From whakamā to whakamana: He aha tēnei?

Kaimahi and tāngata whaiora recounts of whakamā in mental health contexts of Tāmaki Makaurau

Karis Knight

Ngāti Porou, Te Whanau a Ruataupare

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ABSTRACT

Mental health services in Aotearoa must better recognise and respond to the unique worldview and experiences of Māori. This study sought to explore how the mātauranga Māori concept of whakamā is understood and experienced in mental health contexts of Tāmaki Makaurau. Using a Māori centred approach informed by kaupapa Māori principles, semi-structured qualitative interviews were carried out with 18 kaimahi, nine tāngata whaiora, and four peer support workers. Interview transcripts were grouped into two data sets, kaimahi and tāngata whaiora, of which the second included peer support workers. Thematic analysis was used to identify categories and themes across each data set. Kaimahi highlighted the significance of collective experiences associated with whakamā for Māori namely, impacts of colonisation, loss of Māori identity, and whakamā caused by harmful interactions with the 'system.' Kaimahi experienced whakamā as a 'big' concept that felt challenging to talk about with tāngata whaiora although was commonly 'shown' through identifiable behaviour. Kaimahi considered their role in supporting with whakamā which encompassed qualities associated with tikanga values of kaitiakitanga, whanaungatanga, te wā, and whakapapa. Finally, kaimahi stressed that mental health services may contribute to whakamā because of differences in values, lack of cultural competency, and lack of bicultural partnership. Nearly all of the tāngata whaiora and peer support workers told a time-based story about their journey with mental health challenges and, within this, experiences contributing to both whakamā and enhanced mana. As such, tāngata whaiora findings were grouped into two categories. The first category encompassed experiences contributing to whakamā and these included lived experiences of mana diminishing environments, whānau responses to mental health problems, whakamā about having a mental health problem, and whakamā about engaging with services. The second category outlined experiences contributing to whakamana and these included making a choice to speak out, connecting with the right support, and (re)connecting with Te Aō Māori. Findings demonstrate that whakamā is an important concept of relevance to mental health contexts for Māori. The voices of Māori participants in this study contribute to the literature on Māori mental health by offering new ways of understanding, responding to, and healing from whakamā.

–This thesis is dedicated to my Nana: Mere Knight–

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My strength is not mine alone, but that of many

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GLOSSARY OF MĀORI WORDS

Additional translations have also been footnoted throughout the thesis when terms first appear in each chapter to enhance readability.

Aotearoa	New Zealand
Āhua	To form, make, also refers to a shape, appearance, condition, character, likeness
Aroha	Love, caring, compassion, empathy
Awa	River
Awhi	Support, care
Aroha ki te tāngata	Support people to define their own space
Atua	God, supernatural
Hapū	Sub-tribe, to be pregnant
Hakihaki	Skin disease, rash, itch, sore
Hā	To breathe, essential essence
Hā koro ma a kui ma	The breath of life from ancestors
Hara	Transgression, wrongdoing, problem
Hineahuone	The first human, a woman
Hinetītama	Daughter of Hineahuone, also known as Hinenuitepō
Hinenuitepō	Daughter of Hineahuone, also known as Hinetītama
Hohou rongo	Reconciliation process to facilitate peace
Hui	Meeting, gathering
Ihi	Essential force, power, charm, magnetism.
Iwi	Tribe
Iwi katoa	Social discourse and service-level factors that affect client wellbeing
Kaiako	Teacher
Kai	Food, to eat
Kaimahi	Person who is skilled in a particular area; mental health clinician in the context of this study.
Kaitiaki	Guardians
Kaitiakitanga	Guardianship, to oversee, to protect
Kanohi ki te kanohi	Face to face
Kapa haka	Māori cultural group, Māori performing group
Karakia	Incantation, prayer, blessing
Karanga	Ceremonial call, to summon
Kaua e mahaki	Remain humble
Kaua e takahia te mana o te tāngata	Do not trample on the mana of others

Kaumātua/Kuia	Elder(s)
Kaupapa Māori	A Māori approach, Māori service or organisation
Kawa	Protocol
Kawanatanga	Governance
Kia ora	Greeting wishing good health
Kia tupato	Remain cautious and reflective
Koha	Gift
Kōrero	Narrative, speech, conversation
Kohanga reo, Kura kaupapa	Māori language immersion schools
Kumekume	To pull back and forth, draw into, attract
Mahi	Work
Mahi a Atua	Māori model of counselling
Mamae	Painful, sore, hurt
Mana	Authority, prestige, strength, honour, respect, the supernatural force in a person
Mana ake	Unique identity
Mana whenua	Those who whakapapa to hapū and iwi of an area and hold authority over the land.
Manaakitanga	Enhancing the esteem of others through hospitality, generosity, and kindness.
Manaaki ki te tāngata	Collaboration, sharing, giving back
Māori	Founding people of Aotearoa, indigenous people of Aotearoa
Marae	Tribal meeting grounds that are a common space for hapū or groups to meet/gather.
Matakite	To see into the future, supernatural insight, special intuition
Mātāwaka	Māori who reside in an area but whakapapa to hapū and iwi of another region.
Mātauranga Māori	Māori epistemology
Mauri	Life principle, life force, special nature, source of emotions.
Maunga	Mountain
Mau rākau	Māori weaponry
Mauri oho	Unsettled, startled, in shock
Mauri ora	The breath of life, wellbeing, vitality
Mauri mate/noho	Stagnated, stuck, unwell
Meihana Model	Māori model of assessment and intervention
Mihi whakatau, mihi	Speech of greeting, establishing a relationship
Mirimiri	Healing massage
Mokōpūna	Grandchild, descendant

Momo	Type, variety, kind, race, species, offspring, descendant
Ngā manukura	Community leadership
Ngākau mamae	Transmission of deep psychological pain.
Noa	Neutral, common, non-restricted
Paiheretia	Māori model of counselling
Papatūānuku	Earth Mother and wife of Ranginui, all living things originate from them
Patu ngākau	To strike or assault to the heart or emotional core of a person, causing deep psychological shock.
Pākehā	New Zealander of European descent
Pakiwaitara	Legend, story, fiction, folklore
Pepeha	Form of self-introduction in which whakapapa and areas of significance are recited
Pōwhiri	Ceremonial welcoming process, rituals of encounter
Pōwhiri Poutama	Māori model of counselling
Pūmanawa	Talented, gifted, intuitive cleverness
Pūrākau	Traditional story or narrative
Rangatahi	Youth
Rangatira	Chief, leader
Rangahau	Research
Ranginui	Sky Father and husband of Papatūānuku, all living things originate from them
Raranga	Weaving
Riri	Angry
Rongoa	Traditional Māori medicine, treatment, remedy
Rōpū	Group of people
Taha hinengaro	Emotional wellbeing
Taha tinana	Physical wellbeing
Taha wairua	Spiritual wellbeing
Taha whānau	Family wellbeing
Taiao	External physical environment, natural world
Take	To originate, derive
Tāmaki Makaurau	Auckland region
Tamariki	Children
Tāne	Male, man
Tānemahuta	God of the trees and birdlife
Tāngata	People
Tāngata whaiora	A person who is seeking wellness; this term is often used to describe mental health service users

Tāngata whenua	Local people, hosts, indigenous people born of the whenua i.e., of the placenta and of the land where their ancestors lived
Tauiwi	Non-Māori, foreigner
Tautoko	Support
Taumaha	To be heavy
Taunga hou	Mātāwaka who identify as Māori but who do not actively maintain connections and responsibilities to hapū, iwi
Tapu	To be sacred, prohibited, restricted, set apart, forbidden, protected
Tau	To settle down, subside, abate.
Taura here	Mātāwaka who actively maintain connections and responsibilities to hapū, iwi.
Taurawhiri	Māori tikanga or cultural advisor
Tēina	Younger brother (of male) or sister (of female), less skilled individual in a particular area relative to tuākana, or more skilled individual.
Te Aō Māori	The Māori world
Te Aō Mārama	The world of light, understanding
Te Aō Whānui	New Zealand society and the wider world
Te Manuwhakahaere	Autonomy
Te Oranga	Participation in society
Te Pae Māhutonga	Southern Cross, model of Māori health promotion
Te Pō	Darkness, the night, the unknown
Te Reo Māori	Māori language
Te Wā	Time
Te Whare Tapa Whā	Four walls of the whare, model of wellbeing
Te Whetu	The Star, model of wellbeing
Te Wheke	The Octopus, model of wellbeing
Tiaki, tiakitanga	To guard, to protect, to care, to nurture
Tikanga	Customary system of values, correct procedure, lore, method, protocol
Tino rangatiratanga	Self-determination, sovereignty, autonomy, self-government, domination, rule, control, power
Titiro, whakarongo, kōrero	Observe, listen, then speak
Tohu	Sign, gift
Tohunga	To be expert, proficient, adept
Toi ora	Healthy lifestyles
Tīpuna/Tūpuna	Ancestors, grandparent
Tūrangawaewae	Place where one has right to stand, rights of residence and belonging via kinship.

Tūturu	Real, true, actual, authentic
Tuākana	Older brother (of male) or sister (of female), more skilled individual in a particular area relative to tēina, or less skilled individual.
Wāhine	Female, women
Wāhine toa	Strong women
Waiata	Song, chant
Waiora	Total wellbeing
Wairangi	To be beside oneself, unbalanced, suffering from mental illness
Wairua, Wairuatanga	Spirituality, spirit, soul
Whakaora	Restoring wholeness, healing
Waka	Canoe
Wānanga	To meet and discuss, deliberate and consider, collaborative learning
Wehi	Awe
Whaikōrero	Speech, the practice of oratory
Whakaaro	Feedback, idea, reflection
Whakairo	Carving
Whakaotinga	New way of being, transformation
Whakamā	Loss of mana, feeling of shame, embarrassment, shyness
Whakamana	To give authority to, give effect to, to confirm, enable, empower, validate, enact
Whakanoa	To remove tapu restrictions
Whakapapa	Genealogy, lineage, descent, to place in layers
Whakapuaki	Mutual revealing of stories
Whakatangi	Emotional shift
Whakataukī	Proverb, saying, lesson
Whakarata	Physical contact
Whanaungatanga	Relationship, kinship, process of establishing and maintaining relationships
Whakawhanaungatanga	Process of establishing relationships and maintaining links, relating well to others
Whānau	Family, extended kin
Whanaunga	Relative, loved one
Whanganui a Tara	Wellington region
Whatumanawa	Healthy expression of emotion
Whenua	Land, placenta

PEPEHA

Ko Hikurangi te maunga

Ko Horouta te waka

Ko Waiapu te awa

Ko Tuatini te marae

Ko Ngāti Porou te iwi

Ko Te Whanau a Ruataupare te hapu

Tihei mauri ora

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

For centuries, Māori[1] have utilised a range of mediums to transmit knowledge, values, beliefs, and learnings that stem from a mātauranga Māori[2] worldview across successive generations (Hikuroa, 2017). For example, pūrākau[3], traditional stories or narratives, provide depth and insight into Māori understandings and experiences of the world (Mead, 2003). The following pūrākau is a Māori story of creation and introduces the concept of whakamā[4] in its initial form.

In the beginning, Ranginui[1] and Papatūānuku[2] were locked in an eternal embrace and their many children lived between, in the darkness of Te Pō[3]. Overtime, some of their children became restless and wanted to separate their parents so that they could experience light, growth, and new awareness. After a period of disagreement and struggle, Tānemahuta[4] laid down on his back and used his mighty feet to thrust Ranginui up into the sky. In doing so, Tānemahuta pushed his parents apart and welcomed in Te Aō Mārama[5], the natural world in which we live today. Thereafter the children of Ranginui and Papatūānuku became Atua[6] that oversaw different elements of this new world. Although, Tānemahuta who was the god of forests and birds grew tired of living alone. With the help of enchanted soil, Tānemahuta fashioned a mould of the female form and into it he breathed life. Through this exercise, Hineahuone[7], the first female of the Earth came into existence. Tānemahuta and Hineahuone married and had a daughter named Hinetītama[8]. As she grew into a beautiful young woman, Tānemahuta developed feelings for Hinetītama and they eventually married and bore children. It was unknown to Hinetītama that Tānemahuta was her father until one day she was led by curiosity to find out where she came from. Upon discovering the truth, Hinetītama was overcome with whakamā and fled into the darkness of Te Pō where she hid away and transformed into Hinenuitepō[9]. Tānemahuta pleaded for her to come back into Te Aō Mārama but she refused, instead choosing to wait for the arrival of her children. To this day, Hinenuitepō remains at the entrance of Te Pō where she watches over and protects the souls of those who have passed over.

There are different ways in which the pūrākau described above may be understood and interpreted. It could be argued that the transformation of Hinetītama to Hinenuitepō illuminates the significance of whakamā. Whakamā is a mātauranga Māori conceptualisation of distress, which is often translated into English as shyness, embarrassment, or shame.

[1] Founding people of Aotearoa, indigenous people of Aotearoa.
[2] Māori epistemology.
[3] Traditional story or narrative.
[4] Loss of mana, feeling of shame, embarrassment, shyness.
[1] Sky Father and husband of Papatūānuku, all living things originate from them.
[2] Earth Mother and wife of Ranginui, all living things originate from them.
[3] Darkness, the night, the unknown.
[4] God of the trees and birdlife.
[5] The word of light, understanding.
[6] God, supernatural.
[7] The first human, a woman.
[8] Daughter of Hineahuone, also known as Hinenuitepō.
[9] Daughter of Hineahuone, also known as Hinetītama.

Whakamā has also been described as being closely associated with loss of mana[10], another concept that is embedded in mātauranga Māori (Metge, 1986). The above pūrākau demonstrates that whakamā can be associated with urges to physically withdraw. It also demonstrates that experiences of whakamā can lead to changes in self-perception. Not only did Hinetītama remove herself from Te Aō Mārama, but she was transformed from light to darkness upon learning she had unknowingly entered into a relationship with her father, Tānemahuta. At the same time, it could be argued that Hinenuitepō upheld her mana in choosing to remain in Te Pō. There, she found new purpose, meaning, and strength. Whilst Hinenuitepō was initially affected by whakamā, she was not passive in her process of transformation. As such, Hinenuitepō's story could relate to both whakamā and whakamana.[11]

In my own life, whakamā was a word that I often heard growing up within my whānau[12] as a means of describing or explaining particular behaviour. This was not something I thought much of until I started working in mental health settings, where I noticed that Māori clinicians frequently used the word whakamā to convey meaning and understanding about the behaviour and presentation of some Māori tāngata whaiora[13]. Given that whakamā is commonly recognised and understood within Te Aō Māori[14], I was surprised to find that there was hardly any written information about whakamā, particularly for mental health practitioners. After consulting with numerous Māori clinicians, community workers, and taurawhiri[15] it became clear that there was a need to fill this gap. Over the last few decades, Māori across clinical, academic, and political spheres have fought for a greater platform to drive change in mental health spaces within Aotearoa so that these spaces can better respond to the needs and priorities of Māori (Durie, 2017). However, western psychology and western approaches to mental health service provision continue to hold the dominant voice, even as Māori continue to present with mental health challenges in high numbers (Bennett, 2018).

This study aims to contribute to the literature on Māori psychology by offering new insights into whakamā, including its relevance to mental health service delivery. Specifically, the purpose of this study is to explore how whakamā is understood and experienced in mental health contexts of Tāmaki Makaurau[16] by undertaking semi-structured qualitative interviews

[10] To be expert, proficient, adept.
[11] To give authority to, give effect to, to confirm, enable, empower, validate, enact.
[12] Family, extended kin.
[13] A person who is seeking wellness; this term is often used to describe mental health service users.
[14] The Māori world.
[15] Māori tikanga or cultural advisor.
[16] Auckland region.

with Māori kaimahi[17] and tāngata whaiora. The study will also explore the significance of mana in relation to whakamā, including how mana might be uplifted for those in spaces of whakamā.

I acknowledge that within this research, understandings and experiences of whakamā will be drawn from a specific context, that is, urban mental health settings. Whilst it may be that whakamā as a construct is better understood more broadly to reflect potential differences of meaning across hapū[18] and iwi[19]. I hope that the insights, stories, and unique experiences drawn from this research will be one small mechanism for uplifting the voices of Māori in mental health contexts and in doing so, this will provide helpful information needed to improve service provision for Māori. I also acknowledge that my positioning as a woman with both Māori and tauiwi[20] whakapapa[21], having grown up in the urban setting of Tāmaki Makaurau, as well as my experience working in mental health and studying clinical psychology have all shaped my approach to the research. My personal positioning that I bring to this study will be considered in more detail within the methodology chapter of this thesis. To add, I sought to uphold the mana of participants by positioning them as experts in regards to their understandings and experiences of whakamā; it was my job to listen and learn.

The first chapter of this thesis consists of a literature review that will set the scene for this research project. Firstly, to position this research within Te Aō Māori, important concepts associated with wellbeing from a Māori worldview will be introduced and explored. This will be followed by critical discussion of significant historical, political, and social factors arising since colonisation that continue to impede upon Māori experiences of wellbeing. Then, an overview of Māori mental health will be provided including discussion of Māori mental health needs and Māori responses to address these. Finally, the concept of whakamā and its potential relevance to mental health contexts for Māori will be explored further in relation to existing research. Chapter 2 will outline the chosen methodology and study design for this research project and my rationale for selecting these approaches. My personal positioning that I bring to the research will also be explored. Chapter 4 and 5 will present the thematic findings of this study drawn from the process of thematic analysis. Finally, Chapter 5 will discuss the key

[17] Person who is skilled in a particular area; mental health clinician in the context of this study.
[18] Subtribe, to be pregnant.
[19] Tribe.
[20] Non-Māori, foreigner.
[21] Genealogy, lineage, descent, to place in layers.

findings and clinical implications of this study in context to relevant literature, ending with an outline of study limitations, potential for future research, and final thoughts.

Tikanga Māori and wellbeing

Mechanisms for enhancing wellbeing have always existed within Te Aō Māori. This includes the embedment of tikanga Māori[22] across all aspects of life (Kingi, 2005). Tikanga is derived from the word tika, which means to be right, correct, true or proper (Mead, 2003). Tikanga Māori may be conceptualised as a broad set of guiding principles for organising normative values, behaviours, and practices stemming from mātauranga Māori. Before colonisation, tikanga Māori provided a framework for governing systems of effective social order in Māori society (Mikaere, 2005; R. Walker, 2004). Thus, tikanga Māori played an integral role in upholding the wellbeing of whānau, hapū, and iwi. Tikanga Māori could also function as both a preventative and protective framework for those experiencing distress (T. Smith, 2019). Indeed, literature suggests that mental health issues, incidents of whānau violence, and sexual violence were not common in traditional Māori society (Beaglehole & Beaglehole, 1947; E. Cooper, 2012; A. Walters, 2016). This is not to say that these issues did not exist. Rather, historical literature suggests that there were collective systems in place to respond accordingly and effectively when issues arose (Kingi, 2005, 2018). Many of the guiding principles underpinning tikanga Māori have been imparted (both explicitly and implicitly) across generations and so remain integral to Māori ways of being in the world (Mead, 2003). Much can be written about tikanga, although only a few key concepts that may be broadly associated with wellbeing for Māori will be outlined below.

Whakapapa. Rameka (2016) aptly describes whakapapa as "a way of thinking which is fundamental to almost every facet of a Māori world view" (p. 398). Whakapapa can be loosely translated to mean genealogy, although arguably this does not capture the depth of meaning encompassed by this word. Instead, whakapapa can be broken down into two distinct words them being, 'whaka' meaning to cause or enable and 'papa' meaning to layer. Thus, whakapapa relates to the continual layering of connections binding Māori identity to past, present, and future dimensions of being, and spans from Ranginui and Papatūānuku through to mokopuna[23] yet to enter into the world (Rameka, 2016). Whakapapa offers an organising system that connects individuals to whānau, hapū, iwi, and whenua[24] (Gilchrist, 2017). The

[22] Customary system of values, correct procedure, lore, method, protocol.
[23] Grandchild, descendant.
[24] Land, placenta.

concept of tūrangawaewae[25] is closely linked to whakapapa. That is, places of significance (i.e., marae[26], whenua, awa[27], maunga[28]) where, like tupuna[29] many generations prior, it is possible to stand with security and confidence in the knowledge that you belong somewhere through connection to whakapapa (Boulton et al., 2021). It is common for Māori to call upon whakapapa as a means of establishing connections with others. This is often achieved through recitation of pepeha[30], which typically incorporates acknowledgment of maunga, awa, waka[31], tupuna, iwi, hapū, whānau connections and ends with acknowledgement of the individual (Mead, 2003). This process emphasises the collective and interdependent manner to which Māori identity is construed, which extends to relationships with both people and the natural world (T. Smith, 2019).

Whānau. Whānau is another important facet of Te Aō Māori that is integral to Māori identity, individual, and collective wellbeing (Boulton & Gifford, 2014). Whānau may be defined as a kinship group connected together through whakapapa (Lawson-Te Aho, 2010). Although, it must be briefly noted that contemporary definitions incorporate broader conceptualisations of whānau, such as 'kaupapa whānau' or a group of non-biologically related people that function as a whānau typically for a common purpose (Metge, 1995). In the traditional sense, whānau is broader than western notions of nuclear family, with kinship ties typically extending much wider. Further, the whānau unit is also connected, by whakapapa, to larger social units of hapū, iwi, and waka (Lawson-Te Aho, 2010). Traditionally, values of collective responsibility and reciprocity were important to cohesive functioning of the whānau unit. Everyone had roles and responsibilities to uphold and these were shared equally between genders (Moeke-Pickering, 1996). For example, elderly whānau members, or kaumātua[32], were traditionally looked upon for knowledge and guidance and thus, held a respected position within the whānau (Metge, 1995). Further, the practice of tuākana[33], or older more experienced whānau members, supporting tēina[34], or younger less

[25] Place where one has right to stand, rights of residence and belonging via kinship.
[26] Tribal meeting grounds that are a common space for hapū or groups to meet/gather.
[27] River.
[28] Mountain.
[29] Ancestors, grandparent.
[30]Form of self-introduction in which whakapapa and areas of significance are recited.
[31] Canoe.
[32] Elder(s).
[33] Elder brother (of male) or sister (of female), more skilled individual in particular area relative to tēina, or less skilled individual.
[34] Younger brother (of male) or sister (of female), less skilled individual in a particular area relative to tuākana, or more skilled individual.

experienced whānau members, enabled knowledge and skills to be imparted across generations (Reilly, 2010).

Tikanga principles that facilitated group cohesion, harmony, support, and order were embodied and actioned within the whānau unit (Moeke-Pickering, 1996). These include concepts such as whanaungatanga[35], manaakitanga[36], aroha[37], and tiakitanga[38]. Whanaungatanga primarily refers to the process of establishing and maintaining relationships. Whanaungatanga also refers to the upholding of relational responsibilities meaning that whānau members are expected to both provide and receive support (McNatty & Roa, 2002). In turn, maintenance of whanaungatanga affords a sense of belonging and mutual care (Le Grice et al., 2017). Whanaungatanga has an intertwined relationship with the concept of manaakitanga. Manaakitanga broadly relates to the action of valuing and enhancing the esteem of others by demonstrating respect, support, hospitality, and generosity. Provision of manaakitanga may be observed relationally through expression of aroha and tiakitanga and practically through the provision of kai[39], shelter, and comfort (Le Grice et al., 2017; Mead, 2003). Other important facets of tikanga Māori were primarily learnt about within the whānau unit and these are described below.

Tapu and noa. The concepts of tapu[40] and noa[41] are significant to all areas of life (Tate, 2014). In a general sense, tapu relates to sanctity. Tapu is also associated with restriction or controlled access to particular beings, objects, places, and rituals. Anything in a state of tapu may incite respect, care, wehi[42], and separation (Royal, 2003). Conversely, noa is associated with an ordinary state and relaxed access requiring no restrictions or protective mechanisms (Mead, 2003). The importance of maintaining balance and equilibrium to enhance wellness is embedded across tikanga Māori (T. Smith, 2019) although can be most clearly demonstrated through the concepts of tapu and noa. Traditionally, the observance of tapu and noa played a practical role in reinforcing acceptable social code, reducing health risks, and sustaining balance within society (Durie, 1998). Transgressions of tapu, an act known as hara[43], were seen to bring about danger or negative outcomes (Mead, 2003). In

[35] Relationship, kinship, process of establishing and maintaining relationships.
[36] Enhancing the esteem of others through hospitality, generosity, and kindness.
[37] Love, caring, compassion empathy.
[38] To guard, to protect, to care, to nurture.
[39] Food, to eat.
[40] To be sacred, prohibited, restricted, set apart, forbidden, protected.
[41] Neutral, common, non-restricted.
[42] Awe.
[43] Transgression, wrongdoing, problem.

response to these events, balance typically needed to be restored through use of karakia[44] and engagement of particular rituals such as whakanoa[45] (Barlow, 1991; Tate, 2014). Similarly, Māori traditionally believed that experiences of mental illness (i.e., wairangi[46]) were often associated with transgressions of tapu and remediation required treatment from a tohunga[47] specialised in restoring balance (Sanders et al., 2011). The concepts of tapu and mana can be viewed as inherently linked. Thus, when the tapu of a person is either enhanced or threatened, so too is their mana (Tate, 2014).

Mana. Mana broadly refers to an individual or group's propensity to hold and maintain authority, influence, and power. Mana has an empowering effect and is associated with action and the capacity for achievement (Mead, 2003). Mana also sits within a deeper spiritual dimension (Patterson, 1992). For example, mana can be inherited through ancestral lineage (mana tupuna), through enhancing spiritual connections (mana atua), and through connection and belonging to ancestral land (mana whenua). Mana can also be earnt through building expertise and leadership capacity in a particular area or through contributing positively to whānau, hapū, and iwi (mana tāngata) (Barlow, 1991). Mana, especially mana tāngata, is closely associated with social context and social positioning meaning that an individual cannot 'claim' mana, but is instead recognised by others as possessing mana (Barlow, 1991; Mead, 2003). Durie (2001) explains that in Te Aō Māori, "collective responsibility rather than individual brilliance is the norm" (p. 83). T. Smith (2019) asserts that it is important to acknowledge the mana of others as not doing so may negatively affect their self-esteem and self-worth. Unlike other concepts such as mauri[48], a person does not intrinsically possess mana. It may be weakened or lost if an individual is unable to fulfil expected roles or obligations (Patterson, 1992).

Mauri. Mauri may be considered synonymous with the concept of a 'life-force' or a 'life-essence' running through organisms and other natural landmarks (i.e., maunga, awa) (Barlow, 1991). From a Te Aō Māori perspective, life cannot be sustained without the presence of mauri (Mead, 2003). External and internal experiences can affect the energy of mauri (T. Smith, 2019). In regards to personal mauri, internal states of balance, ease, and clarity may be associated with mauri ora[49] (Pohatu & Pohatu, 2011). When mauri is intact and

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[44] Incantation, prayer, blessing.
[45] To remove tapu restrictions.
[46] To be beside oneself, unbalanced, suffering from mental illness.
[47] To be expert, proficient, adept.
[48] Life principle, life force, special nature, source of emotions.
[49] The breath of life, wellbeing, vitality.

functioning well, a person may be deemed capable of contributing fully in society (Edwards, 2009). In contrast, unsettled (mauri oho[50]) or stagnant (mauri noho or mauri mate[51]) states may impede on an individual's capacity to realise their full potential and exude ihi[52] (Pohatu & Pohatu, 2011). Thus, mauri requires ongoing attention, nurturing, and protection (Edwards, 2009; T. Smith, 2019). Unlike wairua[53], mauri never leaves the organisms it embodies until death (Mead, 2003).

Wairua. Wairua relates to the spiritual dimension of life and is integral to all aspects of wellbeing (Valentine, 2009). Wairua can be broken down into two words; wai, meaning water, and rua, meaning two, which have been described as encapsulating the intertwining physical and spiritual streams that run through our experience of existence and 'being' in relation to the seen (i.e., whenua, tāngata[54]) and unseen (i.e., whakapapa, tupuna) world around us (Rameka, 2016). Bidois (2006) describes wairua as, "that which is unique, special, contained within" (p. 1) and he relates this to the concept of having a spirit or soul. However, T. Smith (2019) argues that traditionally, wairua also had a physical basis given its association with water, which represented the intimate connection all living things had to the environment. Valentine (2009) offers the following definition based on qualitative interviews on how Māori conceptualise wairua:

> Wairua can be conceptualised as an intuitive consciousness that exists within all Māori. It may also be the avenue through which Māori identity is expressed and maintained, relationships are forged, balance is maintained, restrictions and safety are adhered to, healing is transmitted, and the mechanism through which the tupuna (ancestors) and atua (Gods) remain connected to the living. (p. 135)

Thus, wairua may be seen as all-encompassing and fundamental to Māori ways of being. Wairua is the spiritual thread that connects us to all aspects of existence and is what binds us to whakapapa across past, present, and future dimensions (Valentine, 2009). Arguably, wairua can alert us to important messages such as our purpose, potential threats, and pathways to healing.

[50] Unsettled, startled, in shock.
[51] Stagnated, stuck, unwell.
[52] Essential force, power, charm, magnetism.
[53] Spirituality, spirit, soul.
[54] People.

In summary, tikanga Māori is fundamental to Māori ways of being in the world. Tikanga has shaped Māori systems of understanding and behaviour for hundreds of years and it continues to play an integral role in Māori society and wellbeing today. However, it is important to note that colonisation has had a deleterious impact on the transmission of protective tikanga Māori across generations. Thus, it is essential to consider historical, political and social factors that Māori have endured since colonisation, how these have caused harm to the wellbeing of Māori whānau, hapū, and iwi.

Historical, political, and social impacts on Māori wellbeing

Māori histories of struggle and resistance inform the contemporary experiences of Māori today. Notably, colonisation and the relationships that followed between Māori and Pākehā[55] have had pervasive implications for Te Aō Māori (Binney et al., 2014). Although Māori only account for approximately 15% of the current population in Aotearoa (StatsNZ, 2017), research has identified disparities between Māori and the general population across health (John Reid et al., 2014), mental health (Baxter et al., 2006; New Zealand Government, 2018), socio-economic, educational (Marriott & Sim, 2015), and correctional domains (Waitangi Tribunal, 2017) for example. Similar disparities can be observed globally across indigenous cultures who have survived colonisation (Anderson et al., 2016; Doyle, 2011; Gracey & King, 2009). The following section will seek to contextualise these disparities in relation to historical, political, and social factors impacting Māori wellbeing. These include colonisation and historical trauma, legislative oppression, urbanisation, and its impact on Māori identity, and racism.

Colonisation and historical trauma. The first British settler ship arrived in Pito-one in January 1840. Settler arrival saw the introduction of new diseases, alcohol, and muskets as well as an increased demand for land ownership (Binney et al., 2014). Indigenous researchers argue that colonisation is not a time bound event. Instead, colonisation consists of a cumulative series of historic events and contemporary structures that serve to oppress Māori and disrupt Te Aō Māori across generations (Pihama et al., 2019). The concept of historical trauma is recognised as a framework for making sense of the mass collective trauma shared by indigenous people caused by repetitive colonial violence (Braveheart & DeBruyn, 1998). Braveheart (2003); an indigenous researcher who has made seminal contributions to this body of literature, describes historical trauma as, "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group

[55] New Zealander of European descent.

experiences" (p. 7). Historical trauma offers a rationale for current disparities faced by indigenous people who through colonisation have suffered disease, mass violence, loss of land, systematic destruction of identity, imposition of colonial gender norms and ideologies, as well as political and cultural marginalisation (Evans-Campbell, 2008; K. Walters et al., 2011). Duran and Duran (1995) likened the experience of colonisation as a 'soul wound' for indigenous people.

Some have argued that intergenerational trauma is a more accurate term to describe the cumulative negative impact of colonial violence transmitted across generations and the continuous (as opposed to historic) looping relationship between political/structural violence and individual experiences (Kirmayer et al., 2014). Kaupapa Māori[56] researchers Wirihana and Smith (2019) describe the impact of historical or intergenerational trauma for Māori as having, "a massive impact on Māori well-being across multiple generations. It began with the loss of entire communities during the land wars and was maintained by the incapacitation of social, cultural, and economic autonomy through land loss and psycho-social domination" (p. 201). From a Te Aō Māori perspective, colonisation can be likened to a patu ngākau[57] which can be loosely translated to mean a strike or assault to the heart or emotional core of a person, causing deep psychological shock (T. Smith, 2019). This patu ngākau disrupted the imparting of protective tikanga, which formerly maintained the wellbeing of whānau, hapū, and iwi (Fitzmaurice, 2020). Ultimately, these disruptions have infringed upon the tapu of Māori as a people causing intergenerational experiences of ngākau mamae[58], or transmission of deep psychological pain stemming from the initial 'patu' (or strike) and other negative emotional states (T. Smith, 2019).

The Treaty of Waitangi and legislative oppression. Arguably, the Treaty of Waitangi represents the ultimate paradox of colonisation in Aotearoa; it sought to protect Māori rights in the wake of mass migration but ultimately, furthered colonial agendas of domination and suppression (R. Walker, 2004). The Treaty of Waitangi is an agreement between the British Crown and about 540 Māori rangatira[59], signed on February 6 1840, which was intended to initiate establishment of a legal institution particularly for managing the growing British settler population and to protect the rights of Māori as tāngata whenua[60]. Since

[56] A Māori approach, Māori service or organisation.
[57] To strike or assault to the heart or emotional core of a person, causing deep psychological shock.
[58] Transmission of deep psychological pain.
[59] Chief, leader.
[60] Local people, hosts, indigenous people born of the whenua i.e., of the placenta and of the land where their ancestors lived.

its inception, the Treaty of Waitangi has sparked debate and controversy due to significant differences between English and Te Reo Māori[61] versions of its three stipulated articles. Significantly, the Te Reo Māori version of Article One of The Treaty stipulates that Māori agree to offer kawanatanga[62] of New Zealand to the British Crown. Māori believed this would help to bring order amongst the growing settler population. However, the English version translates to the cessation of sovereignty of New Zealand to the British Crown pervading to hapū, iwi and rangatira (R. Walker, 2004). This enabled legislation to be established that progressively undermined the rights of Māori across all areas of life (Wirihana & Smith, 2019).

The expanding settler population required land and resources to build new townships. The New Zealand Settlements Act 1863 enabled Māori land to be confiscated when it was determined by the Crown that an iwi or a large number of iwi members had acted in rebellion against the Queen. Following confiscation, land was occupied by Pākehā. Māori who were not deemed 'rebels' could make claims for the return of some land through the Compensation Court. The New Zealand Settlements Act led to thousands of acres of land falling into the ownership of Pākehā (Durie, 2005). The Native Lands Act 1862/1865 instigated the development of the Native Land Court, which investigated titles to land owned by Māori. The court was established for Māori to prove their legal ownership over ancestral land before 'rightful' owners could be issued certificates of title. This process enabled Māori to override exclusive selling rights to the Crown stipulated under the Treaty of Waitangi and sell land to settlers (D. V. Williams, 1999). This system functioned under the guise that Māori had greater opportunity to retain agency if they could partake in the selling of their land. Ultimately however, the Native Land Court undermined Māori beliefs that entire iwi and hapū belonged to whenua as only ten people were able to claim legal ownership over a piece of land. A westernised style of ownership sought to destabilise Māori communities (Hill, 2012). Coupled with the Land Wars (R. Walker, 2004), this legislation contributed to catastrophic land loss for Māori. From the early 20th century, Māori land ownership in the North Island had fallen to about 9% and almost the entire South Island was owned by the crown (Orange, 2004).

Legislation was also enacted as a means of gradually undermining Māori knowledge and belief systems. The Native Schools Act 1867 led to the establishment of a nation-wide, state-controlled system of primary schools for Māori children. Some Māori communities initially

[61] Māori language.
[62] Governance.

welcomed the opportunity for their children to obtain a formal education that better equipped them for navigating the Pākehā world. Although, at their conception most hapū maintained a strong sense of Māori identity, tikanga Māori, and proficiency in Te Reo Māori. Arguably, the primary aim of these schools was to advance Māori assimilation into Pākehā culture and this was achieved by forbidding any use of Te Reo Māori in the classroom (Ngaamo, 2019; Spolsky, 2003). Strikingly, the Waitangi Tribunal reported that although 95% of Māori were fluent speakers of Te Reo Māori in 1905, only 5% could speak the language by 1981. The Native Schools Act 1867 was a significant contributor to this decline (Waitangi Tribunal, 1986). The contemporary schooling system in Aotearoa has continued to perpetuate assimilation and the compromising of Māori identity through the privileging of western models of education (Ngaamo, 2019).

During the early 1890s the government raised concerns about the legitimacy of Tohunga. It was believed by Pākeha that Tohunga were ill equipped to support the health and wellbeing of Māori. The Tohunga Suppression Act 1907 was passed which outlawed the practice of Tohunga across the country (Voyce, 1989). The Act initially had limited effect on Māori communities' engagement with Tohunga as many resumed their practice in secret. Although over time, it contributed to the gradual erosion of traditional mātauranga Māori, medicinal knowledge, healing practices, and engagement with wairua across many Māori communities (Robinson, 2005; Woodard, 2014). Indeed, Durie (1998) argues that out of all the policies designed to assimilate Māori, the Tohunga Suppression Act 1907 did the greatest harm to Māori wellbeing.

Urbanisation and Māori identity in Tāmaki Makaurau. Until the first half of the 20th century the majority of Māori lived in rural areas of Aotearoa on ancestral land (Metge, 1964). However, financial impacts of the Great Depression and World War Two permeated through Aotearoa's rural economy causing rising unemployment and lowered standards of living within Māori communities. The mid-20th century saw large numbers of Māori moving to urban settings, like Tāmaki Makaurau and Te Whanganui a Tara[63], in the search of greater employment prospects and opportunity (Hill, 2012; Metge, 1964). A large proportion of this population obtained labouring jobs in the primary industries where there was high demand at the time. However, this sector was heavily hit by the economic crash of the 1980s meaning that large numbers of labourers, of whom many were Māori, lost their jobs. The economic and social disadvantage that arose for many whānau throughout this period was perpetuated by a

[63] Wellington region.

loss of connection to whenua, hapū, and iwi as well as limited access to cultural institutions that could buffer stressors and help to foster a secure cultural identity (Kingi, 2005; John Reid et al., 2014).

Today, Tāmaki Makaurau is home to the largest population of Māori in Aotearoa. Just over a third of this population reside in the Counties Manukau area (StatsNZ, 2020). Counties Manukau covers the southern region of the Auckland council territorial authority, which includes Manukau City, Papakura district, and Franklin district. Te Kupenga, a nation-wide study exploring cultural, economic, and social wellbeing for Māori found that, of those participants from Counties Manukau, many reported feelings of connection to Te Aō Māori. This included engagement with marae and tikanga, learning or speaking Te Reo, exploring whakapapa, involvement in kapa haka[64], and traditional arts (StatsNZ, 2016). However, this cultural nourishment is at odds with the high rates of social deprivation in the Counties Manukau region, particularly for Māori. The 2013 census found that 58% of all Māori, compared to 17% of Pākehā, in Counties Manukau were living in the most socio-economically deprived areas relative to the national average (StatsNZ, 2013).

