau (laughs) I think is the umm, that was the important thing for me. (P01)

For this participant, having somebody Māori present was key; they did not have to be an expert in things Māori; the unspoken cultural bond was familiar enough. One

participant, as well as having other experiences where she felt at ease with somebody Māori present, spoke of an interesting situation in which she was able to create this on her own without the physical presence of another Māori person:

I don't know whether it was part of the psychosis or what it was, or whether it was because I didn't have my aunty, but we went to a meeting and I got this thing that I should take, I mean I've got like this big folder that has all our whakapapa and family korero in it, and I just got this thing that I should take that with me, and I just sat there with it on my lap. And it was kind of like that's what it felt like it was, it felt like a way of having them with me (laugh), almost like a bridge. No, not so much a bridge but a barrier between me and the doctor.  
(P07)

Even though she was unable to have someone Māori present in the room to put her at ease, she sat with her whakapapa folder on her lap and used its wairua to protect herself. Ideally, she would not have been in this situation, but her use of her whakapapa folder and its wairua in the physical absence of her whānau was empowering and protective for her, and she was able to put herself at ease.

Um, I mean in my ideal world I guess you'd have (laugh) Māori people at that first point of contact for Māori patients. [...] Yeah, but I recognise, you know, that that might be a long time coming. (P07)

In summary, participants expressed an appreciation for a feeling of familiarity. This took many different forms. Nearly all participants appreciated being treated like a friend or whanaunga rather than a mental health client, and professionals showed this by making time for them, working hard for them, and making them feel like they were worthwhile. For Māori professionals, they were often experienced as familiar simply

because they were Māori, which meant participants overwhelmingly appreciated having Māori professionals and support people available.

Overall, participants described how the relationship they experienced between themselves and mental health professionals appeared to be mediated by some common factors, such as genuineness, being able to trust professionals, feeling that their information would be treated confidentially, acknowledgement of individual identity as Māori and of Māori as a culture, and feelings of familiarity in the environment, with professionals, and with services as a whole. When these were experienced, participants were able to build relationships, and expressed gratitude and a feeling that they could heal and recover.

### **Looking beyond mental health services**

This category addresses participants' experiences of seeking support outside of and beyond mental health services. Firstly, family involvement was identified by participants as something very helpful that was not sufficiently integrated into the approach taken by mental health services. Secondly, although some participants experienced Māori healing within services, Māori support sought outside of mental health services was experienced as very positive and helpful.

**Looking beyond mental health services: Going back to whānau.** Just as participants were able to delay their engagement with mental health services with the help of family support, they were also able to utilise this to fill the gaps they felt were left by mental health services. Generally they felt that family were more helpful than mental health services, but were often not included as a significant part of their treatment, if at all, even though they considered whānau involvement to be vital. While



a small number of participants did experience whānau involvement in their treatment, they explained that it was never to the extent that they wished for.

About half of the participants lamented a lack of whānau involvement in their treatment. One participant recalled how she had to take it upon herself to organise a meeting with her whānau and mental health services in order to get them involved:

I basically had to be the one to go to my family and say can you come around home for a meeting, it's about me and the mental health services and where we can go to from here about getting contact with, with my son. And well we, the meeting happened but that was the first and the last of that meeting. Um, yeah I just didn't think that they were supportive enough. (P05)

She sensed a reluctance from the service to involve her family in her treatment:

I just didn't think that there was enough. I, I just don't think that they were strong enough to call a meeting with the whole family. (P05)

Other participants also found it odd that their family was never involved in their treatment at mental health services:

And another thing I thought was kind of interesting was that like I always went and saw like professionals for each thing, so my family wasn't ever really involved in treatment. Even though like, especially in my counselling sessions, they focused a lot on the dynamics between my parents and me and between my parents and like early childhood experiences. [...] But yeah my family wasn't really so involved. (P03)

Even though family was discussed in sessions with this participant, they were not asked to attend or be involved, even though this may have been helpful. Another participant reflected on how it was her whānau and whakapapa that helped her recover:

I think... what helped me, come through things, was actually not, the mental health services, it was that every day mundane day to day experiences of being with whānau, learning about my whakapapa, learning about history of my marae, learning about the history of my tūpuna [ancestors] actually kinda made me think ahh, that's right! Oh that makes sense, and that relates to how I was feeling about this. Hey! Y'know it's a bit of a- it enabled me to put pieces of the puzzle together, and sort've searching through, knowledge bases within my own whānau, within hapū, within iwi, for me, umm, that has been helpful. (P01)

Although whānau involvement in treatment at mental health services was largely absent, participants were often able to involve their family in their own way and benefit from their support and input.

**Looking beyond mental health services: Seeking Māori support outside of mental health services.** Participants highlighted the value of Māori support drawn on outside of mental health services, whether this was quality time with kaumatua and kuia, growth and development of a positive identity as Māori, traditional Māori healing, or other Māori interventions.

Approximately half of the participants described having had a positive experience with Māori healing outside of mental health services. One described an incidental experience with a kuia who was able to pass on some important messages to her:

She just talked to me. She like made me show her my hands and stuff, and kinda said oh I can tell you're doing something to help your people. I didn't know her, I had never spoken to her before [...] that was a pretty powerful experience for me, since I didn't grow up with that kind of spirituality or anything like that, so yeah that was a good experience. (P10)

Another participant had an opportunity to participate in a traditional Māori healing experience:

And so during my, while we were there on this sort of spiritual journey, she said can you see anyone? And I saw one of my ancestors come and she was like what do you want to do? And I was like I sort of want to like give this to him and so it was like me spiritually giving over this sort of thing that I felt like I needed to do to my ancestors in the spirit world for them to take care of. And it, it was just really positive for me to be like, to feel connected to that other part of me and that other part of everything. You know it seemed to give my life greater purpose and feeling well okay I was on the right track. She was sort of like you know they will contact you if, if they need to tell you to change things or if things aren't going right, all that sort of stuff. Which is, yeah it was just like a whole other side of things for me so yeah. (P03)

In contrast to her previous explanation of feeling she was only able to heal her Pākehā self in mental health services, traditional Māori healing allowed her to begin to heal the Māori side of herself:

[...] so helpful, in terms of like my own spiritual journey and nurturing that side of myself. So that was, yeah a really positive experience and something that I probably wouldn't have come into contact with in the mainstream system. (P03)

Having access to this type of healing inside of mental health services might have meant that she would have been able to heal both sides of herself. Another participant spoke to the presence of even the most basic facets of Māori culture being beneficial in the process of healing, particularly for mental health problems:

Yeah, even poi you know, teaching them how to swing it, you know, what the actions mean. Kapa haka, that type of stuff. Cos it's a, it's a, it's a major thing, mental health, just for your wellbeing, to keep you healthy. It's a main muscle, keep it healthy. (P08)

For these participants, this was not something they felt they could access within mental health services, and so they sought it elsewhere. Having access to Māori healing was described as being valuable to participants. When they did not have access to this within mental health services, they looked beyond to fill this gap. While these participant's accounts suggested an appreciation of Māori healing *within* mental health services, most participants lamented there was simply not enough provided, either in quality or quantity. Given this, it makes sense that participants would look beyond mental health services to supplement their need for Māori healing and interventions.

Overall, participants described seeking help outside of services from both whānau support and Māori healing and interventions. It seems that this was experienced as something lacking or completely missing within services that then had to be sought by participants on the outside. In this way, participants demonstrated their determination to take their recovery into their own hands to ensure that they had their needs met.

## **Improving mental health services**

The final category of the analysis looks at themes which focus on the retrospective musings and recommendations of participants. Participants were eager to share their ideas for improving mental health services in the future for Māori women, and Māori in general. Their ideas centred around three general areas. Firstly, they highlighted the importance of having mental health services come to meet people halfway. Secondly, they expressed that more Māori in mental health services would be beneficial. Lastly, they recommended a collective approach to mental health engagement, support, and treatment. Looking back on their own experiences gave them some insight into what might help to improve things for the future, both for themselves and others.

**Improving mental health services: Coming to meet people halfway.** Many participants, looking back on their experiences, spoke about how they wanted mental health services to come to meet people halfway; this could be physically, emotionally, culturally, and spiritually. Finding a way to offer help at the earliest opportunity, increasing awareness and accessibility, and otherwise finding ways to bridge the gap between Māori women and mental health services, so it is easier for the two to meet together, were among the ideas offered by participants to improve things for the future.

Participants often expressed a wish to be able to get help earlier. One participant pondered the need for earlier intervention, which would have improved her experiences, and might improve experiences for others:

Actually I was going through a pretty rough period and that's really hard to go. [...] Like, and I feel like for me I went there because I felt like I had, like I felt like I had to. Like I felt, I was in that place where I just had to get help. But

maybe if there was channels before people get to that place because if it was someone else they might not have gone and got help. [...] But I feel like if there was ways to talk to them, you know, before you felt really, really bad then it would be a lot better instead of some drastic thing like I need to go on pills and I need to get some, yeah, therapy. (P11)

Even though participants delayed engaging with mental health services for a variety of reasons, looking back, this participant would have wanted a way to engage earlier and with more ease. Another participant thought this could be useful in the form of a helpline specifically for Māori women's mental health:

Maybe um, is there a number they can call, you know, making services more available to them cos I've never called a number so, you know, I don't even know if there's one that exists for mental health for Māori women. (P08)

Another participant felt that although her wairua and tūpuna eventually came to help her, looking back she would have preferred earlier intervention from a tangible person:

When I felt most alone, nobody was there. But they came in 'til I got it and then pulled myself out of it. So physically a person would be pretty cool rather than wait for those wairua to come in because it might be too late then. (P12)

This participant also felt that mental health services need to be more accessible, particularly in rural communities, where she recognised her mother's struggles in accessing help:

I think the services need to be far more accessible. The services need to be in the communities. My mother's in a rural community. There's no help [...] It's a small community. There is like a social services place there. Mum can't get help from there because, you know, everybody knows everybody. Everybody talks

everybody's business. So there's people that are totally professional to come into those kinds of communities and ensure that they are, ensure that the people that need to see them can see them. Yeah, so it's easy, it's private and consistent. You know, that they're sort of supported in terms of like, I don't know, somebody there, somebody here. (P12)

Another participant highlighted the importance of contact with others for maintaining mental health and wellbeing:

Their wairua is in a healthy state, they're, they're looking good. My, my way of thinking is that because we get sick from taking pills, we must have a method of making our people aware. You know, we've got the rongoā to help you, to make you well. We've got this mirimiri or whatever, and give them a choice. If they have no choice, um, half of them they die, they die because of it. They die through ignorance because no one's bothered to say oh hello Dad, how are you, or hello Uncle how are you, or hello so and so. Ah, you know, and, and identify what it is their health problem is. And if you identify and plan for it you get the end result which will be, ah, a good mental health. And then anybody will want to know you. (P06)

For this participant, simply medicating people is not enough; going into the community and offering alternative interventions (including Māori healing) as well as simply talking to people and finding out what their needs are, would greatly improve experiences for Māori women and Māori in general. She reflected on her own positive experiences of being visited at home:

I think that, um, the idea of having support for families, ah, coming to my house gave, made me feel like oh, okay, somebody wants to talk to you or listen to

you cos, you know, and, and it's at your request. Sort of like a guardian angel, that's what I thought. (P06)

Like others, she also identified a greater need in rural communities. Another participant echoed this need to talk to people in the community, and check how they are doing:

But there's hundreds or thousands, just pop in, get to know them. Not, you know, just not, you know, every day type thing so it's a chore sort of thing, just yeah. (P12)

She continued on to describe how taking the time to engage with people by going to them, and not expecting them to reach out to services unaided, particularly in communities where accessibility is lower, is something that is sorely needed:

Yeah so accessing, access especially rural communities. A lot of that, a lot of that, so the value stuff that I talked about, they need to form relationships with those people too, that's really, really important. You know, so that's like don't even talk business in the first place, talk would you like a cup of tea? Oh I'm blah blah, I come from blah blah, that kind of stuff. You know, having a homely kind of environment too helps, comfortable environment. And just check all the, those cultural indicators that we'd get to go like oh they're condemning me or they just think I'm blah blah, you know. Make sure those are all checked and put away. (P12)

Unlike experiences participants had where they felt mental health services were checking up on them just to make sure they were taking their medication, her proposal was to really establish relationships in a meaningful way, in order to help people to feel comfortable, and therefore more likely to be able to access help. As another participant



added, simply recognising that asking for help is really difficult might help this type of relationship and communication flourish:

I've got heaps of friends who I think probably need to talk to someone about issues, serious issues but they would never go to a doctor and ask. Just, even just the fear of talking like on a personal level to someone with authority. Like even things like that and I feel like if doctors or whoever understood that maybe just automatically they would be able to communicate or be a bit more sensitive.

