Passive-Aggressive: Māori Resistance and the Continuance of Colonial Psychiatry in Aotearoa New Zealand

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This article offers a comparative discussion on the encroachment of psychiatric imperialism in the Global South through considering the continuance of western psychiatry in a colonized part of the Global North. Whereas the Indigenous population of Aotearoa New Zealand were considered mentally healthier prior to the 1950s, current statistics show that Māori are much more likely to experience a 'mental illness' and be admitted to psychiatric hospital compared to settler groups. A review of the literature highlights socio-economic variables and 'acculturation' issues as key to understanding the difference in prevalence rates. However, utilizing a 'critical model', influenced by writings on colonial psychiatry and race, it is demonstrated in this discussion that a crisis in colonial hegemony between the 1960s and 1980s led to an increased need for colonial psychiatry to pathologize a politically conscious Māori population. As the first academic article to attempt such a critical de-construction of psychiatric practice in Aotearoa New Zealand, it is recommended that future research is re-orientated towards a focus on the psychiatric institution, and the institution of psychiatry, as a site of colonial power and social control.

Keywords: Māori; mental illness; psychiatry; racism; colonization.

Introduction

"There is a crisis in Māori Mental Health of unprecedented proportions."
(Māori Health Commission, 1998:14)

"I have yet to see a Māori patient present with problems as a result of loss of land."
(Psychiatrist, cited in Johnstone and Read, 2000:138)

The colonial project has traditionally been aided by institutions of social control such as the church, the prison, the school and the hospital. In enforcing the norms and values of the Empire on Indigenous societies as the only correct and true principles for governance, such institutions have functioned to formally and informally police dissent and resistance to colonial rule, as well as legitimate acts of genocide against colonized peoples (see for example, LeFrançois, 2013; Smith, 2005). Specifically, colonial psychiatry has served to

normalize colonial rule while pathologizing Indigenous resistance. Rather than political activism and armed struggle being expected, and conceived of as normal and necessary responses to the imposition of foreign rule, colonial psychiatry utilizes the language of medical science to label and silence opposition. As Roman et al. (2009:19) have stated of the imposition of colonial authority on the First Nations people of Canada,

> Colonial Western psychiatry and medical professions have been used to advance colonial nation-building and the very definition of civil society – its boundaries between the so-called 'fit' and 'unfit' citizens, indeed the very uses of psychiatric practices intertwined with legal practices in a fledgling settler-state.

For the Martinique-born psychiatrist and revolutionary Frantz Fanon, colonial psychiatry was 'a form of scientific violence' which drew on clinical language to stereotype and disempower the colonized (Keller, 2007:4). In 1950s French-occupied Algeria (where Fanon worked as a psychiatrist), for example, North African Muslims were often labeled by colonial psychiatrists as suffering from a 'persecution complex' - an example of the institution's role as pacifiers of resistance to colonial authority. As Fanon (1965:200) commented on colonial psychiatry and the Algerian War of Independence (1954-1962):

> We cannot be held responsible that in this war psychiatric phenomena entailing disorders affecting behaviour and thought have taken on importance where those who carry out the 'pacification' are concerned, or that these same disorders are notable among the 'pacified' population. The truth is that colonialism in its essence was already taking on the aspect of a fertile purveyor for psychiatric hospitals. We have since 1954 in various scientific works drawn the attention of both French and international psychiatrists to the difficulties that arise when seeking to 'cure' a native properly, that is to say, when seeking to make him thoroughly a part of a social background of the colonial type.

Other documented examples of attempts to pacify threats to colonial power by western psychiatry include the conceptualization of the Malay population, in the Dutch-occupied East Indies of the 1920s, as 'over emotional', and the Indigenous populations of British-occupied East Africa as being sent mad by 'detribalization' (Vaughan, 2007:11).

Theorizing colonial psychiatry

The point of departure for this article is its investigation of the continuance of colonial hegemony through a case study of psychiatric practice in Aotearoa New Zealand. Since the 1960s, rates in the diagnosis of 'mental illness' amongst the Indigenous Māori population have increased at an alarming rate (see later). In making sense of these disproportionalities,

medical and social researchers have paid little to no attention to two key issues which demand sociological consideration. Firstly, the conceptualization of psychiatric professionals, institutions and discourse as part of a colonial project; that is, to understand western psychiatry in Aotearoa New Zealand as an instrument that furthers the ideological goals of colonialism. Second, and strongly linked to the first, is the understanding of psychiatry as an institution of social control (see for example, Scull's (1993:1-10) discussion on 'the social control of the mad'; see also Foucault (1967) and Szasz (2010), and the consideration of western psychiatry as institutionally racist, for example, Fernando's (2010: 61-73) discussion on racism within psychiatry; and Kutchins and Kirk's (1997:200-237) discussion of the enduring legacy of racism on psychiatric practice in the USA. This article, thus, seeks to fill a sizeable gap in our current understanding of colonial psychiatry within Aotearoa New Zealand.

Colonial psychiatry has served a useful function to colonial governments in utilizing the language of medical science to explain 'a range of vexing behavioural traits amongst colonized peoples, from excessive docility to outright rebellion' (Vaughan, 2007:2). In the discussion that follows, it will be demonstrated that the Māori struggle for land rights and greater self-determination has been met with hostility by the white European population (known to Māori as 'Pākehā') and pathologized by the institution of psychiatry. The article begins with a socio-historical analysis of colonial psychiatry and the struggles of the Māori population, before a detailed discussion of explanatory models for 'mental illness' takes place. Here a 'social model' of 'mental illness' – a theoretical model of mental disturbance based on socioeconomic and cultural causation - will be challenged with reference to a 'critical model', which integrates notions of hegemonic power with psychiatry as a supporting institution of colonial authority.

Background

As the original settlers of Aotearoa New Zealand, Māori arrived from parts of Eastern Polynesia between AD 800 and 900 (Walker 1990:28). Before the arrival of western medicine, understandings of health for the Indigenous population were integrated and inseparable from the wider system of beliefs, customs, myths and practices of the *whānau* (family or immediate community) and *iwi* (tribe). As outlined by Durie (1985:483), this conception of health is an 'integrated and comprehensive model of care' made up of spiritual, psychic, bodily and family components. Briefly, the focus of well-being for Māori centers on spiritual communion, thoughts and expressions of feelings, particular rituals and understandings of the body, and the respect and obligations to extended kinship (Durie, 1985). Deviations from any of these four elements could denote poor health in a member of the *iwi*. This conception of health as spiritual, social, and mutually supportive, conflicts with a western notion of health centered on the individual as a biological organism, where ill

health is conceptualized as pathologies of the body divorced from spirituality, the community and the wider social world.