The current Māori population in Tāmaki Makaurau constitutes a diverse mixture of whakapapa (Gagne, 2013). Being an area that is rich with pre-colonial Māori and iwi history (N. Mahuika, 2009), some Māori living in Tāmaki Makaurau may be identified as mana whenua[65], or those who whakapapa to hapū and iwi that have always occupied the area and thus, hold authority over the land (Auckland City Council, 2016). Many other Māori living in Tāmaki Makaurau may be identified as mātāwaka[66], or those who reside in the area but whakapapa to other parts of the country. Within this population, some may actively maintain their connections and responsibilities to hapū and iwi whereas others may not, but still identify as Māori. These two groups may be distinguished by the respective terms: taura here[67] and taunga hou[68] (Ryks et al., 2016).

In a study about Māori experiences of disconnection and reconnection to whānau, hapū, and iwi, Gilchrist (2017) found that loss of whānau, hapū, and iwi relationships often coincided with feelings of alienation and a longing for whakapapa. Further, the experience of

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[64] Māori cultural group, Māori performing group.
[65] Those who whakapapa to hapū and iwi of an area and hold authority over the land.
[66] Māori who reside in an area but whakapapa to hapū and iwi of another region.
[67] Mātāwaka who actively maintain connections and responsibilities to their hapū and iwi.
[68] Mātāwaka who identify as Māori but who do not actively maintain connections and responsibilities to their hapū and iwi.

disconnection was typically associated with other facets of cultural loss such as knowledge of Te Reo, loss of ability to fulfil traditional roles and pass mātauranga and tikanga Māori on to the next generation. These losses were experienced dually as markers of disconnection as well as barriers to the process of reconnection. Further, experiences of cultural disconnection and the impact this has on Māori identity overlaps with broad social contexts and generational shifts. Houkamau (2006) explored how wāhine Māori[69], residing in Tāmaki Makaurau, construed their identity and found that there were differences across generations. Participants born prior to mass urbanisation were more likely to have been exposed to tikanga Māori and Māori role models during their formative years, which was found to correlate with a positive Māori identity, even for those living outside of hapū and iwi territories. In contrast, the younger generation of participants (aged 35–49) tended to express more uncertainty and tension about their Māori identity and many attributed this to early exposure to racism and discrimination towards Māori. Interestingly however, a third generation (aged 18–35) who were born after/during the 'Māori Renaissance,' were more likely to report cultural pride about being Māori.

Research has highlighted that wellbeing for Māori correlates with having a secure cultural identity, which, in the literature, typically includes maintenance of connections to whenua, marae, hapū, and iwi (Durie, 1997; Edwards, 2009; Sterling & Tan, 2020). On the other hand, existing research also indicates that Māori living in urban areas actively employ a range of methods for affirming and exploring their Māori identity. Examples of these include, participation in whānau wānanga[70] (Maihi, 2016), use of social media to connect with whānau (Sciascia, 2016), engagement with urban marae and Māori community spaces (Gagne, 2013), participation in kapa haka (Papesch, 2015), participation in kura kaupapa schools[71] (G. Cooper et al., 2004), connecting with other Māori in group contexts (i.e., urban Māori organisations, Māori sports groups, churches), and through working in settings that contribute positively to Māori communities (Houkamau, 2006).

Further, it is possible that some Māori will consciously identify with the urban environment in which they reside whilst maintaining their 'Māoriness.' For example, Borell (2005) found that rangatahi[72] Māori living in urban South Auckland tended to identify more with the area they lived in (i.e., 'Southside,' 'Rewa hard,' 'Mangere represent') whilst maintaining a

[69] Māori women.
[70] To meet, discuss, deliberate and consider, collaborative learning.
[71] Māori language immersion schools.
[72] Youth.

positive sense of Māori identity. Many of the rangatahi in this study felt security, connection, and belonging to the South Auckland community in a manner that could be likened to the traditional relationship between tribal territories and tūrangawaewae. Similarities can be drawn between these ideas and McIntosh's (2005) notion of 'fluid' Māori identity that diverges from what she coins 'traditional' Māori identity rooted in tikanga. She describes 'fluid' Māori identity as "the fusing of different ideas and practices from a diversity of cultural backgrounds to articulate a Māori identity that is strongly grounded in its particular social landscape," (p. 46) and thus, can be a way of finding meaning and cultural anchors within difficult social contexts. McIntosh (2005) also refers to a third, 'forced' Māori identity that will be described in the proceeding section on internalised racism.

Impact of racism. Māori identity is influenced by social, political, and economic systems that play an insidious role in accentuating the negative positionality of Māori within society (Mikaere, 2005; John Reid et al., 2014). Colonial structures and dominant discourse continues to position Māori, like other indigenous groups that have experienced colonisation, as 'lesser' and 'other' thus, perpetuating a normative culture that enables racism (Kauanui, 2016). Borell et al. (2018) argue that the normalising of Pākehā culture and cultural narratives reinforcing Pākehā accomplishment contributes to the transmission of intergenerational 'historical privilege' that functions inversely to historical trauma, which again, enables racist attitudes and behaviours towards Māori within society. Analysis of findings from Te Kupenga 2013, the first nationally representative Māori social survey, found that Māori frequently reported experiences of racism as well as other forms of discrimination (i.e., age, gender, income) within 12-months of the survey and over the lifespan, across a range of settings but particularly in educational institutions and the workplace. Those who reported being socially assigned as Māori were significantly more likely to experience racial discrimination than those who were not (Cormack et al., 2020).

Racism exists at multiple levels within society. Researchers have suggested that racism can be delineated into four overlapping categories, them being, societal, institutional, interpersonal, or internalised (Paradies et al., 2008; Tinirau et al., 2020). Barnes et al. (2013) found, in a qualitative study on Māori experiences of racism, that participant accounts appeared to align with these broad constructs. Participants felt that the mainstream media in particular contributed to societal racism towards Māori by 'agenda setting.' That is, silencing coverage that could advance Māori history, worldviews, and achievements and instead, producing stories that reinforce constructs of Māori as dangerous, criminal, and incapable. Participants

believed that the way Māori were perceived by society shaped their own experiences of interpersonal racism. Most participants described being forced to endure daily incidents of name-calling, looks of suspicion, and unwarranted surveillance in shops for example. Participants described how these experiences negatively affected their wellbeing and contributed to feelings of exclusion, anger, anxiety, and resignation.

Racism can also operate at an institutional level. Came-Friar et al. (2019) define institutional racism as, "a pattern of differential access to material resources, cultural capital, social legitimation and political power that disadvantages one group while advantaging another" (p. 62). Institutional racism tends to be surreptitious in that discriminatory practices and policies are embedded within organisational structures contributing to the maintenance of cultural dominance, even when those working within these systems have the best intentions (R. Harris et al., 2006). Literature suggests that institutional racism towards Māori pervades across many areas of life and contributes to current inequities across health (Came-Friar et al., 2019), mental health (New Zealand Government, 2018), correctional (Waitangi Tribunal, 2017), housing (Houkamau & Sibley, 2015) and educational domains (J. Reid, 2006). For example, Māori submissions to the Mental Health and Addiction Inquiry highlighted that two key barriers to the successful provision of Whānau Ora, a nation-wide Māori driven health and wellbeing initiative, were poor government commitment to resourcing and current systems and policies constraining development of Whānau Ora programmes (New Zealand Government, 2018). Further, Boulton (2005) found, in their study exploring the mental health contracting experience of Māori providers, that participants frequently delivered services outside of their specific funding contracts to meet the needs of Māori whānau accessing services, albeit extra-contractual efforts often went unrecognised by funders. Further, barriers to accessing the scarcity of Māori providers, means that Māori whānau may be forced to access mainstream services. Bryers-Brown (2015) who explored understandings of historical trauma with Māori in their own community, found that government agencies (i.e., Work and Income Services, Child Protection Services, Healthcare) were experienced by participants' as key sites of re-traumatisation. Being Pākehā dominated, these sites were experienced by participants as a physical representation of power still held by the crown in Aotearoa.

At an individual level, literature has highlighted the adverse impact that experiences of racism can have on physical health, health risk (e.g., smoking, hazardous drinking, obesity) and mental health (Awofeso, 2011; Paradies et al., 2015; D. R. Williams et al., 2019). Numerous research has highlighted this link within Māori populations specifically (Cormack et al., 2020;

Crengle et al., 2012; R. Harris et al., 2012; R. Harris et al., 2006; Talamaivao et al., 2020; Winter et al., 2019). Houkamau et al. (2017) also found, in their analysis of findings from the New Zealand Attitudes and Values Study, that experiences of racism for Māori significantly predicted poorer ratings across a broad range of life domains. These included subjective healthcare access, job satisfaction and security, satisfaction with standard of living and future security, self-esteem, satisfaction in relationships, and overall satisfaction with life.

Impact of internalised racism. Internalised racism refers to a process in which negative stereotypes, beliefs, and attitudes about a racial group that are received from societal and environmental contexts become absorbed and accepted as reality by members of this group. Examples of this could include believing that one's racial group, and therefore oneself is inherently inferior, flawed, or less intelligent compared to other racial groups (Paradies et al., 2008; Tinirau et al., 2020). In some cases, internalised racism may contribute to a desire to create distance from one's racial group and assimilate to dominant beliefs, values, and appearances (David et al., 2019). A recent systematic review of the psychological literature on internalised racism highlights that existing research clearly points to the relationship between experiences of this phenomenon and poor mental health. This includes self-esteem, life satisfaction, levels of hopelessness and stress as well as in relation to specific psychological disorders such as depression, anxiety, and body dissatisfaction. Further, internalised racism may insidiously contribute to the incorporation of negative stereotypes into cultural values (i.e., 'that's just how we are') resulting in the normalizing of oppressive beliefs that are subsequently transmitted across generations (David et al., 2019).

Overall, there is a dearth of literature on the experience and impact of internalised racism for Māori. As described in the preceding section, Barnes et al. (2013) produced a qualitative study exploring Māori experiences of racism of which findings included internalised racism. In this study, a key indicator of internalised racism were personal feelings of shame about being Māori. This was sometimes associated with participants and/or whānau members choosing to reject or suppress their identity, including through statements such as, 'I'm a Māori but really I'm a Pākehā.' In some recounts, this was context specific and in others, this was seen to be a more pervasive embodiment of the devaluing of Māori culture. Internalised racism was mostly described as being shaped by negative stereotypes fed by the media but in some cases, whānau members played a role in reinforcing a narrative about Māori culture as being shameful or inferior to a Pākehā ideal (Barnes et al., 2013). Te Hiwi (2008) interviewed Māori on their experiences of racism and identity construal. She found that some participants had internalised

a sense of being ‘other’ in relation to Pākehā culture. This belief was viewed by some as an intergenerational wound stemming from assimilative policies affecting parents or grandparents. Paradoxically, some recounted growing up in environments where, to protect them from discrimination, their parents had favoured Pākehā culture, although later in life this often resulted in a perceived sense of not belonging to either the Pākehā or Māori world. For some, this instilled an active desire to resist these narratives and re-connect with Te Aō Māori to reduce experiences of internalised racism for their tamariki[73]. Finally, although McIntosh (2005) does not explicitly refer to internalised racism, she similarly discusses the concept of a ‘forced’ Māori identity whereby the oppressive stereotypes that are forced upon Māori become internalised. She describes how Māori experiencing deprivation may be most at risk of developing a forced identity due to the intersecting realities of oppression that many whānau have to navigate such as unemployment, illness, mental health issues, incarceration, and poverty.

In summary a range of historical, political and social factors have contributed to the disturbing array of disparities faced by Māori. The process of colonisation, which is often looked upon as an historical event, is arguably an active event as evidenced by cumulative, intergenerational trauma experienced by whānau in conjunction with existing colonial structures that enable racism, in all its forms, to be normalised in this country. Given this, it could be argued that mental health service provision in Aotearoa is of particular relevance to Māori, especially in relation to how interventions and responses to Māori mental health challenges can best meet the needs of whānau, address socio-political injustices, and encompass a Te Aō Māori worldview.

Māori mental health

Mental health services in Aotearoa are spaces where the cumulative effects of the historical, political, and social factors described above can be observed as a manifestation of psychological distress for Māori accessing support. Over the last forty years, mental health services have also functioned as sites of structural transformation towards realisation of indigenous aspirations, with Māori leadership pushing for increased recognition and utilisation of mātauranga Māori informed care to better meet the needs of Māori tāngata whaiora and their whānau (Durie, 2011). This section will discuss these areas in further detail.

[73] Children.

Māori mental health needs. In 1998 the Mental Health Commission declared that "mental illness is now the number one health concern for Māori" (Mental Health Commission, 1998, p. vii) and current trends continue to support this argument. Te Rau Hinengaro, The New Zealand Mental Health Survey, revealed that Māori experience a higher incidence of mental health problems throughout their lifespan relative to non-Māori (Baxter et al., 2006). Higher prevalence rates of depression, anxiety, substance use, and schizophrenia have been reported for Māori as compared to Pākehā (Bushnell, 2005; Tapsell et al., 2018; Tapsell & Mellsop, 2007). A 2013 study on the prevalence of suicide and self-harm found that significantly higher numbers of Māori completed suicide relative to the general population, with tāne[74] and rangatahi being most at risk. The study also reported that the rate of hospitalisations from intentional self-harm for Māori was 15% higher than the rate for non-Māori (Ministry of Health, 2016). Despite the high prevalence of mental health challenges amongst Māori, Māori are more likely to be undiagnosed and experience barriers to accessing secondary mental health services (Baxter et al., 2006; R. Cunningham et al., 2018). When Māori do access care, they are more likely to present in crisis, experience mandatory admission (Baxter, 2008; R. Cunningham et al., 2018), or be referred through the social welfare or justice system (Kingi, 2005).

Additionally, literature indicates that stigma and discrimination contribute to delayed treatment seeking for Māori (Te Pou o Te Whakaaro Nui, 2010a; C. Thornicroft et al., 2014). One study exploring New Zealand mental health consumers' experiences of discrimination found that Māori respondents experienced discrimination for having mental health challenges across many areas of life, including from health services, from people in the community, or when looking for employment. However, they were most likely to report experiences of discrimination from whānau and friends, and this was often attributed to a lack of understanding. Misguided attempts at taking a 'tough love' approach were also experienced by some Māori respondents as discriminatory. Additionally, for many of the Māori respondents, fears of being discriminated against caused just as much distress as reported experiences of discrimination (Peterson et al., 2004). Research indicates that Māori experiencing mental health challenges may be faced with intersecting forms of discrimination, notably racial discrimination (Cormack et al., 2020). Further, psychological distress caused by experiences of discrimination may be compounded by self-stigma, that is, internalising negative self-beliefs (e.g., feeling different, feeling wrong or bad, unable to change, less

[74] Male, man.

worthy compared to others) about having mental health challenges (Clement et al., 2015; Peterson & Barnes, 2009).

Māori responses to mental health needs. In response to the rising prevalence of mental health challenges amongst the Māori population, there has been a push for recognition of Māori needs within the mental health system and increasing the autonomy of Māori to support Māori (Bennett, 2018; Bennett & Liu, 2018). This movement has aligned with broader societal shifts taking place over the last forty years in relation to greater acknowledgement of the Treaty of Waitangi principles across societal institutions, including within mental health contexts (Durie, 2011). The last few decades have seen the establishment of Kaupapa Māori services across the country that provide mental health support by Māori, with Māori, and for the benefit of Māori communities (Wratten-Stone, 2016). Kaupapa Māori mental health services are an indigenous response to addressing inequity of care for Māori in mental health contexts (Te Rau Matatini, 2015). One of the defining characteristics of Kaupapa Māori mental health services is that they are self-determined by Māori and place Te Aō Māori at the centre of service provision (Bennett, 2018; Te Rau Matatini, 2015). In this manner, Kaupapa Māori services seek to uphold the spirit of tino rangatiratanga[75] (Ngā Kaitiaki Mauri, 2018).

The Ministry of Health (2017) defines Kaupapa Māori specialist mental health and addiction services as:

> Services that have been specifically developed and are delivered by providers who identify as Māori. Providers of these services may be within a District Health Board (DHB) Provider Arm, a community or iwi organisation, and may be accountable to local whānau, hapū, iwi, Māori communities and within a DHB. (p. 2)

Although Kaupapa Māori specialist mental health and addiction services may still provide assessment and intervention informed by western models of care, they can be distinguished from mainstream services via a number of key characteristics (Ministry of Health, 2017). In particular, service aims for Kaupapa Māori specialist mental health and addiction services are consistent with broad aspirations of Māori development. Other characteristics include maintenance of connections with local hapū, iwi, and Māori community organisations, incorporation of mātauranga and tikanga Māori into all levels of service provision, higher

[75] Self-determination, sovereignty, autonomy, self-government, domination, rule, control, power.

numbers of Māori staff, access to support from kaumātua, emphasis on whanaungatanga, and utilisation of holistic Māori models of care.

It should be noted that Kaupapa Māori specialist mental health and addiction services are not the only Māori led initiative contributing to improved mental health outcomes for Māori. For example, Whānau Ora a whānau oriented, holistic, and strengths based government initiative, has proven to improve whānau wellbeing for Māori in particular (Boulton & Gifford, 2014; Robertson et al., 2013; V. Smith et al., 2019). The Ministry of Social Development and former Māori Party Co-Leader Dame Tariana Turia established the Whānau Ora initiative in 2010 as a means of addressing health and social inequity within Māori communities. The primary focus of Whānau Ora is to support whānau to achieve their collective goals and aspirations. As such, clients are supported within the context of their whānau instead of on the basis of individual need. Community organisations can apply to be Whānau Ora providers. Success of the Whānau Ora initiative can be measured via achievement of seven core outcomes for whānau as conceptualised by the Taskforce in 2009. These are: to be self-managing, to live healthy lifestyles, to participate fully in society, to confidently participate in Te Aō Māori, to be economically secure, to be cohesive, resilient and nurturing, and be responsible stewards of their lived and natural environment. These outcomes may be achieved in a manner that is tailored to the unique needs of each whānau, meaning that support and intervention is pulled from a variety of resources within the community (Whānau Ora Taskforce, 2009).

Māori models of mental health and wellbeing. Since the 1980s numerous models of wellbeing informed by mātauranga Māori beliefs, values, and practices have been developed (Durie, 1998). Although each model is unique in its own right, some underlying similarities embed these approaches within Te Aō Māori. Te Aō Māori informed models of mental health enable us to 'decolonise' the way we understand and respond to emotional distress. Unlike western frameworks of mental health, such as the medical model and the DSM-5, that tend to favour compartmentalisation and symptomisation of psychological distress (Lafrance & McKenzie-Mohr, 2013), a theme of synthesis across holistic domains of wellbeing runs through Māori mental health models (Durie, 2001). This approach aligns with indigenous conceptualisations of health as a holistic construct consisting of interconnected and interdependent emotional, physical, social, spiritual, and environmental domains (NiaNia et al., 2016).

For example, Te Whare Tapa Whā[76] depicts wellbeing as four walls that make up the core frame of a house them being, taha hinengaro[77], taha tinana[78], taha whānau[79], and taha wairua[80]. In order for the house to stand strong, each of the four walls must be equally balanced and so, all domains of wellbeing must be equally valued and nurtured (Durie, 1998). In addition to the four domains described above, Te Whetu[81], incorporates positive connection to land as being one of five wellbeing domains that, together, make up the points of a star: mind, body, spirit, family, and land (Mark & Lyons, 2010). Another model, Te Pae Māhutonga[82] uses the points of the Southern Cross to represent the key tasks of efficacious health promotion for Māori them being: mauri ora[83], te oranga[84], waiora[85], toi ora[86]. Two additional 'pointers' to success include ngā manukura[87] and te manuwhakahaere[88] (Durie, 1999). Te Wheke[89] visualizes whānau health as an octopus with its head representing whānau, its eyes representing waiora, and its intertwined tentacles representing eight interconnected domains of health; hinengaro, tinana, wairua, whāngaungatanga, mauri, mana ake[90], hā koro ma a kui ma[91], and whatumanawa[92] (R. Pere, 1988).

The Meihana Model of assessment and intervention extends beyond the specific needs of the client and explores how broad systemic factors can hinder or facilitate wellbeing. This model asks clinicians to consider whether the services they operate within have systems in place to protect and legitimise mātauranga Māori, and if not, what impact may this have on tāngata whaiora. Further, the model asks clinicians to reflect on their own cultural competency when working with Māori. Through the lens of this model, engaging with clients involves ongoing consideration of their hinengaro, tinana, whānau, wairua, taiao[93], and iwi katoa[94] (Pitama et al., 2007). The final point explicitly highlights how external factors, beyond the control of

[76] Four walls of the whare or house, model of wellbeing.
[77] Emotional wellbeing.
[78] Physical wellbeing.
[79] Family wellbeing.
[80] Spiritual wellbeing.
[81] The Star, model of wellbeing.
[82] Southern Cross, model of Māori health promotion.
[83] In this context, Mauri Ora refers to cultural identity.
[84] Participation in society.
[85] Total wellbeing.
[86] Healthy lifestyles.
[87] Community leadership.
[88] Autonomy.
[89] The Octopus, model of wellbeing.
[90] Unique identity.
[91] Breath of life from ancestors.
[92] Healthy expression of emotion.
[93] External physical environment, natural world.
[94] Social discourse and service-level factors that affect client wellbeing.

clients, may contribute to development of poor mental health. The latter is often overlooked in western models of mental health in favour of internally located distress (Lafrance & McKenzie-Mohr, 2013).

The association between positive wellbeing and nurturing of outward connections (e.g., people, land, and cultural identity) is typically emphasised alongside individualised distress within Te Aō Māori informed assessment and intervention tools. For example, the Paiheretia[95] model of counselling intervention assumes that poor mental health for Māori is correlated with an insecure cultural identity, lack of positive relationships, and lack of access to cultural institutions. In this manner, a therapist using this approach must help clients to strengthen and have better access to these three life areas. The model takes a holistic approach, meaning that areas of accessibility and disconnect should be conceptualised across hinengaro, tinana, whānau, and wairua domains wherever possible (Durie, 2001). Finally, both Mahi a Atua[96] and the Pōwhiri Poutama[97] therapeutic approaches explicitly use mātauranga Māori knowledge to strengthen client cultural identity as Māori and thus, improve (Drury, 2007; Rangihuna et al., 2018). Mahi a Atua utilises a wānanga style of engagement with clients, their whānau, clinicians and other relevant kaimahi to kōrero on how the client's presenting problems relate to traditional pūrākau. Mahi a Atua utilises pūrākau not only as tools for building understanding but also as teachings that may point towards possible solutions or ways forward (Rangihuna et al., 2018). The Pōwhiri Poutama approach uses tikanga associated with pōwhiri[98]as a set of broad guidelines for conducting therapy; mihi whakatau[99], karakia, whakapuaki[100], whakatangi[101], whakarata[102], whakaora[103], and whakaotinga[104] (Drury, 2007).

Overall, there is evidence to suggest that use of mātauranga Māori informed models of mental health and wellbeing correlate with greater engagement as well as meaningful, efficacious intervention for Māori tāngata whaiora (Levy, 2016).

Māori voices in mental health services. Mental health service users are often positioned as a marginalised group in society and traditionally this has extended to research,

[95] Māori model of counselling.
[96] Māori model of counselling.
[97] Māori model of counselling.
[98] Ceremonial welcoming process, rituals of encounter.
[99] Speech of greeting, establishing a relationship.
[100] Mutual revealing of stories.
[101] Emotional shift.
[102] Physical contact.
[103] Restoring wholeness, healing.
[104] New way of being, transformation.

where their voices have been undervalued and underrepresented (G. Thornicroft & Tansella, 2005). However, there is a growing body of qualitative research on service user perspectives about mental health and experiences of mental health services. This body of literature has proven to offer rich insights and valuable contributions that can help to improve mental health service provision (Newman et al., 2015). Notably, insights drawn from mental health service users have challenged principles underpinning the medical model by highlighting the significance of social, contextual, and holistic factors in both conceptualising and responding to poor mental health (Lilja & Hellzén, 2008).

Qualitative research that uplifts Māori voices in mental health contexts may be deemed particularly important given the history of institutional racism within mental health service provision in Aotearoa that has arguably silenced Māori understandings of mental health needs, and priorities, contributing to further inequity of care (Haitana et al., 2020). Although there is only a small body of literature on Māori tāngata whaiora perspectives into mental health and mental health services, some valuable insights can be gained from this research.

For example, literature indicates that Māori tāngata whaiora may appreciate it when practitioners take the time to get to know them and appear genuinely interested in building a relationship (Awatere-Walker, 2015; Cram et al., 2003; Eade, 2007; Johnson, 2009; Pomare, 2015; Tricklebank, 2017). Some research elaborates that tāngata whaiora may particularly appreciate it when practitioners connect in ways that feels like a whānau relationship (Graham & Masters-Awatere, 2020; Pomare, 2015; Tricklebank, 2017). Further, literature suggests that Māori tāngata whaiora may value practitioners who are open to sharing power (Awatere-Walker, 2015; Cram et al., 2003; Eade, 2007) and that power imbalances may be reduced through incorporation of tikanga practices like karakia, whakawhanaungatanga[105], sharing of kai, and waiata[106] (Eade, 2014; Johnson, 2009; Pomare, 2015).

Literature also indicates that Māori tāngata whaiora describe benefiting from holistic care which includes giving space for wairua and accessibility to traditional healing methods (Hughes, 2007; Lapsley et al., 2002; Pitama et al., 2007; Tricklebank, 2017; Wharewera-Mika, 2012). Further, Māori tāngata whaiora want to feel safe to talk about their cultural beliefs (P. Harris, 2014; Johnson, 2009) and Te Aō Māori perspectives that diverge from the medical model for example, being matakite[107] (Ngata, 2014; Taitimu et al., 2018). Literature also

[105] Process of establishing relationships, maintaining links, relating well to others.
[106] Song, chant.
[107] To see into the future, supernatural insight, special intuition.

indicates that Māori tāngata whaiora appreciate working with Māori staff (Eade, 2014; Lapsley et al., 2002; Pomare, 2015) and Kaupapa Māori services that are inclusive and offer effortless understanding of their experiences (P. Harris, 2014; Lapsley et al., 2002; Pomare, 2015).

Qualitative research highlighting the voices of Māori tāngata whaiora has also offered pertinent information about potential barriers to seeking help. These include mistrust of services (Tricklebank, 2017), mental health stigma (Eade, 2007, 2014; P. Harris, 2014; Johnson, 2009; Lapsley et al., 2002; Taitimu et al., 2018), feeling inferior to professionals especially when lots of technical jargon is used (Eade, 2007, 2014; Graham & Masters-Awatere, 2020) and feeling culturally unsafe (Lapsley et al., 2002; Palmer et al., 2019; Taitimu et al., 2018). Practical barriers have also been reported by tāngata whaiora such as cost (Palmer et al., 2019) and challenges to building consistent relationships with practitioners due to high staff turnover (Graham & Masters-Awatere, 2020; Moeke-Maxwell et al., 2008; Wharewera-Mika, 2012).

It can also be useful to gather insights from Māori mental health clinicians to explore how they work effectively with Māori tāngata whaiora despite the constraints and limitations imposed by western models of care (Baker, 2008; Elder, 2008). Indeed a small body of qualitative research on Māori clinicians' experiences working in mental health services is helping to challenge dominant discourse. Notably, this body of literature indicates that Māori mental health clinicians are faced with everyday tension to 'bridge' clinical and tikanga Māori (Baker, 2008; Elder, 2008; Love, 1999) and maintain dual accountability to Māori whānau and their communities whilst also adhering to expectations of their professional role (Elder, 2008; Wilson & Baker, 2012). Existing literature also indicates that Māori mental health clinicians strongly value their identity as Māori and recognise how their connection with Te Aō Māori enables them to build positive relationships with Māori tāngata whaiora and whānau (Love, 1999; Pomare, 2015; Staps et al., 2019). Further, Ihimaera (2004) found that Māori cultural and clinical workers conceptualised taha wairua as being an integral component of healing for Māori tāngata whaiora and their whānau. Use of tikanga processes (e.g., pōwhiri, karanga[108], karakia, whakawhanaungatanga, whakapapa), use of Te Reo Māori, and incorporation of Māori health models were perceived as useful in regards to making space for wairua in clinical practice.

[108] Ceremonial call, to summon.

In summary, this section has focused on literature in the area of Māori mental health. There is evidence to suggest that Māori continue to experience a high prevalence of mental health challenges with barriers to accessing appropriate treatment and intervention only heightening these issues. Although mental health services in Aotearoa continue to be dominated by western models of care, Māori led approaches to addressing mental health challenges and strengthening whānau wellbeing may be a pathway forward to mitigating mental health issues and inequity of care for Māori. The following section will focus exclusively on an area that may be of particular relevance to Māori mental health, that is, the concept of whakamā.

Whakamā and Māori mental health

Although much has been done in mental health contexts of Aotearoa to bring attention to Māori needs and priorities, research continues to play an important role in decolonising the way we conceptualise and respond to mental health challenges (Durie, 2001). This section will introduce the Te Aō Māori concept of whakamā, explore definitions of whakamā, consider the relevance of cross-cultural literature, and explore the place of whakamā within mental health contexts of Aotearoa based on the findings of existing, albeit limited, research.

What is whakamā? Whakamā is a word with no direct English equivalent although, when broken down it directly translates to mean 'whaka,' or to cause, and 'mā,' or to whiten/pale. T. Smith (2019) has described whakamā as being associated with "a sense of powerlessness and the exposure of this lack of power and status by an individual or group with more power" (p. 28). T. Smith (2019) highlights that experiences of whakamā typically have adverse effects on individuals, including onset of an ashen or pale appearance as the word describes. He attributes this to the unbalancing of the mauri caused by "the dispersal and dissipation of energy and light of the mauri from the internal system to the external world" (p. 28). By Māori, whakamā is commonly referred to and understood as a concept, (Metge, 1986) and the pūrākau shared in the Introduction Section of this thesis offers one example of how stories passed down through whānau, hapū, and iwi may help to convey the consequences and effects of whakamā. A well-known whakataukī[109], *'waiho mā te whakamā e patu,'* first expressed by powerful tohunga Te Tahinga-o-te-rā of the Ngāti Awa iwi in response to being abandoned by his people on Whakaari Island teaches us that whakamā itself may be considered adequate punishment for those who have committed an offence. This suggests that whakamā is typically associated with adverse and painful connotations.

[109] Proverb, saying, lesson.

In the early 1980s, anthropologist Metge (1986) conducted 109 qualitative interviews exploring Māori understandings of whakamā as a cultural concept. Participants in this study were aged from 15–74 and the sample incorporated a mixture of participants across rural and urban settings. These findings indicate that whakamā is a uniquely Māori conceptualisation of emotion and may resemble shyness, embarrassment, shame, inadequacy, or a multitude of such feelings at once. Whakamā may be identified in an individual through exhibition of withdrawal behaviours such as reduced eye contact, minimal communication, psychomotor slowness, and physical removal of oneself from a group or situation (Metge, 1986).

In a similar way to T. Smith (2019) who associates whakamā with a perceived lack of power, Metge (1986) argues that whakamā is caused by a perceived loss of mana in relation to others (Mead, 2003). Therefore, whakamā may be considered a painful but appropriate emotional and behavioural response to perceiving oneself incapable of asserting mana in a particular context. Metge (1986) offers four broad categories to distinguish common examples of whakamā that may derive from an individual's loss of mana in everyday life. These include perception of lowered status relative to others, experiencing confusion and uncertainty in settings where an appropriate behaviour or response is unclear, a personal breach of social, moral, or cultural convention, and being insulted or put down. Metge (1986) also notes that overt praise could potentially trigger whakamā in people especially when their mana is perceived as being unduly raised above others. Edwards (2009) offers some examples of potential causes of whakamā in Māori contexts such as being unable to host people adequately on the marae, inability to respond to dialogue (i.e., at a hui[110]), or being unable to recite whakapapa and establish shared linkages with others due to a lack of knowledge. Metge (1986) reports that in cross-cultural settings, feeling out of place and unsure about how to behave as well as being treated as lesser may contribute to experiences of whakamā for Māori. Although overall, potential causes of whakamā may be highly varied.

Metge (1986) also describes how whakamā is usually experienced as transitory and episodic. However, when a person's mana is severely threatened, deeper experiences of whakamā may arise. A contributor to her research provides a useful commentary on the interrelationship between mana and whakamā: "you have a certain place in society and anything that takes you off your base in cultural terms causes whakamā … if you are taken off your tūrangawaewae, you lose your mana" (p. 77). Tūrangawaewae relates to areas of life where we feel a sense of belonging, connection, identity, or empowerment (Panelli & Tipa, 2007). They go on to

[110] Meeting, gathering.

explain that upon losing mana, “there is always an attempt to restore the balance. If that is impossible then you withdraw (Metge, 1986, p. 77).” T. Smith (2019) conceptualises whakamā as being on a spectrum with varying degrees of effects and consequences. On one end, ‘ka patu i te whakamā’ refers to an immediate reaction in response to being ‘struck’ with whakamā caused by a particular context, whereas ‘ka mate i te whakamā’ refers to being ‘sick’ with whakamā which may be experienced as a more insidious reaction, experienced over time and perhaps across generations.

Sachdev (1990), a Pākehā psychiatrist, has also written a descriptive commentary on whakamā drawn from his observations of Māori clients, discussions with kaumatua, and literature. His findings have many similarities to the work of Metge (1986). Sachdev (1990) asserts that whakamā is of fundamentally social origin stemming from two primary causes: experiencing a perceived loss of honour (as opposed to mana) as seen through the eyes of others or experiencing feelings of inferiority, inadequacy, or uneasiness in uncertain social situations. Sachdev (1990) highlights the fact that manifestations of whakamā may include disruption of cognitive processes and normal activity, withdrawal, feelings of hurt, fear, or depression, and physical flight from others. He also reports that if entrenched whakamā is not restored, this could potentially lead to suicide. Indeed, other works have briefly alluded to the relationship between suicide and whakamā, which was traditionally mediated, in many cases, by a deep sense of having committed a significant and potentially irreversible transgression bringing harm to the collective wellbeing of the community (Edwards, 2009; Lawson-Te Aho, 1997; Ministry of Justice, 2001).

Banks (1996) conducted the only study that explicitly compares Māori and Pākehā patterns of emotional responses to whakamā-inducing situations. First, participants reviewed three vignettes designed to elicit experiences of whakamā. These were, (a) prominent lawyer caught embezzling money resulting in loss of professional status and distress to whānau, (b) parent of teenage daughter charged for prostitution and drug dealing, (c) being publically televised and praised for saving someone from drowning at the beach. Participants were then asked, using a 7-point Likert scale, to rate the intensity of nine emotions they might have experienced if placed in each hypothetical situation: shyness, embarrassment, uncertainty, inability to cope, fear, humiliation, depression, shame and anger. These emotions were selected based on being the most salient to whakamā (Metge, 1986).

Some significant, albeit tentative, differences were found. Primarily, Māori participants were significantly more likely to report feelings of shyness in relation to being caught embezzling

money. A number of limitations can be made about this study including its deductive approach. Compartmentalising emotions is a western way of measuring what is in fact a holistic and interconnected construct that may simultaneously encompass a broad range of feelings and behaviours (Metge, 1986; Sachdev, 1990). Further, no qualitative information was provided about why participants chose particular responses for each vignette. Incorporating this would have added deeper insight into the differences between Māori and Pākehā appraisal patterns.

Whakamā and cross-cultural literature. Although there is no exact equivalent for whakamā in other cultures (Metge, 1986; Sachdev, 1990), it could be argued that emotions associated with this phenomenon are part of what some theorists have identified as the 'shame family.' Such emotions have been grouped due to their similar underlying attributional basis: a perceived experience (or threat) of negative evaluation from others. Hence, like whakamā, the shame family of emotions are typically painful and arise within a social context (Gilbert, 1998; Stolorow, 2010).

A wide body of literature suggests that shame is a fundamentally interpersonal phenomenon shaped by the cultural lens through which we view the world (Gilbert, 1998; Mesquita et al., 2016; Mesquita & Karasawa, 2004; Shweder, 2003). Mesquita et al. (2016) argue that our emotions are a socially constructed experience that support us in aligning with cultural norms and reaching cultural goals. Thus, emotions that align with normative behaviour for a particular cultural group are likely to be reinforced through socialisation within that community. Indeed, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) highlights the utility of considering cultural context when formulating distress and also includes a section that outlines a range of culturally bound psychological concepts (American Psychiatric Association, 2013). Much of the existing research on shame draws upon western samples meaning that dominant discourse may be grounded in western ideas and practices that are not conducive to how all cultures construe and appraise this phenomenon (Shweder, 2003).

Dominant discourse asserts that shame refers to the deeply painful experience of failing to achieve some ideal or actual representation of who, what, or how we see ourselves to be, through the eyes of others (Gilbert, 1998). The work of Lewis (1979) compared differences between shame and guilt. According to Lewis (1979), guilt is typically felt after engaging in a particular behaviour that violates a social norm or moral standard that we are then driven to seek remediation for. By contrast, shame appears to be associated with negative judgements

towards the 'self' often in relation to our social standing. Thus, shame is not located in behaviour but rather, triggers beliefs that we *are*, for example, defective, inadequate, or dumb, relative to others. It has been argued that because shame relates to the 'self' it is harder to remediate and so instead, we have a tendency to engage in coping strategies to create distance from the emotional pain (Dearing & Tangney, 2011).

Cross-cultural researchers have demonstrated how the prevalence of shame and shame-related behaviours depends on whether cultural norms render it a condoned or condemned emotion (Fessler, 2004; Furukawa et al., 2012). A developing body of literature highlights that independent and interdependent cultures may conceptualise shame differently. Independent cultures (e.g., United States) tend to construe identity as fundamentally unique, distinct, and autonomous. An independent self is synonymous with values of achievement, individualism, and personal growth. Having personal flaws revealed goes against cultural norms, which may explain why dominant discourse construes shame as ubiquitous to psychological distress (Gilbert, 1998). In contrast, however, interdependent cultures typically consider identity to be defined by connection and responsibility to others. Therefore, personal characteristics like self-sacrifice, self-reflection, and self-criticism that facilitate group attunement have greater utility (Boiger et al., 2013; Mesquita & Karasawa, 2004). Research suggests that within an interdependent cultural context shame may be regarded as more of a constructive tool for reinforcing group norms and facilitating group cohesion (Boiger et al., 2013; Mesquita et al., 2016).