(P11)

For this participant, recognising these barriers to engagement and working to address them could mean that she and others would engage earlier and more willingly.

Participants, however, recognised that the responsibility for facilitating engagement was not solely with the services but with wider society. Some spoke about how family, whānau and wider groups could do more to encourage Māori women to seek help from the mental health services when they needed it:

I guess sometimes I think about those ads, it's okay to ask for help, and I think we need to push that more and more, you know? It's okay to ask for help, it's okay if all the resources you normally use aren't quite enough, it's okay to go outside the whānau, it's okay. I think a lot of it is to do with, one, the shame of it all. The shame. It is, the thought of having to ask strangers for help is really shameful, you know, oh they're just going to think I'm a useless person, and I can't cope but I don't know how to manage my life properly, and they're just going to think the worst of me. (P02)

Another participant spoke of bridging this gap with similar values:

So I rang, rang, I rang them up and oh, ah he's not here but, ah, I'll come and see you, so this woman came to see me. And yeah, I liked it, you know, I really liked having, and I think that's what we need. We need someone that we can, ah, that can come to your place, no strings attached, don't know you from a bar of soap and, um, just say oh okay, I've come, you know, I've come cos you've asked me and I'm prepared to listen. (P06)

For this participant, having somebody physically reach out and bridge the gap between Māori and mental health services meant her whole household got to benefit from talking to somebody who was prepared to listen and help.

Another participant reflected on what can happen when this gap between Māori and mental health services is left open, and people cannot bridge it themselves in order to get their needs met:

I don't even know how I got by, is there anybody that would, like it's like people can die in that time or people can do the worst in that time and it's like nobody, like, so you've, you've gone to seek help and then a big gap, nothing. Is there anybody that can be like an intermediate, intermediary, you know, like following up from like I've got this woman that come into the surgery, you know. She's really stressed and dah, dah, dah, dah. I think she's like, she's talking suicide or whatever. Can you just keep an eye on her, can you get to know her? (P12)

In summary, participants described how they wanted mental health services to meet them halfway. They described how mental health services could engage Māori better by operating in a similar fashion to whānau support, by approaching people and offering them help before they have to ask.

**Improving mental health services: Seeking more Māori professionals, healing, and worldviews.** Participants overwhelmingly expressed a need for more Māori in mental health services, including more Māori mental health professionals, more professional development for non-Māori staff, more Māori healing options, or other ways in which services could be more Māori or cater more for Māori.

One participant described a need for more Māori mental health professionals rather aptly and succinctly:

They need to have some brown... browning up... some brown people. (P06)

This participant went on to suggest that there could be more Māori mental health professionals visible in the community, in the same capacity of something like Māori wardens, in order to bridge the gap discussed above. Māori wardens are community volunteers; they are not police, but have legal responsibilities under the Māori Community Development Act 1962. They often provide support at public events such as security, traffic and crowd control, and first aid, and are recognisable in the community wearing identifiable high-visibility sashes.

It'll have to be something sort of like the Māori Wardens, those kind of things.

Where they do it because they, you know, they, they've always, they've always been a listening ear. (P06)

She also suggested that non-Māori staff might benefit from more exposure to Māori; although this would take effort and hard work. She expressed the idea that if non-Māori could become comfortable with Māori people, culture, and values, they might be able to participate more meaningfully in Māori mental health services:

I think that first of all they've got to broach it, they've got to approach it and then they've gotta, once they're themselves with their Māori colleagues, come

to some conclusion. Because to me, um, those two worlds won't, won't be meeting anyway. That, and that's quite okay with, quite okay except when it's, when it has, when it has to be an ongoing thing. Ah, what about the next Māori woman coming round the corner? (P06)

Participants believed that more Māori mental health professionals and more understanding non-Māori staff might mean being able to pick up difficulties earlier, as one participant described:

[...] the fact that nobody here picked up on any of the issues that I had even though I would go to the doctors for the most crazy things like being down all the time [...] I was the one that did go and say I need help which is cool. But for some people it's just not even an option. I feel like maybe they should pick up on things, health wise. Like I've got a mate who always gets sick every time she, she gets a bit down sometimes and she always gets sick beforehand, like physically sick. And you, I don't know, but I guess they don't look at things, how they connect up, which is I think probably the most important thing, looking at how things are holistically, lifestyle stuff, getting sick all the time. (P11)

For this participant, taking a more holistic and a more Māori approach to mental health might mean that professionals can be more alert to other issues going on, and therefore bridge the gap between Māori and mental health services:

Yeah, like even just wellbeing checks, I don't know. Like even if, I mean if it was a perfect world that they would, you would get wellbeing checks as well as physical. When you go to your doctor for physical they should do maybe something, put it in there, like questions or something to assess that stuff. I don't

know, you know, like to see, to identify things earlier than, yeah, when it's really necessary. (P11)

Participants explained how they felt an established relationship with a GP would help them access mental health services and make their engagement easier. Accessibility, however, as one participant pointed out, could be improved by increasing visibility of already available Māori services:

I guess accessibility and visibility of Māori services, but I only knew about it through going through the other counsellor there. So I think there would be a lot of people that would be too scared to come in the first place that wouldn't know about that kind of thing, and there is a lot of stigma and all that kind of stuff. Positive visibility of those services would be good. (P10)

Participants often described how taking more of a Māori approach to healing, where whānau was highly valued, would have helped them more with their recovery. For one participant, healing and contact with her family was key to her recovery, but she did not feel this was valued by mental health services as much as it was by her:

When you lose your family you lose everything. I don't wanna die alone. I've got my son and I'm lucky to have my son but I've only got him for an hour. It means a lot to me every day, yeah. Getting pictures from him, yeah that's what's keeping me better. Yeah, I suppose for all the other clients it would be to get back with their families again. And get well. Cos you can't do it on your own, you can't cope with the illness on your own. (P09)

Another participant described how she felt her difficulties with whānau were not recognised at the time:

Looking back now I realised that, that was the source of a lot of issues coming up, but nobody had really pinpointed it for me. Like when I was going there I mentioned about my dad and stuff, but they didn't really even though they interrogated me about it, they didn't carry on into anything. I would've thought that was a significant thing especially if it made me that upset to talk about it at the time. (P10)

She went on to wonder aloud about why this was not 'pinpointed' by professionals. Lastly, one participant expressed a wish to be taken seriously as Māori:

Probably to be taken more seriously if you write down that you're Māori that shouldn't be someone who sees your face. It shouldn't be their decision where you get put. You should have the choice I guess, because I didn't have the choice when I was younger. (P10)

This participant expressed the idea that being acknowledged as Māori and having access to Māori healing and interventions would have been much more helpful than what she experienced when she was younger.

Overall, participants expressed both an appreciation of things Māori already present in services, and an expectation that more needs to be provided in future if mental health services for Māori women are to improve. Participants expressed a wish for more Māori mental health professionals and more visible Māori faces in general, more Māori understanding in non-Māori professionals, more Māori healing methods offered and acknowledged as having a legitimate place within services, more broad acknowledgement of Māori worldviews, and more specific acknowledgement of Māori identities of service users.

### **Improving mental health services: Moving toward collective support.**

Lastly, participants saw a need for a collective approach to mental health services. This included ideas such as focusing on collective awareness, collective support, and communicating with groups rather than individuals.

Participants placed an emphasis on awareness. As one participant explained, this was simply about increasing awareness, not by singling people out but by educating the communities rather than just individuals:

I think there should be more awareness cos I met a lot of people that didn't even know what, you know, what depression was sort of thing [...] You know, I just think that's all about education, if they, you know, if you don't know what it is you don't know if you've got it or not (laugh). (P08)

Another participant suggested that Māori community groups could be utilised to help begin a collective approach to Māori mental health:

[...] someone they can signal. I don't know, community worker. There's lots of community, Māori community groups out there, you know. Not necessarily one that's, you know, or they don't need to know the details but just can you check on this person. I'm worried about this person, you know, like I don't know, a signal back. You know, get to know them, something, and they can be your, not Florence Nightingale but, you know, hi, how are you? You're not okay, you know, you haven't even got out of bed today. You alright? You know. Come on, let's go and have a cup of tea, sit out in the sun. Even that, you know. I know the, when, for me, because there was nobody. I was living in a community on my own because my family, me and the children, my family were in the bay, and I was like I'm alone. There's no-one, there's no-one that, you know, cares,

no-one and I can't even look after my children and for me, my kaitiaki [guardians] were wairua, wairua, spirit, you know. (P12)

Some participants explained how they felt that groups could be used to promote sessions in the community, and how approaching mental health concerns collectively might improve engagement and help to bridge the gap further. As one participant elaborated:

I feel like it might be, it might be cool if they did like, I don't know promoted like group sessions or something with the few people who feel, because I feel like that support, that support network is quite important for a lot of Māori women. Maybe about like relationship stuff or specific lifestyle stuff that Māori women seem to face. Like a target, like I don't even know. Like even going into marae or just going into the places where Māori women live instead of the other way round. It might be a good way to just bridge a gap between, you know, those two different... (P11)

She continued to suggest having holistic wellbeing clinics in small towns, who could run groups targeted at everybody for education and support:

Even like they have little Hauora clinics in most little towns and stuff, you know, even having a nurse there who, I don't know, running sessions or talking about abuse or just like something that can, within the big huge thing with mental health. But like something targeted that's not so in individual or something. (P11)

Some participants acknowledged limitations due to funding, however. One participant highlighted the importance of having the necessary funding to carry out a collective approach to Māori mental health:



You would think there would be some money somewhere for, I don't really know. I think having a political system yeah, there needs to be some more things happening out there, that's what I'm trying to say, yeah, in order to improve things to this level, yeah. (P11)

Many participants expressed that a collective approach might have meant they received help sooner and in a more appropriate way. As one participant put it:

Yeah I think making something collective, is, if if it's helpful is always good, or to sort've look for ways that collective support can be accessed, is helpful, I think the times that I've gone through things on my own, umm, were, hard. I mean they were more for the things that, y'know I felt ashamed about. (P01)

The general feeling that seemed to be expressed by participants was that a collective approach to Māori mental health would have a number of benefits, including better education, better exposure in the community, more accessibility, catching people early, reducing shame in asking for help, generally making it easier for people to ask for help, and the ability to further bridge the gap between Māori and mental health services.