It is estimated that at least 800 years passed before there was contact with European populations in Aotearoa New Zealand. As Kingi (2011:92) notes, descriptions of the Indigenous population made by early visitors during the nineteenth century tended to be highly favorable, with John Nicolas, an iron-founder from London, stating of Māori in 1814 that:

> I never thought it likely they could be so fine a race of people as I now found them. They generally rose above the middle stature, some were even six feet and upwards, and all their limbs were remarkable for perfect symmetry and great muscular strength. Their appearance … was pleasing and intelligent (cited in Kingi, 2011:92)

Increasing interest in the lands of Aotearoa New Zealand from a number of European powers (especially France) led the British Crown to sign the Treaty of Waitangi with a number of the Māori chiefs in 1840. The document established the Crown as a 'protectorate' of the country, while sovereignty was said to be maintained in the hands of the Indigenous population. However, as Ranginui Walker (1990:98) has stated, the Treaty provided a 'tenuous beachhead' towards British sovereignty of the country that could subsequently be consolidated through 'acquisition, control and, ultimately, expropriation of land'. In 1860, the conflict over colonial expansionism and rights to land by the European settlers led to the Māori Wars between Indigenous and colonial forces. The eventual defeat of Māori troops sealed the dominance of the Crown and the loss of prosperity and *mana* (pride) of the Māori people for the next hundred years. By the end of the nineteenth century, through conquest or purchase, the colonial powers had ownership and control of over 90 per cent of the land (Walker 1990:139). At the same time, through the spread of settler disease, the Māori population had declined from 100,000 to just 42,000 in 1896 (Kukutai, 2011:14). Reflecting Social Darwinist views of the time, the extinction of the Indigenous population was seen by some as inevitable. As Newman (cited in Kingi, 2011:93) noted in 1881, '[t]aking all things into consideration, the disappearance of the [Māori] race is scarcely subject for much regret. They are dying out in a quick, easy way, and are being supplanted by a superior race.'

The rise of colonial psychiatry

The development of psychiatric services in Aotearoa New Zealand broadly followed the pattern of institutional care practiced in Great Britain. Medical authority was established over the territory in 1871 when a Joint Committee on Lunatic Asylums established the appointment of psychiatric professionals from Great Britain (Thompson, 1992:16). The authority of colonial medicine was further confirmed when the government passed The

Tohunga Suppression Act in 1908. At the urging of western medical organizations in the colony, the legislation outlawed the traditional healing practices of the *tohunga* (experts) within Māori communities; as Coleborne (2010:63) has pointed out, the *tohunga* had become a 'political threat to colonists'. The Tohunga Suppression Act symbolizes the further imposition of cultural hegemony on the Indigenous peoples, as can be seen in the phrasing of the following section from the Act:

> Whereas designing persons, commonly known as tohungas, practice in the superstition and credulity of the Māori people by pretending to possess supernatural powers in the treatment and cure of disease, the foretelling of future events, and otherwise, and thereby induce the Māoris to neglect their proper occupations and gather for meetings where their substance is consumed and their minds are unsettled, to the injury of themselves and the evil example of the Māori people generally (cited in Taitimu, 2007:77)

The legislation (suppressing indigenous healing practices) has been subsequently seen as the 'greatest blow to the organisation and protection of Māori knowledges' (Taitimu, 2007:77; see also Durie 2001). Together with the development of a national system of day schools for Māori (where *te reo Māori*, the Māori language, was discouraged in favor of English), The Tohunga Suppression Act served further assimilation policies of the colonial authorities, and acceptance of colonial society and the "Pākehā way" as the only possible future for the Indigenous people.

Despite the loss of land, culture, customs, language and nearly the entire population at the end of the nineteenth century, rates of hospital admission for 'mental illness' among Māori remained very low compared to European groups (Primrose, 1968:263-70). Western psychiatry's focus in nineteenth century Aotearoa New Zealand was on the insanity of migrant populations, as well as the stressors of a new settler society, rather than the Indigenous population (Brunton, 2001:43). Early recorded notes found few cases of 'insanity' amongst the Māori population (Brunton, 2001:43).
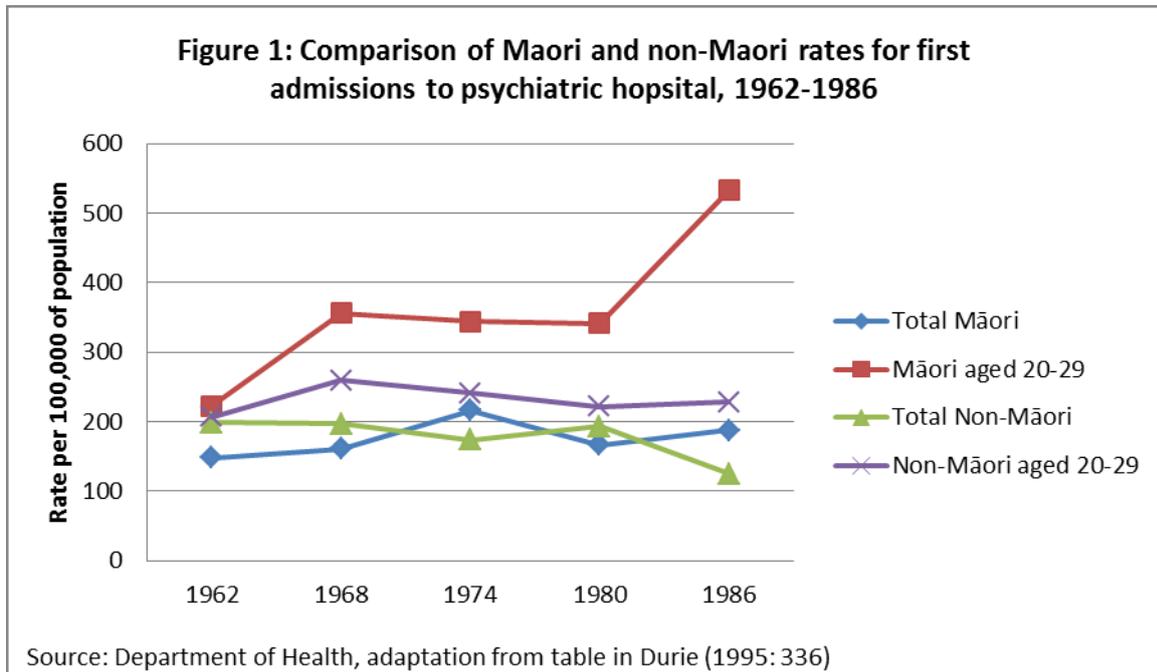
Further, in a study of the Auckland Mental Hospital between the years 1867 and 1926, Primrose (1968:269-270) notes the continuing low rates of admissions for Māori, which fluctuated between no admissions for a number of years up to a high of eight per cent. A review of psychiatric hospital admissions rates across the country by Beaglehole (1939) for the period 1925 to 1935 also demonstrated generally lower rates in diagnoses of psychosis among Māori compared to European populations. Likewise, a follow-up analysis of psychiatric hospital admissions for 1943 concluded that the rates of admission remained significantly lower for Māori compared to non-Māori (a ratio of 52 for non-Māori per 10,000 of general population compared to 20 for Māori per 10,000 Māori population), with the corresponding rate of psychosis for Māori being just one third that of the non-Māori rate

(Beaglehole, 1950:28).