The aforementioned research demonstrates how the manner to which an individual experiences shame is informed by a complex interaction with their cultural and contextual world. Thus, a conclusive definition of shame does not necessarily offer much insight into how shame, its related emotions and behaviours are experienced. A universal definition of shame will inevitably lose some of the rich, idiosyncratic meaning behind the phenomenon for a particular culture.

Whakamā in mental health contexts. Although existing literature is sparse, it could be argued that whakamā as a concept has relevance to mental health contexts for Māori. For example, behavioural presentations of distress and specific causes for these may be associated with experiences of whakamā. Arguably, the experience itself of having mental health challenges, going to a mental health service, and interacting with health professionals may cause whakamā, especially if having mental health challenges is perceived as being associated

with a loss of mana. The latter may have implications for how Māori experience mental health challenges and interact with mental health services.

Sachdev (1990) provides three brief case studies that demonstrate how whakamā may present in clinical settings. Notably, each of the clients in these case studies exhibited withdrawal behaviours, a significant reduction in activity, and impaired communication. The first two examples of whakamā appear to have arisen out of a perceived loss of mana in the context of having disappointed whānau (failing an exam, and vandalizing a store) and one example of whakamā was attributed to feeling unfamiliar and uncomfortable in an impersonal and 'business-like' Pākehā hospital setting. Sachdev (1990) highlights that as whakamā typically arises within a social context, shifting out of this space requires interpersonal intervention. For each of these cases, remission of whakamā firstly involved a knowledgeable Māori clinician or whānau member identifying whakamā for what it was. For the first two cases, whakamā was recognised as a valid response and the affected individuals were given time to experience whakamā in response to their actions as opposed to being pressured to engage in interactions. Following which, they were welcomed back into normal activities and interactions with aroha and acceptance. It was also named that some people may need 'building up' to support them in shifting out of spaces of whakamā once time has passed. For the third case, it was recognised that active intervention was required from the clinical team to support the client in feeling more comfortable within the hospital environment. Sachdev (1990) warns that clinicians without knowledge of whakamā are at risk of misdiagnosing Māori clients as having mental health problems, like depression.

A number of different qualitative studies on Māori experiences of mental health services have referred to the impacts of whakamā. Some of these findings suggest that whakamā can function as a barrier to seeking treatment and communicating in mental health contexts. Eade (2007) interviewed Māori tāngata whaiora and Māori mental health practitioners about their experience of mental health service accessibility via primary health. Some practitioners described observing how whakamā appeared to be a significant barrier to Māori patients articulating what they were going through to the GP, and therefore, Māori patients did not always access appropriate follow-up support. Similarly, a study investigating how Māori talk about health and Māori experiences of healthcare providers found that participants identified whakamā as a barrier to asking for help and sharing information with a healthcare professional. However, some noted that whakamā usually reduced when healthcare professionals took time to build rapport and a trusting relationship. As such, being in an unfamiliar environment and

feeling uncomfortable talking about sensitive topics to an unknown professional could be a potential cause of whakamā in these contexts (Cram et al., 2003).

Other studies indicate that whakamā may be associated with mental health stigma. A study exploring tāngata whaiora experiences of receiving a mental health diagnosis found that although many Māori participants initially felt relief at receiving a diagnosis, they were also often hesitant to discuss the assessment or treatment plans with other people in their life due to feeling whakamā (Moeke-Maxwell et al., 2008). Pomare (2015), who interviewed rangatahi and their whānau accessing support from a Kaupapa Māori child adolescent mental health service, found that many participants shared experiences of whakamā, regarding having to access support for mental health problems, particularly during the initial engagement period. This was especially the case for whānau whose concerns or beliefs had been minimised by health professionals in the past. Some participants also felt whakamā about needing to go beyond their whānau networks to seek support. Another study exploring the recovery narratives of tāngata whaiora found that several Māori participants experienced whakamā about other people knowing they had gone through a mental health crisis, involving mental health clinicians, and having this exposed in public. Some Māori participants also expressed a painful awareness of whānau members who appeared whakamā when it was made publically known that they were associated with someone experiencing mental health problems (Lapsley et al., 2002).

In summary, this section has introduced the concept of whakamā and has argued that whakamā may be of particular relevance to Māori mental health although there is a dearth of research in this area. Similarities can be drawn between whakamā and the emotion of shame, although, from a Te Aō Māori perspective whakamā may be conceptualised as broadly related to the perceived loss of mana in relation to others and thus, be embedded in tikanga Māori. Arguably, there is a need for further research that explores the place of whakamā in Māori mental health contexts.

Summary

This chapter introduces the Te Aō Māori concept of whakamā and considers its place in the lives of Māori. In order to provide context for the reader, relevant tikanga principles associated with wellbeing for Māori were outlined at the beginning of this literature review alongside key historical, political, and social factors that have contributed to the disempowerment of Māori. Specifically, Māori experiences of colonisation, historical trauma, examples of struggle and

resistance in the face of contemporary accounts of racism and disparity were explored. Focus was also given to reviewing Māori mental health and Te Aō Māori informed mental health models and intervention tools. A small number of studies on Māori experiences of mental health services have referred to whakamā, particularly in relation to its impedimental impact on engagement and communication. However, no current research exists that specifically explores Māori experiences of whakamā in mental health contexts.

Research purpose and aims

The purpose of this study is to explore how whakamā is understood and experienced within mental health contexts of Tāmaki Makaurau from the perspectives of Māori kaimahi and tāngata whaiora. The study consists of three broad aims:

1) To explore kaimahi understandings of whakamā, including: how they perceive whakamā as being associated with collective experiences relevant to Māori and how this may relate to psychological distress, how they recognise and describe the experience of whakamā and its effects, and how they perceive their role in supporting tāngata whaiora experiencing whakamā.

2) To explore tāngata whaiora understandings and experiences of whakamā, particularly in the context of their unique stories and experiences of facing mental health challenges, encounters with mental health services, and action towards increased wellbeing.

3) To explore the significance of mana in relation to whakamā and to examine how mana is uplifted for those in spaces of whakamā from the perspective of tāngata whaiora based on their own personal experiences and from a service-level perspective based on kaimahi recounts.

In order to achieve these aims semi-structured interviews were carried out with kaimahi, and tāngata whaiora currently accessing support through Counties Manukau District Health Board Adult Community Mental Health Services, and peer support workers identifying as former tāngata whaiora. It is hoped that insights drawn from this study will have clinical implications for practitioners and enable services to engage more effectively with Māori accessing support for mental health challenges, and, subsequently, will be of benefit to tāngata whaiora and their whānau.

CHAPTER 2: METHODOLOGY

Introduction

This chapter provides an overview of the current study's methodological approach and the rationale for selecting this. It is important to clarify why and how a particular methodology best supports the realisation of research aims. I aim to build insight about how kaimahi[1] and tāngata whaiora[2] of Māori[3] descent understand and experience whakamā[4] in mental contexts of Tāmaki Makaurau[5]. I am also interested in exploring how mana[6] can be enhanced for those in spaces of whakamā. It is hoped that knowledge generated by this study aligns with Māori values and is transformative for Māori. As such, the research is guided by Kaupapa Māori[7] principles and informed by a mātauranga Māori[8] and critical realist epistemological framework. The research takes a qualitative approach to data collection and analysis. Semi-structured qualitative interviews were conducted and analysed using thematic analysis. Further details of the study's methodology and design will be outlined in this chapter.

Kaupapa Māori research

Māori communities have historically been positioned as the subject of Pākehā[9] research that primarily served to benefit western academia (Bishop & Glynn, 1999; S. Walker et al., 2006). Research 'on' Māori has translated Māori understandings of the world and cultural practices through the lens of colonial ideas, beliefs, and assumptions (R. Mahuika, 2008). Not only has Pākehā driven research offered little contribution or benefit to Māori whānau[10], hapū[11], or iwi[12], in many cases it has caused harm. Research has perpetuated colonial discourse about Māori and Māori ways of being as 'other', contributing to the process of colonisation. Pākehā researchers have traditionally positioned themselves as 'observers', with Māori communities under study being excluded from taking active roles in regards to research development and dissemination (Forster, 2003; S. Walker et al., 2006).

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[1] Person who is skilled in a particular area; mental health clinician in the context of this study.
[2] A person who is seeking wellness; this term is often used to describe mental health service users.
[3] Founding people of Aotearoa, indigenous people of Aotearoa.
[4] Loss of mana, feeling of shame, embarrassment, shyness.
[5] Auckland region.
[6] Authority, prestige, strength, honour, respect, the supernatural force in a person.
[7] A Māori approach, Māori service or organisation.
[8] Māori epistemology.
[9] New Zealander of European descent.
[10] Family, extended kin.
[11] Sub-tribe, to be pregnant.
[12] Tribe.

Māori academics have critiqued and challenged western hegemony over research in Aotearoa[13]. As such, the theories, principles, and practices of Kaupapa Māori research have evolved as an exercise of resistance and assertion of tino rangatiratanga[14] within research spaces (Pihama et al., 2002). Kaupapa Māori theory and research emerged at the time of a worldwide indigenous movement towards increasing self-determination over indigenous aspirations. In Aotearoa, development of Kaupapa Māori theory and research can be viewed alongside other movements to increase tino rangatiratanga for Māori such as kura kaupapa, land marches, and efforts towards greater acknowledgement of the Treaty of Waitangi (Forster, 2003; R. Mahuika, 2008; S. Walker et al., 2006).

Kaupapa Māori research is by Māori, with Māori, and for the benefit of Māori communities. This approach shifts Māori from the positioning of 'researched' to researchers who are experts of their own world (R. Mahuika, 2008; Pihama, 2015). Further, Kaupapa Māori research takes a whānau centred and whānau driven approach, encouraging Māori communities to play an active role in controlling research of interest and relevance to them (L. T. Smith, 2006; S. Walker et al., 2006). Additionally, whakawhanaungatanga[15], establishing and maintaining relationships with those who contribute to the study, is seen to be an integral component of Kaupapa Māori research, particularly given the negative connotations of power differentials evident in Pākehā research on Māori (Bishop, 1998).

Kaupapa Māori theory and research seeks to emancipate Māori knowledge, values, and ideals. It also seeks to make known the historical and social contexts that have shaped existing inequalities and power struggles experienced by Māori (Pihama, 2015; Pihama et al., 2002). In doing so, Te Aō Māori[16] is recognised in the conceptualisation, realisation and interpretation of Kaupapa Māori research (G. H. Smith, 2003). Importantly, Kaupapa Māori research seeks to be intentionally transformative. Enhancing social outcomes and quality of life for Māori communities should be a core principle of the research process (Pihama, 2011). There is a strong need for more Kaupapa Māori research to shift discourse in the area of mental health where western modalities prevail whilst Māori continue to access services in high numbers (Baxter, 2012; Durie, 2011).

It must be noted that there is no specific protocol to conducting Kaupapa Māori research. This has led to debate about what may be considered Kaupapa Māori research. C. Cunningham

[13] New Zealand.
[14] Self-determination, sovereignty, autonomy, self-government, domination, rule, control, power.
[15] Process of establishing relationships and maintaining links, relating well to others.
[16] The Māori world.

(2000) asserts that the difference between Māori centred research and Kaupapa Māori is the extent to which Māori have control over the research. He stresses the following,

> Māori control may be exercised in respect of the identification of research priorities, of the methodology and methods employed, of ethical and peer review criteria, of project leadership, of the quality of assessment and disseminations, and of measurement of research outcomes against Māori development goals. (p. 65)

Others have stressed that the legitimacy of Kaupapa Māori research is embedded in the researcher's credibility including their whānau and whakapapa[17] connections, relationships with participants/communities, and commitment to Te Aō Māori and tikanga Māori[18]. Eminent Kaupapa Māori research advocate L. T. Smith (2006) offers seven key tikanga derived principles for guiding a Kaupapa Māori research project: aroha ki te tāngata[19], kanohi ki te kanohi[20], titiro, whakarongo, kōrero[21], manaaki ki te tāngata[22], kia tupato[23], kaua e takahia te mana o te tāngata[24], kaua e mahaki[25].

I sought to uphold these values throughout my research. Although, there are limitations regarding the extent to which my research can be considered Kaupapa Māori. This research was completed as part of my Doctorate of Clinical Psychology, under the demands and constraints of a non-Māori university programme. As such, I consider my research to be Māori centred in approach (C. Cunningham, 2000). Albeit, I still felt it was important to hold to mind and action, to the best of my ability, Kaupapa Māori principles from inception to completion of the research project. This includes the manner to which methodology, data gathering, and analysis were approached to embody Kaupapa Māori principles.

Qualitative Research

Qualitative research generates rich knowledge about how people make meaning from experiences and phenomena (Willig & Stainton-Rogers, 2009). Qualitative research is often exploratory in nature (Patton, 2002), emphasising process, depth, and insight over breadth and generalisability (Liamputtong & Ezzy, 2005). Thus, the questions qualitative research seeks

[17] Genealogy, lineage, descent, to place in layers.
[18] Customary system of values, correct procedure, lore, method, protocol.
[19] Support people to define their own space.
[20] Face to face.
[21] Observe, listen, then speak.
[22] Collaboration, sharing, giving back.
[23] Remain cautious and reflective.
[24] Do not trample on the mana of others.
[25] Remain humble.

to answer typically relate to 'how' and 'what' (Willig & Stainton-Rogers, 2009). Being a methodological framework that privileges subjective experience, a qualitative approach can be a useful fit for psychological research (Mack et al., 2005). This is particularly the case for psychological concepts that are not strongly understood or have been sparsely researched (Marshall & Rossman, 1999). In depth, semi-structured interviews are a common method of data-collection in qualitative research whereby open-ended questions and probers, guided by a broad research question, are used to elicit rich information about subjective experiences and the meaning participant's attribute to these (Mack et al., 2005; Morrow, 2007). By favouring contextualisation over 'legitimacy,' narratives elicited from qualitative research can challenge the normative positioning of power in the production of knowledge (G. H. Smith, 2003). Thus, qualitative research has been used as a tool within indigenous contexts to privilege indigenous knowledge, needs, and aspirations (L. T. Smith, 2006; S. Walker et al., 2006). This is important given that the current study seeks to favour a Māori world-view. Some have questioned the reliability and validity of qualitative research due to its deliberate move away from objectivity, arguably a cornerstone of scientific research and rigour (Young & Arrigo, 1999). Although, I argue that qualitative research is characterised by a range of well-established epistemologies and systematic methods that are intentionally used to generate knowledge inherently different to quantitative data.

Epistemological approach

Epistemology refers to the study of human knowledge. Numerous epistemological frameworks exist, each with differing philosophies about what constitutes the true nature of human knowledge. Epistemological frameworks influence the way we respond, interpret, and engage with qualitative data (Willig & Stainton-Rogers, 2009). The current study is informed by two epistemologies: mātauranga Māori and critical realism.

A mātauranga Māori epistemological framework embodies a Māori way of understanding and experiencing the world. Knowledge underpinning mātauranga Māori stems from tikanga values and learnings passed down from tupuna[26] who utilised a range of mediums to transmit their knowledge of the world such as whaikōrero[27], waiata[28], pūrākau[29], whakataukī[30], and whakairo[31] (Hikuroa, 2017). However, mātauranga Māori is not a static body of knowledge.

[26] Ancestors, grandparent.
[27] Speech, the practice of oratory.
[28] Song, chant.
[29] Traditional story or narrative.
[30] Proverb, saying, lesson.
[31] Carving.

It continuously evolves and adapts to the experiences and needs of our people (Durie, 2017; L. T. Smith et al., 2016). In a contemporary research context, choosing to favour a Te Aō Māori worldview across all aspects of study design and data analysis has the potential to disrupt the ongoing colonisation of our knowledge base and drive transformative outcomes for Māori (Le Grice, 2014). Doing so is synonymous with Kaupapa Māori research principles (S. Walker et al., 2006). The study was also informed by a critical realist approach, which argues that, unlike positivistic theories, we can never fully capture the 'reality' or 'absolute truth' of lived experience. Instead, our realities are multifaceted and subjectively influenced by many layers of personal, interpersonal, cultural, and historical domains. In this manner, kōrero[32] shared by participants can never be deemed a completely accurate representation of fact. Although, kōrero still remains valid and real to their experiences (Danermark et al., 2005). A critical realist approach is well suited to Kaupapa Māori research because it positions western norms, values, and knowledge as one *component* of reality as opposed to a singular truth. Given the significance attributed to subjectivity within a critical realist paradigm, it is important for the researcher to maintain a reflexive approach towards the research context. This includes the external environment where the research is being undertaken as well as the internal beliefs, values, and experiences of the researcher that may impact on how components of the study are construed or interpreted (Berger, 2015). These ideas will be explored further in the following section.

Researcher reflexivity

In the same manner that quantitative research has measures of methodological quality, such as reliability and validity, there are also methods for examining the quality of qualitative research (Mullings, 1999). Braun and Clarke (2006) stress that qualitative research is not a passive approach in which themes just 'emerge' from the data set. Instead, the researcher, informed by their implicit beliefs, assumptions, values, and experiences of the world, actively interprets qualitative data. Thus, it is particularly important for qualitative researchers to be reflexive about their positionality relative to participants within the research context particularly as data is collected and interpreted (Mullings, 1999). As a qualitative researcher, upholding a reflexive attitude throughout the research process requires self-awareness, critical self-evaluation, as well as transparent naming and consideration of both outsider and insider positioning relative to participants (Berger, 2015; Dwyer & Buckle, 2009). Researchers may be considered 'insiders' when they share a social position with participants, and 'outsiders'

[32] Narrative, speech, conversation.

when they do not (Mullings, 1999). Insider status is a pre-requisite of kaupapa Māori research conducted by Māori, in collaboration with Māori, and for the shared benefit of Māori communities. Insider research safeguards research relevant to Māori communities, ensures accountability, and counteracts the history of outsider research that has positioned Māori as 'others' or passive 'subjects' of research. On the other hand, researchers who are positioned as 'insiders' may compromise the quality of the research if they cannot articulate an objective view of the data or critically reflect on their own potential biases and relationship to the research (L. T. Smith, 2006). As such, it is important to acknowledge the unique positionality I bring to the research and consider how this may interact with the overall research process and outcome.

Within this research project, I occupy both an insider and outsider position. My father identifies as Māori and affiliates to the iwi of Ngāti Porou and hapū of Te Whānau a Ruataupare. I also have English heritage from my father's side. My mother is of English and Samoan descent. Although my maternal grandfather was born and raised in Samoa before moving to Aotearoa as a young adult, my mother and her siblings were not immersed in Samoan culture growing up, and instead were raised to privilege 'Kiwi culture'. As such, my identity is informed by a mixture of different cultures, as well as mixed experiences of connection and disconnection to these. Although, my whānau have always been a binding thread, shaping my values, beliefs, and experiences of the world. On my father's side, I was fortunate to be surrounded by wāhine toa[33] growing up. My nana (Mere Knight), who was an advocate and community leader for Māori in South Auckland, and my aunties (particularly Ev Knight, Denise Knight, Aroha Knight, Moana Knight, Maria Knight) instilled in me a passion for serving our community, values of manaakitanga[34], aroha[35], and collective responsibility. Although, both my parents and I myself grew up in South Auckland, I was raised to know about my Māori whakapapa and the importance of my tūrangawaewae[36], and whānau trips to the Coast helped to instil this. Although on the one hand I feel like an 'insider' in regards to my Māori identity, being an urban, fair-skinned Māori, who did not grow up within hapū and iwi territories and who cannot speak fluent Te Reo Māori[37] means that I can sometimes feel like an 'outsider' compared to other Māori. This polemic has encouraged me to seek cultural consultation, not only to safeguard the research process, but also as a means of building

[33] Strong women.
[34] Enhancing the esteem of others through hospitality, generosity, and kindness.
[35] Love, caring, compassion, empathy.
[36] Place where one has right to stand, rights of residence and belonging via kinship.
[37] The Māori language.

confidence in my identity as a Māori researcher. It must also be noted, that many of the participants I interviewed shared similar experiences of feeling in some way disconnected to their Māori identity, or who identified as 'urban Māori,' and I was able to share insider status with these individuals.

Over the last seven years, I have worked in various helping roles, including as a support worker, a counsellor, and most recently as an intern clinical psychologist, within different community mental health, addiction, and intellectual disability services. I completed my child/adolescent and adult clinical psychology placements and my clinical psychology internship at Counties Manukau District Health Board Community Mental Health Services. Like many of the kaimahi I shared kōrero with, I am passionate about serving this community and improving mental health outcomes for Māori. In this context, I held 'insider' positioning with similar values, beliefs, and clinical experiences to the kaimahi participants. At the same time, I was mindful about the risk of convoluting my role within this context as this could influence both the interview process and data interpretation. I aimed to consciously position myself as 'researcher,' albeit one who was open about having many shared experiences, during these interviews. On some level, I did not feel like a total 'outsider' when interviewing tāngata whaiora due to having my own experiences of therapy, although having never accessed secondary mental health care I was an 'outsider' to the challenges of navigating severe mental health challenges and the DHB as a consumer. Therefore, I sought to maintain a stance of respect, curiosity, and openness when interviewing tāngata whaiora. Use of a reflexive journal has also enabled me to critically reflect my positioning and responses as a researcher over the course of this project.

In sum, I undertake this research from both an insider and an outsider position, and sometimes both at the same time. Hence, there are many experiences informing this research, and I am mindful that these experiences have informed the way I have carried out this research and made meaning of the kōrero shared to me by the participants of this study.

Method

This study used a qualitative interview design that was guided by Kaupapa Māori principles. The study consisted of interviews with kaimahi, tāngata whaiora, and peer support workers all of whom resided in Tāmaki Makaurau and identified as Māori. The main aim of the study was to explore participants' unique understandings and experiences of whakamā in mental health contexts, and perspectives on what might enhance mana for those in spaces of whakamā. The

kōrero was grouped and analysed under two sections: Kaimahi and Tāngata Whaiora. It is hoped that separating the analysis in this way allowed for the distinct insights, stories, and experiences of these two groups to be better captured. The following section provides an overview of the methods used in this study, including how I recruited participants, collected, analysed the data, and addressed ethical considerations.

Participants

Kaimahi. For the first part of the study, I interviewed 18 kaimahi Māori who were working as mental health practitioners in Tāmaki Makaurau. Practitioners in the context of this research project included those with clinical training as well as those who were employed because of their cultural expertise to support Māori in a mental health context (i.e., taurawhiri[38]). I initially recruited participants by visiting relevant services in Tāmaki Makaurau (i.e., community mental health services, Non-Government Community Organisations) so that I could provide information about the study and offer advertising posters (see Appendix A) kanohi ki te kanohi. During the later stages of recruitment, snowballing also took place, whereby existing participants shared details of the study with colleagues. Those expressing an interest in the study either spoke with me directly while I was visiting a service or contacted me by email/phone as stated on advertising posters. Following which, potential participants were sent a participant information sheet (see Appendix B) and were encouraged to ask further questions of the study before signing a consent form (see Appendix C) and arranging an interview time.

In order to protect confidentiality, participant demographics will not be specified to an individual level. All of the kaimahi resided in Tāmaki Makaurau and together represented 20 different iwi from across the country. Some participants shared iwi affiliation with each other. Kaimahi participant ages ranged from 28–71 years old. 12 identified as wāhine[39] and six identified at tāne[40]. Years of experience working in mental health settings ranged from 2 years–40 years. The following roles were represented in this sample: social worker, taurawhiri, alcohol and drug counsellor, mental health nurse, psychiatrist, therapist/psychologist, occupational therapist.

Tāngata whaiora. For the second part of the study, I interviewed nine Māori tāngata whaiora who were currently accessing support through Counties Manukau District Health

[38] Māori tikanga or cultural advisor.
[39] Female, women.
[40] Male, man.

Board Adult Community Mental Health Services. As tāngata whaiora may be considered a vulnerable population, I decided to ask Counties Manukau clinicians to identify individuals' off their caseload who in their clinical opinion, were mentally and intellectually capable of providing informed consent. Although it could be viewed that this process gave power to clinicians to 'choose', my intention was to uphold the mana of participants, first and foremost, by ensuring to the best of my ability that informed consent was given by all those taking part in the study.

I spoke with clinicians at Counties Manukau District Health Board Community Mental Health Sites (i.e., at team meetings) and also sent emails out to each service explaining the study, the inclusion criteria, and their role, should they wish to support the research, in identifying potential participants. Clinicians were then invited to provide a letter of invitation (see Appendix D) and participant information sheet (see Appendix E) to possible candidates. My contact details (email and phone number) were listed for candidates to respond to the invitation, although it was made clear that participation was voluntary. To safeguard confidentiality, clinicians were not given any information about client responses to the invitation. Those who contacted me were invited to ask further questions about the study. Following which, they were free to decide whether they would like to sign a consent form (see Appendix F) and arrange an interview time.

As the recruitment process progressed, some Māori peer support workers reached out to me asking if they could also share stories about their lived experiences with whakamā and engaging in mental health services. Peer support workers are individuals who are employed by mental health and addiction services to support tāngata whaiora using knowledge and insights gained from their own lived experiences as former tāngata whaiora (Te Pou o Te Whakaaro Nui, 2020). It seemed appropriate that peer support workers were given the opportunity to have their voices heard and in some respects, this was necessitated, as recruitment of tāngata whaiora proved a slow process. Four peer support workers participated in the study. Two peer support workers reached out to me directly, and two were recruited through snowballing. All had the opportunity to ask questions about the study and invited to review a participant information sheet (see Appendix G) before signing a consent form (see Appendix H). All had experienced mental health and addiction challenges, had accessed mental health and addiction services, and now worked as peer support workers in Tāmaki Makaurau. The peer support workers were made aware that they were contributing to the study from the perspective of former tāngata whaiora and that their kōrero would be analysed under

a combined sample in conjunction with the tāngata whaiora participants. As such, the same interviewing schedule was used for tāngata whaiora and peer support workers.

To safeguard confidentiality of this small sample, demographics for tāngata whaiora and peer support workers will be combined under one overarching tāngata whaiora sample. Again, in order to protect confidentiality, participant demographics will not be specified to an individual level. All of the tāngata whaiora and peer support workers resided in Tāmaki Makaurau and together represented 12 different iwi from across the country. Some participants shared iwi affiliation with each other. Participant ages ranged from 22–61. Six of the participants identified as wāhine and seven identified as tāne. Participants' described a range of experiences that led them to access mental health services including depression, anxiety, psychosis, bipolar disorder, addiction. However, this information will not be specified to an individual level. Firstly, this is to ensure I uphold confidentiality. Secondly, I did not explicitly ask about diagnostic information because this was not the focus of the study, even though many did choose to share details about this.

Data gathering

Interviews were conducted at a mutually convenient location like the participants' home, a room at a mental health service, or in a private room of a community centre. All interviews were audio recorded. For both parts of the study, data gathering took an exploratory, descriptive approach in the form of semi-structured interviews to elicit rich kōrero (Mack et al., 2005; Morrow, 2007). Being a study informed by Kaupapa Māori principles, it was important consider tikanga in the way interviews were conducted (L. T. Smith, 2006). Firstly, all interviews took place kanohi ki te kanohi[41]. Participants were welcome to invite whānau or a support person given all parties agreed to respect confidentiality. Three of the tāngata whaiora opted to have a support person present with them during the interview. Karakia was used to open and close the session and kai[42] was offered as a means of breaking the tapu[43] of the kōrero and bringing the participants and interviewer back into a space of noa[44] (Mead, 2003). Before the interview commenced, I gave a brief mihi[45] to acknowledge the participant and time was spent on whakawhanaungatanga meaning that we shared information about our whānau, hapū, and iwi connections in order to get to know each other and explore any shared

[41] Face to face.
[42] Food.
[43] To be sacred, prohibited, restricted, set apart, forbidden, protected.
[44] Neutral, common, non-restricted.
[45] Speech of greeting.

commonalities. Although western research may expect defined boundaries, objectivity and neutrality of the researcher, Kaupapa Māori research embraces that participant and researcher are connected as Māori and stresses that relationships should be established and maintained (Bishop, 1998). Finally, koha ($30 countdown or Prezzy card voucher) was used as a means of acknowledging participants' time and contribution to the study.

Interviews with kaimahi were structured across four broad phases: 1) time for whakawhanaungatanga, 2) participant understandings of whakamā, 3) participant observations and experiences of whakamā in clinical practice, and 4) participant ideas about enhancing mana. I had an interview schedule at hand with prompting questions (see Appendix I) to guide the kōrero through these broad phases. However, I ensured that participants were leading the content of the interview by making sure not to offer spontaneous information and instead I used active listening skills, reflection, and prompts to encourage the participant's kōrero. This approach aligns with guidelines for kaupapa Māori researchers by L. T. Smith (2006) who stresses our primary role is to look, listen and then speak, in order to raise the mana of participants' kōrero. The duration of kaimahi interviews ranged from 35 minutes to two hours with the average interview time being 59 minutes.

A narrative inquiry style of interviewing was employed for interviews with tāngata whaiora. Narrative inquiry positions participants as protagonists with lived experience of a particular topic (Connelly & Clandinin, 1990). Thus, this framework is useful for eliciting rich, subjective information about the way people navigate a particular phenomenon (Wells, 2011). Narrative inquiry is a useful method for exploring how people experience periods of disruption, change, or transformation in their life (Chase, 2017). It has also been used by indigenous researchers to bring to light indigenous stories that have previously been suppressed or undermined (Polanco, 2013; Ware et al., 2018). For the current study, a narrative inquiry offered an open space for participants to recount their lived experiences of whakamā. To commence the kōrero, time was spent on whakawhanaungatanga. Following this, participants were asked how they came to learn about whakamā and what it means. Participants were then asked to reflect back on times in their life when they felt whakamā and to recount these experiences in a way that made sense to them. Finally, participants were encouraged to reflect back on times in their life when they had coped with or overcame experiences of whakamā and to recount these experiences in a way that made sense to them. As the kōrero progressed, I asked clarifying questions (e.g., What stood out for you about that? How did you make sense of that? What were you feeling/thinking/doing at the time?) and used

prompts (e.g., Tell me more about that? What happened next? Can you give me an example?) to elicit further information about their experiences. Although, I had an interview schedule (see Appendix J) to use as a guiding framework, I always made sure that tāngata whaiora were positioned as experts in sharing their stories and given space to lead this process. The duration of tāngata whaiora interviews ranged from 31 minutes to one hour and 17 minutes with the average interview time being 49 minutes.

Once all the kōrero was gathered, a professional transcriber, who signed a confidentiality agreement, was employed to transcribe approximately half of the data set and I transcribed the remaining interviews.

Data analysis

Braun and Clarke's (2012) six-stage model of thematic analysis was used to analyse the data for both samples. So as not to convolute the process of data analysis, I completed an initial analysis for the kaimahi data set, followed by initial analysis of the tāngata whaiora data set. As such, the findings of this study are structured across two distinct chapters, although kaimahi and tāngata whaiora perspectives are examined more interchangeably in the discussion chapter of this thesis. The process of data analysis was identical for both samples, and this is described below.

Thematic analysis is a systematic tool for identifying and interpreting patterns of collective meaning within a data set (Braun & Clarke, 2012). This model is theoretically flexible meaning it can be utilised within a Kaupapa Māori paradigm. Firstly, I immersed myself in the data set by reading the transcripts multiple times and reflecting on my initial responses to the data. During this process, I highlighted any content that appeared relevant to my research question. Once I was suitably familiarised with each transcript, I transferred all highlighted data into a separate document, which made it more manageable to process information pertinent to my research question. Then, I began to take note of any recurring ideas that appeared to present across the highlighted data and eventually these were organised into meaningful groups. These groups were coded using a few words to describe the data they represented. Once all codes were generated, I grouped together similar or related codes into broad, overarching themes. The process of organising codes into the final themes took place over a long period of time.

Following initial drafting of the findings, themes had ongoing refinement as I continued to reflect on the kōrero, my reflexivity, and discuss ideas with my Supervisors, Kaumatua and

Kuia[46] Rōpū[47], and with colleagues' during research wānanga[48] opportunities (i.e., writing retreats, Māori researcher wānanga at Auckland University, He Paiaka Hui). Eventually, 13 (kaimahi sample) and seven (tāngata whaiora) themes were defined and named. These appeared to best represent the kōrero that was shared (Braun & Clarke, 2012). Themes will be outlined and discussed in depth in the findings chapters of this thesis.

Ethical considerations

Ethical approval was granted by the Health and Disability Ethics Committee (HDEC) on 24 October 2018 (Reference – 18/NTA/164) and Counties Manukau Locality approval was received on 20 March 2019 for recruitment of tāngata whaiora. Careful consideration was given to ensuring the research produced was of the highest ethical standard. This felt particularly important firstly, because academic research with Māori populations has typically contributed to further disempowerment and othering of these groups. Secondly, the negative history associated with academic research for Māori may lead to understandable hesitation about participating (L. T. Smith et al., 2016). Thirdly because the topics of discussion are likely to be considered highly personal and sensitive in nature for participants. This is particularly so for tāngata whaiora who may be considered a vulnerable population.

As well as having a methodologically sound study design, research that is of relevance to Māori communities should consider how the study respects tikanga Māori, which from a Te Aō Māori perspective is an essential component of ethical deliberation (Hudson et al., 2010; Jones et al., 2006). A key step towards ensuring the research maintained appropriate cultural standards was through accessing ongoing consultation throughout the research process from knowledgeable Māori advisors, particularly from my Kuia and Kaumatua Advisory Rōpū: Aunty Moana, Aunty Ope, Whaea Lorraine, Whaea Kahu, and Matua Wi. Members of this rōpū are all well versed in tikanga Māori and have years of experience supporting Māori in community, health, and social services.

Given that interview content was likely to be of a sensitive nature, I was mindful that distress may be evoked for some participants either during or after kōrero. My supervisors (Dr Makarena Dudley, Dr Kerry Gibson) who are trained clinical psychologists were available for debriefing, especially if I had concerns about participants following an interview. To add, I have previously worked in counselling roles in mental health settings and I am currently

[46] Elder(s).
[47] Group of people.
[48] To meet and discuss, deliberate and consider, collaborative learning.

training to be a clinical psychologist. Through my training and experience, I have learnt skills for safely communicating with people experiencing emotional distress. However, it was important to inform participants about what the interview process involved, and limits to confidentiality if risk is disclosed, before consent was requested. Participants were also informed about their right to withdraw from the research at any time.

I acknowledge that involving clinicians in the recruitment process for tāngata whaiora increases the risk of confidentiality being broken. However, it was essential to obtain sound clinical judgement to ensure that potential participants could provide informed consent and ideally presented with no/low risk. Furthermore, to protect confidentiality clinicians were given no information about whether selected candidates chose to participate in the study, nor any details about the interview.

The privacy of participants was maintained through a number of steps. All recordings were destroyed once the transcriptions were received and these were password protected. The information is stored on an encrypted Word document that only myself and my supervisors have access to. The data is stored on a password protected University of Auckland computer, backed up by a server. As per best-practice ethical guidelines, information generated in this study will be stored for 10 years.

Summary

In summary, 18 kaimahi, nine tāngata whaiora, and four peer support workers were recruited for this research project. Participants varied in age, background, and whakapapa. Kaimahi participants were all currently employed as either clinicians or taurawhiri within mental health contexts. Tāngata whaiora were all service users of Counties Manukau District Health Board Adult Community Mental Health Services and the peer support workers all had their own lived experiences of mental health and addiction challenges. Data was gathered via semi-structured qualitative interviews that were recorded and transcribed. Transcripts were split into two separate data sets: kaimahi and tāngata whaiora. The tāngata whaiora data set included interviews with peer support workers. Both data sets were analysed via thematic analysis.

CHAPTER 3: KAIMAHI FINDINGS

This chapter presents findings drawn from thematic analysis of kaimahi[1] interviews. In total, 13 themes are presented and these have been grouped across four categories as shown in Table 1. Overall, these categories and themes aim to present a broad framework of understanding as to how kaimahi understood whakamā[2], experienced and responded to whakamā in mental health contexts, and perceived their role in supporting tāngata whaiora[3] experiencing whakamā, as well as barriers to the latter. Findings draw upon kaimahi accounts of their clinical experiences although within their kōrero[4] many broadly referred to socio-historical contexts, current issues and shared values relevant to Māori[5].

Table 1. List of categories and themes in kaimahi findings

Categories	Themes
How is whakamā associated with collective experiences relevant to Māori?	Impact of colonisation: "It was imposed on us."
	Loss of identity and belonging as Māori: "Some of them don't even know who they are."
	The 'system' depletes mana: "Their backs are already against the wall with us as a system."
How is whakamā expressed in mental health contexts and what are its effects?	Whakamā feels too big to be named: "It all melts into this big feeling."
	Whakamā is challenging to go near: "It feels like poking the bear."
	Whakamā is often shown rather than spoken: "It's like a protective armour."
How do kaimahi Māori perceive their role in supporting with whakamā?	Kaitiakitanga: "Create those safe spaces for healing kōrero to occur."
	Whanaungatanga: "Just treating everyone like my family or whānau."
	Te Wā: "They do need that extra support and that extra time."
	Whakapapa: "It's their entitlement to be reconnected."
How do mental health services contribute to whakamā?	Discrepancy of values: "It's never given the space."
	Lack of cultural competency: "Clinicians don't have the skills."
	Lack of bicultural partnership: "That funding should've gone to a Māori service."

[1] Person who is skilled in a particular area; mental health clinician in the context of this study.
[2] Loss of mana, feeling of shame, embarrassment, shyness.
[3] A person who is seeking wellness, used to describe users of mental health services.
[4] Narrative, speech, conversation.
[5] Founding people of Aotearoa, indigenous people of Aotearoa.

How is whakamā associated with collective experiences relevant to Māori?

This category focuses on three areas that are significant to the collective experiences of Māori, especially for those living in urban contexts like Tāmaki Makaurau[6]. Kaimahi described these collective experiences as being associated with whakamā for Māori, including tāngata whaiora albeit many of the people they worked with did not explicitly name or identify this. The following themes are presented in this category: Impact of colonisation: "It was imposed on us," Loss of identity and belonging as Māori: "Some of them don't even know who they are," The 'system' depletes mana: "Their backs are already against the wall with us as a system."

Impact of colonisation: "It was imposed on us." All of the kaimahi spoke about the impact of colonisation for Māori. Many spoke about these impacts as being intergenerational, pervasive and contributing to current issues such as internalised negative beliefs about what it means to be Māori. Some of the kaimahi spoke about societal structures that normalise and reinforce these beliefs. These factors may be associated with an 'imposed' whakamā for Māori. The following theme will seek to capture these ideas.