Overall, participants expressed the idea that services could be improved by reaching out to people and coming to meet them halfway, offering more Māori healing, professionals, and worldviews in mental health services, and moving from an individual to a collective focus.

## **Summary**

In summary, 19 themes were presented across six categories in an order that aimed to present a story of participants' experiences in a temporal narrative. Participants made sense of their mental health problems as a response to violence or harassment at the hands of men, having difficulties with roles as wāhine, and struggling

with their cultural identity. Participants described managing without mental health services by continuing in the face of adversity and relying on whānau support. Participants gave reasons for delaying contact with mental health services; they expressed the idea that asking for help is hard, that they did not know or trust mental health services, and that they would engage only in a crisis. Participants expressed several areas of importance in building a relationship with mental health services, such as having a genuine relationship, finding understanding, being able to trust mental health services and professionals to maintain confidentiality, not feeling pressured, seeking acknowledgement, and looking for familiarity. Participants also shared stories of looking beyond mental health services by going back to whānau and seeking Māori support outside of mental health services. Lastly, participants also expressed their views on improving mental health services, suggesting that they should be coming to meet people halfway, seeking more Māori professionals, healing, and worldviews, and moving toward collective support.

## CHAPTER 4: DISCUSSION

In this chapter I present a summary of the key findings of this research. I then discuss implications for practice, particularly for mental health professionals and services in New Zealand. Finally, I consider opportunities for further research, as well as the limitations and strengths of this study, before offering some concluding thoughts.

### **Key Findings**

Key findings are presented in the same temporal order as in Chapter 3, reflecting the participants' journey towards and through mental health services. A summary of each key finding is presented in light of previous literature. Any conflicting or additional ideas are considered in context, as well as any new theoretical ideas.

**Making sense of mental health problems.** The way in which participants made sense of their mental health problems was most strongly expressed as a response to difficult experiences, including violence and harassment at the hands of men, difficulties with their roles as wāhine, and struggles with their cultural identity.

Participants saw their mental health problems as arising out of violence or harassment at the hands of men. This fits broadly with research which suggests that service users see their mental health problems as a result of difficult experiences (Koivisto et al., 2003; Lapsley et al., 2002), and that personal trauma has the potential to increase the risk of mental health problems (Read, van Os, Morrison, & Ross, 2005; Schnurr & Green, 2004). It also fits with research that suggests Māori experience more personal trauma than non-Māori (Hirini, Flett, Long & Miller, 2005; Wirihana & Smith, 2014), and statistics that suggest women experience relatively high levels of gendered-violence (Dye et al., 2012; Fanslow, 2011; Ministry of Justice, 2015; United Nations, 2015). Research that links sexist discrimination with poorer mental health also aligns

with this finding, in that participants made sense of their mental health problems as a result of their experiencing sexism (Klonoff et al., 2000; Moradi & Funderburk 2006). While these findings align with research on service users, women, and Māori, my study has drawn particular attention to the intersectionality of being Wāhine Māori, and the exacerbating effect this seems to have for the experience of trauma overall. A number of participants shared their multiple experiences of gender-based violence or harassment, including physical and sexual violence. They often endured prolonged exposure to violence and harassment from men both throughout childhood and into adulthood (usually from fathers or partners). This was sometimes intergenerational, with other women in their whānau affected in the same way. They experienced feeling disempowered, and feeling that they had to endure without complaint in order to 'keep the peace'. This highlights the need to acknowledge the tapu of Wāhine Māori and of these experiences (August, 2004; August, 2005). For many, these experiences provided the backdrop to later mental health problems.

However, participants who went through these difficulties also experienced an empowering sense of their own strength and power, whether that was in the form of being 'tough' and getting through it, or standing up to these men to say 'no more'. This, in contrast, highlights the mana of Wāhine Māori (August, 2004; August, 2005). While these findings pointed to the high levels of trauma the participants in this study seemed to have experienced, it also highlighted the potentially empowering aspect of these experiences, rather than positioning them necessarily and exclusively traumatic. Other researchers have also noted that experiencing traumatic or difficult life events may in fact be linked with resilience (Agaibi & Wilson, 2005; Bonanno, 2004; Bonanno & Mancini, 2008; Iacoviello & Charney, 2014). This might mean that while these experiences have the potential to increase mental health problems, healing from the

potentially traumatic effects, or simply having survived through these experiences, might also provide women with additional skills and strengths.

Participants also saw their mental health problems as a response to struggling with roles as wāhine. This coincides with previous research which has recognised the impact of similar experiences on women's mental health. For example, research has noted the mental health impact of coping with (single) mother hood (Montgomery et al., 2006; Mowbray et al., 2000), and the effects of miscarriage (Broen et al., 2006; Cumming et al., 2007; Rowlands & Lee, 2010) abortion, (Fergusson, Horwood, & Ridder, 2006) or loss of custody of children (Nicholson, Sweeney, & Geller, 1998a; Nicholson, Sweeney, & Geller, 1998b). This again fits with the research on service users in general in that it supports the idea that difficult life experiences and personal trauma have the potential to increase the risk of mental health problems (Read, van Os, Morrison, & Ross, 2005; Schnurr & Green, 2004) and that service users make sense of their mental health problems as a result of these (Koivisto et al., 2003; Lapsley et al., 2002). Participants often spoke about miscarriage as though it was particularly traumatic or upsetting for Māori compared to non-Māori. This has recently been explored in Māori research on reproduction (Le Grice, 2014), but further research is needed to explore the specific significance of this for Māori women's mental health. Another area that was highlighted by participants was the effect on women's mental health when children are removed from their care. Participants who described this experience indicated that although they were not well when their children were removed, their mental health problems became worse due to time spent apart from their children. Although there is a small body of research that highlights this issue in the context of women with serious mental illness (Diaz-Caneja & Johnson, 2004; Nicholson, Sweeney, & Geller, 1998a; Nicholson, Sweeney, & Geller, 1998b), further

research is needed to explore the significance of this for Māori women (though Harris' 2014 research did explore this in regards to those with bipolar disorder). This seems particularly important given the number of Māori children in statutory care. As of March 2016, just over 60% of children in statutory care in New Zealand are Māori (Child, Youth & Family, 2016), which likely reflects a significant number of Māori mothers who do not have care of their children. For Māori women, and women in general, this might mean that extra care and support is needed in order to both heal the self and the role as mother. Participants' experiences highlighted the conundrum of needing to be well in order to have children remain in or returned to their care, but also needing a connection to their children in order to heal.

Participants also saw their mental health problems as a response to struggling with their identity as Māori, which included developing a Māori identity for themselves and having their Māori identity ignored or denied by others. This fits with broader research on service users in New Zealand that suggests identity is an important factor in mental health difficulties (Lapsley et al., 2002), and service user experience research that also broadly positions identity as important to recovery (Katsakou & Priebe, 2007; Lilja & Hellzen, 2008). This finding also fits with specific research on Māori that highlights the importance of a secure cultural identity in good mental health and wellbeing (Durie, 1997; Pere, 2006). New considerations that this research highlights lie in the detail of how this struggle with identity is experienced by Māori women. Although each participant's experience was unique, there were four key aspects to their collective struggles with identity. Firstly, some found it difficult to assert themselves as Māori in childhood and early adulthood, particularly in schooling situations. Secondly, this was distinct from, but often went hand-in-hand with, struggling to have their identity as Māori acknowledged or respected by others. Thirdly, for some this

struggle was also exacerbated by a mixed identity. This sometimes resulted in struggling inwardly to find a more nuanced identity as both Māori and another ethnicity at the same time, and having to exist in two worlds. This concept has been previously explored broadly in both Māori and other Indigenous peoples (Saba, 2007). However this study also highlights the added difficulty of existing as both Māori and Pākehā, in addition to having to exist in Māori and Pākehā worlds. This also often meant that they struggled with an outward appearance that was keenly felt as less Māori (such as a fairer complexion, hair colour, or eye colour), and this also linked strongly with struggling to have their identity as Māori acknowledged by others. Lastly, many participants described feeling the effects of discrimination, which seemed to evoke negative feelings for both those struggling and secure with their identity. Although much of this may be known anecdotally, utilising the concept of Māori identity in mental health recovery seems prudent given previous claims of its importance (Durie, 1997) and these experiences shared by participants.

For Māori women, and indeed for all Māori, this might mean that there is value in working toward developing a positive and solid Māori identity in order to either protect against mental health problems, heal existing ones, or simply improve psychological wellbeing for Māori. Given the negative effects of discrimination on participants regardless of the strength of their identity, reducing discrimination on a broad scale also seems prudent in improving the psychological wellbeing of Māori.

Overall, participants making sense of mental health problems as a response to a range of difficult experiences also fits with broad critiques of the dominant psychiatric model of mental health from Māori, women, and service users in general. As service users, participants did not see their mental health problems in an illness framework in

line with the psychiatric model, but rather as an understandable response to social and psychological experiences.

**Managing without mental health services.** Participants described how they managed without mental health services by using an internal strength to continue in the face of adversity, and utilising whānau as an external resource to manage without mental health services.

Participants saw their resolve to continue in the face of adversity as a way of managing their mental health problems. This seems to speak to the mana of Māori women, and the idea that Māori women continue with strength in the face of adversity and simply carry on. This makes sense in the context of research that suggests Māori present to mental health services much later than non-Māori (Tapsell & Mellsop, 2007). It also fits with contemporary literature that highlights the strength of Māori women (Harris, 2014; Simmonds, 2011; Te Awekotuku, 1991) and traditional views of the strength of Māori women (August, 2004; August, 2005; Pihama, 2001; Simmonds, 2009). The unwavering strength of Māori women might also be double-edged in that it is a true strength that carries them through tough times, but might also mask distress, or prevent/delay them from acknowledging when they need assistance. Participants in this study appear to instead position, and perhaps reframe, this tendency to carry on as a strength. However, it can also be positioned as a kind of pathology that impedes recovery (Herd, 2006). This fits somewhat with research on women which highlighted a tendency to ignore their feelings and carry on (Gammell & Stoppard, 1999). For Māori women, and perhaps for women in general, this might mean that there is a need to acknowledge when this resolve to continue in the face of adversity becomes harmful, while still honouring the strength of Māori women.



Participants also emphasised reliance on whānau support as key in managing their mental health problems. Participants spoke of how they utilised their whānau, to the extent that nearly all issues were dealt with internally within the family. Again, this may help to explain research findings that suggest that Māori present to mental health services much later than non-Māori (Tapsell & Mellsop, 2007). It also fits with the research on Māori which highlights the importance of whānau, both broadly in culture and in the context of mental health and recovery (Durie, 1985; Harris, 2014; Lapsley et al., 2002). This idea is also present in general service user research and research on women that highlights the support of family as important in mental health recovery and treatment (Koivisto et al., 2003; Lapsley et al., 2002; Rydon, 2005). One of the important findings of my study is that whānau support was characterised as both invaluable and as something automatic, that did not need to be asked for but was provided, no questions asked. This might mean there is something unique about the way in which Māori women, and perhaps all Māori, receive help within their whānau. Being used to a support system which offers help before you need it, and does this willingly, without the need to put oneself out there and ask for help, may have implications for how Māori women eventually make contact with mental health services. The contrast between this whānau model of receiving help and the way in which mental health services operate might shed some light on how Māori women, or Māori in general, engage with mental health services.