Urban Māori and the cultural renaissance

One key aspect of social change for Māori during the post-war years was the increased urbanization of the population. Statistics show that the proportion of Māori living in an urban setting rose dramatically between the late 1950s and 1970s, increasing from approximately one to two thirds (Kukutai, 2011:25). In the same period, the rates of psychiatric hospital admission for Māori began to increase considerably, meaning that by the 1970s the Indigenous rate was higher than the non-Māori rate (see Figure 1). This is a trend also evident with the proportion of Māori incarcerated in prison, which increased from 11 per cent in 1930 to 23 per cent in 1958. Thus, despite Māori making up only 15 per cent of the total population of Aotearoa New Zealand, they represent 51 per cent of the current prison population; (Bradley and Walters, 2011:189). Whereas in 1962 the rate of Māori first admissions was 148 per 100,000 of population (compared to 199 for the non-Māori group), by 1974 the rate for non-Māori had declined to 174, while Māori had increased to a rate of 216 per 100,000 of population. Of particular concern were the high rates of psychiatric incarceration being experienced by young Māori people (aged 20-29 years) across this period.

Similarly, attitudes from both professionals and the public towards the colonized population began to change during this period. In 1973, for instance, the psychologist Richard Kelly (1973:729) published an article on the growing rates of psychoses among the colonized population, suggesting that the Māori personality presented in his paper, 'stands in marked contrast to the stereotype commonly held by the European of a simple, good natured, relaxed and often lazy people'.

Figure 1: Comparison of Maori and non-Maori rates for first admissions to psychiatric hopsital, 1962-1986

Source: Department of Health, adaptation from table in Durie (1995: 336)

The concentration of urban Māori (or what became known as 'the young Māori') provided the conditions for the cultivation of a social and political consciousness - an awareness of common disparities and the struggle for common goals against colonial authorities. As Walker (1990:209) succinctly puts it, '[o]ne of the consequences of urbanisation is increased knowledge of the alienating culture of metropolitan society and its techniques for the maintenance of the structural relationship of Pākehā dominance and Māori subjection.' Influenced by the civil rights movement in the USA, as well as countercultural philosophies and struggles against colonial powers in other countries, Māori organizations emerged in the 1960s as a direct challenge to the authority of the Crown - demanding political redress. For example, the decade saw the emergence of the Māori Organisation on Human Rights (MOOHR) which argued for unity among the working classes, 'to organise the downfall of those sections of New Zealand society which oppress and exploit the Māori people' (Walker, 1990:209). Political protest and direct action became more visible, frequent and intense into the 1970s, culminating in the Māori land rights march to Wellington in 1975. The same year saw the Treaty of Waitangi Act, which established the Waitangi Tribunal to hear grievances from Māori and make recommendations to Parliament for settlement (Walker, 1990:212).

The attempt by colonial society to be seen to address Māori land rights did not, however, signal the end of the Crown's role in exploiting former Māori land resources for their own ends. In 1977, the government made known plans to subdivide land at Bastion Point in the coastal suburb of Orakei in Auckland. As Walker (1990:217) notes, the history of this particular piece of stolen Māori land was a typical 'tale of man's inhumanity to man' involving violent dispossession and colonial exploitation of natural resources. The resulting

protests and 506-day occupation of Bastion Point - organized by the Orakei Māori Action Group - represented a watershed moment in the modern struggle of the Māori people. Though the protesters were eventually removed by the police, the event was extensively covered by the local and national media, and inspired a 'new wave of Māori activists' (Walker, 1990:220). The late 1970s and early 1980s, saw the formation of various new political groups, such as the Waitangi Action Committee (WAC), He Taua, Māori People's Liberation Movement of Aotearoa, and Black Women, which centrally framed the liberation struggle of the Indigenous people as liberation from colonial and capitalist forces (Walker, 1990:220). The response from colonial hegemony was to attempt appeasement through a broad set of reforms in the 1980s and 1990s, designed to recognize the 'bicultural' nature of Aotearoa New Zealand and the 'equal partnership' between Pākehā and Māori. As will be highlighted in the next section, however, there remains an inherent contradiction within such a 'post-colonial' discourse between the dominant rhetoric of 'inclusivity' and 'equality', and the reality of continuing practices of colonial oppression and subjugation symbolized by the higher rates of Maori incarceration in both prisons and psychiatric hospitals.

The current situation

Despite the processes of deinstitutionalization, including the development of community care legislation and the extension of psychiatric outpatient facilities from the 1980s onwards, the psychiatric incarceration of Māori has continued to increase over the past thirty years (see Baxter, 2008). In an analysis of psychiatric admissions covering the period 2003-2005, Baxter (2008:103) found a Māori hospitalization rate of 658 per 100,000. Compared to non-Māori groups, Māori are currently 1.8 times more likely to be hospitalized (Baxter, 2008: 108). Again, the higher admission rates are particularly pronounced in the younger age groups of Māori with over half the hospitalizations aged between 25 and 44 years (Baxter, 2008:113). The Indigenous group is also much more likely to be admitted under the label of a psychosis, with Baxter noting that '[s]chizophrenia is by far the leading cause of hospitalisation among Māori, making up almost half (47.9%) of all mental disorder hospitalisations' (2008:105). Compared to other groups, Māori are 3.5 times more likely to be hospitalized for schizophrenia and 2.4 times more likely for bipolar disorder (Baxter, 2008:130). In contrast Māori are less likely to be diagnosed with eating disorders, personality disorders, intellectual disabilities or depressive disorders (Baxter, 2008:110). The proportion of hospital admissions due to referrals from the criminal justice system (previously noted by Durie, 1995:340-341) also continues to be much higher for Māori than for other groups (Baxter, 2008:101). Baxter (2008:107) concludes that while there are fluctuations in these patterns of hospital admissions for psychiatric disorders, 'there is no overall change of rate between Māori and non-Māori for hospitalisation and no evidence that disparities are reducing.'