Kaimahi spoke about Māori experiencing whakamā today due to being conditioned to feel 'lesser' relative to Pākehā[7]. This positioning of feeling lesser has been shaped through colonisation when tupuna[8] were forced to assimilate to the worldview of colonisers. For example,

> It wasn't about them (colonisers) adapting to tāngata whenua, it was about tāngata whenua[9] having to change. Having to adapt and lose their cultural identity ... So there's been a lot of loss. Of language. Loss of culture. Loss all of those things. So the whakamā has been that feeling of loss. It's been a feeling of not being able to be as good as Pākehā in a sense. (K7)

Some kaimahi felt that the mistreatment, othering and suppression of Māori identity through the process of colonisation has contributed to an 'imposed' whakamā about what it means to be Māori. Kōrero[10] shared by the following participant captures these ideas,

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[6] Auckland region.
[7] New Zealander of European descent.
[8] Ancestors, grandparent.
[9] Local people, hosts, indigenous people born of the whenua i.e., of the placenta and of the land where their ancestors lived.
[10] Narrative, speech, conversation.

> It was imposed on us. The way we were treated. We were treated like savages … Colonisation has had a lot to do with imposing whakamā because they suppressed a lot of stuff that should be natural and normal to us. (K17)

For example, one participant related whakamā with the trauma their father had suffered due to being prohibited from speaking Te Reo Māori[11] at school. The following account demonstrates how an 'imposed' whakamā might be transmitted through generations within whānau[12],

> Dad still is traumatised. My father is 80 this year. He said, "I was strapped until my hands bled and I wasn't allowed to speak Te Reo Māori" … and you can see that builds up anxiety, that builds up anger and then my father starts to do - he passes down what he's learnt. (K9)

Kaimahi also spoke about the impacts of urbanisation such as whānau displacement and disruption of tikanga[13] values. Without these protective mechanisms, whānau may be vulnerable to absorbing different values and developing coping strategies that cause further harm and contribute to whakamā. As the same participant shared,

> When we were living in rural areas we were working as a collective. But once you move to an urban context … you have split of the whānau structure and then you get individualised … you've got no old people to teach you your values, nobody to tell you off and then you get caught up in this new environment … and in a negative context that's alcohol, it's drugs, that's gambling, domestic violence and then you start to see that ongoing of intergenerational trauma. (K9).

In contrast, whakamā may be experienced differently in contexts where tikanga Māori continues to guide behaviour. For example, the following participant, who grew up in a rural setting, felt that whakamā could be a response to having behaved in a way that compromises the collective mana of whānau, hapū[14], or iwi[15].

> A lot of that is to give mana[16] back to the whānau … to be growled or frowned upon was a way you could feel that mamae[17], that whakamā for yourself because you have

[11] The Māori language.
[12] Family, extended kin.
[13] Customary system of values, correct procedure, lore, method, protocol.
[14] Sub-tribe, to be pregnant.
[15] Tribe.
[16] Authority, prestige, strength, honour, respect, the supernatural force in a person.
[17] Painful, sore, hurt.

> done something that doesn't enhance I suppose the wellbeing of your people or your hapū or your iwi. (K3)

However, the same participant went on to describe how their perception of whakamā broadened as they got older, particularly in relation to experiences of being looked down upon and treated as "second grade citizens" by Pākehā.

> As I got older I recognised the arrogance of the Pākehā in our town … always looking down at our whānau … treat us like second grade citizens and when you walked in they'll look you up and down and give you a sneer. (K3)

Some spoke about the impact of mana diminishing stereotypes that reinforce ideas about Māori as being 'bad.' The normalising of these negative associations by society can be seen as a continuation of the beliefs and structures established in Aotearoa[18] through colonisation. For example,

> You're always being judged. They put all Māori into one basket … We're all criminals, we're all gang affiliated and all that stuff … It depletes our mana; it depletes our everything that we have as Māori. (K17)

Kaimahi talked about their own experiences of racism. One participant described feeling whakamā about people assuming they must be "on some sort of benefit" because they were Māori, despite being employed as a social worker in Court.

> It's kind of how we walk through life and we shift through life as Māori. I can walk through the supermarket with gumboots and track pants on and people look at me and give me these really funny looks and go, she must be on some sort of benefit … I don't think I should have to prove myself that I work fulltime and my role as a social worker working in the Court Rooms. (K6)

Some expressed anger about the lack of education in schools and more generally, the lack of acknowledgement in Aotearoa about the impact of colonisation on Māori experiences today, which arguably reinforces 'imposed' whakamā.

[18] New Zealand.

> You look at what's currently happening in Aotearoa. Why aren't we teaching our history? Why aren't we sharing the kōrero I just talked with you about? … They (tāngata whaiora) get consumed by their environment and they just react to it. (K9)

In conclusion, colonisation has had a pervasive and insidious impact on Te Aō Māori[19]. Colonisation normalised processes that contributed to the suppression and othering of Māori identity. These processes continue to be entrenched in the fabric of Aotearoa society. One of the consequences of colonisation could be the internalisation of negative beliefs about what it means to be Māori being carried across generations of whānau. Whakamā of this nature has been imposed on Māori whānau, hapū, and iwi.

Loss of identity and belonging as Māori: "Some of them don't even know who they are." Kaimahi spoke about the association between whakamā and perceived loss of Māori identity, including connection to whakapapa[20] and Te Aō Māori in general. Many felt this was particularly relevant for those living in urban settings like Tāmaki Makaurau. Kaimahi observed how many tāngata whaiora accessing mental health services were living outside of spaces that connected them to whakapapa. For some, feeling disconnected was associated with a perceived lack of belonging and whakamā about not being 'Māori enough.'

Many of the kaimahi believed that tāngata whaiora accessing support in urban mental health contexts were more likely to be disconnected from their tūrangawaewae[21] and may not have had opportunities to connect to whakapapa defining spaces such as marae[22], awa[23], maunga[24], and whenua[25]. The following participant noted how these losses may contribute to an overall loss of identity.

> Some of them don't even know who they are, a lot of our clients and I think that's mainly because they're brought up in the city and haven't had their marae. (K8)

Without having a grounding base, a loss of clear direction in life may also be evident. The following participant described how in urban contexts, loss of whakapapa may be 'replaced' with other sources of belonging and connection, like area codes, streets, and gangs.

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[19] The Māori world.
[20] Genealogy, lineage, descent, to place in layers.
[21] Place where one has right to stand, rights of residence and belonging via kinship.
[22] Tribal meeting grounds that are a common space for hapū or groups to meet/gather.
[23] River.
[24] Mountain.
[25] Land.

> The mahi[26] I've done with young people, you're like, "oh, you're Māori." And they're like, "Yeah, I don't know where I come from and I don't know this," and just that whole kind of lost floating around life, and they're more connected to area codes and their gangs and their streets … than actually where their bones and their bloodline whakapapas to. (K1)

One participant offered an example from their own whānau of how limiting opportunities to connect with Te Aō Māori may contribute to a heightened state of whakamā about being in spaces that bring to light this disconnect and loss of knowledge, such as going to the marae.

> I've even got whānau, cousins in my own whānau, they say to me, "cousin, I don't like going to the marae, I don't understand what's being said, can we not do any of that Māori stuff?" … It hurts me when I hear this but I also know that they didn't come through kohanga reo or kura kaupapa[27] Māori, they came through mainstream, so now I've got my own close relations scared of our own culture and language and they don't like going on to the marae because they can't understand. So that places them in a state of whakamā. (K9)

Some of the kaimahi described working with tāngata whaiora who expressed a longing to feel connected to Te Aō Māori but felt limited in their capacity to achieve this. Some kaimahi believed whakapapa disconnect not only contributed to being in a state of whakamā, but whakamā itself functioned as a barrier to taking active steps towards connecting and healing. As one participant shared, lacking "a base" to connect, may led to self-judgement, causing further whakamā.

> The disconnect is the biggest thing I reckon… But then the way that you connect through whakawhānaungatanga[28], if you don't have that as a base, how are you meant to reconnect and who are you meant to go to? And then you feel whakamā because you're like, "I should know this 'cos this is my whakapapa and I should know this because this is where my iwi and my marae are from," but you just don't have that and so then it's kind of like what you need to heal through whakamā is also the thing that causes it. (K1)

[26] Work.
[27] Māori language immersion schools.
[28] Process of establishing relationships and maintaining links, relating well to others.

A few of the kaimahi expressed aroha towards tāngata whaiora who were clearly Māori, despite feeling as if they did not have a Māori identity as a result of disconnection. For example,

> The Māori boy I was talking about before, he's only – He's 18 and doesn't speak Māori, grew up in Auckland, doesn't really associate as Māori, but you know, looking at him he's clearly like a brown Māori boy. (K2)

Many of the kaimahi felt that offering a space to kōrero about identity and reconnecting to Te Aō Māori was an important part of their role, although some spoke about an initial "resistance" from tāngata whaiora because these conversations were often a trigger for whakamā:

> Once you start working around things like identity, around who they are, around pepeha[29], connecting to the Māori world there is a little bit of resistance initially because everybody is whakamā themselves because they don't have – they might have very little or no understanding about themselves and that can be a very whakamā thing. (K7)

In sum, loss of connection and belonging to Māori identity is particularly relevant for Māori living in Tāmaki Makaurau, who may be disconnected from whakapapa and Te Aō Māori affirming spaces. This sense of loss may not only be associated with whakamā about not being 'Māori enough'; the experience of whakamā itself could make steps towards re-connection painful and challenging. Tāngata whaiora and their whānau may carry the mamae of these losses without necessarily articulating them in mental health contexts.

The 'system' depletes mana: "Their backs are already against the wall with us as a system." Many of the kaimahi described mental health services as belonging to a broader governmental 'system' of power that may include services like the police, Oranga Tamariki, and Work and Income. While the system may operate to address safety and welfare concerns, it ultimately functions in a manner that has oppressed Māori across generations. Depletion of mana by the system may take place through different forms of power contributing to tāngata whaiora experiences of whakamā before and during their interactions with a mental health service.

[29] Form of self-introduction in which whakapapa and areas of significance are recited.

Kaimahi identified layers of barriers that made it challenging for whānau to reach out for support from a mental health service such as; stigma, uncertainty, financial burden, confidentiality breaches, and former interactions. These barriers may negatively affect all mental health consumers, including Māori. As one participant shared,

> There's still that stigma about mental health and coming to talk … I mean there's multiple levels isn't there? There's cost and past experiences with seeking help. Discrimination and prejudice. Being vulnerable. Being with that and sharing that with others. Being with others. Being recognised, knowing people. There's lots of multiple levels for whānau. (K14)

However, there may be further barriers preventing Māori from accessing help in particular. Alongside the aforementioned barriers, for Māori, mental health services may be experienced as being part of a broader 'system' of power that has historically depleted the mana of whānau across generations. As such, being a part of this system may contribute to experiences of whakamā.

> It's Police, it's prison, it's corruption, it's Oranga Tamariki, it's health, it's a system and we all have a role to play and so by the time that I've come into this third generation, their backs are already against the wall with us as a system, because that's how they see us … as a part of that system, 'oh, you're just here because you want to remove our kids' … 'you're the third clinician that I have seen, what are you going to tell me that I haven't already seen?' (K6)

The same participant went on to describe how there are specific mechanisms within the system that oppress Māori, keeping whānau dependant on social services and trapped in a stagnant, mana depleted state.

> The benefit is made to again, stigmatise Māori, marginalise Māori and keep Māori at a stagnant place, like keep Māori here and that's it, don't move you just stay there … you become dependent on a government system, the very system that is against you at the same time and you're against them and you're dependant on that system. (K6)

Hence, Māori who reach out for help or require support might be at risk of perceiving themselves as just another "statistic." As a result, they might judge themselves or fear being judged by others including from service providers. As one kaimahi described,

> In terms of all Māori whānau, when I work with them and just that shame of being like – as soon as they come near a mental health system, 'I'm a statistic.' Just the way they're looked at. They're treated. (K1)

Some of the kaimahi spoke about Māori tāngata whaiora as being whakamā about opening up to service providers due to fears about being a target of racism and discrimination. One participant described how tāngata whaiora may be sensitive to judgement from clinicians about "whatever state we're in as Māori."

> I just think sometimes our families are very whakamā about how their house looks, like when we come to visit them. Or whakamā because, 'Oh my gosh, they're gonna judge me, how things look,' … So people's perception of whatever state we're in as Māori … Like 'Oh my gosh, they're gonna be thinking because my house looks like this - oh they're lazy.' Which is actually just a judgement that is always put on some of the families that we have. (K12)

Many kaimahi felt that as a result of these barriers, Māori were less likely to access support from a mental health service and instead were more inclined to rely on support from their own whānau. The following participant described how after becoming a nurse, their whānau chose to get advice from them instead of going to the doctors.

> When they found out that I was becoming a nurse they would lean on me more instead of going to their own doctor's appointments because to them, they had their own whakamā towards clinical settings. So, they don't like to go to the hospitals … they think that they were just a bunch of stuck up white people. (K2)

Some kaimahi reflected on the amount of Māori whānau forced to access mental health services due to being considered at risk. Reduced opportunity to recognise their own need for help and take an active step to reach out contributed to even greater whakamā:

> They're coming in for help but how many of them have been really fully informed by the referrer? … You get some that really genuinely want help, and those that are forced to. I think those ones that get forced to come into mental health are probably the ones that experience whakamā the most because if they understood what their needs were that, 'actually hey I need to see the GP for help,' then that whakamā wouldn't really be as much. (K11)

By contrast, some kaimahi felt that whakamā reduced when Māori clinicians were actively involved in encouraging whānau to seek help. The following participant, who worked in a Kaupapa Māori[30] service, felt that whānau were less likely to feel judged when support is offered by Māori clinicians.

> We know, through our own experience, that if we are the ones who are making the offer, we are more likely to have people interested in coming to us because it's that contact that we can immediately reassure people that, "look, we're not judging" … So you kind of remove all those barriers by the kind of presence you offer. (K15)

This theme seeks to highlight the association kaimahi made between mental health services and other governmental agencies who historically (and in many respects currently) have utilised power to oppress Māori, depleting mana. As such, there may be barriers to Māori accessing support from mental health services and acknowledging the need for help may be associated with whakamā. For those who have been 'forced' into services, whakamā is likely to be even greater.

How is whakamā expressed in mental health contexts and what are its effects?

This group of themes highlights the different ways kaimahi perceived whakamā as being expressed by tāngata whaiora in mental health contexts. The effects of whakamā are also described. Notably, kaimahi felt that whakamā was challenging to articulate not only for tāngata whaiora but also for themselves. Many described whakamā as being 'hidden' underneath other emotions, behaviours, and experiences. Despite being hard to talk about with tāngata whaiora, whakamā was often seen and felt by kaimahi. Three themes encapsulate these ideas: Whakamā feels too big to be named: "It all melts into this big feeling," Whakamā is challenging to 'go near': "It feels like poking the bear," Whakamā is often shown rather than spoken: "It's like protective armour."

Whakamā is difficult to name: "It all melts into this big feeling." Kaimahi spoke about whakamā as being hard to name and describe. Many felt that it was challenging to have a conversation about whakamā with tāngata whaiora because of its 'bigness.' As such, identifying a specific trigger for whakamā was often difficult or not possible. To add, some kaimahi believed that tāngata whaiora found it hard to put the experience of whakamā into words. This theme attempts to capture these ideas.

[30] A Māori approach, Māori service or organisation.

Kaimahi observed that tāngata whaiora were more likely to describe thoughts, feelings, and behaviours associated with whakamā before labelling it as such. As one participant shared,

> They can't name it. They can tell you what it feels like but they don't know exactly what they're dealing with. (K11)

Like others, the following kaimahi expressed how it could be hard to identify a specific trigger for whakamā, instead describing whakamā as an "invisible thing" that "accumulates."

> Whakamā is this thing that's put on you, like this invisible thing but it's not as easy to identify a trigger. If you get sad or angry it's really easy to be like, this made me sad or that made me angry and it might take a bit of work, but with whakamā, it all melts into this big feeling so it accumulates. (K1)

Some of the kaimahi experienced whakamā as being like a 'taumaha[31]' or a heavy burden that could be recognised in those carrying it even though it was hard to unpack and make sense of:

> It's just there. It's there in a person and it's hard to unravel a lot of the issues. It's like a taumaha, it's like a heaviness, a burden and yeah I see it, I see it in many of our whānau who present here. (K7)

A few kaimahi spoke about having a physical reaction in response to experiencing or noticing whakamā in others. These changes in the body might precede naming whakamā or putting words to possible causes:

> For myself I do get a physical reaction. I feel something heavy or something kind of tied up, something tight, you know – it's kind of from the bottom of my chest down to maybe my pelvis, somewhere in there I feel something like that. That usually tells me that something's not right. (K4)

Many described whakamā as something that was "hidden." The following participant describes how the hidden nature of whakamā may be collectively evident across whānau, hapū, and iwi. Therefore despite being hard to name and describe, whakamā may be pervasively felt.

[31] To be heavy.

> Even though you can kinda make assumptions that there's whakamā there it's often hidden. The depths of it are hidden in individuals, and whānau, and I suspect hapū and iwi. (K15)

For example, the following participant described whakamā as being associated with "the whole context of Māori" as opposed to "one specific thing," meaning that it may be experienced as more of a "state."

> It's a broad thing … it's not something that's one specific thing. When I look at whakamā I look at the whole context of Māori and what comes to mind straight away is colonisation and when you look at colonisation and how - still 150 years later we are still in a state of whakamā, were still in that – that's how I see whakamā. (K6)

Many described whakamā as being passed down and shared through whakapapa, meaning that similar patterns of behaviour and related āhua[32] may be seen across generations of whānau. For example,

> You can get a sense from a person and hear about their upbringing from childhood - it perpetuates through generations. Through whakapapa. You can see the same āhua when you meet other siblings. You can see the same thing within the families. (K7)

Some spoke about the negative impacts of keeping whakamā hidden, perpetuating trauma by potentially causing further harm across all aspects of life including to tinana[33], hinengaro[34], wairua[35], whānau, and mauri[36]:

> Whakamā is a type of trauma. When you have experienced a trauma or mamae and you keep it hidden, you are holding onto things that you cannot release. They fester and cause a wound to your tinana, to your hinengaro, to your wairua, and it will affect your whānau, it will diminish your mauri. (K15)

Many of the kaimahi believed that people might not recognise the extent of the whakamā they are carrying as well as how much power it has over them until active steps are taken to address and acknowledge it, as opposed to allowing it to remain hidden. As one participant reflected,

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[32] To form, make, also refers to a shape, appearance, condition, character, likeness.
[33] Body.
[34] Mind, thought, intellect, consciousness, awareness.
[35] Spirituality, spirit, soul.
[36] Life principle, life force, special nature, source of emotions.

> When you're ignoring it and stuff like that, it's not until you start to unpack you realise how much you've ignored it and how much it's just sat there and it operates and drives your life. (K1)

In conclusion, this theme seeks to highlight how challenging it can be to identify and describe whakamā because of how 'big' it might feel. Whakamā may be experienced as pervading into broad areas of life, making it hard to identify specific causes. Whakamā may accumulate across generations and within whānau, again, making it difficult to explicitly name. Although difficult to identify, whakamā may be 'felt' as a taumaha with ongoing negative impacts.

Whakamā is difficult to go near: "It's like poking the bear." All of the kaimahi experienced whakamā as being a challenging topic to kōrero about with tāngata whaiora. Kaimahi felt that people often avoided speaking about experiences associated whakamā because this made them feel vulnerable. Further, kaimahi experienced whakamā in tāngata whaiora as often being hidden underneath other layers of emotion and coping behaviours, making it hard to bring to the open and address.

Like others, the following participant believed that they could feel whakamā in a room but found it difficult to address. The presence of protective layers made speaking to experiences associated with whakamā feel taboo, like "poking the bear."

> It's just there in the room and you can't go near it – you know how people say it's like poking the bear … It's like this bear hidden in a cave deep inside them and they've dug it deep and have they all this stuff around them to try and protect them. Whether it's using substances or violence or just not wanting to talk or not wanting to be vulnerable – it's just really hard to get near it. (K1)

The following kaimahi described how such barriers could be a mechanism to avoid feeling the pain of exposure. For example, feeling whakamā about not 'measuring up' up to others,

> There may be whakamā in the picture but people, obviously because they do experience that they don't want to be exposed and for people to see how vulnerable they might feel or how they don't feel like they measure up and of course they're not gonna want to reveal that to people. (K15)

Some kaimahi spoke about the role whānau might play in silencing kōrero about whakamā, especially if speaking out had shared implications like bringing further shame onto whānau, hapū, or iwi.

> Whānau put boundaries around it because of the shame and the whakamā that it would impose on other people within the hapū … It's like suicide and all those other things you don't talk about it. You isolate it because it brings shame on the whānau. (K17)

One kaimahi spoke about how this silencing behaviour may not only be associated with preventing further whakamā, but might function to protect the mana of others from being threatened.

> People don't want to tread on other people's mana so they use that haven of whakamā to perhaps just try and deflect it away from that particular conversation. (K10)

Although, many other kaimahi spoke about the negative implications of keeping whakamā hidden. Despite being painful to open up about, carrying whakamā in silence may create an even heavier burden. As one kaimahi described,

> I see it often and I think the quietness of whakamā can be a real burden for a person to carry because they are unable to speak the truth of what's happened to them or able to really, clearly articulate the issues. (K7)

The same person went on to express that whakamā could lead to disconnection, not only from others but also from other important internal processes like attuning to wairua, which ultimately could negatively affect wellbeing.

> I think whakamā and wairua, they have a connection – whakamā can be a block for people to be able to channel themselves to having wairua experiences because they're stuck in this dark place … there's a bubble around them that prevents them from being connected. (K7)

Some kaimahi felt that whakamā could stagnate progress in therapy, although this was sometimes hard to recognise due to its hidden nature,

> That's that unspoken again. That silent piece which they haven't talked … in my early stages I didn't understand that whakamā … I found, somethings blocking them,

> something's not allowing them to hold and take ownership and it wasn't until I worked more on it I found this whakamā. (K13)

However some kaimahi challenged that behaviours associated with whakamā may serve a protective function, especially for tāngata whaiora who may not feel ready to expose themselves in particular ways. As one kaimahi shared,

> Whakamā is a protective uh, it's our way of not letting the unsaid be said. (K10)

Many of the kaimahi described noticing when it was uncomfortable for tāngata whaiora to speak about topics that were associated with whakamā and when this arose, some experienced a need to steer away from the conversation. Often these exchanges were not directly spoken about but cues from tāngata whaiora were felt or seen. For example,

> You know when people are getting to that stage where, 'ah yeah, you're getting a bit close to walking on shaky ground with me there.' So that's another thing. It's a sense thing. You feel that maybe we shouldn't be going down there, that road, maybe we should try something else and change the subject altogether and move away from it … so people will let you know in their own way how they're feeling about things that are too touchy to talk about. So recognising that. A change in the way they look at you, a change in the way that they talk. All those things come into it. (K16)

Although others felt it was important to give tāngata whaiora the opportunity to "release" and talk through experiences associated with whakamā as opposed to keeping these hidden. As one kaimahi shared, despite initial feelings of discomfort it was possible to create a space for healing kōrero to occur.

> It's just been bubbling away, bubbling away and you give them that opportunity to release, then they release but then they can try and dart off. So um, it's bringing them back, acknowledging their kōrero as they dart off and then bringing them back in, 'hey come on,' (laughs) 'let's sit in this place for awhile.'(K13)

Another kaimahi stressed that holding on to whakamā was a choice. They stressed the importance of taking an active step towards opening up and talking about whakamā to reduce the suffering caused by keeping these experiences hidden.

> I do think it's us that carries it. We're holding onto it and the power is ours to release that and to shed the light on things and to open our hearts and share. While the

conditions that contribute to whakamā may happen around us in society, the pain is actually the suffering that we are causing by holding onto that, by keeping things hidden. (K15)

Overall, whakamā may be experienced as difficult and painful to talk about. As such, tāngata whaiora may feel vulnerable talking about whakamā and close off or avoid such conversations. This behaviour might be seen as appropriate within some whānau or in certain contexts in order to not cause further whakamā. On the other hand, keeping whakamā hidden in the long term could contribute to further pain and a greater sense of disconnection from others.

Whakamā is often shown rather than spoken: "It's like a protective armour." Many of the kaimahi felt that internal experiences of whakamā were most readily identified through behaviour. Thus, kaimahi perceived internal experiences of whakamā as more often being communicated through the 'seen' behaviour of tāngata whaiora than expressed through kōrero.

For example the following participant, like many others, described noticing experiences of whakamā in tāngata whaiora well before these were spoken about, particularly during the initial stages of accessing support:

> It takes courage to even talk about it you know, especially when they first come into the service and you see them holding back and that's where you see the whakamā, just don't like to talk about things. (K8)

Many of the kaimahi described noticing withdrawing behaviours and associating these with internal experiences of whakamā. As one participant shared,

> In clients I notice it in their behaviour, or their posture, their avoidance of eye contact. (K14)

Kaimahi also described noticing how tāngata whaiora tended to disengage from them while experiencing active states of whakamā. As such, whakamā may create social disconnection from others. For example,

> I see it a lot in the people we deal with when they're in classes and their heads are down and they're not talking and they're not engaging. (K7)

A few kaimahi felt withdrawal behaviours associated with whakamā could sometimes function as a means of communicating wrongdoing to others. For example,

> I've had a kid just sit down on the floor and just not even budge and that is about being whakamā about what he or she has done. (K5)

On the other hand, some kaimahi noticed how some tāngata whaiora withdrew from others in their lives more generally and related this to whakamā. These experiences were a part of life for some tāngata whaiora as opposed to being associated with a particular situation or incident.

> When I first walked into the house it was in disarray, you could feel – I don't know, how would you call – a state of whakamā within that house … So, this is a family that had never been out of society, dad had isolated them for so long from society and from the community that they would just stay inside doors. Go to school but just come back home and just stay inside doors and not get out there and venture out or anything like that. (K6)

Many described the importance of being attuned to behavioural cues that could indicate triggers for whakamā of particular relevance for Māori accessing services. For example, one kaimahi described observing "sheer terror" across the faces of those who might feel pressured to know certain tikanga as Māori or be versed in their whakapapa when they might not have access to this knowledge.

> As soon as you like go into the room and like – like if you know they're Māori and you start to do whakawhanaungatanga[37], it's just sheer terror that comes across people's faces as soon as you say you're Māori and you're like, okay I know you're Māori but obviously the sheer terror on your face and the whakamā that comes with that, and it's just seen and you can just feel it. (K1)

Like other kaimahi, the following participant believed whakamā could sometimes be masked by more overt behaviours that served as "protective armour" to distance tāngata whaiora from underlying feelings.

> I think in other people it can be shown in different ways, so I think some people can come across as quite, maybe passive or they just seem down or not very energetic or motivated. But then I think there's been other people that I've seen, they don't like that

[37] Process of establishing relationships and maintaining links, relating well to others.

> feeling and so they will kind of put on something else – it's like a protective armour and so they portray themselves as being quite aggressive or you know quite out there and so, I think people show it in different ways. (K4)

Some described alcohol and drug use as being a component of the protective armour masking whakamā, particularly for those who are accessing support from mental health services:

> People cope with using drugs and alcohol to try and make them feel better but it's not really a – it doesn't solve the long term issues, it's just the temporary relief from feeling the heaviness of whakamā. (K7)

Some reflected on how these protective layers of behaviour also functioned as a means of creating social distance and disconnection from others, perhaps so that experiences of whakamā remained hidden. One participant recounted experiences with Māori tāngata whaiora who were whakamā about speaking with Pākehā clinicians albeit these vulnerabilities were masked by "verbally abusive" behaviour.

> They were a lot more verbally abusive towards Pākehā clinicians or they would be a lot more staunch, a lot more abusive and so yeah, I feel - I don't know how, if that would ever be addressed, the whole – what's the word? You know how there's like a wall? (K2)

In conclusion, kaimahi described active states of whakamā as most readily communicated and identified through the behaviour of tāngata whaiora. Behaviour associated with whakamā could be viewed as a 'protective armour' to avoid exposure and vulnerability. These behaviours could include withdrawing, avoiding, disengaging or additional layers of emotions and coping mechanisms like anger, alcohol and drugs. Although these behaviours may serve a protective purpose, they may contribute to further disconnection from others.

How do kaimahi Māori perceive their role in supporting with whakamā?

This section of themes discusses the roles, responsibilities, and priorities kaimahi spoke about upholding to create a space in which tāngata whaiora felt more comfortable opening up about experiences contributing to whakamā. Kaimahi described ways of relating and connecting to others and these may have particular implications in regards to the way whakamā is given space, experienced, and processed. Of note, many of the ideas shared by kaimahi appeared to align with values drawn from Te Aō Māori ways of being, relating, and connecting. The

themes discussed include: Kaitiakitanga[38]: "Create those safe spaces for healing kōrero to occur," Whanaungatanga[39]: "Just treating everyone like my family or whānau," Te Wā[40]: "They do need that extra support and that extra time," Whakapapa: "It's their entitlement to be reconnected."

Kaitiakitanga: "Create those safe spaces for healing kōrero to occur." The following theme speaks to the way kaimahi described how they created a safe space for tāngata whaiora to kōrero. In Te Aō Māori, kaitiakitanga is often referred to in the context of the deep spiritual relationship between tāngata whenua and the land, which through whakapapa they are kaitiaki or guardians and protectors. However, principles that align with kaitiakitanga may be observed in other contexts, including in the way relationships are formed. A basic definition of 'tiaki' is to guard, but it can also mean to nurture, protect and watch over (Marsden & Henare, 1992). Many of the kaimahi prioritised these values especially when working with tāngata whaiora in spaces of whakamā.

Kaimahi recognised that speaking about whakamā could often be a very vulnerable experience for tāngata whaiora. Therefore, it was important to honour the significance of this by treating the kōrero "as something really precious," and actively working to uphold mana. As one participant shared,

> I feel like if someone shows you that they are whakamā that's them being at their most vulnerable and I don't think that that's always held where it needs to be held. It needs to be treated as something really precious. If someone is willing to allow themselves to be that vulnerable to let you anywhere near that, you need to like tread with care and really think about their mana and how you can be really proactive and work in a way that really enhances them. (K1)

Some of the kaimahi described the importance of creating a settled environment for tāngata whaiora to reduce barriers associated with whakamā. This may be achieved through use of processes located in Te Aō Māori such as karakia[41], whakawhanaungatanga, and waiata[42]. For example,

[38] Guardianship, to oversee, to protect.
[39] Relationship, kinship, process of establishing and maintaining relationships.
[40] Time.
[41] Incantation, prayer, blessing.
[42] Song, chant.

> It's probably more around, how do I get that to settle 'cos if I've got those things unsettling my client's in a room, usually karakia, whakawhanaungatanga breaks those barriers down for me and waiata … we deal with that whakamā everyday with our whānau coming up here so it's definitely about how do we settle that, so that they're not feeling taumaha or riri[43] about being here. (K5)

All of the kaimahi recognised the importance of tikanga when connecting to Māori tāngata whaiora. The following participant highlights the importance of following appropriate tikanga processes when connecting with tāngata whaiora to establish a safe and containing space in which "healing kōrero" may be shared, held and processed.

> There's just the tikanga and the values that create those safe spaces for healing kōrero to occur … you have your karakia and your mihi[44] and your round of whakawhanaungatanga … whether or not somebody shares the same beliefs as you or identifying with wairua, you still tend to that and create those safe spaces so that you know when you enter into a space that people can bring their own tikanga into the picture. (K15)

One of the ways in which some kaimahi tried to provide safety was by demonstrating manaakitanga[45] through acts of hospitality and generosity to address unmet needs that tāngata whaiora might not directly speak out about, perhaps as a result of whakamā. For example,

> You offer things that they most probably wouldn't have asked for but you offer it anyway, so they don't feel embarrassed. You know, they're not gonna say, 'Oh I don't have any milk and bread,' but part of the tikanga of Māori is that you know – part of us getting together is always with food and you'll always take bread and milk. (K12)

Many spoke about the need for containment and consistency when working with tāngata whaiora so as to create a safe space for kōrero about whakamā to be shared. The regular use of karakia to open and close kōrero was viewed by many as a means of establishing these parameters. Karakia also made space for wairua and allowed sensitive kōrero to be contained. As one participant shared,

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[43] Angry.
[44] Speech of greeting, establishing a relationship.
[45] Enhancing the esteem of others through hospitality, generosity, and kindness.

> If you maintain the wairua from the beginning right through their treatment, it's (whakamā) easier to deal with … Each person that I've got under my care will know that we won't start anything without a karakia. When I go to visit them, 'Ohh it's my turn eh bro,' and I say 'yeah it's your turn bro,' and I say, 'well what you got?' And they karakia … Because things are changeable. People change. Moods change. So we bring it back to, 'Where was it when we started bro? 'We started with a karakia.' 'Well things haven't changed that much.' (K10)

Some of the kaimahi spoke about the relationship between whakamā and violation of tapu[46], alongside the negative impact this may have on a person's mana. The following participant described the need to address this violation so that whakamā does not "fester" and cause further harm. A few kaimahi shared that, at times, it may be appropriate to call in taurawhiri[47] to facilitate restorative healing processes such as hohou rongo[48].

> I always work with, is always to address, enhance and restore tapu, sacredness, wellbeing so that that person has the mana, the spiritual power and authority to play their role and achieve their goals in life. So it's addressing and finding where the violation is. Addressing it. If that looks like in a hohou rongo - let's get that done ASAP. If there is any take[49] it has to be addressed straight away 'cos under the carpet it's like a festering hakihaki[50]. (K9)

A few of the kaimahi also highlighted that sharing sensitive kōrero could place tāngata whaiora into a state of tapu and so it was important to follow appropriate tikanga to support them in transitioning back into a state of whakanoa[51] and creating a sense of safety by maintaining this balance. For example,

> To do it in a mana enhancing way … to settle and tau[52] that space by acknowledging through mihi … acknowledging all those elements in the space is a way to whakanoa that process. (K18)

Some kaimahi described the impact of physical space and the importance of attending to whether tāngata whaiora felt comfortable sharing kōrero within a particular environment.

[46] To be sacred, prohibited, restricted, set apart, forbidden, protected.
[47] Māori tikanga or cultural advisor.
[48] Reconciliation process to facilitate peace.
[49] To originate, derive.
[50] Skin disease, rash, itch, sore.
[51] To remove tapu restrictions.
[52] To settle down, subside, abate.

Sometimes there was a need to break away from an office space and connect to whenua. As one participant described,

> What I found working with tāne[53] was, I couldn't work with them in the office, for some reason the walls didn't feel right in the office and I don't know if that was a western model or something but it just didn't feel right … Summer was beautiful cos it was light late, so we'd sit out on a bench, if it was raining I found that we needed to find a bench under shelter, where they just seemed to be able to connect outside. It was still in the surroundings of the service but it was outside. For some reason, that really allowed them to start feeling and connecting. (K13)

Kaimahi recognised the responsibility they held when supporting tāngata whaiora in vulnerable spaces. This responsibility extended to recognising their own āhua, acknowledging, and responding to how this may impact their relationships, so as to not cause further whakamā.

> It comes with a responsibility. You need to be aware of what you bring and how your own āhua, your own kind of wairua can affect those relationships and interactions and then there's that commitment to tikanga and doing things right because you don't want to do any harm and it's not just words. (K15)

In summary, establishing safety within the relationship between tāngata whaiora as well as within the environment that kōrero took place in was considered to be an important factor when establishing a space to name and process whakamā. The notion of establishing safety within relationships may relate to the value of kaitiakitanga, with kaimahi acting as kaitiaki over this process. Ways of creating safety may include utilisation of containing tikanga processes, like karakia, and use of more intensive restorative healing processes (e.g., hohou rongo) where appropriate. Kaimahi also recognised the importance of being attuned to their own āhua and how they might respectfully respond to potential triggers for whakamā.

Whanaungatanga: "Just treating everyone like my family or whānau." Many of the kaimahi described how they built and maintained positive relationships with tāngata whaiora. These processes appeared to align with the concept of whanaungatanga. In this context, the process of fostering whanaungatanga was about building genuine and reciprocal relationships through shared linkages and commonalities. Kaimahi observed Māori tāngata whaiora as being sensitive to power imbalances in mental health services as well as the threat

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[53] Male, man.

to mana these could pose. The latter may create barriers in regards to tāngata whaiora feeling comfortable talking about whakamā. Conversely, embodying whanaungatanga in the way relationships with clients are built could help to defuse clinical hierarchies.

Kaimahi spoke about the unhelpfulness of focusing primarily on "clinical stuff." Making space for whanaungatanga was about connecting to tāngata whaiora as a whole person. As one kaimahi described,

> It's just like, let's leave the clinical stuff and let's focus on the you. Who is your whānau? Who are you? You tell me in your words. (K11)

Many of the kaimahi described how they preferred to treat tāngata whaiora like members of their own whānau enabling them to connect as a whanaunga[54] instead of as a clinician. The following participant observed how tāngata whaiora immediately felt more comfortable through relating in this manner,

> Just treating everyone like my family or whānau. 'Cos I'm Māori, you're Māori, we're probably whānau! So yeah, just treating them like that and then it came across, and so they would interact with me a lot more. They'll be a lot warmer. (K2)

The same participant went on to describe how over time, tāngata whaiora began to reciprocate as whanaunga,

> I would just walk on the ward and they would immediately, they would be like, 'Kia ora[55], Sis.' (K2)

Kaimahi spoke about creating a structured space for whakawhanaungatanga, which then gave them the opportunity to share more about themselves and reciprocate when connecting with tāngata whaiora.

> I always feel that, like they're giving me an hour of information but it's kind of like, 'why would I give that to you if I don't know who you are?' So yeah that whakawhanaungatanga. It always works and it always helps and I always find that. (K10)

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[54] Relative, loved one.
[55] Greeting wishing good health.

As the following participant describes, the structured process of whakawhanaungatanga typically involves giving everyone an opportunity to introduce themselves including their whakapapa so that shared connections can be identified that set the foundation for genuine relationships to be built,

> I say where I'm from, my name, and what I do here and then I get whoever else is in the room as well to do the rounds … and get them to say where they're from and say, "oh yeah, you know so and so. Or, are you related to so and so?" And that's the good of having whakawhanaungatanga, it breaks their whakamā thing … Gets you that connection straight away. (K8)

One kaimahi spoke about how whakawhanaungatanga can be used as a means of defusing clinical hierarchies and instead allowing kaimahi to connect as a Māori and through whakapapa,

> It's like they're remembering that there's not this whole hierarchy thing of me being this nurse that has to tell you to take your meds, or help you … It's like, I'm just another Māori girl … It doesn't always have to be about all the physical and mental health things, just learning about their whakapapa. (K2)

Some kaimahi felt that the process of building reciprocal relationships through whakawhanaungatanga did not have to be explicitly focused on shared whakapapa. Instead, shared commonalities can be identified across all areas of life,

> That's whakawhanaungatanga. Creating and establishing relationships with your tāngata whaiora through pepeha, through whakapapa, through commonalities. "Okay, what do we have in common?" Doesn't necessarily have to be whakapapa … You might like sewing and I like sewing too and then we both like sewing and then now we've got a common – we're building that dynamic into relationships. (K9)

Some kaimahi observed how offering a structured space for whakawhanaungatanga could sometimes trigger whakamā in tāngata whaiora, especially for those who might feel disconnected from their whakapapa. A few kaimahi described how normalising the pain of feeling disconnected and sharing their own experiences of this could be a means of connecting and actually strengthening whanaungatanga,

> Often when I'm doing whakawhanaungatanga and stuff like that, if I can see that sheer terror, it's just normalising it. I'm like, "nah, it's completely understandable", like kind of talking about the fact that like my dad's Māori and my mum's Pākehā, raised in the city, not raised in my iwi but trying to reconnect and just kind of sharing that like, actually it's not something that I was just born with … I've actually come on a journey too. (K1)

A few kaimahi spoke about the connection between whanaungatanga and aroha. As one kaimahi described, aroha is not just about 'love' as the word is typically translated. Showing aroha by recognising and connecting to the 'hā[56]' or essential essence of a person may in turn give space for whakamā to be revealed.