Overall, although participants' management of mental health problems without mental health services makes sense in light of previous literature, it offers a new point of view by specifically framing these as empowering ways of managing without mental health services, rather than assumed deficits in how and when help is sought from mental health services by Māori women and perhaps Māori in general.

**Delaying contact with mental health services.** Participants' reasons for delaying contact with mental health services were most strongly expressed as a result of finding it difficult to ask for help, not trusting or knowing mental health services well enough, and only engaging at a time of crisis.

Participants saw their difficulties in asking for help as a reason for delaying contact with mental health services. Participants detailed how asking for help was sometimes difficult because of shame related to their experiences such as sexual abuse, having to ask strangers for help, and having to admit they were not coping. This links with other research with sexual abuse survivors that also suggests people wait many years to disclose and seek help (Arata, 1998; Jonzon & Lindblad, 2004; Lange et al., 1999; Smith, 2001). This again highlights the tapu nature of these experiences, and the tapu status of Wāhine Māori (August, 2004; August, 2005). Given participants' experiences with gender-based violence, this barrier or delay in asking for help also links with research on partner violence (Ahmad, Driver, McNally, & Stewart, 2009; Overstreet & Quinn, 2013). This may again shed light on why Māori women delay presentation to mental health services, and informs how mental health services and professionals might encourage or facilitate earlier contact. As this also links to the idea of Māori women being strong and continuing in the face of adversity, it offers insight into what could be the harmful or vulnerable side of this narrative. It also links back to the idea of whānau not only as helpful but as providing automatic help. These two ideas may connect together in the sense that help may more likely to be accepted from whānau, because it is less shameful or difficult to be helped without having to explicitly put oneself in a vulnerable position and ask.

Participants also saw a mistrust of, and lack of familiarity with mental health services, as factors in delaying contact. They expressed a general caution around mental

health services. This took the form of not knowing mental health services, not feeling familiar with services or their individualistic approach, and family narratives of not trusting mental health services. This fits with the literature on Māori that challenges the dominant psychiatric model and instead argues for a collective and holistic approach to mental health (Mark & Lyons, 2010; Stephens, Nettleton, Porter, Willis & Clark, 2005; Wilson, 2004). It also fits with Māori service user research that highlights the value of Māori mental health services (Harris, 2014; Lapsley et al., 2002; Wilson, 2004). It suggests these services might offer some familiarity in both theoretical approach and in trust building with Māori, which means Māori are more willing to engage with them (Wilson, 2004). Knowing that this mistrust and unfamiliarity is still felt by Māori women sheds some light both on the delay in presentation and on how services could change in order to build better relationships with service users.

Participants in this study described how they often only sought help from mental health services in an absolute crisis. This meant exhausting all other avenues of support before going to mental health services, and often only engaging with mental health services when they felt they had no other choice. This again might shed new light on the reasoning behind Māori presenting to mental health services with higher severity (Tapsell & Mellsoy, 2007). Help-seeking behaviours have been explored with Māori women in regards to bipolar disorder (Harris, 2014). However, further research focusing on help-seeking behaviours in Māori women may help to further elucidate the nuances of how and why they might present in crisis.

In the findings of this study, there is an intersection between how participants managed their mental health difficulties without mental health services, and their delayed contact with mental health services. That is, the methods used to manage and the reasons for delay seem inextricably linked. Continuing in the face of adversity might

mean that having to maintain a strong persona makes it difficult to ask for help. Likewise, the whānau model of support described earlier, one which offers help automatically and without needing to ask, might mean that Māori women are not accustomed to asking for help in the way that mental health services might expect. Asking for help might be difficult because help is usually found within the whānau and often does not need to be sought or asked for, but is proactively offered by whānau. Mental health services seldom provide help unless sought, with the exception of when people are very unwell. This might that make it seem like Māori present late when instead they simply do not have the same model of help-seeking behaviour as non-Māori. It may be that Māori do not automatically reach out for help because they are used to someone else reaching out to them, or at least meeting them halfway. Likewise, help may only be sought from mental health services in a crisis because whānau support is effective and adequate up until this point. This strength, and reliance on whānau support, might also enable a safe distancing from the unfamiliar and untrustworthy façade of mental health services. These four elements of management and delay might then together enable Māori women to present with higher severity than they might without these tools and supports.

Overall these findings seem to support a partial reframing of a later presentation of Māori to mental health services as something more positive; as empowerment to remain well without intervention from services, rather than a failure of Māori women as service users to present to mental health services earlier. However, it is also important to consider, as participants did, that delaying contact with mental health services can also have downsides. Hiding vulnerability might be a bad thing, and might delay or prevent Wāhine Māori from getting help.

**Building a relationship with mental health services.** Important factors for participants in building a relationship with mental health services included a genuine relationship, cultural understanding, trust and confidentiality, not feeling pressured, being acknowledged, and finding familiarity.

Participants saw that a genuine relationship is important to building a broader relationship with mental health services. This consisted of professionals allowing themselves to be human, treating participants like human beings, being honest, and being non-judgemental. This aligns strongly with all literature on the experiences of service users in general (Agar-Jacomb & Read, 2009; Goodwin et al., 1999; Hodgetts & Wright, 2007; Katsakou & Priebe, 2007; Lilja & Hellzen, 2008; Rodgers, 2002; Rydon, 2005; Timulak, 2007; Walsh & Boyle, 2009) as well as that with Māori (Harris, 2014; Wilson, 2004). The current study adds to previous research in confirming the importance of this genuine, human relationship. Perhaps, particularly given that identity struggles can play a role in mental health problems (Katsakou & Priebe, 2007; Lilja & Hellzen, 2008), part of the healing process for those who come into contact with mental health services might be found in a relationship in which they can feel human again. As noted in previous research, being greeted with mental health professionals who alienate service users might stall or even worsen recovery (Lapsley et al., 2002). While the importance of relationships aligns strongly with previous service user research in general, I would argue that building relationships is even more important with Māori service users because of the aforementioned unfamiliarity of mental health services. Given the importance of whakawhanaungatanga for Māori, particularly in mental health (Durie, 2003; Wharewera-Mika, 2012), building a relationship with mental health professionals and services seemed to be particularly important to participants as Māori.

Participants emphasised that finding understanding with professionals facilitated a good relationship. This was often to do with Māori understandings, but seemed to also reflect finding understanding more generally. The importance of cultural understanding in particular has also been widely recognised in the broader therapy and service user literature base (Agar-Jacomb & Read, 2009), and with Māori specifically (Hodgetts & Wright, 2007; Gilbert et al., 2007). Participants described a graded experience of being understood by their professionals. The best experiences were when professionals appeared to genuinely understand the participant effortlessly, in a sort of unspoken understanding, and no explanation was required in order to help the professional ‘get it’. However a relationship could still be built when participants had to explain something, but the professional ‘got it’ afterwards, and was willing to accept and hear the participant. When participants explained and professionals still did not ‘get it’ and did not appear to want to, building and maintaining a relationship was difficult. In any scenario, even if understanding was difficult to come to, simple efforts and willingness by the professional were greatly appreciated. Even if this was not as helpful as unspoken understanding, it strengthened the relationship. This aligns with previous research as mentioned above, but offers some new insight into how professionals and services might be able to meet this and how they might temper their approach to understanding in order to build better relationships.

Linked closely with the idea of understanding, and cultural understanding, is that of acknowledgement, particularly of things Māori. Participants saw receiving acknowledgement from professionals as fostering a good relationship with mental health services. Broadly, this echoes general service user research that values acknowledgment in general (Thomas, Wilson & Joes, 2010). A specific acknowledgement of Māori worldviews and healing aligns with the research on cultural

competency (Fulcher, 2001), and Māori service user research that values Māori mental health services (Harris, 2014; Lapsley et al., 2002; Wilson, 2004), and Māori healing offered within and outside of these (Dyall et al., 1999; Lapsley et al., 2002; Wirihana, 2008). Māori professionals in particular may be experienced as offering this acknowledgement more frequently (Johnstone & Read, 2000). This acknowledgment of participants as Māori intersects with previous ideas of the importance of, and struggles with, Māori identity, both in this study and in previous research (Lapsley et al., 2002). The potential healing that can happen as a result of being acknowledged as Māori could be an important factor in recovery, as well as in building a relationship with mental health services. Thus, this intersection could provide valuable guidance for mental health services and professionals to not only acknowledge the struggle with identity that Māori women may present with, but also to work with building or repairing this identity to build a closer relationship with, and facilitate healing of, these service users.

Participants saw being able to trust professionals, particularly with confidentiality, as important in building a relationship with mental health services. This aligns with research on service user experiences in general (Gilburt et al., 2007; Walsh & Boyle, 2009) but sheds new light on the specifics of confidentiality and how this might affect the ability of professionals and services to build relationships with Māori women. It also links with this study's theme of distrust of mental health services, and means that although confidentiality is of course important at all times, it could be particularly damaging to break this trust with Māori women. The importance of this trust and confidentiality is also reflected in research regarding sexual abuse and other traumatic experiences for Māori women (Hirini et al., 2005) and women in general (Fanslow, 2011; Feder et al., 2006; Ministry of Justice, 2015). This again is particularly

important given the tapu nature of these experiences and the tapu status of Wāhine Māori (August 2004; August, 2005). This might also explain why confidentiality was framed as particularly important by participants. This study supports the idea that asking for help from a stranger regarding these experiences might in itself be positioned as difficult or shameful (Arata, 1998; Jonzon & Lindblad, 2004; Smith, 2001). This is then likely to be exacerbated by breaches of confidentiality and trust. Having confidentiality broken about particularly sensitive experiences was framed by participants as more damaging than general breaches of trust. While this is supported in previous literature, it appears to shed new light on the importance of this in the context of Māori women in particular.

Not feeling pressured or coerced by professionals was also important to participants. This included not feeling pressured to take medication, to address certain topics in therapy and to end treatment before the client felt they were ready. When participants were given choices and allowed autonomy, the feeling of pressure eased and their experiences were more helpful. This aligns very closely with service user research in general (Gilburt et al., 2007; Sheehan & Burns, 2011) and that which relates specifically to medication (Hodgetts & Wright, 2007; Walsh & Boyle, 2009). It speaks to sentiments expressed by service users in previous research, such as wanting a choice in intervention options (Katsakou & Priebe, 2007), wanting autonomy (Agar-Jacomb & Read, 2009; Elstad & Eide, 2009; Goodwin et al., 1999; Katsakou & Priebe, 2007; Lapsley et al., 2002; Rodgers, 2002; Thomas, Wilson & Joes, 2010; Walsh & Boyle, 2009), and feeling like medication is often the only treatment offered (Katsakou & Priebe, 2007). It also echoes previous research that highlighted the need for professionals to allow ample time for recovery and not 'pushing clients out the door' (Dennis & Chung-Lee, 2006; Gilburt et al., 2007). Overall this study appears to



complement the previous body of literature with broader groups in service user research, and suggests the same elements of pressure, or lack thereof, are important to Māori women.