Rather than see this grim picture of mental health admissions as a cause for some soul-searching by the (predominantly white, European) psychiatric profession, to argue for further government resources for research, 'awareness' campaigns, and specialist services that can better reach particularly 'vulnerable' groups. There has, for example, been a recent expansion in Kaupapa Māori Services (KMS) which aim to 'facilitate healing through access to cultural resources within a service run by Māori, for Māori, in a Māori way' (Taitimu, 2007:96). The mental health system has been keen to offer such 'culturally appropriate' services, aware that there remains a large 'unmet need', especially among the young Māori population (see for example, McClintock et al. 2013). While KMS may appear attractive, such services often work alongside and are reliant on mainstream psychiatry, they employ clinicians (whether Pākehā or Māori) trained in western psychiatry, and they are not utilized when hospital admission is considered necessary (see Taitimu, 2007:96-98). Thus, there is a danger that western psychiatry has appropriated the language of Māori well-being and healing in the name of the further expansion and surveillance of the Māori population. The result has been a proliferation of the psychiatric discourse in recent years, one which has been particularly aided by the country's first epidemiological study on the general mental health of the population in 2003/04 (see Oakley Browne et al. 2006).

Surveying a representative sample of 12,000 New Zealanders with standard psychiatric measures, the findings of Oakley Browne et al.'s (2006) epidemiological study unsurprisingly showed even higher rates of 'mental illness' in the population than had previously been known. Just over half the Māori population (51 per cent) were estimated to have a mental disorder in their lifetime, with nearly a third (30 per cent) experiencing a mental disorder in the previous 12 months (Baxter, et al. 2006:139). As if to confirm the current hospital admission rates, the research also found that, compared to all other groups, Māori were more likely to suffer a mental disorder, especially a serious disorder (for example, schizophrenia or bipolar disorder) (Wells, 2006:34).

Discussion

In the previous sections this article has described the growth in the rates of diagnosing Māori with a 'mental illness' together with some key socio-historical changes within colonial Aotearoa New Zealand society. Whereas the Indigenous population was traditionally seen as having much lower rates of 'mental illness', this picture radically changed during the 1960s, and by the early 1970s showed an over-representation of Māori in rates of hospitalization. Such disparities have widened into the twenty-first century, and arguably the view of Māori as (now) particularly vulnerable to pathology has become institutionalized, both within and, to an extent, outside of medicine. In the following section, I will outline a number of explanations from sociologists, psychologists, and psychiatrists that have been given for the growth and current high rates in diagnosis of 'mental illness' among Māori. These

explanatory frameworks broadly follow a 'social model' of health in which differing rates of 'mental illness' can be explained with reference to socio-economic and cultural factors. This model of mental health accepts as self-evident the 'truth' of 'mental illness' within society and perceives psychiatry as a neutral and objective discipline of scientific medicine, thus ignoring the wider social processes and power dynamics involved in the development of professional practice and expertise, including the construction and implementation of diagnostic classifications within medical practice (for a detailed discussion, see Jutel, 2011). The social model will then be challenged by the development of a 'critical model' that problematizes psychiatry as a racializing enterprise that serves the needs of colonial society.

The social model of mental health

Beaglehole's (1939; 1950) work in the first half of the twentieth century suggested that Māori maintained good mental health through isolation from European populations in largely rural areas of the country. The continuance of specific Māori customs, practices and traditions through community/*iwi* organization, which enforced collective solidarity and the importance of the extended family/*whānau,* were argued to act as a significant support and 'safety net' that neutralized the threat of mental disorder (see also Primrose, 1968:263-264). Summarizing the difference between Māori and Pākehā rates of 'mental illness' at the time, Beaglehole (1950:94) noted that the 'tribal group' provides 'psychological security, the warmth and friendliness of tradition, cooperative customs, mutual aid and help for all those descended from the common tribal ancestor', whereas the Pākehā was 'essentially alone in all his dealings with other people, standing on his own feet and getting on as best he can…'. Such understandings of 'cultural strain' were later used by scholars to explain the growing rates of Māori 'mental illness' as a consequence of increasing urban migration (see for example, Kingi, 2011:98-99). As Kelly argued in 1973, the traditional group solidarity of Māori society was being fundamentally challenged by increased contact with European culture and its contrasting norms and values, such as the emphasis on 'personal goals and achievements' (729). In highlighting the higher rates in diagnosis of 'mental illness' among groups of younger Māori, this analysis stated that the 'pressure of acculturation' was having a particularly profound effect on Māori children as a result of the increased anxieties of their parents in this new, alien environment (Kelly 1973:730-1; see also Tam in this volume).

While there is some value in exploring further the impact of increased urbanization on rates of mental well-being for those who migrate to the city, the cultural strain thesis can essentialize 'cultural' features of different ethnic groups at the expense of other variables, such as socio-economic factors. There is also an implicit stereotyping of the 'other' in relation to western 'civilized' culture, in which the 'other' must necessarily 'adapt' to western society as the more progressive and advanced culture. This can be illustrated by Kelly's (1973:730) summation that in the urban setting, '[c]onfusing new role expectations are

encountered by the Māori, whose typical ways of relating are not particularly well suited to adaptation in the urbanized, highly organized and sophisticated European society.' A more explicit statement on Māori assimilation to 'modern life' was made by the Department of Māori Affairs in 1961, when Hunn (1961:15-16) wrote that:

> There is at least a century of difference between the most advanced and the most retarded Māoris in their adjustment to modern life. The Māoris today could be broadly classified in three groups:
>
> A. A completely detribalised minority whose Māoritanga [Māori culture or way of life] is only vestigial.
> B. The main body of Māoris, pretty much at home in either society, who like to partake in both (an ambivalence, however, that causes psychological stress to some of them).
> C. Another minority complacently living a backward life in primitive conditions

Hunn (1961:16) concluded that '[h]ere and there are Māoris who resent the pressure brought to bear on them to conform to what they regard as the Pākehā mode of life. It is not, in fact, a Pākehā but a modern way of life, common to advanced people…'. Leaving aside the orientalism of such ideas, with the continuing high rates of diagnosis of 'mental illness' among Māori currently experienced in Aotearoa New Zealand, especially amongst young Māori, it would be increasingly difficult to argue the case for 'culture shock' after fifty years of the majority of the Indigenous population living in urban settings.

Probably the most often cited set of explanatory variables for the increase in 'mental illness' amongst the Indigenous population are given as the continuing socioeconomic disparities between Māori and non-Māori populations (see for example, Durie, 1995). Statistics show that Māori are the most disadvantaged ethnic group across a range of indicators related to mental disorder, including unemployment, poverty, physical health, infant mortality, life expectancy, educational attainment, and family income (see for example, Kukutai, 2011; Robson et al. 2007). There remain, however, some specific issues which should cause us to be skeptical of these disparities in explaining the original increase and continuance of Māori over-representation in 'mental illness' statistics. Firstly, there is an analytical problem with isolating different variables of deprivation that appear to *cause* 'mental illness' when studies suggest *correlation* only at present. There may still be an unknown independent variable which causes both deprivation and 'mental illness'.