> It's about aroha. Because aroha in my mind is when you turn to or face or pay attention to someone's hā, their essential essence, not this persona, not their Instagram persona or anything, the true person and if you are seeing that you will see those things that are whakamā, those things that are hidden. (K15)

Overall, kaimahi spoke about the importance of building reciprocal relationships with tāngata whaiora. Many directly referred to this process as establishing whanaungatanga. Connecting through shared commonalities may help to defuse clinical hierarchies contributing to experiences of whakamā. Further, prioritising whanaungatanga may spark a transformative shift away from a client – clinician relationship towards a whanaunga relationship, facilitating connection at a deeper level.

Te Wā: "They do need that extra support and that extra time." This theme refers to the importance of upholding mana of tāngata whaiora by allowing sufficient space and time, or Te Wā. Kaimahi spoke about allowing stages of kōrero to unfold so that whakamā may be spoken to through a process that is driven by tāngata whaiora. Conversely, rushing this kōrero process may contribute to further whakamā. This theme attempts to capture these ideas.

Some kaimahi felt that it was particularly important to take extra time when working with Māori tāngata whaiora. This was seen as particularly important because of the additional barriers to accessing services that Māori may face. For example,

[56] To breathe, essential essence.

> Spending the time with them. Like, putting time into them, 'cos that's really how it's done really with anyone, but with Māori definitely. Because those walls are there, they do need that extra support and that extra time. (K2)

The following kaimahi, like many others, felt that processing whakamā often required time and patience especially for tāngata whaiora who may have lived with whakamā for a long time.

> You need to allow people to feel the freedom of letting things go, helping people let go of their whakamā. But it's a long process, a long process for people because they carry it with them for most of their lives. (K7)

Many cautioned against rushing the kōrero process when someone is whakamā. Taking the time to build a relationship with tāngata whaiora and allowing them to lead the conversation had the potential to be healing. Conversely, when kaimahi go "straight to the guts" it is possible that tāngata whaiora will become "defensive." For example,

> What I see from non-Māori is they just go straight to the guts … then all of a sudden instead of being whakamā, they become defensive … 'oh no, I don't know anything,' yet they've got the whole picture. Whereas with Māori, when they meet someone whose whakamā – but the word whakamā doesn't come into the fore until they make a relationship with that person. (K16)

One participant associated the process of speaking to whakamā with kumekume[57], which in this context could relate to tāngata whaiora experiencing an internal struggle between wanting to open up and wanting to retreat from the kōrero process. They described needing to strike a balance between allowing tāngata whaiora to lead the kōrero at their own pace, while also ensuring that the kōrero is maintained and not shut down.

> Allowing where they're feeling … They can lead the way. But don't rush them and don't cut it off too quick. Cos I've noticed that they'll start doing so much but then they'll stop cos they're in that kind of, kumekume with themselves. The kumekume has been with them for a long time so it's allowing that kumekume and if they're starting to fade back, that's when I'll pull them back into that healthy kumekume again. (K13)

[57] To pull back and forth, draw into, attract.

The same participant described how sitting in silence could give tāngata whaiora an opportunity to connect with whakamā. Often wairua could be felt during these moments. As one participant shared,

> Working with the wairua I feel the whakamā connect and come into it yeah and that's when I see them sitting in that space in silence and that's where you've got to allow them that time for that silence, however long that may be. (K13)

Others described feeling limited in their capacity to spend adequate time unpacking layers of whakamā with tāngata whaiora and connecting to wairua given the demands of their workload.

> I think for me in this role that I've got at the moment it is quite fast paced and so I haven't actually been able to go to a wairua space with many of my current whaiora. (K4)

In lieu of one-to-one kōrero, some kaimahi expressed that groups provided the time for tāngata whaiora to grow comfortable and begin to open up. The same participant reflected on how they were able to foster a space of sharing at a raranga[58] group they facilitated,

> The group will become quite close and quite tight – because when you're just sitting there just weaving it's like – you know the stuff we're doing is not complicated and so you end up just chatting. Talk, talk, talk, talk, talk and then it's our job as the facilitator to start dropping little, 'oh, how's things at home?' … we just drop these little conversation starters and off people go. (K4)

Many of the kaimahi felt that opening up and working through whakamā did not have to happen all at once or in one particular context. Instead, it was possible to gradually build confidence in sharing kōrero with others through, "a series of little steps."

> If you have one experience like that then it means that you can feel comfortable with having more like that, and it doesn't need to be all or nothing, it can be a series of little steps through the relationships that you form with people and the kōrero that comes out of it. (K15)

[58] Weaving.

At the same time, opening up and sitting with whakamā was seen by many to require making an active choice to do the opposite of go-to coping strategies like avoiding or withdrawing. As one participant shared,

> Yeah, so in that moment that I was crying I kind of had to feel, like do I stay in that state of whakamā? … Or do I just feel? Do I let my wairua take over and breathe and then feel those emotions and go through those emotions and cry? (K6)

The same participant described how in the same way whakamā has the power to shape a person or whānau, it was also possible to take steps toward shaping a new narrative in which it is possible to make active choices towards positive change.

> It can either shape you as a person or it can either give you the driving force to do something different … So, for a little while there I allowed it shape me – I was in a state of whakamā for quite some time until I became an adult in my 30s and then realised, actually education was my way of changing. (K6)

In summary, kaimahi described how making space for time, or te wā, may allow for wairua to direct how and when kōrero unfolds. Being a step-wise process, te wā does not require that tāngata whaiora open up about experiences of whakamā at one occasion or within a specific context or relationship. Instead, tāngata whaiora may have a series of experiences that allow them to kōrero and build confidence in doing so. Although, kaimahi may also play an active role in facilitating a kōrero process.

Whakapapa: "It's their entitlement to be reconnected." This theme highlights the relationship that many of the kaimahi described between fostering a greater sense of belonging and connection to whakapapa and healing entrenched experiences of whakamā. Kaimahi felt that learning more about whakapapa afforded tāngata whaiora the experience of belonging to something 'bigger' than experiences of whakamā. Kaimahi spoke about many different ways of supporting tāngata whaiora in their journey to connect with whakapapa, as outlined below.

Some of the kaimahi described wairua as being a transcending and binding component to whakapapa, connecting us to the mana of our tupuna even for those in Tāmaki Makaurau who might feel disconnected. As one participant shared,

> Wairua informs me that this person does not just come alone … they bring with them the vibration and the experiences that their ancestors have had. (K18)

All of the kaimahi believed that finding ways to help tāngata whaiora reconnect with their whakapapa was an important part of their role as kaimahi Māori, especially given the large proportion of whānau in Tāmaki Makaurau who may have experienced some disconnection.

> A lot of our kids these days are not connected but as a Māori clinician I feel as though that's their entitlement. It's their entitlement to be reconnected and if they're even that little bit open to it, then I'd like to be able to awhi[59] them. (K11)

Many recognised the significance of returning to tūrangawaewae and connecting to whenua especially for tāngata whaiora living outside of tribal territories and who may feel disconnected to whakapapa. As one participant shared,

> I talk to people and they say 'I'm from Otara,' but, 'You're not really from Otara. Where's your family from?' Oh they're from up North. 'But I haven't been back there.' 'You think it' about time? It's not that far away. Go and touch your mountain go and get a drink from your river and go for a swim.' (K10)

Some kaimahi reflected on the mana enhancing impact of recognising and celebrating āhua of tāngata whaiora that might have been shared by tupuna. In this manner it can be demonstrated that they are not only connected to, but "a part" of their whakapapa.

> Being a part. Imagine having a kaumatua[60] be able to recognise in your face your tupuna and connect you, and also, so there's that āhua, you may have the same momo[61], you may have the same gifts, talents, and pūmanawa[62] and having that from a kaumatua, like I said can be profoundly healing, validating, mana enhancing. (K15)

In turn, identifying with whakapapa may enable us to be propelled toward a particular direction in life that aligns to the dreams and aspirations instilled by tupuna. Thus, whakapapa is not purely associated with the past; whakapapa drives us to take active steps forward.

> Yeah, our tupuna, kua mohio kē ratou (they always knew). I think it's about our generation to carry those aspirations and dreams of them alive and you know, despite

[59] Support, care.
[60] Elder(s).
[61] Type, variety, kind, race, species, offspring, descendant.
[62] Talented, gifted, intuitive cleverness.

what's happened with colonisation, our tipuna[63], it's in our DNA, it's in you, who you are, your whakapapa. (K9)

One kaimahi felt that enhancing action in tāngata whaiora could be ignited through kōrero about their mana to carry out roles held within their whānau or community. Further, pointing out the roles they have inherited through whakapapa such as being tuākana[64] of the whānau, might challenge the beliefs of tāngata whaiora who feel they lack mana.

> Imagine if you ask people where do you rate yourself on your mana? Where would you want your mana to go? What about mana you hold in your whānau? What is your role in terms of having that mana, whether you're a tuākana or a tēina[65] in your whānau? We all have, based on our role in our whānau, or our system, the mana you carry would have different roles and expectations and responsibility. (K1)

Many kaimahi felt that giving tāngata whaiora an opportunity to build positive connections with Te Aō Māori could be mana enhancing. The following participant ran a kapa haka[66] group so that tāngata whaiora who may have had limited access to Te Aō Māori could learn waiata and build a sense of connectedness.

> I ran that kapa haka group and a lot of them didn't know anything about Māori waiata … I had a book made up and they'd go through it, "oh, can we sing this one? I don't know this one" … after five weeks, man I tell you, they were all keen to carry on. (K8)

Some kaimahi reflected that specific healing practises located in Te Aō Māori could be used to support tāngata whaiora in spaces of whakamā. Sharing these processes with whānau who have become disconnected from this knowledge could be healing in itself so that these traditions can be once again passed down through whakapapa.

> Another kōrero again (is) on how to take you out of that state of whakamā through a healing process, what our tupuna already knew, hohou rongo. And see, these are the values I'm talking about that were passed down from our tupuna but our whānau, the

[63] Ancestors, grandparent.
[64] Older brother (of male) or sister (of female), more skilled individual in a particular area relative to tēina, or less skilled individual.
[65] Younger (of male) or sister (of female), more skilled individual in a particular area relative to tuākana, or more skilled individual.
[66] Māori cultural group, Māori performing group.

> ones that I've come across here in South Auckland they don't know this kōrero, they've never been shown. (K9)

Some kaimahi compared the transformative effects of shaping a positive Māori identity to western models of mental health that may not always be mana enhancing for tāngata whaiora.

> People go round and round and round in a western models … it's a matter of learning, claiming, reclaiming our language, identity, is I think a step towards addressing whakamā. Being proud of who we are. (K7)

For example, instead of taking a deficit approach the counselling model Te Tuakiri o Te Tāngata focuses on building a strengthened sense of identity as Māori across holistic aspects of the self, which may inadvertently address whakamā.

> It takes away that whole tauiwi[67] kōrero around depression and anxiety and suicide and self-harming (pause) but it doesn't – it replaces aye? It replaces. Te Tuakiri o te Tāngata replaces a lot of those kupu that we so freely use in our clinical decisions making but it gives the whānau a better picture on who they are and understanding around what it is to be tauiwi to what it is to be Māori. (K5)

In conclusion, kaimahi felt that an important part of their role when working with Māori tāngata whaiora was supporting them to build a stronger connection to whakapapa, especially given the level of disconnection many Māori face in Tāmaki Makaurau which for some may be associated with a sense of whakamā. This could look like, facilitating connection to tūrangawaewae or access to Te Aō Māori affirming spaces such as, kapa haka group. This could also look like exploring and reconnecting with internal attributes and traits linking tāngata whaiora to their whakapapa. Reconnection to whakapapa may bolster a strengthened identity, reducing experiences of whakamā and uplifting mana.

How do mental health services contribute to whakamā?

Almost all of the kaimahi expressed frustration about their capacity to work effectively with Māori tāngata whaiora under the limitations and constraints of tauiwi mental health services and because of the inequitable way mental health service provision is structured in Aotearoa. These barriers may contribute to further whakamā for tāngata whaiora accessing mental health services. This section speaks to these barriers across three themes; Discrepancy of values: "It's

[67] Non-Māori, foreigner.

never given the space," Lack of cultural competency: "Clinicians don't have the skills," and Lack of bicultural partnership: "That funding should've gone to a Māori service."

Discrepancy of values: "It's never given the space." Kaimahi spoke about the differences between tikanga values and processes significant to Te Aō Māori and the values underpinning tauiwi mental health services. These discrepancies made it hard for them to feel like they could fully utilize their knowledge, skills, and ways of relating as Māori within their clinical roles. These ideas are described below.

Kaimahi felt that whakamā was rarely understood or recognised by tauiwi mental health clinicians. As one participant stressed, when whakamā is not acknowledged as contributing to mental health challenges, clinicians were at risk of invalidating tāngata whaiora and causing further whakamā.

> Whakamā never comes into formulations … it's never given the space … I think when space isn't given to it that produces whakamā. (K11)

However, kaimahi also expressed caution about the way whakamā might be wrongly interpreted especially within tauiwi mental health services operating through a medical model. For example,

> The issue with our mental health system is because it's based on a medical model … But actually like whakamā, why does it have to be pathologised? … If you pathologise it, it means it's something that's bad and the more you make whakamā bad, then the less likely people are going to address it. (K1)

Further, some kaimahi spoke about the discrepancies between western ideologies underpinning tauiwi mental health services and values important to Te Aō Māori, resulting in a need to decolonise our way of thinking. For example,

> To address whakamā and the causes we have to decolonise our way of thinking to develop an indigenous lens as practitioners … We have to decolonise our way of thinking about and it's about understanding the whakapapa of all these imported ideologies. (K18)

Similarly, some felt limited in their capacity to demonstrate values important to Te Aō Māori within a mainstream context. One participant described their own whānau as relating in ways

that embodied aroha and manaaki but this was in contrast to what they felt were "cold" clinical settings.

> There's that whole communication thing. It's like, you know, kaupapa Māori family, we do a lot of things through food and a lot of things with lots of love. So lots of hugs, lots of kisses, lots of greetings and then when they were in hospital, it was just different because like, you know, it's very clinical, very cold, you know, their approach towards them was different. (K2)

Similarly, one participant described experiencing an incongruence between the tikanga values in which they were raised and their "professional" roles and responsibilities. This was especially apparent when supporting Māori tāngata whaiora.

> So, having those debates. Who should have been the one to tell his parents? Who should have been the one to do that kōrero? He says, "As a professional it is my job." But as a Māori there are some processes that you should have done, like ask no hea koutou? (Where are you from?) Ko wai tō whānau? (Who is your family?) Have you got kids here? Who should I go and ring? Those sort of things. (K2)

More broadly speaking, some of the kaimahi spoke about the discrepancies evident between the individual client relationship and the place of collective identity in Te Aō Māori.

> The differences are just very different in terms of tauiwi. I just think that to work with an individual on their own when there's a whole whānau, hapū over here who wants to know what's going on, it's a bit hard. (K5)

Some felt that because Te Aō Māori was not valued by tauiwi mental health, the specific skills held by kaimahi Māori often went unrecognised. With mana being attributed to university qualifications, taurawhiri in particular may feel whakamā in mainstream services despite the depth of mātauranga Māori[68] they may hold.

> If you're a taurawhiri and you don't have a tohu[69], you haven't been to a university but actually, you're raised by your kaumatua and your kuia - that is your degree … You have a unique, valuable experience and mātauranga that this valuable, but if you're not necessarily valued by the organisation. (K15)

[68] Māori epistemology.
[69] In this context – qualification.

In summary, kaimahi noted differences between values relevant to Te Aō Māori and values driving the way tauiwi mental health services are structured, particularly values drawn from the medical model. The medical model typically conceptualises tāngata whaiora as an individual 'patient' requiring treatment from a clinician for an illness. By comparison, kaimahi firstly valued building whakawhanaungatanga and connecting with aroha with both the client and their wider whānau. Because of these discrepancies, some felt they were unable to best utilise their skills as Māori clinicians when supporting tāngata whaiora.

Lack of cultural competency: "Clinicians don't have the skills." Kaimahi raised concerns about tauiwi mental health services not prioritising the development of cultural competence amongst clinicians. Kaimahi described how this lack of cultural accountability may contribute to greater experiences of whakamā for Māori accessing services that fail to recognise or understand the significance of cultural experiences and context.

Many believed that clinicians were not held accountable for building and maintaining cultural competency to work with Māori. Some believed that university training programmes reinforced a complacent attitude toward developing cultural competence due to being saturated by western paradigms.

> Clinicians don't have the skills. I think it's ridiculous that you can go through and get a doctorate or you can go through and get a degree but you can't learn five lines of a pepeha or you can't learn a karakia or you can't learn to pronounce a name right. (K1)

Some of the kaimahi stressed that clinicians who lack cultural competence could cause further harm and whakamā to tāngata whaiora by misunderstanding or misinterpreting behaviour and presentation. For example,

> I was called in to see this young Māori boy and they thought he had mental health because of the responses he was giving back to them when they were asking questions … so he spoke fluent Te Reo … he had a lot of whakamā because of his language. He goes 'no, I can't understand them.' He goes, 'I wish I never had this, I wish I never had Te Reo, I wish I could speak English like everyone else.' (K17)

Some described feeling unsafe talking with Pākehā colleagues about wairua experiences or healing processes relevant to Te Aō Māori, even if they felt deeply connected to these, out of fear that their clinical practice may come into question. As one participant shared,

> It (wairua) comes in my work as well. I mean I have shared it and I got some feedback from someone that misunderstood my intentions so I'm quite careful now … It was a Pākehā person as well. They just didn't receive it in the way it was given so I thought, well it was good to understand these things. (K14)

A few expressed anger at hearing Māori tāngata whaiora being spoken about by tauiwi clinicians in a way that perpetuated negative ideas and assumptions about what it means to be Māori. These comments and assumptions could be made in place of actual knowledge about the client's own history. As one participant described,

> I've seen it a few times with you know, 'Oh, he's Māori … he's probably exposed to all the gangs, probably is in a gang, probably wants to be in a gang … if it was a Pākehā boy … they wouldn't say, 'Oh, that's a Pākehā boy, he wants to be in a gang, he wants to do this, this and this.' They'll be like, 'Oh, this is a Pākehā boy.' That's it. (K2)

Perhaps because of a general lack of cultural competency within tauiwi mental health services, some kaimahi recounted stories of tāngata whaiora being discharged for 'not engaging' instead of taking responsibility as a service. Such experiences could lead to greater whakamā and avoidance of services in the future:

> If you're not towing the line then you're probably going to be closed and probably that whakamā will be even greater. (K8)

Some kaimahi felt that high disengagement rates for Māori accessing tauiwi mental health services was again indicative of a lack of cultural competency to meet the needs of whānau. For example,

> You either make the choice to come back or you say 'actually, I don't need you.' We've seen it, we have quite high DNA rates. Māori have high DNA rates. But has anyone asked them why? Is it because maybe after their first assessment they feel judged or they feel even more embarrassed or shy to come back. (K11)

The same participant highlighted the tendency for tauiwi services to displace responsibility onto Māori clinicians when there are challenges with 'engagement' of Māori tāngata whaiora, instead of addressing structural issues like failing to have culturally safe processes in place at initial point of entry, or addressing the lack of Māori staff. Instead, kaimahi Māori can be left to feel like the "clean-up crew":

> After having an initial assessment with another clinician whose not Māori, they're actually coming back to be re-allocated because of engagement issues and often the ask is for a Māori clinician to step in and we are so short on the floor that we can't always provide that cultural service … I felt like the Māori clinicians were being used as the clean-up crew. (K11)

One participant reflected on the difficulties of challenging clinicians within "their setting" as well as the pain and personal experiences of whakamā this has caused them:

> I had to challenge these two psychiatric nurses around being straight clinical … You imagine having to walk away from that process knowing, because they don't have any indigenous methodology at a level to understand me – you imagine how much whakamā was going on then? … having to challenge the status quo, the dominant culture in their setting. (K18)

Overall, kaimahi expressed concern at how building cultural competence to work with Māori tāngata whaiora did not appear to be a priority for tauiwi mental health services. Tauiwi clinicians who lack understanding and awareness about areas relevant to Māori are at risk of distancing not only Māori tāngata whaiora but kaimahi as well. Further, kaimahi stressed the importance of services taking responsibility for engaging tāngata whaiora instead of displacing this onto clients and Māori clinicians.

Lack of bicultural partnership: "That funding should've gone to a Māori service." The final theme brings attention to the disparate resourcing afforded to Kaupapa Māori service provision relative to mainstream services, despite the high representation of Māori accessing mental health, creating further barriers for Māori tāngata whaiora in spaces of whakamā to access appropriate support.

Notably, a couple of kaimahi questioned whether tauiwi mental health services were even the appropriate space to be unpacking whakamā for Māori? One participant queried whether clinicians should be leaving that process to those who held mana within Māori communities.

> I feel like coming in this system and the way they are set up and clinic rooms, it's not the right environment ... I feel like whakamā needs to be in that safe environment and needs to be not necessarily guided by clinicians but people who can help with that

> process like cultural advisors and kaumatua and kuia who can awhi along people in terms of those processes of whakamana[70]. (K1)

Although some noted that given health and social disparities evident for Māori, many will inevitably find themselves in a tauiwi mental health service especially when Kaupapa Māori services are not resourced to the equivalent of mainstream supports. As one participant shared,

> Māori are overrepresented in the negative social stats. The justice system, mental health, but if Māori wanted to access a Kaupapa Māori service (pause) tough luck. 'Cos basically we're very few and far between. (K15)

The same participant spoke about problems in the way access to Kaupapa Māori was offered. In their experience, gatekeepers to services were often tauiwi clinicians with limited knowledge about what Kaupapa Māori services could offer. This may pose a barrier for tāngata whaiora who may struggle to reach out for support, let alone advocate for a specific type of service.

> Who provides the service offer to our Māori tāngata whaiora? Do you get a tauiwi kaimahi with no familiarity with a Kaupapa Māori service? … With a piece of paper going "ehhh, do you really wanna go to a Māori service?" (K15)

Further, kaimahi spoke about the inequity between resourcing of mainstream services and Kaupapa Māori. The following participant described how Kaupapa Māori services that are already poorly resourced are often forced to compete against larger mainstream services for contracts or funding.

> If it doesn't work, they'll give it to a bigger organisation or service that will do it much better? Well, they don't! All those big services, they end up getting the funding for the service that was dis-established to actually use it for their own purpose and that funding that should've gone to a Māori service. (K16)

Many kaimahi stressed that Kaupapa Māori services upheld the mana of tāngata whaiora and therefore were more effective in igniting change compared to mainstream services that may hold a more deficit-focused lens that inadvertently reinforces whakamā:

[70] To give authority to, give effect to, to confirm, enable, empower, validate, enact.

> If we try and be like mainstream services then we're just going to be perpetuating much of the same and people will just keep walking in and out and they haven't changed. They'll still carry that whakamā with them and often that whakamā will become more entrenched because of the way people are treated within services, they are treated as statistics and not as tāngata. (K7)

In sum, many of the kaimahi described Kaupapa Māori mental health services as the best option for Māori tāngata whaiora to access mana enhancing support, ignite change, and have vulnerable topics like whakamā understood and appropriately held. However, inequities in the way mental health services are offered funding and resourcing means that Kaupapa Māori mental health services are limited and often challenging for tāngata whaiora to access, meaning that many will ultimately find themselves in tauiwi mental health services.

CHAPTER 4: TĀNGATA WHAIORA FINDINGS

This chapter presents findings drawn from the thematic analysis of tāngata whaiora[1] interviews. In total, seven themes are presented and these have been grouped across two categories as shown in Table 2. These categories and themes aim to capture tāngata whaiora experiences of both whakamā[2] and enhancing mana[3], or whakamana[4]. In sharing their kōrero[5], nearly all of the tāngata whaiora told a time-based story of their experiences, which encompassed a beginning, middle, and ending. So as to reflect this, themes have been ordered in a manner that loosely portrays a temporal account of tāngata whaiora experiences including, environments contributing to whakamā, whakamā in response to having a mental health problem and accessing support from mental health services (as well as barriers to the latter), and finally experiences associated with enhancing mana and transformation. As such, these themes present a broad collective narrative of participant's journeys from whakamā through to whakamana. It is also acknowledged that each participating tāngata whaiora has their own unique story, which may not always be fully captured across these themes.

Table 2: List of categories and themes in tāngata whaiora findings

Categories	Themes
Experiences contributing to whakamā	Mana diminishing environments: "Whakamā is a lot to do with the upbringing."
	Whānau responses to mental health problems: "I'd hate them to think, 'oh she's loopy.'"
	Whakamā about having a mental health problem: "It's sorta turned my life upside down."
	Whakamā about engaging with services: "They need to stop trying to help our people in a Pākehā twisted way."
Experiences contributing to whakamana	Making a choice to speak out: "You have to get it out so it can't come back and hurt you."
	Connecting with the right support: "I didn't have to be anything different."
	(Re)Connecting with Te Aō Māori: "You've got something inside of you that you can hold on to."

[1] A person who is seeking wellness, used to describe users of mental health services.
[2] Loss of mana, feeling of shame, embarrassment, shyness.
[3] Authority, prestige, strength, honour, respect, the supernatural force in a person.
[4] To give authority to, give effect to, to confirm, enable, empower, validate, enact.
[5] Narrative, speech, conversation.

Experiences contributing to whakamā

The following category consists of four themes as outlined in Table 2. Each of these themes aim to capture the different ways in which whakamā appeared to manifest in the lives of participants both prior to accessing support for mental health challenges and throughout their journey of seeking help.

Mana diminishing environments: "Whakamā is a lot to do with the upbringing."

All of the tāngata whaiora spoke about navigating experiences within their environment that they perceived as being mana diminishing. Many of the tāngata whaiora recounted growing up in mana diminishing environments that shaped experiences of whakamā in adult life. Others had a broader perspective about the causes of whakamā including the impact of stigma and discrimination towards Māori within society. Examples of these experiences are described below.

Many of the tāngata whaiora described growing up in environments that contributed to experiences of whakamā. Whakamā itself was often perceived as something very personal to discuss. For example, the following tāngata whaiora referred to whakamā as being to do with their "heart," and associated with their upbringing.

> For me, what I'm whakamā about is something to do with my heart. Yeah. Because of the way I was raised. (TW3)

For some, significant mana diminishing experiences happened while growing up that caused whakamā. Greater entrenchment of whakamā appeared to arise for participants living in environments that failed to recognise or respond to such events. A few tāngata whaiora connected early incidents of sexual abuse to ongoing experiences of whakamā. As the same participant from the above example shared,

> It was just situations that happened in the environment. I could go one night at my house getting molested by my cousin and next day I wake up and my cousin's making breakfast and stuff like that and I just have to carry on with a normal day … that was how I grew up to think. (TW3)

Some tāngata whaiora spoke about the long-term impact of whakamā including urges to withdraw and disconnect. For example, one participant described whakamā as a "barrier … stopping you from being your true self" (TW3). Indeed, for others, withdrawing from the

world had become a way of life. This was often a consequence of growing up in environments experienced by tāngata whaiora as mana diminishing. As the following participant shared,

> Whakamā is a lot to do with the upbringing … Cos you're kinda being downgraded so many times. You're shy. You wanna stay in the corner. You don't wanna be heard or seen. I'm like that. (TW1)

Some recounted growing up in whānau[6] environments where they were expected to "harden up." This contributed to experiences of whakamā, especially when tāngata whaiora struggled to meet these expectations. Some tāngata whaiora related a "be tough" mentality as a normal part of being Māori[7]. It must be noted that only one tāngata whaiora spoke directly about the impact of colonisation and intergenerational trauma for Māori. As such, it could be argued that some participants may have internalised intergenerational experiences of whānau trauma and inherited mechanisms of coping/surviving. For example,

> Growing up with Māoris they used to be a bit rough with their kids and if one of them cries … I've seen it heaps of times, and then they go 'eh, stop crying sookie bubba, harden up.' That's just Māoris, that's how they go … unfortunately, that's just how it happens in a lot of the houses, thousands of houses in Māoridom, not all of them, but majority. It's like, harden up, be tough. (TW1)

Another participant described being "put down all the time" while growing up which made it feel like "they stripped my mana off me." They go on to describe how feeling without mana diminished them of their capacity to engage in the world and, similar to the recounts of other participants', this contributed to the mental health challenges they faced.

> I felt like I had nothing inside me. It meant a lot cos without your mana you can't do nothing basically. And then I think that's why I ended up being unwell. (TW9)

A few of the tāngata whaiora spoke about the relationship between discrimination faced by Māori and experiences of whakamā. Having to navigate these experiences daily may contribute to a "deeper reason" for why not only tāngata whaiora but Māori as a people might experience whakamā. As one participant shared,

[6] Family, extended kin.
[7] Founding people of Aotearoa, indigenous people of Aotearoa.

> When I think of whakamā … I think of on a surface that there's a lot of shame or shyness but I think of a deeper reason of that shame, like where that comes from and why that's there in the first place. A lot can be influenced by the media, like stigma. (TW8)

Some participants described hearing negative ideas about what it means to be Māori from an early age within their environment. They described having internalised these ideas, which ultimately had a long-term impact on how their experiences through life progressed. For example,

> When I'm told you're bad, you're bad. All the time, you're bad, you're violent, you're a criminal, gang member, drug dealer. That's the message I get, I'm gonna do that … I guess that's where I belong then brother, it's off I go! (TW10)

Overall, mana-diminishing environments appeared to contribute to tāngata whaiora participants' experiences of whakamā. For some, growing up in environments where it was not okay to be vulnerable, where it felt like they were not taken seriously, or where it felt like they were not good enough compared to the rest of the whānau, shaped experiences of whakamā. Some described absorbing the messages received from these environments, which contributed to urges to withdraw and isolate as well as a perceived lack of mana to make take control of their life. For some, day-to-day environments that reinforce negative ideas about what it means to be Māori were perceived as contributing to whakamā

Whānau responses to mental health problems: "I'd hate them to think 'oh, she's loopy.'" Although whānau were often seen to provide support and advocacy, tāngata whaiora also recounted interactions with whānau that contributed to experiences of whakamā. For some, whānau were unfamiliar with the concepts, language, or interventions for mental health challenges, which contributed to them responding in a way that made tāngata whaiora feel misunderstood, isolated, or othered. Some participants did not actually recount experiencing negative responses from whānau for having mental health challenges but anticipated that they would be judged or perceived as lacking compared to other whānau members, which contributed to experiences of whakamā. Further, some described whānau members as having their own whakamā about accessing services for a loved one and this functioned as a barrier to tāngata whaiora getting support.

A few participants expressed really struggling to speak with whānau about challenges with mental health due to whakamā, and this was often associated with fears of being judged. For

example, the following participant described whakamā as a "barrier" that prevented them from communicating with whānau about their experiences.

> My family do not know I have a mental illness … it's just, really hard. I want to say to family 'this is what's happening for me' … even though we have this 'talk to someone,' 'talk to family,' I can't see that *(crying)* … There is a barrier and that's that whakamā. It's there and *(pause)* I'd hate them to think 'oh she's loopy,' and all that sort of stuff, so I don't say it. (TW12)

A small number of participants described having caused some hurt within their whānau and felt whakamā about this. Consequently, it was challenging to speak out and ask for support. For example,

> I find it hard to communicate with my family and *(crying)* I know I've hurt people. I can't do anything about it cos I did it and I can't take it back. It's already happened. (TW6)

In some cases, tāngata whaiora felt that family members had their own whakamā about being perceived as incapable of caring for their loved one and requiring support from mental health services. Consequently, some whānau tried to put off accessing services. For example,

> I knew that nothing could help me that my Mum and Dad could provide for me. So I said, "Nah, you need to ring up the services, you need to put me into the services, you can't help me." Mum tried to hold off, and hold off, and hold off … I think she was thinking this is my boy, this is my son, I know my son. And so for her it meant that she had to just let me go into the system, mmm. She didn't want to. So there was a lot of shame going into the system too. (TW11)

Accessing services was a novel experience for some whānau that necessitated challenging a shared belief about only getting help as a 'last resort.' Like others, the following tāngata whaiora spoke about how depending on services, including social welfare, during a period of un-wellness led to a whānau response of whakamā.

> My family's the type, like don't go to the doctors until you're dying type. Like a lot of our people. So this was the first time that we dealt with health professionals, the first time we've seen a psychologist, a counsellor, psychiatrist, social workers a whole lot of things like even the consequences of the mental health like first time I had to apply

> for WINZ for the sickness benefit. That was whakamā for my family, it was like, 'oh why don't you just go out and work, blah, blah, blah.' (TW8)

Although for some tāngata whaiora, whānau themselves were viewed as a trigger for whakamā because they did not feel up to standard in comparison to other family members. For the following participant, whakamā was associated with being different to their family and feeling unable to meet expectations:

> They all do well, they've all got good jobs. And I guess if you don't do well it's a shame … Not many of my family are shy so that's quite challenging for myself coz they wonder why I am … I think I'm shy because they have too much expectation, and I'm too scared to be myself because I'm not as clever as them. (TW9)

Some participants had mixed experiences when it came to seeking the support of whānau. For example, the following participant appreciated the opportunity to go home but also experienced whakamā in response to being surrounded by loved ones who were limited by mental health problems in the way they were.

> It was good to be home but the whakamā levels just went right up because I'm surrounded by a loving family who are doing what I wanna do but I can't do. (TW8)

A few participants described having chosen to step away from whānau environments that did not support their recovery, especially if whānau members were facing their own challenges although not yet ready to change. As one participant explained,

> They all still drink so if I was to go back and see them- I haven't seen them for a while. Just that I might have to drink with them, the pressure to drink… Even though alcohol wasn't really my choice of poison, I have such an addictive personality I could just switch. (TW4)

Some tāngata whaiora felt that their whānau were whakamā about anything related to mental health because the ideas felt "foreign" and separate to a Māori way of understanding. Although, in the below example it is stressed that whakamā about having mental health challenges could actually be borne out of misunderstanding as opposed to difference.

> It's seen as such a scientific or western approach, we can be whakamā in even learning it (mental health) because it's not our way.… The terms are all foreign but if we really

look deep into our culture and the mamae[8] people faced … different names but it's the same things. When I think of whakamā that's what I think of, misunderstanding. (TW8)

A couple of participants reflected on misunderstandings that can arise in whānau contexts about gifts such as being matakite[9]. Being judged as opposed to celebrated for having these experiences may contribute to whakamā:

> People with mental illness they've got a gift and there's a lot of families that disown them because of how they look, how they walk, how they speak, it's not making the hapū[10] look strong … it could be a spiritual thing, or something that the tupuna[11] have connected to them. (TW1)

In sum, unhelpful whānau responses (i.e., judging, putting off accessing help) to mental health challenges appeared to contribute and, at times, exacerbate experiences of whakamā for tāngata whaiora. Such responses were typically associated with a lack of understanding contributing to beliefs about mental health being 'different,' 'other,' or something to fear. Notably, for many tāngata whaiora it was more about anticipation that they would be judged or seen to be not good enough through the eyes of whānau – whether this was actually the case or not. Whakamā about being judged also functioned as a barrier to challenging these fears through communication and seeking support from whānau.

Whakamā about having a mental health problem: "It's sorta turned my life upside down." Most of the tāngata whaiora described experiencing whakamā about having a mental health problem, not necessarily at the time of the interview but at points in their journey. This theme explores how some of the tāngata whaiora experienced whakamā due to the perceived stigma of having a mental health problem and the ongoing visible impacts of poor mental health.

A few of the tāngata whaiora had spent years fluctuating in and out of periods of un-wellness. The following participant reflected on societal shifts that have enabled people to speak about mental health issues more openly. By contrast, "huge stigma" contributed to whakamā for this participant when they first experienced mental health challenges 15 years ago.

[8] Painful, sore, hurt.
[9] To see into the future, supernatural insight, special intuition.
[10] Sub-tribe, to be pregnant.
[11] Ancestors, grandparent.

When I came into the services there was a huge stigma around mental health. I think people are more aware of it now but back then and we're talking about 15 years ago … it wasn't as open. (TW4)

For some tāngata whaiora, whakamā about coming to terms with having mental health challenges was exasperated by perceived mental health stigma resulting in urges to withdraw, isolate, and keep problems hidden for fear of being judged or rejected by others:

I think at the start when you're first diagnosed with a mental health condition whakamā is very present. Because it's not things that you would like other people to hear about you … that's when people start to isolate themselves and you end up hiding in the room, behind the curtains, don't want to go out … there's a lot of stigma around it. And if you're a person that hasn't experienced this before, or for the first time, whakamā is very present. (TW8)

Some participants described how navigating periods of un-wellness, including symptoms of psychosis, left them feeling like something was wrong with them, contributing to an experience of whakamā:

You end up in a place into mental health and then you get whakamā of your thoughts, you get whakamā of your whakaaro[12] pattern and you get whakamā of things you normally think about and things you don't normally think about and none of it seems to make sense. (TW3)

Another participant described how it felt like their experience with mental health problems were made visible through scarring from previous suicide attempts and tried to keep these hidden so that others would not know about the difficulties they had faced.

One of the things I'm still whakamā about is I have scars from suicide attempts, I'm pretty good at holding my arms so they can't be seen but when they are and people mention it, it's like "Don't go there." It's that whakamā. (TW13)

Some tāngata whaiora talked about how mental health problems had left other visible markers on their lives in the form of loss of friends and social identity. They spoke about how these signs felt like a kind of failure that contributed to whakamā. For example,

[12] Feedback, idea, reflection.

> It's sorta turned my life upside down …. I never thought I'd be where I am now. Growing up I was always working. Always busy. Always have heaps of friends. (TW6)

A couple of tāngata whaiora described feeling as if they no longer 'measured up' to the expectations of peers due to the mental health challenges they faced. Feeling not accepted and like an outcast contributed to experiences of whakamā:

> The streets of South Auckland. It's about being tough. It's about standing tall … when I was going through the initial stage of mental health and I tried to reach out to my friends, man when I lean on them they were gone. (TW11)

Participants spoke about the loss of control that arose in response to having a mental health problem and for many this included side effects from medication. Below, the following participant described how side effects from medication made it visible to others that something was 'wrong' and being exposed in this way contributed to whakamā.