Finding familiarity in mental health services also helped participants to build a good relationship with the service. A familiar, home-like environment, familiar healing practices, familiar faces, and being treated as a friend or whanaunga, all helped to build a relationship with mental health services. While this has been highlighted in previous service user research in general (Agar-Jacomb & Read, 2009; Gilbert et al., 2007) and with both Māori and women (Harris, 2014; Wilson, 2004), this study frames it as particularly important for Māori women. This is perhaps because it directly addresses mistrust of services, and allows mental health services to mimic whānau support, which was so heavily utilised by participants both before and outside of services. An additional component was appreciating and feeling relaxed and supported by the presence of another Māori person, whether this was a professional, a support person, or simply someone in the vicinity. This may extend to all service users in terms of feeling supported by a familiar face (even if the face is not familiar, cultural similarity to the client may be able to put them at ease and foster building a relationship). This is in line with Māori service user research (Semmons, 2006), however, it appears to have been expressed with particular importance in this study. This finding highlights a new dimension in familiarity, and puts a stronger emphasis on services being more like whānau support in order to be effective at both building relationships and helping clients to recover.

**Looking beyond mental health services.** The ways in which participants sought help outside of mental health services included going back to the support of whānau, and seeking Māori support and healing outside of mental health services.

Participants saw whānau support as helpful even while engaged with mental health services. As previously acknowledged, this aligns with earlier theoretical and service user experience research, and reflects participants' reliance on and preference for whānau support in this study. It also strongly highlights the need for more whānau involvement in mental health services (Durie, 1985) and adds a new dimension in that it also specifies the need for services to be more like whānau support. This might mean that Māori women look beyond mental health services to fill an important gap, which could be avoided if services took a more holistic approach and involved whānau in the recovery process, and acted more like whānau in their methods of offering and providing help.

Participants also spoke about the helpfulness of other interventions or healing offered outside of mainstream mental health services. This outside help, sometimes in the form of traditional Māori treatments, was often positioned as more helpful than mainstream mental health services. Although this fits with the research with Māori that positions Māori interventions as valuable (Dyall et al., 1999; Lapsley et al., 2002; Mark & Lyons, 2010; Wirihana, 2008), it also sheds new light on the need for further integration of Māori healing into mental health services. While some participants were able to access a small amount of Māori healing from within services, those who did always expressed the idea that what was available was nowhere near what they needed in terms of quantity and frequency, and expressed a wish for more availability and access to Māori interventions.

**Improving mental health services.** Participants' ideas for improving mental health services in the future were most strongly expressed as wanting services to come to meet people halfway, wanting more Māori professionals, healing, and worldviews

within services, and a general move towards collective support, rather than an individual focus in assessment and intervention.

Participants saw services coming to meet people halfway as important for improving mental health services in the future. Because it is hard to ask for help, and Māori may be accustomed to people reaching out to offer support rather than having to ask for it, mental health services could be improved by mirroring whānau support and offering help before people have to ask for it. Although this aligns with the spirit of previous literature on Māori mental health (Durie, 1985; Wirihana, 2008), it sheds new light on how mental health services might go about reaching out to Māori earlier. An ideal process would be akin to the pōwhiri (to welcome) process. The tāngata whenua (people of the land) do not sit inside the whareniui (meeting house) waiting idly for the manuhiri (visitors) to approach, they send out their strongest voices to karanga (summon) and call the manuhiri in, and stand and sing and speak to greet them when they enter, and then welcome them like old friends once that bond has been established. This fits with previous research that highlights pōwhiri as important to Māori more broadly (Durie, 2003). A pōwhiri model of engagement has already been proposed in regards to mental health research (McClintock, Mellsop, Moeke-Maxwell, & Merry, 2010) and child and adolescent mental health services (McClintock, Moeke-Maxwell, & Mellsop, 2011), and actual pōwhiri have also been a valued part of Māori mental health services in previous research (Dyall et al., 1999). Likewise, participants expressed the idea that mental health services should be reaching and calling out into the community, engaging in a process with tāngata whaiora (Māori service users) in order to welcome them in, so mental health services develop a good name and reputation. This might help reframe it as normal and helpful for Māori women to engage with mental health services. In order to intervene earlier, before crisis point, services

could reach out, so Māori do not have to reach so far for help. Consequently, potential service users could feel aroha and a welcoming presence. As a result, their recovery might be more successful.

Participants also saw more Māori professionals, healing, and worldviews as important to improving mental health services in New Zealand. Participants wanted more Māori professionals, more Māori services, more Māori healing, more Māori models of mental health, more Māori faces, and generally more Māori presence in mental health services. This aligns with Māori literature on cultural competency and cultural safety (Fulcher, 2001; Papps & Ramsden, 1996; Wilson, 2008), and also with Māori service user research that values Māori approaches to mental health as important to recovery (Harris, 2014; Lapsley et al., 2002; Semmons, 2006; Wilson, 2004). It also supports research that advocates for the need for more Māori professionals (Harris, 2014; Lapsley et al., 2002; Wilson, 2004; Levy, 2002; Wilson, 2004; Reid & Robson, 2006), and a change to the dominant Western model of treating mental health problems (Nikora et al., 2004; Tapsell & Mellsop, 2007; Wilson, 2008), by highlighting the importance of alternative models of mental health and methods of healing, and their legitimacy and value (Durie, 1994; Mark & Lyons, 2010; Pere, 1984; Wirihana, 2008).

Participants also saw moving away from individualised focus and toward collective support as important to improving mental health services for Māori in New Zealand. Community approaches could potentially lessen the shame associated with being singled out as needing mental health services, and may also allow for earlier intervention. Group based interventions may also align more closely with Māori collectivism rather than Western individualism (Stephens et al., 2005).

## **Implications for Practice**

Implications for practice are again presented in the same temporal order as in Chapter 3, reflecting the participants' journey towards and through mental health services. Here, I consider each theme and the implications for practice both for mental health professionals individually and mental health services collectively.

**Making sense of mental health problems.** The ways in which Māori women understood their mental health problems has implications for practice, for broader considerations in mental health services, and even how mental health is defined.

A broad implication for practice is that it might be useful to move away from the pathologising language of illness, and to recognise that mental health problems arise out of difficult life experiences. This aligns not only with the views of participants in this study, but also with previous service user research (Cohen, 2008; Koivisto et al., 2003; Lapsley et al., 2002), and wider research with the public (Walker & Read, 2002). This is an important implication because it challenges the dominant definition of mental health as an illness, and supports previous research that asserts this challenge (Cohen, 2008; Koivisto et al., 2003; Lapsley et al., 2002; Walker & Read, 2002). Moving toward recognising that mental health problems arise out of difficult life experiences, and being sincere about this, might encourage Māori women to see that mental health services could be relevant to them.

Within this framework of explicitly acknowledging that mental health problems arise out of difficult life experiences, it would also be prudent to consider the benefits of screening for experiences of gender-based violence or harassment in childhood and adulthood as part of a mental health assessment or regular trauma screen. Not only would this acknowledge and reinforce the idea that mental health problems are

understood as a response to difficult life experiences, improving experiences for service users, it would allow mental health professionals to acknowledge and position this idea as both salient and legitimate. This might help foster a shift in thinking for both mental health professionals and services in general.

Positioning gendered violence or harassment at the hands of men as having the potential to be both traumatic and empowering might allow professionals to utilise this knowledge in two ways. Professionals could understand the experiences of their clients, and use this to build a meaningful relationship, but could also work with their clients to harness the strength and healing that could be gained from transforming these experiences into something empowering for their clients, and acknowledge the mana of Wāhine Māori service users.

Additionally, there might be benefits to also incorporating screening for other potentially traumatic experiences that affect women, such as previous miscarriage (Broen et al., 2006; Cumming et al., 2007; Rowlands & Lee, 2010), abortion (Fergusson et al., 2006), or removal of children from their care (Diaz-Caneja & Johnson, 2004; Nicholson et al., 1998a; Nicholson et al., 1998b). This could allow mental health services to pick up on unresolved difficulties as a result of these experiences, and find opportunities for earlier intervention to address concerns that might previously have been missed. Again, the tapu nature of these experiences for wāhine should be acknowledged, particularly in regards to miscarriage and abortion (Le Grice, 2014). This might make it easier to hold these experiences in mind as important and potentially salient for Wāhine Māori presenting as tāngata whaiora.

Professionals should also be aware that when they meet with a client, even one they might not immediately recognise as Māori, the person standing before them may

be struggling with their cultural identity. Although clients may not name this as their 'presenting problem', asking about identity and making space for it as an area that clients might want to develop could help with building relationships and their recovery. Opening a space for Māori clients to speak about their own Māori identity is imperative, and professionals should not be fearful of opening this door, for the risk of leaving it closed is far greater than the risk of offending or upsetting, and working alongside the client around their identity distress may be a helpful intervention in itself.

**Managing without mental health services.** The ways in which participants managed without mental health services also has implications for practice. Professionals could benefit by acknowledging and utilising the strength and mana of Māori women, whilst also being aware that this could be problematic for them personally, as well as potentially hindering their engagement with mental health services. Professionals could acknowledge the sheer strength and mana of Māori women; to cherish, praise, and utilise this strength, but also give them permission to be vulnerable by offering help.

Professionals and services should also recognise the value of whānau support, and incorporate them into recovery in services if possible. It would be prudent for professionals and services to utilise this resource as part of a holistic mental health service, rather than keep them disparate. This fits well with an already established Māori health initiative known as the Whānau Ora Programme. Initiated in 2010, Whānau Ora aims to increase wellbeing, and utilises the power of whānau to do this, by providing the appropriate services and support to whānau, so that they can self-manage (Ministry of Health, 2015; Te Puni Kōkiri, 2017). Although Whānau Ora is already in action, this research lends further weight to the appropriateness of this approach particularly in the area of mental health. The concept of whānau support also

links to the later theme of seeking whānau support outside of mental health services, even while engaged. Participants often sought to take their own action to fill this gap. For those Māori women who might struggle to do so, or might delay doing so, mental health services could purposefully and more reliably help to connect service users with whānau to provide a richer and more effective healing experience.

**Delaying contact with mental health services.** Māori women's understandings of why they delay contact with mental health services also has implications for practice. Because it is hard to ask for help, professionals and services as a whole could be mindful to offer help, rather than waiting for service users to ask. To address the unfamiliarity and mistrust of mental health services, services in general should aim to build trust with Māori over time by networking with Māori, working collaboratively with Māori, and supporting Māori models of mental health service delivery. While this has progressed over the decades (Durie, 2011), this should continue to develop so that mental health services become increasingly indigenised. This might help Māori to engage better and see that mental health services are both relevant and useful, as well as trustworthy and familiar.

**Building a relationship with mental health services.** Participants strongly emphasised the idea that building a relationship with mental health services is important. While this is already well-established, professionals should hold in mind the value of being human, treating clients as human, being honest, and being non-judgemental.

Although professionals should adhere to confidentiality requirements as a minimum, the particular importance of confidentiality with women and sensitive experiences should be noted and kept in mind. This again highlights the importance of



honouring the tapu of Wāhine Māori and these sensitive experiences (August, 2004; August, 2005; Herd, 2006), in the sense that the sacred nature of these experiences should be acknowledged. For participants, building trust was a key component in building a relationship with mental health services, and the breaking of this trust was most keenly expressed in the context of confidentiality. This is important for individual clients but could also contribute to a general building of trust between Māori women and mental health services.

Professionals should also note the importance of not pressuring Māori women, and advocating for their right to choices of healing and treatment, including medication. Making Wāhine Māori service users feel as though you have time for them could be expressed by acknowledging limitations, but projecting a feeling of caring and wanting to spend more time with them. Professionals could also make efforts to foster autonomy, and check in with Māori women about whether they feel they are ready to move on or not during recovery. This may contribute to helping them feel less pressure and coercion. Services in general should be wary of how session limits might affect treatment outcomes; it would be better to be flexible and allow more time for longer treatments wherever possible. Funding, therefore, should address this need.