Secondly, the claim that urbanization led to greater levels of socioeconomic deprivation for Māori - and thus, greater levels of 'mental illness' - is contestable. Tahu Kukutai (2011:15), for instance, notes that, since the 1950s, the health of the Indigenous people has significantly *improved*, with a current life expectancy of a new-born Māori boy being 70.4 years (16 years

longer than his counterpart in the 1950s). While there were certainly a range of negative issues associated with migrating to urban areas, this should be balanced with an understanding of the potential gains which were made by such a migration from sometimes very isolated and poor parts of the country. As Walker (1990:198) summarizes, '[t]he major reasons for the urban migration were the "big three" factors of work, money and pleasure.' The social causation model of mental health tends to over-generalize the negative impact of urban life while ignoring some features which may actually promote *better* mental health than in rural areas (see for example, Fischer, 1984).

Thirdly, some recent studies have statistically controlled their samples for socioeconomic variables and have still found differences between Māori and non-Māori rates of 'mental illness', suggesting that other factors may affect levels of mental health. The MaGPIe Research Group (2005), for example, found that while there were differences in social and material deprivation, 'higher rates of mental disorder among Māori attending GPs [General Practitioners] compared to non-Māori cannot be accounted for by these differences alone' (2005:401). Similarly, in a meta-analysis of mental health rates for schizophrenia in Aotearoa New Zealand, Kake et al. (2008) found a significantly higher prevalence rate for Māori compared to non-Māori, even when the figures were adjusted for age and socioeconomic deprivation. As with the MaGPIe Research Group, Kake et al. (2008:948) suggested that 'other factors associated with Māori ethnicity can contribute to the higher prevalence of schizophrenia in this group'.

The utilization of the social model of mental health to explain the growth in rates of diagnoses of 'mental illness' among Māori has dominated the academic discourse and research focus in Aotearoa New Zealand. Although I have outlined above some serious flaws in such understandings of the nature of 'mental illness', scholars are still keen to talk-up the relevance of a variety of socioeconomic and cultural variables as a 'mixing bowl' of factors which can better explain prevalence rates (for example, see Durie, 1995:343). Kingi's (2011:100) summation exemplifies such social analysis when he states that,

> In the end, it is difficult to say with any certainty the reason for the sudden spike in Māori admissions in the 1970s … What is clear, however, is that no single issue was to blame and that a combination of factors – cultural, environmental, socio-economic and behavioural – played a part.

The social model ultimately relies on the scientific credibility of western psychiatric discourse; a western, colonial-based knowledge which remains highly contested due to the continued lack of scientific evidence for the existence of any 'mental illness'(see for example Cohen, 2013; Kirk and Kutchins, 1992; 1997; see also Ingleby in this volume). On this basis, the section that follows argues for a re-direction in research focus from Māori as *pathological* to colonial psychiatry in Aotearoa New Zealand as *pathologizing*. It will be contended that a

more critical and theoretically-informed understanding of the shifting priorities of the psychiatric profession within colonial society can open up more useful avenues for future research.

A critical model: Colonial psychiatry and Indigenous resistance

As was noted in the introduction of this article, the institution of psychiatry has played an important role in the advancement of colonial governance and the control of Indigenous populations. This was, and I would suggest currently is, primarily achieved through naturalizing colonial goals and objectives under the lexicon of medical science. In essence, colonial psychiatry normalizes colonial rule while pathologizing local resistance. This can lead to direct forms of control of the colonized through incarceration in asylums/psychiatric wards and coercive treatments such as psychosurgical interventions, electroconvulsive treatment and drugs. Or it can take more indirect forms, such as the identification and labeling of political opposition as *symptoms* of sickness through the construction and proliferation of certain racialized categories of 'mental illness'. Thus, psychiatry can be considered as an institution of social control, one that serves to neutralize threats to the prevailing social order while reinforcing ruling ideologies as normal and common-sense through the use of scientific rhetoric (for a broader discussion of psychiatry under neoliberal conditions, see Cohen, 2013).

This section will discuss the possibility that the increase in the rates of diagnoses among Māori, beginning in the 1960s, can be understood as a response by colonial psychiatry to the growing political consciousness and organization of the Indigenous population in the urban setting. It will be suggested that this response was underlined by a change in perception of the colonized - from passive to aggressive - by white society.

Prior to the 1960s, Pākehā conceptions of the colonized in Aotearoa New Zealand were of a relatively harmonious and happy - if sometimes 'backward' - people (Hunn, 1961:16). This perception of the relative passivity of the Māori people is arguably informed by lingering Social Darwinist notions of racial hierarchies, where 'less developed' races lack the cognitive skills for higher states of thinking and the development of a more 'complex' culture (see Littlewood, 2001:4-7). This is a position that offers a possible subtext for previously noted psychiatric conceptions of Māori as much less prone to 'mental illness'. A similar example is noted by Gambino (2008:392), who describes doctors' explanations for the low rates of depression and neuroses among African Americans in the USA in the early decades of the twentieth century as due to limited biological and 'cultural development'.

However, with the growth of an urban Māori population from the 1960s onwards, the perceptions within Pākehā society changed; one might argue that, contrary to Kelly's (1973)

suggestion of 'acculturation' causing difficulties for the Indigenous population, the resulting 'culture shock' actually affected white society much more profoundly than the Māori (who were arguably, after more than hundred years of colonialism, hardened to the trauma of social change and structural disadvantage). The increased visibility of Māori within the urban environment together with the increased political activism among the 'young Māori' frightened Pākehā society. As Walker (1990:200-201) makes clear, Māori migration to the towns and cities brought about a multi-tribal alliance based around newly established marae-meeting houses. Rather than culture being lost through such migrations, '[w]ith the culture firmly rooted in the new [urban] environment, the energy of the cultural renaissance was turned to political action directed at liberating the Māori from Pākehā domination' (Walker, 1990:201). Recent research from Hill (2012:257) has supported this view, noting that, with urban migration, Māori culture 'gained new ways of expression that assisted rather than hindered its survival and helped create the base from which a major "Māori Renaissance" was firmly in place by the mid-1970s.' This political consciousness among Māori - possibly always evident but never before quite as visible to white society - was transformed by urban critical mass into a significant force for social and political change. While the Māori cultural renaissance did not involve armed struggle, Walker (1990:220) notes that the rhetoric of a number of groups were 'couched in terms of revolutionary struggle.' Thus, as opposed to scholars who theorize urbanization as fundamentally detrimental to the Māori people, Walker rightly sees the formation of a growing political consciousness among the Indigenous people - particularly the young people - as a direct challenge to the hegemony of colonial rule.