> One day I was up with the kids, my son, daughter-in-law and mōkopūna[13] and my son was sitting opposite me and he said, 'Mum what's wrong with your mouth?' And I said, 'Oh, side effects from the antipsychotics,' and he froze up, cos he knows I have a mental illness but he feels uncomfortable talking about it. I felt whakamā. (TW13)

In conclusion, many of the tāngata whaiora had battled experiences of whakamā due to the mental health challenges they faced. Mental health stigma contributed to whakamā and led to urges to hide issues, especially for those coming to terms with the marked changes in their lives. Feeling out of control of their experiences and like something was 'wrong' with them also contributed to whakamā for some tāngata whaiora. Further, visible markers of mental health such as self-harm scarring, medication side effects or losses (i.e., social, occupational) were exposing and linked to whakamā for some, especially those who were in a space of relative wellness at the time of the interview.

Whakamā about engaging with services: "They need to stop trying to help our people in a Pākehā twisted way." All of the tāngata whaiora described experiencing whakamā at some point during their interactions with mental health services. For some, whakamā was associated with general fears about being judged, invalidated, or ignored by

[13] Grandchild, descendant.

services. Others described whakamā specifically in response to having unmet needs as Māori accessing mental health services. This theme attempts to capture these ideas.

Many of the participants described being whakamā about articulating their experiences to mental health professionals, especially if they themselves were struggling to make sense of what was happening, or what they needed. Given that mental health issues often go ‘unseen,’ some tāngata whaiora initially hesitated to speak with clinicians for fear that their experiences were not relevant. The following participant compared these dilemmas to medical settings where comparatively, seeking help for physical disability is a straightforward process.

> I think when you go into a doctor in a physical space you know the outcome is that the broken bone needs to be healed, you’ve got a diagnosis to receive treatment. But the mental health, because the symptoms are difficult to recognise in others and even in yourself, it’s whakamā to even explain why you’re there or what’s happening. (TW8)

Participants who had experiences of being referred to mental health services against their will or admitted to a mental health unit while acutely unwell expressed strong opposition. For a few, this looked like anger at a surface level although underneath they expressed feeling anxious and scared. One participant described their response to being taken onto a ward and suddenly feeling as if they had no rights.

> When I first came in contact with them, I was very vulnerable to becoming a different fullah, a different guy … I just started mouthing off. I shouldn’t have mouthed off … I was a bit afraid, I was a bit worried, cos I seen them lock the doors behind me … I was quite scared. I was quite worried. And I’d say ‘hey, why you lock me in here for? I want to go home, I’ve got things to do.’ (TW7)

During their time spent in a mental health unit, another tāngata whaiora described feeling dehumanised, like a “herd of sheep.” This environment felt mana diminishing and did not appear to be conducive to recovery or hope.

> We were just in the hospital and it kind of felt like a herd of sheep directed everywhere they need to go. There was not really much going on. So you’re sick in a place where everyone else is sick too. The environment’s sick. So how are you supposed to regain, recover? (TW11)

Some participants' described opposing feelings about wanting to access support to improve their mental health, while also battling with whakamā about needing this help in the first place, creating barriers to reaching out. One participant was familiar with the idea of "internal stigma" and used this term to capture their experience of whakamā.

> Every time I come to a CMHC *(community mental health centre)* I feel whakamā and I know that's to do with internal stigma and I've worked through that over the years quite a lot but it still grabs me it's like, 'I don't want to be here, I shouldn't be here, this isn't for me.' (TW13)

A few of the tāngata whaiora felt that whakamā contributed to them feeling unworthy or undeserving of taking up time and getting help from mental health clinicians, despite this support being appreciated, as can be seen below,

> I've always been given time from the clinicians. I never really understood why and that was part of me being whakamā. Because I never understood why I deserved those things. I didn't understand why people would be trying to help me. (TW3)

Most of the participants' described having an experience in mental health services whereby their unique needs as Māori were not recognised or understood. For many, this contributed to feelings of whakamā about engaging with services.

For example, the following tāngata whaiora highlighted differences in the way mainstream versus kaupapa Māori[14] services offered support. Clinicians from the kaupapa Māori service recognised that this participant withdrew from asking for help due to feeling whakamā and so attempted to address these unspoken needs by actively initiating kōrero.

> The mainstream, they're different. They tautoko[15] you and all that but you have to ask if you need something. Whereas the Māori clinical team they name if you need something. They'll tell you. And so that's why with the mainstream service I felt whakamā. (TW7)

[14]A Māori approach, Māori service or organisation.
[15] Support.

Some participants felt there was a need for more Māori mental health clinicians who understood Te Aō Māori[16] and so were better placed to help Māori tāngata whaiora. For example,

> I reckon more Māori need more Māori clinicians or nurses … they need to stop trying to help our people in a Pākehā[17] twisted way. (TW3)

For those accessing support from tauiwi[18] mental health clinicians, there were sometimes perceived barriers to fully opening up, especially when speaking about concepts and processes pertinent to Te Aō Māori. This could be due to tauiwi lacking awareness, understanding, and sometimes due to feeling like they were not in a culturally "safe" space. As can be seen below,

> I've been seeing a clinical psychologist for quite some time and we've never touched on the concept of whakamā which I feel is a downfall on my side, however she is German born and English second language and I didn't feel safe talking to her about whakamā, yet I would really love to. (TW13)

Some of the participants' expressed frustration towards the lack of space given to Te Aō Māori within mental health settings. For some, this was likened to feeling as if the service diminished important parts of their identity. For the following tāngata whaiora, like others, connecting to Te Aō Māori was an integral part of their wellness. Having this go unrecognised by services contributed to even more significant distress.

> There was no Māori processes … I'm struggling with what's going on –trying to get clean –and being Māori is a huge component of who I am – It's my safe space – to be going through all that stuff without any Māori support was really frustrating, it made me sad, it made me angry. (TW10)

Some participants reflected on the discrepancies between a Māori and tauiwi way of forming relationships and sharing kōrero. For example, although an allotted hour may be considered an appropriate amount of time for a meeting in mainstream services, in Te Aō Māori the time given to kōrero can vary greatly depending on factors like who is in the room, giving everyone a chance to speak, and following tikanga[19] processes:

[16] The Māori world.
[17] New Zealander of European descent.
[18] Non-Māori, foreigner.
[19] Customary system of values, correct procedure, lore, method, protocol.

> The clinical services today, you have an hour … In Māori culture an hour is (laughs), what's that? ... We're just ready for a cuppa now! So it's timing as well. (TW12)

A few participants suggested that investing in specific services for Māori, like a Māori mental health crisis team, could help reduce barriers for Māori accessing support for mental health problems. Having kaumatua and kuia[20] who could intrinsically understand Te Aō Māori concepts like whakamā and walk alongside tāngata whaiora may promote a greater sense of being heard and feeling safe to reach out. For example,

> If we had a Māori mental health crisis team … that would be wonderful because I was calling out for kaumatua and kuia …When I got to Auckland, I've always had kaumatua and kuia with me all of my life, coming up here, I don't have them … you're having to deal with lots of other things related to whakamā which is not spoken about or said. (TW12)

To conclude, interactions with mental health services often added another layer of whakamā for tāngata whaiora. For some, this included whakamā about needing support in the first place and feeling unworthy of this. For others, it was about fears of not being understood, judged, or having problems seen as irrelevant. Those forced into services appeared to feel particularly whakamā about having their mana taken away from them. To add, many expressed concerns about services not meeting their needs as Māori. For example, the lack of Māori clinicians, Māori processes, or specialist Māori services contributed to feeling unseen in mental health contexts. Already vulnerable, not having these safe spaces could contribute to further whakamā for tāngata whaiora.

Experiences contributing to whakamana

All of the tāngata whaiora shared ideas about the kinds of conditions that helped to reduce experiences of whakamā and uplift mana. These ideas have been grouped into three themes as outlined in Table 2. Much of the kōrero shared across these themes appears to also be related to the experience of tāngata whaiora fostering a strong sense of identity beyond the mental health challenges they faced as well increased experiences of belonging and connection to others. The latter could be viewed as the opposite to experiences of internal and external disconnection associated with whakamā.

[20] Elder(s).

Making a choice to speak out: "You have to get it out, so it can't come back and hurt you." In sharing their stories, nearly all participants recounted a significant moment or moments within their journey in which they made an active choice to speak out and ask for help. This could look like sharing and connecting with loved ones, accepting help from mental health clinicians, and opening up to the need for change. For tāngata whaiora, taking action in this way was perceived as mana enhancing and in opposition to being held back by urges to withdraw and remain silent because of whakamā. Participants' described experiencing a sense of forward momentum in response to these significant moments and in many circumstances, an opportunity was created to experience feeling heard and more connected to others, which could reduce whakamā. The following theme aims to capture these points.

Most participants expressed that building up the courage to reach out and kōrero was a lengthy process, especially due to the barrier of whakamā. Some described getting to a point where it was too painful and hindering to withdraw any longer and they were suddenly compelled to speak out. For many, the process of speaking out consisted of multiple "little steps," as confidence began to grow.

> I just had to get it out. I just *(pause)* I didn't know if it was wanting to share it, it was more of a need. Having to share. You have to get it out, so it can't come back and hurt you *(crying).* There were heaps of little steps. The first one I told was my girlfriend … then I told my son. (TW6)

For some participants' seeking support from a mental health service meant going against the advice of friends and family who may have felt that professional help was not necessary, who mistrusted services, or who thought that getting help was "weak." This required taking a step forward based on what they felt was best for themselves, as can be seen below:

> I was actually quite embarrassed when I first came here, cos I was told not to be weak when I asked for help … I thought, 'I'm not listening to anybody, I'm going to listen to myself' … my whānau said, 'Don't do that, you're fine.' I said, 'I'm not fine and I'm going to.' (TW9)

Feeling comfortable within mental health services was a process that took time for many tāngata whaiora. For some, being in an unfamiliar environment and feeling uncertain about what (if any) help they needed, contributed to whakamā. In this context one participant described that, "the word whakamā … it represents incomplete knowledge" (TW8). However, as they began to share more with their support worker, they learnt more about themselves. As

such, “that misunderstanding lifted” and they felt more connected to the service, as described below:

> When I walked into the office at the beginning … I looked around the room and there were a lot of people who had obvious mental health problems and there were some who you couldn’t tell if they were there as a support person or being supported … at the beginning I thought ‘why?’ I didn’t understand why I was there … it wasn’t until I started sharing about my symptoms and talking to my support worker that, that misunderstanding lifted and now when I walk in and see them I say, ‘oh kia ora[21] bro.’ (TW8)

A few participants shared that their initial experience with mental health services was mandatory and against their will. These experiences were perceived as being whakamā, although at the same time a necessary step in their journey towards being able to assert their mana and eventually accept help. For example,

> I didn’t really reach out for it. I was a drug addict so I got brought in against my will, put under compulsory treatment order for years, so at that time I wasn’t very receptive to help … being put under compulsory treatment order and given the IMI, it forced me into my recovery for me to say ‘I can’t do this … I think once I had come off the drugs and all that, then I reached out, then I was receptive, then I listened. (TW4)

Many participants noted the difference between being forced into treatment and making a decision to access help, with only the latter being associated with healing,

> The healing begins as soon as you decide to walk in the door … as soon as your mind decides to. (TW8)

Participants spoke about the importance of having a solid purpose to make a change. Without having, “a foundation that will push you through the journey” (TM9), it could be hard to push through the barrier of whakamā and speak out. For some participants’ their purpose was to do better for whānau, especially tamariki[22]. For example,

[21] Greeting wishing good health.
[22] Children.

> If you can't find that stuff to push through you're just going to remain there. And so I pushed through … I couldn't be like that. I had two kids at the time and my wife, and I just couldn't be like that. So I just had to. (TW11)

For some participants, the decision to seek help was driven by recognising that if they did not change, a negative cycle would continue to repeat within their whānau and hurt their tamariki. Thus, the decision to change was not just for themselves but also for the benefit of the next generation and their whakapapa[23].

> There was pain there and I used drugs to suppress that pain. I got to the stage when I was like fuck, the drugs stopped working. They stopped working and I needed to address the pain … My kids were getting older … I says bro you can't do this – someone has to step up bro for the kids. Someone has to break that cycle. I thought, fuck it's you bro – let's go. (TW10)

As participants' grew in confidence and had positive experiences of speaking out and pushing past whakamā, taking on additional challenges became easier, and for this transformed into a new way of life. The following tāngata whaiora described a turning point in which they stood up in front of their Mau Rākau[24] class and successfully performed a wero[25] leading to a shift in mind-set towards recognising that they had mana and beginning to treat life's challenges as a 'metaphorical' wero.

> Just treating everything as a wero, especially through Mau Rākau's made me stronger. If I can do the wero up there all by myself then (pause) yeah!" (laughs). (TW2)

In summary, making an active choice to speak out and ask for help was seen to be an integral step towards overcoming whakamā for many of the tāngata whaiora. Speaking out required making an active decision to push past barriers caused by whakamā, including tendencies to withdraw and keep problems hidden from others. Speaking out often took time and happened in multiple steps as opposed to on one occasion. Some participants' associated speaking out with also making a decision to accept help. Sometimes the decision to accept help happened later in their interactions with mental health services, especially for participants' who were forced into services or for those who were uncertain about why and what they might need help for. Some tāngata whaiora were compelled to speak out after no longer feeling as if they could

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[23] Genealogy, lineage, decent, to place in layers.
[24] Māori weaponry.
[25] Challenge.

bear to keep problems hidden. Others were driven by a particular purpose and often this was to do better for whānau, especially their tamariki.

Connecting with the right support: "I didn't have to be anything different." The following theme highlights the kind of support that was perceived as mana enhancing by tāngata whaiora when seeking help for mental health challenges. For many participants, accessing the 'right' kind of support played a significant role in building agency in their recovery as well as fostering a healing sense of belonging and connection, therefore reducing experiences of whakamā. Although some did refer to the helpfulness of having an ongoing one-to-one relationship with a particular mental health clinician, many had a broader perception of what support could look like.

Many participants referred to numerous clinicians and services as being part of their support network. For these tāngata whaiora, it was mana enhancing to have consistent support from a number of people, each with different areas of expertise. Support of this nature was not time bound but could be drawn from on an ongoing basis. In this manner, help did not explicitly look like an hour long one-to-one therapy relationship, but like an interconnected whānau of support, greatly enhancing experiences of connection and belonging. For example,

> Just grateful people like *(peer support worker)* came along and just helped me out a bit. Never had much support growing up … Got a few people I can call on now …. Like, *(peer support worker)*. I got a support worker, key worker, an iwi support worker, all the whānau at *(Kaupapa Māori NGO)* is good to me. We just got back from Iron Māori. (TW5)

Many tāngata whaiora expressed that through seeking help, they had the opportunity to connect with like-minded people with similar experiences who became integral in their healing journey. For some, other tāngata whaiora with whom they built strong connections became a part of their whānau, and for a few they became a substitute or 'kaupapa whānau' when family members were going through their own challenges that made it hard to access their support.

> I met these guys at *(NGO).* They were all Māori. Pretty much the same background as me – whānau problems, crime, violence, gangs, drugs. There's my bros! There's my crew. And we're still tight today. So, I found whānau. Whānau kaupapa. Brothers that were on the same journey as me. So I started to pull them close and got close with them and we are still. It's my tight five. That's my crew. (TW10)

Further, the experience of building connection and belonging with fellow tāngata whaiora was perceived by some participants as being more helpful than the support gained from clinicians because of their intrinsic understanding and compassion for the struggles they were facing. These experiences helped to break down communication barriers caused by whakamā and enhance mana. These ideas are reflected in the following example shared by a participant who, after a few years, was finally able to open up with the support of peers from a distress tolerance group.

> They understood me. I didn't have to be anything different … they were more support than clinicians … I mean we are whānau really. We have all got the same, similar life journeys. So they *know*, it's a knowing. It took me a lot of years, a few years to get me to talking again over the last few years and this year has been really good, I've been able to talk. (TW12)

Some tāngata whaiora spoke about meeting particular people along their journey who were in life positions that they aspired to. For some, these people offered advice and support much like a tuākana. The tuākana-tēina relationship is common in Te Aō Māori whereby, a tuākana or older/more expert person acts as a role model and teacher to a tēina, or younger/less expert. These roles can shift depending on the context and progress of the tēina (Reilly, 2010). Parallels can be drawn from the example below,

> I went into *(respite service)* … there's a guy, I think he's like the manager there now, he's like, 'I've been on clozapine for like nine years and I've been employed for that whole time.' I thought, if he can be on this medication and work this whole time, I can so do that as well. So I went and did my peer employment training at *(training service)*. That was so cool in itself, it's probably one of the best things I've ever done. (TW4)

For some participants, the tuākana-tēina relationship described above was not specifically about being supported by someone with similar lived experiences. For example, the following participant spoke about connecting with a support worker who had a strong connection to Te Aō Māori and taught them waiata[26], karakia[27], and mihi[28], which helped to strengthen their Māori identity.

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[26] Song chant.
[27] Incantation, prayer, blessing.
[28] Speech of greeting.

> He knows heaps of Māori songs. He knows tonnes! He's been teaching me. He knows heaps of karakia. Cos what he does, he goes in the morning to the maunga[29] … he goes up there and he says his karakia and he says his mihi. (TW1)

A few participants spoke about the benefits of accessing psychological support. Particular qualities were perceived as being mana enhancing such as walking alongside tāngata whaiora in their journey over an ongoing basis, showing aroha, and believing in their potential. The latter can be seen in the example below,

> She just encourages you … she just gives you good advice and she always gives you confidence. And she always says you're a good person, you're a great person. I guess having someone like that by your side helps as well. (TW9)

Many participants spoke about the significance of aroha[30]. Although aroha is typically translated to mean love in English, it may also refer to feeling seen by others through recognition of the 'hā' or essential essence of a person (Mead, 2003). In doing so, experiences of belonging and connection may be increased, which could be seen as the opposite to whakamā. The following anecdote demonstrates how aroha may be demonstrated in seemingly small and unexpected ways.

> It's some funny little things that I remember, like- I got dragged down one time, because I used to live in *(township)* so *(mental health unit)* was my second home *(laughs)* and one of the nurses there, she was a Māori nurse, just the small things, like she had a nice bottle of conditioner and she goes 'here look' … Yeah and I was like, 'ohh.'Cos those kind of things, you're not allowed anything … you get stripped of everything and just to have something that smells nice, that was huge for me. (TW4)

Further, some participants were grateful for the consistent aroha and, at times, advocacy that whānau could offer as they navigated mental health services and took steps towards recovery:

> The day I ended up in mental health my mother never stopped fighting for me. She *(pause)* she wanted more out of me than having a mental illness. (TW3)

For some participants, their perception of clinicians changed as they made steps in their recovery. As their mana increased, they became more receptive to the support provided. Thus,

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[29] Mountain.
[30] Love, caring, compassion, empathy.

participants' perceptions of support may differ across time depending on their specific needs and capacity to make autonomous decisions.

> I became more receptive of my recovery that my view of my keyworkers changed, from them just being the bad police who just wanna come and lock me up and jab me … I don't know if it was just my viewpoint at that time, but keyworkers definitely did help and I *wanted* to be helped at that so I think that made a huge difference too. (TW4)

Overall, all of the tāngata whaiora expressed the importance of having a support network. Having access to the right support empowered tāngata whaiora to take steps towards healing; this was mana enhancing. Although there were differences in what tāngata whaiora described as being particularly helpful, support that offered a sense of belonging, connection, and aroha was important. Arguably, these factors may be considered an antidote to isolation and disconnection caused by whakamā. Although many referred to kaimahi as being part of their support network, building supportive relationships with like-minded peers, whānau, and mentors were often considered to be equally helpful. To add, although some tāngata whaiora did particularly benefit from one-to-one support and intervention, many also referred to multiple people as being equally part of their support network, like a 'whānau' of support.

(Re)Connecting with Te Aō Māori: "You've got something inside of you that you can hold on to." All of the tāngata whaiora reflected on what their identity as Māori meant for them. Some were raised on their tūrangawaewae[31], immersed in tikanga from an early age. Many others grew up in Auckland, amongst whānau who had experienced intergenerational impacts of urbanisation including loss of Te Reo Māori[32], tikanga values, and connection to whenua. For many, rediscovering their inherent connection to Te Aō Māori contributed to whakamana through broadening their sense of identity beyond the mental health challenges they faced. Tāngata whaiora expressed a diverse range of ways to connect with Te Aō Māori including; learning Te Reo Māori and whaikōrero[33], participating in mau rakau, pakiwaitara[34], and kapa haka[35], returning to their tūrangawaewae and marae[36], embodying tikanga Māori values. The following theme touches on these ideas.

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[31] Place where one has right to stand, rights of residence and belonging via kinship.
[32] The Māori language.
[33] Speech, the practice of oratory.
[34] Legend, story, fiction, folklore.
[35] Māori cultural group, Māori performing group.
[36] Tribal meeting grounds that are a common space for hapū or groups to meet/gather.

Some of the participants described growing up in whānau environments that enabled them to develop a strong connection to knowledge, values, and beliefs located within Te Aō Māori. Tāngata whaiora could draw strength from this foundation of understanding and connection to help them work through mental health challenges. For example,

> Growing up with my Mum she taught me how to speak fluent Te Reo Māori … she taught me how to sing Māori songs, she taught me how to respect and behave in front of elders … she taught me how to be hospitable to guests and stuff like that in a Māori way … I think because I had a really staunch upbringing, that's why my drive or motivation or will to want to get better never left me. (TW3)

For those who may not have had the privilege of developing a strong connection to Te Aō Māori from an early age, it was still possible to seek out spaces where they could strengthen their knowledge, understanding, and confidence. For many, such experiences played a significant role in enhancing a positive sense of identity and building mana. The following participant recounted that joining a Te Reo Māori class was a healing experience and although their focus was initially about learning the language, it became about connecting to their whakapapa and identity:

> Te Reo Māori is all about connecting with your marae and the ones that are on the wall, the photos. It covers a lot of things. Like our kaiako[37] says that you thank everyone for coming to the classes because it's a tohu[38] that's been handed down from our tupuna to learn Te Reo and it's a gift. (TW1)

Through learning Te Reo Māori the same participant described building motivation to make positive changes in their life such as stopping heavy alcohol and cannabis use which they described as having previously been their way of coping with whakamā. Instead, the desire to learn and fully participate in Te Reo class became a mechanism for building confidence and pushing through whakamā.

> This dude was trying to sell me a tinny … he goes, "bro I've got some good tinnies bro," and I just said, "oh nah bro, I've gotta keep focused I'm doing Te Reo Māori. 'Cos if I get on that or even drink bro I can't process anything properly … I switched

[37] Teacher.
[38] Sign, gift.

> his thinking around cos he went to a distant thought … he was dazed and he went quiet because he knew that's what he should be doing was learning our Te Reo. (TW1)

Eventually, this participant was asked by their whānau to lead the karakia at a marae hui due to their developing proficiency in Te Reo. This participant had previously spent a lot of time withdrawn in their bedroom due to becoming whakamā in social situations. Despite some anxiety, they described being given the mana by whānau to speak on the marae as "an honour":

> My cousin made me stand up in the blinking marae at the beginning of this year … I told him that I was doing Te Reo Māori … I was practising on the Marae, I was fidgeting, on my own walking around, looking at the photos, doing it again and doing it again. I was nervous but once you start off the Lord's Prayer and the Karakia the old people just join in … I spose it's good to be put on the spot … You got no choice to be whakamā then, cos it's all on you (laughs). (TW1)

Similarly, another participant spoke about how reciting karakia and their pepeha[39] on a daily basis gave them the confidence to talk again after an episode of un-wellness that caused them to spend some time in a mental health unit. Eventually, they were also given the mana to speak on behalf of the NGO they were involved with,

> I went to *(mental health unit)*, I was mute … I tell people the thing that gave me my voice back was when I left *(mental health unit)* I went to *(Kaupapa Māori NGO)* … every day we had to say our pepeha and karakia … eventually I moved up to doing whaikōrero[40]. I contribute that to me getting my voice back and I can sort of see that being mute is whakamā. (TW2)

They went on to describe how 'stepping up' became important not only for themselves but also for the benefit of their whole whānau given that no one else could speak Te Reo. Thus, having the opportunity to learn also, "comes with responsibility" to be a voice and uphold the mana of the whānau.

> I needed to step up in my role as a Māori and be that voice for the family because the rest of the family don't really have their Reo. So it comes with responsibility as well. (TW2)

[39] Form of self-introduction in which whakapapa and areas of significance are recited.
[40] Speech, the practice of oratory.

Another tāngata whaiora described how they built confidence in their ability to talk and participate in a group setting through taking part in a pakiwaitara, an interactive Māori storytelling course. After being asked to help run the course, they expressed feeling "quite empowered" for one of the first times in their life.

> I was help running the course and then they asked would I like to go down to *(town)* and do exactly what I'm doing at course there. I said 'oh well, I'll do it a try,' and it was a success though … It was cool we had like 60 people turn up … I felt quite empowered, I felt like I had a bit of authority. (TW5)

Some participants recounted healing experiences of returning to their tūrangawaewae and connecting with the whenua of their tupuna. Building a greater sense of belonging to whenua was experienced as mana enhancing, particularly for those who had experienced some disconnection from these spaces.

> We did a trip up to *(town)* cos that's where my grandmother's ashes were taken … all her Māori connections is up there … so I was able to do a bit of soul searching on that side up there … Sitting there, you know when you get up in the meeting and you say, "This is my maunga, this is my awa[41]", you know. Is that like your whakapapa? … It was like, oh that's so cool I can say where I'm from … my sense of belonging. (TW4)

Building a positive sense of belonging and connection to Māori identity could be seen as both a protective factor and guiding force to overcoming mental health challenges, as one participant shared,

> That's what I think will make them feel safe, make us feel safe, tāngata whaiora is being grounded is knowing who you are or knowing where you come from … then you know that you've got something inside of you that you can hold onto and push yourself to move forward and back yourself up. (TW3)

Some participants drew parallels between skills taught for managing mental health challenges and processes located in Te Aō Māori. Identifying these similarities made concepts such as 'mindfulness' more meaningful for tāngata whaiora as Māori, reducing experiences of whakamā about engaging in these skills.

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[41] River.

> Even in kapa haka we're told to breathe … anything we do, any ritual, on the marae or whatever, there's always a moment where you just be still and you just await the karanga[42], you just await the call, you have to be present and if your mind is elsewhere you're gonna miss it. And so when I was introduced to mindfulness, that really was like ah okay we've been doing it but it's called something else. (TW8)

Others felt like western mental health was not the right framework of understanding for making sense of the distress they faced and that more meaning could be gained through a Te Aō Māori lens for example,

> When I did my paper I re-diagnosed myself. I took away the Pākehā diagnoses and I diagnosed myself as someone suffering from chronic to acute whakamā, which had not been treated or nurtured and I still have that now. I have had labels which are Pākehā labels … But whakamā, I could relate to. I understood that. (TW13)

Overall, there appeared to be an association between maintaining or strengthening connections with Te Aō Māori and whakamana. Those tāngata whaiora who grew up connected to Te Aō Māori could draw strength from this foundation of values, knowledge, and sense of belonging. For others, it was possible to nurture these connections later in life and this could happen in a number of ways such as; through learning Te Reo, through returning to their tūrangawaewae, through joining Te Aō Māori affirming groups like kapa haka, mau rakau, and pakiwaitara. Connecting to Te Aō Māori was also associated with connecting to inherent mana and thus, could strengthen identity and agency. For some, this growth was also associated with a sense of purpose, including responsibility to utilize new knowledge and skills in a way that could uplift mana for their whānau.

[42] Ceremonial call, to summon.

CHAPTER 5: DISCUSSION

Outline

Over the last few decades, there has been a promising shift towards recognising and addressing Māori[1] needs and priorities within mental health contexts of Aotearoa[2]. However, Māori continue to experience high rates of psychological distress, which in part may be driven by the cumulative effects of colonisation, intergenerational trauma, disconnection from traditional supports and knowledge, socio-economic adversity, discrimination, and racism (Inquiry into Mental Health and Addiction, 2019; New Zealand Government, 2018). There continues to be a need for research in mental health contexts that uplifts Māori voices and highlights topics of relevance to Māori. This study contributes to the existing literature on Māori mental health while also shedding light on an area of relevance to Māori of which, to date, there has been little research. This study also has potential to contribute to international literature on similar experiences amongst other indigenous and marginalised groups.

The purpose of this study was to explore how whakamā[3] is understood and experienced in mental health contexts of Tāmaki Makaurau[4] from the perspectives of Māori kaimahi[5] and tāngata whaiora[6] and consisted of three broad research aims:

1) To explore kaimahi understandings of whakamā including: how they perceive whakamā as being associated with collective experiences relevant to Māori and how this may relate to psychological distress, how they recognise and describe the experience of whakamā and its effects, and how they perceive their role in supporting tāngata whaiora experiencing whakamā.

2) To explore tāngata whaiora understandings and experiences of whakamā, particularly in the context of their unique stories and experiences of facing mental health challenges, encounters with mental health services, and action towards increased wellbeing.

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[1] Founding people of Aotearoa, indigenous people of Aotearoa.
[2] New Zealand.
[3] Loss of mana, feeling of shame, embarrassment, shyness.
[4] Auckland region.
[5] Person who is skilled in a particular area; mental health clinician in the context of this study.
[6] A person who is seeking wellness, used to describe users of mental health services.

3) To explore the significance of mana[7] in relation to whakamā and to investigate how mana is uplifted for those in spaces of whakamā from the perspective of tāngata whaiora based on their own personal experiences and from a service-level perspective based on kaimahi recounts.

The research drew from interviews with 18 kaimahi currently working in a mental health setting in Tāmaki Makaurau, nine tāngata whaiora currently accessing support through Counties Manukau District Health Board Adult Community Mental Health Services, as well as four peer support workers who identified as former tāngata whaiora. To the best of my knowledge, this is the first study that specifically explored understandings of whakamā from the perspectives of both Māori mental health clinicians and consumers. In this chapter, I will provide a summary of the key findings of the research. I will then discuss clinical implications of those findings in relation to mental health contexts in urban settings of Aotearoa[8] as well as in relation to international research and practice. The limitations of this study as well as possibilities for future research will also be considered.

Summary of key findings

In the following section, a summary of key findings are presented in relation to mātauranga[9] and tikanga[10] Māori, existing Kaupapa Māori[11] research, and relevant international literature. This section seeks to elucidate how these findings contribute to our current knowledge base. It will link to existing literature and identify novel ideas emerging through this research. Key findings will be presented under the same main categories and in the same order as Chapters Three and Four because these categories broadly align with the study's research aims outlined above. This will be followed by a commentary on pertinent similarities and differences that can be drawn between the kaimahi and tāngata whaiora findings.

Kaimahi findings

How is whakamā associated with collective experiences relevant to Māori? Although there may be many different causes of whakamā at an individual level, whakamā can also be felt as a collective response to shared experiences (Metge, 1986). In the current study, kaimahi identified a number of shared experiences relevant to Māori that may be

[7] Authority, prestige, strength, honour, respect, the supernatural force in a person.
[8] New Zealand.
[9] Māori epistemology.
[10] Customary system of values, correct procedure, lore, method, protocol.
[11] A Māori approach, Māori service or organisation.

broadly associated with whakamā. It must be noted that these experiences do not explicitly relate to tāngata whaiora. However, kaimahi felt that it was important to be attuned to the significance and impact of these shared experiences for Māori accessing their support in urban mental health contexts.

Kaimahi spoke about the harmful impact of colonisation on Māori wellbeing, particularly concerning the endurance of multiple losses, including loss of whenua[12], loss of traditional whānau[13], hapū[14], and iwi[15] support systems, loss of Te Reo Māori[16], loss of mātauranga and tikanga Māori. Kaimahi recognised that in place of these losses, Māori have been forced to adapt and assimilate to colonial norms, which continue to be maintained by dominant social structures that position Te Aō Māori[17] as 'lesser.' Kaimahi likened internalised negative beliefs about being Māori (e.g., 'other,' 'lesser,' 'not good enough,' 'bad') to an 'imposed' whakamā, stemming from colonisation and carried through generations. Similarities can be drawn between these ideas and the concept of internalised racism (David et al., 2019). Indeed, in a qualitative study on Māori experiences of racism, Barnes et al. (2013) found that internalised racism was associated with, what was described as, a 'cultural shame' about being Māori. To add, parallels can also be drawn between the notion of an 'imposed' whakamā and internalised oppression. Although similar to internalised racism, some indigenous researchers have described this concept as better encapsulating the endurance of oppression faced by indigenous people across all facets of life (Gonzalez et al., 2013). Findings of the current study demonstrated how whakamā may sometimes manifest in similar ways to internalised oppression (Gonzalez et al., 2013), whereby the voices of colonial oppressors become internalised, informing how Māori view themselves and their place in the world. In turn, this finding contributes to the literature on Māori experiences of historical trauma (Wirihana & Smith, 2019) of which the 'imposed' whakamā that kaimahi described could be a product of.

Paradoxically, kaimahi highlighted that Māori may also experience whakamā about not feeling 'Māori enough.' Kaimahi stressed that this was particularly the case for Māori living in urban settings who lacked access to whakapapa[18] or Te Aō Māori[19] affirming spaces. Kaimahi felt this experience of whakamā was relevant to many of the tāngata whaiora they worked with.

[12] Land.
[13] Family, extended kin.
[14] Sub-tribe, to be pregnant.
[15] Tribe.
[16] The Māori language.
[17] The Māori world.
[18] Genealogy, lineage, descent, to place in layers.
[19] The Māori world.

Kaimahi noticed that tāngata whaiora who were whakamā about not feeling 'Māori enough' tended to personally blame or criticise themselves even when events that contributed to experiences of disconnection within their whānau had occurred generations prior. Kaimahi also expressed that, in some instances, tāngata whaiora might choose not to identify as being Māori due to the extent of felt disconnection. As such, whakamā about not feeling 'Māori enough' is similarly associated with the endurance of multiple losses and may also be considered a product of historical trauma (Wirihana & Smith, 2019). Existing literature highlights the positive relationship between having a secure cultural identity and wellbeing for Māori (Durie, 1997; Moeke-Maxwell, 2005; Muriwai et al., 2015; Sterling & Tan, 2020) as well as other indigenous groups who have survived colonisation (Gone, 2013; Hartmann et al., 2019). Qualitative research has also given voice to the deep pain, or ngākau mamae[20], that may be experienced by Māori who are navigating cultural disconnection (Gilchrist, 2017). Interestingly, kaimahi who participated in the current study highlighted that whakamā about not feeling 'Māori enough' often caused people to actively avoid cultural spaces (e.g., marae[21]) due to feeling incapable, undeserving, and sometimes even fearful about navigating these contexts. As such, this finding builds on existing literature by dually highlighting that experiences of disconnection may be associated with whakamā for Māori, while at the same time, whakamā may function as a key barrier to pursuing reconnection and the potential for healing.

Finally, kaimahi spoke about state funded mental health services as belonging to a broad governmental system of 'power' that contributes to Māori experiences of whakamā. Arguably, Māori experience power differentiation within governmental systems on multiple intersecting levels. Historically, these systems abused power to marginalise and oppress Māori, like other indigenous groups, contributing to whānau experiences of intergenerational trauma, fear and mistrust towards services (Bryers-Brown, 2015; Te Pou o Te Whakaaro Nui, 2010a). Historic abuse of power is compounded by issues of institutional racism in current governmental systems limiting access to appropriate care and contributing to health and social disparities for Māori (Came-Friar et al., 2019; Kaiwai et al., 2020; New Zealand Government, 2018; Waitangi Tribunal, 2017). Power may also be experienced at a relational level with professionals for many reasons. For example, because of their expert status (Eade, 2007; Graham & Masters-Awatere, 2020), because of differences in communication and cultural understandings (Lapsley et al., 2002; Palmer et al., 2019; Taitimu et al., 2018), because of

[20] Transmission of deep psychological pain.
[21] Tribal meeting grounds that are a common space for hapū or groups to meet/gather.

discrimination (Graham & Masters-Awatere, 2020), and because of their authority to mandate care (Gibbs et al., 2004; Wharewera-Mika, 2012). In contrast, kaimahi felt that tāngata whaiora might perceive themselves as having little power. The silencing of these power imbalances and socio-political context that has nourished inequity of care for Māori means that tāngata whaiora who struggle to engage with the system may attribute (or have others attribute) this to personal deficit or irresponsibility. This finding brings attention to how intersecting layers of power within the mental health system of Aotearoa may contribute to experiences of whakamā for Māori, which may also function as a barrier to Māori accessing support within these spaces.

How is whakamā expressed in mental health contexts and what are its effects? Kaimahi spoke about the different ways they experienced the expression of whakamā and its effects when supporting tāngata whaiora. Importantly, many of the kaimahi felt that whakamā was difficult to identify and clearly articulate because it was experienced as such a 'big' yet deeply internalised cultural concept. Significantly, whakamā is demonstrated in this study to be a way of being that is as meaningful, but less likely to be acknowledged, than other concepts associated with tikanga Māori, such as mana, whanaungatanga[22] and manaakitanga[23] for example (Mead, 2003). Kaimahi also perceived whakamā as being difficult for tāngata whaiora to talk about because of its potential to bring about feelings of vulnerability. As such, kaimahi felt that when tāngata whaiora were whakamā, this was more readily 'observed' and communicated through behaviour, particularly withdrawal behaviours.

Similar to existing literature (Metge, 1986; Sachdev, 1990), kaimahi described whakamā as a 'big' concept that can be felt simultaneously at both an individual and collective level. As such, kaimahi felt that it was often hard to explicitly name and identify a specific cause for whakamā. Many stressed that whakamā that has not been addressed and processed may accumulate and pervade into different areas of life. Again, in a manner that seems to resonate with literature on Māori experiences of historical trauma (Wirihana & Smith, 2019), kaimahi referred to whakamā as a phenomenon that could be 'carried' across generations and some likened this to a heavy weight or a taumaha[24]. Similarities can be drawn between these findings and the way chronic or 'mate' (to be sick) whakamā is depicted in existing literature. Unlike transitory, episodic experiences of whakamā that may arise within a particular social context, chronic or 'mate' whakamā may be experienced as recurrent and more pervasive, with lasting

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[22] Relationship, kinship, process of establishing and maintaining relationships.
[23] Enhancing the esteem of others through hospitality, generosity, and kindness.
[24] To be heavy.

negative implications on the wellbeing of a person or group (Metge, 1986; T. Smith, 2019). Indeed, the following commentary by Metge (1986) appears to be particularly relevant in today's context and seems to reflect some of the kaimahi perspectives in the current study:

> It seems to me that an unduly large proportion of Māori, especially those born and bred in the city, show signs of chronic whakamā … many young Māori today know comparatively little about ngā tikanga because their opportunities for learning about them have been limited. They are whakamā in many Māori situations, feeling uncomfortable, uncertain, and out of place … At the same time, they are whakamā in relation to Pākehā[25] because of the higher status of Pākehā as a group in NZ society and their reputed power. (p. 122)

Kaimahi described whakamā as being difficult and often painful for tāngata whaiora to talk about. This may be particularly the case for tāngata whaiora experiencing whakamā alongside other areas of psychological distress. Kaimahi expressed that speaking about whakamā could prompt vulnerability or exposure and so for some tāngata whaiora it may feel more comfortable to avoid talking about altogether. A few kaimahi expressed that if causes of whakamā are deeply embedded within whānau attitudes and behaviours it might not feel appropriate for an individual to speak to these areas, especially if there is a risk of causing further whakamā within the whānau. Some kaimahi described being acutely aware of these barriers and experienced discomfort at addressing the topic with tāngata whaiora. At the same time, many spoke about the painful implications of keeping whakamā hidden and felt that it was important to give tāngata whaiora an opportunity to 'release' by offering opportunities to talk about whakamā. Similar to the research of T. Smith (2019), a few of the kaimahi spoke about the dissipating effect that whakamā can have on an individuals' mauri[26], hindering people from actively engaging in the world and reaching their full potential, especially when whakamā is kept hidden or allowed to fester over a period of time.