Professionals should also afford Wāhine Māori as much autonomy and informed choice as possible about treatments. This could include broader choices like whether to have medication, therapy, or other interventions. They could also be afforded options within these choices such as what they want and do not want from medication or therapy. Seeking regular and meaningful feedback from Wāhine Māori in this regard should be standard practice, as feeling in control of their own treatment will not only help the client to feel better but may make the treatment more successful.

Another implication is that cultural competency is still important, relevant, and imperative. While cultural competency has progressed in recent decades (Durie, 2011), it is clear that it should still be a continuous process. Professionals should make sure to voice acknowledgment of clients in general, in order to build a strong and meaningful relationship. However, there seems to be a particular importance in acknowledging Māori identity, and acknowledging Māori healing and worldviews as legitimate. Because Wāhine Māori may be experiencing distress around their Māori identity, having this go unacknowledged, or even being dismissed outright, might exacerbate their distress. Professionals and services could also acknowledge that Māori have a unique Indigenous history which might contribute to mental health problems today. They could also acknowledge the idea that Māori worldviews, beliefs, and healing in regards to mental health often do not match with those of the dominant culture. Professionals should strive to be knowledgeable about and accepting of these differences, knowing that prospective clients likely value things Māori more than mainstream definitions of mental health. Cultural competency, rather than being a checklist that can be ticked off, should be considered as a way of being with clients. There is a need for a continuous shift in thinking within mental health services as a whole, towards positioning Māori identity, methods of healing, and worldviews, as legitimate, important, and worthy of acknowledgement.

Another implication for professionals is that, in lieu of cultural knowledge and expertise, professionals can engage clients by being honest about their shortcomings in cultural competency. However, it should be noted that while this is helpful in situations when professionals find themselves lacking knowledge, this is not acceptable as a permanent stance. As above, professionals should always be striving to move towards cultural competency as a continuous process, not an end goal. While a knowledgeable

professional is preferred, professionals and services can build better relationships by being honest about not holding this knowledge or expertise, or about their own outsider status (for example, a non-Māori professional being upfront about not having an adequate knowledge of things Māori, and perhaps referring to another more appropriate professional if they recognise they are not the best fit for their client and their difficulties). This may also apply to service users in general, in areas aside from cultural competency (for example, a male professional acknowledging he does not hold equal knowledge about uniquely feminine experiences). It appears that the most appreciated stance in these situations is for the professional to both strive to improve their knowledge and capacity to understand, whilst also acknowledging and accepting their own limitations and shortcomings.

The need for familiarity also has implications for practice, and professionals and services should recognise the value of this. In terms of the physical environment, this should be made warm and home-like rather than cold and clinical. For example, spaces should have comfortable couches, cups of tea, biscuits, friendly people, and a welcoming environment. Professionals and services should welcome clients into the service as one would welcome friends or family into their home. This is also another way in which mental health services and professionals might emulate the model of whānau support. This could help service users to feel relaxed, safe, and comfortable in their encounters with mental health services, improving their engagement and recovery. It might also help mental health professionals to relax and be more human and genuine, further improving the relationship.

For Māori in particular, having a stronger Māori presence in services, more Māori staff, access to kuia and kaumatua, and access to Māori healing and interventions was important and appreciated. This is another way in which services can mimic

whānau support. When participants encountered a familiar face, even if the only thing familiar about the face was that they were Māori, they expressed feeling instantly at ease. For mental health services, this might mean that prioritising better representation of Māori in their staff and intervention options could not only attract more Māori clients, but improve the outcomes of interventions carried out with them.

For both Māori and non-Māori professionals, treating clients like a friend or whanaunga should be recognised as important to Wāhine Māori service users. For professionals, this might be about finding a way of being, in between being friends, which risks a blurring of boundaries, and being a cold and clinical professional, which might mean relationships could be strained, or may not be able to be built. Although this balance may be difficult to find, and may feel risky to professionals, the benefits to the relationship, and being able to offer the best of both aspects, would be immense.

**Looking beyond mental health services.** Participants highlighted the phenomenon of seeking Māori healing and interventions outside of mental health services, even whilst engaged with mental health services. As an implication for practice, this highlights that there is not enough of this available within services, or not as much as is wanted by service users. Just as offering opportunities for whānau involvement in mental health services is recommended, it would be beneficial for Māori healing to be included in mental health services as part of a holistic service, rather than keeping them separate. Including Māori healing options within mental health services might also help Māori to see that mental health services are relevant to them, and improve both engagement and outcomes.

**Improving mental health services.** Participants' ideas for improving mental health services in New Zealand clearly have implications for practice, and directly inform how services might change in the future.

Coming to meet people halfway, or reaching out to potential service users, links back to the idea of using a pōwhiri model of engagement (Durie, 2003; McClintock, Mellsop, Moeke-Maxwell, & Merry, 2010). Practically, this could mean moving out into the community, as participants suggested, such as holding group sessions and workshops in marae. Instead of positioning mental health services as a distant entity that must be journeyed to in order to seek help, there could be a shift toward framing mental health services as a hand that reaches out and that could be grasped at any time with relative ease.

Services should understand that Māori may come from a whānau where people do not ask for help because it is readily provided and offered before that crisis point occurs. This may make it seem like these clients are avoiding or masking until crisis point, but Māori may be coping well with whānau support or their own strength until this point. As previously acknowledged, services should offer help like whānau would, rather than placing the onus on those in need to reach out when they are struggling. This might help to alleviate the 'gap' between services and service users. Developing a strengths-based understanding of why Māori may be hesitant to engage with mental health services, including a healthy caution in approaching, for historical reasons, might help services to justify reaching out to people rather than waiting for people to come to them.

Clearly, future practices should also be informed by a growing influence and presence of things Māori in mental health services. This could be ensured in three ways.

Services should support Māori mental health services, Māori healing within Māori and mainstream services, and ensuring the existence of more Māori mental health professionals. Firstly, the presence of more Māori mental health professionals should be ensured. With a stronger Māori presence in services, cultural matching could be more feasible, particularly in a social climate where Māori are disproportionately overrepresented in the client base. Indeed, the training of more Māori professionals should continue to be supported more, not just by services but by the institutions that train professionals, and wider society. This could help to work towards a level of critical mass that has been highlighted as important to ‘bridging the gap’ between overrepresentation in Māori service users and underrepresentation in Māori mental health professionals (Levy, 2002).

Secondly, services should also be integrating and increasing, where available, whānau support into mainstream mental health services by including whānau meaningfully in assessment, intervention, treatment, and discharge. Services could make sure to offer the opportunity for support people and whānau to attend to help clients feel more at ease either alongside or in the absence of Māori professionals.

Thirdly, services should also be increasing and prioritising access to kuia and kaumatua and other Māori support staff within mainstream and Māori mental health services, and look at offering more traditional Māori healing alongside Western treatments in order to validate and accommodate Māori clients and culture. Generally, services should look at becoming more entrenched in the community, more integrated, and less separate.

These core recommendations would require extensive systemic change in the way mental health services are currently operated, however these changes would

potentially be valuable to all mental health service users, not just Māori, and not just women, and as such are worth implementing as part of the next evolution in mental health service delivery.

### **Further Research**

Further research should be conducted on the topic of Māori women's mental health, and indeed further research on Māori mental health or even New Zealand mental health in general would also be appreciated given its current scarcity in relation to its potential value. Here I consider how methodological changes within my research, and expanding beyond it, might provide ideas for further research in this field.

Within this research design, further research might consider interviewing participants during their journey through mental health services, rather than retrospectively, so that the accounts given are more current. For example, interviewing participants at the point of first contact with services might yield more recent accounts of the difficulties faced, and the details of this initial contact, which might provide a different perspective and more of an 'in the moment' narrative. Participants could then be interviewed several times throughout the research in order to gain these 'in the moment' accounts at various points, including at different stages of engagement, and immediately after discharge, which might provide richer information about each stage of experience.

Further research could also add to this study's design by interviewing participants' family members to see how they experienced the period before participants' engagement with mental health services. Whānau could also be interviewed later to explore their experiences of how their whānau member built a relationship with mental health services, with a particular focus on how whānau were

involved in participants' recovery within mental health services. Given the importance of whānau expressed within this study and in other research (Dyall et al., 1999; Lapsley et al., 2002; Harris, 2014; Jahnke, 2002; Wilson, 2004), involving whānau in the research process would also be in line with the spirit of Kaupapa Māori.

As well as whānau, key informant interviews with mental health professionals, including Māori mental health professionals, and other Māori experts such as healers (as in Mark & Lyons, 2010) could provide valuable insight to accompany participants' accounts of their experiences. Such interviews might be able to deepen and enrich the accounts given by participants, and provide support or nuanced contrast to provide a wider look at the topic at hand.

Expanding beyond this research, I wondered if focusing on subgroups of Māori women might also yield valuable information. For example, in doing this research I noticed some slight differences between the experiences and stories of older Māori women and younger Māori women (for example, younger participants struggled more with identity). Future research with more participants could focus specifically on younger or older populations in order to study nuanced differences between them. This might provide valuable information in regards to generational differences, but also in how mental health services are experienced over time.

Likewise, although participants were living in urban areas, they often shared anecdotes about their rural background or friends and whānau in rural areas, and highlighted a particular need for mental health support in these areas. Examining the nuances between urban and rural Māori could therefore be valuable, and given the invisibility of this group, further research that focuses particularly on rural Māori is perhaps needed to address what might be a higher need.



Further research with specific iwi and different geographical areas of New Zealand may also be valuable, as my research was limited to women living in Auckland at the time of interviewing, and to the iwi affiliations reported in the methodology chapter. Research focusing on specific iwi might also be valuable. Such research could be helpful for informing iwi-managed or iwi-informed services and therefore could provide specific information about the needs of particular groups of Māori.

In addition, further research might also focus on specific services, as my research was extremely broad in that it did not seek to review any service type in particular. Within this, further research might also look at Māori service user experiences of mainstream mental health services, as well as experiences of Māori mental health services. This might confirm the value of Māori mental health services, and might also provide further insight on the specific benefits of Māori mental health services in relation to mainstream services, and how they might be managed in the future.

### **Limitations and Strengths**

Many of the limitations of this study are methodological. However, as outlined in the section above, these limitations can be used to inform further research. Some of these limitations could be improved largely by utilising a fully developed Kaupapa Māori methodology. One of the methodological limitations of this research was the scope of the interviews. Interviewing only the service users, and interviewing them only once, meant that some potential richness of data was missed. Utilising a methodology more in line with Kaupapa Māori may have involved conducting several interviews with each participant, and getting to know them better, which may have provided much richer information. Interviewing more broadly, particularly with whānau as outlined

above, would also have enhanced the spirit of Kaupapa Māori in this study, and might have been more empowering for participants *and* their whānau, as well as being able to provide key information from a whānau perspective.

A Kaupapa Māori methodology would also have allowed for much more extensive cultural consultation with iwi and other groups with a stake in the outcome of this research. Although I was able to engage in some informal consultation with relevant Māori experts in my own networks, more formal and extensive cultural consultation would lend a more methodologically rigorous process, and help to further ensure the cultural safety, usefulness, and relevance of the research. More consultation might also have revealed methodological limitations earlier, and provided direction for change and improvement throughout the study.