Thus it can be argued that the 1960s was a time of crisis in hegemonic rule in Aotearoa New Zealand. Similar to the response to armed struggles and uprisings against colonial rule in other parts of the world at this time, counter-revolutionary processes were required from supporting institutions of colonial authority in Aotearoa New Zealand. As with the previously noted examples of Algeria, the East Indies, and East Africa, the response of colonial psychiatry in Aotearoa New Zealand was a move towards the increased surveillance, classification, diagnosis, incarceration and forced treatment of the Māori population from the 1960s onwards. By 1960, Labrum (2013:67) notes, there was a 'preoccupation with "Māori problems" in official and popular discussions' in Aotearoa New Zealand. Hill (2012:263-264) confers that, at the time,

> Official and news reports tended to focus on the negative or anti-social aspects of [Māori] mass migration to cities. Growing alcohol consumption and crime among the uprooted was particularly stressed, especially with reference to young men freed from the informal social constraints of the marae and facing tempting situations that could readily bring them into conflict with law and society.

The social and health services were also in the process of expanding their numbers as well as areas of professional jurisdiction, and this too allowed for the further surveillance of 'deviant'

groups beyond the institutional setting and, in the case of the mental health system, a widening of the medical gaze into parts of the urban environment previously untouched by psychiatric practice.

The greater visibility of Māori within the urban environment and the crisis in colonial hegemony it provoked led social and public services to increase their focus on the Indigenous population through scientific and professional discourses which problematized the population as unhealthy, poor, criminal and mad. More specifically, psychiatry's role has been to pathologize the Māori people as over-susceptible to 'mental illness', particularly to severe forms of 'mental disorder' that require hospitalization. Some scholars have suggested that part of the reason for the sudden increase in rates of diagnosis of 'mental illness' among Māori in the 1960s was due to psychiatric professionals' over-diagnosis or misinterpretation of symptoms (for example, Kingi, 2011:98). Kake et al. (2008:948) reiterates this issue in explaining the continued differences in diagnostic rates of schizophrenia: '[m]ost clinicians who make such diagnoses in New Zealand … are non-Māori, so the possibility remains that misdiagnosis might contribute to the higher prevalence of schizophrenia … for Māori.' Further, in a study of 247 psychiatrists, Johnstone and Read (2000:142) found that 27 per cent believed over-diagnosis or misdiagnosis by the profession could explain the over-representation of Māori in psychiatric institutions.

While acknowledged, such racial bias by western psychiatry is not often theorized as systematic or institutional (for a rare exception, see Fernando, 2003), though socio-historical analyses suggest otherwise (for an overview, see Kirk and Kutchins, 1997:200-237). Rogers and Pilgrim (2003:32-33) note that racial categories of 'mental illness' have for a long time been constructed within psychiatry as a means of social control of certain ethnic populations. For example, 'drapetomania', the category of 'mental illness' given by psychiatrists in the USA to black slaves in the nineteenth century who ran away from their 'owners' (Cartwright 2004), is perhaps the most infamous historical example of a racialized diagnosis. However, Fernando (2010:68) highlights a more contemporary example when he discusses British psychiatry's construction and use of the 'cannabis psychosis' category in the 1980s (see full discussion in McGovern and Cope, 1987) – a diagnosis which pathologised the growing anger of a disenfranchised, young, black population as due to smoking cannabis. Such racist assumptions of illegal drug usage and pathology being confined to certain ethnic groups is also evident in Aotearoa New Zealand psychiatry today, with Kake et al. (2008:948) suggesting that higher cannabis use among the young Māori population is a possible explanatory variable for the current higher rates of schizophrenia. Perhaps more revealing, Johnstone and Read (2000) found that drug and alcohol use (including cannabis use) was seen as a contributing factor to higher rates of psychiatric incarceration among Māori by 42 per cent of psychiatrists in their study, with one psychiatrist complaining that the Māori patients 'just don't take their pills - if cannabis was prescribed, I'd bet they'd bloody take that' (cited in Johnstone and Read, 2000:142).

Probably the most racialized diagnostic category of psychiatric imperialism, however, is schizophrenia. The point at which the label has been utilized by psychiatry to pathologize an indigenous or ethnic group has varied across societies, but correlates closely with a crisis in colonial or hegemonic power. The social and political actions of oppressed populations at these times are profiled as signs of aggressive and violent personality traits, as well as delusional patterns of thought (for example, of 'persecution' by others). Consequently, collective action is depoliticized by psychiatry as signs of acute 'mental illness', usually described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as schizophrenia (see American Psychiatric Association, 2013:87-110). Such a pattern of evidence has been found by Metzl (2009) in his study of increasing rates of the diagnosis of 'mental illness' among African Americans in the USA in the 1960s. Through research on cultural documents as well as clinical evidence, Metzl records a change in the use of the 'schizophrenia' diagnosis from describing 'sensitive', white, middle class patients between the 1920s and the 1950s, to a signifier for a growing population of 'violent' young black men. As Metzl (2009:xiii) comments:

> American assumptions about race, gender, and temperament of schizophrenia changed beginning in the 1960s. Many leading medical and popular sources suddenly described schizophrenia as an illness manifested not by docility, but by rage. Growing numbers of research articles from leading psychiatric journals asserted that schizophrenia was a condition that also afflicted 'Negro men,' and that black forms of illness were marked by volatility and aggression. In the worst cases, psychiatric authors conflated the schizophrenic symptoms of African American patients with the perceived schizophrenia of civil rights protests, particularly those organized by Black Power, Black Panthers, Nation of Islam, or other activist groups.

Thus, the growth in rates of schizophrenia among minority groups could be understood as a result of psychiatry's medicalization of protest and resistance (see also Cohen, 2013). Psychiatry's role is to enforce the current social order; any threats must be neutralized through medical rhetoric which makes the rational appear irrational and potentially psychotic. The rise of the urban Māori and the cultural renaissance changed general Pākehā sentiment towards the Indigenous population. No longer were the Māori considered as a happy if passive people, they were now seen as argumentative and aggressive. This change is probably best symbolized by Alan Duff's (1995) infamous portrait of Māori society in the book and subsequent film *Once Were Warriors* (first published in 1990); the former idyllic view of Māori as a happy and spiritually-connected people had been replaced by a picture of the urban Māori as alcoholics, domestic abusers and violent gang members.