Kaimahi observed that people in active states of whakamā were more likely to communicate this through identifiable behaviour. This state could be similar to what T. Smith (2019) calls a 'patu' (to be struck) whakamā that may be triggered in response to a particular context. Kaimahi described whakamā as more often 'seen' and 'felt' as opposed to expressed or articulated in kōrero[27] with tāngata whaiora. Behaviours that kaimahi described as being

[25] New Zealander of European descent.
[26] Life principle, life force, special nature, source of emotions.
[27] Narrative, speech, conversation.

associated with whakamā included: silence, a withdrawing posture, avoidance of eye contact, putting head down, passivity, physically exiting a particular situation, or more generally isolating from others and the world over a period of time. Similarly, Metge and Kinloch (1978) describe that through this behaviour, "he or she is trying to get a message across to those around him – to 'speak' by not speaking" (p. 23). Kaimahi felt that this behaviour could be a means of communicating whakamā about a wrongdoing, feeling uncomfortable, unsure, incapable, or incompetent within a particular context. Consequently, some kaimahi likened whakamā to a 'protective armour,' that could initiate social disconnection. Notably, some of the kaimahi felt that whakamā could serve a functional purpose when tāngata whaiora did not feel ready or safe to bring particular kōrero to the surface. At the same time, kaimahi also described whakamā as sometimes being hidden underneath other layers of behaviour like aggression, alcohol and drugs, and over-confidence, which could have harmful effects. Similarities can be drawn between patterns of behaviour (and their function) associated with whakamā and shame (Gilbert, 1998), an emotion that is particularly influenced by social and cultural context (Mesquita & Karasawa, 2004; Shweder, 2003; Vanderheiden & Mayer, 2017). However, from a Te Aō Māori perspective, experiences of whakamā are associated with a perceived loss of mana in relation to others (Metge, 1986; Sachdev, 1990; T. Smith, 2019). In contrast to whakamā, an individual with mana can be seen as having power, authority, or knowledge to act in a particular situation or context. Mana can be inherited or earnt as can it be lost or trampled on (Barlow, 1991; Royal, 2003). As such, the behaviours described above could also be viewed as a means of communicating a loss of mana, and thus incapacity to act or engage with others in a particular context.

Further, it could be argued that emotional acculturation has influenced how Māori understand and experience whakamā (Mesquita et al., 2016). This may be particularly the case for those living in urban settings. In Māori contexts where values of interdependence, tikanga, and kawa[28] are entrenched in the way people behave and respond to others, whakamā may play a more transient and functional role in reinforcing cohesion within whānau, hapū, and iwi groups. Ideas about whakamā painfully relating to the absorbing of messages about feeling 'lesser,' 'bad', 'not enough,' for example, does seem to relate to western ideologies of shame (Gilbert, 1998). Indeed, Māori navigate between Te Aō Māori and Pākehā worlds every day and it is possible that this has contributed to a shift, or broadening, in the way whakamā is conceptualised. Arguably, the latter is reinforced by colonial discourse and structures that

[28] Protocol.

reinforce the absorbing of 'absolute' messages that serve to disempower and 'other' difference (Pihama, 2017).

How do kaimahi Māori perceive their role in supporting with whakamā? Kaimahi emphasised the importance of supporting tāngata whaiora with whakamā. They described particular ways of relating and connecting that enabled tāngata whaiora to feel more comfortable, to share kōrero, and begin processing experiences of whakamā. The different ways in which kaimahi formed supportive relationships with tāngata whaiora appeared to align with tikanga values located in Te Aō Māori. These included kaitiakitanga[29], whanaungatanga[30], te wā[31], and whakapapa.

Kaimahi described the importance of attending to conditions that promoted a sense of safety within their relationships with tāngata whaiora. This set the foundation for kōrero about whakamā to be shared. Similarities can be drawn between this idea and the Te Aō Māori concept of kaitiakitanga. While kaitiakitanga is most commonly referred to in relation to protection and guardianship over whenua (Marsden & Henare, 1992), the prefix 'tiaki' can more broadly be defined as: to guard, nurture, protect, and keep watch over (Marsden & Henare, 1992). As such, the values underpinning kaitiakitanga can extend to other areas of life, including in the way relationships are formed. Existing literature indicates that entering a mental health service, for Māori in particular, may bring about feelings of whakamā, uneasiness, uncertainty, mistrust, fear, and memories of traumatic whānau experiences with the system (Bryers-Brown, 2015; Pomare, 2015; Tricklebank, 2017). In the current study, kaimahi stressed the importance of attending to the physical space and making this feel as comfortable as possible for tāngata whaiora and whānau. Importantly, attending to the 'metaphysical' space was seen to be equally, if not more, integral to the process of fostering safe relationships. Similar to existing research (Ihimaera, 2004), many of the kaimahi spoke about the usefulness of following tikanga processes to contain and give space for healing kōrero to occur with tāngata whaiora. Examples included use of karakia[32] to open and close kōrero, hariru[33], mihi[34], whakawhanaungatanga[35], and provision of kai[36] to whakanoa[37].

[29] Guardianship, to oversee, to protect.
[30] Relationship, kinship, process of establishing and maintaining relationships.
[31] Time.
[32] Incantation, prayer, blessing.
[33] Physical touch.
[34] Speech of greeting.
[35] Process of establishing relationships and maintaining links, relating well to others.
[36] Food.
[37] To remove tapu restrictions.

Pomare (2015) notes that Māori clinicians who embed tikanga into their relationships with clients, "enable a pathway to acknowledge the depth of mana and tapu[38] of individuals and whānau during interactions and ongoing engagement" (p. 130). Wilson and Baker (2012) found that Māori mental health nurses perceived themselves as 'guardians' of spiritual wellbeing for tāngata whaiora and attending to this strengthened trust and depth within their relationship. Findings of the current study indicate that kaimahi tended to conceptualise their role as a kaitiaki[39] over the way relationships were formed and maintained with tāngata whaiora so that safety could be established. In particular, kaimahi expressed that use of tikanga processes could allow the tapu nature of whakamā to be appropriately contained and enabled tāngata whaiora to be transitioned back into a state of noa[40] (e.g., through karakia, provision of kai, or other tikanga processes) following the end of kōrero (Mead, 2003).

All the kaimahi felt that relationship building was essential when supporting tāngata whaiora in spaces of whakamā. This finding corroborates existing research that demonstrates the importance of rapport building between clinician and client to mitigate communication barriers caused by whakamā for Māori in healthcare settings (Eade, 2007). In the current study, the particular quality of this relationship was emphasised further. Many believed that it was especially important to build reciprocal relationships with a focus on commonalities to defuse power imbalances that may contribute to experiences of whakamā in mental health settings. Similarities can be drawn between these ideas and relational values embedded in the process of whanaungatanga (Le Grice et al., 2017; McNatty & Roa, 2002), of which many of the kaimahi explicitly referred to. Existing literature has exemplified how Māori mental health clinicians may intuitively recognise and uphold whanaungatanga as a mechanism for strengthening relationships when working with Māori tāngata whaiora (Baker, 2008; Baker & Levy, 2013; Gilgen & Stephens, 2016; Swann et al., 2017). The notion of bringing commonalities to the forefront of relationship building may diverge from western attitudes towards clinical boundaries and the therapeutic alliance (Bennett & Liu, 2018), although is integral to Te Aō Māori ways of relating to others (Le Grice et al., 2017). To add, many of the kaimahi in the current study described their relationship with Māori tāngata whaiora as being like 'whanaunga[41],' rejecting western clinical ideologies even further. Treating tāngata whaiora like whanaunga involved embracing their shared connection as Māori, relating in ways that embodied manaakitanga, and recognising the whakapapa both kaimahi and tāngata

[38] To be sacred, prohibited, restricted, set apart, forbidden, protected.
[39] Guardians.
[40] Neutral, common, non-restricted.
[41] Relative, loved one.

whaiora brought with them into relationship. Findings suggest that fostering these elements of reciprocity and closeness may serve to mitigate experiences of disconnection and difference associated with whakamā.

Kaimahi spoke about the importance of allowing sufficient time and space for stages of kōrero about whakamā to unfold and giving tāngata whaiora agency over this process as a means of upholding their mana. In contrast, rushing, taking over, or jumping to conclusions may exacerbate whakamā causing tāngata whaiora to close off and retreat from kōrero. Existing research highlights how, for Māori, whakamā may impede communication in GP contexts when seeking support for mental health challenges (Eade, 2007). The current study expands on this research by demonstrating how limited time may be a mediating factor in these contexts, especially when sensitive or difficult to articulate topics are being addressed. Many felt that opening up about experiences associated with whakamā did not have to happen on one occasion, nor with the same person. Instead, te wā[42] could guide the steps to which kōrero unfolded. Indeed, in Te Aō Māori te wā is a flexible construct, with focus being more on correct 'process' than a designated end point (Rameka, 2016; Tate, 2014). This finding aligns with existing literature on the significance of being attuned to te wā particularly when working with Māori in a therapy context (Davis et al., 2017; Elder, 2013). Davis et al. (2017) highlight the utility of noticing, watching, and feeling the emerging āhua[43] of whānau entering therapy and stress the importance of adapting in response to the ebs-and-flows of te wā. Notably, kaimahi in the current study felt their capacity to give space for te wā depended on the context and their role; some had a busy workload and experienced this as a hindrance to te wā. A consequence of this could be that opportunities for kōrero about whakamā are missed or not given enough time to unfold.

In their kōrero, kaimahi described transformative experiences of having helped tāngata whaiora to strengthen their connection to whakapapa. There appeared to be a relationship between this process and healing experiences of chronic or 'mate' (to be sick) whakamā (Metge, 1986; Smith, 2019). In Te Aō Māori, whakapapa may be perceived as a continuous layering of connections that bind past, present, and future generations of whānau, hapū, and iwi together (Rameka, 2016). Whakapapa is what connects Māori to physical spaces of belonging (e.g., tūrangawaewae[44]). In addition, whakapapa connects Māori to aspirations for

[42] Time.
[43] To form, make; also refers to a shape, appearance, condition, character, likeness.
[44] Place where one has right to stand, rights of residence and belonging via kinship.

the future instilled by former generations of tupuna[45]. Thus, connecting to whakapapa is synonymous with strengthening belonging, identity and purpose for Māori (Swann et al., 2017). Kaimahi felt that strengthening connection to whakapapa could lead to increased recognition and awakening of inherent mana particularly for tāngata whaiora in spaces of whakamā. These findings build on literature highlighting the significance of whakapapa in fostering wellbeing and strengthened identity for Māori (Edwards, 2009; Fox et al., 2018; Gilchrist, 2017; L. M. Pere, 2006). Kaimahi recognised that a large proportion of tāngata whaiora in Tāmaki Makaurau will feel disconnected from their whakapapa, and so, believed that Māori clinicians had a responsibility to explore ways in which these bonds could be strengthened. Participants described a range of strategies to facilitate this process. These included: encouraging tāngata whaiora to visit their tūrangawaewae, highlighting shared traits and strengths inherited from tupuna, and identifying roles and responsibilities held within whānau. Kaimahi also felt that offering pathways to engage with Te Aō Māori affirming spaces such as kapa haka[46], mau rakau[47], raranga[48], community gardens, and urban marae could strengthen Māori identity. Durie (2001) argues that facilitating healing for Māori is an 'outward' (as opposed to internal) process of building accumulative meaningful connections and these ideas appear to align with this approach.

How do mental health services contribute to whakamā? One of the study's research aims was to explore how mana may be uplifted for those in spaces of whakamā from a service level perspective. However, kaimahi tended to focus their kōrero more on how mental health services in Aotearoa contributed to whakamā. All of the kaimahi spoke about service barriers that made it challenging to work effectively as Māori clinicians. Barriers included discrepancies between Te Aō Māori and clinical values, lack of cultural competency from tauiwi[49] staff and service providers, and concerns about lack of bicultural partnership given current disparities between kaupapa Māori[50] and tauiwi service providers. Addressing and reducing these barriers may increase support options for tāngata whaiora in spaces of whakamā.

Kaimahi described facing challenges navigating discrepancies between Te Aō Māori ways of understanding the world and western ideologies, such as the medical model, underpinning

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[45] Ancestors, grandparent.
[46] Māori cultural group, Māori performing group.
[47] Māori weaponry.
[48] Weaving.
[49] Non-Māori, foreigner.
[50] A Māori approach, Māori service or organisation.

tauiwi mental health services. Existing literature has referred to constraints the medical model places on giving space for Te Aō Māori ways of understanding, relating, and working in mental health contexts, which ultimately is a barrier to Māori tāngata whaiora and whānau accessing appropriate care (Eade, 2014; Jeffery, 2005; Wilson & Baker, 2012). In the current study, kaimahi believed that whakamā was more likely to be incorrectly pathologised through the lens of the medical model. Additionally, kaimahi expressed that tauiwi services often failed to recognise or foster the unique attributes, skills, and knowledge they could offer as Māori clinicians, which limited opportunities for them to work effectively with Māori tāngata whaiora. Literature on dual competency argues that Māori mental health clinicians who can interweave clinical and cultural practice offer specialist skills and thus should be supported to embrace their Māori identity (Baker, 2008; Baker & Levy, 2013). Indeed, findings of the current study indicate that kaimahi often draw upon values and processes located in Te Aō Māori when supporting tāngata whaiora in spaces of whakamā. However, service providers may not always recognise the value and efficacy of these approaches.

In addition, kaimahi felt that cultural competence was not being upheld as a key priority within mental health services often resulting in complacent attitudes towards cultural competency amongst tauiwi clinicians. As stipulated under legislation (Ministry of Health, 2020) mental health professionals must strive to develop cultural competency. Numerous organisations and professional bodies offer role-specific documentation and frameworks on how this may be actioned (New Zealand Psychologists Board, 2011; Occupational Therapy Board of New Zealand, 2006; Te Pou o Te Whakaaro Nui, 2010b; The Royal New Zealand College of General Practitioners, 2007). Māori voices of the Mental Health and Addictions Inquiry also viewed increasing cultural competency of the mental health sector as integral to reducing inequities and improving care for Māori tāngata whaiora and whānau (Inquiry into Mental Health and Addiction, 2019). These findings stress that clinicians who do not recognise the significance of cultural experiences and context may exacerbate experiences of whakamā for tāngata whaiora accessing services. Of note, a number of kaimahi spoke about the tendency for tauiwi services to shift responsibility for engagement onto Māori tāngata whaiora and then, onto Māori clinicians when there are issues with the latter. This is not surprising given that principles of individualism, self-advocacy, and self-efficacy tend to be favoured in western systems (Ngata, 2014). It is likely that a more proactive approach is needed for tāngata whaiora in spaces of whakamā in particular. Indeed, Tricklebank (2017) suggests that clinicians could improve engagement with Māori tāngata whaiora by taking proactive steps to ‘meet them halfway’ in a manner that she likens to the pōwhiri process. Pōwhiri is a welcoming process

or ritual of encounter that signifies two groups coming together. Formal steps are followed to facilitate movement from tapu to noa as relationships are formed and intentions established. Connection through whanaungatanga and active demonstration of manaakitanga from host (in this context clinician) to visitor (in this context tāngata whaiora) are important components of this process (Mead, 2003). Māori models of health like Pōwhiri Poutama[51] may offer a framework to facilitate this process (Drury, 2007).

Finally, kaimahi expressed concerns about inequities between tauiwi and kaupapa Māori mental health organisations particularly in regards to service provision and accessibility. This feedback corroborates existing evidence that kaupapa Māori providers often must compete against better resourced mainstream organisations for contracts and funding (Boulton, 2005; Chant, 2013; Kingi, 2018). Barriers impeding accessibility to appropriate mental health care for Māori contradict government obligations to the Treaty of Waitangi (Levy, 2016) and arguably reflect issues of institutional racism within these systems (Came-Friar et al., 2019). Although government initiatives like Whānau Ora have made steps towards realising bicultural aspirations and improving wellbeing in Māori communities (Boulton, 2019), Māori still require access to specialist mental health services (Inquiry into Mental Health and Addiction, 2019). In these contexts, research indicates that Kaupapa Māori services are better placed to meet these needs (Bennett, 2018; Inquiry into Mental Health and Addiction, 2019; Wirihana, 2008). This argument is supported by international literature which highlights the value of indigenous specific health organisations and their important role in fostering a sense of connection, belonging, and holding of mind, body, and spirit for indigenous people accessing support (Wendt & Gone, 2012). Findings of the current study echo these points with many kaimahi expressing that kaupapa Māori services had the best staff, knowledge, resources, and unspoken understanding to mitigate experiences of whakamā for Māori tāngata whaiora.

Tāngata whaiora findings

Experiences contributing to whakamā. Tāngata whaiora recounted a variety of ways in which whakamā manifested in their lives both prior to and during their experiences with mental health challenges and mental health services. Thus, whakamā was experienced in different ways and across multiple facets of their lives. Overall, whakamā was perceived as

[51] Māori model of counselling.

having a negative impact on their lives, particularly in regard to their self-esteem and relationships with others.

All of the tāngata whaiora spoke about particular aspects of their social environment that contributed to experiences of whakamā. Although specific details of these differed, it is important to note that environments that were perceived as mana diminishing appeared to be an overarching theme. For example, some tāngata whaiora described growing up in environments where they perceived themselves as weaker, lesser than, or bad, relative to others. For some, these beliefs developed because of ongoing interactions with people in their environment (e.g., being put down, expected to harden up) or following specific traumatic experiences such as sexual abuse for example. For others, beliefs appeared to arise more from internalising experiences of racism and mana diminishing discourse about what it means to be Māori. Similar to Metge (1986), impacts of whakamā described by tāngata whaiora included tendencies to withdraw and avoid being heard or seen as well as an overall loss of potential and personal agency. These findings highlight that experiences of whakamā were not exclusively associated with mental health challenges for tāngata whaiora. Rather, formative experiences associated with diminishment of mana contributed to the ongoing development of whakamā, which became interwoven into their lives. These findings broadly align with literature on consumer experiences of mental health challenges in that people are far more likely to conceptualise their experiences of distress within the stories of their lives as opposed to in the context of an explicit, diagnostic category (Lapsley et al., 2002).

Although tāngata whaiora did describe benefiting from whānau support, many also spoke about interactions with whānau members that appeared to contribute to experiences of whakamā. Indeed, although there is a wide body of literature stressing the essential role that whānau play in supporting Māori tāngata whaiora through mental health challenges (Eade, 2007; Graham & Masters-Awatere, 2020; P. Harris, 2014; Lapsley et al., 2002; Waitoki et al., 2014), research also indicates that Māori tāngata whaiora report experiences of discrimination from whānau members (Peterson et al., 2004; C. Thornicroft et al., 2014). Given the importance of whānau as a primary support system, unhelpful or negative whānau responses to mental health challenges may be particularly hurtful for Māori tāngata whaiora (L. M. Pere & Barnes, 2009). Some tāngata whaiora believed that whānau struggled to respond to them in a supportive way either because they lacked understanding, so mental health felt unfamiliar and foreign or because they were experiencing their own struggles. Feeling misunderstood, isolated, or othered by whānau contributed to experiences of whakamā. In a qualitative study

about Māori experiences of identity and mental health, L. M. Pere (2006) stresses that although whānau are integral to recovery, the whānau system must be functioning in a manner that enables understanding and support to be provided. To add, many of the tāngata whaiora did not necessarily recount any explicit experiences with whānau that were indicative of being discriminated against, but assuming that they were or would be judged, misunderstood, seen to be a failure, or thought lesser of for having mental health issues contributed to whakamā. As such, it could be argued that whakamā itself sometimes functioned as a barrier to reaching out and accepting the support of whānau.

In addition, some tāngata whaiora recounted how whānau members experienced their own whakamā in response to a loved one requiring support from services and at times this created barriers to seeking help. Tricklebank (2017) notes that Māori whānau may be more likely to wrap around loved ones in distress, meaning that accessing services may be considered a 'last resort.' Findings of the current study indicate that requiring services may be associated with a collectively felt whānau whakamā about having failed to support a loved one. Whakamā may be exacerbated by fears, mistrust, and uncertainty about whether services will provide appropriate and effective support for their loved one (Eade, 2007; Pomare, 2015).

Tāngata whaiora also described experiencing whakamā in response to having a mental health problem. For many, coming to terms with having a mental health problem was a painful process that contributed to beliefs about there being something 'wrong' with them. Similarities can be drawn between such beliefs and the concept of mental health stigma (Peterson & Barnes, 2009). Indeed, in other qualitative studies Māori tāngata whaiora described experiencing mental health stigma, including beliefs about feeling like a loser, a failure (Eade, 2007, 2014) and feelings of shame, guilt, and self-doubt (P. Harris, 2014). Although in the current study, tāngata whaiora broadly attributed such experiences to whakamā. Some tāngata whaiora attributed whakamā about having mental health challenges to experiences of discrimination. A few tāngata whaiora who had been under services for many years felt that nowadays, there was less discrimination towards people with mental health challenges and so no longer felt whakamā about their own experiences. However, many others described experiences of whakamā in response to having mental health challenges, particularly during the initial stages, and this contributed to self-isolating behaviours in order to hide issues from others. These findings are similar to literature suggesting that mental health related stigma has a negative effect on help seeking for mental health problems (Clement et al., 2015; C. Thornicroft et al., 2014). To add, tāngata whaiora described being triggered into spaces of

whakamā when markers of poor mental health and ‘difference’ were made visible to others. Examples include scarring from self-harm, side effects from medication, as well as more broad markers of loss caused by mental health challenges such as loss of friends or employment. This finding aligns with existing qualitative literature in which Māori tāngata whaiora described experiencing whakamā in response to other people knowing they had experienced a mental health crisis and having this publicly identified (Lapsley et al., 2002).

Finally, tāngata whaiora described experiencing whakamā in response to requiring support from mental health services. Whakamā was associated with fears about being judged, invalidated, feeling dehumanised, having rights taken away or needs ignored by services, both generally as mental health consumers and specifically as Māori accessing services. Tāngata whaiora perceived whakamā as a barrier to seeking help and communicating openly with mental health professionals. Indeed, qualitative studies highlighting Māori tāngata whaiora experiences have identified whakamā as hindering communication with professionals in primary care and mental health settings (Eade, 2007; Jansen & Smith, 2006; Lapsley et al., 2002). It could be argued that intersecting forms of discrimination (e.g.., racial, age, gender, income, mental health stigma) (Cormack et al., 2020; Peterson et al., 2004) alongside experiences of inadequate care shaped by institutional racism (Inquiry into Mental Health and Addiction, 2019), exacerbates experiences of whakamā for Māori accessing services. Given the relationship between discrimination and whakamā, it could be suggested that other indigenous and marginalised groups experience similar reactions to accessing mainstream mental health services especially when there is an expectation placed on individuals to be vulnerable albeit without recognition of the structures contributing to whakamā (or similar reactions). Indeed, many of the tāngata whaiora referred to whakamā arising in response to experiences with mental health services whereby it felt as if their identity as Māori was not valued or recognised. Some tāngata whaiora struggled to express themselves and open up in spaces where ways of relating, connecting, and understanding were very different to Te Aō Māori. Further, the lack of Māori clinicians and specialist Māori services who could offer effortless understanding contributed to not feeling heard or seen in mental health contexts. Existing qualitative literature has called to attention the positive impact of services that incorporate Māori worldviews and tikanga for Māori tāngata whaiora (Eade, 2014; Johnson, 2009; Tricklebank, 2017) as well as the effectiveness of Māori specialist mental health services (P. Harris, 2014; Lapsley et al., 2002; Pomare, 2015). Findings of the current study indicate that failing to make space for Māori identity may heighten whakamā for Māori accessing mental health services contributing to poor engagement and adverse experiences.

Experiences contributing to whakamana. All of the tāngata whaiora shared recounts about the kinds of experiences that helped to not only reduce whakamā but also uplift mana and contribute to transformative action in their lives. Thus, it was important for the research findings to convey a balance between experiences contributing to whakamā and whakamana. This also seemed fitting given the reciprocal relationship between whakamā and loss of mana (Metge, 1986). Often, experiences of uplifted mana appeared to be associated with a sense of empowerment and personal agency to take action. To add, much of the kōrero shared across these themes seemed to be related to the experience of fostering a positive sense of identity as well as belonging and connection to others, which could be viewed as the antidote to experiences of disconnection and disempowerment associated with whakamā.

While reflecting on their experiences with mental health challenges, all of the tāngata whaiora recounted significant moments in their journey when they made an active decision to speak out and ask for help. These moments appeared to stand out for tāngata whaiora because in order to speak out, they had to push past communication barriers associated with whakamā like remaining silent, being isolated, keeping hidden, or withdrawing. Some described being compelled to speak out after feeling as if they could no longer suffer alone in silence. Others were driven to action by an outward purpose like their tamariki[52], or to change harmful generational cycles in their whānau. For many, the process of speaking out did not just happen on one occasion but in accumulative steps over time. For some, despite already receiving support from mental health services, making an active decision to accept and respond to help, happened later in their journey, especially for those who were mandated or felt coerced into treatment. Broadly speaking, the notion of personal agency and empowerment as a factor contributing to improved wellbeing has been highlighted by existing literature about recovery from mental health challenges (Ihimaera, 2004; Tew et al., 2012). From a Te Aō Māori perspective, it could be argued that in these moments of speaking out, tāngata whaiora were connecting to aspects of their own mana, which empowered them into action and towards seeking connection with others (Mead, 2003; Metge, 1997). Following the action of speaking out, a snowballing effect often arose whereby tāngata whaiora began to feel more confident to express themselves, which facilitated experiences of being accepted, supported, and connected to others in their lives.

Indeed, tāngata whaiora expressed that receiving the right kind of support from others helped to reduce experiences of whakamā. For some, whānau support played a key role in reducing

[52] Children.

experiences of whakamā. Further, some referred to numerous professionals and services as being a part of their support network, in a way that resembled a 'whānau' of support that contributed to transformative experiences of connection and belonging. Others 'found' whānau through like-minded peers who had similar lived experience and who could offer implicit understanding and unconditional acceptance. Indeed, existing literature has noted how belonging to a 'kaupapa whānau' that offers practical or emotional support can have a positive impact on tāngata whaiora and this may be especially the case when there are barriers to whānau providing appropriate care (L. M. Pere, 2006; L. M. Pere & Barnes, 2009; Waigth, 2017). Some tāngata whaiora described helpful relationships with individuals who resembled a tuākana[53] figure within a life area that they aspired to. Although within these relationships, tuākana figures were recognised as having more mana, this was experienced in a positive and supportive way that empowered tāngata whaiora to take action towards particular goals including across areas pertaining to mental health, employment, and strengthening of Māori identity. Thus, although what was perceived as the 'right' support varied it appeared support that conveyed aroha[54], acceptance, and belonging helped to mitigate disconnect and difference associated with whakamā. Further, support that empowered tāngata whaiora to reach their goals across holistic areas of life was also valued and in many cases, this required input from multiple people.

All of the tāngata whaiora reflected on their Māori identity in relation to experiences of whakamā and whakamana. Although some participants grew up on their tūrangawaewae, immersed in Te Aō Māori from a young age, many were born and raised in the urban context of Tāmaki Makaurau outside of hapū and iwi territories. While most of the tāngata whaiora did not explicitly attribute experiences of whakamā to cultural disconnect, many drew associations between strengthening connections to Te Aō Māori and enhancing mana. This ultimately contributed to improved wellbeing and transformation. Enhancing connections to Te Aō Māori empowered tāngata whaiora to strengthen aspects of their identity, beyond the mental health challenges they faced, which propelled them to action in life. These findings align with literature highlighting the therapeutic impact of strengthening cultural identity for Māori tāngata whaiora (Hughes, 2007; Lapsley et al., 2002; L. M. Pere, 2006; Waigth, 2017) and indeed, for other indigenous groups who have survived colonisation (Gone, 2009; Gone et al., 2020; Hartmann et al., 2019; Wendt & Gone, 2012). Further, connecting to Te Aō Māori

[53] Older brother (of male) or sister (of female), more skilled individual in a particular area relative to tēina, or less skilled individual.
[54] Love, caring, compassion, empathy.

gave tāngata whaiora opportunities to build new knowledge and skills that increased their mana. In some instances, whānau recognised this shift in mana and tāngata whaiora were invited to take on roles of responsibility. In doing so, tāngata whaiora were able to give back to their whānau and in some instances, this drew them closer, which helped to mitigate experiences of whakamā.

Similarities and differences between kaimahi and tāngata whaiora findings

Findings of this research offer unique insights into the experience of whakamā from two different perspectives: kaimahi and tāngata whaiora. A number of overarching similarities can be drawn between kaimahi and tāngata whaiora findings. At the same time, there were also differences in the way these two groups spoke about whakamā. Considering the overall similarities and differences between kaimahi and tāngata whaiora findings may enrich our understanding of how whakamā is understood and experienced in mental health contexts.

Both kaimahi and tāngata whaiora participants spoke about whakamā in very broad terms. Although, in their recounts, chronic experiences of whakamā seemed to be similarly associated with the absorbing and internalising of mana diminishing messages received through particular social contexts. Kaimahi participants tended to describe causes of whakamā in relation to socio-historical issues affecting Māori as a collective such as colonisation, intergenerational trauma, and institutional racism. Some of the tāngata whaiora did also associate experiences of whakamā with internalising of racist discourse about what it means to be Māori. Importantly, others did not consciously make this link, although in their recounts it seemed as if they were 'living' these internalisations. That is to say, mana diminishing environments were just a part of 'being Māori.' Similarities can be drawn between this finding and the concept of a 'forced' Māori identity shaped by the internalisation of racist and oppressive stereotypes (McIntosh, 2005). This study clearly demonstrates that internalisations of this nature are a product of colonisation and its cumulative impact on Te Aō Māori, including experiences of historical trauma (Wirihana & Smith, 2019). Kaimahi, who may have a broader perspective on the causes of whakamā, are well placed to support tāngata whaiora in making these links so as to bring awareness to the existence of internalised racism/stigma and to help tāngata whaiora break free of these self-limiting realities.

Additionally, many of the tāngata whaiora also had to contend with their own personal experiences which they perceived as contributing to whakamā such as being put down, being negatively compared to others in their life, living through experiences of abuse, and mental

health stigma. Overall, findings from both groups indicate that whakamā can be experienced as something with multiple, accumulative layers and this may particularly be the case for tāngata whaiora. Indeed, many of the kaimahi had a tendency to describe whakamā as something that was ‘carried,’ ‘burdensome,’ ‘heavy,’ and like a ‘taumaha.’

Interestingly, whakamā about having mental health challenges featured strongly in the recounts of tāngata whaiora participants. By comparison, kaimahi did not particularly emphasize this relationship. For many of the tāngata whaiora, whakamā appeared to have a significant impact on the way they experienced and responded to having mental health challenges. Whakamā contributed to urges to keep mental health challenges hidden from others, uncertainty about whether they were deserving of support, self-judgements and negative comparisons to others. At times, whakamā appeared to function as a barrier to communicating openly and accepting the support of whānau members or professionals. To add, whānau members sometimes created barriers to accessing services due to their own whakamā about engaging with the system. Unsurprisingly, those who were referred to services against their will, experienced whakamā about having rights stripped away and feeling dehumanised. Importantly, these findings indicate that whakamā particularly in regards to experiencing mental health challenges may be more pertinent for tāngata whaiora than what kaimahi may realise. For tāngata whaiora, whakamā of this nature may be experienced alongside other collectively shared experiences of whakamā, previously discussed, that are relevant to Māori more generally.

Kaimahi in particular more frequently experienced whakamā as being difficult to name, discuss, and unpack with tāngata whaiora. In contrast, it must be noted that tāngata whaiora who participated in this research project appeared to have an implicit understanding of whakamā with good insights into their experiences. Notably, tāngata whaiora viewed whakamā as an important topic and appreciated the opportunity to speak about their experiences in this research project. Tāngata whaiora in particular highlighted the benefits of speaking out about whakamā instead of keeping these experiences hidden. Although, it must be noted that tāngata whaiora (some of whom were now peer support workers) volunteered to be a part of this study because they were interested and willing to discuss the topic of whakamā. Therefore, it cannot be assumed that all/most Māori tāngata whaiora will feel ready or able to talk about experiences of whakamā when accessing support for mental health challenges. Indeed, this may reflect the views of kaimahi participants who, in their kōrero,

drew from their experiences of having worked with many different tāngata whaiora and whānau.

Both kaimahi and tāngata whaiora participants described whakamā as contributing to disconnection from others which over time could negatively impact a persons' personal agency and self-worth. Thus, it is not surprising that participants from both groups emphasised connection as an antidote to experiences of whakamā. Kaimahi recognised the importance of taking the time for relationship building. It seemed that kaimahi had an implicit understanding of the tapu nature of whakamā and sought to honour this in their relationships with tāngata whaiora as a first step towards allowing kōrero to unfold. Further, kaimahi acknowledged their own mana as clinicians although actively sought to address and defuse this dynamic in order to show that they recognised and honoured tāngata whaiora as having mana too. Tāngata whaiora also spoke about the significance of building positive connections to others although, compared to kaimahi participants, they tended to have a broader perspective on how relationships mitigated experiences of whakamā. For many of the tāngata whaiora, this seemed to be associated with a general sense of feeling positively connected to others as opposed to there being an emphasis on one particular relationship. Findings from both groups allude to the significance of aroha that is, being unconditionally 'seen' and valued without judgement or questioning (Mead, 2003). It could be argued that aroha is a binding thread of connection that in the current study was experienced as drawing people closer to others and out of whakamā. Connecting inwardly was also recognised as important by both groups. Kaimahi and tāngata whaiora both spoke about the power of connecting to intrinsic mana inherited through whakapapa. Unlike kaimahi participants, tāngata whaiora did not explicitly refer to the negative impact of cultural disconnect and feeling not 'Māori enough', but many spontaneously talked about the different ways they experienced whakamana through connecting with Te Aō Māori. Recognising that Māori have mana by nature of being Māori is clearly a way of buffering, instead of internalising, racist constructs about what it means to be Māori. The latter may have broader implications for indigenous groups that have experienced colonisation who may similarly benefit from connecting with traditional ways of understanding and experiencing the world.

Kaimahi and tāngata whaiora equally expressed frustration, sadness, and, at times, a sense of helplessness at the lack of space and recognition given to Te Aō Māori in mental health contexts of Tāmaki Makaurau. Although, arguably this issue extends across Aotearoa. Findings from both kaimahi and tāngata whaiora participants indicate that Māori ways of

understanding, connecting, and processing often play an important role in healing experiences of whakamā. Further, Māori specialist services may be best placed for engaging, supporting, and empowering Māori tāngata whaiora. Kaimahi explicitly referred to inequities in funding and accessibility between mainstream and Kaupapa Māori mental health services. Kaimahi also highlighted that these inequities were often compounded by the general lack of cultural competency and accountability of mainstream services and tauiwi clinicians to respond to the specific needs of Māori tāngata whaiora. For tāngata whaiora, these inequities were not necessarily named but often felt as they sought support for mental health challenges. For example, tāngata whaiora described experiences of whakamā being exacerbated by services that did not seem to acknowledge or recognise the importance of Te Aō Māori and Māori processes. Also, experiences of not having a 'familiar' Māori face who could intrinsically offer unspoken understanding seemed to heighten experiences of whakamā for tāngata whaiora when navigating services. Kaimahi themselves often felt like they were limited in their capacity to support tāngata whaiora as Māori first and clinicians second in the context of mainstream mental health services. Broadly speaking, these findings highlight the reality that mental health services in Aotearoa operate within limiting colonial structures that continue to treat Te Aō Māori as 'lesser.' A resulting outcome of failing to recognise the mana held within Te Aō Māori may be that Māori tāngata whaiora and kaimahi navigating these spaces subsequently experience a diminishment of their own mana.

At the same time, both kaimahi and tāngata whaiora participants had ways of resisting the constraints placed upon them and continued to assert their Māori identity. All of the kaimahi recognised the importance of tikanga values and had ways of actively incorporating these into their practice especially when working with Māori tāngata whaiora in spaces of whakamā. Also, most of the tāngata whaiora described ways in which they had strengthened their connection with Te Aō Māori and this was often seen to be an important facet of healing. In many cases, this took place outside of government funded mental health services. For example, tāngata whaiora who participated in Te Reo classes, community programmes (e.g., to learn mau rakau, raranga, kapa haka), and Kaupapa Māori non-government organisations often saw these services as having equally contributed to their healing journey. Some of the tāngata whaiora found strength in their Māori identity through the support and guidance of whānau and through connecting to their tūrangawaewae.

Clinical implications

The current study has clinical implications for those supporting Māori tāngata whaiora in mental health contexts. Findings of the current study clearly indicate that whakamā is an important topic for Māori and is relevant to mental health contexts. It may be challenging for tāngata whaiora to speak openly about whakamā both because it is such a broad, far-reaching concept and because it may feel like a particularly sensitive area to discuss. However, it would be helpful for clinicians to at least offer opportunities to talk about whakamā, while maintaining a stance of openness, curiosity, and acceptance. Findings of the current study demonstrate that speaking out about whakamā can be a mana enhancing experience in and of itself for tāngata whaiora as this requires overcoming withdrawing behaviours commonly linked to whakamā. During the process of assessment or intervention, clinicians may want to interweave exploratory questions about whether tāngata whaiora have ever heard of the word whakamā, what it means to them, and how (if at all) whakamā is of relevance to their lives? Given that many tāngata whaiora described experiences of whakamā in relation to having mental health challenges and accessing mental health services, clinicians may want to ask some prompting questions around this. Although, it is equally important for clinicians to maintain an open mind-set about the many different ways whakamā may present in a persons' life and allow space for tāngata whaiora to lead kōrero based on their own experiences and perspectives. This approach worked well when interviewing tāngata whaiora in the current study. In taking this approach, clinicians are recognising and uplifting the mana that tāngata whaiora hold as experts of their own lived experiences.