Another limitation is that the sample in this study may have been limited. As acknowledged above, this research sample was limited to Māori women living in Auckland at the time of interviewing, and as a result is also limited to urban Māori. This means that the findings of this study may have little relevance for rural women. The sample was also limited to those iwi listed in the methodology section. Given that Māori are not a homogenous group, this might have meant I missed differences in how Māori with different whakapapa may have different experiences.

However, despite the limitations above, this study provided a deep temporal narrative account of Māori women's experiences of mental health services in New Zealand. The reflexivity, or self-reflexivity employed throughout the duration of this research, is also a strength. By striving to acknowledge my own values and biases, I hope I have been able to lend an authenticity and genuineness to this research, and improve its quality and rigor as a result. In doing so, I hope I have been able to

contribute a piece of research to an important and significant area, that empowered participants to share their stories, and might also inform practice to help improve mental health service experiences for Māori women in the future.

### **Final Thoughts**

This study examined the unique, lived experiences of Māori women as mental health service users in New Zealand, and heard the stories of 12 Māori women which were then crafted into a temporal narrative account of 19 themes which captured their experiences of the difficulties they struggled with, how they managed before engaging with mental health services, what delayed their contact with mental health services, their experiential relationship with mental health services, help sought outside of mental health services, and their recommendations for change going forward. I hope that their recommendations for change, and the implications for practice that came out of their experiences, can later be developed into comprehensive mental health service provision and policies to benefit and empower Māori women in the future.

## APPENDICES

### Appendix A

#### Research Poster and Email Advertisement



# ARE YOU A MĀORI WOMAN?

## DO YOU HAVE PREVIOUS EXPERIENCE WITH MENTAL HEALTH SERVICES?

We are interviewing Māori women to hear their stories about experiences of using mental health services in New Zealand.  
We'd like to invite you to take part!

The interview should take no more than an hour and a half to complete. Your participation will be anonymous and confidential.

Want to find out more or take part in the interview?

Contact Gemma Tricklebank on [gtri006@aucklanduni.ac.nz](mailto:gtri006@aucklanduni.ac.nz)

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS  
COMMITTEE ON 13 Jan 2012 FOR A PERIOD OF THREE YEARS.  
REFERENCE NUMBER 2012/7812



Māori women's mental  
health interview  
[gtri006@aucklanduni.ac.nz](mailto:gtri006@aucklanduni.ac.nz)

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ARE YOU A MĀORI WOMAN?

DO YOU HAVE PREVIOUS EXPERIENCE WITH MENTAL HEALTH SERVICES?

We want to hear your stories about your experiences!

We (Gemma Tricklebank, Dr Virginia Braun, Kerry Gibson, and Erana Cooper, Department of Psychology, The University of Auckland) are inviting Māori women to share their stories about experiences of using mental health services in New Zealand. We'd like to invite you to take part!

The interview should take no more than an hour and a half to complete. Your participation will be anonymous and confidential.

Want to find out more or take part in the interview?  
Please contact Gemma Tricklebank on  
gtri006@aucklanduni.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 13 Jan 2012 FOR A PERIOD OF THREE YEARS. REFERENCE NUMBER 2012/7812

## Appendix B

### Participant Information Sheet



THE UNIVERSITY OF AUCKLAND  
NEW ZEALAND

DEPARTMENT OF PSYCHOLOGY  
Faculty of Science

Human Sciences Building  
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Telephone 64 9 373 7599 ext. 82287  
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The University of Auckland  
Private Bag 92019  
Auckland, New Zealand

**INVESTIGATING THE EXPERIENCES OF MĀORI WOMEN AS SERVICE USERS IN NEW  
ZEALAND'S MENTAL HEALTH SERVICES  
PARTICIPANT INFORMATION SHEET.**

To .....

Ko Tainui te waka

Ko Taupiri te maunga

Ko Waikato te awa

Ko Ngāti Maniapoto te iwi

Ko Ngāti Mahuta, Ngāti Hari, Ngāti Pou te hapū

Ko Horahora te marae

Ko Gemma Tricklebank ahau

My name is Gemma Tricklebank. I am a student at The University of Auckland, conducting research with and for Māori. I am enrolled for a Doctor of Clinical Psychology in the Department of Psychology. I am doing this research as part of my Doctoral thesis, supervised by Dr Virginia Braun and Dr Kerry Gibson and with cultural advice from Erana Cooper (Ngāpuhi, Ngāti Hine).

The aim of this research is to explore the experiences that Māori women have had with using New Zealand mental health services. I am hoping to find out what your experiences have been like, especially in relation to how appropriate you have found mental health services to be for you as a Māori woman. You are invited to participate in my research, and I would appreciate any assistance you can offer me. In order to participate you must meet the following selection criteria:

- You are a Māori woman over 18 years old
- You have had previous experience(s) of using any kind of mental health service in New Zealand during the past 3 years
- Your experiences with mental health services have been primarily in relation to your mental health and wellbeing, not for primarily dealing with alcohol or substance abuse
- You are currently well (for example, you are not psychotic or feeling extremely distressed about something)



I will be conducting confidential interviews, and the interview will include discussion of topics around any experiences you have had in mental health services in New Zealand in the past two years. Interviews will likely take between an hour and an hour and a half, and if you choose to participate, the session time will be arranged at your convenience in a suitable location. You will be given a \$20 grocery or petrol voucher (of your choice), as a koha to thank you for your time and help with the research. You will only have to contribute as much as you want to, and at any time of the interview you will have the right to not answer a question or end the session. The interview will be recorded and then transcribed by Gemma or another transcriber who will have signed a confidentiality agreement. The audio recording equipment can be turned off at any time or you will be able to withdraw parts of all of your information up to a month after data collection.

All specific identifiable information provided by you, such as your name and address, will not be seen by anyone, for any reason, other than the researchers, and only we will know the identity of the participants. Extracts from the information you provide may be quoted in the report and in possible publications, however this will be written in a way that will preserve your anonymity (no one will be able to identify you). Your interview and consent forms will be stored securely, and separately, and destroyed 6 years after the research is finished. There is a possibility that I might continue to do related, and possibly more in-depth, research after this project, on the same, or similar, topics. With your permission, I would like to be able to use your interview for other related projects in the future, for up to 10 years.

Because this research will involve talking about your experience(s) of using mental health services, it could also involve thinking about some things that have previously upset you, or caused you to be distressed, or contributed to you needing to use mental health services. This means it is possible that you might feel upset or distressed again during the interview. If you think you are likely to become very upset if you think or talk about your past experiences, it may be better that you do not take part in this study. Alternatively, we can begin and then have a break or stop if you feel uncomfortable. If necessary, I can help you to access any support you might require should that be needed. If any issues arise that suggest your safety or someone else's safety may be at risk, I will need to talk about this with someone that I think can help reduce this risk. People I may talk to include two of my supervisors (Kerry Gibson [Clinical Psychologist] and Erana Cooper [Kaupapa Māori lecturer and Māori clinical psychologist]), who are both qualified to assist with a referral to mental health services if this was thought to be necessary. You can also be provided with a list of appropriate agencies where you can obtain support if needed.

Should you have any concerns about any aspect of this project, but do not wish to talk with me about this, you may contact my supervisor Dr Virginia Braun, my cultural advisor Erana Cooper, or Dr Douglas Elliffe, Head of the Psychology Department, or the Chair of the Ethics Committee, at the addresses supplied below.

Thank you very much for your interest in making this study possible. I am hoping this study will contribute towards informing mental health services about the best ways to provide service(s) to Māori women, and welcome you to take part in it. I will contact you again soon to see if you are willing to take part. In the meantime, if you have any queries or wish to know more please phone me at the number given below or email/write to me at:

Department of Psychology,  
The University of Auckland  
Private Bag 92019  
Auckland.  
Telephone: 09 3737599 ext 86309

Email: gtri006@aucklanduni.ac.nz

My supervisor is: Dr Virginia Braun.  
Department of Psychology,  
The University of Auckland.  
Private Bag 92019, Auckland.  
Telephone 09 3737599 ext 87561

My cultural advisor is: Erana Cooper  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
Telephone 09 3737599 ext 88522 or 86869

The Head of Department is: Dr. Douglas Elliffe  
Department of Psychology,  
The University of Auckland.  
Private Bag 92019, Auckland.  
Telephone 09 373599 ext 85262.

For any queries regarding ethical concerns please contact:  
The Chair,  
The University of Auckland Human Subjects Ethics Committee,  
University of Auckland,  
Private Bag 92019, Auckland.  
Tel. (09) 3737599 extn. 87830.

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN  
PARTICIPANTS ETHICS COMMITTEE ON 13 Jan 2012 FOR A PERIOD OF  
THREE YEARS. REFERENCE NUMBER 2012/7812**



THE UNIVERSITY OF AUCKLAND  
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**TE AROTAKE I NGA WHEAKO O NGA WAHINE MĀORI TANGATA WHAIORA I ROTO I  
NGA RATONGA HAUORA-A-HINENGARO I AOTEAROA  
HE PEPA WHAKAMARAMA KŌRERO HEI ARATAKI I A KOUTOU**

Tena koe .....

Ko Tainui te waka

Ko Taupiri te maunga

Ko Waikato te awa

Ko Ngāti Maniapoto te iwi

Ko Ngāti Mahuta, Ngāti Hari, Ngāti Pou ngā hapū

Ko Horahora te marae

Ko Gemma Tricklebank ahau

Ko Gemma Tricklebank toku ingoa. He tauira ahau i Te Whare Wānanga o Tāmaki Makaurau, e whakataki ana i tētahi rangahau kōrero mo tōku Tākutatanga (DClinPsy), e hāngai pū ana ki a Ngāi Māori, ā, mō Māori hoki te take. Mā tēnei, ka puta ai ahau hei Tākuta o roto i ngā āhuatanga o ngā mahi Whakamātai Hinengaro (Psychology) mai i Te Tari Whai Mātai Hinengaro (Department of Psychology) o Te Whare Wānanga o Tāmaki Makaurau (The University of Auckland). Ko Tākuta Virginia Braun rātou ko Tākuta Kerry Gibson, ko Erana Cooper (Ngāpuhi, Ngāti Hine) ngā kaiwhakahaere o tēnei rangahau.

Ko te whaingā o tēnei rangahau hei arotake i ngā wheako o ngā wāhine Māori kua noho hei tangata whaiora i roto i ngā rātonga hauora ā-hinengaro i Aotearoa nei. Ko te tumanako ka whai wāhi mai koe ki te kōrero mai kia ahau. Ko te hiahia, kia uru mai koe hei kaiāwhina i taku rangahau. He īnoi nui tēnei ki a koe, ā, ahakoa te iti, te rahi rānei o tō āwhina, he pounamu tonu mōku. Kei te hiahia ahau ki te kōrero ki ngā wāhine mehemea:

- He wahine Māori koe, 18 tau neke atu
- Kua uru atu koe ki tētahi rātonga hauora ā-hinengaro i ngā tau e rua kua taha.
- Ko to hauoratanga ā-hinengaro te tino take i tae atu koe ki tētahi rātonga hauora ā-hinengaro, kua ko te kai tarutaru, inu waipiro rānei.

□ Kei te piki te ora i tēnei wā tonu (hei tauira, kāore koe i te tino āwangawanga mo tētahi take matua i tēnei wā).