Informed by the change in Pākehā conceptions of Māori from passive to aggressive over the past fifty years, colonial psychiatry continues to utilize its 'scientific' discourse to legitimize

the pathologization of the Indigenous population today. This includes the production of dubious research evidence which infers the supposed innate aggressiveness of the Māori. For example, in a meta-analysis of recent mental health data, Mellsop et al. (2007:394) found that although overall rates of bipolar affective disorder for Māori and European groups were similar, the Indigenous sample were rated significantly higher for having 'overactive, disruptive, agitated, or aggressive behaviour'. Occasionally the more 'culturally-sensitive' veneer of the social model slips and psychiatry's underlying racist tendencies are exposed. A prime example is the genetic epidemiologist Rod Lea who claimed, in 2006, that he had found a 'warrior' gene in Māori. Based on a sample of 17 Māori males, Lea stated that the genetic variance he found, 'goes a long way to explaining some of the problems Māori have … they are going to be more aggressive and violent and more likely to get involved in risk-taking behaviour like gambling' (cited in Crampton and Parkin, 2007:U2439). In Johnstone and Read's study, it was found that 11 per cent of the psychiatrists in the sample believed Māori were biologically or genetically predisposed to 'mental illness' (2000:140-141). 'Genetically', states one of Johnstone and Read's sample, 'Māori as a culture seem predisposed to mental illness'-'…especially psychosis' another psychiatrist comments (2000:142). With the undercurrent of such views within Aotearoa New Zealand psychiatry today, it is worth remembering that only fifty years ago the profession considered Māori much less prone to 'mental disorder' than their Pākehā counterparts. Colonial psychiatry has, once again, served to maintain the privileges of the Empire and of capital through a systematic problematizing of Indigenous peoples at a time of social and political crisis in colonial hegemony. It can be argued that this is an on-going struggle that continues to be played-out in institutions of power, such as medicine, and will continue as long as colonial forces remain in control.

Conclusion

Through an examination of the psychiatric response to Māori resistance beginning in the 1960s, this article has argued for an understanding of the mental health system as a site of colonial hegemony in Aotearoa New Zealand. It has been demonstrated that the increased urbanization of the Indigenous population during this period brought about a political consciousness and visibility which frightened Pākehā society, and in turn led to a change in the general perception of the colonized from passive to aggressive. Psychiatry's response has been to pathologize Māori protest as constituting the 'symptoms' of various forms of 'mental illness' (particularly psychotic illness). Furthermore, and as previously noted, this psychiatric process of normalizing colonial rule while pathologizing Indigenous resistance has been found in many other sites of colonial authority. The relative success of this counter-revolutionary process by the mental health system can be measured by the current extremely high rates of psychiatric diagnosis and incarceration of Māori. Critical interrogation of the

processes behind these high rates in diagnosis of 'mental illness' by academics and health researchers, meanwhile, have remained minimal, with this article being the first to make a sustained argument to challenge the institution of psychiatry in Aotearoa New Zealand as a part of colonial hegemony.

It is hoped that this article leads to further critical debate on race, colonization and western psychiatry's role in maintaining white privilege in Aotearoa New Zealand. There is also a need to re-orientate future research towards the psychiatric institution as a site of colonial power and social control. A survey of the views of psychiatric professionals on Māori mental health, as conducted by Johnstone and Read (2000), demonstrates the fruitfulness of such a reorientation in research priorities. More detailed ethnographic and interview work is needed on psychiatric professionals in the country to assess, for instance, the informal processes involved in the diagnosing of different groups, the norms and values which frame their interactions with other professionals, and the means of justification used to label and incarcerate Māori at higher rates. While academics fail to interrogate the 'experts' with the power to diagnose, treat and incarcerate the colonized, we remain in danger of accepting their world-view uncritically; this article has argued for a new approach, one that offers a more critical reading of colonial psychiatry as a continuing hegemonic power.

Acknowledgements

References

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*. 5th edn. Washington, D.C.: American Psychiatric Association.

Baxter, J., Kingi, T. K., et al. (2006). Māori. In M. A. Oakley Browne, J.E. Wells, et al. (Eds.) *Te Rau Hinengaro: The Aotearoa New Zealand Mental Health Survey.* (pp. 139-178). Wellington: Ministry of Health.

Baxter, J. (2008). *Māori Mental Health Needs Profile. A Review of the Evidence*. Palmerston North: Te Rau Matatini.

Beaglehole, E. (1939). Culture and Psychosis in Aotearoa New Zealand. *The Journal of Polynesian Society*, 48(191), 144-155.

Beaglehole, E. (1950). *Mental Health in Aotearoa New Zealand*. Wellington: New Zealand University Press.

Bradley, T. & Walters, R. (2011). *Introduction to Criminological Thought*. 2nd edn. Auckland: Pearson.

Brunton, W. (2001). 'A Choice of Difficulties': National Mental Health Policy in Aotearoa New Zealand, 1840-1947. Doctor of Philosophy thesis. Dunedin: University of Otago.

Cartwright, S. A. (2004). Report on the Diseases and Physical Peculiarities of the Negro Race. In A. L. Caplan, J. J. McCartney & D. A. Sisti (Eds.) *Health, Disease, and Illness: Concepts in Medicine* (pp. 28-39). Washington: Georgetown University Press.

Cohen, B. M. Z. (2013). Psychiatric Hegemony: A Marxist View on Social Constructionism. In F. Davies and L. González (Eds.) *Madness, Women and the Power of Art* (pp. 3-23). Oxford: Inter-Disciplinary Press.

Coleborne, C. (2010). *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914*. Houndmills: Palgrave Macmillan.

Crampton, P. & Parkin, C. (2007). Warrior Genes and Risk-Taking Science. *Aotearoa New Zealand Medical Journal,* 120(1250), U2439.

Duff, A. (1995). *Once Were Warriors*. London: Vintage Books.

Durie, M. H. (1985). A Māori Perspective of Health. *Social Science Medicine*, 20(5), 483-486.

Durie, M. H. (1995). Mental Health Patterns for the Aotearoa New Zealand Māori. In I. Al-Issa (Ed.). *Handbook of Culture and Mental Illness: An International Perspective* (pp. 331-346). Madison: International Universities Press.

Durie, M. H. (2001). *Mauri Ora: The Dynamics of Māori Health*. Auckland: Oxford University Press.

Fanon, F. (1965). *The Wretched of the Earth*. Harmondsworth: Penguin.

Fernando, S. (2003). *Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism.* Hove: Brunner-Routledge.

Fernando, S. (2010). *Mental Health, Race and Culture.* 3rd edn. Houndmills, Basingstoke: Palgrave Macmillan.

Fischer, C. F. (1984). *The Urban Experience*. 2nd edn. Boston: Harcourt.