It is important for clinicians to recognise that the concept of whakamā sits within a Māori worldview. As such, clinicians should avoid being overly pathologising and steer clear of western diagnostic models of mental health when sharing kōrero about whakamā with tāngata whaiora, as this could ultimately cause further harm. Instead, using Māori models of mental health and wellbeing to explore tāngata whaiora understandings of whakamā across different life domains offers a more holistic and mana enhancing way of structuring kōrero. The Meihana Model may be a particularly useful tool as it scaffolds assessment across holistic domains of experience specific to tāngata whaiora (hinengaro[55], tinana[56], whānau[57], wairua[58])

[55] Emotional wellbeing.
[56] Physical wellbeing.
[57] Family wellbeing.
[58] Spiritual wellbeing.

alongside broad environmental, systemic, and service level factors (taiao[59], iwi katoa[60]) externally connected to enhanced or compromised wellbeing (Pitama et al., 2007). As such, this model may offer a framework for unpacking the many different layers and causes of whakamā that could be experienced by tāngata whaiora.

It is important to recognise that not all tāngata whaiora will feel comfortable or ready to talk about experiences of whakamā with clinicians. Again, clinicians should respect these boundaries. At the same time, findings of the current study indicate that particular conditions may set the foundation for kōrero to be more likely to arise. Firstly, Māori clinicians should be allowed to incorporate tikanga Māori, mātauranga, and Māori ways of relating into their work with tāngata whaiora without being constrained by mainstream service-level priorities and expectations. Kaimahi particularly expressed the importance of using appropriate tikanga processes to establish safe and containing spaces that hold the tapu of kōrero, prioritising genuine reciprocal connection through whakawhanaungatanga, and taking sufficient time for sharing to unfold. On the other hand, Pākehā clinicians should strive to deepen their understanding of Te Aō Māori as well as socio-political contexts affecting the experiences of Māori whānau accessing services. This will firstly require, acknowledging their own gaps in knowledge and recognising the influence of their own cultural lens, challenging any explicit or implicit attitudes they may have towards Māori, and sitting with any discomfort this may provoke. Thus, it would be helpful for Pākehā clinicians to seek cultural supervision and/or ongoing consultation from cultural advisors so that they are better placed to build supportive relationships with Māori tāngata whaiora.

Findings of the current study indicate that there may be a propensity for people in spaces of whakamā to take personal responsibility for the reasons causing these experiences, even if these sit well outside of their control. In mental health settings, this may result in tāngata whaiora absorbing and internalising negative self-judgements (i.e., about being Māori, about not being Māori enough, about having mental health challenges, about mistreatment from services) that only serve to deepen experiences of whakamā. As such, clinicians might collaboratively explore with tāngata whaiora, contexts that have shaped their experiences of whakamā. Indeed, we live in a society where socio-political dimensions that perpetuate racial discrimination and stigma are normalised. Further, not all Māori have had the privilege of access to education on Māori history, events, and legislation that have shaped present day

[59] External physical environment, natural world.
[60] Social discourse and service-level factors that affect client wellbeing.

inequity and experiences of historical trauma (Pihama, 2017). As such, scaffolding conversations that enable tāngata whaiora to recognise and place any outward or intergenerational causes of whakamā may help to reduce the intensity of negative thought and affect, and contribute to empowerment. Similarities can be drawn between this approach and narrative therapy (Madigan, 2011) which indigenous writers have named as a promising therapeutic modality for indigenous peoples, particularly as this model seeks to expose socio-political-historical contexts contributing to the problem stories of clients (Swann et al., 2017), internalised racism and oppression (David et al., 2019; Gonzalez et al., 2013).

Limitations and directions for future research

There are a number of limitations to the current study. However, these limitations offer useful information for future research opportunities. This study consists of two small samples specifically located in Tāmaki Makaurau. As such, findings cannot be generalised to the wider Māori population. Indeed, given that Māori are not a homogenous group it may not be appropriate to generalise these findings, but future research could explore how whakamā is understood in other geographical areas of Aotearoa. Māori living in rural settings may have different insights and experiences that impact on their understandings of whakamā. To add, differences between mental health service provision in rural and urban settings may contribute to nuances in experiences of whakamā that could be explored further.

It is possible that specific subgroups within the samples of the current study had differences in their understandings and experiences of whakamā that were not fully captured in the findings. Future research could explore these nuances in greater depth by focusing on these specific groups. For example, given the significance of socio-historical context in relation to whakamā, future research could explore whether there are generational differences in the understandings and experiences of whakamā between younger and older populations of Māori. Indeed, in existing qualitative research (Houkamau, 2006), this approach has proven to offer nuanced differences in understanding across generations of Māori. As the tāngata whaiora sample size was already small, and given the importance of saturation in qualitative research (Braun & Clarke, 2006), I decided not to distinguish the voices of peer support workers and tāngata whaiora. However, future research could more closely track the stories of peer support workers as tāngata whaiora to employed mental health clinicians and highlight any unique insights they may hold as a result of navigating these two worlds. I deliberately did not ask tāngata whaiora direct questions about mental health diagnoses they may have received, as I wanted the focus of the study to be on experiences of whakamā. However, given many of the

tāngata whaiora described whakamā in response to having mental health challenges (in a way that was similar to mental health stigma), it could be useful for future research to explore whether experiences of whakamā differ depending on the nature of mental health issues.

To add, many of the kaimahi and tāngata whaiora alike spoke about the many challenges of navigating mainstream services. Although the current study has provided some insight into how Māori mental health services may be better placed to mitigate experiences of whakamā, future research could separately analyse perspectives of those engaged (both kaimahi and tāngata whaiora) with mainstream versus Māori mental health services to highlight the specific benefits of Māori specialist support.

All of the tāngata whaiora who participated in this study had been involved with mental health services for some time and described being actively open to accepting help. However, many reported heightened experiences of whakamā at the onset of their mental health challenges and during initial interactions with mental health services, which, in many cases, appeared to influence their experiences of engagement. Future research could aim to recruit Māori who are struggling with emotional distress but not currently accessing services, or tāngata whaiora who have been recently referred to a mental health service. In this manner, instead of taking a retrospective approach, kōrero would be 'in the moment' and thus, offer greater saliency and insight into experiences of whakamā during initial stages of treatment. Exploration into this particular area may offer useful information about how treatment barriers may be lessened for Māori tāngata whaiora.

Some of the tāngata whaiora described whānau as having their own experiences of whakamā in response to a loved one facing mental health challenges. Some tāngata whaiora also experienced whakamā due to anticipating that whānau members would respond negatively to their mental health challenges. It would be useful for future research to incorporate the voices of whānau members and to explore whether their perspectives are similar or different to the ideas shared by tāngata whaiora in the current study. Further, research that encourages whānau participation and upholds whānau voices is more in align with Kaupapa Māori research principles (L. T. Smith, 2006; S. Walker et al., 2006).

Finally, this study is limited in that it places whakamā within the particular context of mental health. Although, whakamā as a construct is much broader. For example, experiences of whakamā on a marae may be perceived very differently to findings of the current study. Although I informally consulted with kaumatua and kuia throughout the research process,

incorporating their ideas into this thesis could have added greater depth and mātauranga to the research. Given the scarcity of literature on whakamā, future research could explore Māori understandings of the concept more generally. It could also be useful for future Kaupapa Māori research to explore how understandings of whakamā differ across specific hapū and iwi and for this research to be controlled and led by these communities. Research of this nature may strengthen our overall conceptual understanding of whakamā.

Final thoughts

Despite above limitations, this study makes an important contribution to the literature on Māori mental health. This is the first study to have explored how the mātauranga Māori concept of whakamā is understood and experienced in mental health contexts of Tāmaki Makaurau from the perspectives of Māori kaimahi and tāngata whaiora. This study offers a framework of understanding whakamā that may be of benefit to mental health clinicians. Notably, findings exemplify how whakamā is a broad and deep construct and, depending on the cause, can carry through whakapapa. Although whakamā is relevant to Māori in general, this study has demonstrated how tāngata whaiora may particularly experience multiple intersecting layers of whakamā in relation to personal experiences of navigating mental health challenges as well as in relation to collectively felt whakamā stemming from the far-reaching impacts of colonisation. While whakamā may lend itself to being kept hidden, mainstream mental health services contribute to the silencing of whakamā by rarely acknowledging its existence, significance, and their role in contributing to experiences of whakamā for Māori. This study highlights the healing effects of making space for whakamā and offers ideas about how kōrero may be shared in a way that upholds the mana of tāngata whaiora.

Like Hinenuitepō[61] from the pūrākau[62] shared at the beginning of this thesis, this study has also demonstrated how whakamā can equally be associated with movement towards transformation, personal growth, and new purpose. The tāngata whaiora, who bravely and generously shared their stories, have illustrated how it is possible to move from whakamā into spaces of empowerment and connection. It is hoped that their voices offer hope and inspiration for tāngata whaiora navigating similar experiences. Their insights provide pertinent information for improving mental health service provision in Aotearoa particularly in regards

[61] Daughter of Hineahuone, also known as Hinetītama.
[62] Traditional story or narrative.

to how whakamā may function as a barrier to accessing support as well as how this may be overcome. Finally, I would like to close this thesis with the following whakataukī[63]:

He iti rā, he iti māpihi pounamu.

This study may be small and focuses on whakamā within a specific context. However, I hope that it offers valuable information and an opening for more robust discussion so that future research on whakamā can continue to grow and develop.

[63] Proverb, saying, lesson.

Appendix A: Research Poster

Whakamā: He aha tēnei?

Are you Māori

and a practitioner working in a mental health service?

Have you ever observed the effects of whakamā in clinical practice?

Nau mai, haere mai!

A new research project is seeking information about how Māori understand, experience, and cope with whakamā in mental health settings.

For more information feel free to have a confidential kōrero with the researcher, Karis Knight on:
021 029 71620 or
kkni746@aucklanduni.ac.nz.

You will be thanked for your participation in the research with kai and a $30 koha.

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kkni746@aucklanduni.ac.nz

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Appendix B: Participant Information Sheet (Practitioners)

From whakamā to whakamana: He aha tēnei?

Information Sheet for Potential Participants

School of Psychology Reception
Building 302, Level 2
Science Centre
23 Symonds Street
Auckland Central
T +64 9 373 7599
W psych.auckland.ac.nz
E psych@auckland.ac.nz
School of Psychology
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

PARTICIPANT INFORMATION SHEET

What is the project about?

Whakamā is a Māori word that has no English translation but may loosely mean shyness, embarrassment, or shame. The overall purpose of this research project is to increase knowledge about what whakamā means to Māori, how whakamā affects experiences with mental health services, and how Māori cope with whakamā. We will be interviewing Māori who are getting support from mental health services and Māori mental health practitioners. We hope this research project will contribute helpful information about how mental health settings can better understand and respond to whakamā.

You will be thanked for your participation with a $30 koha (voucher) and provision of kai during the kōrero.

Who is the researcher?

Ko Hikurangi te Maunga

Ko Waiapu te Awa

Ko Tuatini te Marae

Ko Ngāti Porou te Iwi

Ko te Whānau a Ruataupare te Hapū

Ko Horouta te Waka

Ko Karis Knight taku ingoa

Kia Ora, my name is Karis Knight. I am of both Māori and Pākehā descent and whakapapa to different parts of the North Island including the East Coast. I am a 26-year old student studying psychology at the University of Auckland. This research is part of my Doctoral thesis. My Supervisor is Dr Margaret Dudley (Te Rarawa, Te Aupouri, Ngati Kahu) from the School of Psychology at the University of Auckland. I am passionate about exploring how we can make the mental health system in Aotearoa more accessible for our Māori whānau.

What will I be asked in the interview?

In the interview, I will ask for your whakaaro (opinion) on whakamā. This may include questions about how whakamā can be recognized and the effects of whakamā. I will also be asking about any experiences you have had with whakamā as a professional working with Māori in mental health settings. In addition, I will ask for your thoughts about how Māori might cope with whakamā and the best ways to support those who are experiencing whakamā. The interview will last for about one to one and a half hours.

Where will the interview take place?

We will complete the interview at a location that is convenient to you. This may include your home, a local Marae, a booked room at a community centre, a private room at the University of Auckland. If you would prefer to complete the interview through an online video chat medium like Skype or Zoom, this is also possible.

How will my information be recorded?

The interview will be audio recorded and transcribed word for word. Recordings will be transcribed by myself or a third party who has signed a confidentiality agreement.

What will happen to my information?

The notes gathered from the interview will be used as the basis of my research for my Doctorate thesis. I would also like to use the material for articles for publication. All recorded information will be stored on a password protected University of Auckland computer, backed up by a server. This information will be destroyed after publication.

Can I check my information?

Yes. Once I have written up your interview notes, I will then return them to you for a consultation session. This will allow you to add any thoughts you've had on the information you shared.

Will other people know who I am?

No. In writing up the research findings I will use pseudonyms (false names) and erase or disguise potentially identifiable information such as place names, occupation and easily identifiable events.

What if I agree to participate and then change my mind?

You may stop the interview at any time. You may withdraw from the research at any stage without permission up until the time you approve the interview notes to be used. If you do withdraw from the project, any information recorded about you will be immediately returned or destroyed.

Will I be asked to sign anything?

Yes. Before you begin, you will be asked to sign a consent form acknowledging that you have been adequately informed about:

- The study
- What you are being asked to do
- What will happen to your information
- Your right to withdraw without being disadvantaged or penalized

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Are there any risks involved?

Thinking about and recalling difficult experiences may possibly be upsetting. Even if you have successfully dealt with these difficulties, there may still be a risk of becoming upset when talking about them. If you think the risk of becoming upset during this research may be a problem for you, it may be better that you do not take part in this study. Alternatively, we can begin and stop if you become uncomfortable. You can have a break and then continue, or stop altogether.

Reducing the risk of harm?

If an issue arises during the interview that indicates your safety, my safety, or someone else's safety is at risk of harm, I will discuss this with you (the participant) first, and I will also need to discuss this with my Supervisor Dr Margaret Dudley who is a Registered Clinical Psychologist so that the risk of harm can be reduced and we can ensure that you receive further support.

Who can I speak with about my participation in this project?

If you have any further questions or concerns please feel free to contact either myself (Karis Knight) kkni746@aucklanduni.ac.nz or my supervisor (Margaret Dudley) m.dudley@auckland.ac.nz

WHERE CAN I GET MORE INFORMATION ABOUT THIS STUDY?

Researcher:
Karis Knight
Email: kkni746@aucklanduni.ac.nz
School of Psychology
The University of Auckland
Private Bag 92019, Auckland

Supervisor:
Dr Margaret Dudley
(09) 923-5869
Email: m.dudley@auckland.ac.nz
School of Psychology
Private Bag 92019
Auckland 1142

Secondary Supervisor:
Dr Kerry Gibson
(09) 923 8556
Email: kl.gibson@auckland.ac.nz
School of Psychology
Private Bag 92019
Auckland 1142

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If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:
Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz
You can also contact the Health and Disability Ethics Committee (HDEC) that approved this study on:
Phone: 0800 4 ETHICS
Email: hdecs@moh.govt.nz

ACC statement: If you were injured in this study, which is unlikely, you would be eligible to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery. If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

APPROVED BY THE NORTHERN A HEALTH AND DISABILITY ETHICS COMMITTEE ON OCTOBER 24th FOR (3) YEARS REFERENCE NUMBER *18/NTA/164*

Appendix C: Consent Form (Practitioners)

SCIENCE
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Consent Form for Participants

School of Psychology Reception
Building 302, Level 2
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School of Psychology
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

THIS FORM WILL BE HELD FOR A PERIOD OF 10 YEARS

Project title: From whakamā to whakamana: He aha tēnei?

Researcher(s): Karis Knight (Ngāti Porou, Rongowhakaata), Dr Makarena Dudley (Te Rarawa, Te Aupōuri, Ngāti Kahu)

I have read the Participant Information Sheet and I have understood the nature of the research and that my participation is voluntary. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports, either written or verbal, on this study.
- I understand the interview will take approx 1 hour of my time.
- I understand that I will be audio recorded. I understand that this will be transcribed.
- I understand that Karis Knight will transcribe the recording of our interview.
- I agree that extracts from the information I provide may be quoted in any reports which will be written about this research, and also in possible publications and presentations about the research findings, and that this information will be anonymised to protect my identity and privacy.
- I understand that I am free to withdraw my participation at any time. I understand that I am able to withdraw the information I provide up to one month after the interview, without needing to provide a reason.
- I understand that information will be kept for 10 years, in a locked cabinet at the University of Auckland, after which time it will be destroyed.
- I understand that if I indicate that harm is occurring to myself or another person, the researcher will talk with me first, but she will then need to talk the research supervisor Dr. Makarena Dudley so that the risk of harm can be reduced and ensure that I receive further support.
- I wish / do not wish to receive the summary of findings of this study (expected to be 2021). If yes, please provide either email or postal details below for the summary to be sent to you when it is completed:

Contact Details: ____

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- Iwi/Hapū:
- Age:
- Role/profession:
- Years in role/profession:

Signature: Date:

Ngā mihi!

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Appendix D: Letter of Invitation for Tāngata Whaiora

SCIENCE
SCHOOL OF PSYCHOLOGY

Invitation to participate in a rangahau (research project)

School of Psychology Reception
Building 302, Level 2
Science Centre
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Auckland Central
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W psych.auckland.ac.nz
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School of Psychology
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

Tēnā koe,

This letter is to inform you about a rangahau (research project) that you might like to participate in.

A study is being conducted by Karis Knight (clinical psychology student) from the University of Auckland on whakamā. You might already know that whakamā can loosely mean shyness, embarrassment, or shame but has no direct English translation. Karis is interested in exploring Māori experiences and understandings of whakamā.

As part of this rangahau, she would like to interview Māori Tangata Whaiora on how they experience, understand, and cope with whakamā. She believes that Māori Tangata Whaiora can provide important knowledge and insight on whakamā that will help clinicians to provide more culturally meaningful support for Māori.

You are invited to participate in this rangahau.

Your participation is completely voluntary and confidential. I myself, your clinician, will not be told about whether you are participating in this rangahau. Your decision about participating will not have a negative effect on the support you receive at community mental health services.

You will be thanked for your participation with a $30 koha (voucher) and provision of kai during the kōrero.

I have attached a Participant Information Sheet which includes further information about the rangahau.

If you are interested in participating or have any questions, feel free to contact Karis. Her contact details are attached to the Participant Information Sheet.

Ngā mihi nui ki a koe

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Appendix E: Participant Information Sheet (Tāngata Whaiora)

School of Psychology Reception
Building 302, Level 2
Science Centre
23 Symonds Street
Auckland Central
T +64 9 373 7599
W psych.auckland.ac.nz
E [illegible]
School of Psychology
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

From whakamā to whakamana: He aha tēnei?

Information Sheet for Potential Participants

PARTICIPANT INFORMATION SHEET

What is the project about?

Whakamā is a Māori word that has no English translation but may loosely mean shyness, embarrassment, or shame. The overall purpose of this research project is to increase knowledge about what whakamā means to Māori, how whakamā affects experiences with mental health services, and how Māori cope with whakamā. We will be interviewing Māori who are getting support from mental health services and Māori mental health practitioners. We hope this research project will contribute helpful information about how mental health settings can better understand and respond to whakamā.

You will be thanked for your participation with a $30 koha (voucher) and provision of kai during the kōrero.

Who is the researcher?

Ko Hikurangi te Maunga
Ko Waiapu te Awa
Ko Tuatini te Marae
Ko Ngāti Porou te Iwi
Ko te Whānau a Ruataupare te Hapū
Ko Horouta te Waka
Ko Karis Knight taku ingoa

Kia Ora, my name is Karis Knight. I am of both Māori and Pākehā descent and whakapapa to different parts of the North Island including the East Coast. I am a 26-year old student studying clinical psychology at the University of Auckland. This research is part of my Doctoral thesis. My Supervisor is Dr Margaret Dudley (Te Rarawa, Te Aupouri, Ngati Kahu) from the School of Psychology at the University of Auckland. I am passionate about exploring how we can make the mental health system in Aotearoa more accessible for our Māori whānau.

What will I be asked in the interview?

In the interview, I will be asking about what whakamā means to you. I will also be asking about any experiences you have had with whakamā. This could include personal experiences or experiences you have had as a consumer of mental health services. I will also ask for your thoughts about how Māori might cope with whakamā and the best ways to support people who are experiencing whakamā. The interview will last for about one to one and a half hours.

Where will the interview take place?

We will complete the interview at a location that is convenient for you. This may include a private room at your community mental health service, a local Marae, your home, a private room at the University of Auckland. If you would prefer to complete the interview through online video chat like Skype or Zoom, this is also possible.

How will my information be recorded?

The interview will be audio recorded and will be transcribed word for word. These recordings will be transcribed by myself or a third party who has signed a confidentiality agreement.

What will happen to my information?

The notes gathered from the interview will be used for my Doctorate thesis. I would also like to use the material for articles for publication. All recorded information will be stored on a password protected University of Auckland computer, backed up by a server. This information will be destroyed after publication.

Can I check my information?

Yes. Once I have written up your interview notes, I will then return them to you for a consultation session. This will allow you to add any thoughts you have had on the information you shared.

Will my clinician know that I am participating in this study?

No. Although you may have received advertising and information about this study from your clinician they will not be told about whether you are participating or not. Participation in this study will not have a negative effect on the support you are receiving from community mental health services.

Will other people know who I am?

No. In writing up the research findings, I will use pseudonyms (false names) and erase or disguise identifiable information like place names, occupation and easily identifiable events.

What if I agree to participate and then change my mind?

You may stop the interview at any time. You may withdraw from the research at any stage without providing a reason up until the time you approve the interview notes to be used. If you do withdraw from the project, any information recorded about you will be immediately returned or destroyed.

Will I be asked to sign anything?

Yes. Before you begin, you will asked to sign a consent form acknowledging that you have been informed about:

- The study
- What you are being asked to do
- What will happen to your information
- Your right to withdraw without being disadvantaged

Are there any risks involved?

Thinking about difficult experiences may be upsetting. Even if you have dealt with these difficulties, there may still be a risk of becoming upset when talking about them. If you think the risk of becoming upset during this research may be a problem for you, it may be better that you do not take part in this study. Or, we can begin and stop if you become uncomfortable. You can have a break and then continue, or stop altogether.

Reducing the risk of harm?

If an issue arises during the interview that means your safety, my safety, or someone else's safety is at risk of harm, I will discuss this with you (the participant) first, and I will also need to discuss this with my Supervisor Dr Margaret Dudley who is a Registered Clinical Psychologist so that the risk of harm can be reduced and we can ensure that you receive further support.

WHERE CAN I GET MORE INFORMATION ABOUT THIS STUDY?

Researcher:
Karis Knight
Email: kkni746@aucklanduni.ac.nz
School of Psychology
The University of Auckland
Private Bag 92019, Auckland

Supervisor:
Dr Margaret Dudley
(09) 923-6869
Email: m.dudley@auckland.ac.nz
School of Psychology
Private Bag 92019
Auckland 1142

Secondary Supervisor:
Dr Kerry Gibson
(09) 923 8556
Email: kl.gibson@auckland.ac.nz
School of Psychology
Private Bag 92019
Auckland 1142

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:
Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz
You can also contact the Health and Disability Ethics Committee (HDEC) that approved this study on:
Phone: 0800 4 ETHICS
Email: hdecs@moh.govt.nz

ACC statement: If you were injured in this study, which is unlikely, you would be eligible to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery. If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

APPROVED BY THE NORTHERN A HEALTH AND DISABILITY ETHICS COMMITTEE ON OCTOBER 24th FOR (3) YEARS REFERENCE NUMBER *18/NTA/164*

Appendix F: Consent Form (Tāngata Whaiora)

Consent Form For Participants

School of Psychology Reception
Building 302, Level 2
Science Centre
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Auckland Central
T +64 9 373 7599
W psych.auckland.ac.nz
E psych@auckland.ac.nz
School of Psychology
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

THIS FORM WILL BE HELD FOR A PERIOD OF 10 YEARS

Project title: From whakamā to whakamana: He aha tēnei?

Researcher(s): Karis Knight, Dr Margaret Dudley, Dr Kerry Gibson

I have read the Participant Information Sheet and I have understood the nature of the research and that my participation is voluntary (my choice). I have had the opportunity to ask questions and have them answered to my satisfaction.

- I understand the interview will take from 1 – 1.5 hours of my time.
- I understand that I will be audio recorded. I understand that this will be transcribed (typed word for word).
- I understand that it is not possible to ask for the recorder to be turned off. However, I can choose to not answer any questions (that is, stay silent) or leave the room, without needing to provide a reason.
- I understand that Karis Knight will transcribe the recording of our interview, but that a third party who has signed a confidentiality agreement may also assist to transcribe the recording.
- I wish / do not wish (please circle) to be a part of a consultation session to review my transcript.
- I understand that although my clinician might have invited me to participate in this research, they will not be told about whether I choose to participate or not.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports, either written or verbal, on this study.
- I agree that extracts from the information I provide may be quoted in any reports which will be written about this research, and also in possible publications and presentations about the research findings, and that this information will be anonymised to protect my identity and privacy.
- I understand that I am free to withdraw my participation at any time. I understand that I am able to withdraw the information I provide up to one month after the interview, without needing to provide a reason.
- I understand that information will be kept for 10 years, in a locked cabinet at the University of Auckland, after which time it will be destroyed.

- I understand that if I indicate that harm is occurring to myself or another person, the researcher will talk with me first, but she will then need to talk with the research supervisor Dr. Margaret Dudley so that the risk of harm can be reduced and ensure that I receive further support.
- I wish / do not wish to receive the summary of findings of this study (expected to be 2021). If yes, please provide either email or postal details below for the summary to be sent to you when it is completed:

Contact Details: ______________________________

Name ______________________

Signature ______________________ Date ______________

Participant Number ________

APPROVED BY THE NORTHERN A HEALTH AND DISABILITY ETHICS COMMITTEE ON OCTOBER 24th FOR (3) YEARS REFERENCE NUMBER *18/NTA/164*

Appendix G: Participant Information Sheet (Peer Support Workers)

From whakamā to whakamana: He aha tēnei?

Information Sheet for Potential Participants

School of Psychology Reception
Building 302, Level 2
Science Centre
23 Symonds Street
Auckland Central
T +64 9 373 7599
W psych.auckland.ac.nz
E [illegible]
School of Psychology
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

PARTICIPANT INFORMATION SHEET

What is the project about?

Whakamā is a Māori word that has no English translation but may loosely mean shyness, embarrassment, or shame. The overall purpose of this research project is to increase knowledge about what whakamā means to Māori, how whakamā affects experiences with mental health services, and how Māori cope with whakamā. We will be interviewing Māori who are getting support from mental health services and Māori mental health practitioners across a range of professions. These will include nurses, psychologists, psychiatrists, social workers, and peer support workers. We hope this research project will contribute helpful information about how mental health settings can better understand and respond to whakamā.

Who is the researcher?

Ko Hikurangi te Maunga
Ko Waiapu te Awa
Ko Tuatini te Marae
Ko Ngāti Porou te Iwi
Ko te Whānau a Ruataupare te Hapū
Ko Horouta te Waka
Ko Karis Knight taku ingoa

Kia Ora, my name is Karis Knight. I am of both Māori and Pākehā descent and whakapapa to different parts of the North Island including the East Coast. I am a 27-year old student studying clinical psychology at the University of Auckland. This research is part of my Doctoral thesis. My Supervisor is Dr Margaret Dudley (Te Rarawa, Te Aupouri, Ngati Kahu) from the School of Psychology at the University of Auckland. I am passionate about exploring how we can make the mental health system in Aotearoa more accessible for our Māori whānau.

What will I be asked in the interview?

In the interview, I will be asking about what whakamā means to you. I will also be asking about any experiences you have had with whakamā. This could include personal experiences or prior experiences you had as a consumer of mental health services. I will also ask for your thoughts about how Māori might cope with whakamā and the best ways to support people who are experiencing whakamā. The interview will last for about one to one and a half hours.

Where will the interview take place?

We will complete the interview at a location that is convenient for you. This may include your home, in a private room at your community mental health service, a local Marae, a booked room at a community centre, a private room at the University of Auckland. If you would prefer to complete the interview through online video chat like Skype or Zoom, this is also possible.

How will my information be recorded?

The interview will be audio recorded and will be transcribed word for word. These recordings will be transcribed by myself or a third party who has signed a confidentiality agreement.

What will happen to my information?

The notes gathered from the interview will be used for my Doctorate thesis. I would also like to use the material for articles for publication. All recorded information will be stored on a password protected University of Auckland computer, backed up by a server. This information will be destroyed after publication.

Can I check my information?

Yes. Once I have written up your interview notes, I will then return them to you for a consultation session. This will allow you to add any thoughts you have had on the information you shared.

How can I access the findings of this research?

There is a section of the Consent Form that asks if would like to access a summary of findings for this research project. If you are interested, there is space to provide contact details (email or postal address) to receive these. It is expected that a summary of findings will be available by the end of 2020.

Will other people know who I am?

No. In writing up the research findings, I will use pseudonyms (false names) and erase or disguise identifiable information like place names, occupation and easily identifiable events.

What if I agree to participate and then change my mind?

You may stop the interview at any time. You may withdraw from the research at any stage without providing a reason up until the time you approve the interview notes to be used. If you do withdraw from the project, any information recorded about you will be immediately returned or destroyed.

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Will I be asked to sign anything?

Yes. Before you begin, you will asked to sign a consent form acknowledging that you have been informed about:

- The study
- What you are being asked to do
- What will happen to your information
- Your right to withdraw without being disadvantaged

Are there any risks involved?

Thinking about difficult experiences may be upsetting. Even if you have dealt with these difficulties, there may still be a risk of becoming upset when talking about them. If you think the risk of becoming upset during this research may be a problem for you, it may be better that you do not take part in this study. Or, we can begin and stop if you become uncomfortable. You can have a break and then continue, or stop altogether.

Reducing the risk of harm?

If an issue arises during the interview that means your safety, my safety, or someone else's safety is at risk of harm, I will discuss this with you (the participant) first, and I will also need to discuss this with my Supervisor Dr Margaret Dudley who is a Registered Clinical Psychologist so that the risk of harm can be reduced and we can ensure that you receive further support.

WHERE CAN I GET MORE INFORMATION ABOUT THIS STUDY?

Researcher:
Karis Knight
Email: kkni746@aucklanduni.ac.nz
School of Psychology
The University of Auckland
Private Bag 92019, Auckland

Supervisor:
Dr Margaret Dudley
(09) 923-6869
Email: m.dudley@auckland.ac.nz
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Secondary Supervisor:
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If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

You can also contact the Health and Disability Ethics Committee (HDEC) that approved this study on:

Phone: 0800 4 ETHICS
Email: hdecs@moh.govt.nz

ACC statement: If you were injured in this study, which is unlikely, you would be eligible to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery. If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

Appendix H: Consent Form (Peer Support Workers)

Consent Form For Participants

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The University of Auckland
Private Bag 92019
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THIS FORM WILL BE HELD FOR A PERIOD OF 10 YEARS

Project title: From whakamā to whakamana: He aha tēnei?

Researcher(s): Karis Knight, Dr Margaret Dudley, Dr Kerry Gibson

I have read the Participant Information Sheet and I have understood the nature of the research and that my participation is voluntary (my choice). I have had the opportunity to ask questions and have them answered to my satisfaction.

- I understand the interview will take from 1 – 1.5 hours of my time.
- I understand that I will be audio recorded. I understand that this will be transcribed (typed word for word).
- I understand that it is not possible to ask for the recorder to be turned off. However, I can choose to not answer any questions (that is, stay silent) or leave the room, without needing to provide a reason.
- I understand that Karis Knight will transcribe the recording of our interview, but that a third party who has signed a confidentiality agreement may also assist to transcribe the recording.
- I wish / do not wish (please circle) to be a part of a consultation session to review my transcript.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports, either written or verbal, on this study.
- I agree that extracts from the information I provide may be quoted in any reports which will be written about this research, and also in possible publications and presentations about the research findings, and that this information will be anonymised to protect my identity and privacy.
- I understand that I am free to withdraw my participation at any time. I understand that I am able to withdraw the information I provide up to one month after the interview, without needing to provide a reason.
- I understand that information will be kept for 10 years, in a locked cabinet at the University of Auckland, after which time it will be destroyed.
- I understand that if I indicate that harm is occurring to myself or another person, the researcher will talk with me first, but she will then need to talk with the research supervisor Dr. Margaret Dudley so that the risk of harm can be reduced and ensure that I receive further support.

- I wish / do not wish to receive a summary of findings for this study (expected to be end of 2020). If yes, please provide either email or postal details below for the summary to be sent to you when it is completed:

Contact Details: ______________________________

Name ____________________

Signature ____________________ Date ____________

Participant Number ________

APPROVED BY THE NORTHERN A HEALTH AND DISABILITY ETHICS COMMITTEE ON OCTOBER 24th FOR (3) YEARS REFERENCE NUMBER *18/NTA/164*

Appendix I: Interview Schedule (Practitioners)

Interview Schedule – Practitioners

Building 721, Level 3
261 Morrin Road, St Johns
Auckland
T +64 9 373 7599
W psych.auckland.ac.nz
E psych-admintamaki@auckland.ac.nz
School of Psychology
The University of Auckland
Tamaki Innovation Campus
Private Bag 92019
Auckland 1142
New Zealand

Mihi whakawātea

Karakia (spiritual acknowledgement), mihimihi (introduction to each other and what will happen), whakawhanaungatanga (relationship building), provision of Kai.

Preamble

Thank you for taking the time to kōrero with me and share your whakaaro (thoughts) on whakamā. I am hoping that this study will provide a better understanding of what it means to experience whakamā and how we can best support and respond to whakamā in mental health settings. I hope that the insights you share today will contribute to further development of services that are more responsive to the needs of Māori. So, thank you for agreeing to be part of this research. Arohanui ki a koe.

The next few questions are gathered to ensure that information about the people involved in this study is accurately reported. I want to reassure you that your privacy will be protected throughout this research. Information will be used to generally describe the people who have participated. For example, 25 people aged 20-85 years old participated in this study.

Structured Questions (NB. the following questions are structured to elicit demographic information and lead into the semi structured aspect of the interview)

1. Age: ___________
2. Gender identification: ______________________________________
3. Iwi and hapū links: ____
4. Role: ____
5. Years of professional experience: __________________________

Semi Structured Questions. These bullet pointed questions are a guide to prompt discussion with regard to:

(What do Māori understand to be the place of whakamā in Māori experiences of psychological distress?)

- What does whakamā mean to you?
- How does whakamā specifically relate to Māori experiences of distress?
- What is the place of whakamā in mental health settings/in general?

(How do Māori recognize and describe the experience of whakamā? How do Māori describe and experience the consequences and effects of whakamā?)

- Can you recall any experiences you have had with whakamā as a practitioner working with Māori?
    - How did you know it was whakamā?
        - Thoughts? Feelings? Sensations? Behaviours? Physical presentation?
    - What happened before, during, and after?
    - What did you or the service do to whakamana the individual/s?
- How would you describe the consequences of whakamā?
    - In general? In mental health settings?
    - Good? Bad?

(How can the mana of those experiencing whakamā be enhanced and what are the clinical implications of whakamā?)

- How do Māori cope with whakamā?
    - Individual factors? Whānau factors? System factors?
- How can we whakamana those experiencing whakamā?
    - Community? Whānau? Service? Practitioner?

Whakamutunga (end of interview process)

Thank you for your time and for sharing your whakaaro (thoughts) about this topic. Before we finish, is there anything else you would like to say about what we have talked about today? Do you have any questions before we finish? Is there anything you would like to say about how the interview has gone (feedback)?

Karakia whakmutunga

Appendix J: Interview Schedule (Tāngata Whaiora)

SCIENCE
SCHOOL OF PSYCHOLOGY

Interview Schedule –
Tangata Whaiora

Building 721, Level 3
261 Morrin Road, St Johns
Auckland
T +64 9 373 7599
W psych.auckland.ac.nz
E psych-admintamaki@auckland.ac.nz
School of Psychology
The University of Auckland
Tamaki Innovation Campus
Private Bag 92019
Auckland 1142
New Zealand

Mihi whakawātea
Karakia (spiritual acknowledgement), mihimihi (introduction to each other and what will happen), whakawhanaungatanga (relationship building), provision of Kai.

Preamble
Thank you for taking the time to talk to me and share your whakaaro (thoughts) on whakamā. I am hoping that this study will provide a better understanding of what it means to experience whakamā and how we can best support and respond to whakamā within mental health settings. I hope that the insights you share today will contribute to further development within psychological, health and social services that are more culturally and socially responsive to the needs of Māori. Thank you very much for agreeing to be part of this research. Arohanui ki a koutou.

The next few questions are gathered to ensure that information about the people involved in this study is accurately reported. I want to reassure you that your privacy will be protected throughout this research. Please know that you, your whānau members or any services you are involved with will not be identified in any report. Information will be used to generally describe the people who have participated. For example, 25 people aged 20-85 years old participated in this study.

Structured Questions (NB. the following questions are structured to elicit demographic information and lead into the semi structured aspect of the interview)

1. Age: ____________
2. Gender identification: ______________________________________
3. Iwi and hapū links: ____

SCIENCE
SCHOOL OF PSYCHOLOGY

Semi Structured Questions. These bullet pointed questions are a guide to prompt discussion with regard to:

(What do Māori understand to be the place of whakamā in Māori experiences of psychological distress?)

- What does whakamā mean to you?
- What are some things that make whakamā a specifically Māori experience?
  - Historical? Current?

(How do Māori recognize and describe the experience of whakamā? How do Māori describe and experience the consequences and effects of whakamā?)

- Can you recall any experiences you have had with whakamā?
  - As someone accessing mental health services?
  - Personal experiences?
  - Whānau experiences?
- How did you know it was whakamā?
  - Thoughts? Emotions? Sensations? Behaviours?
- What happened?
  - Before? During? After?
- Did the experience have any ongoing consequences or effects for you?
  - Good? Bad?
- What helped and how did you move forward?
  - Individual factors? Whānau factors? System factors?

(How can the mana of those experiencing whakamā be enhanced and what are the clinical implications of whakamā?)

- Is there anything you would like mental health workers to know about whakamā?
- Is there anything you would like mental health workers to know about how to support those who are feeling whakamā?

Whakamutunga (end of interview process)

Thank you for your time and for sharing your whakaaro (thoughts) about this topic. Before we finish, is there anything else you would like to say about what we have talked about today? Do you have any questions before we finish? Is there anything you would like to say about how the interview has gone (feedback)?

Karakia whakmutunga

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