He mahi uiui kōrero muna tā tāua, e pā ana ki ōu whakaaro mo ōu ake wheako whaiaro i roto i ngā rātonga hauora ā-hinengaro i ēnei tau e rua kura pahure. Ka āhua kotahi ki te kotahi me te hāwhe hāora te roanga o tēnei uiui kōrero, ā, ina whakaāe mai koe kia uru mai hei kaiāwhina, ka pai kia tū te uiui kōrero nei ki tētahi wā pai māu. He paku pūtea kai, pūtea penehīni, pūtea pukapuka rānei ki te wāriu o te \$20, hei koha māu mo tau āwhina. Kei a koe te rahi, te iti rānei o ngā kōrero ka whakamahia i roto i tēnei rangahau, ā, kei a koe tonu te mana kia kapia te uiui i reira. Kia whakaāe mai koe, ka rīpenehia ou kōrero e Gemma, katahi a muri mai, ka whakatakotohia ā-tuhi nei. E āhei ana te mīhini hopu reo te whakaweto i waenganui i ngā whakawhiti kōrero, ā, e pai ana hoki kia tangohia ētahi, te katoa rānei o ōu kōrero mai te rangahau tae noa atu ki te kotahi marama i mua i te mutunga o tēnei rangahau.

E kore rawa ngā kōrero e pā ana ki a koe tonu, arā ki tō ingoa, ki tō wāhi noho, ā, aha noa atu, e kitea, e rangona rānei e tētahi atu, ahakoa te aha. Ko ēnei kōrero, ko ahau anake te kaitirotiro. Ina whakamahia ētahi o wāu kōrero ki rō rīpoata, ki rō pānuitanga rānei, ka tuhia kia huna tonu ai to tuakiritanga. Ko wāu rīpene kōrero, me wāu pepa whakaāetanga mō tēnei rangahau, ka waiho ki tētahi wāhi whakaruruhau, ā, ka turakinatia i te 6 tau whai muri mai i te otinga o tēnei rangahau. Ko ngā kōnae hiko ka whakakorehia, ā, ko ngā kōnae pepa ka ngakungakutia e ono tau i muri i te mutunga o tēnei rangahau.

I te mutunga o tēnei rangahau, tērā pea ka hohonu ake taku titiro ki ēnei kaupapa, hei rangahau hou mōku. Ina whaia tonu ko ngā kōwai ōrite ki ēnei e rangahaua ana i tēnei wā, kia whakaāe mai koe, ka pai kia whakamahi i ōu rauemi hei arataki i ahau mo nga tau tekau whai muri i te mutunga o tēnei rangahau?

Ko te kaupapa o tēnei rangahau he ātā whiriwhiri i ngā kōrero e pā ana ki ōu wheako whaiaro i roto i ngā rātonga hauora ā-hinengaro na tērā take, tēnā pea ka pūpū ake ōu whakaaro mo ngā take i whakapōraruraru i a koe i aua wā, ā, ka āhua pōuri ano koe ki te kōrero mo aua kaupapa. Tērā pea ka āhua pōuri koe i te wā o te uiui. Menā ki ōu whakaaro ka pōuri rawa atu koe tērā pea he pai ake kia kua tāua e kōrero, e uiui rānei. Heoi, mēnā he pai ake kia koe, ka taea te whakatū i te uiui, whakatā mo te wā poto i waenganui i te uiui rānei. Mehemea e hiahia ana koe, ka āwhina, tautoko hoki ahau i a koe ki te rapu i ētahi āwhina e tika ana māu. Mehemea ka kōrero mai koe ki ahau e pā ana ki tētahi take haumarū, mōrearea rānei e pā ana kia koe ki tētahi atu rānei, me kōrero ahau ki tētahi kaiarahi e pa ana ki aua kōrero kia kore tētahi raru e pā atu kia koe ki tētahi atu rānei.

Ina he raruraru āu e hāngai ana ki ngā āhuatanga o tēnei rangahau, ā, kāre pea koe e pirangi kōrero mai ki ahau, ka taea e koe te kōrero ki taku kaiwhakahaere, a Tākuta Virginia Braun taku kaiarahi tikanga Māori ranei a Erana Cooper. Ka taea ranei te kōrero ki te tumuaki rānei o te Tari Whai Mātai Hinengaro, a Douglas Elliffe. Kei raro, e whai ake nei o rāua whakamārama.

Heoi, ngā mihi maioha ki a koe mo te tautoko ki ahau, kia tutuki pai ai taku rangahau.

Ko taku tumanako ka hapai tēnei rangahau i ngā wāhine Māori i roto i ngā rātonga hauora ā-hinengaro i ngā tau e heke mai ana. Ina pirangi koe te hou mai ki tēnei mahi, waea mai. Mehemea he pātai tonu āu, waea mai, tuku reta mai rānei ki au. Tono mai, wāea mai ki a:

Gemma Tricklebank  
Department of Psychology,  
The University of Auckland  
Private Bag 92019  
Auckland.

Waea: 09 3737599 ext 86309  
Imera: gtri006@aucklanduni.ac.nz

Taku Kaiwhakahaera :

Dr Virginia Braun.  
Department of Psychology,  
The University of Auckland.  
Private Bag 92019, Auckland.  
Telephone 09 3737599 ext 87561

Taku Kaiwhakahaere Māori:

Erana Cooper  
Department of Psychology  
The University of Auckland  
Private Bag 92019, Auckland  
Telephone 09 3737599 ext 88522 or  
86869

Te tumuaki o Te Tari Whai Mātai Hinengaro:

Dr. Douglas Elliffe  
Department of Psychology,  
The University of Auckland.  
Private Bag 92019, Auckland.  
Telephone 09 373599 ext 85262.

Mehemea he pātai, he raruraru hoki āu e pā ana ki ngā tikanga matatika, wāea atu ki  
a:

The Chair,  
The University of Auckland Human Subjects Ethics Committee,  
University of Auckland,  
Private Bag 92019, Auckland.  
Tel. (09) 3737599 extn. 87830.

**I WHAKAAETIA TĒNEI RANGAHAU E TE ROPU PARTICIPANTS ETHICS  
COMMITTEE O TE WHAREWANAGA O TAMAKI MAKAU AU 13 Jan 2012  
MO NGA TAU E TORU. TE NAMA WHAKAHOKI 2012/7812**

## Appendix C

### Interview Schedule

Background:

Can you tell me about where you are from and a little about your background?

To prompt background from the participant.

Mental Health:

Can you tell me how you came to be involved with mental health services?

To prompt a telling of their story.

Were there any positive experiences for you? Tell me about that.

To prompt further telling of their story.

Were there any negative experiences for you? Tell me about that.

To prompt further telling of their story.

Were there other experiences that were neither positive nor negative? Tell me about that.

To prompt further telling of their story.

How did you make sense of that experience?

To prompt further telling of their story.

How do these experiences relate to you as a Māori woman?

To prompt further telling of their story.

If anything, what do you think mental health services did well in your experience?

To prompt further telling of their story.

If anything, what do you think mental health services did poorly, in your experience?

To prompt further telling of their story.

Is there anything you think would have changed this experience for you?

To prompt further telling of their story.

Is there anything else you would like to say about your experience with New Zealand mental health services?



Appendix D

Consent Form



THE UNIVERSITY OF AUCKLAND  
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Auckland, New Zealand

## CONSENT TO PARTICIPATE IN RESEARCH THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS.

**Title of Project:** Investigating the experiences of Māori women as users of New Zealand's mental health services

**Researchers:** Gemma Tricklebank, Virginia Braun, Kerry Gibson, and Erana Cooper.

I have been given, and have understood, the explanation of this research project. I have had an opportunity to ask any questions, and have had them answered.

- I am aware that my participation in this project is entirely voluntary
- I am aware that extracts from the information I provide may be quoted in the report and in possible publications, and that this will be anonymised to protect my identity
- I also understand that I may withdraw any or all of the information I provide at any time up to a month after data collection, without giving a reason.
- I agree to take part in this research, and understand the interview will take up to one and half hours of my time
- I agree that I am not currently distressed, though I may still be engaged with services.
- I understand that I may withdraw myself from the interview at any point I choose, and that I am under no obligation to answer any particular questions.
- I understand that there is a possibility I may become distressed in talking or thinking about some things that have previously upset me, or caused me to be distressed, or contributed to my needing to use mental health services. In the case that I do become distressed, Kerry Gibson (clinical psychologist) and Erana Cooper (Kaupapa Māori lecturer and Māori clinical psychologist) are qualified to assist with a referral to mental health services if need be. I will be provided with a list of appropriate agencies where I can obtain support, if needed.
- I agree to the interview being digitally recorded and transcribed, and understand my data will be stored in a locked filing cabinet at The University of Auckland
- I agree that Gemma Tricklebank may keep the data for use in future *related* research projects, if relevant, for up to 10 years

- I would like I see a summary of the results (if yes, please provide contact details)

Contact details:

---

Name:  
(please print clearly)

Date:

Signed:

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS  
ETHICS COMMITTEE ON 13 JAN 2012 FOR A PERIOD OF THREE YEARS.  
REFERENCE 2011/7182**



THE UNIVERSITY OF AUCKLAND  
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Auckland, New Zealand

## HE PEPA WHAKAĀETANGA HEI KAIĀWHINA MŌ TE RANGAHAU KA MAU TĒNEI PEPA WHAKAĀETANGA MO NGĀ TAU E ONO

**Te Kaupapa:** Te arotake i ngā wheako o ngā Wahine Māori i roto i ngā rātonga hauora ā-hinengaro

**Kairangahau:** Gemma Tricklebank, Virginia Braun, Kerry Gibson ratou ko Erana Cooper.

Kua homai ki au, ā, e mārama pai ana au ki te take o tēnei rangahau. I whai wā au ki te tuku pātai, ā, kia whai whakautu hoki.

- E whakaāe ana au kia uru mai au hei kaiāwhina i tēnei rangahau.
- Kei te mōhio au, tērā pea ka whakamau ētahi wāhanga o aku kōrero ki roto i te rīpoata, ki rō pānuitanga rānei, ā, ka huna hoki tōku tuakiritanga.
- E mārama hoki ana au he pai kia tango au i aku kōrero mai i te rangahau nei mena e hiahia ana ahau, kotahi marama i mua i te mutunga o tēnei Rangahau, kāhore he raru.
- E whakaāe ana ahau ki te uru mai ki tēnei rangahau, e mārama ana ahau kotahi hāora me te hāwhe te roa o te uiui.
- E mārama ana au, ina whakakore au i te uiui kōrero, kāre au i te whakautu i ngā pātai.
- E whakaāe ana au kia kapea, ā, kia whakatakotohia ā-tuhi aku kōrero. Ka noho enei kōrero i roto i tētahi kāpata raka i Te Wharewānanga o Tāmaki Makaurau.
- E whakaāe ana au kia tū a Gemma Tricklebank hei kaiponu i ōku rauemi, ka taea hoki ia te pupuri i enei rauemi mo ngā tau tekau e whai ake nei ina tuhia ētahi kōrero mo ētahi rangahau he pānga ki tēnei rangahau i ngā tau e heke mai ana.

E pirangi ana au i tētahi whakarāpopoto o ngā hua i puta i te uiui kōrero.  
(Ki te pirangi, tuhia mai ō kōrero whakamārama ki raro.)

Ngā kōrero whakamārama:

---

Ingoa:  
(Kia āta te tuhi)

Te Rā:                    /                    /

Waitohu:

**I WHAKAAETIA TĒNEI RANGAHAU E TE ROPU PARTICIPANTS ETHICS  
COMMITTEE O TE WHAREWANAGA O TAMAKI MAKAUURAU 13 Jan 2012  
MO NGA TAU E TORU. TE NAMA WHAKAHOKI 2012/7812**

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