Foucault, M. (1967). *Madness and Civilisation: A History of Insanity in the Age of Reason.* London: Routledge.

Gambino, M. (2008). 'These Strangers within our Gates': Race, Psychiatry and Mental Illness among Black Americans at St Elizabeths Hospital in Washington, DC, 1900-40. *History of Psychiatry*, 19, 387-408.

Hill, R. S. (2012). Māori Urban Migration and the Assertion of Indigeneity in Aotearoa/New Zealand, 1945–1975. *Interventions: International Journal of Postcolonial Studies*, 14(2), 256-278.

Hunn, J. K. (1961). Report on Department of Māori Affairs with Statistical Supplement. Wellington: Department of Māori Affairs.

Johnstone, K. and Read, J. (2000). Psychiatrists' Recommendations for Improving Bicultural Training and Māori Mental Health Services: A Aotearoa New Zealand Survey. *Australian and Aotearoa New Zealand Journal of Psychiatry*, 34, 135-145.

Jutel, A. G. (2011). *Putting a Name to It: Diagnosis in Contemporary Society*. Baltimore: John Hopkins University Press.

Kake, T. R., Arnold, R., et al. (2008). Estimating the Prevalence of Schizophrenia Amongst Aotearoa New Zealand Māori: A Capture-Recapture Approach. *Australian and Aotearoa New Zealand Journal of Psychiatry*, 42, 941-949.

Keller, R. C. (2007). *Colonial Madness: Psychiatry in French North Africa*. Chicago: University of Chicago Press.

Kelly, R. (1973). Mental Illness in the Māori Population of Aotearoa New Zealand. *Acta Psychiat. Scand.*, 49, 722-734.

Kingi, T. K. R. (2011). Māori Mental Health: Past, Present, Future. In T. McIntosh and M. Mulholland (Eds.). *Māori and Social Issues* (pp. 89-107). Wellington: Huia.

Kirk, S. A. & Kutchins, H. (1992). *The Selling of DSM: The Rhetoric of Science in Psychiatry*. New York: Aldine De Gruyter.

Kirk, S. A. & Kutchins, H. (1997). *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York: Free Press.

Kukutai, T. (2011). Contemporary Issues in Māori Demography. In T. McIntosh and M. Mulholland (Eds.). *Māori and Social Issues* (pp. 11-48). Wellington: Huia.

Labrum, B. (2013). 'Not On Our Street': New Urban Spaces of Interracial Intimacy in 1950s and 1960s Aotearoa New Zealand. *Journal of Aotearoa New Zealand Studies*, NS14, 67-86.

LeFrançois, B. A. (2013). The Psychiatrization of our Children, or, an Autoethnographic Narrative of Perpetuating First Nations Genocide through 'Benevolent' Institutions. *Decolonization: Indigeneity, Education & Society*, 2(1), 108-123.

Littlewood, R. (2001). Colonialism and Psychiatry. In D. Bhugra and R. Littlewood (Eds.). *Colonialism and Psychiatry* (pp. 3-14). New Delhi: Oxford University Press.

MaGPIe Research Group (2005). Mental Disorders among Māori attending their General Practitioner. *Australian and Aotearoa New Zealand Journal of Psychiatry*, 39, 401-406.

Māori Health Commission (1998). Tihei Mauri Ora: Report of the Māori Health Commission June 1998. Wellington: The Māori Health Commission.

McClintock, K., Tauroa, R., et al. (2013). Te Tomo Mai Appropriate Child and Adolescent Mental Health Service (CAMHS) for an Indigenous Population: Rangatahi (Youth) Perspectives. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 11(1), 125-131.

McGovern, D. & Cope, R. (1987) The Compulsory Detention of Males of Different Ethnic Groups, with Special Reference to Offender Patients. *British Journal of Psychiatry,* 150, 505-512.

Mellsop, G., Dutu, G., et al. (2007). CAOS Contribution to Understanding Cultural/Ethnic Differences in the Prevalence of Bipolar Affective Disorder in Aotearoa New Zealand. *Australian and Aotearoa New Zealand Journal of Psychiatry*, 41, 392-396.

Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became a Black Disease.* Boston: Beacon Press.

Oakley Browne, M. A., Wells, J. E., et al. (Eds.) (2006). Te Rau Hinengaro: The Aotearoa

New Zealand Mental Health Survey. Wellington: Ministry of Health.

Primrose, M. S. (1968). A Study of Mental Illness in Aotearoa New Zealand, 1867-1926 with Special Reference to the Auckland Mental Hospital. Masters of Arts thesis. Auckland: University of Auckland.

Robson, B., Cormack, D., et al. (2007). Social and Economic Indicators. In B. Robson and R. Harris (Eds.). *Hauora: Māori Standards of Health IV: A Study of the Years 2000-2005* (pp. 21-32). Wellington: Te Ropu Rangahau Hauora a Eru Pomare.

Rogers, A. & Pilgrim, D. (2003). *Mental Health and Inequality.* Houndmills, Basingstoke: Palgrave Macmillan.

Roman, L. G., Brown, S., et al. (2009). No Time for Nostalgia!: Asylum-Making, Medicalized Colonialism in British Columbia (1859-97) and Artistic Praxis for Social Transformation. *International Journal of Qualitative Studies in Education*, 22(1), 17-63.

Scull, A. (1993). *The Most Solitary of Afflictions: Madness and Society in Britain 1700–1900.* New Haven: Yale University Press.

Smith, A. (2005). *Conquest: Sexual Violence and American Indian Genocide*. Cambridge: South End Press.

Szasz, T. S. (2010). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* Rev. edn. New York: Harper Perennial.

Taitimu, M. (2007). Nga Whakiwhitinga: Standing at the Crossroads. Māori Ways of Understanding Extra-Ordinary Experiences and Schizophrenia. Doctor of Philosophy thesis. Auckland: University of Auckland.

Thompson, S. A. (1992). "The Keepers of Happiness": European Psychiatry and the Insane in Aotearoa New Zealand, 1911-1950. Masters of Arts thesis. Auckland: University of Auckland.

Vaughan, M. (2007). Introduction. In S. Mahone and M. Vaughan (Eds.). *Psychiatry and Empire* (pp. 1-16). Houndmills, Basingstoke: Palgrave Macmillan.

Walker, R. (1990). *Ka Whawhai Tonu Matou Struggle Without End*. Auckland: Penguin.

Wells, J. E. (2006). Prevalence and Severity across Aggregated Disorders. In M. A. Oakley Browne, Wells, J. E., et al. (eds*.). Te Rau Hinengaro: The Aotearoa New Zealand Mental Health Survey* (pp. 23-36). Wellington: Ministry of Health.